OGC 7855

LAW OFFICES
MANATT, PHELPS & PHILLIPS
A PARTNERSHIP INCLUDING PROFESSIONAL CORPORATIONS
1200 NEW HAMPSHIRE AVENUE, N.W.
SUITE 200
WASHINGTON, D.C. 20036

TELEPHONE (202) 463-4300
FAX (202) 463-4394
(202) 463-4395

LOS ANGELES
11355 WEST OLYMPIC BOULEVARD
LOS ANGELES, CALIFORNIA 90064
(213) 312-4000

September 17, 1990

Lawrence M. Noble, Esq.
General Counsel
Office of the General Counsel
Federal Election Commission
999 E Street, N.W.
Washington, D.C. 20463

AOR 1990-22

Re: Request for an Advisory Opinion

Dear Mr. Noble:

On behalf of the Blue Cross and Blue Shield Association ("BCBSA"), we hereby request an advisory opinion pursuant to 2 U.S.C. § 437f. This request relates to BCBSA's corporate status for purposes of the Federal Election Campaign Act of 1971, as amended, ("Act") 2 U.S.C. § 431 et seq., and specifically, whether BCBSA may establish a payroll deduction program to solicit contributions from the executive and administrative personnel of licensed Blue Cross and Blue Shield Plans for the BCBSA separate segregated fund ("SSF"), CarePAC.

Factual Background

BCBSA is a nonprofit corporation formed in 1982 under the laws of the State of Illinois upon the merger of the Blue Cross Association and Blue Shield Association[1/]. BCBSA is exempt from taxation as a social welfare organization described in 26 U.S.C. § 501(c)(4) of the Internal Revenue Code.

1. Blue Cross and Blue Shield System

BCBSA is the national association that licenses Blue Cross and Blue Shield Plans throughout the United States. No person may use the Blue Cross and Blue Shield names or symbols (the

---

1/ Copies of the BCBSA Articles of Incorporation and By-Laws are attached to this request. Exhibit A. The BCBSA By-Laws were recently amended at a meeting of the Plans held in June 1990. These amendments will be effective January 1, 1991. For the Commission's information, we also have attached copies of the revised By-Laws. Exhibit B.

"service marks") unless it is granted that right pursuant to a Licensing Agreement with BCBSA or an approved sublicense with a licensee. Copies of the current and revised Licensing Agreements, to be effective January 1, 1991, are attached to this request. Exhibits C and D. The license to use the Blue Cross and Blue Shield service marks is contingent upon compliance with licensing and membership standards established and monitored by BCBSA.

BCBSA is governed by a Board composed of representatives from Regular Member Plans throughout the United States. There are three categories of "Member" Plans, regular, associate and affiliate. There are currently 74 Regular Member Plans, 9 Associate Member Plans and 3 Affiliate Member Plans. Regular Member Plans (those inside the United States) have full voting rights; Associate Member Plans (those outside the United States) have voting rights, except for membership on the Board of Directors; and Affiliate Members have no voting rights.[2/] Dues are determined on the basis of Plan enrollment, and voting rights are based on the amount of dues paid. Overall, the BCBSA system employs approximately 120,000 people and has over 72 million subscribers.

In order to become a Member, a Plan must be found in substantial compliance with the membership standards. Approval of a majority of the BCBSA Board is required to become a Member Plan and a 2/3 majority is required to revoke membership. Each Plan's right to maintain its membership status must be renewed annually after a finding that the Plan is in substantial compliance with the BCBSA By-Laws and the applicable membership standards. The membership standards include the following:

1. A Plan shall be organized on a not-for-profit basis;

2. A Plan's activity shall be directed principally to health care financing and delivery;

3. A Plan shall maintain a governing board composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care providers, nor be a member of a profession which provides health care services;

2/ BCBSA intends only to solicit contributions from executive and administrative personnel employed by Regular Member Plans in the United States.

4. A Plan shall be operated in a manner responsive to the marketplace; and

5. A Plan shall maintain adequate financial resources to protect the interests of its subscribers.

Other standards relate to cooperative measures between Blue Cross and Blue Shield Plans and between Blue Cross and Blue Shield Plans and BCBSA. There are currently ten standards, seven of which are considered core standards. The revised membership standards, to be effective January 1, 1991, have been consolidated into seven standards. Copies of the current membership standards and guidelines for their interpretation and the revised membership standards are attached as Exhibits E and F.

Under its By-Laws, BCBSA may on its own initiative audit all records of regular Member Plans and may study performance, enrollment, finance, utilization and other subjects of any Member Plan. If, during the course of the annual review or at any time during the year, any Plan is found to be in non-compliance with one standard, its membership status becomes "conditional." If that Plan is not brought into full compliance within a specified period, its license and membership may be revoked.

The authority to grant and revoke membership and licensure to use the Blue Cross and Blue Shield service marks and to review compliance with the licensing and membership standards vests BCBSA with a significant amount of control over the Plans even though BCBSA does not ordinarily interfere with day-to-day management of the Plans.[3/] For example, under the authority of Article II, Section 8 of the By-Laws, BCBSA may review any aspect of a Plan's activities or management. If a review of a Plan's performance demonstrates the need for management or operational changes, BCBSA may recommend those changes to the Plan Board. If, in the opinion of the BCBSA Board, failure to follow these recommendations results in non-compliance with membership standards, that Plan's membership and license can be revoked.

Plans are organized under and regulated by state insurance commissioners pursuant to special state enabling legislation governing the operations of nonprofit plans for the prepayment of health care services. Twelve Plans are regulated as nonprofit

---

3/ Pursuant to the By-Laws and License Agreements to be effective January 1, 1991, membership and licensure may be revoked only by the vote of three-fourths of the regular Member Plans.

mutual insurers and two as nonprofit stock insurers.[4/] Under many enabling Acts, Plans must receive approval from the state insurance commissioner before they change rates or benefits.

Each Plan is organized locally and operates autonomously within the standards set by BCBSA. BCBSA licenses Plans to use the Blue Cross and Blue Shield service marks in exclusive service areas. The Plans contract with local hospitals, physicians, and other health care providers to provide pre-paid health care services to subscribers. This structure enables the Plans to provide coverage tailored to the needs and based upon the health care costs of each community.

While each Plan operates autonomously, there are significant links among the Plans and between the Plans and BCBSA. In addition to the centralized administrative and operational services provided to the Plans by BCBSA and described below, in many respects the Blue Cross and Blue Shield system appears to its subscribers and operates, insofar as they are concerned, as a single corporate entity. Thus, for example, subscribers moving from one Plan area to another may transfer to the new local Plan without interrupting their coverage, and subscribers who encounter medical needs while outside their Plan area receive treatment through the local Plan where their medical needs arise. Through BCBSA, these claims between Plans are processed without additional burden to the subscriber.

2. Role of BCBSA

BCBSA plays a key centralized role in the management and administration of the Blue Cross and Blue Shield system. BCBSA acts in a dual role, performing both administrative and operational functions. BCBSA functions as the owner and licensor of the Blue Cross and Blue Shield service marks, monitors compliance with the licensing agreements and polices service mark infringements. In addition to developing, maintaining and enforcing the licensing and membership standards, BCBSA provides a variety of support services to its Member Plans. These support services include representing the Blue Cross and Blue Shield system's interest in Congress and the courts, and providing research, actuarial and other services. BCBSA also serves a central informational function for the Plans, coordinating public education and professional relations programs, maintaining a computerized telecommunications

---

4/ Copies of the enabling legislation, articles of incorporation and by-laws governing the operations of two Plans are attached to this request: Kansas, and Michigan. The State enabling Acts do not contain the name Blue Cross and Blue Shield because the right to use the name may be obtained only through a Licensing Agreement with BCBSA. Exhibits G and H.

system linking the Plans, providing marketing assistance and product development services, and transmitting claims between Plans.

BCBSA provides centralized liaison with key national organizations and groups that affect Plans, such as the Federal government, business, labor and health organizations. BCBSA also serves as Plan liaison to organizations such as the National Association of State Insurance Commissioners. Member Plans pay dues monthly to BCBSA based upon their number of subscribers. In addition, special assessments on Member Plans may be levied to fund specific, discrete projects and activities.

Organizationally, BCBSA provides centralized management of various BCBSA Plan employee benefit programs, such as the National Retirement Program, the Long Term Disability Program and the Group Life Insurance Program. Under power of attorney from the Plans, BCBSA contracts with the Office of Personnel Management on behalf of its Member Plans to provide the Government-wide Service Benefits Plan to federal employees under the Federal Employees Health Benefits Act of 1959, as amended (5 U.S.C. § 8901-8914), and is the prime contractor with the Health Care Finance Administration ("HCFA") for the provision of administrative services with respect to Part A of the Medicare Program. BCBSA also serves as a facilitator under Medicare Part B and CHAMPUS. As an integral part of these activities and contractual relationships, there is an extensive flow of funds between Plans and BCBSA.

In addition to these regular administrative and operational services, BCBSA periodically develops and implements special programs for the benefit of Member Plans and their subscribers. Under one current program, BCBSA is reviewing medical facilities throughout the country to identify those health care providers which are "centers of excellence" in providing efficient and successful organ transplants.

BCBSA has a political committee ("CarePAC") registered with the Federal Election Commission as the separate segregated fund of a membership organization. Eleven Plans have federal political committees as well. Some Plans also have political committees organized to operate only at the state and local levels. Presently, each Plan political committee is considered and treated as affiliated with the other committees.

In sum, BCBSA is a non-profit, non-stock corporation that licenses entities meeting specific performance and quality standards to use the Blue Cross and Blue Shield service marks in exclusive areas, while also performing various other functions designed to facilitate the operations of the Blue Cross and Blue Shield system.

Questions Presented

1. May CarePAC, the Blue Cross and Blue Shield Association's PAC, directly solicit contributions from the executive and administrative employees of the Blue Cross and Blue Shield Regular Member participating Plans?

2. Alternatively, may representatives of the Plans be designated as collecting agents under 11 C.F.R. §§ 114.5(k) and 102.6 (c)(2), and raise contributions on behalf of CarePAC and transfer them to CarePAC?

Legal Discussion

Corporate Regulation Under the Act

The Act and the FEC regulations implementing the corporate prohibition of 2 U.S.C. § 441b essentially divide corporations into the following categories: corporations with capital stock, corporations without capital stock, national banks, incorporated membership organizations, incorporated trade associations, and incorporated cooperatives. 2 U.S.C. § 441b; 11 C.F.R. Part 114. The Commission has long recognized that the provisions concerning operation of political committees, solicitation of contributions, and corporate communications differ depending upon the type of corporation.

The Blue Cross and Blue Shield system does not easily fit into any of the 441b categories. In some respects, it resembles several of the corporate structures, but in other respects it resembles none. A corporation that does not fall within one of the specific categories above is covered by the general regulations governing corporate activity. BCBSA believes that, based upon the unique structure of the Blue Cross and Blue Shield system and the relationship of BCBSA with the licensed Blue Cross and Blue Shield Plans, BCBSA does not fit into any of the specific corporate structures identified in Section 441b, and thus that BCBSA is covered by the general corporate provisions of the Act.

1. General Corporate Provisions

a. Licensees

While the Act does not specifically refer to corporate licensor/licensee and franchiser/franchisee structures, the Commission has on a number of occasions analyzed such corporate relationships. Based upon prior Commission opinions, the unique structure of the BCBSA system appears most analogous to a licensor/licensee relationship. The Commission has previously addressed this type of relationship in the context of

franchiser/franchisees and found that, based on the degree of control exercised over a licensee, the franchiser's political committee may solicit the executive and administrative personnel of the franchisees. AOs 1979-38, 1978-61, and 1977-70. In AO 1979-38 issued to Hardee's Food Systems, Inc., the Commission relied on Hardee's continuing control of franchisees' business practices, the franchisees' compliance with certain standards and policies, and the extent of the contractual obligations under the licensing agreement. Id.[5/]

Similarly, the BCBSA exhibits a significant degree of control over its Member Plans. No Plan may become a Member Plan without approval of the BCBSA Board. Every Member Plan must be licensed by BCBSA to use the Blue Cross and Blue Shield service marks and to maintain BCBSA membership, and must comply with the membership and licensing standards set by BCBSA. The BCBSA Board reviews each Plan annually for compliance with the membership standards and licensing requirements. Moreover, BCBSA has the authority under its By-Laws and the Licensing Agreement to exercise a significant amount of control over the Plans since failure to implement the recommendations of BCBSA can result in revocation of a Plan's license and membership.

Further, there are extensive contractual relationships between BCBSA and the Plans, including those related to the Federal employees program and Medicare, as well as the benefit programs available to Blue Cross and Blue Shield employees. It is through BCBSA and its centralized operations that individual Plan subscribers can receive uninterrupted coverage when transferring from one Plan to another and when in need of care outside their Plan area. These contractual relationships result in a substantial flow of funds among the Plans and BCBSA.

Thus, as described more fully in the Factual Background section of this request, there are significant licensure and regulatory ties between BCBSA and the Plans. These ties should permit BCBSA and the Plans to be treated as licensor/licensees under the Act and allow for the solicitation of executive and administrative personnel of all of the Plans directly for contributions to CarePAC.

b. Corporations Without Capital Stock

Alternatively, BCBSA may be deemed a corporation without capital stock and the Member Plans would be considered subsidiaries, affiliates or local units of the "parent"

5/ The Commission applied a similar analysis in two prior requests (from McDonald's and Jerrico) and reached the same result. AOs 1978-61 and 1977-70.

corporation.6/ If BCBSA is treated as a corporation without capital stock, and the state Plans are considered subsidiaries, affiliates or local units, then the general corporate solicitation provisions would apply.

Under the general corporate regulations, a corporation may solicit contributions from the executive and administrative personnel of its subsidiaries, branches, divisions and affiliates and their families. 11 C.F.R. § 114.5(g)(1). The Commission interprets the regulations as permitting "contribution solicitation rights in a corporate context [to] go downstream (parent to subsidiary), upstream (subsidiary to parent), and between subsidiaries of the same parent corporation." Advisory Opinions 1982-19, 1980-18, 1979-44, 1978-75." AO 1987-34.

Thus, if it is determined that the relationship between BCBSA and the Plans is materially different from the licensor-licensee relationships considered by the Commission in AOs 1979-38, 1978-61 and 1977-70, then BCBSA is seeking FEC approval to treat the state Plans as affiliates, local subsidiaries or units of a corporation. As a result, BCBSA could solicit the executive and administrative personnel of all of the Plans directly for contributions to CarePAC, as well as communicate directly with these employees. Those Plans that wish to continue to operate their own political committees could do so. As they are now, those committees would continue to be affiliated committees subject to shared limits on receipts and on contributions made to candidates.

BCBSA belives that the Member Plans may properly be considered affiliates, subsidiaries or local units since they are all part of the Blue Cross and Blue Shield system governed by BCBSA. Each Plan operates in an exclusive local service area as granted by BCBSA. As a result of the significant interconnection among the Plans and between Plans and BCBSA in providing benefits to subscribers and handling national accounts such as the Federal employee program, operationally the Blue Cross and Blue Shield system is much like a national corporation with local affiliates. Therefore, treatment of the Plans as affiliates, local subsidiaries or local units of a non-stock corporation would be appropriate under the Act.

2. Membership Organizations

BCBSA believes its unique system to be most analogous to a licensor/licensee relationship or a non-stock corporation with

---

6/ The FEC regulations do not define "corporation without capital stock." This category presumably covers those nonstock corporations that are neither membership organizations nor trade associations.

local units.7/ However, both the Articles of Incorporation and By-Laws of BCBSA describe the Blue Cross and Blue Shield Plans as "members." BCBSA is a 501(c)(4) corporation, though not all corporations with 501(c)(4) status under tax law are "membership organizations" under the FECA.

Despite the reference to "members" in these corporate documents, BCBSA, in several significant respects, is unlike a traditional membership organization as contemplated by the FEC in its regulations. BCBSA has the exclusive authority to license Blue Cross and Blue Shield Plans. "Membership" in BCBSA is neither voluntary nor automatic. A Plan must be a member in order to participate as a Blue Cross and Blue Shield Plan, and membership is subject to review and approval by the BCBSA Board. Further, although BCBSA and its Member Plans are non-profit, the Plans are all in the business of providing pre-paid health care services, and therefore operate as business corporations. Finally, unlike voluntary membership organizations, the creation of Plans is governed by special State enabling Acts and they are regulated by the State insurance commissions, as are insurance companies.

If the Commission were to consider BCBSA as a membership organization, notwithstanding its hybrid and unique structure, it would not then be able to operate as requested above. Generally, a membership organization with incorporated members may solicit contributions from its own individual (non-corporate) members and its own executive and administrative personnel and their families

---

7/ None of the other 441b categories appear to fit the BCBS system. BCBS does not have capital stock and is neither a national bank nor an incorporated cooperative. BCBSA is not a trade association, i.e., not a "business association organized under 26 U.S.C. § 501(c)(6)." The Explanation and Justification of the FEC Regulations explaining the definition of "trade association" states that the term is defined by reference to 26 U.S.C. § 501(c)(6)." E&J of 11 C.F.R. § 114.8 as printed in 1 Fed. Elec. Camp. Fin. Guide (CCH) ¶ 923, p. 1608. Unlike trade associations, BCBSA controls the standards of membership for BCBS Plans and, in order to use the BCBS service mark a Plan must be a member. In its role as prime contractor for Medicare Part A and in coordinating services for the provision of health care benefits to federal employees by its Member Plans, BCBSA itself provides services unlike a trade association, which ordinarily does not engage in the business (whether for profit or not-for-profit) engaged in by its members.

but not from the executive and administrative personnel of its corporate members. 11 C.F.R. § 114.5 and 114.7.[8/]

If the Commission determines that BCBSA is nonetheless a membership organization, the same end result as requested above could be achieved through the Commission's collecting agent regulations. Therefore, while it would be much more cumbersome for BCBSA, alternatively, our request is that BCBSA be permitted to operate as follows. Specifically, BCBSA seeks to receive funds contributed by the executive and administrative personnel of Plans through (1) the designation of Plan representatives as "collecting agents" and (2) the transfer of funds between "affiliated" committees established by BCBSA and the Plans.[9/]

For those Plans having federal committees, the Plan PAC would conduct its own solicitation of personnel and then make lump sum transfers to CarePac as an affiliated committee. Transfers between affiliated committees are unlimited. 11 C.F.R. § 102.6(a)(1). The general rules on corporate solicitations would apply to Plan solicitations for contributions to a separate segregated fund. 11 C.F.R. § 114.5. Contributions would be itemized and reported by the Plan PAC soliciting the contributions. 11 C.F.R. § 104.3(a)(2). The amounts transferred to CarePac would be reported as lump sum transfers. 11 C.F.R. § 104.3(a)(2)(v). All contributions received and made by CarePac and all Plan PACs would be aggregated and monitored for compliance with the joint contribution limits.

Plans in those states without Federal committees would operate as collecting agents for CarePac. These solicitations would be carried out in accordance with the procedures set forth in 11 C.F.R. § 102.6, permitting an organizational entity or committee that is related to the connected organization of a separate segregated fund to serve as a "collecting agent" for that separate segregated fund. 11 C.F.R. § 102.6(b)(1). A parent, subsidiary, branch, division, department, or local unit of the connected organization may serve as a collecting agent. 11 C.F.R. § 102.9(b)(1)(iii). For example, in AO 1983-36, the Commission found that the state nurse anesthetist associations may act as collecting agents for the American Association of Nurse

---

8/ Similarly, a membership organization is prohibited from soliciting contributions from the political committees established by its corporate members, although it is permitted to accept unsolicited contributions from those political committees. 11 C.F.R. § 114.7(j).

9/ Under both methods of operation, contributions would be received by the Plans through payroll deductions. 11 C.F.R. §§ 114.5(k) and 102.6(c)(2).

Anesthetists, based on the conclusion that the state associations operate as subsidiaries or local units of AANA. The factors identified by the Commission as demonstrating the requisite relationship included common membership, interconnected directorates and funding flowing from the national association to the state associations. Id.

Here, the Plans all have representation on the BCBSA Board. BCBSA licenses Plans and establishes and monitors compliance with membership standards, and there is a substantial flow of funds between BCBSA and the Plans. Thus, the Plans are established and operate as "local units" of BCBSA, making them eligible to be collecting agents. Under the collecting agent provisions a Plan, either through its non-federal political committee or directly, would solicit its own executive and administrative personnel for contributions, and transfer them to CarePac, the BCBSA PAC, without the Plan or its committee incurring any registration or reporting obligations under the Act.

In conclusion, BCBSA requests that the Commission permit it to solicit the executive and administrative personnel of the Plans for contributions to CarePAC. Given the BCBSA structure and operation, we believe this plan will be in full compliance with the letter and spirit of the Federal Election Campaign Act. Alternatively, BCBSA requests the Commission's approval of the designation of the Plans as collecting agents for CarePAC.

If you have any additional questions, please contact us.

Sincerely,

Lyn Utrecht

Lyn Utrecht
Eric F. Kleinfeld
Manatt, Phelps & Phillips

Exhibits
A. BCBSA Association Articles of Incorporation & Bylaws
B. BCBSA Bylaws (Revised)
C. License Agreement (Current)
D. License Agreement (Revised)
E. Membership Standards & Guidelines (Current)
F. Membership Standards (Revised)
G. Kansas - Enabling Act, Articles of Incorporation & Bylaws
H. Michigan - Enabling Act, Articles of Incorporation & Bylaws

Exhibit A

Blue Cross and Blue Shield Association

Articles of Incorporation and Bylaws

for

Blue Cross and Blue Shield Association

January 1988

ARTICLES OF INCORPORATION
OF
BLUE CROSS AND BLUE SHIELD ASSOCIATION

(As filed December 28, 1948 and as amended by Articles of Amendment dated July 11, 1956 and by the Articles of Merger with Blue Shield Association dated June 23, 1982)

To: EDWARD J. BARRETT,
Secretary of State
Springfield, Illinois

We, the undersigned

Paul R. Hawley, 425 N. Michigan Ave., Chicago, Illinois

Richard M. Jones, 425 N. Michigan Ave., Chicago, Illinois

Antone G. Singsen, 425 N. Michigan Ave., Chicago, Illinois

being natural persons of the age of twenty-one or more and citizens of the United States, for the purpose of forming a corporation under the "General Not for Profit Corporation Act" of the State of Illinois, do hereby adopt the following Articles of Incorporation:

1. The name of the corporation is BLUE CROSS AND BLUE SHIELD ASSOCIATION.

2. The period of duration of the corporation is perpetual.

3. The address of its initial Registered Office in the State of Illinois is 425 N. Michigan Ave., in the City of Chicago, County of Cook, and the name of its initial Registered Agent at said address is Paul R. Hawley.

4. The first Board of Governors shall be 15 in number, their names and addresses being as follows:

E. Dwight Barnett, M.D. 3825 Brush Street Detroit 1, Michigan	Fredric P. G. Lattner Liberty Building Des Moines 7, Iowa	Richard O. Parker 214 Peoples Bank Building Canton 2, Ohio
J. Douglas Colman 15 East Fayette Street Baltimore 3, Maryland	Edson P. Lichty 11 South LaSalle Street Chicago 90, Illinois	Louis H. Pink 80 Lexington Avenue New York 16, New York
Edward Groner American Bank Building New Orleans, 12, Louisiana	Basil C. MacLean, M.D. 260 Crittenden Boulevard Rochester 7, New York	Oliver G. Pratt 593 Eddy Street Providence 2, Rhode Island
F. Kenneth Helsby 1021 McGee Street Kansas City 6, Missouri	E. Duncan Millican 1200 St. Alexandre Street Montreal 2, Quebec	Stanley H. Saunders 31 Canal Street Providence 3, Rhode Island
Robert E. Johnson Wellman Building Jamestown, New York	Abraham Oseroff Farmers Bank Building Pittsburgh 22, Pennsylvania	Ralph Walker 431 South Fairfax Avenue Los Angeles 54, California

5. The purposes of the corporation are to promote the betterment of public health and security, to secure the widest public acceptance of the principles of voluntary, nonprofit prepayment of health service, to protect the Blue Cross and Blue Shield words and symbols, to develop and maintain membership standards for the corporation, to cooperate with federal, state and local governments in providing health services to the needy and aged, to establish and maintain support and other services to Members through the exercise of authority delegated by the Members, and to conduct its affairs, carry on its operations, and have offices within and without the State of Illinois, and to exercise the powers granted by the General Not for Profit Corporation Act of the State of Illinois. Inherent in its purpose is a recognition that Member Plans are, and should be autonomous in their operation and that the needs, facilities, resources and practices of their respective areas shall be given due consideration.

6. No part of the net earnings of the corporation shall inure to the benefit of any Member. Upon any dissolution or final liquidation of the corporation, whether voluntary or involuntary, no part of its assets shall be paid or distributed to or for the benefit of any Member. Said assets shall be applied and distributed, first, to the payment and discharge of all liabilities and obligations of the corporation, second, to the return, transfer or conveyance of assets held by the corporation upon condition requiring return, transfer or conveyance by reason of dissolution of the corporation and third, the balance, if any, shall be transferred and conveyed to one or more corporations, societies or organizations, wherever organized or operating, engaged not for profit in the advancement of health service, pursuant to a plan of distribution adopted in accordance with the Illinois General Not for Profit Corporation Act.

Paul R. Hawley
Richard M. Jones
Antone G. Singsen
Incorporators

Original filed December 28, 1948;
Amended July 11, 1956 and
June 23, 1982.

BYLAWS
BLUE CROSS & BLUE SHIELD ASSOCIATION

ARTICLE I
NAME AND PURPOSE

Section 1. Name. The name of this corporation is BLUE CROSS AND BLUE SHIELD ASSOCIATION, herein referred to as "the Association."

Section 2. Purposes. The purposes of the Association are:

a. To promote the betterment of public health and security, and to secure wide public acceptance of the principle of voluntary, nonprofit prepayment of health services by:

1. Promoting the commonality of objectives and collective capacity of Members, exchanging information of common interest, developing and securing Member acceptance of programs of joint action, and increasing the effective performance of Members;

2. Establishing and maintaining programs to facilitate Members' marketing activities;

3. Initiating and coordinating programs of public education, national advertising and provider relations;

4. Making available actuarial, statistical and research services to Members;

5. Assisting Members to acquire and maintain public and provider support and in the orderly expansion of their roles in the financing of health services, including the development of education programs which recognize the mutuality of responsibility of Members and providers; and

6. Exerting constructive influence on the quality and availability of health care services and aiding Members to discharge their responsibilities to public and private subscribers, providers and the community at large;

b. To protect the Blue Cross and Blue Shield service marks;

c. To develop and maintain the Associations' membership standards;

d. To cooperate with federal, state and local governments for the provision of health services to the needy and aged;

e. To establish and maintain support and other services to Members through the exercise of authority delegated by the Members; and

f. To conduct its affairs, to have offices within and without the State of Illinois, and to exercise the powers granted by the General Not For Profit Corporation Act of the State of Illinois.

Section 3. Plan Support. The Association exists to serve the common needs of its Members, and it shall be supported in every lawful effort regularly approved or adopted by its Members. Each Member shall use its best efforts to cooperate with and support the Association in the achievement of its objects and purposes, and to abide by the intent and spirit of these Bylaws.

Section 4. Plan Autonomy. Inherent in its purposes is a recognition that Member Plans are, and should be, autonomous in their operations and that the needs, facilities, resources and practices of the respective areas shall be given due consideration.

ARTICLE II
ORGANIZATION AND MEMBERSHIP

Section 1. Regular Membership. Except as otherwise provided in these Bylaws, there shall be three (3) classes of regular membership in the Association.

a. Class I shall consist of each Blue Cross Plan which complies with these Bylaws and with the standards for membership established by the Members of the Association.

b. Class II shall consist of each Blue Shield Plan which complies with these Bylaws and with the standards for membership established by the Members of the Association.

c. Class III shall consist of each Blue Cross and Blue Shield Plan which complies with these Bylaws and with the standards for membership established by the Members of the Association.

Eligible organizations shall become Regular Members upon receipt of written applications for membership, and acceptance thereof by affirmative vote of a majority of the Board of Directors. Any Regular Member may resign upon not less than twelve (12) months written notice to the Association. Membership shall automatically terminate at the expiration of three (3) months after termination of eligibility for membership, if eligibility is not restored by the Association within that period. Membership may be revoked or conditioned upon such terms as may be determined by the Board of Directors at any time by two-thirds (2/3) vote of the entire Board of Directors for failure to comply with these Bylaws or with the standards for membership applicable to Re · ılar Members. Unless the Board of Directors finds that an emergency exists, such action may be taken only upon at least thirty (30) days prior written notice to the Member advising of the specific matters at issue, and granting the Member an opportunity to be heard and to present its response to the Board of Directors, whose determination shall be conclusive.

Section 22. Associate Membership. Each nonprofit health service organization located outside the United States which meets such requirements as may be prescribed by the Members of the Association is eligible for Associate Membership. Eligible organizations shall become Associate Members upon receipt of written applications for membership and acceptance thereof by affirmative vote of a majority of the Board of Directors. Any Associate Member may resign upon not less than twelve (12) months written notice to the Association. Membership shall automatically terminate at the expiration of three (3) months after termination of eligibility for membership, if eligibility is not restored by the Association within that period. Membership may be revoked at any time by two-thirds (2/3) vote of the entire Board of Directors for failure to comply with these Bylaws or with the standards for membership applicable to Associate Members.

Associate Members shall have all rights and privileges of Regular Members except the right to vote in the election of Directors. Each Associate Member shall be entitled to one (1) vote for each one thousand dollars ($1,000) or fraction thereof, of annual dues last assessed by the Association, but no Associate Member shall have less than one (1) vote. Associate Members having their principal offices in Canada may, as a group, designate a representative who shall be entitled to receive notices of and to attend all meetings of the Board of Directors but without vote and whose presence shall not be required or counted to constitute a quorum.

Section 3. Affiliate Membership. Each nonprofit health service organization which meets such standards and requirements for affiliation as may from time to time be established by the Board of Directors, which manifests a continuing interest in the policies of the Association, and which evidences significant contributions to the field of prepaid health care, is eligible for Affiliate Membership. Eligible applicants shall become Affiliate Members upon the affirmative vote of a majority of the Board of Directors.

Afiliate Members may attend meetings of Members but without vote. Any Affiliate Member may resign upon written notice to the Association, and membership shall automatically terminate upon termination of eligibility for membership. The membership of an Affiliate Member may be revoked at any time by a two-thirds (2/3) vote of the entire Board of Directors for failure to comply with these Bylaws or with the standards of membership applicable to Affiliate Members.

Section 4. Duration of Membership. Unless terminated or conditioned by the Board of Directors, membership shall be effective July 1 through June 30 of each year, and shall thereupon terminate, unless renewed as herein provided. The Board of Directors, at any time within four (4) months prior to the scheduled termination, shall renew for the above described period the membership of each Member which it finds in substantial compliance with all the provisions of these Bylaws and such applicable standards for membership as have been established.

Section 5. Conditional Membership. If any time a Member is found not to be in substantial compliance with the provisions of these Bylaws or with any applicable membership standard, the Board of Directors may declare its membership to be conditional for such period of time as may, in the Board's judgment, be required to permit the Member to present evidence that it fully qualifies for membership. During a period of conditional membership, a Member shall continue to be liable for payment of its dues and shall be entitled to all privileges of membership.

Section 6. Report to the Association. The Board of Directors shall make an annual report to the Association on membership. Such report shall include all actions of the Board of Directors on applications for membership, renewals of membership and conditions thereon, and terminations of membership for whatever cause.

Section 7. Waiver of Membership Standards. The Board of Directors shall have the right to waive, for a stated time, application to Members of any membership standard whenever in its judgment circumstances may warrant such action.

Section 8. Visitation. The Association may make special studies of performance, enrollment, finances, utilization experience and other subjects and may audit, on its own initiative, all records of a Regular Member and make recommendations with respect thereto, first to the Member's chief executive officer, and then to the governing board of the Member.

ARTICLE III

FINANCES AND DUES

Section 1. Raising of Funds. Funds for conducting the affairs of the Association may be raised by dues, such special assessments as the Members may impose, and contributions, devises, bequests, gifts or other legal means.

Funds may be raised from and allocated to only Class I and Class III, or Class II and Class III Regular Members for special projects of specific interest only to those classes of Regular Members. Approval of such special projects and funding shall require a two-thirds (2/3) weighted vote of the Regular Members in the affected classes present and voting and a majority vote of the Regular Members in the remaining class present and voting.

Section 2. Regular Members. Each Regular Member shall pay monthly dues to the Association calculated at rates and according to a formula adopted by a two-thirds (2/3) weighted vote of: 1) the Class I and Class II Regular Members; and 2) the Class II and Class III Regular Members, after not less than thirty (30) days prior written notice of such proposed rate and formula.

In the event of the merger or consolidation of two (2) or more Regular Members or the withdrawal of a Regular Member from the part or all of its geographical area of operation and the transfer of part or all of its active subscriber contracts to another Regular Member, the Board of Directors may adjust the dues payable by such Regular Members on the date of such merger, consolidation, withdrawal or transfer.

Section 3. Associate Members. Each Associate Member shall pay dues of one-half (1/2) mill per month per active subscriber contract. The dues of Associate Members may be changed at any meeting, after not less than thirty (30) days prior written notice of such proposed change, by a two-thirds (2/3) weighted vote of the Members of the Association.

Section 4. Affiliate Members. Each Affiliate Member shall pay dues of five hundred ($500) per annum, or such other amount as the Board of Directors may determine.

Section 5. Arrears. Members who have been declared by the Board of Directors to be sixty (60) days in arrears in the payment of dues or special assessments, in whole or in part, shall not be eligible to vote. The membership of any Member whose dues or special assessments have not been paid for one (1) year from the date on which they last fell due shall terminate automatically. Any Member in arrears for dues or special assessments which resigns its membership or whose membership terminates for non-payment shall remain liable to the Association for unpaid dues and special assessments to the date of such resignation or termination. No Member may be reinstated until and unless all monies have been paid, and then such reinstatement shall be upon application and acceptance or election as provided in these Bylaws. No refund of dues shall be made if a Member resigns before expiration of the current period for which dues have been paid.

Section 6. Appropriation and Expenditure of Funds. At the annual meeting of Members the Board of Directors shall submit a budget of the expected income and expenses for the ensuing year. The Board of Directors shall have authority to appropriate and disburse funds in accordance with a budget approved by majority weighted vote of the Regular Members present and voting.

If during the course of any fiscal year the approved budget is found insufficient to cover one or more programmed activities or projected administrative expenses, expenditures in excess of such budgeted items, but not to exceed the Association's surplus, may be authorized by a two-thirds (2/3) vote of all members of the Board of Directors present.

ARTICLE IV

MEETING OF MEMBERS

Section 1. Annual Meeting. The Members of the Association shall meet annually for the consideration

of matters of general interest to Members.

Section 2. Special Meeting. Special meetings of the Members may be called by the President, Chairman of the Board, the Board of Directors, or not less than ten (10) Regular Members.

Section 3. Place of Meeting. The Board of Directors may designate any place, either within or without the State of Illinois, as the place of any annual meeting. The person or persons calling any special meeting may designate any place, either within or without the State of Illinois, as the place of meeting.

Section 4. Notice. Written notice stating the place, day and hour of any meeting of Members shall be delivered to each Member not less than thirty (30) days before the date of an annual meeting, and not less than ten (10) days nor more than sixty (60) days before the date of any special meeting, by or at the direction of the President, the Chairman of the Board, the Board of Directors, the Members calling the meeting, or the Secretary. In cases of a special meeting and when required by statute or these Bylaws, the purpose for which the meeting is called shall be stated in the notice. The notice of a meeting shall be deemed delivered when deposited in the United States mail addressed to the Member at its address as it appears on the records of the Association, with postage prepaid. Such notice may be waived in writing and attendance at any meeting shall constitute waiver of notice thereof unless the person at the meeting objects to the holding of the meeting because proper notice was not given.

Section 5. Quorum. Regular Members entitled to a majority of the weighted vote, and numbering at least a majority of the Regular Members, shall constitute a quorum for the transaction of business at any meeting of Members. If a quorum is not present at any meeting of Regular Members, the Regular Members entitled to a majority of the weighted vote present may adjourn the meeting from time to time without further notice.

Section 6. Voting. The Regular members shall vote by weighted vote at all meetings on all questions, except as specifically otherwise required by the laws of the State of Illinois or by these Bylaws. Unless otherwise specified, the affirmative vote of a majority of Regular Members present and voting representing a majority of the weighted vote, or of one half (1/2) of all Regular Members, whichever is lesser, shall govern. Each Regular Member shall be entitled to one (1) vote for each one thousand dollars ($1,000) or fraction thereof of annual dues last assessed by the Association, but no Member shall have less than one (1) vote. In the event of the merger or consolidation of two (2) or more Regular Members or the withdrawal of a Regular Member from part or all of its geographical area of operation and the transfer of part or all of its active subscriber contracts to another Regular Member, the Board of Directors may adjust the votes to which such Regular Members are entitled as of the date of such merger, consolidation, withdrawal or transfer.

Section 7. Proxies. At any meeting of Members, each Regular Member may vote by proxy executed in writing and filed with the Secretary. No proxy shall be valid after eleven (11) months from the date of its execution unless otherwise provided in the proxy.

Section 8. Voting Representatives. Each Regular Member shall have the right to designate its official voting representative and one alternate representative at any meeting by an instrument in writing signed by one of its executive officers and filed with the Secretary prior to the meeting. In the absence of designation, the Member's chief executive officer shall be its official voting representative. The representative shall cast all the Member's votes, except that in the representative's absence, the alternate representative shall be entitled to vote.

ARTICLE V

BOARD OF DIRECTORS

Section 1. Number and Qualifications. The Association shall be governed by a Board of thirty-four (34) Directors. The President of the Association shall serve ex-officio, and thirty-three (33) District Directors shall be elected from the Districts as follows:

a. One chief executive officer of a Regular Member Plan elected by the Regular Members in each District on the basis of one (1) vote per Member;

b. One chief executive officer of a Regular Member Plan elected by the Regular Members in each District on the basis of weighted vote;

c. One Member of the Board of Directors of a Regular Member Plan or a chief executive officer of a Regular Member Plan elected by the Regular Members in each District on the basis of weighted vote.

d. In the event that a District shall have fewer chief executive officers eligible to serve than the number of Directors eligible to be elected from that District, then a member of the Member's Board of Directors or an employee of the Member also shall be eligible.

Section 2. District Designations. The Regular Members in the United States are divided into eleven (11) Districts, the boundaries of each District having been filed with the Secretary of the Association. Such boundaries may from time to time be changed by vote of the Regular Members. For the purposes of electing, removing and replacing District Directors, the Regular Members shall be deemed classified into eleven (11) classes, one for each District.

Section 3. District Elections. District elections required by this Article shall be called and held not less than sixty (60) days prior to the annual meeting of Members immediately preceding expiration of a District Director's term of office.

Section 4. Tenure of Directors. Each elected Director shall hold office for a period of three (3) years, commencing with the conclusion of the annual meeting of Members following the Director's election, and until a successor shall be elected and qualified.

Section 5. Removal and Vacancy. A Director may be removed, with or without cause, by the affirmative vote of two-thirds (2/3) of the present and voting Regular Members in the District which elected the Director. If one or more Directors is to be removed at a Members' meeting, written notice of the meeting, stating that a purpose of the meeting is to vote upon the removal of the one or more named director, shall be delivered to all members entitled to vote on the removal of the Director(s). In the event of death, inactivity, ineligibility, resignation or removal of a Director, a successor shall be elected to fill the unexpired term by two-thirds (2/3) of the Regular Members in the District, on the same basis by which the prior Director was elected, at an election to be held in such manner as a majority of the Regular Members may determine.

Section 6. Compensation. Directors and members of committees shall receive no compensation for services in such capacity but may be reimbursed for all expenses incurred in attending any Board or committee meeting.

Section 7. Resolution of Tie Votes. In the event the Regular Members in a District are unable to agree on election of a Director, the Nominating Committee shall, after hearing, select a Director.

ARTICLE VI

MEETINGS OF THE BOARD

Section 1. Regular Meetings. A regular annual meeting of the Board of Directors shall be held without other notice than this Bylaw, immediately after, and at the same place as, the annual meeting of Members. The Board of Directors shall hold at least three (3) additional regular meetings each year, either within or without the State of Illinois.

Section 2. Special Meetings. Special meetings of the Board of Directors may be called by or at the request of the President, Chairman of the Board or any three (3) Directors. The person or persons authorized to call special meetings of the Board may fix any place, either within or without the State of Illinois, as the place for holding any special meeting of the Board called by them.

Section 3. Notice. Written notice stating the place, day and hour of any special meeting of the Board of Directors shall be delivered personally or sent by mail or telegram to each Director not less than ten (10) days before the date of the meeting to the Director's address as it appears on the records of the Association. If mailed, such notice shall be deemed to be delivered when deposited in the United States mail in a sealed envelope so addressed, with postage prepaid. If notice be given by telegram, such notice shall be deemed to be delivered when the telegram is delivered to the Telegraph Company. Any Director may waive notice of any meeting. The attendance of a Director at any meeting shall constitute a waiver of notice of such meeting, except when a Director attends a meeting for the express purpose of objecting to the transaction of any business on the ground that the meeting is not lawfully convened. The business to be transacted at any regular or special meeting of the Board need not be specified in the notice of such meeting.

Section 4. Quorum. A majority of the members of the Board of Directors then in office shall constitute a quorum for the transaction of business at any meeting of the Board, provided, that if less than a majority is present at said meeting, a majority of the Directors present may adjourn the meeting from time to time without further notice.

Section 5. Manner of Acting. The act of a majority of the members of the Board of Directors shall be the act of the Board of Directors except where otherwise provided by law or by these Bylaws. No Director may act by proxy on any matter. A Director who is present at a meeting of the Board of Directors at which action on any corporate matter is taken shall be conclusively presumed to have assented to the action taken unless his or her dissent or abstention is entered in the minutes of the meeting or unless he or she files his or her written dissent or abstention to such action with the person acting as secretary of the meeting before the adjournment thereof or forwards such dissent or abstention by registered or certified mail to the Secretary of the Association immediately after the adjournment of the meeting. Such right to dissent or abstain shall not apply to any Director who voted in favor or such action.

Section 6. Electronic Meetings. Meetings of the Board of Directors may be held through the use of conference telephones or other communications equipment whereby all persons participating in the meeting can communicate with each other. Participation by any Board member in a meeting so held shall constitute presence in person at the meeting, and the minutes of any such meeting shall be prepared in the same manner as a meeting of the Board of Directors held in person.

ARTICLE VII

COMMITTEES

Section 1. Executive Committee. There shall be an Executive Committee consisting of nine (9) members of the Board of Directors, to be elected by the Board of Directors at its annual meeting; one member to be the Chairman of the Board who shall also serve as Chairman of the Executive Committee. If the office of any member of the Executive Committee shall become vacant, a successor shall be elected by the Board of Directors at its next meeting. The Executive Committee shall advise and aid the officers of the Association in all matters concerning its interests and the management of its affairs and, when the Board of Directors is not in session, the Executive Committee shall have all the powers of the Board of Directors except those powers expressly reserved by the Board of Directors or those prohibited by law. All actions by the Executive Committee shall be reported to the Board of Directors at its meeting next succeeding such action and shall be subject to revision and alteration by the Board, but no rights of third parties shall be affected by any such revision or alteration. Regular minutes of the proceedings of the Executive Committee shall be kept in a book provided for that purpose. A majority of the members of the Executive Committee may determine its action and fix the time and place of its meetings.

Section 2. Nominating Committee. There shall be a Nominating Committee consisting of five (5) members of the Board of Directors (other than the Chairman) elected by the Board of Directors to serve for terms of one (1) year, and no member may serve more than three (3) consecutive terms. A member may not serve in the year in which the member's term expires. The Chairman of the Board shall recommend persons to serve. The Nominating Committee shall nominate candidates for election by the Board of Directors as members of the Executive Committee and as Chairman of the Board. Such nominations shall be submitted to Members and to the Board of Directors not less than fifteen (15) days prior to the date scheduled for election unless waived by the Board of Directors.

Section 3. Audit Committee. There shall be an Audit Committee consisting of not more than eight (8) members appointed by the Board of Directors upon recommendation of the Chairman of the Board. The Audit Committee shall serve as the channel of communication between the Board and the Association's independent auditors, and shall have such other duties as authorized by the Board of Directors.

Section 4. Other Committees. The Board of Directors may establish or dissolve such other committees as it deems expedient; define the scope of activities, authority and responsibilities of such committees; and appoint and remove the chairman and members of such committees. The Board of Directors may also authorize any such committee to appoint one or more subcommittees. All recommendations of each such committee shall be submitted to the Board of Directors and shall be subject to its approval.

Section 5. Committee Meetings. Unless the appointment by the Board of Directors requires a greater number, a majority of any committee shall constitute a quorum, and a majority of committee members present and voting at a meeting at which a quorum is present shall be necessary for committee action. Meetings of any committee of the Board of Directors may be held through the use of conference telephone, or other communications equipment whereby all persons participating in the meeting can communicate with each other. Participation by any committee member in a meeting so held shall constitute presence in person at the meeting, and the minutes of any such meeting shall be prepared in the same manner as a meeting of the committee members held in person.

ARTICLE VIII

ELECTIVE OFFICERS

Section 1. Officers. The elective officers of the Association shall be a Chairman of the Board, President, Secretary, Treasurer and such other officers, upon recommendation of the President, as the Board of Directors may elect. Only a member of the Board of Directors shall be qualified to be elected Chairman of the Board, and no other officer, except the President, shall be a member of the Board of Directors. The offices of President and Secretary may not be held by the same person.

Section 2. Election of Officers. All officers, except those appointed pursuant to Article IX, Section 1, shall be elected by the Board of Directors at its annual meeting, or as soon thereafter as convenient. Officers shall assume office immediately upon election and serve for a period of one year or until their successors are elected and assume office.

Section 3. Vacancies. In the event of the death, resignation, removal or disability of any elective officer, the Board of Directors may at any meeting elect a successor who shall serve during the remainder of the term or until a successor is elected and assumes office.

Section 4. Chairman of the Board. The Chairman shall preside at all meetings of the Board of Directors and at all business meetings of the Association, and shall exercise general supervision over affairs and activities of the Association as are not expressly reserved for the President. No person may serve more than three (3) consecutive terms as Chairman of the Board.

Section 5. President. The President shall be the chief executive officer of the Association and shall supervise and administer all of the business and affairs of the Association. He may sign with the Secretary or other officer of the Association authorized by the Board of Directors, any deeds, bonds, contracts, or other instruments which the Board of Directors has authorized to be executed. He shall perform such other duties as usually pertain to his office or as may be prescribed by the Board of Directors.

Section 6. Vice Presidents. The Board of Directors may elect one or more Vice-Presidents who shall, in general, perform all duties as from time to time may be assigned to them by the President or by the Board of Directors. In the event more than one Vice-President is so elected, and in the absence of the President or in the event of his inability or refusal to act, the Board of Directors shall designate a Vice-President who shall perform the duties of the President, and when so acting, shall have all the powers of and be subject to all the restrictions upon the President.

Section 7. Treasurer. The Treasurer shall cause to be entered on the books of the Association the dues of each Member as determined by the Association; shall demand and receive all funds due the Association; shall cause the same to be promptly deposited, together with all devises, bequests, and donations, in a depository approved by the Board of Directors; shall cause to be kept proper and accurate records thereof, as well as of funds disbursed by the Association; shall pay out of the monies of the Association only such amounts as are approved by the Board of Directors; shall give bond in such sum, if any, as the Board of Directors may determine, the premium of such bond to be paid by the Association; shall perform such other duties as may be required by these Bylaws, by the President, or by the Board of Directors. In the absence or inability of the Treasurer to act, the duties shall be performed as specified by the Board of Directors.

Section 8. Secretary. The Secretary shall be the custodian of the minutes of the meeting of the Association and the Board of Directors, and of all other records, books and papers belonging to the Association, and of the Corporate Seal; shall receive applications for membership and transmit them to the Board of Directors; shall provide for the registration of all Members at meetings of the Association and keep a record of such registration; shall keep a register of Regular, Associate and Affiliate Members; shall sign any instruments required by law to be executed by a Secretary; shall cause notice of all meetings of the Association and the Board of Directors to be given; shall have the authority to certify these Bylaws, resolutions of the Members and the Board of Directors and committees thereof, and other documents of the Association as true and correct copies thereof; and shall perform such other duties as may be required by these Bylaws, by the President, or by the Board of Directors. In the absence or inability of the Secretary to act, the duties shall be performed as specified by the Board of Directors.

Section 9. Other Officers. All other officers shall have such powers and duties as from time to time may be assigned to them by the President or by the Board of Directors.

Section 10. Removal. Any officer or agent of the Association may be removed by the Board of Directors whenever in its judgment the best interests of the Association would be served thereby.

Section 11. Compensation. The officers of the Association shall receive such compensation for their services as may, from time to time, be fixed by the Board of Directors, but no officer, except the Chairman of the Board, may be an employee of or receive compensation from any Member.

ARTICLE IX

APPOINTIVE OFFICERS

Section 1. Appointive Officers. The President of the Association may appoint such other officers of the Association as he deems wise, with the advice and consent of the Executive Committee. Appointive officers shall have such powers and duties as may be assigned to them by the President.

Section 2. Removal. Any appointive officer may be removed at any time by the President of the Association.

Section 3. Compensation. The appointive officers of the Association shall receive such compensation for their services as the President shall determine within the guidelines established by the Executive Committee. No appointive officer may be an employee of, or receive compensation from, any Member.

ARTICLE X

CONTRACTS, CHECKS, DEPOSITS AND FUNDS

Section 1. Contracts. The Board of Directors may authorize any officer or officers, agent or agents of the Association, in addition to the officers so authorized by these Bylaws, to enter into any contract or execute and deliver any instrument in the name of and on behalf of the Association, and such authority may be general or confined to specific instances.

Section 2. Checks. All checks, drafts and other orders for the payment of money, notes or other evidences of indebtedness issued in the name of the Association shall be signed by such officer or officers, agent or agents of the Association and in such manner as shall from time to time be determined by resolution of the Board of Directors. In the absence of such determination by the Board of Directors, such instruments shall be signed by the Treasurer and countersigned by the President or a Vice-President.

Section 3. Deposits. All funds of the Association shall be deposited from time to time to the credit of the Association in such banks, trust companies or other depositories as the Board of Directors may select.

Section 4. Bonds. All officers and agents of the Association responsible for the receipt, custody or disbursement of funds shall give bonds for the faithful discharge of their duties in such sums and with such sureties as the Board of Directors shall determine.

Section 5. Gifts. The Board of Directors may accept on behalf of the Association any grant, contribution, gift, bequest or devise for the general purposes or for any special purposes of the Association. The Board of Directors shall have the right to contribute funds of the Association to any other corporation or association which is operated not for pecuniary profit and in furtherance of the purposes of this Association as stated in Article I of these Bylaws.

ARTICLE XI

DISSOLUTION

Upon dissolution or final liquidation of the Association, whether voluntary or involuntary, no part of its assets shall be paid or distributed to or for the benefit of any Member. Said assets shall be applied and distributed, first to the payment, satisfaction and discharge of all liabilities and obligations of the Association, or adequate provision shall be made therefore; second, to the return, transfer or conveyance of assets held by the Association upon condition requiring return, transfer or conveyance by reason of dissolution of the Association; and third, the balance, if any, shall be transferred and conveyed to one (1) or more corporations, societies or organizations, wherever organized or operating, engaged not for profit in the advancement of health service, pursuant to a plan of distribution adopted in accordance with the Illinois General Not For Profit Corporation Act.

ARTICLE XII

AMENDMENTS

These Bylaws may be amended or repealed and new Bylaws may be adopted by the affirmative vote of at least one-half (1/2) of the Regular Members, present and voting, entitled to two-thirds (2/3) of the

weighted vote at any regular meeting or at any special meeting, provided that the proposed amendment, addition or action is submitted in writing to each Member at least thirty (30) days prior to the meeting at which the same is to be considered.

ARTICLE XIII

INDEMNIFICATION OF DIRECTORS AND OTHERS

Section 1. Persons Who May Be Indemnified. (a) To the extent permitted by law, the Association shall indemnify any person who was or is a party, or is threatened to be made a party, to any threatened or pending or completed action or suit or proceeding, whether civil, criminal, administrative or investigative (other than an action by or in the right of the Association) by reason of the fact that he or she is or was (i) a director, officer, employee, or agent of the Association; (ii) a member of a committee appointed by the Board of Directors; or (iii) serving at the request of the Association as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise (such persons being hereinafter referred to in this Article as "persons who may be indemnified"), against expenses (including attorneys' fees), judgments, fines and amounts paid in settlement, actually and reasonably incurred by him or her in connection with such action, suit or proceeding, provided that he or she acted in good faith and in a manner he or she reasonably believed to be in, or not opposed to, the best interests of the corporation and, with respect to any criminal action or proceeding, had no reasonable cause to believe his or her conduct was unlawful. (b) To the extent permitted by law, the Association shall indemnify any person who was or is a party, or is threatened to be made a party to any threatened or pending or completed action or suit by or in the right of the Association to procure a judgment in its favor by reason of the fact that he or she is or was (i) a director, officer, employee or agent of the Association; (ii) a member of a committee appointed by the Board of Directors; or (iii) serving at the request of the Association as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise (such persons being hereinafter referred to in this Article as "persons who may be indemnified"), against expenses (including attorneys' fees) actually and reasonably incurred by him or her in connection with the defense or settlement of such action or suit, provided that such person acted in good faith and in a manner he or she reasonably believed to be in, or not opposed to, the best interests of the corporation, and provided further, that no indemnification shall be made in respect of any claim, issue or matter as to which he or she shall have been adjudged to be liable for negligence or misconduct in the performance of his or her duty to the corporation.

Section 2. Indemnification Procedure. Any indemnification under Section 1 above (unless ordered by a court) shall be made by the Association only as authorized in the specific case upon determination that indemnification of a person who may be indemnified is proper in the circumstances because such person has met the criteria set forth in Section 1 above. Such determination shall be made: (1) by the Board of Directors by a majority vote of a quorum consisting of members thereof who were not parties to such action, suit or proceeding, or (2) by independent legal counsel in a written opinion if such a quorum is not obtainable, or even if obtainable, if a quorum of disinterested members of the Board of Directors so directs.

Section 3. Advances. Expenses incurred in defending an action, suit or proceeding may be paid by the Association in advance of the final disposition of such action, suit or proceeding, as authorized by the Board of Directors in the specific case, upon receipt of an undertaking by or on behalf of the person who may be indemnified to repay such amount unless such a person shall ultimately be determined to be entitled to be indemnified.

Section 4. Other Indemnification Arrangements. The indemnification provided by this Article shall not be deemed exclusive of any other rights to which those seeking indemnification may be entitled under any agreement, vote of the members of the Board of Directors or disinterested members thereof, or otherwise, both as to action in an official capacity and as to action in another capacity while holding such office, and shall continue as to a person who has ceased to hold the office and shall inure to the benefit of the heirs, executors and administrators of such a person.

Section 5. Insurance. The Association shall have the power to purchase and maintain insurance on behalf of any person against any liability asserted against and incurred by such person as a result of serving any capacity defined in Section 1 above, whether or not the Association would have the power to indemnify against such liability under the provisions of this Article.

ARTICLE XIV

BOOKS AND RECORDS

The Association shall keep correct and complete books and records of account and shall also keep minutes of the proceedings of its Members, Board of Directors and Executive Committee and shall keep at the registered or principal office a record giving the names and addresses of the Members. All books and records of the Association may be inspected by any Member, or its agent or attorney, for any proper purpose at any reasonable time.

ARTICLE XV

OFFICES AND SEAL

Section 1. Offices. The Association shall have and continuously maintain in the State of Illinois its principal executive office and also a registered office and a registered agent whose office is identical with such registered office, and may have other offices within or without the State of Illinois as the Board of Directors may determine.

Section 2. Seal. The Board of Directors shall provide a corporate seal which shall be in the form of a circle and shall have inscribed thereon the name of the Association and the words "CORPORATE SEAL—ILLINOIS."

ARTICLE XVI

FISCAL YEAR

The fiscal year of the Association shall be the calendar year or such other fiscal year as the Board of Directors shall select.

ARTICLE XVII

WAIVER OF NOTICE

Whenever any notice is required to be given by statute or the Bylaws of the Association, a waiver thereof in writing signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice.

Exhibit B

BCBS-#7.RED

MARKED AGAINST 11/1/89 BYLAWS

BYLAWS
BLUE CROSS AND BLUE SHIELD ASSOCIATION

ARTICLE I

NAME AND PURPOSE

Section 1. Name. The name of this corporation is BLUE CROSS AND BLUE SHIELD ASSOCIATION, herein referred to as "the Association."

Section 2. Purposes. The purposes of the Association are:

a. To promote the betterment of public health and security, and to secure wide public acceptance of the principle of voluntary, nonprofit prepayment of health services by:

1. Promoting the commonality of objectives and collective capacity of Members, exchanging information of common interest, developing and securing Member acceptance of programs of joint action, and increasing the effective performance of Members;

2. Establishing and maintaining programs to facilitate Members' marketing activities;

3. Initiating and coordinating programs of public education, national advertising and provider relations;

4. Making available actuarial, statistical and research services to Members;

5. Assisting Members to acquire and maintain public and provider support and in the orderly expansion of their roles in the financing of health services, including the development of education programs which recognize the mutuality of responsibility of Members and providers; and

6. Exerting constructive influence on the quality and availability of health care services and

aiding Members to discharge their responsibilities to public and private subscribers, providers and the community at large;

b. To protect the Blue Cross and Blue Shield service marks;

c. To develop and maintain the Associations' membership standards;

d. To cooperate with federal, state and local governments for the provision of health services to the needy and aged;

e. To establish and maintain support and other services to Members through the exercise of authority delegated by the Members; and

f. To conduct its affairs, to have offices within and without the State of Illinois, and to exercise the powers granted by the General Not For Profit Corporation Act of the State of Illinois.

Section 3. Plan Support. The Association exists to serve the common needs of its Members, and it shall be supported in every lawful effort regularly approved or adopted by its Members. Each Member shall use its best efforts to cooperate with and support the Association in the achievement of its objects and purposes, and to abide by the intent and spirit of these Bylaws.

Section 4. Plan Autonomy. Inherent in its purposes is a recognition that Member Plans are, and should be, autonomous in their operations and that the needs, facilities, resources and practices of the respective areas shall be given due consideration.

ARTICLE II

ORGANIZATION AND MEMBERSHIP

Section 1. Regular Membership. Except as otherwise provided in these Bylaws, there shall be three (3) classes of regular membership in the Association.

a. Class I shall consist of each Blue Cross Plan which complies with these Bylaws and with the standards for membership established by the Members of the Association.

b. Class II shall consist of each Blue Shield Plan which complies with these Bylaws and with the standards for membership established by the Members of the Association.

c. Class III shall consist of each Blue Cross and Blue Shield Plan which complies with these Bylaws and with the standards for membership established by the Members of the Association.

Eligible organizations shall become Regular Members upon receipt of written application for membership, and acceptance thereof by affirmative vote of a majority of the Board of Directors. Any Regular Member may resign upon not less than twelve (12) months written notice to the Association. Membership shall automatically terminate at the expiration of three (3) months after termination of eligibility for membership, if eligibility is not restored by the Association within that period. Membership may be revoked or conditioned upon such terms as may be determined by the Board of Directors at any time by two-thirds (2/3) vote of the entire Board of Directors for failure to comply with these Bylaws or with the standards for membership, applicable to Regular Members. Unless the Board of Directors finds that an emergency exists, such action may be taken only upon at least thirty (30) days prior written notice to the Member advising of the specific matters at issue, and granting the Member an opportunity to be heard and to present its response to the Board of Directors, whose determination shall be conclusive. **Membership may be revoked by the vote of the Regular Members representing three-fourths (3/4) of all of the Regular Members and three-fourths (3/4) of the weighted votes of all of the Regular Members for failure to comply with these Bylaws or with the standards for membership applicable to Regular Members.**

Section 2. Associate Membership. Each nonprofit health service organization located outside the United States which meets such requirements as may be prescribed by the Members of the Association is eligible for Associate Membership. Eligible organizations shall become Associate Members upon receipt of written applications for membership and acceptance thereof by affirmative vote of a majority of the Board of Directors. Any Associate Member may resign upon not less than twelve (12) months written notice to the Association. Membership shall automatically terminate at the expiration of three (3) months after termination of eligibility for membership, if eligibility is not restored by the Association within that period. Membership may be revoked at any time by two-thirds (2/3) vote of the entire Board of Directors for failure to comply with these Bylaws or with the standards for membership applicable to Associate Members.

Associate Members shall have all rights and privileges of Regular Members ~~except the right to vote in the election of Directors. Each Associate Member shall be entitled to one (1) vote for each one thousand dollars ($1,000) or fraction thereof, of annual dues last assessed by the Association, but no Associate Member shall have less than one (1) vote~~, except any right to designate a Director as provided in Article V, Section 2, and except those rights expressly granted to the Regular Members herein. Associate Members having their principal offices in Canada may, as a group, designate a representative who shall be entitled to receive notices of and to attend all meetings of the Board of Directors but without vote and whose presence shall not be required or counted to constitute a quorum.

Section 3. Affiliate Membership. Each nonprofit health service organization which meets such standards and requirements for affiliation as may from time to time be established by the Board of Directors, which manifests a continuing interest in the policies of the Association, and which evidences significant contributions to the field of prepaid health care, is eligible for Affiliate Membership. Eligible applicants shall become Affiliate Members upon the affirmative vote of a majority of the Board of Directors.

Affiliate Members may attend meetings of Members but without vote. Any Affiliate Member may resign upon written notice to the Association, and membership shall automatically terminate upon termination of eligibility for membership. The membership of an Affiliate Member may be revoked at any time by a two-thirds (2/3) vote of the entire Board of Directors for failure to comply with these Bylaws or with the standards of membership applicable to Affiliate Members.

Section 4. Duration of Membership. Unless terminated or conditioned [redacted] as provided in this Article II, membership shall be effective July 1 through June 30 of each year, and shall thereupon terminate, unless renewed as herein provided. The Board of Directors, at any time within four (4) months prior to the scheduled termination, shall renew for the above described period the membership of each Member which it finds is in substantial compliance with all the provisions of these Bylaws and such applicable standards for membership as have been established.

Section 5. Conditional Membership. If at any time a Member is found not to be in substantial compliance with the provisions of these Bylaws or with any applicable membership standard, the Board of Directors may declare its membership to be conditional for such period of time as may, in the Board's judgment, be required to permit the Member to present evidence that it fully qualifies for membership. During a period of conditional membership, a Member shall continue to be liable for payment of its dues and shall be entitled to all privileges of membership.

Section 6. Report to the Association. The Board of Directors shall make an annual report to the Association on membership. Such report shall include all actions of the Board of Directors on applications for membership, renewals of membership and conditions thereon, and terminations of membership for whatever cause.

Section 7. Waiver of Membership Standards. The Board of Directors shall have the right to waive, for a stated time, application to Members of any membership standard whenever in its judgment circumstances may warrant such action.

Section 8. Visitation. The Association may make special studies of performance, enrollment, finances, utilization experience and other subjects and may audit, on its own initiative, all records of a Regular Member and make recommendations with respect thereto, first to the Member's chief executive officer, and then to the governing board of the Member.

ARTICLE III

FINANCES AND DUES

Section 1. Raising of Funds. Funds for conducting the affairs of the Association may be raised by dues, such special assessments as the Members Board may impose approve, and contributions, devises, bequests, gifts or other legal means.

Funds may be raised from and allocated to only Class I and Class III, or Class II and Class III Regular Members for special projects of specific interest only to those classes of Regular Members. Approval of such special projects and funding shall require ~~a two-thirds (2/3) weighted~~ vote of a majority of the Board of Directors present and voting representing two-thirds (2/3) of the weighted votes of the Regular Members in the affected classes present and voting and a majority vote of the Regular Members in the remaining class present and voting.

Section 2. Regular Members. Each Regular Member shall pay monthly dues to the Association calculated at rates and according to a formula adopted ~~by a two-thirds (2/3) weighted vote of~~

~~the Class I and Class III Regular Members; and 2) the Class II and Class III Regular Members~~, after not less than thirty (30) days prior written notice of such proposed ~~rate and formula~~ rates and formula, by two-thirds (2/3) of the Directors present and voting representing two-thirds (2/3) of the weighted votes of: 1) all the Class I and Class III Regular Members; and 2) all the Class II and Class III Regular Members.

In the event of the merger or consolidation of two (2) or more Regular Members or the withdrawal of a Regular Member from part or all of its geographical area of operation and the transfer of part or all of its active subscriber contracts to another Regular Member, the Board of Directors may adjust the dues payable by such Regular Members on the date of such merger, consolidation, withdrawal or transfer.

Section 3. Associate Members. Each Associate Member shall pay dues of one-half (1/2) mill per month per active subscriber contract. The dues of Associate Members may be changed at any meeting, after not less than thirty (30) days prior written notice of such proposed change, by ~~a two-thirds (2/3) weighted vote of the Members of the Association~~ vote of two-thirds (2/3) of the Directors present and voting representing two-thirds (2/3) of the weighted votes of all the Members.

Section 4. Affiliate Members. Each Affiliate Member shall pay dues of five hundred dollars ($500) per annum, or such other amount as the Board of Directors may determine.

Section 5. Arrears. Members who have been declared by the Board of Directors to be sixty (60) days in arrears in the payment of dues or special assessments, in whole or in part, shall not be eligible to vote. The membership of any Member whose dues or special assessments have not been paid for one (1) year from the date on which they last fell due shall terminate automatically. Any Member in arrears for dues or special assessments which resigns its membership or whose membership terminates for non-payment shall remain liable to the Association for unpaid dues and special assessments to the date of such resignation or termination. No Member may be reinstated until and unless all monies have been paid, and then such reinstatement shall be upon application and acceptance or election as provided in these Bylaws. No refund of dues shall be made if a Member resigns before expiration of the current period for which dues have been paid.

Section 6. Appropriation and Expenditure of Funds. At the annual meeting of ~~Members~~ the Board of Directors, the Executive ~~Committee~~ shall submit a budget of the expected income and expenses for the ensuing year. The Board of Directors shall have authority to appropriate and disburse funds in accordance with a budget approved by ~~majority weighted vote~~ a majority of the Directors

present and voting representing a majority of the weighted votes of the Regular Members present and voting.

If during the course of any fiscal year the approved budget is found insufficient to cover one or more programmed activities or projected administrative expenses, expenditures in excess of such budgeted items, but not to exceed the Association's surplus, may be authorized by a two-thirds (2/3) vote of all members of the Board of Directors present and voting.

ARTICLE IV

MEETINGS OF MEMBERS

Section 1. Annual Meeting. The Members of the Association shall meet annually for the consideration of matters of general interest to Members.

Section 2. Special Meeting. Special meetings of the Members may be called by the President, Chairman of the Board, the Board of Directors, or not less than ten (10) Regular Members.

Section 3. Place of Meeting. The Board of Directors may designate any place, either within or without the State of Illinois, as the place of any annual meeting. The person or persons calling any special meeting may designate any place, either within or without the State of Illinois, as the place of meeting.

Section 4. Notice. Written notice stating the place, day and hour of any meeting of Members shall be delivered to each Member not less than thirty (30) days before the date of an annual meeting, and not less than ten (10) nor more than sixty (60) days before the date of any special meeting, by or at the direction of the President, the Chairman of the Board, the Board of Directors, the Members calling the meeting, or the Secretary. In cases of a special meeting and when required by statute or these Bylaws, the purpose for which the meeting is called shall be stated in the notice. The notice of a meeting shall be deemed delivered when deposited in the United States mail addressed to the Member at its address as it appears on the records of the Association, with postage prepaid. Such notice may be waived in writing and attendance at any meeting shall constitute waiver of notice thereof unless the person at the meeting objects to the holding of the meeting because proper notice was not given.

Section 5. Quorum. Regular Members entitled to a majority of the weighted vote, and numbering at least a majority of the Regular Members, shall constitute a quorum for the transaction of business at any meeting of Members. If a quorum is not present at

any meeting of Regular Members, the Regular Members entitled to a majority of the weighted vote present may adjourn the meeting from time to time without further notice.

Section 6. Voting. The Regular and Associate Members shall vote by weighted vote at all meetings on all questions, except as specifically otherwise required by the laws of the State of Illinois or by these Bylaws. Unless otherwise specified, the affirmative vote of a majority of Regular Members present and voting representing a majority of the weighted vote of all Members, or of one-half (1/2) of all Regular and Associate Members, whichever is lesser, shall govern. Each Regular Member and each Associate Member shall be entitled to one (1) vote for each one thousand dollars ($1,000) or fraction thereof of annual dues last assessed by the Association, but no Member shall have less than one (1) vote. In the event of the merger or consolidation of two (2) or more Regular or Associate Members or the withdrawal of a Regular or Associate Member from part or all of its geographical area of operation and the transfer of part or all of its active subscriber contracts to another Regular or Associate Member, the Board of Directors may adjust the votes to which such Regular or Associate Members are entitled as of the date of such merger, consolidation, withdrawal or transfer.

Section 7. Proxies. At any meeting of Members, each Regular Member may vote by proxy executed in writing and filed with the Secretary. No proxy shall be valid after eleven (11) months from the date of its execution unless otherwise provided in the proxy.

Section 8. Voting Representatives. Each Regular Member shall have the right to designate its official voting representative and one alternate representative at any meeting by an instrument in writing signed by one of its executive officers and filed with the Secretary prior to the meeting. In the absence of designation, the Member's chief executive officer (a "CEO") shall be its official voting representative. The representative shall case all the Member's votes, except that in the representative's absence, the alternate representative shall be entitled to vote.

ARTICLE V

BOARD OF DIRECTORS

Section 1. Number and Qualifications. The Association shall be governed by a Board of ~~thirty-four (34) Directors. The President of the Association shall serve ex-officio, and thirty-three (33) District Directors shall be elected from the Districts as follows:~~

~~a. One chief executive officer of a Regular Member Plan elected by the Regular Members in each District on the basis of one (1) vote per Member;~~

~~b. One chief executive officer of a Regular Member Plan elected by the Regular Members in each District on the basis of weighted vote;~~

~~c. One Member of the Board of Directors of a Regular Member Plan or a chief executive officer of a Regular Member Plan elected by the Regular Members in each District on the basis of weighted vote;~~

~~d. In the event that a District shall have fewer chief executive officers eligible to serve than the number of Directors eligible to be elected from that District, then a member of the Member's Board of Directors or an employee of the Member also shall be eligible~~ Directors equal in number to an amount calculated as follows:

(a) the number of Regular Members; minus

(b) the number of Regular Members which fail to designate a Director pursuant to Section 2 of this Article V; minus

(c) the number of Regular Members (other than those which have so failed to designate a Director) which have a CEO (or Acting CEO) who is the CEO (or Acting CEO) of another Regular Member; plus

(d) the number of persons who are CEOs (or Acting CEOs) identified in the immediately preceding subparagraph (c); plus

(e) one (1).

Such total amount shall be determined by the Secretary of the Association at each annual meeting of the Members immediately preceding the election of the Board of Directors and shall remain effective until the next annual Members' meeting. The duly elected and qualified CEO (or, if none and if the Chairman of the Board consents, the Acting CEO), of each Regular Member and the President of the Association shall be eligible to serve as Directors.

Section 2. Election. Each Regular Member which desires to designate a Director shall, at least sixty (60) days before the annual meeting, designate in writing received by the Secretary of the Association, on forms provided by said Secretary, the person selected by the Regular Member to serve as a Director, which person

shall be the duly elected and qualified CEO (even if such CEO is the CEO of more than one Regular Member) or, if none, and if the Chairman of the Board consents, the Acting CEO of the Regular Member. Each such designation shall constitute the irrevocable proxy of the designating Regular Member to the Secretary of the Association authorizing and directing said Secretary to vote on behalf of such Member at the next year's meetings of the Members in favor of the election of the President of the Association and all the CEOs designated by Regular Members in accordance with this Section 2, to serve as Members of the Board ~~District Designations. The Regular Members in the United States are divided into eleven (11) Districts, the boundaries of each District having been filed with the Secretary of the Association. Such boundaries may from time to time be changed by vote of the Regular Members. For the purposes of electing, removing and replacing District Directors, the Regular Members shall be deemed classified into eleven (11) classes, one for each District.~~

~~Section 3. District Elections. District elections required by this Article shall be called and held not less than sixty (60) days prior to the annual meeting of Members immediately preceding expiration of a District Director's term of office.~~

~~Section 4. Tenure~~ of Directors.

Section 3. Tenure of Directors. Each ~~elected~~ Director shall hold office for a period of ~~three (3) years~~ one year, commencing with the conclusion of the annual meeting of Members following the Director's election, and until a successor shall be elected and qualified.

Section [illegible]. Removal and Vacancy. A Director may be removed with or without cause, by the affirmative vote of two-thirds (2/3) of the Regular Members present and voting [illegible]. If one or more Directors is to be removed at a Members' meeting, written notice of the meeting, stating that a purpose of the meeting is to vote upon the removal of the one or more named directors, shall be delivered to all [illegible] Members [illegible]. In the event of the death, inactivity, ineligibility, resignation or removal of a Director, a successor ~~shall be elected to fill the unexpired term by two thirds (2/3) of~~ may be designated by the relevant Regular Member and elected by the Regular Members ~~in the District, on the same basis by which the prior Director was elected, at an election to be held in such manner as a majority of the Regular Members may determine.~~ No person other than such relevant Regular Member may designate or nominate any person to be elected as a successor to such Director.

Section 5. Chairman. The Board shall, at each annual meeting, elect a CEO of a Regular Member to serve as Chairman of the Board and Executive Committee.

Section 6. Compensation. Directors and members of committees shall receive no compensation for services in such capacity but may be reimbursed for all expenses incurred in attending any Board or committee meeting.

~~Section 7. Resolution of Tie Votes. In the event the Regular Members in a District are unable to agree on election of a Director, the Nominating Committee shall, after hearing, select a Director.~~

ARTICLE VI

MEETINGS OF THE BOARD

Section 1. Regular Meetings. A regular annual meeting of the Board of Directors shall be held without other notice than this Bylaw, immediately after, and at the same place as, the annual meeting of Members. The Board of Directors shall hold at least three (3) additional regular meetings each year, either within or without the State of Illinois.

Section 2. Special Meetings. Special meetings of the Board of Directors may be called by or at the request of the President, Chairman of the Board or any ten (10) Directors. The person or persons authorized to call special meetings of the Board may fix any place, either within or without the State of Illinois, as the place for holding any special meeting of the Board called by them.

Section 3. Notice. Written notice stating the place, day and hour of any special meeting of the Board of Directors shall be delivered personally or sent by mail or telegram to each Director not less than ten (10) days before the date of the meeting to the Director's address as it appears on the records of the Association. If mailed, such notice shall be deemed to be delivered when deposited in the United States mail in a sealed envelope so addressed, with postage prepaid. If notice be given by telegram, such notice shall be deemed to be delivered when the telegram is delivered to the Telegraph Company. Any Director may waive notice of any meeting. The attendance of a Director at any meeting shall constitute a waiver of notice of such meeting, except when a Director attends a meeting for the express purpose of objecting to the transaction of any business on the ground that the meeting is not lawfully convened. The business to be transacted at any regular or special meeting of the Board need not be specified in the notice of such meeting.

Section 4. Quorum. A majority of the members of the Board of Directors then in office shall constitute a quorum for the transaction of business at any meeting of the Board, provided, that if less than a majority is present at said meeting, a majority of the Directors present may adjourn the meeting from time to time without further notice.

Section 5. Manner of Acting. The act of a majority of the members of the Board of Directors present and voting shall be the act of the Board of Directors except where otherwise provided by law or by these Bylaws. No Director may act by proxy on any matter. A Director who is present at a meeting of the Board of Directors at which action on any corporate matter is taken shall be conclusively presumed to have assented to the action taken unless his or her dissent or abstention is entered in the minutes of the meeting or unless he or she files his or her written dissent or abstention to such action with the person acting as secretary of the meeting before the adjournment thereof or forwards such dissent or abstention by registered or certified mail to the Secretary of the Association immediately after the adjournment of the meeting. Such right to dissent or abstain shall not apply to any Director who voted in favor of such action.

Section 6. Electronic Meetings. Meetings of the Board of Directors may be held through the use of conference telephones or other communications equipment whereby all persons participating in the meeting can communicate with each other. Participation by any Board member in a meeting so held shall constitute presence in person at the meeting, and the minutes of any such meeting shall be prepared in the same manner as a meeting of the Board of Directors held in person.

ARTICLE VII

COMMITTEES

Section 1. Executive Committee.

a. Composition and Selection. There shall be an Executive Committee consisting of ~~nine (9)~~ twenty-six (26) members as follows; one member to be the Chairman of the Board who shall also serve as Chairman of the Executive Committee; one member to be the President of the Association; and twenty-four (24) members to be elected by the Regular Members of the Districts ("District Members") as provided in Article VIII, Section 2. If the office of any District Member ~~of the Executive Committee~~ shall become vacant, for example, by the election of a District Member to be

Chairman of the Board, then a successor District Member shall be elected by the Regular Members of the relevant District by the same type of vote received by successor District Member's predecessor within ninety (90) days or may be appointed by the Board of Directors ~~at its next meeting~~ as provided in Article VIII, Section 2.

b. Role and Procedures. The Executive Committee shall advise and aid the officers of the Association in all matters concerning its interests and the management of its affairs and, when the Board of Directors is not in session, the Executive Committee shall have all the powers of the Board of Directors except those powers expressly reserved by the Board of Directors or those prohibited by law. All actions by the Executive Committee shall be reported to the Board of Directors at its meeting next succeeding such action and all be subject to revision and alteration by the Board, but no rights of third parties shall be affected by any such revision or alteration. Regular minutes of the proceedings of the Executive Committee shall be kept in a book provided for that purpose.

~~A majority of the members of the Executive Committee may determine its action and fix the time and place of its meetings.~~

Section 2. Nominating Committee.

a. Composition and Selection. There shall be a Nominating Committee ~~consisting of five (5) members~~ of ~~of~~ twelve (12) members consisting of the District Members on the Executive Committee elected by majority vote of the Regular Members in each District.

b. Role and Procedures. The Nominating Committee shall nominate a candidate for election by the Board of Directors ~~(other than the Chairman) elected by the Board of Directors to serve for terms of one (1) year, and no member may serve more than three (3) consecutive terms. A member may not serve in the year in which the member's term expires. The~~ as Chairman of the Board ~~shall recommend persons to serve. The Nominating Committee shall nominate candidates for election by the Board of Directors as members of the Executive Committee and as Chairman of the Board. Such nominations~~ and Executive Committee. Such nomination shall be submitted to Members and to the Board of Directors not less than fifteen (15) days prior to the date

scheduled for election unless waived by the Board of Directors. The Nominating Committee shall also recommend to the Board of Directors, in January of each year, candidates for chairman and members of the nine (9) standing committees.

~~Section 2. Audit Committee. There shall be an Audit Committee consisting of not more than eight (8) members appointed by the Board of Directors upon recommendation of the Chairman of the Board. The Audit Committee~~

c. Chairman. The Nominating Committee shall elect a committee member to serve as Chairman.

Section 3. Standing Committees of the Board. The Board of Directors shall, in February of each year, appoint nine (9) Standing Committees of the Board. Except as otherwise provided by these Bylaws, a majority of each Standing Committee shall consist of CEOs of Regular Members. Only District Members of the Executive Committee shall be eligible to serve as chairmen of the Standing Committees, and no Member shall have more than one representative on any Standing Committee. The Board of Directors shall define the scope of activities, authority and responsibilities of each Standing Committee, and select the chairman.

a. Audit Committee. The Audit Committee ~~shall consist~~ of not more than eight (8) members. It shall serve as the channel of communication between the Board and the Association's independent auditors, and shall have such other duties as authorized by the Board of Directors.

b. FEP Board of Managers. The FEP Board of Managers shall consist of ten (10) Chief Executive Officers of Regular Members and the President of the Association. It shall monitor the operations of the Federal Employee Program and, within general policy guidelines established by the Board of Directors, develop and implement specific FEP policies and procedures.

c. Government Programs Committee. The Government Programs Committee shall consist of ten (10) persons. It shall recommend policies and objectives for acquiring and maintaining Member participation in existing and proposed government health programs, excluding the Federal Employees Health Benefits Program, shall oversee relations between the Association and Members relative to Medicare, and shall oversee Medicare contractor performance monitoring and intervention activities.

d. Inter-Plan Operations Committee. The Inter-Plan Operations Committee shall consist of nine (9) persons. It shall provide guidance to Association management on Inter-Plan programs, and consider and make recommendations regarding the use of PLAN-NET and Inter-Plan data and telecommunications needs of Members. It shall also consider and make recommendations for programs to improve benefit delivery to National Accounts and out-of-area subscribers.

e. Mediation Committee. The Mediation Committee shall consist of six (6) to eight (8) persons. It shall develop and implement processes for resolving disputes between Members or between Members and the Association under specified circumstances.

f. National Employee Benefits Committee. The National Employee Benefits Committee shall consist of six (6) Chief Executive Officers of Regular Members participating in the National Retirement Program, and three (3) Chief Executive Officers of Regular Members participating in any of the National Employee Benefit Programs. It shall serve as the legal administrator of the National Employee Benefits Programs, and represent the interests of Members participating in the Programs.

g. Plan Performance and Membership Committee. The Plan Performance and Membership Committee shall consist of six (6) to eight (8) Chief Executive Officers of Regular Members. It shall recommend and oversee implementation of policies to aid Members to achieve performance objectives, evaluate programs to establish financial and operational stability, review and make recommendations regarding compliance with and proposals for new membership, licensing and sublicensing standards, and recommend actions to protect the registered Marks.

h. Private Sector Program Committee. The Private Sector Program Committee shall consist of six (6) to eight (8) persons. It shall recommend policies regarding private market opportunities, marketing communications, National Account acquisition and retention, and cost containment programs, and to meet demands for alternative forms of health care delivery. It shall also monitor administration of the equalization program.

i. Provider Affairs Committee. The Provider Affairs Committee shall consist of six (6) to eight (8) persons. It shall recommend policies for and oversee programs designed to secure and maintain health provider and business support for Blue Cross and Blue Shield policies, and shall recommend policies concerning medical and dental necessity and changes in medical and dental technology.

Section 4. Other Committees. The Board of Directors may establish or dissolve such other committees as it deems expedient; define the scope of activities, authority and responsibilities of such committees; and appoint and remove the chairman and members of such committees. The Board of Directors may also authorize any ~~such committee~~ standing committee or other committee to appoint one or more subcommittees. All recommendations of each ~~such~~ committee shall be submitted to the Board of Directors and shall be subject to its approval.

Section 5. Committee Meetings. Unless the appointment by the Board of Directors requires a greater number, a majority of any committee shall constitute a quorum, and a majority of committee members present and voting at a meeting at which a quorum is present shall be necessary for committee action. Meetings of any committee of the Board of Directors may be held through the use of conference telephones, or other communications equipment whereby all persons participating in the meeting can communicate with each other. Participation by any committee member in a meeting so held shall constitute presence in person at the meeting, and the minutes of any such meeting shall be prepared in the same manner as a meeting of the committee members held in person.

ARTICLE VIII
DISTRICTS

Section 1. District Designations. The Regular Members in the United States are divided into twelve (12) Districts, the boundaries of each District having been filed with the Secretary of the Association. Such boundaries may from time to time be changed by vote of the Regular Members.

Section 2. District Elections. Each District shall annually elect two (2) CEOs of Regular Members in the District who are Directors to serve on the Executive Committee. The person receiving a majority of the weighted vote of the Regular Members in the District shall be one District Member, and the person receiving a majority vote of the Regular Members in the District shall be the other District Member on the Executive Committee. For the purposes of the foregoing, the Regular Members shall be deemed classified into twelve (12) classes, one for each District. If a

District fails to elect a District Member or Members, or fails to elect a successor District Member or Members, the Board of Directors may elect a District Member or successor District Member for that District.

ARTICLE IX

ELECTIVE OFFICERS

Section 1. Officers. The elective officers of the Association shall be a Chairman of the Board, who shall also serve as Chairman of the Executive Committee, President, Secretary, Treasurer and such other officers, upon recommendation of the President, as the Board of Directors may elect. Only a member of the Board of Directors shall be qualified to be elected Chairman of the Board and Executive Committee, and no other officer, except the President, shall be a member of the Board of Directors. The offices of President and Secretary may not be held by the same person.

Section 2. Election of Officers. All officers, except those appointed pursuant to Article [redacted], Section 1, shall be elected by the Board of Directors at its annual meeting, or as soon thereafter as convenient. Officers shall assume office immediately upon election and serve for a period of one [redacted] year or until their successors are elected and assume office.

Section 3. Vacancies. In the event of death, resignation, removal or disability of any elective officer, the Board of Directors may at any meeting elect a successor who shall serve during the remainder of the term or until a successor is elected and assumes office.

Section 4. Chairman of the Board. The Chairman shall preside at all meetings of the Board of Directors and [redacted] at all business meetings of the Association, and shall exercise general supervision over such affairs and activities of the Association as are not expressly reserved for the President. No person may serve more than three (3) consecutive terms as Chairman of the Board [redacted].

Section 5. President. The President shall be the chief executive officer of the Association and shall supervise and administer all of the business and affairs of the Association. He may sign with the Secretary or other officer of the Association authorized by the Board of Directors, any deeds, bonds, contracts or other instruments which the Board of Directors has authorized to be executed. He shall perform such other duties as usually pertain to his office or as may be prescribed by the Board of Directors.

Section 6. Vice President. The Board of Directors may elect one or more Vice Presidents who shall, in general, perform all duties as from time to time may be assigned to them by the President or by the Board of Directors. In the event more than one Vice President is so elected, and in the absence of the President or in the event of his inability or refusal to act, the Board of Directors shall designate a Vice President who shall perform the duties of the President, and when so acting, shall have all the powers of and be subject to all the restrictions upon the President.

Section 7. Treasurer. The Treasurer shall cause to be entered on the books of the Association the dues of each Member as determined by the Association; shall demand and receive all funds due the Association; shall cause the same to be promptly deposited, together with all devises, bequests, and donations, in a depository approved by the Board of Directors; shall cause to be kept proper and accurate records thereof, as well as of funds disbursed by the Association; shall pay out of the monies of the Association only such amounts as are approved by the Board of Directors; and shall give bond in such sum, if any, as the Board of Directors may determine, the premium of such bond to be paid by the Association; shall perform such other duties as may be required by these Bylaws, by the President, or by the Board of Directors. In the absence or inability of the Treasurer to act, the duties shall be performed as specified by the Board of Directors.

Section 8. Secretary. The Secretary shall be the custodian of the minutes of the meetings of the Association and the Board of Directors, and of all other records, books and papers belonging to the Association, and of the Corporate Seal; shall receive applications for membership and transmit them to the Board of Directors; shall provide for the registration of all Members at meeting of the Association and keep a record of such registration; shall keep a register of Regular, Associate and Affiliate Members; shall sign any instruments required by law to be executed by a Secretary; shall cause notice of all meetings of the Association and the Board of Directors to be given; shall have the authority to certify these Bylaws, resolutions of the Members and the Board of Directors and committees thereof, and other documents of the Association as true and correct copies thereof; and shall perform such other duties as may be required by these Bylaws, by the President, or by the Board of Directors. In the absence or inability of the Secretary to act, the duties shall be performed as specified by the Board of Directors.

Section 9. Other Officers. All other officers shall have such powers and duties as from time to time may be assigned to them by the President or by the Board of Directors.

Section 10. Removal. Any officer or agent of the Association may be removed by the Board of Directors whenever in its judgment the best interests of the Association would be served thereby.

Section 11. Compensation. The officers of the Association shall receive such compensation for their services as may, from time to time, be fixed by the Board of Directors, but no officer, except the Chairman of the Board and Executive Committee, may be an employee of or receive compensation from any Member.

ARTICLE [redacted]

APPOINTIVE OFFICERS

Section 1. Appointive Officers. The President of the Association may appoint such other officers of the Association as he deems wise, with the advice and consent of the Executive Committee. Appointive officers shall have such powers and duties as may be assigned to them by the President.

Section 2. Removal. Any appointive officer may be removed at any time by the President of the Association.

Section 3. Compensation. The appointive officers of the Association shall receive such compensation for their services as the President shall determine within the guidelines established by the Executive Committee. No appointive officer may be an employee of, or receive compensation from, any Member.

ARTICLE [redacted]

CONTRACTS, CHECKS, DEPOSITS AND FUNDS

Section 1. Contracts. The Board of Directors may authorize any officer or officers, agent or agents of the Association, in addition to the officers so authorized by these Bylaws, to enter into any contract or execute and deliver any instrument in the name of and on behalf of the Association, and such authority may be general or confined to specific instances.

Section 2. Checks. All checks, drafts and other orders for the payment of money, notes or other evidences of indebtedness issued in the name of the Association shall be signed by such officer or officers, agent or agents of the Association and in such manner as shall from time to time be determined by resolution of the Board of Directors. In the absence of such determination by the Board of Directors, such instruments shall be signed by the Treasurer and countersigned by the President or a Vice President.

Section 3. Deposits. All funds of the Association shall be deposited from time to time to the credit of the Association in such banks, trust companies or other depositories as the Board of Directors may select.

Section 4. Bonds. All officers and agents of the Association responsible for the receipt, custody or disbursement of funds shall give bonds for the faithful discharge of their duties in such sums and with such sureties as the Board of Directors shall determine.

Section 5. Gifts. The Board of Directors may accept on behalf of the Association any grant, contribution, gift, bequest or devise for the general purposes or for any special purposes of the Association. The Board of Directors shall have the right to contribute funds of the Association to any other corporation or association which is operated not for pecuniary profit an in furtherance of the purposes of this Association as stated in Article I of these Bylaws.

ARTICLE [redacted]

DISSOLUTION

Upon dissolution or final liquidation of the Association, whether voluntary or involuntary, no part of its assets shall be paid or distributed to or for the benefit of any Member. Said assets shall be applied and distributed, first to the payment satisfaction and discharge of all liabilities and obligations of the Association, or adequate provision shall be made therefor; second, to the return, transfer or conveyance of assets held by the Association upon condition requiring return, transfer or conveyance by reason of dissolution of the Association; and third, the balance, if any, shall be transferred and conveyed to one (1) or more corporations, societies or organizations, wherever organized or operating, engaged not for profit in the advancement of health service, pursuant to a plan of distribution adopted in accordance with the Illinois General Not For Profit Corporation Act.

ARTICLE [redacted]

AMENDMENTS

These Bylaws may be amended or repealed and new Bylaws may be adopted by the affirmative vote of at least one-half (1/2) of the Regular Members [redacted] present and voting, ~~entitled to~~ representing two-thirds (2/3) of the weighted [redacted] votes of all the Regular Members at any regular meeting or at any special meeting, provided that the proposed amendment, addition or action is submitted in

writing to each Member at least thirty (30) days prior to the meeting at which the same is to be considered.

ARTICLE [redacted]

INDEMNIFICATION OF DIRECTORS AND OTHERS

Section 1. Persons Who May Be Indemnified. (a) To the extent permitted by law, the Association shall indemnify any person who was or is a party, or is threatened to be made a party, to any threatened or pending or completed action or suit or proceeding, whether civil, criminal, administrative or investigative (other than an action by or in the right of the Association) by reason of the fact that he or she is or was (i) a director, officer, employee, or agent of the Association; (ii) a member of a committee appointed by the Board of Directors; or (iii) serving at the request of the Association as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise (such persons being hereinafter referred to in this Article as "persons who may be indemnified"), against expenses (including attorneys' fees), judgments, fines and amounts paid in settlement, actually and reasonably incurred by him or her in connection with such action, suit or proceeding, provided that he or she acted in good faith and in a manner he or she reasonably believed to be in, or not opposed to, the best interests of the corporation and, with respect to any criminal action or proceeding, had no reasonable cause to believe his or her conduct was unlawful.

(b) To the extent permitted by law, the Association shall indemnify any person who was or is a party, or is threatened to be made a party to any threatened or pending or completed action or suit by or in the right of the Association to procure a judgment in its favor by reason of the fact that he or she is or was (i) a director, officer, employee or agent of the Association; (ii) a member of a committee appointed by the Board of Directors; or (iii) serving at the request of the Association as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise (such persons being hereinafter referred to in this Article as "persons who may be indemnified"), against expenses (including attorneys' fees) actually and reasonably incurred by him or her in connection with the defense or settlement of such action or suit, provided that such person acted in good faith and in a manner he or she reasonably believed to be in, or not opposed to, the best interests of the corporation, and provided further, that no indemnification shall be made in respect of any claim, issue or matter as to which he or she shall have been adjudged to be liable for negligence or misconduct in the performance of his or her duty to the corporation.

Section 2. Indemnification Procedure. Any indemnification under Section 1 above (unless ordered by a court) shall be made by the Association only as authorized in the specific case upon determination that indemnification of a person who may be indemnified is proper in the circumstances because such person has met the criteria set forth in Section 1 above. Such determination shall be made: (1) by the Board of Directors by a majority vote of a quorum consisting of members thereof who were not parties to such action, suit or proceeding, or (2) by independent legal counsel in a written opinion if such a quorum is not obtainable, or even if obtainable, if a quorum of disinterested members of the Board of Directors so directs.

Section 3. Advances. Expenses incurred in defending an action, suit or proceeding may be paid by the Association in advance of the final disposition of such action, suit or proceeding, as authorized by the Board of Directors in the specific case, upon receipt of an undertaking by or on behalf of the person who may be indemnified to repay such amount unless such a person shall ultimately be determined to be entitled to be indemnified.

Section 4. Other Indemnification Arrangements. The indemnification provided by this Article shall not be deemed exclusive of any other rights to which those seeking indemnification may be entitled under any agreement, vote of the members of the Board of Directors or disinterested members thereof, or otherwise, both as to action in an official capacity and as to action in another capacity while holding such office, and shall continue as to a person who has ceased to hold the office and shall inure to the benefit of the heirs, executors and administrators of such a person.

Section 5. Insurance. The Association shall have the power to purchase and maintain insurance on behalf of any person against any liability asserted against and incurred by such person as a result of serving any capacity defined in Section 1 above, whether or not the Association would have the power to indemnify against such liability under the provisions of this Article.

ARTICLE [redacted]

BOOKS AND RECORDS

The Association shall keep correct and complete books and records of account and shall also keep minutes of the proceedings of its Members, Board of Directors and Executive Committee and shall keep at the registered or principal office a record giving the names and addresses of the Members. All books and records of the Association may be inspected by any Member, or its agent or attorney, for any proper purpose at any reasonable time.

ARTICLE [redacted]

OFFICES AND SEAL

Section 1. Offices. The Association shall have and continuously maintain in the State of Illinois its principal executive office and also a registered office and a registered agent whose office is identical with such registered office, and may have other offices within or without the State of Illinois as the Board of Directors may determine.

Section 2. Seal. The Board of Directors shall provide a corporate seal which shall be in the form of a circle and shall have inscribed thereon the name of the Association and the words "CORPORATE SEAL - ILLINOIS."

ARTICLE [redacted]

FISCAL YEAR

The fiscal year of the Association shall be the calendar year or such other fiscal year as the Board of Directors shall select.

ARTICLE [redacted]

WAIVER OF NOTICE

Whenever any notice is required to be given by statute or the Bylaws of the Association, a waiver thereof in writing signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice.

[redacted]

SUNSET PROVISION

Unless ratified at the 1993 Annual Meeting of Members by the affirmative note of at least one-half (1/2) of the Regular Members present and voting, entitled to two-thirds (2/3) of the weighted votes of all Regular Members, the amendments to these Bylaws adopted at the 1990 Special Meeting of Members shall be null and void, and the Bylaws in effect on November 1, 1989, shall govern the affairs of the Association, effective at the commencement of the 1994 Annual Meeting of Members; provided, however, that

Article V, Board of Directors, as set forth on November 1, 1989, shall govern regarding the election and selection of persons to serve on the Board of Directors at said 1994 Annual Meeting of Members.

Exhibit C

BCA LICENSE AGREEMENT

SERVICE MARK AND TRADE NAME "BLUE CROSS"

AGREEMENT, effective as of , 1972, by and between BLUE CROSS ASSOCIATION ("BCA") and the BLUE CROSS PLAN known as ("Plan").

PREAMBLE:

A. BCA is the owner of the term "BLUE CROSS" and the design of a Blue Cross as service marks for prepayment plans for hospital care and related services ("BCA Marks").

B. Plan desires to use the BCA Marks and any revisions and variations hereafter developed (collectively called "Licensed Marks") as service marks and the term "BLUE CROSS" as a trade name and as part of the Plan's corporate name ("Licensed Name"), upon the terms and conditions of this License Agreement.

AGREEMENT:

1. BCA hereby grants to Plan upon the terms and conditions of this License Agreement, the right and license to use the Licensed Marks as service marks, in the sale and advertising of programs for health care and related services operated on a non-profit basis in a manner approved by BCA in regulations of general application to prevent the impairment of the distinctiveness of the Licensed Marks and Licensed Name and the good will pertaining thereto. BCA also grants to Plan upon the terms and conditions of this agreement, the right and license to use the Licensed Name as a trade name and as part of the Plan's corporate name. The rights hereby granted are exclusive to Plan within the geographical area served by the Plan on the effective date of this License Agreement, except that BCA itself reserves the right to use the Licensed Marks and Licensed Name in said area, and except to the extent that said area may overlap the area or areas served by one or more other licensed Blue Cross Plans on the effective date of this License Agreement, as to which overlapping areas the rights hereby granted are non-exclusive as to such other Plan or Plans only.

2. Plan agrees to maintain the license requirements of general application prescribed by BCA for the services in connection with which the Licensed Marks are used and in the conduct of the business operations in connection with which the Licensed Name is used as set forth in Attachment "1" affixed hereto and made a part hereof.

3. Plan agrees that it will display the Licensed Marks and Licensed Name only in such form, style and manner as shall be specifically prescribed by BCA in regulations of general application to prevent the impairment of the distinctiveness of the Licensed Marks and Licensed Name and the good will pertaining thereto. Plan also shall cause to appear on all materials on or in connection with which the Licensed Marks or Licensed Name are used, such legends, markings and notices as BCA may request in order to give appropriate notice of any trademark, trade name or other rights therein or pertaining thereto.

4. Plan agrees to submit data annually to BCA or at other times, upon the written request of BCA, which demonstrates its compliance with the requirements of this License Agreement. If BCA believes that the data submitted by Plan does not establish compliance with the said requirements, BCA shall have the right to request Plan to furnish, and Plan shall furnish, within thirty (30) days after receipt of notice to that effect, additional data as will be reasonably required to demonstrate the compliance of Plan with said requirements.

5. BCA agrees that it will not grant any other license effective during the term of this License Agreement for use of the Licensed Marks or Licensed Name which is inconsistent with the rights granted to Plan hereunder. Plan agrees that it will not, during the term of this License Agreement, attack the title of BCA in and to the Licensed Marks or Licensed Name or attack the validity of this license. Plan further agrees that all use by it of the Licensed Marks and Licensed Name hereunder shall inure to the benefit of BCA.

6. This License Agreement shall remain in effect until terminated, or until the Ownership Agreement among AHA, Plan and BCA, effective as of the same date as this License Agreement, is terminated, whichever is earlier.

7. The license of a Plan may not be terminated except for its failure to perform its obligations under paragraphs 2, 3, and 4 hereof, in which event BCA shall have the right to terminate this License Agreement (without prejudice to any other rights which BCA may have) upon one hundred and twenty (120) days' written notice, and such notice of termination shall become effective unless Plan shall completely remedy the default within such one hundred and twenty (120) day period. A hearing will be accorded such Plan within the one hundred and twenty (120) day period before the BCA Board of Governors pursuant to rules and regulations established by the Board. Such rules and regulations shall provide, among other things, for Plan representation by legal counsel and the making and availability of a transcript.

8. If Plan shall file a voluntary petition in bankruptcy or take any other voluntary action seeking a reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other laws governing insolvency, or finally be adjudged bankrupt or insolvent by any court of competent jurisdicition, or make a general assignment of its assets for the benefit of creditors, or if a receiver, trustee or other officer shall be appointed for its property or business and the order, judgment or decree making such appointment shall not be vacated or set aside within sixty (60) days after the date thereof, this License Agreement automatically shall terminate.

9. Rights in the Licensed Marks and Licensed Name other than those specifically granted herein are reserved by BCA for its own use. Upon the termination of this License Agreement for any reason whatsoever, unless by reason of termination of the Ownership Agreement and then to the extent that

the Ownership Agreement does not provide otherwise, all rights in and to the Licensed Marks and Licensed Name shall automatically revert to BCA, and Plan agrees that it will promptly discontinue all use of the Licensed Marks and Licensed Name, will not use them thereafter, and will promptly upon written notice from BCA, change its corporate name so as to eliminate the Licensed Name therefrom.

10. If any provision, or part thereof, of this License Agreement is judicially declared unlawful, each and every other provision, or part thereof, nevertheless shall continue in full force and effect.

11. No waiver by BCA of any breach of any provision of this License Agreement by Plan shall be construed to be a waiver of any preceding or succeeding breach of the same provision, or of any other provision.

12. The license hereby granted to Plan to use the Licensed Marks and the Licensed Name is and shall be personal to the Plan so licensed and shall not be assignable by any act of the Plan, directly or indirectly, without the written consent of BCA. Said license shall not be assignable by operation of law, and Plan shall have no right to grant any sublicense, nor shall Plan mortgage or part with possession or control of this license or any of its rights hereunder.

IN WITNESS WHEREOF, the parties hereto have caused this License Agreement to be executed, effective as of the date first above written.

BLUE CROSS ASSOCIATION

By_____

_____

/Blue Cross Plan/

By_____

License Requirements of General Application - BCA License Agreement

The PLAN shall, as a condition to the grant and to the continuance of its licensing hereunder, comply with the following requirements:

(a) The corporate body of each PLAN shall be representative of the community and hospitals served by such PLAN.

(b) Trustees, board and corporation members of each PLAN shall receive no compensation for services as such.

(c) No portion of the earnings remaining after payment of the cost of operation shall inure to the benefit of any individual.

(d) Every qualified general hospital in the area served by the PLAN shall have reasonable opportunity to become a contracting hospital.

(e) Subscribers shall have free choice among contracting hospitals.

(f) Service benefits, as distinguished from wholly cash indemnity benefits, and as determined in good faith by the PLAN, shall be provided through contract between the PLAN and its contracting hospitals.

(g) Provision shall be made for benefits in qualified non-contracting hospitals.

(h) The finances of every PLAN shall be kept separate from those of any hospital.

(i) No employee of a Plan shall be paid principally by commission or on a production fee basis.

(j) The foregoing requirements shall apply except to such extent as may be prohibited by law.

AGREEMENT RELATING TO THE

COLLECTIVE SERVICE MARK

"BLUE SHIELD"

THIS AGREEMENT made and entered into as of the effective dates hereinafter stated, by and between BLUE SHIELD MEDICAL CARE PLANS, an Illinois nonprofit corporation, hereinafter called the National Organization, and each and all of the nonprofit medical care plans that are full or associate members of the National Organization.

PREAMBLE:

A. The National Organization was organized as an Illinois nonprofit corporation on the 28th day of March, 1946, for the purpose of promoting the establishment and operation of nonprofit voluntary medical care plans throughout the United States and Canada. It is a membership corporation having two classes of members, full members and associate members. Eligibility to membership is determined by certain "membership standards" heretofore adopted by its governing body, known as the Blue Shield Commission. The National Organization now has 68 full members and 10 associate members, all of which are nonprofit corporations engaging in the operation of prepayment medical care plans within the respective states or territories or provinces (or portions thereof) under the laws of which they are incorporated.

B. Prior to the incorporation of the National Organization, several of the medical care plans that are now full members of the National Organization adopted and used, in both intra-state and interstate commerce, a service mark, consisting of the words "Blue Shield," either used alone or in conjunction with a symbol in the shape of a shield, colored blue and bearing various identifying or symbolical insignia thereon such as the caduceus. Such service mark was first used by Western New York Medical Plan, Inc., of Buffalo, New York, on 23 September 1939. Between that date and December 13, 1947, the words "Blue Shield" and their accompanying symbol gradually acquired, in the areas in which used and elsewhere, a definite meaning, i.e. as identifying nonprofit prepayment medical care plans owned, controlled or sponsored by county medical societies or state, district, territorial or provincial medical associations. On said December 13, 1947, the governing body of the National Organization (the Blue Shield Commission) formally adopted the words "Blue Shield" and their accompanying symbol as the official service mark for the National Organization, and for all full or associate members of the National Organization that desired to adopt or use such mark.

After the adoption of said service mark by the National Organization, it filed several applications with the United States Patent Office under the Trade Mark Act of 1946, seeking registration of said service mark in the various forms in which it is actually used. Said applications bear the following serial numbers: 589371, 606403 and 616543. Applications numbered 589371 and 606403, relating to the use of the words "Blue Shield," have been granted by the Commissioner of Patents, and certificates of registration each dated April 1, 1952 and bearing the numbers 557037 and 557040, respectively, have been issued to the National Organization. Application bearing serial number 616543 is currently pending. Further applications to protect all forms in which the service mark is used by the National Organization are contemplated.

C. At the 1951 annual conference of member plans of the National Organization, it was voted that an agreement be entered into by all member plans, embodying the following points:

(1) Recognition that the words "Blue Shield" and the identifying symbol are the property of the National Organization;

(2) Definition of the right to the use of said words and symbol by the member plans;

(3) Prescription of the limitations on misuse and the action to be taken to prevent same;

(4) Provision for the preservation of the right of members to use variations of the symbol in accordance with local practice; and

(5) Provisions for protection of the rights in said service mark as against third party infringement.

D. This agreement is entered into by the National Organization and each of its member plans for the purposes as specified at the 1951 annual conference.

AGREEMENTS:

1. The words "Blue Shield" and the symbol consisting of a shield colored blue, with or without a caduceus superimposed thereon, constitute a service mark, which is the property of the National Organization and through it inures to the benefit of its member plans.

2. Each member plan that is a party hereto is entitled by virtue of its membership to use the words "Blue Shield" in order to identify to the public its nonprofit medical care plan and its membership in the National Organization. In addition, each such member plan may use the symbol consisting of a shield colored blue, with a caduceus superimposed thereon, or to use said symbol with words or insignia other than the caduceus superimposed thereon.

3. (a) The National Organization hereby grants to each of its member plans that are parties to this agreement, subject to the terms of this agreement, permission to use said service mark in commerce among the several states or in foreign commerce.

(b) Said member plans shall, subject to the terms of this agreement, display with said service mark as used the words "Reg. U. S. Pat. Off," or the letter R enclosed within a circle, thus (R)

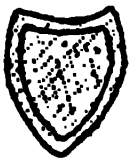
(c) Subject to the provisions of Paragraph 8 of this agreement, a full or associate member of the National Organization who ceases to be a member of the National Organization, shall automatically, and without any notice or action on the part of the National Organization, or such member, immediately forfeit and surrender the permission to use said service mark granted in this paragraph 3.

4. In the event that any member Plan of the National Organization shall use said service mark, in commerce among the several states or in foreign commerce, either (a) contrary to the provisions of this agreement, or (b) for services other than medical or surgical care, or health services auxiliary or ancillary to same, then and in either of such events all rights and privileges of such member Plan derived

under this agreement shall be subject to termination but only after notice, investigation and hearing as provided in Section II of the Membership Standards of the National Organization.

5. For the protection of its members, it is the duty of the National Organization to take such lawful steps and proceedings as may be necessary or proper to prevent further use of said service mark by any person who is either (a) not authorized under the provisions of this agreement to use said service mark, or (b) has been so authorized and has lost the privilege of use for any of the reasons specified herein. Any action or proceedings undertaken by the National Organization under the provisions of this paragraph shall be at its sole cost and expense.

6. (a) Nothing contained in this agreement shall interfere with or prevent any member plan of the National Organization that is a party to this agreement from continuing to use, in connection with the words Blue Shield, variations that are now in use of the symbol, specimens of which appear below.



the rights of the members of the National Organization reserved in this paragraph are, however, expressly conditioned upon compliance with each and all of the other terms and provisions hereof.

(b) Prior to adopting or using any new variation of the above basic symbols a member plan must submit three specimens of same to the National Organization for its approval and shall not use any such new variation until written approval is obtained.

7. A full or associate member of the National Organization upon becoming a party of this agreement does not waive, forfeit or relinquish any legal right to the use of the words "Blue Shield" or to the use of the Blue Shield symbol that may have been heretofore acquired by such member under the laws of the state or province in which it is incorporated or from whom it holds its charter; provided, however, that this reservation of local right is limited as follows:

(a) It shall not be asserted by any party to this agreement in derogation or limitation of any right, privilege or power acquired by the National Organization as a result of its use or registration of said service mark; and

(b) In the event that any member of the National Organization ceases to be a member thereof or ceases to have the privilege of use of said service mark by operation of this said agreement, said local rights herein reserved shall not be asserted by way of defense or counterclaim in derogation of the commerce rights of the National Organization in any action or proceeding that may be commenced by the National Organization to enforce the provisions of this agreement.

8. In the event that a member Plan which is a party to this agreement, voluntarily surrenders such membership this agreement shall nevertheless remain in effect as to such party as long as such party continues to abide by and conform to the

Membership Standards of the National Organization. In order that the National Organization may determine whether any such Plan is operating in conformance with said Membership Standards, such Plan shall furnish to the National Organization at such times as it shall require all of the information required under Section XI, Paragraph 3 of the Membership Standards entitled "Annual Review of Membership Status." If at any time the Blue Shield Commission shall determine that such former member Plan is no longer conforming to and abiding by the Membership Standards, the Commission may so declare by resolution, in which event this agreement shall immediately and automatically terminate as to such former member Plan.

9. This agreement may be executed by the member plans in any number of counterparts and each counterpart shall be conclusively deemed to be an original and all counterparts shall together constitute one instrument.

10. Within 30 days following receipt by the National Organization of written notice signed by at least five member Plans which are parties to this agreement, stating that they desire that this agreement be revised or revoked, the National Organization shall give all member Plans that are parties to this agreement written notice of such proposed revision or revocation and call a special meeting of all such member Plans that are parties to this agreement, to be held not less than 30 days nor more than 60 days thereafter, to consider and act upon the proposed revision or revocation. At such meeting, or any adjournment thereof, the said member Plans may revise or revoke this agreement but only by the majority vote of all member Plans that are parties to this agreement (the Plans constituting such majority shall also represent a majority of all subscribers to said member Plans that are parties to this agreement). The majority of all said member Plans and of all subscribers to all of said member Plans as of the date of issuance of said notice shall be determined from the latest available records of the Blue Shield Commission.

11. The effective date of this agreement as to each member of the National Organization shall be the date set opposite the signature of such member, and this agreement shall remain in full force and effect until terminated (1) as to any member of the National Organization due to breach of this agreement by it or (2) until terminated as a whole in the manner provided in Paragraph 10 or by mutual agreement in writing of all of the parties hereto.

IN WITNESS WHEREOF, the parties hereto have hereunto set their hands as of the date set opposite their respective names.

BLUE SHIELD MEDICAL CARE PLANS

by _____

Its

National Organization

_____

by _____

Its

Member Plan

Effective date: _____

Exhibit D

BLUE CROSS LICENSE AGREEMENT

This agreement by and between Blue Cross and Blue Shield Association ("BCBSA") and The Blue Cross Plan, known as _____ (the "Plan").

Preamble

WHEREAS, the Plan and/or its predecessor(s) in interest (collectively the "Plan") had the right to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") for health care plans in its service area, which was essentially local in nature;

WHEREAS, the Plan was desirous of assuring nationwide protection of the Licensed Marks, maintaining uniform quality controls among Plans, facilitating the provision of cost effective health care services to the public and otherwise benefitting the public;

WHEREAS, to better attain such ends, the Plan and the predecessor of BCBSA in 1972 simultaneously executed the BCA License Agreement(s) and the Ownership Agreement; and

WHEREAS, BCBSA and the Plan desire to supercede the BCA License Agreement(s) and to revise certain provisions of the Ownership Agreement to reflect their current practices and to assure the continued integrity of the Licensed Marks and of the BLUE CROSS system;

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

Agreement

1. BCBSA hereby grants to the Plan, upon the terms and conditions of this License Agreement, the right to use BLUE CROSS in its trade and/or corporate name (the "Licensed Name"), and the right to use the Licensed Marks, in the sale, marketing and administration of health care plans and related services in the Service Area set forth and defined in paragraph 5 below. As used herein, health care plans and related services shall include acting as a nonprofit health care plan, or mutual health insurer operating on a not-for-profit basis, under state law; financing access to health care services; providing health care management and administration; and delivering health care services.

2. The Plan may use the Licensed Marks and Name in connection with the offering of health care plans and related services in the Service Area through Controlled Affiliates, provided that each such affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit A hereto (the "Controlled Affiliate License Agreement") and further provided that the offering of such services does not and will not dilute or tarnish the unique value of the Licensed Marks and Name. With respect to any HMO previously sublicensed as provided in a License Addendum between BCBSA and the Plan, the Plan shall have one (1) year from the date hereof to obtain execution of the direct license required herein. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such

a manner that it is subject to the bona fide control of a Plan or Plans. Absent written approval by BCBSA of an alternative method of control, bona fide control shall mean the legal authority, directly or indirectly through wholly owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having not less than 51% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Plan or Plans shall own at least 51% of any for-profit Controlled Affiliate.

3. The Plan may engage in activities not required by BCBSA to be directly licensed through Controlled Affiliates and may indicate its relationship thereto by use of the Licensed Name as a tag line, provided that the engaging in such activities does not and will not dilute or tarnish the unique value of the Licensed Marks and Name and further provided that such tag line use is not in a manner likely to cause confusion or mistake. Consistent with the avoidance of confusion or mistake, each tag line use of the Plan's Licensed Name: (a) shall be in the style and manner specified by BCBSA from time to time; (b) shall not include the design service marks; (c) shall not be in a manner to import more than the Plan's mere ownership of the affiliate; and (d) shall be restricted to the Service Area. No rights are hereby created in any Controlled Affiliate to use the Licensed Name in its own name or otherwise. At least annually, the Plan

shall provide BCBSA with representative samples of each such use of its Licensed Name pursuant to the foregoing conditions.

4. The Plan agrees (a) to maintain in good standing its membership in BCBSA; (b) promptly to pay its dues to BCBSA, said dues to represent the royalties for this License Agreement; (c) materially to comply with all applicable laws; (d) to comply with the Membership Standards of BCBSA, a current copy of which is attached as Exhibit B hereto; and (e) reasonably to permit BCBSA, upon a written, good faith request and during reasonable business hours, to inspect the Plan's books and records necessary to ascertain compliance herewith. As to other Plans and third parties, BCBSA shall maintain the confidentiality of all documents and information furnished by the Plan pursuant hereto, or pursuant to the Membership Standards, and clearly designated by the Plan as containing proprietary information of the Plan.

5. The rights hereby granted are exclusive to the Plan within the geographical area(s) served by the Plan on June 30, 1972, and/or as to which the Plan has been granted a subsequent license, which is hereby defined as the "Service Area," except that BCBSA reserves the right to use the Licensed Marks in said Service Area, and except to the extent that said Service Area may overlap the area or areas served by one or more other licensed Blue Cross Plans as of said date or subsequent license, as to which overlapping areas the rights hereby granted are nonexclusive as to such other Plan or Plans only.

6. Except as expressly provided by BCBSA with respect to National Accounts, Government Programs and certain other necessary and collateral uses, the current rules and regulations governing which are attached as Exhibit C and Exhibit D hereto, or as expressly provided herein, the Plan may not use the Licensed Marks and Name outside the Service Area or in connection with other goods and services, nor may the Plan use the Licensed Marks or Name in a manner which is intended to transfer in the Service Area the goodwill associated therewith to another mark or name. Nothing herein shall be construed to prevent the Plan from engaging in lawful activity anywhere under other marks and names not confusingly similar to the Licensed Marks and Name, provided that engaging in such activity does and will not dilute or tarnish the unique value of the Licensed Marks and Name.

7. The Plan agrees that it will display the Licensed Marks and Name only in such form, style and manner as shall be specifically prescribed by BCBSA from time to time in regulations of general application in order to prevent impairment of the distinctiveness of the Licensed Marks and Name and the goodwill pertaining thereto. The Plan shall cause to appear on all materials on or in connection with which the Licensed Marks or Name are used such legends, markings and notices as BCBSA may reasonably request in order to give appropriate notice of service mark or other proprietary rights therein or pertaining thereto.

8. BCBSA agrees that: (a) it will not grant any other license effective during the term of this License Agreement for

the use of the Licensed Marks or Name which is inconsistent with the rights granted to the Plan hereunder; and (b) it will not itself use the Licensed Marks in derogation of the rights of the Plan or in a manner to deprive the Plan of the full benefits of this License Agreement. The Plan agrees that it will not attack the title of BCBSA in and to the Licensed Marks or Name or attack the validity of the Licensed Marks or of this License Agreement. The Plan further agrees that all use by it of the Licensed Marks and Name or any similar [derivative or related] mark or name shall inure to the benefit of BCBSA, and the Plan shall cooperate with BCBSA in effectuating the assignment to BCBSA of any service mark or trademark registrations of the Licensed Marks or any similar [derivative or related] mark or name held by the Plan or a Controlled Affiliate of the Plan, all or any portion of which registration consists of the Licensed Marks.

9 (a). Should the Plan fail to comply with the provisions of paragraphs 2-4, 6, 7 and/or 12, and not cure such failure within thirty (30) days of receiving written notice thereof (or commence curing such failure within such thirty day period and continue diligent efforts to complete the curing of such failure if such curing cannot reasonably be completed within such thirty day period), BCBSA shall have the right to issue a notice of noncompliance. Except as to the termination of a Plan's License Agreement or the merger of two or more Plans, disputes as to noncompliance, and all other disputes between or among BCBSA, the Plan, other Plans and/or Controlled Affiliates,

shall be submitted promptly to mediation and mandatory dispute resolution pursuant to the rules and regulations of BCBSA, a current copy of which is attached as Exhibit E hereto, and shall be timely presented and resolved.

(b). To the extent not otherwise provided therein, neither: (i) the Membership Standards; nor (ii) the rules and regulations governing National Accounts, Government Programs and certain other uses; nor (iii) the rules and regulations governing mediation and mandatory dispute resolution, may be amended unless and until each such amendment is first adopted by the affirmative vote of three-fourths of the Plans and of three-fourths of the total then current weighted vote of all the Plans.

(c). For impending financial insolvency or such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans and/or the Licensed Marks, a Plan's license to use the Licensed Marks and Name may be forthwith terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice. If a state of noncompliance as aforesaid is undisputed by the Plan or is found to exist by a mandatory dispute resolution panel and [persists thereafter] <u>is uncured as provided above</u>, BCBSA shall have the right to seek judicial enforcement of the License Agreement or to issue a notice of termination thereof. Except, however, as provided in ¶ 15(a)(i)-

(viii) below, no Plan's license to use the Licensed Marks and Name may be finally terminated for any reason without the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

10. This License Agreement shall remain in effect: (a) until terminated as provided herein; or (b) until this and all other License Agreements are terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans; or (c) until termination of the aforesaid Ownership Agreement; or (d) until terminated by the Plan upon six (6) months written notice to BCBSA.

11. Except as otherwise provided in paragraph 15 below or by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans, or unless this and all such other License Agreements are simultaneously terminated by force of law, the termination of this License Agreement for any reason whatsoever shall cause the reversion to BCBSA of all rights in and to the Licensed Marks and Name, and the Plan agrees that it will promptly discontinue all use of the Licensed Marks and Name, will not use them thereafter, and will promptly, upon written notice from BCBSA, change its corporate name so as to eliminate the Licensed Name therefrom.

12. The license hereby granted to Plan to use the Licensed Marks and Name is and shall be personal to the Plan so licensed and shall not be assignable by any act of the Plan, directly or indirectly, without the written consent of BCBSA.

Said license shall not be assignable by operation of law, nor shall Plan mortgage or part with possession or control of this license or any right hereunder, and the Plan shall have no right to grant any sublicense to use the Licensed Marks and Name.

13. BCBSA shall maintain appropriate service mark registrations of the Licensed Marks and BCBSA shall take such lawful steps and proceedings as may be necessary or proper to prevent use of the Licensed Marks by any person who is not authorized to use the same. Any actions or proceedings undertaken by BCBSA under the provisions of this paragraph shall be at BCBSA's sole cost and expense. BCBSA shall have the sole right to determine whether or not any legal action shall be taken on account of unauthorized use of the Licensed Marks, such right not to be unreasonably exercised. The Plan shall report any unlawful usage of the Licensed Marks to BCBSA in writing and agrees, free of charge, to cooperate fully with BCBSA's program of enforcing and protecting the service mark rights, trade name rights and other rights in the Licensed Marks.

14. [The Plan and BCBSA each hereby agree to save, defend, indemnify and hold the other and any other Plan(s) harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise exclusively and directly as a result of the activities of the Plan or of BCBSA, as the case may be.] <u>The Plan hereby agrees to save, defend, indemnify and hold BCBSA and any other Plan(s) harmless from and against all claims, damages, liabilities and</u>

costs of every kind, nature and description which may arise exclusively and directly as a result of the activities of the Plan. BCBSA hereby agrees to save, defend, indemnify and hold the Plan and any other Plan(s) harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise exclusively and directly as a result of the activities of BCBSA.

15 (a). This Agreement shall automatically terminate upon the occurrence of any of the following events: (i) a voluntary petition shall be filed by the Plan or by BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against the Plan or BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other laws governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within sixty (60) days of the date upon which it was filed, or (iii) an order for relief is entered against the Plan or BCBSA in any case under the bankruptcy laws of the United States, or the Plan or BCBSA is adjudged bankrupt or insolvent (as that term is defined in the Uniform Commercial Code as enacted in the state of Illinois) by any court of competent jurisdiction, or (iv) the Plan or BCBSA makes a general assignment of its assets for the

benefit of creditors, or (v) the Department of Insurance or other regulatory agency assumes control of the Plan or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted against the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within sixty (60) days of the date upon which it was instituted, or (viii) a trustee, interim trustee, receiver or other custodian for any of the Plan's or BCBSA's property or business is appointed, or (ix) the Plan shall fail to pay its dues and shall not cure such failure within thirty (30) days of receiving written notice thereof.

(b). BCBSA, or the Plans (as provided and in addition to the rights conferred in Paragraph 10(b) above), may terminate this Agreement immediately upon written notice upon the occurrence of either of the following events: (a) the Plan or BCBSA becomes insolvent (as that term is defined in the Uniform Commercial Code enacted in the state of Illinois), or (b) any final judgment against the Plan or BCBSA remains unsatisfied or unbonded of record for a period of sixty (60) days or longer.

(c). If this License Agreement is terminated as to BCBSA for any reason stated in subparagraphs 15(a) and (b) above, the ownership of the Licensed Marks shall revert to each of the Plans as provided in the Ownership Agreement.

16. This Agreement supersedes any and all other agreements between the parties with respect to the subject matter herein, and contains all of the covenants and agreements of the parties as to the licensing of the Licensed Marks and Name. This Agreement may be amended only by a signed writing, the form of which shall have been approved by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

17. If any provision or any part of any provision of this Agreement is judicially declared unlawful, each and every other provision, or any part of any provision, shall continue in full force and effect notwithstanding such judicial declaration.

18. No waiver by BCBSA or the Plan of any breach or default in performance on the part of BCBSA or the Plan or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

19. All notices provided for hereunder shall be in writing and shall be sent in duplicate by regular mail to BCBSA or the Plan at the address currently published for each by BCBSA

and shall be marked respectively to the attention of the President and, if any, the General Counsel, of BCBSA or the Plan.

20. Nothing herein contained shall be construed to constitute the parties hereto as partners or joint venturers, or either as the agent of the other, and Plan shall have no right to bind or obligate BCBSA in any way, nor shall it represent that it has any right to do so. BCBSA shall have not liability to third parties with respect to any aspect of the business, activities, operations, products, or services of the Plan.

[21. This Agreement shall become effective upon its execution in counterparts by three-fourths of the Plans and by Plans with three-fourths of the then current weighted vote.]

21. This Agreement shall be governed, construed and interpreted in accordance with the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

CONTROLLED AFFILIATE LICENSE AGREEMENT

This agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a controlled affiliate of The Blue Cross Plan, known as _____ ("Plan").

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks for health care plans and related services;

WHEREAS, the Plan and the Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name");

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with, [describe service, e.g., "a Health Maintenance Organization"] in the Service Area served by the Plan. Controlled Affiliate cannot use the Licensed Marks or Name outside the Service Area or in its legal name.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed

Marks and Name only in relation to the sale, marketing and rendering of health care plans and related services and further agrees to be bound by the conditions regarding quality control shown in Exhibit A as it may be amended by BCBSA from time-to-time [the current Exhibit A applies to HMOs; if the Controlled Affiliate offers other services falling within the definition of health care plans and related services with respect to which BCBSA requires a license, it may be necessary to revise the quality control provisions applicable thereto].

B. Controlled Affiliate agrees that Plan and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans. Absent written approval by BCBSA of an alternative method of control, bona fide control shall mean the legal authority, directly or indirectly through wholly owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having not less than 51%

voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Plan or Plans shall own at least 51% of any for-profit Controlled Affiliate.

3. SERVICE MARK USE

Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks, and shall comply with such rules (applicable to all Controlled Affiliates licensed to use the Marks) relative to service mark use, as are issued from time-to-time by BCBSA. If there is any public reference to the affiliation between the Plan and the Controlled Affiliate, all of the Controlled Affiliate's services in the Service Area of the Plan shall be rendered under the Licensed Marks. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENTS

Controlled Affiliate shall promptly notify Plan and BCBSA

of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate hereby agrees to save, defend, indemnify and hold Plan and BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Controlled Affiliate's rendering of health care services under the Licensed Marks.

7. LICENSE TERM

The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods upon evidence satisfactory to the Plan and BCBSA that Controlled Affiliate meets the then applicable quality control standards, unless one of the parties hereto notifies the other party of the termination hereof at least sixty (60) days prior to expiration of any license period.

This Agreement may be terminated by the Plan or by BCBSA for cause at any time provided that Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the

intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Controlled Affiliate's failure to abide by the quality control provisions of Paragraph 2, above, shall be considered a proper ground for cancellation of this Agreement.

This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

A. Controlled Affiliate shall no longer comply with Standard No. 1 (Organization and Governance) of Exhibit A or, following an opportunity to cure, with the remaining quality control provisions of Exhibit A, as it may be amended from time-to-time; or

B. Plan ceases to be authorized to use the Licensed Marks; or

C. Appropriate dues for Controlled Affiliate pursuant to item 8 hereof, which are the royalties for this License Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks, including any use in its trade name.

In the event of any disagreement between Plan and BCBSA as to whether grounds exist for termination or as to any other term

or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

8. DUES

Controlled Affiliate will pay to BCBSA [Plan] a fee for this license in accordance with the following formula:

[Insert appropriate, agreed upon formula.]

[Plan will promptly and timely transmit to BCBSA all dues owed by Controlled Affiliate as determined by the BCBSA dues formula and if Plan shall fail to do so, Controlled Affiliate shall pay such dues directly.]

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

10. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

11. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by a writing executed by all parties.

12. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way effect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

13. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

_____	_____
Controlled Affiliate	BCBSA
By:_____	By:_____
Date:_____	Date:_____
_____	
Plan	

Exhibit E

Blue Cross and Blue Shield Association

Guidelines to Administer Membership Standards

Applicable to Regular Members

1990 Membership Approval Process

June 1989

Guidelines To Administer Membership Standards
Applicable to Regular Members
As Adopted By The Plan Performance and Membership Committee
To Be Used in The 1990 Membership Approval Process

The following guidelines were developed as a method for evaluating compliance with the ten (10) Membership Standards adopted at the 1984 Annual Meeting of Member Plans.

The attached packet provides a full description of the guidelines that will be used in evaluating 1989 performance for the 1990 Membership Year, which is July 1, 1990 through June 30, 1991. The guidelines are based on the original set of guidelines developed in 1985 and incorporate the annual changes approved by the Plan Performance and Membership Committee, including those made in 1988. An outline of the changes was distributed to Plan chief executive officers in a memorandum dated December 2, 1988.

In developing the guidelines, the following framework was followed:

- Performance levels that define compliance with a Standard are set at the minimum acceptable level of performance, rather than at target performance levels.
- Guidelines must be flexible so as to reflect the current environment.
- Guidelines must provide an objective, measurable test of compliance with each Membership Standard.
- Guidelines should not be process oriented.
- Guidelines should allow for an application process that is as simple as possible.
- Noncompliance does not automatically trigger a recommendation of nonrenewal of membership unless:
  - -- the Plan is not in compliance with a mandated Standard (#1 - #7), and/or
  - -- the Plan has failed to comply with terms of conditional membership.

The Plan Performance and Membership Committee does not have the final authority to grant, renew or terminate a Plan's membership; it recommends to the BCBSA Board of Directors, the final authority, whether membership should be granted, renewed or terminated. The Committee's recommendations are based on the Guidelines contained in this pamphlet. In making its decision, the Board applies the Standards and the terms of the License Agreements and may accept, reject or request the Plan Performance and Membership Committee to modify the Guidelines. In addition, the Plan Performance and Membership Committee may change the Guidelines from time to time.

Membership Status Categories

According to the By-Laws of the Association, the annual membership renewal process can result in the following recommendations.

Full

A Plan is found to be in substantial compliance with all ten Membership Standards.

Conditional

The Plan is found not to be in substantial compliance with any one membership standard. The Plan Performance and Membership Committee will require the Plan to develop a rehabilitation plan, including time frames, for approval by the Committee. The implementation of the rehabilitation plan will be monitored for the Committee by Association staff. In addition, the Plan may be included in the Plan Performance Response Process.

Nonrenewal

A Plan's membership is not renewed only if: 1) the Plan failed to meet the mandated membership Standards (#1 - #7); or 2) the Plan failed to meet the agreed upon terms of its conditional membership; or 3) the Plan failed to apply for renewal of membership.

The Plan Performance and Membership Committee may determine that some Plans in the full category warrant additional attention. The Committee will communicate with the Plan and offer appropriate assistance.

MEMBERSHIP STANDARDS
APPLICABLE TO REGULAR MEMBERS
AS ADOPTED AT ANNUAL MEETING OF MEMBER PLANS, 1984

Preamble

The Membership Standards apply to all organizations seeking to become or to continue as Regular Members of the Association. Any organization seeking to become a Member must be found to be in substantial compliance with all Membership Standards at the time membership is granted and for a period of two (2) years preceding date of its application. Any organization seeking to continue as a Member must be in substantial compliance with Membership Standards 1-7, inclusive, at the time of renewal and, if appropriate, must agree to conditions placed on it by the Board of Directors for failure to be in substantial compliance with any of the remaining Membership Standards.

The Board of Directors shall have authority to interpret these Standards. Should a Plan be notified that its membership is being terminated, nonrenewed, or conditioned for noncompliance with one or more of these Standards, it shall have the right, upon request to the Board of Directors, to be heard and present evidence of the extent to which circumstances prevent compliance or of action plans to attain compliance.

Compliance with any Membership Standard may be excused, at the Board's discretion, if the Board agrees that compliance with such Standard would require the Plan to violate a law or governmental regulation governing its operation or activities.

Standard 1: Not-For-Profit Operation

The Standard is:

A PLAN SHALL BE ORGANIZED ON A NOT-FOR-PROFIT BASIS.

Determination of Compliance:

- Compliance is based on:
  - The Plan*: (a) is organized under statute that prohibits direct or indirect distribution of net earnings to individuals who exercise control over it, e.g., corporate members or shareholders, directors, officers and key employees: or (b) includes in its charter/articles of incorporation or bylaws an express prohibition against direct or indirect distribution of its net earnings to individuals who exercise control over it. (NOTE: Payment of reasonable compensation for services or capital provided to the Plan does not violate the nondistribution constraint.)
- Noncompliance is a result of failure to be organized as described above or to have such a provision in its charter, articles or bylaws. The Plan will not be renewed for membership as of July 1 if the Plan is found not to be in compliance.

* *"Plan" is defined as the applicant organization.*

Standard 2: Health Care Prepayment and Financing

The Standard is:

A PLAN'S ACTIVITY SHALL BE DIRECTED PRINCIPALLY TO HEALTH CARE FINANCING AND DELIVERY.

Determination of Compliance:

- Compliance is based on
  - Allocation of at least 51 percent of the assets (GAAP basis) of the Plan* corporation and of all related corporations in which the Plan has at least majority ownership or control.
  - Activity shall be defined as being health care financing and delivery if the activity is:
    1) generally accepted as a health care insurer and/or financier and/or deliverer role, and/or
    2) included in the federal definition of "personal health care** expenditures" and/or
    3) directly supports the operation of 1 and/or 2.
- Noncompliance is a result of failure to have allocated, in total, at least 51 percent of the assets (GAAP basis) of the Plan corporation and of all related corporations in which the Plan has at least majority ownership or control directed to health care financing and delivery. The Plan will not be renewed for membership as of July 1 if the Plan is not found to be in compliance.

* *"Plan" is defined as the applicant organization.*

** *Personal health care is defined as:*

"A major subsystem of the overall health system which includes those services delivered to individuals in order to improve or maintain their health status. Major service categories within personal health care include: prevention and detection, diagnosis and treatment, habilitation and rehabilitation maintenance, and personal health care support."

Standard 3: Board Composition

The Standard is:

A PLAN SHALL MAINTAIN A GOVERNING BOARD COMPOSED OF A MAJORITY OF PERSONS OTHER THAN PROVIDERS OF HEALTH CARE SERVICES, WHO SHALL BE KNOWN AS PUBLIC MEMBERS. A PUBLIC MEMBER SHALL NOT BE AN EMPLOYEE OF OR HAVE A FINANCIAL INTEREST IN A HEALTH CARE PROVIDER, NOR BE A MEMBER OF A PROFESSION WHICH PROVIDES HEALTH CARE SERVICES.

Determination of Compliance:

- Compliance is based on:
    - The Plan's governing board being comprised of a majority of public members. A "public member" includes any person who is not engaged in the active practice of a health care profession; or who is not an officer, partner, or employee of an organization that primarily sells health care services (other than the Plan or an organization controlled by the Plan); or who does not have a direct or indirect beneficial interest of more than five percent of the equity of an organization that sells health care services.
- Noncompliance is a result of failure to have a 51 percent majority of public members of the governing board. The Plan will not be renewed for membership as of July 1 if the Plan is found not to be in compliance.

Standard 4: Examination

The Standard is:

A PLAN SHALL GRANT THE ASSOCIATION THE RIGHT TO EXAMINE ITS AFFAIRS AND SHALL AGREE THAT THE ASSOCIATION'S BOARD MAY SUBMIT A WRITTEN REPORT TO ITS GOVERNING BODY THROUGH ITS CHIEF EXECUTIVE OFFICER.

Determination of Compliance:

- Compliance is based on:
  - the Plan agreeing upon request by the Association to an examination (for example a request for reports as required under the Plan Performance Response Process), and
  - the Plan providing access to requested staff and/or documentation, and
  - the Plan CEO submitting all reports to the Plan's governing body within 30 days of receipt, if requested to do so.
- Noncompliance is a result of failure to do one or more of the above. Such failure also may support a recommendation to the Board to condition or revoke Plan membership. The Plan will not be renewed for membership as of July 1 if compliance has not been achieved.

Standard 5: Reports and Records

The Standard is:

A PLAN SHALL FURNISH, ON A TIMELY AND ACCURATE BASIS, SUCH REPORTS AND RECORDS AS MAY BE REQUIRED BY THE BOARD.

Determination of Compliance:

- Compliance is based on:
  - The completeness, timeliness and accuracy of required reports included under Standards 5, 8 and 9.
- Noncompliance is a result of substantial incompleteness and/or chronic pattern of tardiness and/or nonsubmission of required reports included under Standards 5. 8 and 9. The Plan will not be renewed for membership as of July 1 if the Plan is found not to be in compliance.

Reports Included Under Standard 5:*

- Annual Application of renewal of Association Membership including trade name and service mark usage material
- Plan governance changes --
  - A Plan shall within 15 days of the decisi ı notify the Association of any changes pertaining to the governance of the Plan. Included are changes in:

    bylaws
    articles of incorporation
    principal officers
    board composition

**See Guidelines under Membership Standards 8 and 9 for other required reports.*

Standard 6: Compliance with Designated Policies

The Standard is:

A PLAN SHALL COMPLY WITH EACH DESIGNATED POLICY ADOPTED BY TWO-THIRDS AFFIRMATIVE VOTE OF THE ENTIRE BOARD PROVIDED THAT THE PROPOSED DESIGNATED POLICY IS SUBMITTED TO THE BOARD AND TO PLANS AT LEAST 14 DAYS PRIOR TO THE BOARD MEETING AT WHICH IT IS TO BE CONSIDERED.

Determination of Compliance:

- Compliance is based on:
    - A Designated Policy must be identified as such by the Board. It is assumed that in adopting a Designated Policy, the Board will specify acceptable levels of compliance.

Standard 7: Mediation

The Standard is:

A PLAN SHALL AGREE TO USE BOARD ESTABLISHED MEDIATION BEFORE LEGAL ACTION IS INSTITUTED AGAINST ANOTHER PLAN OR THE ASSOCIATION.

Determination of Compliance:

- Compliance is based on:
  - The Plan agreeing to use and using the process as approved by the Board of Directors of the Association. (See Attachment III for Board-approved protocol.)
- Noncompliance is a result of failure to do the above. Such failure also may support a recommendation to the Board to condition or revoke Plan membership. The Plan will not be renewed for membership as of July 1 if compliance has not been achieved.

Standard 8: Marketplace Responsibility

The Standard is:

A PLAN SHALL BE OPERATED IN A MANNER RESPONSIVE TO MARKETPLACE DEMANDS.

Determination of Compliance:

- Compliance is based on
  - Enrollment
  - Service levels
  - Reporting Performance (See Attachment I for definition of performance measures and list of required reports)
  - IPDR Performance
- The level of compliance will be determined as follows:
  - A Plan will be recommended for nonrenewal ONLY
    - if the Plan's performance in one area is not in compliance with the guidelines for at least two consecutive years

      AND

    - the Plan has not submitted and implemented a Committee-approved rehabilitation plan within the agreed upon time frames.
  - A Plan will be recommended for Conditional Membership ONLY if the Plan's performance is determined not to be in compliance with one or more of the guidelines.

• Area of Compliance: Enrollment Losses

Membership Status	Full		Conditional	Nonrenewal
Compliance Level	**Full**	**Possible Comment**	**Noncompliant**	
1a. %* decrease in enrollment in one year — hospital LOB	2.5% or less	2.6% to 7.9%	8% or greater	Noncompliant 2 years in a row AND has failed to meet requirements of previous year's conditional status.
1b. %* decrease in enrollment in one year — medical/surgical LOB	2.5% or less	2.6% to 7.9%	8% or greater	Noncompliant 2 years in a row AND has failed to meet requirements of previous year's conditional status.
2a. %* decrease in enrollment in 3 years — hospital LOB	Less than 13%	13% to 19%	20% or greater	Noncompliant 2 years in a row AND has failed to meet requirements of previous year's conditional status.
2b. %* decrease in enrollment in 3 years — medical/surgical LOB	Less than 13%	13% to 19%	20% or greater	Noncompliant 2 years in a row AND has failed to meet requirements of previous year's conditional status.

* *Percent may change on an annual basis to reflect systemwide enrollment trends. Net enrollment will be adjusted for special group losses, i.e., State group, large national account.*

• Area of Compliance: Service Levels

Membership Status	Full		Conditional	Nonrenewal
Compliance Level	**Full**	**Possible Comment**	**Noncompliant**	
Annual score on the NMIS Performance Index (see Attachment II for description)	Score of 70 or greater	Score between 60 and 69	Less than an annual score of 60 and scores of less than 60 in at least 3 of the 4 quarters or when an Index cannot be calculated.	Noncompliant 2 years in a row AND has failed to meet requirements of previous year's conditional status.

• Area of Compliance: Reporting Performance

Membership Status	Full		Conditional	Nonrenewal
Compliance Level	**Full**	**Possible Comment**	**Noncompliant**	
The number of instances* of late, not reported or inaccurate reports.	0-5	6-10	11-18	Noncompliant 2 years in a row AND has failed to meet requirements of previous year's conditional status.

**If a report is both late and inaccurate, only one instance of noncompliance with reporting guidelines will be recorded.*

• Area of Compliance: IPDR Performance

Membership Status	Conditional	Nonrenewal
Compliance Level	**Noncompliant**	
Par Plan	• The number of cumulative suspense file (CSF) workdays is greater than 6 in at least 8 months of the year, and • 50% or more of CSF in dollars is greater than 90 days old in at least 8 months of the year, and • The cycle time for original claim billing is greater than 10 days old in at least 8 months of the year.	Noncompliant 2 years in a row AND has failed to meet requirements of previous year's conditional status.
Control Plan	• The annual average disallowed rate (percent of dollars processed) is 10% or greater, and • The reimbursement cycle time for all claims is greater than 10 days in at least 8 months of the year.	Noncompliant 2 years in a row AND has failed to meet requirements of previous year's conditional status.

Standard 9: Financial Responsiblity

The Standard is:

A PLAN SHALL MAINTAIN ADEQUATE FINANCIAL RESOURCES TO PROTECT THE INTERESTS OF ITS SUBSCRIBERS.

Determination of Compliance:

- Compliance is based on
  - Compliance with GAAP/SAP
  - Adequate unpaid claim liability
  - Adequate contingency reserve
  - Adequate liquidity
  - Reporting Performance (See Attachment I for definition of performance measures and list of required reports)
- The level of compliance will be determined as follows:
  - A Plan will be recommended for nonrenewal ONLY
    - if the Plan's performance in one area is not in compliance with the guidelines for at least two consecutive years

      AND

    - the Plan has not submitted and implemented a Committee-approved rehabilitation plan within the agreed upon time frames.
  - A Plan will be recommended for Conditional Membership ONLY if the Plan's performance is determined not to be in compliance with one or more of the guidelines.

Membership Status	Full		Conditional	Nonrenewal
Compliance Level	**Full**	**Possible Comment**	**Noncompliant**	
Areas of Compliance				
• Number of months in liquidity as of December 31.	2.5 months or greater	2.4 to 1.0 months	Less than 1 month	Noncompliant 2 years in a row AND has failed to meet requirements of previous year's conditional status.
• Adequate Unpaid Claim Liability (determined by submission or annual Actuarial certifying statement).	Unqualified certifying statement received	_ ... - ...	Qualified or no statement received	Qualified or no statement received second year in a row AND has failed to meet requirements of previous year's conditional status.
• Adequate Contingency Reserves as of December 31.	3.0 months or greater (GAAP)	2.0 to 1.5 months (GAAP)	1.5 months or less (GAAP) or 1.0 months or less (SAP)	Noncompliant 2 years in a row AND has failed to meet requirements of previous year's conditional status.
• Adheres to GAAP or SAP, as required (determined by submission of annual CPA certifying statement).	Unqualified certifying statement received	Qualified statement received that leads to question of financial stability	Plan fails compliance test	Plan fails compliance test second year in a row.
• The number of instances* of late, not reported or inaccurate reports.	0-4	5-7	8-11	Noncompliant for 2 years in a row AND has failed to meet requirements of conditional status.

**If a report is both late and inaccurate, only one instance of noncompliance with reporting guidelines will be recorded.*

Standard 10: Participation in Inter-Plan Programs

The Standard is:

A PLAN SHALL EFFECTIVELY AND EFFICIENTLY PARTICIPATE IN EACH NATIONAL PROGRAM AS MAY FROM TIME TO TIME BE ADOPTED BY THE PLANS.

- **The following is a list of currently required programs:**
    - Inter-Plan Service Benefit Bank Agreement
    - Inter-Plan Reciprocal Benefit Agreement
    - Inter-Plan Transfer Agreement
    - National Account Equalization Program
    - Central Certification Program
    - Uniform I.D. Card Program
    - National Health Care Matrix Contract and Related Manuals
    - IPDR (performance measured under Standard 8)
    - ITS*

Determination of Compliance:

- The Plan Performance and Membership Committee will review Plan participation in all Inter-Plan Programs and performance, as described below, to determine overall compliance with Standard 10.

Central Certification

A Plan will be considered not in compliance with the program if:

- The Plan has repeatedly violated the terms of the Central Certification Program,

and

- Association management, after contact with the Plan, concludes that the situation is not likely to be solved, given existing Plan efforts and/or capacities.

Inter-Plan Transfer Agreement

A Plan will be considered not in compliance with the program if:

- The Plan has repeatedly violated the terms of the Inter-Plan Transfer Agreement,

and

- Association management, after contact with the Plan, concludes that the situation is not likely to be solved, given existing Plan efforts and/or capacities.

* *Although this program has not been adopted by the Plans as part of this Standard, the Plan Performance and Membership Committee has decided to include this program in interpreting the Standard.*

Inter-Plan Service Benefit Bank Agreement

A Plan will be considered not in compliance with the program if:

- The Plan has repeatedly violated the terms of the Inter-Plan Service Benefit Bank Agreement,

and

- Association management, after contact with the Plan, concludes that the situation is not likely to be solved, given existing Plan efforts and/or capacities,

and/or

- The percent of cases disallowed by the Clearinghouse is 15% or greater.

Inter-Plan Reciprocal Benefit Agreement

A Plan will be considered not in compliance with the program if:

- The Plan has repeatedly violated the terms of the Inter-Plan Reciprocal Benefit Agreement,

and

- Association management, after contact with the Plan, concludes that the situation is not likely to be solved, given existing Plan efforts and/or capacities,

and/or

- The percent of cases disallowed by the Clearinghouse is 15% or greater.

Uniform I.D. Card Program

A Plan will be considered not in compliance with the program if:

- The Plan's most commonly issued I.D. Card is not in substantial compliance with the requirements of the program,

and

- Association management, after contact with the Plan, concludes that the situation is not likely to be solved, given existing efforts and/or capacities.

ITS

- The Plan is not certified to use the Membership & Coverage facility, and an exception has not been granted,

and

- Association management, after contact with the Plan, concludes that the situation is not likely to be solved, given existing Plan efforts and/or capacities.

Points are assigned on a continuous scale within established ranges. The top of each range is determined by the guideline level, which was set when the new measures were adopted. The bottom of each range is set either on the basis of market research indicating levels unacceptable to the market, on-site review experience or historical levels estimating the low end of Plan performance. The continuous allocation of points within the range eliminates the problem with the interval approach, which distributes points unevenly in some cases.

Data not reported are counted as zeros in the calculation of the Index so that there is an incentive to report all measures.

For more information, contact the NMIS department at the Association.

Attachment I

Required Reports and Reporting Performance Measures

Required Reports -- Standard 8:

Annual Cost Containment Survey
Quarterly Utilization Reports
Quarterly Enrollment Reports
Annual Blue Cross Cost Containment Savings Report
NMIS Quarterly Reports
OPL Reports
Quarterly Blue Shield Cost Containment Reports

Required Reports -- Standard 9:

Quarterly Financial Reports
Quarterly Financial Forecasts
Annual Certified Audit Report
Insurance Department Examination Reports
Annual Statement as filed with State Insurance Department -- with actuarial certifying statement
National Cost Reports
Annual Consolidating Financial Statements & Questionnaire

Reporting Performance Measures:

- Timely submission of reports -- A report will be considered late if it is received by the Association 15 days after the published deadline or after an agreed upon reasonable extension due to extenuating circumstances.

- Accuracy -- A report will be considered inaccurate if the data submitted do not conform to published instructions and/or are not reasonable and are not corrected by the Plan within an agreed upon reasonable time period.

- Nonreporting -- A report will be considered not submitted if data are: 1) not presented to the Association within 30 days after the published deadline or after a reasonable agreed upon extension or 2) if significant portions of the submitted report are not completed.

Attachment II

1990 NMIS Performance Index

The NMIS Performance Index was adopted in late 1985 by the Plan Performance and Membership Committee as one of the guidelines under Standard #8: Marketplace Responsibility. The index used in 1989 also will be used in 1990.

The Index includes all the measures in the program with three exceptions:

- The inquiry accessibility measures are too new to be included until the system has some experience with them.
- Eligibility response wires have significant volume in only a few Plans.
- OPL represents a different type of service which cannot readily be included with the others in a single index.

The following is the broad reasoning behind the Index.

The Performance Index combines the performance measures in three major processing areas and calculates a composite score for each. The areas are weighted to reflect the market's valuation of each of the categories in relation to the others. The three processing areas are weighted as follows:

Claims Processing (timeliness and accuracy):	55 points
Inquiry Processing (timeliness and accuracy):	35 points
Membership Processing:	10 points
Total	**100 points**

Each of the categories is composed of individual NMIS measures, combined for the calculation of the composite category score. The categories contain a varying number of measures. The category weighting, as listed above, has been established in such a way that:

- no individual measure represents more than ten percent of the total score, and
- no measure represents less than two percent of the total score.

In this way, severe problems in just one measure cannot affect a Plan's compliance with the guideline. yet each measure included in the Index is worth at least two percent of the score. Within the claims categories, measures are volume weighted to assure that points are allocated proportionately to the impact of each measure on the overall Plan business.

(continued on next page)

Blue Cross
and
Blue Shield
Association

676 North St. Clair Street
Chicago, Illinois 60611
312/440-6000

ATTACHMENT III

September 25, 1987

TO: Chief Plan Executives

FROM: Roger G. Wilson, Corporate Secretary

SUBJECT: MEDIATION COMMITTEE PROTOCOL AND PROCEDURE

As you know, BCBSA Membership Standard 7 provides: "A Plan shall agree to use Board established mediation before legal action is instituted against another Plan or the Association."

Pursuant to that standard, the BCBSA Board at its meeting of September 17, 1987, approved a Mediation Committee Protocol and Procedure, which is attached hereto for your information. Please do not hesitate to call if there are any questions.

RGW:cny
Attachment
2285L

Distribution: Chief Plan Executives -- List 1
Plan Inside Counsel -- List 29A

Blue Cross
and
Blue Shield
Association

676 North St. Clair Street
Chicago, Illinois 60611
312/440-6000

September 17, 1987

MEDIATION COMMITTEE PROTOCOL

1. Purpose: The purpose of this document is to describe the procedure for requesting dispute resolution before the BCBSA Mediation Committee.

2. BCBSA Membership Standard: BCBSA Membership Standard 7 provides as follows: "A Plan shall agree to use Board established mediation before legal action is instituted against another Plan or the Association." To implement this standard, the BCBSA Board has established the Mediation Committee.

3. Filing Mediation Request: To commence the dispute resolution procedure before the Mediation Committee, the applicant should write a letter to the BCBSA Corporate Secretary requesting such a proceeding. The letter should contain the following: (i) identification of the applicant requesting the proceeding; (ii) identification of the entity or entities against whom legal action is contemplated by the applicant; (iii) identification of any other

persons or entities who are indispensable to a resolution of the dispute; (iv) identification of all of the issues which the Mediation Committee is being requested to resolve; (v) request, if applicable, that one or more members of the Mediation Committee be disqualified from the proceeding and the grounds for such request; (vi) request, if applicable, that the matter be handled on an expedited basis and the reasons therefor; (vii) statement indicating whether applicant is willing to agree to a dispute resolution procedure other than the Mediation Procedure set forth in Exhibit A, attached hereto; (viii) statement indicating whether the applicant is willing to agree to be bound by the Mediation Procedure or by any alternative dispute resolution procedure. If the applicant requests expedited procedure. (see Section 9, infra), the letter must also contain a full exposition of all the arguments supporting the applicant's position. It is important that the letter afford the Mediation Committee an opportunity to resolve all the issues which the applicant could subsequently raise in a legal action; failure to do so could result in a finding of non-compliance with Membership Standard 7. For purposes of this Protocol, a "party" is the person or persons described in (i) and (ii) above.

4. Determination of Jurisdiction: Upon receipt of the applicant's letter, the Corporate Secretary will make an initial determination about whether the dispute falls within the jurisdiction of the Mediation Committee or should be referred to another BCBSA Committee. (e.g., the Mediation Committee's Charge provides that "determination of equalization allowances and/or cost allowances under FEP shall not be considered by this Committee.") If the dispute appears to fall within the Mediation Committee's jurisdiction, the Corporate Secretary will promptly furnish the Mediation Committee with copies of the applicant's letter. In addition, copies of the applicant's letter will be forwarded promptly to the party or parties against whom the applicant may file a legal action.

5. Disqualification: The Corporate Secretary will also determine whether any member of the Mediation Committee is a representative of a party. Members of the Mediation Committee who appear to fall into such category will be so advised by the Corporate Secretary. Such Members will not be permitted to serve on the Mediation Committee to mediate the dispute unless: (i) a majority of the other members of the Mediation Committee votes to retain

such member or members on the Committee; and (ii) the parties agree to retain such member or members on the Committee. If a party has requested that any Member of the Mediation Committee be disqualified on any other ground, the other Members of the Committee not previously disqualified for the foregoing reasons shall consider such grounds and a majority of such other members shall decide whether to grant the party's request. Other grounds for disqualification include, but are not limited to: (i) personal bias or prejudice either against or in favor of any party to the proceeding; (ii) a financial interest in the controversy or in any party to the proceeding. Any party may request disqualification, provided that such request is supported by a full written statement of the grounds therefor, and provided further, that such written statement is received in writing by the Corporate Secretary at least three days before the date of any scheduled hearing. The Corporate Secretary shall promptly advise the parties of any disqualifications.

6. Binding Decision: Before the date of the hearing scheduled pursuant to the Mediation Procedure described in Exhibit A, the Corporate Secretary will contact the parties and any other

persons or entities identified by the parties to determine whether they wish to be bound by any recommendation of the Committee for resolution of the dispute pursuant to the procedure described in Exhibit A. If they wish to be bound, the Corporate Secretary will send appropriate documentation to them for their signatures before the hearing begins.

7. Mediation Procedure: The Mediation Committee shall follow the procedure set forth in Exhibit A, attached hereto. The Corporate Secretary shall promptly advise the parties of the scheduled hearing date. Unless a party requested expedited procedure, the Mediation Procedure set forth in Exhibit A, attached hereto, shall be completed within 30 days of BCBSA's receipt of the request for mediation, unless all parties to the proceeding agree to one or more extensions of time. In the event that the mediation proceeding requested by a party cannot be completed within the prescribed or agreed time period due to the lack of cooperation of any other party, the requesting party may initiate legal action after expiration of such time period and the party requesting mediation shall be deemed to have complied fully with membership Standard 7. The Mediation Committee will so inform the BCBSA Board of Directors at its next regularly scheduled meeting.

8. Expedited Mediation Procedure: Any party to the mediation proceeding may direct a request for an expedited procedure to the Corporate Secretary at any time. Such a request must be supported by the statement of the reasons therefor and, if not previously submitted to the Corporate Secretary, a full explanation of all the arguments supporting the position of the requesting party on the merits of the controversy. The Mediation Committee shall grant any request which is supported by good and sufficient reasons. If such a request is granted, the Mediation Procedure set forth in Exhibit A, attached hereto, shall be completed within 10 business days of BCBSA's receipt of the request for expedited procedure, unless all parties to the proceeding agree to one or more extensions of time. In the event that the expedited procedure granted by the Committee and requested by the party requesting mediation cannot be completed within the prescribed or agreed time period due to the lack of cooperation of any other party, the party requesting mediation may initiate legal action after the expiration of such time period, and the party requesting mediation shall be deemed to have complied fully with Membership Standard 7. The Mediation Committee will so inform the BCBSA Board of Directors at its next regularly scheduled meeting.

9. Additional Voluntary Methods of Dispute Resolution: The Charge of the Mediation Committee described by the BCBSA Board is to "develop and implement processes for resolving misunderstandings or disagreements between Plans or between Plans and the Association" under certain circumstances. To carry out this charge, the Mediation Committee desires to maintain the flexibility to offer to the parties any one of several additional voluntary methods of dispute resolution, including, but not limited to, a formal adversary proceeding, or binding or non-binding arbitration. If the parties are interested in exploring these additional methods, in lieu of the regular mediation procedure described herein, the Corporate Secretary will send to the parties involved in the dispute a description of the various alternative voluntary methods of dispute resolution available to the Committee, with a request for each party's recommendation about the method or methods most likely to produce resolution of the dispute. Any such recommendations will be forwarded by the Corporate Secretary to the Chairman. After consideration of the parties' recommendations, the Committee will select a voluntary dispute resolution procedure which is acceptable to all parties.

10. Additional Claims: If a Plan, after complying with the Mediation Committee Procedure, files a legal action against BCBSA or another Plan or Plans, the Defendant or Defendants may assert any and all claims against the Plaintiff Plan or any other Plan which arise out of the transaction or occurrence that is the subject matter of the Plaintiff Plan's claim or claims, without first complying with the Mediation Committee Procedure. Nothing contained herein shall preclude the Defendant BCBSA or the Defendant Plan or Plans, however, from using this Mediation Committee procedure for any claims asserted by it against the Plaintiff Plan.

MEDIATION PROCEDURE

In most circumstances, resolution should be obtainable by a frank, in-depth discussion of the positions of each party before the Mediation Committee. This method strives for a settlement or compromise following an opportunity for both sides to hear the relevant information, to respond and hear responses to questions from the Committee and to hear the Committee's evaluations and recommendations.

Unless modified by the Committee with the agreement of the parties, the following will be the procedure for this review:

1. A hearing will be called by the Committee Chairman.

2. Each party must be represented by its chief executive officer or one who has been delegated full authority to resolve the dispute. However, both parties may send additional representatives as they see fit.

3. Each party will be given an opportunity to submit, in writing, a statement of the facts as it sees them, along with a position paper summarizing its argument. Each may submit any other documentation it would like the Committee to consider. Along with the position paper, each Plan should supply a list of all persons who will be attending the hearing, and indicate who will have the authority to resolve the dispute. Upon request of the Committee, BCBSA staff may also submit documentation, which shall constitute a part of the record referenced in Paragraph 4.

4. All documents must be received by a date designated by the Chairman. The position papers and supporting documentation will constitute the record, and will be supplied to all parties prior to the hearing date. All should be directed to the Corporate Secretary of the Blue Cross and Blue Shield Association.

5. Each party's presentation before the Committee may be made by one or more representatives, including outside counsel. The parties are free to structure their presentations as they see fit; using oral statements or direct examinations of witnesses. However, neither cross-examination nor questioning of opposing representatives will be permitted.

EXHIBIT A

6. Each party will be given one-half hour to present its case, beginning with the applicant, followed by the other party or parties. At the close of each presentation, the Committee will be given an opportunity to ask questions of the presenters. All parties must be present throughout the hearing. The Committee may extend the time allowed for each party's presentation at the hearing. The Committee may meet in executive session, outside the presence of the parties, at any time to discuss the controversy.

7. After the close of the presentations, the parties will attempt to negotiate a settlement of the dispute. If they desire, the Chairman or the full Committee will sit in on the negotiations and act as a mediator.

8. After the close of the presentations, the Committee may meet privately to agree upon a recommendation for resolution of the dispute which would be submitted to the parties for their consideration and approval. If the parties have previously agreed to be bound by the results of this procedure, this recommendation shall be binding upon the parties.

9. The purpose of the hearing is to assist the parties to settle their grievances short of litigation. As a result, the hearing has been designed to be as informal as possible. Rules of evidence shall not apply. There will be no transcript of the proceedings, and no party may make a tape recording of the hearing.

10. In order to facilitate a free and open discussion, the proceedings shall remain confidential. A "Stipulation to Confidentiality" which prohibits future use of settlement offers, all position papers or other statements furnished to the Committee, and committee decisions or recommendations in any litigation should be executed by each party.

1425L

Exhibit F

MEMBERSHIP STANDARDS *

PREAMBLE

The Membership Standards apply to all organizations seeking to become or to continue as Regular Members of the Blue Cross and Blue Shield Association. Any organization seeking to become a Regular Member must be found to be in substantial compliance with all Membership Standards at the time membership is granted and the organization must be found to be in substantial compliance with all Membership Standards for a period of two (2) years preceding the date of its application. If membership is sought by an entity which controls or is controlled by one or more Plans, such compliance shall be determined on the basis of compliance by such Plan or Plans.

The Regular Member Plans shall have authority to interpret these Standards. Compliance with any Membership Standard may be excused, at the Plans' discretion, if the Plans agree that compliance with such Standard would require the Plan to violate a law or governmental regulation governing its operation or activities.

Standard 1: A Plan shall be organized and operated on a not-for-profit basis.

Standard 2: A Plan's Board shall not be controlled by any special interest group, and shall act in the interest of its Corporation in providing cost-effective health care services to its customers. A Plan shall maintain a governing Board, which shall control the Plan, composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Standard 3: A Plan shall furnish to the Association on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between the Association and the Plans. Such reports and records are the following:

A. Annual Application for Renewal of BCBSA Membership, including tradename and service mark usage material;

B. Changes in the governance of the Plan, including changes in a Plan's Charter,

*Guidelines for application of the revised Membership Standards have not yet been published.

Articles of Incorporation, or Bylaws, changes in a Plan's Board Composition, or changes in the identity of the Plan's Principal Officers;

C. Quarterly Financial Reports, Quarterly Financial Forecast, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with actuarial certifying statement), and Consolidating Report;

D. Quarterly Utilization Report, Quarterly Enrollment Report, Annual Blue Cross Cost Containment Savings Report, NMIS Quarterly Report, OPL Report, Quarterly Blue Shield Cost Containment Report.

Standard 4: A Plan shall maintain adequate financial resources to protect its customers and meet its long term business obligations.

Standard 5: A Plan shall use its best efforts to contract with providers of health care services in a manner that assures the availability of cost-effective health care services to its customers.

Standard 6: A Plan shall be operated in a manner responsive to customer needs and requirements.

Standard 7: A Plan shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the Plans and ease of claims processing for customers receiving benefits outside of the Plan's Service Area. Such programs are:

A. Inter-Plan Service Benefit Bank Agreement (applicable to Blue Cross Plans);

B. Inter-Plan Reciprocal Benefit Agreement (applicable to Blue Shield Plans and participating Blue Cross Plans);

C. Inter-Plan Transfer Agreement (applicable to Blue Cross and Blue Shield Plans);

D. National Account Equalization Program (applicable to Blue Cross and Blue Shield Plans);

E. Central Certification Program (applicable to Blue Cross and Blue Shield Plans);

F. Uniform Identification Card Program (applicable to Blue Cross and Blue Shield Plans);

G. National Health Care Matrix Contract and Related Manuals (applicable to Blue Cross and Blue Shield Plans);

H. Inter-Plan Data Reporting (IPDR) Program (applicable to Blue Cross and Blue Shield Plans);

I. Inter-Plan Teleprocessing System (ITS) (applicable to Blue Cross and Blue Shield Plans).

Exhibit G

AN ACT relating to mutual nonprofit hospital service corporations, prescribing powers and duties of such corporations, and providing for supervision thereof by the Commissioner of Insurance.

40-1801 TITLE OF ACT.

This Act shall be known as the mutual nonprofit hospital service corporation Act.

40-1802 ORGANIZATION PURPOSES; BOARD OF DIRECTORS; OATHS; QUORUM.

Mutual nonprofit corporations may be organized for the purpose of entering into contracts with participating hospitals to provide hospital service for their subscribers and to provide indemnity or other benefits in accordance with clause (7) of subsection (b) of K.S.A. 1979 Supp. 40-1805, as amended, to subscribers receiving hospital service in hospitals with which such mutual nonprofit corporations have no contracts. Such corporations heretofore or hereafter organized may provide service or indemnity for other health services or facilities but not to exceed reasonable and customary charges that a subscriber may incur for these services.

The affairs of any such nonprofit hospital service corporations organized under this act shall be managed by a board of directors of not less than fifteen (15) members composed of administrators or trustees of participating hospitals, and licensed physicians who participate in providing professional and institutional service to subscribers and members of the public who at the time of their election are subscribers exclusive of hospital trustees or administrators and physicians. The members of the public, exclusive of hospital trustees or administrators and physicians, shall at all times comprise a majority of the membership of the board of directors. The directors shall take the oath of office as in other corporations and duplicates of such subscribed oaths shall be forwarded at the time of election to the commissioner of insurance for filing. The bylaws shall specify the number of directors necessary to constitute a quorum, which shall not be less than ten (10) members.

40-1803 CONTRACTS.

Corporations organized under the provisions of this act are empowered and authorized to enter into contracts to provide hospital services for its subscribers with such hospitals, including municipal, county, proprietary and charitable hospitals, as may be licensed by the secretary of health and

environment. The governing bodies of municipal or county hospitals are hereby authorized and empowered to contract with corporations organized under this act to provide hospital service for the subscribers of such corporations. Such contracts shall constitute direct obligations of the participating hospitals to the subscribers but nothing in any contract to be made by any such corporations with a participating hospital or subscriber shall have effect of imposing upon any participating hospital any obligation or liability for any act, omission or default of any other participating hospital or of such corporation.

Corporations organized under the provisions of the mutual nonprofit hospital service corporation act may also enter into contracts with any health maintenance organization, partnership, domestic or foreign corporation or association in the state of Kansas or in other states, territories, possessions of the United States or Dominion of Canada, or with any local, state or federal governments or units thereof, so that:

(1) Reciprocity of benefits may be provided to subscribers of such corporations;

(2) transfer of subscribers from one corporation to another may be effected to conform to the subscriber's place of residence;

(3) uniform benefits may be provided for all employees and the dependents of such employees of corporations and other organizations transacting business in Kansas and elsewhere, and a composite rate (a rate representing the composite experience) of the areas involved may be charged for such employees and their dependents;

(4) services or indemnity benefits for hospital care or other health services for the subscribers, members or policyholders of such corporations or associations may be provided but not to exceed reasonable and customary charges that a subscriber may incur for these services;

(5) administrative, accounting, data processing, cost control, marketing, claims processing, fiscal and other services may be provided for a hospital care or other health service plan with any agency, instrumentality of political subdivision of the United States or the state of Kansas, or with any person, corporation, health maintenance organization, partnership, group or association providing such hospital care or other health service plan under any applicable state or federal law. Such contract may authorize such corporation to accept, receive, and administer in trust, funds directly or indirectly made available for the purposes set forth in said contract;

(6) reinsurance or joint assumption of risks may be undertaken with nonprofit medical service corporations organized and existing under the laws of the state of Kansas for hospital and other health services. Such contracts may provide for experience rating, the sharing of premiums, claims and expenses by the participating corporations, or for acceptance or ceding of the whole or portions of the risk on a reinsurance basis;

(7) administrative, accounting, data processing, cost control, marketing, claims processing, fiscal and other services may be provided to employers or voluntary employees' beneficiary associations where such employers or voluntary employees' beneficiary associations provide indemnity for hospital care or other health services to their employees or members under the terms of a plan of indemnification. Such contract may authorize such corporation to accept, receive and administer in trust, funds directly or indirectly made available for the purposes set forth in said contract. Contracts entered into pursuant to the provisions of this subsection shall provide for recoupment of all expenses incurred by the corporation in performing the services required by said contract and shall not adversely affect the interests of subscribers. Such corporation may enter into contracts with participating hospitals to provide hospital or other health service for such employees or members; and

(8) experimental and demonstration projects may be undertaken to determine the relative advantages and disadvantages of various alternative methods of providing service or indemnity benefits for hospital care or other health services. Such projects may include payment systems to providers designed to encourage providers to use their facilities and personnel more efficiently and thereby to reduce the total costs of hospital care and other health services involved without adversely affecting the quality of such services.

40-1804 CERTIFICATE OF AUTHORITY; CONDITIONS; EXAMINATION.

The commissioner of insurance shall issue a certificate of authority to such corporation upon compliance with the following conditions:

(A) It shall file with the commissioner of insurance a certified copy of its articles of incorporation, bylaws, and the subscription agreement forms and rates it proposes to use all of which shall be subject to the approval of the commissioner of insurance.

(B) It shall file with the commissioner of insurance contracts with at least twenty (20) participating hospitals having a total of not less than three hundred (300) beds to provide hospital service to the subscribers as required by K.S.A. 1979 Supp. 40-1803, as amended.

(C) It shall hold bona fide applications for hospital service upon which it shall have collected a minimum of two months' premiums from at least two hundred (200) subscribers, upon which it shall issue subscription agreements simultaneously. The total of such premiums shall be held in cash and shall not be disbursed until the subscription agreements are in force. Any such corporation shall be in possession of lawful assets over and above all liability in an amount not less than five thousands dollars ($5,000) and shall file with the commissioner of insurance a financial statement certified to by at least two executive officers.

Before issuing a certificate of authority the commissioner shall cause an examination to be made of the affairs of the corporation as provided by K.S.A. 40-208.

40-1805 CONDITIONS UPON WHICH POLICY MADE.

(a) No subscription agreement except as provided in subsection (d) of this section, between any such corporation and a subscriber, shall entitle more than one person to benefits, except that a "family subscription agreement" may be issued, at an established rate, granting benefits to a husband and wife, or husband, wife and their dependent child or children and any other person dependent upon the subscriber. Only the subscriber must be named in the subscription agreement.

(b) Every subscription agreement entered into by any such corporation with any subscriber thereto shall be in writing and a certificate stating the terms and conditions thereof shall be furnished to the subscriber to be kept by such subscriber. No such certificate form shall be made, issued or delivered in this state unless it contains the following provisions: (1) A statement of the nature of the benefits to be furnished and the period during which they will be furnished; and if there are any benefits to be excepted, a detailed statement of such exceptions printed as hereinafter specified; (2) a statement of the terms and conditions, if any, upon which the subscription agreement may be canceled or otherwise terminated at the option of

either party; (3) a statement that the subscription agreement includes the endorsements thereon and attached papers, if any, and contains the entire contract; (4) a statement that no statement by the subscriber in the application for a subscription agreement shall avoid the subscription agreement or be used in any legal proceeding thereunder unless such application or an exact copy thereof is included in or attached to such subscription agreement, and that no agent or representative of such corporation, other than an officer or officers designated therein, is authorized to change the subscription agreement or waive any of its provisions; (5) a statement that if the subscriber defaults in making any payment under the subscription agreement, the subsequent acceptance of a payment by the corporation or by one of its duly authorized agents shall reinstate the subscription, but with respect to sickness and injury, only to cover such sickness as may be first manifested more than ten (10) days after the date of such acceptance; (6) a statement of the period of grace which will be allowed the subscriber for making any payment due under the subscription agreement. Such period shall be less than ten (10) days; (7) a statement of the kind of hospital in which the subscriber may receive benefits and the types of benefits to which the subscriber shall be entitled to benefits in any non-participating hospital in Kansas which is licensed by the secretary of health and environment and in which the average length of stay of patient is similar to the average length of stay in participating hospitals.

(c) In every such subscription agreement made, issued or delivered in this state: (1) All printed portions shall be plainly printed; (2) there shall be a brief description of the subscription agreement on the first page and on its filing back; (3) the exceptions of the subscription agreement shall appear with the same prominence as the benefits to which they apply; and (4) if the subscription agreement contains any provisions purporting to make any portion of the articles of incorporation or bylaws of the corporation a part of the subscription agreement, such portions shall be set forth in full.

(d) A hospital service corporation may issue a group or blanket subscription agreement, provided the group of persons thereby insured conforms to the requirements of law applicable to other companies writing group or blanket sickness and accident insurance policies, and provided such subscription agreement and the individual certificates issued to members of the group shall comply in substance with this section. Any such subscription agreement may provide for the adjustment of the rate of

premium based upon the experience thereunder at the end of the first year or of any subsequent year of insurance thereunder and such readjustment may be made retroactive in the form of a rate credit or a cash refund.

(e) (1) Any group subscription agreement issued pursuant to subsection (d) of this section shall provide that an employee or member whose insurance under the group subscription agreement has been terminated for any reason, including discontinuance of the group in its entirety or with respect to an insured class, and who has been continuously insured under the group subscription agreement or under any group policy or subscription agreement providing similar benefits which it replaces for at least three months immediately prior to termination, shall be entitled to obtain a converted subscription agreement providing coverage equal to not less than eighty percent (80%) of those afforded under the group subscription agreement for basic hospital benefits. Any person eligible for a converted subscription agreement shall also be entitled to obtain major medical expense coverage which, when combined with the major medical expense coverage required by K.S.A. 1979 Supp. 40-1905 (5) (a), as amended, will provide hospital, medical and surgical expense benefits to an aggregate maximum of not less than fifty thousand dollars ($50,000). The major medical expense coverage required herein may be subject to a co- payment by the covered person of not more than twenty percent (20%) of covered charges and a deductible stated on a per person, per family, per illness, per benefit period, or per year basis or a combination of such bases of not more than five hundred dollars ($500) per person subject to a maximum annual deductible of seven hundred fifty dollars ($750) per family. The requirement imposed by this subsection shall not apply to a group subscription agreement which provides benefits for specific diseases or for accidental injuries only nor shall it apply to any employee or member whose termination of insurance under the group subscription agreement occurred because (A) such person failed to pay any required contribution, or (B) any discontinued group coverage was replaced by similar group coverage within thirty-one (31) days.

(2) Written application for the converted subscription agreement shall be made and the first premium paid to the insurer not later than thirty-one (31) days after termination of the group coverage and shall become effective the day

following the termination of insurance under the group subscription agreement. In addition, the converted subscription agreement shall be subject to the provisions contained in paragraphs (2), (5), (6), (7), (8), (9), (13), (14), (15), (16), (18), (19) and (20) of subsection (D) of K.S.A. 1979 Supp. 40-2209.

40-1806 POLICY FORMS AND RATES; FILINGS; APPROVAL OR DISAPPROVAL OF COMMISSIONERS; DETERMINATION OF RATES, FACTORS, RULES AND REGULATIONS; APPEALS FROM ORDERS OF COMMISSIONERS; PREMIUMS PAYABLE IN CASH.

Every such corporation shall file with the commissioner a copy of all subscription agreement forms and rates pertaining thereto and all modifications of either that it proposes to use. Every such filing shall indicate the character and extent of the coverage contemplated by such rates, the plan of operation contemplated and shall be accompanied by the information upon which such corporation supports the filing. Any filing made pursuant to this section shall be approved by the commissioner unless the commissioner finds that such filing does not meet the requirements of this act or establishes an unreasonable, excessive or unfairly discriminatory rate. As soon as reasonably possible after the filing has been made, the commissioner shall in writing approve or disapprove the same. Any filing shall be deemed approved unless disapproved within thirty (30) days after receipt of such filing or supporting information connected therewith. In the event the commissioner disapproves a filing, the commissioner shall specify in what respect such filing does not meet the requirements of this section or of article 18 of chapter 40 of the Kansas Statutes Annotated and acts amendatory thereof and shall state that a hearing will be granted within twenty (20) days after receipt of request in writing by such corporation. Such request for a hearing shall be made within thirty (30) days from the date of disapproval.

The commissioner may at any time, after a hearing of which not less than twenty (20) days' written notice shall have been given, withdraw approval of any such subscription agreement or rate in the event the commissioner finds such filing no longer meets the requirements of this section and article 18 of chapter 40 of the Kansas Statutes Annotated and acts amendatory thereof.

All rates, filed pursuant to this section, shall be made in accordance with the following provisions:

(a) Due consideration shall be given to (1) past and prospective loss experience; (2) past and prospective expenses; (3) adequate contingency reserves; (4) the provisions of contracts between such corporation and participating hospitals; and (5) all other relevant factors within and without the state;

(b) risks may be grouped by classifications for the establishment of rates for individual subscription agreements or for group subscription agreements; and

(c) rates shall be reasonable, not excessive and not unfairly discriminatory.

Nothing in this act is intended to prohibit or discourage reasonable competition or discourage or prohibit uniformity of rates except to the extent necessary to accomplish the aforementioned purpose. The commissioner is hereby authorized to adopt such rules and regulations as are necessary and not inconsistent with this act.

Any party adversely affected by the order or action of the commissioner of insurance, within sixty (60) days from the date of such order or action, may commence an action in a court of competent jurisdiction against the commissioner of insurance in the commissioner's representative capacity to vacate or set aside the order or action in whole or in part on the ground that the order or action is unlawful or unreasonable. Premiums shall be payable in cash and no subscription agreement issued by such corporation shall provide for any assessment or contingent premium.

40-1807 UNEARNED PREMIUMS AND OTHER RESERVES.

Such corporation shall maintain unearned premium and other reserves upon the same basis as that required of domestic stock insurance companies transacting the same kind of insurance.

40-1808 ADVANCEMENTS TO CORPORATION; ANNUAL REPORT; COMMISSION OR PROMOTION EXPENSES PROHIBITED.

Any director, officer or member of any such corporation, or any other person, may advance to such corporation any sum or sums of money necessary for the purposes of its business or to enable it to comply with any of the requirements of the laws

of this state and such moneys and such interest thereon as may have been agreed upon, not exceeding eight (8) per centum per annum, shall be payable only out of the surplus remaining after providing for all reserves and other liabilities, and shall not otherwise be a liability or claim against the corporation or any of its assets. No commission or promotion expenses shall be paid in connection with the advance of any such money to the corporation, and the amount of such advance shall be reported in each annual statement.

40-1809 PROVISIONS OF CODE APPLICABLE.

Such corporations shall be subject to the provisions of the Kansas general corporation code, articles 60 to 74, inclusive, of chapter 17 of the Kansas Statutes Annotated, applicable to nonprofit corporations, and to the provisions of K.S.A. 40-216, 40-218, 40-219, 40-224, 40-225, 40-226, 40-229, 40-230, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-254, 40-2a01 to 40-2a19, inclusive, and 40-2401 to 40-2421, inclusive, and amendments thereto, and K.S.A. 1979 Supp. 40-214, 40-215, 40-223, 40-231, 40-252, 40-2,102, 40-2,105, 40-2216 to 40-2220, inclusive, and 40-3301 to 40-3313, inclusive, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

40-1810 CHARITABLE & BENEVOLENT (REPEALED BY 1969 LEGISLATURE)

40-1811 DISBURSEMENTS FOR SOLICITING OF SUBSCRIBERS AND ADMINISTRATIVE EXPENSES LIMITED.

(a) No corporation subject to the provisions of this act shall during any one year disburse more than five percent (5%) of the aggregate amount of the payments received from subscribers during that year as expenditures for the soliciting of subscribers, except that during the first year after the issuance of a permit, such corporation may so disburse not more than twenty percentum (20%) of such amount, during the second year not more than fifteen percentum (15%) and during the third year not more than ten percentum (10%).

(b) No such corporation shall, during any one year, disburse a sum greater than eight percentum (8%) of the payments received from subscribers during that year as administrative expenses, except that during the first two (2) years after the issuance of the permit, such corporation may disburse not more than twenty percentum (20%) of the payments received from subscribers. The term,

"administrative expenses" as used in this section, shall include all expenditures for nonprofessional services including all activities, contractual arrangements and projects authorized by K.S.A. 1979 Supp. 40-1803, as amended, and in general, all expenses not directly connected with the furnishing of the benefits specified in this act, but not including expenses referred to in subsection (a) hereof.

(c) Each such corporation shall devote a reasonable effort to control costs, including both its administrative costs and costs charged to it by participating hospitals. Such effort shall include, but not be limited to, a continuing attempt by such a corporation through a combination of education, persuasion and financial incentives and disincentives to control costs and to encourage participating hospitals to control costs by: (1) Elimination of duplicative or unnecessary services, facilities and equipment; (2) nonprovider participation in the affairs of the corporation; (3) subscriber support of cost containment activities; (4) promotion of sound management practices in participating hospitals; (5) implementation of sound management practices within the nonprofit hospital service corporation; (6) promotion of alternative forms of health care; and (7) engagement in, and evaluation of, cost control experiments, including incentive reimbursement and utilization and peer review programs.

40-1812 FEES. (REPEALED BY 1970 LEGISLATURE)

40-1813 WORKMEN'S COMPENSATION LAW NOT AFFECTED.

No provisions of this act or of any subscription agreement for hospital service, between a corporation subject to the provisions of this act and a subscriber shall in any way affect the operation of article 5, of chapter 44 of the Kansas Statutes Annotated and amendments to the provisions thereof, constituting the workmen's compensation law.

40-1814-40-1815 (REPEALED BY 1951 LEGISLATURE)

40-1816 TRANSACTION OF BUSINESS BY FOREIGN CORPORATIONS.

A nonprofit mutual hospital service corporation organized under the laws of any other state or territory may be authorized to transact business in this state subject to the approval of the commissioner of insurance, only in such areas that form part of a natural medical area of the area in which such corporation operates or where the interests of the subscriber are better served.

ARTICLES OF INCORPORATION

of

BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

(A Not For Profit Missouri Health Services Corporation)

Revised: 7/21/82

KNOW ALL MEN BY THESE PRESENTS:

First: The name of the Corporation shall be BLUE CROSS AND BLUE SHIELD OF KANSAS CITY.

Second: The duration of its existence shall be perpetual.

Third: The address of its Registered Office in the State of Missouri is 3637 Broadway, Kansas City, Missouri 64111, and the name of its Registered Agent at said address is Frederick A. Tromans.

Fourth: The first Board of Directors shall be forty-three (43) in number and thereafter such number as shall be specified from time to time by the Bylaws of the Corporation.

Fifth: The purposes for which the corporation is organized are:

1. To operate and maintain in Kansas City, Missouri, and elsewhere in the State of Missouri and in the State of Kansas, a health services corporation for the purposes of establishing and operating a voluntary, nonprofit plan or plans under which hospital care, medical-surgical care, and other health care and services, or reimbursement therefor, when necessary, may be furnished to persons who become members or beneficiaries; of acting as agent or intermediary for other health services corporations, for any governmental body or agency, or for other corporations, associations, partnerships or individuals in the field of health care and services; and of research, education or related activity.

2. To act as a not-for-profit personal service agency in bringing together subscribers to the service and such hospitals which may contract with the Corporation to render such hospital services in accord with the conditions of their participation, and such providers who may render such services or supply such materials under the terms and provisions as may be prescribed by its Bylaws or in its contracts.

3. To do such other things consistent with its necessary activities as tend to provide for the relief of persons residing within the territory it serves, in providing a plan whereby such persons may obtain hospital and health care services at the minimum cost and expense consistent with existing circumstances.

4. To enter into formal or informal relationships with concerned individuals, corporations, or other organizations to enhance the quality and maintain an acceptable quantity of health care, and to minimize its cost to all, whether paid for directly by the individual, or through the media of group prepayment, government grant, subsidy, or otherwise.

5. To create programs and systems under which all people can pay for all or any part of their health care costs through regular periodic payments.

6. To collect, verify, analyze and record, through the physicians and surgeons rendering services to its subscribers, case histories, statistics and other scientific and educational information and analyses of value to the community and to providers in general.

7. To concern itself with the health of persons living or coming within the territory in which it operates or may operate or to which it may extend any of its services, and to conserve and to protect the health of the public.

8. To promote social welfare, health, the assembly of scientific information, medical, surgical and health research, and for the purposes of benevolence and charity and of civic interest.

9. To undertake, as it becomes necessary and proper in its operations, any or all of the services and purposes under any power specified by law.

10. No part of the net earnings of the corporation shall inure to the benefit of, or be distributable to, its officers, directors, or other private persons except that the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered.

11. No substantial part of the activities of the Corporation shall be the carrying on of propaganda or otherwise attempting to influence legislation and the Corporation shall not participate in or intervene in (including the publishing or distribution of statements) any political campaign on behalf of any candidate for public office.

12. Notwithstanding any other provisions of these Articles, the Corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from Federal Income Tax under Section 501 (c) (4) of the Internal Revenue Code of 1954 (or the corresponding provisions of any future United States Internal Revenue Law) or (b) by a Corporation, contributions to which are deductible under Section 170 (c) (2) of the Internal Revenue Code of 1954 (or the corresponding provisions of any future United States Internal Revenue Law).

13. These Articles shall be binding upon all Directors of BLUE CROSS AND BLUE SHIELD OF KANSAS CITY, a Corporation, as originally organized and operating and by all persons who hereafter become Directors.

14. The management and control of the Corporation shall be in the charge and control of the present officers and Board of BLUE CROSS AND BLUE SHIELD OF KANSAS CITY and shall so continue during the terms for which said officers and Board members, respectively, have been elected, and thereafter in the charge and control of such officers and Board members as may be elected in accord with the Bylaws of the Corporation, as the same now exist or hereafter may be amended.

15. The officers of the Board shall be a Chairman, a Vice Chairman, a Secretary, a Treasurer, an Assistant Secretary, an Assistant Treasurer, and such other officers or assistant officers as may be authorized by the Bylaws.

16. There shall be not less than three (3) members of the Board, their number, classes, qualifications, and tenure to be determined as provided by the Bylaws, and such Board shall have the exclusive authority to make or amend Bylaws for the Corporation.

17. Upon dissolution of the corporation, after all liabilities and obligations have been satisfied and discharged, any excess assets shall be distributed for one or more exempt purposes within the meaning of Sections 501(c)(3) or 501(c)(4) of the Internal Revenue Code, or corresponding section of any future Federal tax code, or shall be distributed to the Federal government, or to a state or local government, for a public purpose.

_____ Secretary

B Y L A W S

of

BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

Kansas City, Missouri

May 19, 1982

Revised: 12/15/82
5/22/85
3/26/86

ARTICLE I NAME, LOCATION AND CORPORATE SEAL

Section 1 Name

The name of the Corporation is Blue Cross and Blue Shield of Kansas City, and its principal place of business shall be in Kansas City, Missouri.

Section 2 Location

The location of the registered office of the Corporation is Kansas City, Missouri.

Section 3 Corporate Seal

The seal of the Corporation shall be circular in form and have inscribed thereon the name of the Corporation and the words "Corporate Seal."

ARTICLE II PURPOSES

The purposes for which this Corporation is organized are those defined in the Articles of Incorporation.

ARTICLE III BOARD OF DIRECTORS

Section 1 Number

The governing body of the corporation shall be the Board of Directors which shall consist of twenty-five (25) members.

Section 2 Composition

The Board of Directors shall be comprised of the following:

a) At least two-thirds of the Directors shall be representatives of the general public.

b) Not more than one-third of the Directors shall be licensed physicians who practice in the geographic area served by the Plan. These physicians shall be participating physicians and can be licensed doctors of medicine, osteopathy, and dentistry in appropriate numbers to be in accordance with the total number of physicians on the Board.

c) The President and Chief Executive Officer of the Plan may be a member of the Board of Directors. The President and Chief Executive Officer shall have all the rights and obligations of other Board Members except that he/she shall not be a member of any permanent Committee of the Board, nor shall he/she be an officer of the Board, nor shall he/she be eligible for compensation as defined in Article IV, Section 2, of these Bylaws.

Section 3 Selection

a) The Nominating Committee shall select and recommend candidates for election to the Board of Directors to fill all expiring terms and vacancies in unexpired terms.

b) The election of the Board of Directors shall take place at the Annual Meeting in May.

c) Any eight (8) members of the Board of Directors may place in nomination other eligible candidates in addition to the Nominating Committee selections for election to the Board. Such other nominations shall be made by petition in writing signed by eight (8) or more Board Members and consented to in writing by the candidate proposed. Election shall be by majority vote until all vacant positions have been filled.

d) Each member of the Board of Directors shall be entitled to cast one vote for each office. Candidates receiving the largest number of votes shall be declared elected.

Section 4 Tenure

Members of the Board of Directors so elected shall serve for a term of five (5) years except that, if any member should become unable or unwilling to serve or should not attend three successive meetings without acceptable excuse, the Board of Directors on recommendation of the Nominating Committee may choose a successor.

In the event a Public member is elected to a hospital board, or becomes a paid employee of a hospital, or member of the medical, osteopathic, or dental profession, or in the case a medical, osteopathic, or dental member becomes disqualified as a Participating Physician, he/she is automatically ineligible for service on the Board of Directors.

Section 5 Age Limit

Members of the Board of Directors reaching age seventy-five (75) shall not be eligible for re-election to the Board of Directors.

Section 6 Vacancies

Any vacancy occurring on the Board of Directors between the Annual Meetings may be filled for the unexpired term by the Board of Directors, on recommendation of the Nominating Committee.

ARTICLE IV OFFICERS

Section 1 Officers of the Board

The officers of the Board shall be a Chairman of the Board, a Vice Chairman of the Board, a Secretary, a Treasurer, an Assistant Treasurer, and an Assistant Secretary. Upon recommendation of the Nominating Committee, all officers shall be elected by the Board of Directors at its Annual Meeting. Each officer shall serve until a successor has been elected and qualified.

Section 2 Compensation

Directors may receive a stipend in addition to actual expenses incurred by them in attendance at any meetings or in the performance of other duties. The Board of Directors may establish and review, from time to time, such stipend.

Section 3 Qualification

No officer or member of the Board shall be considered to have qualified for office until such officer or member has filed a letter announcing acceptance of the elected office with the Secretary.

Section 4 Duties of Officers

a) The Chairman of the Board shall preside at all meetings of the Board, perform such duties as usually pertain to such office, and exercise such other powers and perform such other duties as may be assigned by the Board. The Chairman shall be an ex-officio member of all committees except the Nominating Committee.

b) The Vice Chairman, in the absence or incapacity of the Chairman of the Board, shall exercise the powers and perform the duties of the Chairman of the Board.

c) The Secretary shall have recorded the minutes of all meetings, have custody of the corporate seal, and, when authorized by the Board, affix the same to any instrument requiring it, when duly signed by the Chairman of the Board, or when so directed by the Board.

d) The Treasurer shall perform such duties and submit such reports, statements and accounting as the Board of Directors may prescribe. The Treasurer shall arrange for the deposit of all funds and the safekeeping of all securities of the Corporation in the name of the Corporation in such banks or other financial institutions as the Board of Directors may designate, and for the withdrawal of funds on the signature of such officers as the Board of Directors may direct.

e) The Assistant Treasurer shall perform such duties as are assigned by the Treasurer of the Board, and may be empowered to sign checks in the event the Treasurer is unavailable.

f) The Assistant Secretary shall perform such duties as are assigned by the Secretary of the Board and shall perform the duties of the Secretary in the Secretary's absence.

ARTICLE V SALARIED OFFICERS OF THE CORPORATION

Section 1 President and Chief Executive Officer

The President and Chief Executive Officer shall be selected and employed by the Board, and shall report and be directly responsible thereto. The President and Chief Executive Officer may also be a member of the Board as provided for in Article III, Section 2(c) of these Bylaws. The President and Chief Executive Officer shall have immediate supervision of the work of the Corporation, including the employment and discharge of employees, keeping the Corporation's records, attending meetings of the Board, making reports as may be directed by the Board to the Board or to any other organization to which the Board may direct, and be chief salaried officer of the Corporation. The President and Chief Executive Officer shall give bond in such amount as may be determined by the Board.

Section 2 Executive Vice President

An Executive Vice President may be selected and employed by the Board. Such Executive Vice President shall have full power to act in place and instead of the President and Chief Executive Officer, and to perform all of the duties of the latter in his/her absence. The Executive Vice President shall give bond in such amount as may be determined by the Board. Such Executive Vice President shall be a salaried officer of the Corporation.

Section 3 Vice Presidents

One or more Vice Presidents may be selected, employed, or discharged upon recommendation of the President and Chief Executive Officer with approval by the Personnel Committee and ratification by the Executive Committee, such action to be reported at the next regular meeting of the Board. These Vice Presidents shall be salaried officers of the Corporation and shall give bond in such amount as may be determined by the Board.

Section 4 Corporate Secretary

A Corporate Officer may be designated as Corporate Secretary by the Board of Directors. Such Corporate

Secretary shall be responsible for signing appropriate documents and attesting signatures on various legal documents as assigned by the Board Secretary.

ARTICLE VI CONFLICT OF INTEREST

All members of the Board, officers and responsible employees of the Corporation shall disclose to the Board any material interest or affiliation on their part which is, or likely to be, in conflict with the official duties of such person, and any or all such information shall be at all reasonable times open to inspection by members of the Board. In addition to the foregoing requirement of disclosure, all members of the Board, officers and responsible employees of the Corporation shall, not less than annually, complete a statement setting forth any conflicts or potential conflicts of such person. It shall be said parties' responsibility to make appropriate disclosure if their situation changes between periods of completion of conflict of interest statements.

Should a Board member find himself/herself in a conflict of interest position because of the nature of issues being discussed in the course of a meeting, he or she must disclose such conflict. Thereafter, if requested by the Chairman, he/she shall abstain from deliberating on the matter in question and from voting, or shall remove himself/herself from the room in which the matter is being discussed. The Board may meet in executive session at which time the Chairman may request that all or some members of Blue Cross and Blue Shield Management refrain from attending said session.

ARTICLE VII MEETINGS

Section 1 Annual Meeting of the Board of Directors

The Annual Meeting of the Board of Directors shall be held during the month of May as determined by the Board.

Section 2 Board Meetings

The Board shall meet not less than four (4) times annually, not including the Annual Meeting of the Board to be held in May, to receive reports and to transact such business as may be presented to it. The Board shall meet on any date at the call of the Chairman. The Secretary shall call a meeting of the Board upon receipt of written request thereof by any eight (8) Board members.

Section 3 Executive Committee Meetings

The Executive Committee of the Board shall meet monthly to receive reports and to transact such business as may be presented to it. The Chairman of the Board may cancel any meeting at his/her discretion with advance notice to Committee members.

Section 4 Special Meetings

A statement of the general nature of the business to be transacted at any special meeting of the Board shall accompany the notice of such meeting, and no business not within the scope of such statement shall be transacted at such meeting unless all of the members of the Board are present, and then only by unanimous consent.

Section 5 Written Notice

Not less than five (5) days written notice, nor more than forty (40) days, of any special meeting shall be mailed to every Board member, but any Board member at any time may waive this required notice.

ARTICLE VIII QUORUMS

Section 1 Board of Directors

A majority of the members of the Board shall constitute a quorum at any meeting of the Board.

Section 2 Executive Committee

A majority of the members of the Executive Committee shall constitute a quorum at any meeting of the Executive Committee.

Section 3 Other Committees

For all other committees, a majority of the members shall constitute a quorum at any meeting of the Committee.

ARTICLE IX COMMITTEES

Section 1 Executive Committee

a) There shall be an Executive Committee composed of the six (6) officers, who shall be the Chairman, the Vice Chairman, the Secretary, the Treasurer, the Assistant Treasurer, and the Assistant Secretary, and not more than four (4) additional members of the Board of Directors.

b) A majority of the members of the Executive Committee shall be Public representatives and at least one member shall be a physician. The Chairman of the Board shall serve as Chairman of the Executive Committee.

c) Members of the Executive Committee, subject to the limitations of Section 1 (a) and (b) of this article, shall be elected by the Board at the Annual Meeting in May, upon recommendation of the Nominating Committee.

d) The Executive Committee shall, during intervals between regular Board meetings or where a specially called meeting of the Board is not feasible, possess and may exercise all the powers of the full Board in the management of the business and affairs of the Corporation, except those powers expressly reserved by the Board or those prohibited by law. Said Executive Committee shall at all times act under the direction and control of the Board of Directors and shall make reports of such actions to the Board at the next meeting following such actions.

e) Upon recommendation from the Personnel Committee, the Executive Committee shall establish and review compensation for all salaried officers of the Corporation.

Section 2 Finance Committee

a) The Finance Committee shall not exceed seven (7) members of the Board, and shall include the Treasurer and Assistant Treasurer.

b) A majority of the members of the Finance Committee shall be Public representatives.

c) Members of the Finance Committee and its Chairman, subject to the limitations of Section 2 (a) and

(b) of this article, shall be appointed by the Chairman of the Board with ratification by the Board at the next regular or special meeting, which includes this as its purpose, following the Annual Meeting.

d) The Finance Committee shall supervise the investments of the Corporation and make recommendations in respect to such investments to the Board. The Finance Committee shall have the authority to invest funds of the Corporation in conformity with the investment policies approved from time to time by the Board. At each meeting of the Board, the Finance Committee shall report on the financial status of the corporation. The Finance Committee shall approve the selection of auditors and such fiscal advisors as may be employed from time to time, and such other duties as assigned by the Chairman.

The Chairman of the Finance Committee may appoint an Audit Sub-Committee to meet regularly with Management, the independent certified public accountants, and the company's internal auditors to review results of auditing activities. The Sub-Committee shall also recommend independent public accountants for review by the Finance Committee and appointment by the Board of Directors.

Section 3 Nominating Committee

a) The Nominating Committee shall consist of not more than five (5) members, one (1) of whom shall be a physician, who shall serve one-year, two-year, or three-year terms.

b) A majority of the members of the Nominating Committee shall be Public representatives.

c) Members of the Nominating Committee with term expirations, subject to the limitations of Section 3 (a) and (b) of this article, shall be elected by the Executive Committee with ratification by the Board at the next regular or special meeting, which includes this as its purpose, following the Annual Meeting.

The Chairman of the Board, Vice Chairman of the Board, and Treasurer shall appoint an ad hoc committee to present to the Executive Committee nominees to fill expiring terms on the Nominating Committee.

d) Members of the Nominating Committee cannot be elected to consecutive terms.

e) This Committee shall be responsible for recommendation of nominees to fill expiring terms and vacancies in unexpired terms on the Board of Directors and nominees for the officers and the remaining members of the Executive Committee.

Section 4 Personnel Committee

a) The Personnel Committee shall consist of not more than five (5) members of the Board of Directors.

b) A majority of the members of the Personnel Committee shall be Public representatives.

c) Members of the Personnel Committee and its Chairman, subject to the limitations of Section 4 (a) and (b) of this article, shall be appointed by the Chairman of the Board with ratification by the Board at its next regular or special meeting, which includes this as its purpose, following the Annual Meeting.

d) This Committee shall be responsible for making recommendations to the Executive Committee pertaining to selection, employment, or discharge of Vice Presidents, and any change in compensation for salaried officers of the Corporation. The Executive Committee shall approve the actions of the Personnel Committee.

Section 5 Bylaws Committee

a) The Bylaws Committee shall consist of not more than five (5) members of the Board of Directors.

b) A majority of the members of the Bylaws Committee shall be Public representatives.

c) Members of the Bylaws Committee and its Chairman, subject to the limitations of Section 5 (a) and (b) of this article, shall be appointed by the Chairman of the Board with ratification by the Board at its next regular or special meeting, which includes this as its purpose, following the Annual Meeting.

Section 6 Marketing and Public Relations Committee

a) The Marketing and Public Relations Committee shall consist of not more than seven (7) members of the Board of Directors.

b) A majority of the members of the Marketing and Public Relations Committee shall be Public representatives.

c) Members of the Marketing and Public Relations Committee and its Chairman, subject to the limitations of Section 6 (a) and (b) of this article, shall be appointed by the Chairman of the Board with ratification by the Board at its next regular or special meeting, which includes this as its purpose, following the Annual Meeting.

Section 7 Health Benefits Management Committee

a) The Health Benefits Management Committee shall consist of not more than seven (7) members of the Board of Directors.

b) A majority of the Members of the Health Benefits Management Committee shall be Public representatives and the Chairman shall be a Public representative.

c) Members of the Health Benefits Management Committee and its Chairman, subject to the limitations of Section 7 (a) and (b) of this Article, shall be appointed by the Chairman of the Board with ratification by the Board at its next regular or special meeting, which includes this as its purpose, following the Annual Meeting.

d) Recommendations of the Health Benefits Management Committee concerning reimbursement issues are subject to the approval of the Board of Directors.

Section 8 Long Range Planning Committee

a) The Long Range Planning Committee shall consist of not more than five (5) members of the Board of Directors.

b) A majority of the members of the Long Range Planning Committee shall be Public representatives.

c) Members of the Long Range Planning Committee, subject to the limitations of Section 8 (a) and (b) of this Article, shall be appointed by the Chairman of the Board with ratification by the Board at its next regular or special meeting, which includes this as its purpose, following the Annual Meeting.

Section 9 Other Committees

The Chairman of the Board may alsc create, with approval or ratification of the Executive Committee, special committees deemed advisable or necessary. The members of such committees need not be chosen from the membership of the Board, but shall be under the control and supervision of the Board.

Section 10 Committees Recognized by the Board of Directors

Special adjunct committees may be recognized from time to time but such committees shall not be under the control and supervision of the Board. Such committees may have various purposes but their general purpose shall be to provide information and advice to the Board on issues relevant to the Corporation's business. The Professional Affairs Committee and the Hospital Advisory Committee are such special adjunct committees and are recognized for the purposes of providing information and advice to the Board on matters relating to medical and hospital issues.

ARTICLE X RECORDS

Section 1 Reports

All reports of officers, the President and Chief Executive Officer, and Vice Presidents, made to the Board shall be preserved and filed on behalf of the Secretary in the offices of the Corporation.

Section 2 Books and Records of the Corporation

All books and records of the Corporation, regardless in whose custody same may be, shall be open to the inspection of any officer or member of the Board at any reasonable time.

Section 3 Assets of the Corporation

The Board shall have complete control of the assets of the Corporation.

Section 4 Audits

An audit of the Books and accounts of all financial matters of the Corporation shall be made by a firm of independent Certified Public Accountants at least annually and at the direction of the Board. The report covering the audit should be addressed to the Board of Directors and a copy thereof distributed to each member of the Board and a copy filed with the Secretary as a permanent record of the Corporation.

Section 5 Checks

All checks of the Corporation shall be signed by the Treasurer or the Assistant Treasurer or by such other person or persons as the Board may from time to time designate. The Board is authorized to approve facsimile signatures. Notes, mortgages, or deeds of trust, or other evidence of debt of the Corporation shall be given only upon the affirmative vote of the Board and then shall be signed by the Treasurer and countersigned by the Chairman of the Board.

Section 6 Retention of Records

Any records which, in the opinion of the Board, have no further value after having been on file for a period of not less than five (5) years may be destroyed by order of said Board.

ARTICLE XI CONTRACTS

The nature and form of all contracts now effective between the Corporation and Member Providers, the Corporation and Participating Physicians, and the Corporation and subscribers to its contracts, are hereby authorized and approved. Additional contracts with Providers, Participating Physicians, Plans, agencies, or corporations as may be necessary in the judgment of the Board to fulfill the purpose of Blue Cross and Blue Shield of Kansas City are authorized when approved by the Board.

ARTICLE XII INDEMNIFICATION

a) The Corporation shall indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending or completed action, suit, or proceeding, whether civil, criminal, administrative or investigative, other than an action by or in the right of the Corporation, by reason of the fact that the person is or was a director, officer, employee, or agent of the Corporation, or is or was serving at the request of the Corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise against expenses, including attorney's fees, judgments, fines and amounts paid in settlement actually and reasonably incurred in

connection with such action, suit, or proceeding if the person acted in good faith and in a manner reasonably believed to be in or not opposed to the best interests of the Corporation, and, with respect to any criminal action or proceeding, had no reasonable cause to believe the conduct was unlawful. The termination of any action, suit, or proceeding by judgment, order, settlement, conviction, or upon a plea of nolo contendere or its equivalent, shall not, of itself, create a presumption that the person did not act in good faith and in a manner which was reasonably believed to be in or not opposed to the best interests of the Corporation, and, with respect to any criminal action or proceeding, had reasonable cause to believe that the conduct was unlawful.

b) The Corporation shall indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending or completed action or suit by or in the right of the Corporation to procure a judgment in its favor by reason of the fact that the person is or was a director, officer, employee or agent of the Corporation, or is or was serving at the request of the Corporation as a director, officer, mployee or agent of another corporation, partnership, joint venture, trust or other enterprise against expenses, including attorney's fees, actually and reasonably incurred in connection with the defense or settlement of the action or suit if the person acted in good faith and in a manner reasonably believed to be in or not opposed to the best interests of the Corporation; except that no indemnification shall be made in respect of any claim, issue or matter as to which such person shall have been adjudged to be liable for negligence or misconduct in the performance of duties to the Corporation unless and only to the extent that the court in which the action or suit was brought determines upon application, that, despite the adjudication of liability and in view of all the circumstances of the case, the person is fairly and reasonably entitled to indemnity for such expenses which the court shall deem proper.

c) Any indemnification under paragraphs (a) and (b) of this section, unless ordered by a court, shall be made by the Corporation only as authorized in the specific case upon a determination that

indemnification of the director, officer, employee or agent is proper in the circumstances because such person has met the applicable standard of conduct set forth in this section. The determination shall be made by the Board of Directors by a majority vote of a quorum consisting of directors who were not parties to the action, suit, or proceeding, or if such a quorum is not obtainable, or even if obtainable a quorum of disinterested directors so directs, by independent legal counsel in a written opinion, or by the members.

d) Expenses incurred in defending a civil or criminal action, suit or proceeding shall be paid by the Corporation in advance of the final disposition of the action, suit, or proceeding as authorized by the Board of Directors in the specific case upon receipt of an undertaking by or on behalf of the director, officer, employee or agent to repay such amounts unless it shall ultimately be determined that such person is entitled to be indemnified by the Corporation as authorized in this section.

e) The indemnification provided by this section shall not be deemed exclusive of any other rights to which those seeking indemnification shall be entitled under any other bylaw, agreement, vote of members or disinterested directors or otherwise, both as to action in such person's official capacity and as to action in another capacity while holding such office, and shall continue as to a person who has ceased to be a director, officer, employee or agent and shall inure to the benefit of the heirs, executors and administrators of such a person.

ARTICLE XIII AMENDMENTS AND INTERPRETATIONS

Section 1 Amendments

These Bylaws may be altered, amended, or repealed at any quorum meeting of the Board by the affirmative vote of at least two-thirds of those present, provided notice of the proposed additions, alterations, or amendments be contained in the notice of the meeting, such notice to be mailed each member of the Board not less than fourteen (14) days prior to the meeting.

Section 2 Interpretations

The authority to interpret and construe these Bylaws shall be vested in the Board.

_____ Secretary

Amended December 15, 1982
Amended May 22, 1985
Amended March 26, 1986

Exhibit H

MICHIGAN

SENATE SUBSTITUTE FOR
HOUSE BILL No. 4555

A bill to provide for the incorporation of nonprofit health care corporations; to provide their rights, powers, and immunities; to prescribe the powers and duties of certain state officers relative to the exercise of those rights, powers, and immunities; to prescribe certain conditions for the transaction of business by those corporations in this state; to define the relationship of health care providers to nonprofit health care corporations and to specify their rights, powers, and immunities with respect thereto; to provide for the regulation and supervision of nonprofit health care corporations by the commissioner of insurance; to prescribe powers and duties of certain other state officers with respect to the regulation and supervision of nonprofit health care corporations; to regulate the merger or consolidation of certain corporations; to prescribe an expeditious and effective procedure for the maintenance and conduct of certain administrative appeals relative to provider class plans; to provide for

certain administrative hearings relative to rates for health care benefits; to provide for certain causes of action; to prescribe penalties and to provide civil fines for violations of this act; and to repeal certain acts and parts of acts.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

PART 1

Sec. 101. This act shall be known and may be cited as "the nonprofit health care corporation reform act".

Sec. 102. (1) It is the purpose of and intent of this act, and the policy of the legislature, to promote an appropriate distribution of health care services for all residents of this state, to promote the progress of the science and art of health care in this state, and to assure for nongroup and group subscribers, reasonable access to, and reasonable cost and quality of, health care services, in recognition that the health care financing system is an essential part of the general health, safety, and welfare of the people of this state. Each corporation subject to this act is declared to be a charitable and benevolent institution and its funds and property shall be exempt from taxation by this state or any political subdivision of this state.

(2) It is the intention of the legislature that this act shall be construed to provide for the regulation and supervision of nonprofit health care corporations by the commissioner of insurance so as to secure for all of the people of this state who apply for a certificate, the opportunity for access to health care services at a fair and reasonable price.

(3) It is the public policy of this state that, in the interest of facilitating access to health care services at a fair and reasonable price, an alternate, expeditious, and effective procedure for the resolution

of issues and the maintenance of administrative appeals relative to provider class plans be established and utilized, and to that end, the provisions of this act regarding administrative review of those provider class plans shall be construed so as to minimize uncertainty and delays.

Sec. 103. For the purposes of this act, the words and phrases defined in sections 104 to 108 shall have the meanings ascribed to them in those sections.

Sec. 104. (1) "Administrative procedures act" means Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 TO 24.315 of the Michigan Compiled Laws, or a successor act.

(2) "Bargaining representative" means a representative designated or selected by a majority of employees for the purposes of collective bargaining in respect to rates of pay, wages, hours of employment, or other conditions of employment relative to the employees so represented.

(3) "Certificate" means a contract between a health care corporation and a subscriber or a group of subscribers under which health care benefits are provided to members, including a contract containing an administrative services only or cost-plus arrangement. A certificate includes any approved riders amending the contract.

(4) "Collective bargaining agreement" means an agreement entered into between the employer and the bargaining representative of its employees, and includes those agreements entered into on behalf of groups of employers with the bargaining representative of their employees pursuant to the national labor relations act, 29 U.S.C. 151 to 169, under Act No. 176 of the Public Acts of 1939, as amended, being sections 423.1 to 423.30 of the Michigan Compiled Laws, or under Act No. 336 of the Public Acts of 1947, as amended, being sections 423.201 to 423.216 of the Michigan

Compiled Laws.

(5) "Commissioner" means the commissioner of insurance. Commissioner includes an authorized designee of the commissioner, if written notice of the delegation of authority has been given as provided in section 601.

(6) "Contingency reserve" means the sum of all assets minus the sum of all liabilities of a health care corporation, as shown in the annual financial statement filed under section 602.

Sec. 105. (1) "Health care benefit" means the right under a certificate to have payment made by a health care corporation for a specified health care service, regardless of whether or not the payment is made pursuant to an administrative services only or cost-plus arrangement.

(2) "Health care corporation" means a nonprofit hospital service corporation, medical care corporation, or a consolidated hospital service and medical care corporation incorporated or reincorporated under this act, or incorporated or consolidated under former Act No. 108 or 109 of the Public Acts of 1939.

(3) "Health care facility" means a facility or agency as defined in section 22104 of Act No. 368 of the Public Acts of 1978, being section 333.22104 of the Michigan Compiled Laws, and includes a home health agency, or other facility with the approval of the commissioner.

(4) "Health care provider" or "provider", except as provided in section 301(8)(a), means a health care facility; a person licensed, certified, or registered under parts 161 to 182 of Act No. 368 of the Public Acts of 1978, as amended, being sections 333.16101 to 333.18237 of the Michigan Compiled Laws; or any other person or facility, with the approval of the commissioner, who or which meets the standards set by the health care

corporation for all contracting providers.

(5) "Health care services" means services provided, ordered, or prescribed by a health care provider, including health and rehabilitative services and medical supplies, medical and rehabilitative services and medical supplies, medical prosthetics and devices, and medical services ancillary or incidental to the provision of those services.

Sec. 106. (1) "Large subscriber group" means a group of 10,000 or more subscribers.

(2) "Medium subscriber group" means a group of 150 or more subscribers, but less than 10,000 subscribers.

(3) "Member", except as used in parts 2 and 3, means a subscriber, a dependent of a subscriber, or any other individual entitled to receive health care benefits under a nongroup or group certificate.

(4) "Nongroup subscriber" means an individual subscriber who is not enrolled as a subscriber through any subscriber group.

(5) "Objectives" means an expected achievement level by a health care corporation of the goals provided in section 504, for a provider class. Insofar as is reasonably practicable, objectives shall be capable of quantitative measurement.

Sec. 107. (1) "Participating provider" means a provider that has entered into a participating contract with a health care corporation and that meets the standards set by the corporation for that class of providers.

(2) "Participating contract" means an agreement, contract, or other arrangement under which a provider agrees to accept the payment of the health care corporation as payment in full for health care services or parts of health care services covered under a certificate, as provided for in section 502(1).

(3) "Person" means an individual, corporation, partnership, organization, or association.

(4) "Personal data" means a document incorporating medical or surgical history, care, treatment, or service; or any similar record, including an automated or computer accessible record, relative to a member, which is maintained or stored by a health care corporation.

(5) "Proposed rate" means any of the following:

(a) A proposed increase or decrease in the rates to be charged to nongroup subscribers.

(b) For group subscribers, any proposed changes in the methodology or definitions of any rating system, formula, component, or factor subject to prior approval by the commissioner.

(c) A proposed increase or decrease in deductible amounts or coinsurance percentages.

(d) A proposed extension of benefits, additional benefits, or a reduction or limitation in benefits.

(e) A review pursuant to section 608(2).

(6) "Provider class" means classes of providers, as defined in section 105(4), that have a provider contract or a reimbursement arrangement with a health care corporation to render health care services to subscribers, as those classes are established by the corporation.

(7) "Provider class plan" or "plan" means a document containing a reimbursement arrangement and objectives for a provider class, and, in the case of those providers with which a health care corporation contracts, provisions that are included in that contract.

(8) "Provider contract" or "contract" means an agreement between a provider and a health care corporation that contains provisions to imple-

ment the provider class plan.

Sec. 108. (1) "Reimbursement arrangement" means policies, practices, and methods by which a health care corporation makes payments to a provider to implement the provider class plan.

(2) "Small subscriber group" means a group of less than 150 subscribers.

(3) "Subscriber" means an individual who contracts for health care benefits, either individually or through a group, with a health care corporation. Subscriber includes an individual whose contract contains an administrative services only or cost-plus arrangement authorized under section 207(1)(g).

PART 2

Sec. 201. (1) A health care corporation shall not be incorporated in this state except under this act.

(2) Not less than 7 persons, all of whom shall be residents of this state, may form a health care corporation under this act for the purpose of providing 1 or more health care benefits at the expense of the corporation to persons or groups of persons who become subscribers to the plan, under certificates which will entitle each subscriber to certain health care services by providers with which the corporation has contracted for that purpose.

(3) A certificate shall not provide for the payment of cash or any other material benefit to a subscriber or the estate of a subscriber on account of death, illness, or injury except where payment is made to a subscriber for health care services by a provider who has not entered into a participating contract with the corporation or to reimburse a subscriber who has made, or is obligated to make, payment directly to a provider.

(4) A health care corporation shall not be subject to the laws of this state with respect to insurance corporations, except as provided in this act. A health care corporation shall not be subject to the laws of this state with respect to corporations generally.

(5) A health care corporation subject to this act is declared to be a charitable and benevolent institution, and its funds and property shall be exempt from taxation by this state or any political subdivision of this state.

(6) A person shall not act as a health care corporation or issue a certificate except as authorized by and pursuant to a certificate of

authority granted to the person by the commissioner pursuant to this act.

(7) A health care corporation shall provide only the kinds of health care benefits and certificates authorized by this act. A health care corporation shall not make or issue a certificate relative to health care benefits except as approved or otherwise authorized under this act.

Sec. 202. (1) Persons associating to form a health care corporation under this act shall subscribe to articles of incorporation that shall contain all of the following:

(a) The names and addresses of the incorporators.

(b) The location of the principal office of the corporation for the transaction of business in this state.

(c) The name by which the corporation shall be known and all assumed names under which the corporation does busine- . The corporate name shall not include the words insurance, casualty, surety, health and accident, mutual, or other words descriptive of the insurance or surety business, and shall not be so similar to the name of an insurance or surety company doing business in this or other states at the time of incorporation so as to tend, in the judgment of the commissioner, to create confusion in identity with that insurance or surety company.

(d) The purposes of the corporation, which shall be:

(i) To provide health care benefits.

(ii) To secure for all of the people of this state who apply for a certificate, the opportunity for access to coverage for health care services at a fair and reasonable price.

(iii) To assure for nongroup and group subscribers, reasonable access to, and reasonable cost and quality of, health care services.

(iv) To achieve the goals of the corporation relative to access,

quality, and cost of health care services, as prescribed in section 504.

(v) To offer supplemental coverage to all medicare enrollees as provided in section 411.

(vi) If under contract to serve as fiscal intermediary for the federal medicare program, to do all of the following:

(A) Carry out its contractual responsibilities efficiently, including the timely processing and payment of claims.

(B) Actively represent, in negotiations with the federal government and with providers of medical, hospital, and other health services for which benefits are provided under the federal medicare program, the interests of senior citizens as they relate to cost and quality of, and access to, health care services and administration of the program.

(vii) To engage in activity otherwise authorized by this act, within the purposes for which corporations may be organized under this act.

(e) The term of existence of the corporation, which may be in perpetuity.

(f) The time for the holding of the annual meeting of the corporation.

(g) Other terms and conditions not inconsistent with this act, necessary for the conduct of the affairs of the corporation.

(2) The articles shall be acknowledged by the persons signing them before a notary public. The notary public shall append his or her certificate of acknowledgment to the articles. The articles shall be in triplicate and upon proper forms as prescribed by the commissioner.

(3) Before the articles or amendments to the articles are effective for any purpose, they shall be submitted to the attorney general for examination. If the attorney general finds the articles or amendments to the articles to be in compliance with this act, the attorney general shall certify

this finding to the commissioner. The articles or amendments shall be effective at the time certified by the attorney general.

(4) Each health care corporation shall pay a fee of $250.00 to the attorney general for the examination of its articles of incorporation, or $100.00 for the examination of amendments to the articles of incorporation. Each health care corporation shall pay a filing fee of $100.00 to the commissioner for filing its articles of incorporation or $50.00 for the filing of amendments to the articles of incorporation. The fees prescribed in this subsection shall be deposited in the state treasury and credited to the general fund of the state.

Sec. 203. By action of its board of directors, a health care corporation may integrate into a single instrument the provisions of its articles of incorporation which are then in effect and operative, as theretofore amended. If the restated articles restate and integrate and also further amend the articles, they shall also be adopted by the board of directors. Any amendment or restatement of the articles shall be subject to review, approval, or both, as provided in section 202(3) or 701, as applicable.

Sec. 204. (1) Before entering into contracts or securing applications of subscribers, the persons incorporating a health care corporation shall file all of the following in the office of the commissioner:

(a) Three copies of the articles of incorporation, with the certificate of the attorney general required under section 202(3) attached.

(b) A statement showing in full detail the plan upon which the corporation proposes to transact business.

(c) A copy of all certificates to be issued to subscribers.

(d) A copy of the financial statements of the corporation.

(e) Proposed advertising to be used in the solicitation of certificates

for subscribers.

(f) A copy of the bylaws.

(g) A copy of all proposed contracts and reimbursement methods.

(2) The commissioner shall examine the statements and documents filed under subsection (1), may conduct any investigation which he or she considers necessary, may request additional oral and written information from the incorporators, and may examine under oath any persons interested in or connected with the proposed health care corporation. The commissioner shall ascertain whether all of the following conditions are met:

(a) The solicitation of certificates will not work a fraud upon the persons solicited by the corporation.

(b) The rates to be charged and the benefits to be provided are adeq[illegible]e, equitable, and not excessive, as defined in section 609.

(c) The amount of money actually available for working capital is sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of issuance of the certificate of authority, and is not less than $500,000.00 or a greater amount, if the commissioner considers it necessary.

(d) The amounts contributed as the working capital of the corporation are payable only out of amounts in excess of minimum required reserves of the corporation.

(e) Adequate and reasonable reserves are provided, as defined in section 205.

(3) If the commissioner finds that the conditions prescribed in subsection (2) are met, the commissioner shall do all of the following:

(a) Return to the incorporators 1 copy of the articles of incorporation, certified for filing with the chief officer of the department of commerce

or of any other agency or department authorized by law to administer Act No. 284 of the Public Acts of 1972, as amended, being sections 450.1101 to 450.2099 of the Michigan Compiled Laws, or his or her designated representative, and 1 copy of the articles of incorporation certified for the records of the corporation itself.

(b) Retain 1 copy of the articles of incorporation for the commissioner's office files.

(c) Deliver to the corporation a certificate of authority to commence business and to issue certificates which have been approved by the commissioner, or which are exempted from prior approval pursuant to section 607(2) or (7), entitling subscribers to certain health care benefits.

Sec. 205. (1) A health care corporation shall record or estimate liabilities at reasonable values, neither excessive nor inadequate and in accordance with sound actuarial practices and generally accepted accounting principles, to provide for the payment of all debts of the corporation. The assets of the corporation shall be valued in accordance with sound actuarial practices and generally accepted accounting principles. The commissioner shall disapprove the amount of any assets or liabilities which violate this subsection. The commissioner shall have the authority to disapprove the creation of any new liability which is properly includable in the contingency reserves. A liability shall be considered to be a new liability if the liability was not in existence on or before December 31, 1978.

(2) At all times while engaged in business, a health care corporation shall maintain a contingency reserve which, on a projected basis, progresses toward the target contingency reserve level established pursuant to this section. Until a target contingency reserve level is established pursuant

to this section, the corporation shall maintain a contingency reserve in the form and amount determined by the commissioner, or 11.5% of the previous year's total incurred claims and incurred expenses, whichever is greater.

(3) Within 30 days after the filing of a health care corporation's annual financial statement under section 602, the commissioner shall determine the target contingency reserve level for the corporation, expressed as a percentage of the total incurred claims and incurred expenses of the corporation for the previous calendar year. The target shall be equal to the adjustment factor established in subsection (7) multiplied by the sum of the risk factors weighted by the distribution of business of the corporation as of the previous December 31. The commissioner shall transmit a copy of the t.. get to the corporation, rounded up to the nearest 1/10 of a percent.

(4) A health care corporation, for purposes of this section, shall define at least 5 lines of business and shall assign a risk factor to each line of business. The risk factors shall be established in accordance with sound actuarial practices, and the health care corporation shall file these risk factors with the commissioner within 6 months after the following times:

(a) In the case of a health care corporation established under former Act No. 108 or 109 of the Public Acts of 1939, upon the effective date of this act.

(b) In the case of a health care corporation newly incorporated under this act, upon formation of the corporation.

(c) In the case of a health care corporation which has previously determined risk factors pursuant to this section, upon request of either

the corporation or the commissioner, provided that the request is not made within 3 years after a previous determination of risk factors pursuant to this section, except as provided in subsection (8).

(5) Within 30 days after receipt of the risk factors filed pursuant to subsection (4), the commissioner shall do 1 of the following:

(a) Approve the factors and proceed under subsection (7).

(b) Define 1 or more additional lines of business, transmit the definitions to the health care corporation, and request that the corporation establish risk factors for those additional lines. The corporation shall then have 60 days to submit a risk factor for each line of business defined by either the commissioner or the corporation, which shall be approved or disapproved by the commissioner under this subsection. A health care corporation may revise a previously filed risk factor under this subsection.

(c) Disapprove the factors, and proceed under subsection (6).

(6) If the risk factors are disapproved by the commissioner pursuant to subsection (5)(c), the commissioner shall immediately notify the health care corporation of the disapproval. Within 6 months following notification, a panel of 3 actuaries, 1 appointed by the commissioner, 1 by the corporation, and 1 appointed by the 2 previously appointed actuaries, shall determine a risk factor for each line of business. The agreement of any 2 actuaries on the panel shall be sufficient for the determination of the risk factors, and the panel shall transmit a copy of the risk factors to both the commissioner and the corporation.

(7) Within 15 days after the determination of the risk factors under subsection (6), or the approval of the risk factors under subsection (5)(a), the commissioner shall calculate an adjustment factor, which shall be transmitted to the health care corporation and the legislature. The adjust-

ment factor shall equal:

(a) In the case of a filing pursuant to subsection (4)(a), 11.5% divided by the sum of the risk factors weighted by the distribution of business of the corporation as of December 31, 1979.

(b) In the case of a filing pursuant to subsection (4)(b), 11.5% divided by the sum of the risk factors weighted by the distri bution of business of the corporation as of 6 months following the formation of the corporation.

(c) In the case of a filing pursuant to subsection (4)(c), the current target contingency reserve level divided by the sum of the risk factors weighted by the distribution of business of the corporation as of the previous December 31.

(8) At any time the health care corporation and the commissioner, by mutual agreement, may enter into a stipulation setting forth lines of business, risk factors for each line of business, and an adjustment factor.

(9) The contingency reserve of a health care corporation shall not be less than 65%, nor more than 120% of the target contingency reserve level. If the contingency reserve is above the required range at the end of a calendar year, the corporation shall implement adjustments as necessary to achieve the required range and shall file with the commissioner, for information, a description of the adjustments.

(10) The commissioner shall examine a health care corporation's annual financial statement filed in accordance with section 502 to determine, in accordance with generally accepted accounting principles, whether the contingency reserve is outside the required range described in subsection (9). If the contingency reserve is outside the required range at the

end of 2 successive calendar years, the corporation shall file a plan, for approval by the commissioner, to adjust the contingency reserve to a level within the required range. If the commissioner disapproves the corporation's plan, the commissioner shall formulate a plan and shall forward the plan to the corporation. The corporation shall begin implementation of the commissioner's plan immediately upon receipt of the plan in writing.

(11) Contributions to the contingency reserve shall consist of 2 contribution components. The first is the contribution for risk which shall be actuarially determined as a normal part of the rate-making process. The second is the contribution for plan-wide viability. Both components shall be considered contributions to the contingency reserve and shall be taken into consideration in determining compliance with this section.

(12) With respect to contributions for plan-wide viability, those contributions shall be made in accordance with the following:

(a) For contributions by small group and nongroup subscribers, if the contingency reserve is below 65% of the target, the contribution rate shall be 1% of the rate established pursuant to part 6; if the contingency reserve is between 65% and 95% of the target, the contribution rate shall be 0.5% of the rate established pursuant to part 6; if the contingency reserve is greater than 95% of the target, the contribution rate shall be 0%.

(b) For contributions by medium group and large group subscribers, if the contingency reserve is below 65% of the target, the contribution rate shall be 1% of the rate established pursuant to part 6; if the contingency reserve is between 65% and 105% of the target, the contribution shall be 0.5% of the rate established pursuant to part 6; if the contingency

reserve is greater than 105% of the target, the contribution rate shall be 0%.

(c) At any time the corporation and the commissioner, by mutual agreement, may enter into a stipulation setting forth uniform adjustments to the contributions established in subdivisions (a) and (b).

(13) As used in this section:

(a) "Actuary" means a person who has the professional designation of a fellow of the society of actuaries, or a fellow of the society of casualty actuaries.

(b) "Distribution of business" means the percentage of a health care corporation's total business attributable to a given line of business, based on dollar amount of incurred claims and incurred expenses.

(c) "Risk factor" means the relative probability of loss associated with a given line of business, expressed as a percentage of incurred claims and incurred expenses for a calendar year.

(14) Arrangements for health benefit programs authorized under section 207(1)(f) shall not be included under this section unless, as part of the arrangement, contributions are made to the contingency reserve.

(15) The costs of a panel established under subsection (6) shall be split equally between a health care corporation and the commissioner, except that both the corporation and the commissioner shall pay the full costs associated with their appointed actuary.

Sec. 206. (1) The funds and property of a health care corporation shall be acquired, held, and disposed of only for the lawful purposes of the corporation and for the benefit of the subscribers of the corporation as a whole. A health care corporation shall only transact such business, receive, collect, and disburse such money, and acquire, hold, protect,

and convey such property, as are properly within the scope of the purposes of the corporation as specifically set forth in section 202(1)(d), for the benefit of the subscribers of the corporation as a whole, and consistent with this act.

(2) The funds of a health care corporation shall be invested only in securities permitted by the laws of this state for the investments of assets of life insurance companies, as described in chapter 9 of Act No. 218 of the Public Acts of 1956, as amended, being sections 500.901 to 500.947 of the Michigan Compiled Laws.

(3) Without regard to the limitation in subsection (2), up to 2% of the assets of the health care corporation may be invested in venture-type investments. For purposes of calculating the contingency reserve pursuant to section 205, a venture-type investment shall be carried on the books of a health care corporation at the original acquisition cost, and losses may only be realized as an offset against gains from venture-type investments. All venture-type investments under this subsection shall provide employment or capital investment primarily within this state. Each investment under this subsection shall be subject to prior approval by the board of directors. As used in this subsection, "venture-type investments" include:

(a) Common stock, preferred stock, limited partnerships, or similar equity interests acquired from the issuer subject to a provision barring resale without consent of the issuer for 5 years from the date of acquisition by the corporation.

(b) Unsecured debt instruments which are either convertible into equity or have equity acquisition rights. These debt instruments shall be subordinated by their terms to all borrowings of the issuer from other

institutional lenders and shall have no part amortized during the first 5 years.

(4) A health care corporation shall not market or transact, as defined in sections 402a and 402b of Act No. 218 of the Public Acts of 1956, being sections 500.402a and 500.402b of the Michigan Compiled Laws, any type of insurance described in chapter 6 of Act No. 218 of the Public Acts of 1956, as amended, being sections 500.600 to 500.644 of the Michigan Compiled Laws. This subsection shall not be construed to prohibit the provision of prepaid health care benefits.

Sec. 207. (1) A health care corporation, subject to any limitation provided in this act, in any other statute of this state, or in its articles of incorporation, may do any or all of the following:

(a) Contract to provide computer service and other administrative consulting services to 1 or more providers or groups of providers, if the services are primarily designed to result in cost savings to subscribers.

(b) Engage in experimental health care projects to explore more efficient and economical means of implementing the corporation's programs, or the corporation's goals as prescribed in section 504 and the purposes of this act, to develop incentives to promote alternative methods and alternative providers, including nurse midwives, nurse anesthetists and nurse practitioners, for delivering health care, including preventive care and home health care.

(c) For the purpose of providing health care services to employees of this state, the United States, or an agency, instrumentality, or political subdivision of this state or the United States, or for the purpose of providing all or part of the costs of health care services to disabled, aged, or needy persons, contract with this state, the United States, or

an agency, instrumentality, or political subdivision of this state or the United States.

(d) For the purpose of administering any publicly supported health benefit plan, accept and administer funds, directly or indirectly, made available by a contract authorized under subdivision (c), or made available by or received from any private entity.

(e) For the purpose of administering any publicly supported health benefit plan, subcontract with any organization which has contracted with this state, the United States, or an agency, instrumentality, or political subdivision of this state or the United States, for the administration or furnishing of health services or any publicly supported health benefit plan.

(f) Provide administrative services only and cost-plus arrangements for the federal medicare program established by parts A and B of title XVIII of the social security act, 42 U.S.C. 1395c to 1395w; for the federal medicaid program established under title XIX of the social security act, 42 U.S.C. 1396 to 1396k; for the child health act of 1967, 42 U.S.C. 701 to 716; for the program of medical and dental care established by the military medical benefits amendments of 1966, Public Law 85-861, 80 Stat. 862; for the Detroit maternity and infant care--preschool, school, and adolescent project; and for any other health benefit program established under state or federal law.

(g) Provide administrative services only and cost-plus arrangements for any health benefit plan established by a subscriber group, subject to the requirements of section 211.

(h) Establish, own, and operate a health maintenance organization, subject to the requirements of Act No. 368 of the Public Acts of 1978,

as amended.

(i) Guarantee loans for the education of persons who are planning to enter or have entered a profession that is licensed, or certified, or registered under parts 161 to 182 of Act No. 368 of the Public Acts of 1978, as amended, being sections 333.16101 to 333.18237 of the Michigan Compiled Laws, and has been identified by the commissioner, with the consultation of the office of health and medical affairs in the department of management and budget, as a profession whose practitioners are in insufficient supply in this state or specified areas of this state and who agree, as a condition of receiving a guarantee of a loan, to work in this state, or an area of this state specified in a listing of shortage areas for the profession issued by the commissioner, for a period of time determined by the commissioner.

(j) Receive donations to assist or enable the corporation to carry out its purposes, as provided in this act.

(k) Bring an action against an officer or director of the corporation.

(l) Designate and maintain a registered office and a resident agent in that office upon whom service of process may be made.

(m) Sue and be sued in all courts and participate in actions and proceedings, judicial, administrative, arbitrative, or otherwise, in the same cases as natural persons.

(n) Have a corporate seal, alter the seal, and use it by causing the seal or a fascimile to be affixed, impressed, or reproduced in any other manner.

(o) Invest and reinvest its funds and, for investment purposes only, purchase, take, receive, subscribe for, or otherwise acquire, own, hold, vote, employ, sell, lend, lease, exchange, transfer, or otherwise dispose

of, mortgage, pledge, use, and otherwise deal in and with, bonds and other obligations, shares, or other securities or interests issued by entities other than domestic, foreign, or alien insurers, as defined in sections 106 and 110 of Act No. 218 of the Public Acts of 1956, being sections 500.106 and 500.110 of the Michigan Compiled Laws, whether engaged in a similar or different business, or governmental or other activity, including banking corporations or trust companies. A health care corporation shall not guarantee or become surety upon a bond or other undertaking securing the deposit of public money.

(p) Purchase, receive, take by grant, gift, devise, bequest or otherwise, lease, or otherwise acquire, own, hold, improve, employ, use and otherwise deal in and with, real or personal property, or an interest therein, wherever situated.

(q) Sell, convey, lease, exchange, transfer or otherwise dispose of, or mortgage or pledge, or create a security interest in, any of its property, or an interest therein, wherever situated.

(r) Borrow money and issue its promissory note or bond for the repayment of the borrowed money with interest.

(s) Make donations for the public welfare, including hospital, charitable, or educational contributions which do not significantly affect rates charged to subscribers.

(t) Participate with others in any joint venture with respect to any transaction which the health care corporation would have the power to conduct by itself.

(u) Cease its activities and dissolve, subject to the commissioner's authority under section 606(2).

(v) Make contracts, transact business, carry on its operations,

have offices, and exercise the powers granted by this act in any jurisdiction, to the extent necessary to carry out its purposes under this act.

(w) Have and exercise all powers necessary or convenient to effect any purpose for which the corporation was formed.

(2) In order to ascertain the interests of senior citizens regarding the provision of medicare supplemental coverage, as described in section 202(1)(d)(v), and to ascertain the interests of senior citizens regarding the administration of the federal medicare program when acting as fiscal intermediary in this state, as described in section 202(1)(d)(vi), a health care corporation shall consult with the office of services to the aging and with senior citizens' organizations in this state.

(3) An act of a health care corporation, otherwise lawful, is not invalid because the corporation was without capacity or power to do the act. However, the lack of capacity or power may be asserted:

(a) In an action by a director or a member of the corporate body against the corporation to enjoin the doing of an act.

(b) In an action by or in the right of the corporation to procure a judgment in its favor against an incumbent or former officer or director of the corporation for loss or damage due to an unauthorized act of that officer or director.

(c) In an action or special proceeding by the attorney general to enjoin the corporation from the transacting of unauthorized business, to set aside an unauthorized transaction, or to obtain other equitable relief.

Sec. 208. (1) An action may be brought in the right of a health care corporation to procure a judgment in its favor, by a member of the corporate body.

(2) In such an action, the complaint shall allege:

(a) That the plaintiff is a member of the corporate body at the time of bringing the action, and that he or she was a member of the corporate body at the time of the transaction of which he or she complains.

(b) With particularity, the effort of the plaintiff to secure the initiation of the action by the board or the reasons for not making the effort.

Sec. 209. An action authorized by section 208 shall not be discontinued, compromised, or settled without approval by the court having jurisdiction of the action. If the court determines that the interest of the members of the corporate body or of any component thereof will be substantially affected by the discontinuance, compromise, or settlement, the court may direct that notice, by publication or otherwise, be given to the members of the corporate body or any component thereof, whose interests it determines will be so affected. If notice is so directed to be given, the court may determine which 1 or more of the parties to the action shall bear the expense of giving the notice, in an amount which the court determines and finds reasonable under the circumstances. The amount of this expense shall be awarded as special costs of the action and shall be recoverable in the same manner as statutory taxable costs.

Sec. 210. (1) If an action brought in the right of the corporation is successful, in whole or in part, or if anything is received by the plaintiff or a claimant as a result of a judgment, compromise, or settlement of an action or claim, the court may award the plaintiff or claimant reasonable expenses, including reasonable attorney's fees, and shall direct him or her to account to the corporation for the remainder of the proceeds so received by him or her. This section does not apply to a judgment

rendered for the benefit of an injured corporate body member only and limited to a recovery of the loss or damage sustained by him or her.

(2) In an action brought in the right of the corporation by a member of the corporate body, the court having jurisdiction, upon final judgment and finding that the action was brought without reasonable cause, may require the plaintiff to pay to the parties named as defendants the reasonable expenses, including fees of attorneys, incurred by them in the defense of the action.

Sec. 211. (1) Pursuant to section 207(1)(g), a health care corporation may enter into contracts containing an administrative services only or cost-plus arrangement, if the arrangement is for a group containing not less than 500 subscribers, except that a health care corporation may continue an administrative services only or cost-plus arrangement with a subscriber group of less than 500, which arrangement is in existence in September of 1980. An administrative services only or cost-plus arrangement for a group containing less than 2,000 subscribers shall include provisions which provide that if the group's claims for a given month exceed 150% of the projected average monthly claims for the group, the group shall have at least 3 months to pay the excess over 150% prior to termination of the arrangement. Arrangements subject to this section shall include provisions which establish the liability of the health care corporation for all claims incurred up to the date of termination of the arrangement. For purposes of this subsection, the number of subscribers in a group shall be computed without regard to the residence of the subscriber.

(2) Relative to actual administrative costs, fees for administrative services only and cost-plus arrangements shall be set in a manner which precludes cost transfers between subscribers subject to either of these

arrangements and other subscribers of the health care corporation. Administrative costs for these arrangements shall be determined in accordance with the administrative costs allocation methodology and definitions filed and approved under part 6, and shall be expressed clearly and accurately in the contracts establishing the arrangements, as a percentage of costs rather than charges. This subsection shall not be construed to prohibit the inclusion, in fees charged, of contributions to the contingency reserve of the corporation, consistent with section 205.

(3) Before a health care corporation may enter into contracts containing administrative services only or cost-plus arrangements pursuant to section 207(1)(g), the board of directors of the corporation shall approve a marketing policy with respect to such arrangements which is consistent with the provisions of this section. The marketing policy may contain other provisions as the board considers necessary. The marketing policy shall be carried out by the corporation consistent with this act.

(4) A health care corporation shall comply with all provisions of state law pertaining to administrative services only and cost-plus arrangements, and with any rules promulgated relative to those provisions. To the extent that those provisions are different from the applicable provisions of this act, those other provisions shall supersede this act and rules promulgated under this act.

Sec. 212. When, under this act or the articles of incorporation or bylaws of a health care corporation or by the terms of an agreement or instrument, a health care corporation or the board of directors of the health care corporation or any committee of the board may take action after notice to any person or after lapse of a prescribed period of time, the action may be taken without notice and without lapse of the period

of time, if at any time before or after the action is completed the person entitled to notice or to participate in the action to be taken or, in case of a subscriber, by his or her attorney-in-fact, submits a signed waiver of those requirements. The attorney-in-fact may not be employed by, or receive substantial income from, the health care corporation.

Sec. 213. (1) A health care corporation may indemnify any person who was or is a party to, or is threatened to be made a party to, any threatened, pending, or completed action, suit, or proceeding, whether civil, criminal, administrative, or investigative, other than an action by or in the right of the health care corporation, by reason of the fact that he or she is or was a director, member of the corporate body, officer, employee, or agent of the health care corporation, or is or was serving at the request of the health care corporation as a director, officer, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise. This indemnification shall be against expenses, including attorneys' fees, judgments, fines, and amounts paid in settlement, actually and reasonably incurred by him or her in connection with the action, suit, or proceeding, if he or she acted in good faith and in a manner which he or she reasonably believed to be in, or not opposed to, the best interests of the health care corporation, or its subscribers as a whole, and, with respect to any criminal action or proceeding, had no reasonable cause to believe his or her conduct was unlawful. The termination of any action, suit, or proceeding by judgment, order, settlement, conviction, or upon a plea of nolo contendere or its equivalent, shall not, of itself, create a presumption that the person did not act in good faith and in a manner which he or she reasonably believed to be in or not opposed to the best interests of the health care corporation, or its

subscribers as a whole, and, with respect to any criminal action or proceeding, had reasonable cause to believe that his or her conduct was unlawful.

(2) A health care corporation may indemnify any person who was or is a party to, or is threatened to be made a party to, any threatened, pending, or completed action or suit by or in the right of the health care corporation to procure a judgment in its favor, by reason of the fact that he or she is or was a director, member of the corporate body, officer, employee, or agent of the health care corporation, or is or was serving at the request of the health care corporation as a director, officer, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise. This indemnification shall be against expenses, including attorneys' fees, actually and reasonably incurred by him or her in connection with the defense or settlement of the action or suit, if he or she acted in good faith and in a manner he or she reasonably believed to be in or not opposed to the best interests of the health care corporation, or its subscribers as a whole. However, indemnification shall not be made with respect to any claim, issue, or matter as to which the person has been adjudged to be liable for negligence or misconduct in the performance of his or her duty to the health care corporation unless, and only to the extent that, the court in which the action or suit was brought determines upon application that, despite the adjudication of liability, but in view of all circumstances of the case, the person is fairly and reasonably entitled to indemnity for those expenses which the court considers proper.

(3) To the extent that a director, member of the corporate body, officer, employee, or agent of a health care corporation has been successful on the merits or otherwise in defense of any action, suit, or proceeding

referred to in subsection (1) or (2), or in defense of any claim, issue, or matter therein, he or she shall be indemnified against expenses, including attorneys' fees, actually and reasonably incurred by him or her in connection therewith.

(4) Any indemnification under subsection (1) or (2), unless ordered by a court, shall be made by the health care corporation only as authorized in the specific case, upon a determination that indemnification of the director, member of the corporate body, officer, employee, or agent is proper in the circumstances because he or she has met the applicable standard of conduct set forth in subsections (1) and (2). The determination shall be made in any of the following ways:

(a) By the board by a majority vote of a quorum consisting of directors who were not parties to the action, suit, or proceeding.

(b) If such a quorum is not obtainable, by independent legal counsel in a written opinion.

(5) Expenses incurred in defending a civil or criminal action, suit, or proceeding described in subsection (1) or (2) may be paid by the health care corporation in advance of the final disposition of the action, suit, or proceeding, as authorized in the manner provided in subsection (4), upon receipt of an undertaking by or on behalf of the director, member of the corporate body, officer, employee, or agent to repay that amount, unless it is ultimately determined that he or she is entitled to be indemnified by the corporation.

(6) A provision made to indemnify directors, members of the corporate body, or officers in any action, suit, or proceeding referred to in subsection (1) or (2), whether contained in the articles of incorporation, the bylaws, a resolution of the directors, an agreement, or otherwise, shall

be invalid only insofar as it is in conflict with subsections (1) to (5) and this subsection. Nothing contained in subsections (1) to (5) and this subsection shall affect any rights to indemnification to which persons other than directors and officers may be entitled by contract or otherwise by law. The indemnification provided in subsections (1) to (5) and this subsection continues as to a person who has ceased to be a director, member of the corporate body, officer, employee, or agent, and shall inure to the benefit of the heirs, executors, and administrators of that person.

(7) A health care corporation may purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, or agent of the corporation, or is or was serving at the request of the health care corporation as a director, officer, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise against any liability asserted against him or her and incurred by him or her in that capacity, or arising out of his or her status as described in this subsection, whether or not the health care corporation would have power to indemnify him or her against this liability under subsections (1) to (6).

(8) For the purposes of subsections (1) to (7), references to a health care corporation include all constituent corporations absorbed in a consolidation or merger and the resulting or surviving corporation, so that a person who is or was a director, officer, employee, or agent of a constituent corporation or is or was serving at the request of such a constituent corporation as a director, officer, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise shall stand in the same position under the provisions of this section with respect to the resulting or surviving corporation as he or she would

if he or she had served the resulting or surviving corporation in the same capacity.

Sec. 214. A health care corporation may by agreement in writing, and not otherwise, agree to pay a rate of interest in excess of the legal rate, and in that case, the defense of usury is prohibited.

Sec. 215. When a health care corporation, consistent with the purposes of the corporation prescribed in this act, is a shareholder in any other nonprofit corporation, its president and other officers or any of its directors may hold the office of director of the other nonprofit corporation the same as if they were individual shareholders in the other nonprofit corporation. The health care corporation, being a shareholder in the other nonprofit corporation, shall possess and exercise all the rights, powers, privileges, and liabilities of individual shareholders.

Sec. 216. (1) A health care corporation existing and authorized to do business under this act may merge into or consolidate with a corporation existing and authorized to do business under this act; Act No. 125 of the Public Acts of 1963, being sections 550.351 to 550.373 of the Michigan Compiled Laws; or part 210 of Act No. 368 of the Public Acts of 1978, as amended, being sections 333.21001 to 333.21099 of the Michigan Compiled Laws, by filing with the commissioner a plan of merger or consolidation adopted by a majority of the board members then in office in each constituent corporation.

(2) The plan of merger or consolidation shall set forth all of the following:

(a) The name and principal place of business of each constituent corporation and the name and principal place of business of the surviving or consolidated corporation, which shall conform to the requirements set

forth in section 202(1)(c).

(b) The number, qualifications, and identity or method of selection of the first board of directors or trustees of the surviving or consolidated corporation, and the term of existence of the surviving or consolidated corporation, which may be in perpetuity.

(3) The purpose of the surviving or consolidated corporation shall incorporate the purposes of each of the constituent corporations as set forth in their respective articles of incorporation in effect at the time of their respective adoptions of the plan of merger or consolidation.

(4) The filing of the plan of merger or consolidation shall be accompanied by a certificate of consolidation or a certificate of merger signed by the president or a vice-president and the secretary or an assistant secretary of each of the constituent corporations certifying that the plan of merger or consolidation was duly adopted by a majority of the board members of each of the constituent corporations in compliance with this section. The plan of merger or consolidation and the certificate shall be filed with the commissioner. The filing shall be accompanied by a filing fee of $10.00 to be deposited in the state treasury to the credit of the general fund. A copy of the certificate shall also be filed with the chief officer of the department of commerce or of any other agency or department authorized by law to administer Act No. 284 of the Public Acts of 1972, as amended, being sections 450.1101 to 450.2099 of the Michigan Compiled Laws, or his or her designated representative.

(5) The surviving or consolidated corporation shall have all the rights, powers, privileges, immunities, and franchises, public or private, of each of the merging or consolidating corporations, including the rights, powers, privileges, immunities, and franchises of each of the merging

or consolidating corporations under this act, and all property, real, personal and mixed, and all debts due on whatever account, and all other choses in action. All interests of or belonging to or due to each of the corporations merged or consolidated shall be considered transferred to and vested in the surviving or consolidated corporation without further act or deed. The title to real estate, or any interest in real estate, vested in the corporation shall not revert or be in any way impaired because of the merger or consolidation. The surviving or consolidated corporation shall be responsible and liable for all liabilities and obligations of each of the corporations merged or consolidated.

(6) A claim existing or an action or proceeding pending by or against the health care corporation may be prosecuted as if the merger or consolidation had not taken place, or the surviving or consolidated corporation may be substituted in its place. The rights of creditors or a lien upon the property of the health care corporation shall not be impaired by the merger or consolidation.

(7) The plan of merger or consolidation shall become effective 30 days after filing with the commissioner for review and approval, unless the commissioner within that time serves written notice on the constituent corporations designating those provisions of the proposed plan of merger or consolidation which do not satisfy the requirements of this act. In this case, the constituent corporations may institute an action in the circuit court for Ingham county for an adjudication by that court as to whether the proposed plan of merger or consolidation filed with the commissioner of insurance satisfies the requirements of this act, and the court may make any order or grant any relief as it considers appropriate.

(8) The surviving or consolidated corporation shall continue to

be subject to regulation by the commissioner to the same extent that is provided by this act.

Sec. 217. Upon dissolution of a health care corporation, the assets remaining after the payment of all debts of the corporation shall escheat to the state. Merger or consolidation under section 216 does not constitute dissolution within the meaning of this section.

PART 3

Sec. 301. (1) The property and lawful business of a health care corporation existing and authorized to do business under this act shall be held and managed by a board of directors to consist of not more than 35 members. The board shall exercise the powers and authority necessary to carry out the lawful purposes of the corporation, as limited by this act and the articles of incorporation and the bylaws of the corporation.

(2) Four voting members of the board shall be representatives of the public appointed by the governor by and with the advice and consent of the senate. Two of those members shall be retired individuals 62 years of age or older. The term of office of each representative of the public shall be 2 years, and until a successor is appointed and qualified. If a va. ıcy occurs before the conclusion of a 2-year term, the appointment of a representative to complete the term shall be made in the same manner as the original appointment.

(3) The board of directors shall consist of not more than 25% provider directors. In addition to physician and hospital provider directors, not less than 1 provider director shall be a registered professional nurse who shall be representative of licensees under part 172 of Act No. 368 of the Public Acts of 1978, as amended, being sections 333.17201 to 333.17242 of the Michigan Compiled Laws, and not less than 1 provider director shall be representative of the provider whose services, in the calendar year immediately preceding the effective date of this act in the case of an existing health care corporation, or, in the calendar year immediately following incorporation in the case of a newly-formed health care corporation, generated the largest number of benefit claims received by the corporation from its subscribers. Other provider directors shall be as broadly represen-

tative of provider classes as possible.

(4) The bylaws of a health care corporation may authorize not more than 1 officer or employee of the corporation to serve as a voting or nonvoting director.

(5) The remaining members of the board of directors shall include representatives of large subscriber groups, medium subscriber groups, small subscriber groups, and nongroup subscribers, in proportions which fairly represent the total subscriber population of the health care corporation. However, at least 3 directors shall represent nongroup subscribers, at least 1 of whom shall be a retired individual 62 years of age or older, and at least 3 directors shall represent small subscriber groups. Large and medium subscriber groups shall be represented, to the greatest extent possible, by an equal number of labor and management representativ and shall be categorized as labor subscriber representatives or management subscriber representatives.

(6) The method of selection of the directors, other than the directors who are representatives of the public, and additional provisions and requirements for further refinement or specification regarding the number of directors comprising each component shall be specified in the bylaws. The terms of office of directors, other than the directors who are representatives of the public, and the method for filling vacancies in those offices shall be provided in the bylaws. However, if a term of office of more than 1 year is prescribed by the bylaws, at least 1/3 of the members of the board shall be selected each year.

(7) The method of selection of each category of subscribers entitled to representation on the board under subsection (5) shall maximize subscriber participation to the extent reasonably practicable. This subsection shall

permit, but not require, the statewide election of a director or member of the corporate body. The method of selection shall neither permit nor require nomination, endorsement, approval, or confirmation of a candidate or director by the corporate body, the board of directors, or the management of the health care corporation, or any member or members of any of these. This subsection shall not apply to the selection of an officer or employee as a director pursuant to subsection (4). This subsection shall not limit the rights of any director, member of the corporate body, or employee or officer of the health care corporation to participate in the selection process in his or her capacity as a subscriber, to the same extent as any other subscriber may participate.

(8) For the purposes of this section:

(a) "Health care provider" or "provider" includes:

(i) A person defined as a health care provider or provider in section 105(4); a person employed by a health care facility, as defined in section 105(3); or a director, officer, or trustee of a health care provider, as defined in section 105(4), unless the person serves in that capacity as a representative selected by the same subscriber group or collective bargaining representative which the person represents on the board of a health care corporation.

(ii) A spouse, child, or parent of a health care provider who resides in the same household.

(iii) A person who receives more than 25% of his or her annual income through the provision of goods or services to health care providers, or who is an employee, officer, trustee, or director of a firm or organization which receives more than 25% of its annual income through the provision of goods or services to health care providers.

(9) A director shall not be an employee, agent, officer, or director of an insurance company writing disability insurance inside or outside this state.

Sec. 302. (1) The board of directors shall adopt initial bylaws and may amend or repeal those bylaws or adopt new bylaws, subject to the prior approval or certification by the attorney general. The bylaws may contain any provision for the regulation and management of the affairs of the health care corporation not inconsistent with the articles of incorporation, this act, or any other applicable provision of law.

(2) The initial bylaws, and any new bylaws, amendments, or repealers shall be submitted to the attorney general for review and approval. The attorney general shall approve the initial bylaws, new bylaws, amendments, or repealers if the attorney general determines that they comply with this act.

(3) If the attorney general disapproves all or any part of the initial bylaws, new bylaws, amendments, or repealers, he or she shall return them to the board with a written statement setting forth the reasons for the disapproval and any recommendations for change which he or she may wish to suggest, not later than 30 days following their receipt. Bylaws, amendments, and repealers not returned to the health care corporation within this 30-day period shall be considered to comply with this act and shall be considered approved.

Sec. 303. (1) Regular or special meetings of the board or a committee of the board shall be held within this state. With respect to regular or special meetings of the board or a committee of the board, the bylaws shall include provisions regarding all of the following:

(a) The minimum number of regular meetings to be held each year.

(b) The publication and advance distribution of an agenda, including provisions respecting the time and place of the meeting and the business to be conducted.

(c) Voting procedures. The use of proxies and round robins shall not be allowed.

(2) Notice of a regular meeting shall be given at least 15 days before the meeting and notice of a special meeting shall be given at least 24 hours before the meeting. Attendance of a director at a meeting constitutes a waiver of notice of the meeting, except in cases in which a director attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened.

(3) Unless otherwise restricted by the articles of incorporation or bylaws, a member of the board or of a committee designated by the board may participate in a meeting by means of conference telephone or similar communications equipment by means of which all individuals participating in the meeting can hear each other. Participation in a meeting pursuant to this subsection constitutes presence in person at the meeting.

(4) A majority of the members of the board then in office, or of the members of a committee thereof, constitutes a quorum for the transaction of business, unless the articles or bylaws provide for a larger number. The vote of the majority of members present at a meeting at which a quorum is present constitutes the action of the board or of the committee, unless the vote of a larger number is required by this act, the articles, or the bylaws. The following actions shall require the vote of not less than a majority of the members of the board then in office:

(a) Adoption of bylaws, amendments to bylaws, or repealers of bylaws.

(b) Adoption of articles of incorporation, amendments to articles,

or repealers of articles.

(c) The proposal or establishment of rates or rating systems; the adoption of provider class plans or provider contracts; or the adoption of compensation for officers of the corporation.

(5) The bylaws shall provide that a record roll call vote shall be taken at the request of any 5 board members. The vote of each member shall be recorded in the minutes.

Sec. 304. (1) A health care corporation shall keep accurate books and records of account and minutes of the proceedings of the board of directors of the health care corporation, committees of the board, and the corporate body. The books, records, and minutes may be in written form or in any other form capable of being converted into written form within a reasonable time. One copy of the minutes or draft minutes from each meeting of the board of directors shall be transmitted to the commissioner within 15 days after the meeting was held. Upon the request of a member of the board of directors, consistent with the board member's fiduciary duty under section 310, a subscriber shall receive, within 15 days after receipt of the request, a copy of the minutes or draft minutes of 1 or more meetings of the board, its committee, or the corporate body, and may be charged not more than the reasonable cost of copying and postage.

(2) Minutes shall be kept and need not be disclosed, except to the commissioner as provided in section 603, for those portions of meetings which are held for the following purposes:

(a) To consider the hiring, promotion, dismissal, suspension, or discipline of an employee.

(b) To consider the purchase, lease, or sale of real property.

(c) For strategy and negotiation sessions connected with the negotia-

tions of a collective bargaining agreement when either party requests a closed meeting.

(d) For trial or settlement strategy sessions in connection with specific contemplated or pending litigation. If these sessions are with respect to litigation to which the commissioner or the attorney general is a party, minutes regarding these sessions shall not be subject to examination and free access under section 603.

(e) To consider medical records of an individual.

(f) To consider the acquisition or disposal of certificates of stock, bonds, certificates of indebtedness, and other intangibles in which the corporation may invest funds under section 206, if the information regarding proposed acquisition or disposal may affect the price paid or received.

(g) To consider provider appeal, when the provider has requested a closed hearing.

(h) To discuss marketing strategy with regard to a particular customer or limited group of customers, or to discuss a new or changed benefit, the premature disclosure of which would have an adverse impact on the health care corporation.

(i) To consider the removal of a director from the board when the director requests a closed hearing.

(3) The date and time of preparation and existence of the minutes described in subsection (2), the contents of which shall not be disclosable except to the commissioner as provided in section 603, shall be noted in the minutes required to be kept under subsection (1). Once action is taken by the board to implement a consideration or discussion described in subsection (2)(b), (f), (g), or (h), once a collective bargaining agreement is reached as described in subsection (2)(c), once litigation is

no longer pending as described in subsection (2)(d), or once a closed hearing is concluded as described in subsection (2)(i), and upon the request of the director to whom the hearing pertained, the minutes relating to the consideration, discussion, or strategy session shall be published and disseminated with the next succeeding set of minutes published and disseminated under subsection (1), and may be disclosed by the commissioner to other persons under section 603(3).

(4) The circuit court, upon proof of a proper purpose, may compel the production of books and records for examination by a subscriber or the attorney general.

Sec. 305. (1) A health care corporation may establish a corporate body. The corporate body shall consist of individuals selected in the same manner as individuals are selected to serve as nonpublic members on the board of directors. The size of the corporate body shall be such that, for each nonpublic voting director on the board of directors of the corporation, there are 2 members of the corporate body. The 4 public members selected pursuant to section 301(2) shall be considered to be members of the corporate body as well as members of the board of directors. An additional 4 public members shall be appointed to the corporate body by the governor by and with the advice and consent of the senate, 2 of whom shall be retired individuals 62 years of age or older.

(2) Members of the corporate body may serve on committees of the board of directors. A member of the corporate body may be selected for membership on the board of directors, provided that the selection is made in accordance with the provisions of this part governing the selection of voting directors of the board.

Sec. 306. (1) A contract or other transaction between a health

care corporation and 1 or more of its directors or officers, or between a health care corporation and any other corporation, firm, or association of any type or kind in which 1 or more of its directors or officers are directors or officers, or are otherwise interested, is not void or voidable solely because of such common directorship, officership, or interest, or solely because the directors are present at the meeting of the board or committee thereof which authorizes or approves the contract or transaction, if all of the following conditions are satisfied:

(a) The contract or other transaction is fair and reasonable to the corporation when it is authorized, approved, or ratified.

(b) The material facts as to the officer's or director's relationship or interest and as to the contract or transaction are disclosed or known to the board or committee, and the board or committee authorizes, approves, or ratifies the contract or transaction by a vote sufficient for the purpose. The conditions of this subdivision shall be considered satisfied only if the officer or director has announced the potential conflict prior to the vote, the minutes of the meeting reflect that announcement, and the officer or director abstained from the vote.

(2) When the validity of a contract described in subsection (1) is questioned, the burden of establishing its validity on the grounds prescribed is upon the director, officer, corporation, firm, or association asserting its validity.

(3) Common or interested directors shall not be counted in determining the presence of a quorum at a board or committee meeting at the time a contract or transaction described in subsection (1) is authorized, approved, or ratified.

(4) The board, by affirmative vote of a majority of directors in

office and irrespective of any personal interest of any of them, may establish reasonable compensation of directors for services to the health care corporation as directors or officers of the health care corporation.

(5) The bylaws of a health care corporation may include provisions regarding conflict of interest which are more stringent than this section.

Sec. 307. The board of directors may establish those advisory councils and, unless otherwise provided in the articles of incorporation or bylaws, those committees it considers necessary to perform its duties. Members of the corporate body may serve on committees of the board of directors. With respect to committees of the board, the bylaws shall include provisions regarding all of the following:

(a) Provisions which assure that the membership of each committee provides for representation of all of the components of directors, as defined in the bylaws, to the greatest extent practicable.

(b) Provisions regarding emergency meetings of the executive committee of the health care corporation, and action by that committee on behalf of the board in cases of emergency, as defined by the bylaws.

Sec. 308. (1) To the extent provided by resolution of the board or in the bylaws or articles, a committee established pursuant to section 307 may exercise the powers and authority of the board in management of the business and affairs of the health care corporation. The board shall review and may modify subject to the rights of third parties any action or decision of a committee. A committee shall not do any of the following:

(a) Amend the articles of incorporation.

(b) Adopt an agreement of merger or consolidation.

(c) Authorize the sale, lease, or exchange of all or substantially

all of the corporation's property and assets.

(d) Approve, adopt, or amend provider contracts, provider class plans, rates charged to subscribers, or a certificate.

(e) Amend the bylaws of the corporation.

(f) Fill vacancies on the board.

(g) Fix compensation of the directors or officers.

(h) Perform other similar acts of a final or binding nature with respect to the business of the corporation.

(2) This section shall not prohibit emergency actions by the executive committee on behalf of the board, as authorized in the bylaws of the health care corporation.

Sec. 309. (1) The board of directors shall select the officers of the health care corporation and a chairperson, vice-chairperson, and other board officers and assistants as the board considers necessary. However, an officer shall not execute, acknowledge, or verify an instrument in more than 1 capacity. Officers shall have only the authority, and assistants shall perform only those duties, in the management of the property and affairs of the corporation, as is provided in the bylaws or delegated to the officers and assistants by the board of directors, consistent with the bylaws. An officer or assistant may be removed by the board of directors with or without cause, subject to the contract rights, if any, of the officer or assistant. The selection of an officer or assistant does not of itself create contract rights. The board of directors may secure the fidelity of any or all of the officers by bond or otherwise. Unless otherwise provided in the articles or bylaws, the board of directors may fill vacancies in an office described in this subsection which occur for any reason.

(2) A health care corporation shall not pay a salary, compensation, or emolument to a director or officer unless the payment is first authorized by the board of directors of the corporation. A director, officer, assistant, or employee shall not be compensated unreasonably.

(3) A health care corporation shall not grant a pension to an officer or director, or to a member of the family of an officer or director after the death of the officer or director. However, the corporation, pursuant to the terms of a retirement plan adopted by the board of directors of the corporation and approved by the commissioner, may provide for any person who is or has been a salaried employee or officer of the corporation, a pension payable upon retirement, as provided in the approved retirement plan, and life insurance benefits payable at death.

Sec. 310. (1) With respect to management of the affairs and property of the health care corporation, and in the selection, supervision, and control of committees of the board, employees of the health care corporation, and officers, each director and officer, and the composite board, shall exercise the duties of a fiduciary toward the health care corporation and the subscribers of the health care corporation as a whole, and shall discharge his or her duties with the degree of diligence, care, and skill which an ordinarily prudent person would exercise under the same or similar circumstances in a like position. In discharging his or her duties, a director or officer, when acting in good faith, may rely upon the opinion of counsel for the corporation, upon the report of an independent appraiser selected with reasonable care by the board, or upon financial statements of the corporation represented to the director or officer to be correct by the president or the officer of the corporation having charge of its books of account, or stated in a written report by an independent public

or certified public accountant or firm of such accountants fairly to reflect the financial condition of the corporation.

(2) After notice and a hearing before the board, a director may be removed from the board by a vote of 2/3 of the directors selected and serving on the board for a breach of fiduciary duty.

Sec. 311. Each director or officer of a health care corporation shall be individually liable for the misapplication or misuse of corporate money or property caused through the neglect or failure of that director or officer to discharge his or her duties in compliance with the standards prescribed in section 310, or through wilful violation of this act or other laws governing the health care corporation.

Sec. 312. An action against a director or officer for failure to perform the duties imposed by this act shall be commenced within 3 years after the cause of action has accrued, or within 2 years after the time when the cause of action is discovered, or should reasonably have been discovered, by a person complaining of the failure to perform, whichever occurs sooner.

Sec. 313. (1) Except with respect to statements which are subject to prosecution for perjury, as defined in section 423 of Act No. 328 of the Public Acts of 1931, being section 750.423 of the Michigan Compiled Laws, a person, or an agent, director, or officer of a health care corporation, who knowingly makes any false oral or written statement as to a material fact, in or with respect to a report required by this act, or in the course of a hearing or examination held pursuant to this act, is guilty of a misdemeanor. In addition, the person, agent, director, or officer knowingly making the false statement and each person, agent, director, or officer knowingly authorizing, signing, or making the false

report shall be jointly and severally personally liable to any person who has become a creditor of the health care corporation upon the faith of the false statement or the false report.

(2) An action for the civil liability imposed by this section shall be commenced within 2 years after discovery of the false statement or within 6 years after the report has been made by the person, agent, director, or officer of the health care corporation, whichever is sooner.

PART 4

Sec. 401. (1) A health care corporation established, maintained, or operating in this state shall offer health care benefits to all residents of this state, and may offer other health care benefits as the corporation specifies with the approval of the commissioner.

(2) A health care corporation may limit the health care benefits that it will furnish, except as provided in this act, and may divide the health care benefits which it elects to furnish into classes or kinds.

(3) A health care corporation shall not do any of the following:

(a) Refuse to issue or continue a certificate to 1 or more residents of this state, except while the individual, based on a transaction or occurrence involving a health care corporation, is serving a sentence arising out of a charge of fraud, is satisfying a civil judgment, or is making restitution pursuant to a voluntary payment agreement between the corporation and the individual.

(b) Refuse to continue in effect a certificate with 1 or more residents of this state, other than for failure to pay amounts due for a certificate, except as allowed for refusal to issue a certificate under subdivision (a).

(c) Limit the coverage available under a certificate, without the prior approval of the commissioner, unless the limitation is as a result of: an agreement with the person paying for the coverage; an agreement with the individual designated by the persons paying for or contracting for the coverage; or a collective bargaining agreement.

(4) Nothing in subsection (3) shall prevent a health care corporation from denying to a resident of this state coverage under a certificate for any of the following grounds:

(a) That the individual was not a member of a group which had contracted for coverage under this certificate.

(b) That the individual is not a member of a group with a size greater than a minimum size established for a certificate pursuant to sound underwriting requirements.

(c) That the individual does not meet requirements for coverage contained in a certificate.

(4) A certificate may provide for the coordination of benefits, subrogation, and the nonduplication of benefits. Savings realized by the coordination of benefits, subrogation, and nonduplication of benefits shall be reflected in the rates for those certificates.

(5) A health care corporation shall have the right to status as a party in interest, whether by intervention or otherwise, in any judicial, quasi-judicial, or administrative agency proceeding in this state for the purpose of enforcing any rights it may have for reimbursement of payments made or advanced for health care services on behalf of 1 or more of its subscribers or members.

(6) A health care corporation shall not directly reimburse a provider in this state who has not entered into a participating contract with the corporation.

(7) A health care corporation shall not limit or deny coverage to a subscriber or limit or deny reimbursement to a provider on the ground that services were rendered while the subscriber was in a health care facility operated by this state or a political subdivision of this state. A health care corporation shall not limit or deny participation status to a health care facility on the ground that the health care facility is operated by this state or a political subdivision of this state, if

the facility meets the standards set by the corporation for all other facilities of that type, government-operated or otherwise. To qualify for participation and reimbursement, a facility shall, at a minimum, meet all of the following requirements, which shall apply to all similar facilities:

(a) Be accredited by the joint commission on accreditation of hospitals.

(b) Meet the certification standards of the medicare program and the medicaid program.

(c) Meet all statutory requirements for certificate of need.

(d) Follow generally accepted accounting principles and practices.

(e) Have a community advisory board.

(f) Have a program of utilization and peer review to assure that patient care is appropriate and at an acute level.

(g) Designate that portion of the facility which is to be used for acute care.

Sec. 402. (1) A health care corporation shall not do any of the following:

(a) Misrepresent pertinent facts or certificate provisions relating to coverage.

(b) Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim arising under a certificate.

(c) Fail to adopt and implement reasonable standards for the prompt investigation of a claim arising under a certificate.

(d) Refuse to pay claims without conducting a reasonable investigation based upon the available information.

(e) Fail to affirm or deny coverage of a claim within a reasonable time after a claim has been received.

(f) Fail to attempt in good faith to make a prompt, fair, and equitable settlement of a claim for which liability has become reasonably clear.

(g) Compel members to institute litigation to recover amounts due under a certificate by offering substantially less than the amounts due.

(h) By making reference to written or printed advertising material accompanying or made part of an application for coverage, attempt to settle a claim for less than the amount which a reasonable person would believe was due under the certificate.

(i) For the purpose of compelling a member to accept a settlement or compromise in a claim, make known to the member a policy of appealing from administrative hearing decisions in favor of members.

(j) Attempt to settle a claim on the basis of an application which was altered without notice to, or knowledge or consent of, the subscriber under whose certificate the claim is being made.

(k) Delay the investigation or payment of a claim by requiring a member, or the provider of health care services to the member, to submit a preliminary claim and then requiring subsequent submission of a formal claim, seeking solely the duplication of a verification.

(l) Fail to promptly provide a reasonable explanation of the basis for denial of a claim or for the offer of a compromise settlement.

(m) Fail to promptly settle a claim where liability has become reasonably clear under 1 portion of a certificate in order to influence a settlement under another portion of the certificate.

(2) In order to induce a person to contract or to continue to contract with the health care corporation for the provision of health care benefits or administrative or other services offered by the corporation; to induce a person to lapse, forfeit, or surrender a certificate issued by the health

care corporation; or to induce a person to secure or terminate coverage with another health care corporation, insurer, health maintenance organization, or other person, a health care corporation shall not, directly or indirectly:

(a) Issue or deliver to the person money or any other valuable consideration.

(b) Offer to make or make an agreement relating to a certificate other than as plainly expressed in the certificate.

(c) Offer to give or pay, or give or pay, directly or indirectly, a rebate or part of the premium, or an advantage with respect to the furnishing of health care benefits or administrative or other services offered by the corporation except as reflected in the rate and expressly provided in the certificate.

(d) Make, issue, or circulate, or cause to be made, issued, or circulated, any estimate, illustration, circular, or statement misrepresenting the terms of a certificate or contract for administrative or other services, the benefits thereunder, or the true nature thereof.

(e) Make a misrepresentation or incomplete comparison, whether oral or written, between certificates of the corporation or between certificates or contracts of the corporation and another health care corporation, health maintenance organization, or other person.

(3) Nothing in subsection (2) shall prevent a health care corporation from readjusting the rates charged to a subscriber group which is experience-rated based on the previous claims of the group.

(4) The commissioner shall allow a health care corporation to participate in any trade practice conference for disability insurers convened under section 2047 of Act No. 218 of the Public Acts of 1956, being section

500.2047 of the Michigan Compiled Laws, and may bind a health care corporation to any rules promulgated as provided in that section.

(5) Nothing in this section shall alter or supersede any provider class plan established pursuant to part 5.

(6) When the commissioner has probable cause to believe that a health care corporation is violating, or has violated subsection (1), indicating a persistent tendency to engage in conduct prohibited by that subsection, or has probable cause to believe that a health care corporation is violating, or has violated subsection (2), he or she shall give written notice to the corporation, pursuant to the administrative procedures act, setting forth the general nature of the complaint against the corporation and the proceedings contemplated under this section. Before the issuance of a notice of hearing, the staff of the bureau of insurance responsible for the matters which would be at issue in the hearing shall give the corporation an opportunity to confer and discuss the possible complaint and proceedings in person with the commissioner or a representative of the commissioner, and the matter may be disposed of summarily upon agreement of the parties. This subsection shall not be construed to diminish the right of a person to bring an action for damages under this section.

(7) A hearing held pursuant to subsection (6) shall be held in accordance with section 2030 of Act No. 218 of the Public Acts of 1956, as amended, being section 500.2030 of the Michigan Compiled Laws. The hearing shall be held pursuant to the administrative procedures act. If, after the hearing, the commissioner determines that the health care corporation is violating, or has violated subsection (1), indicating a persistent tendency to engage in conduct prohibited by that subsection, or has probable cause to believe that the corporation is violating, or has violated subsection

(2), the commissioner shall reduce his or her findings and decision to writing, and shall issue and cause to be served upon the corporation a copy of the findings and an order requiring the corporation to cease and desist from engaging in the prohibited activity. The commissioner may at any time, by order, and after notice and opportunity for a hearing, reopen and alter, modify, or set aside, in whole or in part, an order issued by him or her under this subsection, when in his or her opinion conditions of fact or law have so changed as to require that action, or if the public interest so requires.

(8) A health care corporation which violates a cease and desist order of the commissioner issued under subsection (7), after notice and an opportunity for a hearing, and upon order of the commissioner, may be subject to a civil fine of not more than $10,000.00 for each violation.

(9) In addition to other remedies provided by law, an aggrieved member may bring an action for actual monetary damages sustained as a result of a violation of this section. If successful on the merits, the member shall be awarded actual monetary damages or $200.00, whichever is greater, together with reasonable attorneys' fees. If the health care corporation shows by a preponderance of the evidence that a violation of this section resulted from a bona fide error notwithstanding the maintenance of procedures reasonably adapted to avoid the error, the amount of recovery shall be limited to actual monetary damages.

Sec. 403. (1) A health care corporation, on a timely basis, shall pay to a member or a participating provider benefits as are entitled and provided under the applicable certificate. When not paid on a timely basis, benefits payable to a member shall bear simple interest from a date 60 days after a satisfactory claim form was received by the health

care corporation, at a rate of 12% interest per annum. The interest shall be paid in addition to, and at the time of payment of, the claim.

(2) A health care corporation shall specify in writing the materials which constitute a satisfactory claim form not later than 30 days after receipt of a claim, unless the claim is settled within 30 days. If a claim form is not supplied as to the entire claim, the amount supported by the claim form shall be considered to be paid on a timely basis if paid within 60 days after receipt of the claim form by the corporation.

Sec. 404. (1) A person who has reason to believe that a health care corporation has violated section 402 or 403, if the violation was with respect to an action or inaction of the corporation with respect to that person, shall be entitled to a private informal managerial-level conference with the corporation, and to a review before the commissioner if the conference fails to resolve the dispute.

(2) A health care corporation shall establish reasonable internal procedures to provide a person with a private informal managerial-level conference as provided in subsection (1). These procedures shall include all of the following:

(a) A method of providing the person, upon request and payment of a reasonable copying charge, with information pertinent to the denial of a certificate or to the rate charged.

(b) A method for resolving the dispute promptly and informally, while protecting the interests of both the person and the corporation.

(3) If the health care corporation fails to provide a conference and proposed resolution within 30 days after a request by a person, or if the person disagrees with the proposed resolution of the corporation after completion of the conference, the person shall be entitled to a

determination of the matter by the commissioner.

(4) The commissioner shall by rule establish a procedure for determination under this section, which shall be reasonably calculated to resolve these matters informally and as rapidly as possible, while protecting the interests of both the person and the health care corporation.

(5) If either the health care corporation or the person disagrees with a determination of the commissioner under this section, the commissioner, if requested to do so by either party, shall proceed to hear the matter as a contested case under the administrative procedures act.

Sec. 405. (1) A health care corporation, in consultation with the department of social services, shall develop a single billing form to be used for the billing of each of the following: hospital services, physician services, and pharmaceutical services. If such forms are subsequently developed by the federal government, they may be used in the place of forms developed pursuant to this subsection.

(2) A health care corporation shall provide each member with a detailed and accurate explanation of his or her total bill for services rendered by a health care provider and provided under a certificate with a health care corporation, including charges for specific types of services rendered, the date of services rendered, the amounts reimbursed by the corporation, and the reasons for denial of any payments for expenses incurred.

Sec. 406. (1) A health care corporation shall, in order to ensure the confidentiality of records containing personal data that may be associated with identifiable members, use reasonable care to secure these records from unauthorized access and to collect only personal data that are necessary for the proper review and payment of claims. Except as is necessary to comply with section 503 or for the purpose of claims adjudication, claims

verification, or when required by law, a health care corporation shall not disclose records containing personal data that may be associated with an identifiable member, or personal information concerning a member, to a person other than the member, without the prior and specific informed consent of the member to whom the data or information pertains. The member's consent shall be in writing. Except when a disclosure is made to the commissioner or another governmental agency, a court, or any other governmental entity, a health care corporation shall make a disclosure for which prior and specific informed consent is not required upon the condition that the person to whom the disclosure is made protect and use the disclosed data or information only in the manner authorized by the corporation, pursuant to subsection (2). If a member has authorized the release of personal data to a specific person, a health care corporation shall make a disclosure to that person upon the condition that the person shall not release the data to a third person unless the member executes in writing another prior and specific informed consent authorizing the additional release. This subsection shall not preclude the release of information to a member, pertaining to that member, by telephone, if the identity of the member is verified. This subsection shall not preclude a representative of a subscriber group, upon request of a member of that subscriber group, or an elected official, upon request of a constituent, from assisting the individual in resolving a claim.

(2) The board of directors of a health care corporation shall establish and make public the policy of the corporation regarding the protection of the privacy of members and the confidentiality of personal data. The policy, at a minimum, shall do all of the following:

(a) Provide for the corporation's implementation of provisions in

this act and other applicable laws respecting collection, security, use, release of, and access to personal data.

(b) Identify the routine uses of personal data by the corporation; prescribe the means by which members will be notified regarding such uses; and provide for notification regarding the actual release of personal data and information that may be identified with, or that concern, a member, upon specific request by that member. As used in this subdivision, "routine use" means the ordinary use or release of personal data compatible with the purpose for which the data were collected.

(c) Assure that no person shall have access to personal data except on the basis of a need to know.

(d) Establish the contractual or other conditions under which the corporation will release personal data.

(e) Provide that enrollment applications and claim forms developed by the corporation shall contain a member's consent to the release of data and information that is limited to the data and information necessary for the proper review and payment of claims, and shall reasonably notify members of their rights pursuant to the board's policy and applicable law.

(f) Provide that applicants for new or renewed certificates shall be advised that the corporation does not require the use of the applicant's federal social security account number and that, when applicable, another authority does require use of the number.

(3) A health care corporation which violates this section is guilty of a misdemeanor, punishable by a fine of not more than $1,000.00 for each violation.

(4) A member may bring a civil action for damages against a health

care corporation for a violation of this section and may recover actual damages or $200.00, whichever is greater, together with reasonable attorneys' fees and costs.

(5) This section shall not be construed to limit access to records or to enlarge or diminish the investigative and examination powers of governmental agencies, as provided for by law.

Sec. 407. (1) A health care corporation shall establish and maintain a complaint system which affords adequate and reasonable procedures for the expeditious resolution of written complaints initiated by members concerning any matter relating to the provisions of a certificate. At a minimum, procedures shall be developed by a corporation for the resolution of claims for reimbursement; denial, cancellations, or nonrenewals of certificates; and complaints regarding the quality of the services delivered by health care providers and health care facilities which receive reimbursement from the corporation.

(2) A health care corporation, within 30 days after receipt of written complaint, shall give a reasonable written response to each written complaint which it receives. The commissioner shall have free access, as defined in section 603(2), to complaints and responses, which shall be made available to the commissioner for inspection. If the matter complained of is reasonably believed by the complainant to be a violation of section 402 or 403, the complainant shall be entitled to a private informal managerial-level conference with the health care corporation, as provided for in section 404.

(3) The health care corporation shall maintain a complete record of all of the written complaints of its members which the corporation has received since the date of the last examination. This record shall indicate the total number of complaints; and by line of business, the

nature of each complaint, the disposition of each complaint, and the time taken to process each complaint.

(4) A health care corporation shall submit to the commissioner an annual report which describes the complaint system of the corporation, and includes a compilation and analysis of the written complaints filed with the corporation, their disposition and underlying causes, and measures being implemented to alleviate those causes. The report shall be compiled in a manner which protects an individual's right to privacy with respect to medical information and shall not disclose the identity of a member by name or other personal identifier without the member's consent pursuant to section 406(1). The annual report shall be a public record.

(5) This section shall not prevent a member from seeking other remedies available by law.

Sec. 408. Any provider, member, or other person who knowingly makes, presents, or causes to be presented to a health care corporation any false, dishonest, or fraudulent claim for payment to or from the health care corporation, is guilty of a misdemeanor, punishable by a fine of not more than $1,000.00 or imprisonment for not more than 3 months, or both. This section shall not preclude a civil action for recovery of money due the corporation, nor shall it preclude the prosecution of any such provider, member, or other person under the applicable provisions of Act No. 328 of the Public Acts of 1931, as amended, being sections 750.1 to 750.568 of the Michigan Compiled Laws.

Sec. 409. A civil action for negligence based upon, or arising out of, the health care provider-patient relationship shall not be maintained against a health care corporation.

Sec. 410. Any certificate issued by a health care corporation which

provides that coverage of a dependent of the subscriber terminates at a specified age shall not terminate with respect to an unmarried child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, if the following conditions are met:

(a) The child became incapable before 19 years of age and is chiefly dependent upon the subscriber for support and maintenance.

(b) Before the child turns 19 years of age, or within 31 days thereafter, the subscriber has submitted proof of the dependent's incapacity to the corporation.

Sec. 411. In addition to other supplemental medicare benefits certificates offered by the corporation, a health care corporation shall offer to all nongroup applicants at least 1 supplemental medicare benefits certificate without a preexisting condition exclusion or limitation. Such a certificate shall cover, at a minimum, the deductible and co-payment requirements of part A and part B of the federal medicare program at rates in accordance with rate standards set forth in section 608.

Sec. 412. (1) A health care corporation which provides a certificate to a person eligible for medicare shall provide the subscriber with a medicare supplemental buyer's guide.

(2) As used in this section, "medicare supplemental buyer's guide" means the document entitled, "guide to health insurance for people with medicare", which was developed by the national association of insurance commissioners and the United States department of health and human services, or a substantially similar document, as approved by the commissioner.

Sec. 413. A corporation which offers a certificate to complement the federal medicare program shall provide to the applicant at the time of application a coverage outline in substantially the following form,

as approved by the commissioner:

(HEALTH CARE CORPORATION NAME)

MEDICARE COMPLEMENTARY COVERAGE

1. READ YOUR CERTIFICATE CAREFULLY. This outline of coverage provides a very brief description of the important features of your certificate. This is not the certificate, and only the actual certificate provisions will control. The certificate itself sets forth in detail the rights and obligations of both you and your health care corporation. It is important that you read your certificate carefully.

2. Medicare has 2 parts. Part A covers many hospital costs. Part B covers many medical costs. If you are applying for a medicare supplemental certificate, but you are not enrolled in medicare part B, you should read this notice carefully. If you are not enrolled in medicare part B, it is probably to your advantage to buy medicare part B coverage before you consider buying a medicare supplemental certificate. Although the cost changes yearly, in [1980] medicare part B coverage was available at a cost of [$8.70] per month. This is an excellent buy because the federal government subsidizes more than 2/3 of the actual cost of the coverage. (The health care corporation issuing the certificate shall change the bracketed figures each year to reflect the proper figures.)

3. Medicare supplemental coverage--Certificates of this category are designed to supplement medicare by covering some hospital, medical, and surgical services which are partially covered by medicare. Coverage is provided for hospital inpatient charges and some physician charges, and for the deductibles and co-payment provisions required under medicare. The certificate does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing, and

taking medicine (delete if this coverage is provided in the certificate).

4. The (insert health care corporation's name) certificate is not connected with medicare.

5. (Insert health care corporation's name) is not connected with medicare.

6. The following is a brief summary of the major benefit gaps in medicare parts A and B with a parallel description of supplemental benefits, including dollar amounts, provided by the medicare supplemental coverage:

SERVICE	BENEFIT	MEDICARE PAYS	THIS CERTIFICATE PAYS	YOU PAY
Hospitalization	First 60 days	All but [$180.00]		
Semiprivate room and board, general nursing, and miscellaneous hospital services and supplies	61st to 90th day	All but [$45.00] a day		
Meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthesia, and rehabilitation services	90th to 150th day	All but [$90.00] a day		
	Beyond 150 days	Nothing		
Posthospital skilled nursing care	First 20 days	100%		
In a facility approved by medicare, you must have been in a hospital for at least 3 days and enter the facility within 14 days after discharge from the hospital	Additional 80 days	All but [$22.50] a day		
	Beyond 100 days	Nothing		

Medical expenses	Physician's services, inpatient and outpatient medical services and supplies at a hospital, physical and speech therapy, and ambulance	80% of reasonable charge (after $60.00 deductible)

(The corporation issuing the certificate shall change the bracketed figures each year to reflect current changes.)

7. A statement that the certificate does or does not cover the following:

(a) Private duty nursing.

(b) Skilled nursing home care costs beyond what is covered by medicare.

(c) Custodial nursing home care costs.

(d) Intermediate nursing home care costs.

(e) Home health care above number of visits covered by medicare.

(f) Physician charges above medicare's reasonable charge.

(g) Drugs other than prescription drugs furnished during a hospital or a skilled nursing facility stay.

(h) Care received outside of the United States.

(i) Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, or examinations for eyeglasses or hearing aids.

8. A statement that the chart summarizing medicare benefits only briefly describes the benefits, and that the health care financing administration or its medicare publications should be consulted for further details and limitations.

9. The amount of the premium for this certificate.

Sec. 414. (1) A health care corporation established, maintained, or operating in this state shall offer benefits for the inpatient and

outpatient treatment of alcoholism and drug abuse by a licensed allopathic physician or a licensed osteopathic physician in a health care facility operated by this state or approved by the department of public health for the hospitalization for, or treatment of, alcoholism or drug abuse.

(2) A health care corporation subject to this act may enter into contracts for the rendering of alcoholism and drug abuse treatment with providers of health care facility providing inpatient or outpatient care for alcoholism and drug abuse. The provider shall be a licensed hospital or a substance abuse service program approved under part 62 of Act No. 368 of the Public Acts of 1978, being sections 333.6201 to 333.6251 of the Michigan Compiled Laws, and shall meet the standards set by the corporation for contracting health care facilities.

Sec. 415 (1) Not later than 12 months after the effective date of this act, a health care corporation shall offer or include coverage, in all group and nongroup certificates, to provide benefits for prosthetic devices to maintain or replace the body part of an individual whose covered illness or injury has required the removal of that body part. However, certificates resulting from collective bargaining agreements shall be exempted from this subsection. This coverage shall provide that reasonable charges for medical care and attendance for an individual fitted with a prosthetic device shall be covered benefits after the individual's attending physician has certified the medical necessity or desirability for a proposed course of rehabilitative treatment.

(2) Not later than 12 months after the effective date of this act, a health care corporation shall include coverage, in all group and nongroup certificates, to provide benefits for prosthetic devices to maintain or replace the body part of an individual who has undergone a mastectomy.

This coverage shall provide that reasonable charges for medical care and attendance for an individual who receives reconstructive surgery following a mastectomy or who is fitted with a prosthetic device shall be covered benefits after the individual's attending physician has certified the medical necessity or desirability of a proposed course of rehabilitative treatment. The cost and fitting of a prosthetic device following a mastectomy is included within the type of coverage intended by this subsection.

PART 5

Sec. 501. (1) A health care corporation subject to this act may enter into contracts with health care facilities.

(2) Contracts entered into under this section shall be subject to the provisions of sections 504 to 518.

Sec. 502. (1) A health care corporation may enter into participating contracts for reimbursement with professional health care providers practicing legally in this state for health care services which the professional health care providers may legally perform. A participating contract may cover all members or may be a separate and individual contract on a per claim basis, as set forth in the provider class plan, if, in entering into a separate and individual contract on a per claim basis, the participating provider certifies to the health care corporation:

(a) That the provider will accept payment from the corporation as payment in full for services rendered for the specified claim for the member indicated.

(b) That the provider will accept payment from the corporation as payment in full for all cases involving the procedure specified, for the duration of the calendar year.

(c) That the provider will not determine whether to participate on a claim on the basis of the race, color, creed, marital status, sex, national origin, residence, age handicap, or lawful occupation of the member entitled to health care benefits.

(2) A contract entered into pursuant to subsection (1) shall provide that the private provider-patient relationship shall be maintained to the extent provided for by law. A health care corporation shall continue to offer a reimbursement arrangement to any class of providers with which

it has contracted prior to the effective date of this act and which continues to meet the standards set by the corporation for that class of providers.

(3) A health care corporation shall not restrict the methods of diagnosis or treatment of professional health care providers who treat members. Each member of the health care corporation shall at all times have a choice of professional health care providers. This subsection shall not apply to limitations in benefits contained in certificates, to the reimbursement provisions of a provider contract or reimbursement arrangement, nor to standards set by the corporation for all contracting providers.

(4) A health care corporation may provide to a member, upon request, a list of providers with whom the corporation contracts, for the purpose of assisting a member in obtaining a type of health care service. However, an employee, agent, or officer of the corporation, or an individual on the board of directors of the corporation, shall not make recommendations on behalf of the corporation with respect to the choice of a specific health care provider. An employee, agent, or officer of the corporation, or a person on the board of directors of the corporation who influences or attempts to influence a person in the choice or selection of a specific professional health care provider on behalf of the corporation, is guilty of a misdemeanor.

(5) A health care corporation shall provide a symbol of participation, which can be publicly displayed, to providers who participate on all claims for covered health care services rendered to subscribers.

(6) This section shall not be construed to impede the lawful operation of, or lawful promotion of, a health maintenance organization owned by a health care corporation.

(7) Contracts entered into under this section shall be subject to

the provisions of sections 504 to 518.

(8) A health care corporation shall not deny participation to a freestanding medical or surgical outpatient facility on the basis of ownership if the facility meets the reasonable standards set by the health care corporation for similar facilities, is licensed under part 208 of Act No. 368 of the Public Acts of 1978, being sections 333.20801 to 333.20821 of the Michigan Compiled Laws, and complies with part 221 of Act No. 368 of the Public Acts of 1978, as amended, being sections 333.22101 to 333.22181 of the Michigan Compiled Laws.

Sec. 503. In the course of developing and establishing provider class plans under this part, a health care corporation shall address the issue of uniform reporting by health care providers.

Sec. 504. (1) A health care corporation shall, with respect to providers, contract with or enter into a reimbursement arrangement to assure subscribers reasonable access to, and reasonable cost and quality of, health care services, in accordance with the following goals:

(a) There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber.

(b) Providers will meet and abide by reasonable standards of health care quality.

(c) Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth.

(2) As used in this section:

(a) "Gross national product in constant dollars" means that term

as defined and annually published by the United States department of commerce, bureau of economic analysis.

(b) "Implicit price deflator for gross national product" means that term as defined and annually published by the United States department of commerce, bureau of economic analysis.

(c) "Inflation" or "I" means the arithmetic average of the percentage changes in the implicit price deflator for gross national product over the 2 calendar years immediately preceding the year in which the commissioner's determination is being made.

(d) "Compound rate of inflation and real economic growth" means the ratio of the quantity "100 plus inflation", multiplied by the quantity "100 plus real economic growth", to 100; minus 100; or as expressed in the following formula:

$$\left(\frac{(100 + I) \times (100 + REG)}{100} \right) - 100$$

(e) "Rate of change in the total corporation payment per member to each provider class" means the arithmetic average of the percentage changes in the corporation payment per member for that provider class over the 2 years immediately preceding the commissioner's determination.

(f) "Real economic growth" or "REG" means the arithmetic average of the percentage changes in the per capita gross national product in constant dollars over the 4 calendar years immediately preceding the year in which the commissioner's determination is being made.

(3) Nothing in this section shall preclude efforts by a health care corporation supplemental to the goals prescribed in subsection (1).

Sec. 505. (1) A health care corporation shall establish and implement procedures to obtain advice and consultation from a provider class, either

through individual providers of that class or through 1 or more organizations or associations that represent the provider class, in any combination, in the development of the provider class plan. A health care corporation may negotiate with 1 or more organizations or associations that represent providers in the relevant provider class in the development and modification of the provider class plan and objectives and methods for implementing that plan.

(2) The commissioner shall establish and implement procedures whereby any person, including a subscriber, may offer advice and consultation on the development, modification, implementation, or review of a provider class plan.

(3) A health care corporation shall establish and implement procedures to obtain advice and consultation from subscribers in the development and modification of the provider class plan and objectives for implementing that plan.

Sec. 506. (1) A health care corporation shall transmit a copy of each provider class plan to the commissioner 45 days before the earliest effective date of a provider contract or reimbursement arrangement for the appropriate provider class. The initial provider class plan for each class, which shall include provider contracts and reimbursement arrangements under which the corporation and a provider class are operating on the effective date of this act, shall be transmitted to the commissioner within 45 days after the effective date of this act, except where a provider class plan reimburses on a prospective basis, in which case the plan shall be transmitted within 1 year and 45 days after the effective date of this act.

(2) Upon receipt of a provider class plan, the commissioner shall

examine the plan and shall determine only if the plan contains a reimbursement arrangement and objectives for each goal provided in section 504, and, for those providers with which a health care corporation contracts, provisions that are included in that contract. For purposes of making the determination required by this subsection only, the commissioner shall liberally construe the items contained in a provider class plan.

(3) If the commissioner determines that the plan does not contain a reimbursement arrangement, objectives for each goal provided in section 504, and, for those providers with which a health care corporation contracts, contract provisions, the commissioner, within 15 days after receipt of the plan, shall notify the corporation by certified or registered mail, along with a written statement of the items omitted.

(4) If the commissioner does not notify the health care corporation pursuant to subsection (3), the provider class plan shall be automatically placed into effect, and shall be retained for the commissioner's records. Provider class plans approved by the commissioner or an independent hearing officer under this part shall be considered retained for the commissioner's records under this subsection.

Sec. 507. Within 15 days after receipt of the notification as provided in section 506(3), the health care corporation shall include the items omitted from the provider class plan, after taking into consideration any advice and consultation received from providers and subscribers pursuant to section 505, and shall transmit the items omitted, as provided in section 506(1).

Sec. 508. (1) Except during the 6-month period provided in section 509(2), a provider class plan retained by the commissioner as provided in section 506(4) may be modified by the health care corporation after the retention, under either of the following circumstances:

(a) If the plan was prepared by the health care corporation and is not a plan prepared pursuant to section 511(1) or 515(4). However, the modification shall not take effect until after the modification has been filed with the commissioner.

(b) In all other cases, if the modification has been filed with and is agreed to by the commissioner.

(2) A modification made under subsection (1) shall not extend the time periods provided in section 509(1). In developing plan modifications, a health care corporation shall obtain advice and consultation from providers in the relevant provider class and from subscribers pursuant to section 505. Before agreeing to plan modifications under subsection (1)(b), the commissioner shall obtain advice and consultation pursuant to section 505(2).

Sec. 509. (1) The commissioner may determine if the health care corporation has substantially achieved the goals of a corporation as provided in section 504 and achieved the objectives contained in the provider class plan, at the following times:

(a) For a provider contract or a reimbursement arrangement that was in effect prior to the effective date of this act, upon the expiration of 2 years after the filing date under section 506.

(b) For a provider class plan retained by the commissioner as provided in section 506(4), upon the expiration of 2 years after the earliest effective date of the provider contract or a reimbursement arrangement for the appropriate provider class.

(c) For a class plan retained by the commissioner as provided in section 506(4) that has not been subject to a determination under this section within the time period provided in subsection (2), within 2 years after the expiration of that time period.

(2) Before making a determination under subsection (1), and not later than 30 days following expiration of the appropriate 2-year time period described in subsection (1)(a), (b), or (c), the commissioner shall give written notice to the health care corporation, and to each person who has requested a copy of such notice, that he or she intends to make a determination with respect to a particular provider class plan. The commissioner shall have 6 months to reach a determination under subsection (1).

(3) A modification made pursuant to section 508(1) shall not be taken into consideration for purposes of computing the time periods described in subsections (1) and (2).

(4) The commissioner shall consider all of the following in making a determination pursuant to subsection (1):

(a) Annual reports transmitted pursuant to section 517.

(b) The overall balance of the goals provided in section 504, achieved by the health care corporation under the plan. The commissioner shall give weight to each of the goals provided in section 504, shall not focus on 1 goal independently of the other goals of the corporation, and shall assure that no portion of the corporation's fair share of reasonable costs to the provider are borne by other health care purchasers.

(c) Information submitted or obtained for the record concerning: demographic trends; epidemiological trends; and long-term economic trends, including changes in prices of goods and services purchased by a provider class not already reflected in the calculation in section 504(2)(d); sudden changes in circumstances; administrative agency or judicial actions; changes in health care practices and technology; and changes in benefits that affect the ability of the health care corporation to reasonably achieve the goals provided in section 504.

(d) Health care legislation of this state or of the federal government. As used in this subdivision, "health care legislation" does not include Act No. 218 of the Public Acts of 1956, as amended, being sections 500.100 to 500.8302 of the Michigan Compiled Laws.

(e) Comments received from an individual provider of the appropriate provider group, or from an organization or association that represents the appropriate provider class, and comments received pursuant to section 505(2).

(5) In making a determination pursuant to subsection (1), the commissioner shall provide a detailed statement of findings which support that determination, including a consideration of the information and factors described in subsection (4).

(6) All data, analyses, and factors, quantified or otherwise, at a minimum, shall include the 2-year period being evaluated.

(7) The commissioner shall make a sufficient number of determinations regarding provider class plans under this section, so that during each 3-year period following the effective date of this act, there is a review of provider class plans which, taken together, account for at least 75% of the total corporation payout to providers for the 3-year period.

(8) Determinations by the commissioner shall not be contested case hearings under chapter 4 of the administrative procedures act. This subsection shall not be construed to apply with respect to appeals under section 515.

Sec. 510. (1) After considering the information and factors described in section 509(4), the goals of a health care corporation as provided in section 504, and the objectives contained in the provider class plan, the commissioner shall determine 1 of the following:

(a) That the provider class plan achieves the goals of the corporation as provided in section 504.

(b) That although the provider class plan does not substantially achieve 1 or more of the goals of the corporation, a change in the provider class plan is not required because there has been competent, material, and substantial information obtained or submitted to support a determination that the failure to achieve 1 or more of the goals was reasonable due to factors listed in section 509(4).

(c) That a provider class plan does not substantially achieve 1 or more of the goals of the corporation as provided in section 504.

(2) The commissioner shall notify the health care corporation, and each person who has requested a copy of such notice, of a determination under subsection (1) by certified or registe d mail. Determinations made pursuant to subsection (1)(b) or (c) shall include a concise written statement of specific findings supporting that determination.

(3) An existing provider contract or reimbursement arrangement shall remain in effect until a new provider class plan has been retained and placed into effect as provided in section 506(4). A provider class plan shall not be subject to further review until the expiration of the time period provided in section 509(1).

(4) A provider class plan with respect to which a determination was made under subsection (1)(a) or (b) shall not be subject to further review until the expiration of 2 years following the determination.

Sec. 511. (1) Upon receipt of notice under section 510(2), the health care corporation, within 6 months or a period determined by the commissioner pursuant to section 512, shall transmit to the commissioner a provider class plan that substantially achieves the goals, achieves

the objectives, and substantially overcomes the deficiencies enumerated in the findings made by the commissioner pursuant to section 510(2). In developing a provider class plan under this subsection, the corporation shall obtain advice and consultation from providers in the provider class and subscribers, using procedures established pursuant to section 505.

(2) If, after the expiration of 6 months or a period determined by the commissioner pursuant to section 512, the health care corporation has failed to act pursuant to subsection (1), the commissioner shall prepare a provider class plan pursuant to section 513(2)(A), for that provider class.

Sec. 512. The commissioner may extend the 6-month period provided in section 511(1) once, for not more than 90 days, if the commissioner determines that a health care corporation requires additional time to assess the findings made by the commissioner or to prepare a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings. In making a determination under this section, the commissioner shall consider the number of provider class plans, the extent of the changes to each plan, and the stage of development of each plan being prepared by the health care corporation pursuant to section 511(1).

Sec. 513. (1) Upon receipt of a provider class plan under section 511(1), the commissioner, after considering the information and factors described in section 509(4), within 90 days shall examine the plan and determine if the plan substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made by the commissioner. If the commissioner determines that the plan substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made

by the commissioner, the plan shall be automatically retained and placed into effect as provided in section 506.

(2) If the commissioner determines that the plan does not substantially achieve the goals, does not achieve the objectives, and does not substantially overcome the deficiencies enumerated in the findings made by the commissioner pursuant to section 510(2), the commissioner shall do all of the following:

(a) Prepare a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made pursuant to section 510(2), and transmit that plan to the health care corporation. A provider class plan prepared pursuant to this subdivision shall be retained for the commissioner's records and placed into effect as provided in section 506(4), unless a request for an appeal is made under subdivision (b).

(b) Give written notice to the health care corporation of an opportunity for an appeal pursuant to section 515. The notice shall state that a request for an appeal shall be made by the corporation within 30 days after the receipt of notice under this subdivision.

(3) In making a determination pursuant to subsection (1), or preparing a plan pursuant to subsection (2)(a), the commissioner shall obtain advice and consultation pursuant to section 505(2). The commissioner shall also forward a copy of each notice issued under subsection (2)(b) to each person requesting a copy. The copy shall notify the person of an opportunity for an appeal pursuant to section 515, and that a request for such an appeal is required to be made within 30 days after the receipt of notice given under this subsection.

Sec. 514. (1) All appeals under this part shall be held before an independent hearing officer. The state court administrator shall

compile and maintain a list of individuals possessing all of the following qualifications:

(a) Is a retired circuit court judge.

(b) Is a resident of this state.

(c) Is not engaged in the provision of health care services.

(d) Is not an officer or employee of a health care provider, health care corporation, or an employee of this state. For purposes of this subdivision, an employee of an educational institution shall not be considered to be employed by this state.

(2) The hearing officer shall be selected at random by the commissioner from the list described in subsection (1), on a per appeal basis. If the individual selected is performing judicial duties, another individual shall be selected.

(3) The hearing officer shall have the power to consolidate appeals related to a provider class.

(4) The commissioner shall prepare and file with the appropriate standing committees of the legislature an annual report regarding the operation of the appeals procedure prescribed in this part, including data regarding the identity of individuals available to serve as independent hearing officers whose names are on the administrator's list; the number of appeals heard; the nature of the controversy involved; the disposition of the appeal; and whether a judicial appeal was subsequently taken, and the disposition of that appeal.

Sec. 515. (1) An appeal may be brought from any action or determination of the commissioner under section 509(1), 510(1), or 513(1) or (2), by a subscriber, the health care corporation, the attorney general, an employer, an organization or association representing a subscriber or

an employer, or an organization or association representing the affected provider class. An appeal may also be brought by a person whose contractual or legal rights, duties, or privileges are substantially affected. The request for an appeal shall identify the issue or issues which the affected party asserts are involved, and how the party is aggrieved. The independent hearing officer shall determine the standing of any party to appeal.

(2) An appeal from an action or determination of the commissioner under this part shall be brought within 30 days after the action or determination. All appeal hearings shall begin within 30 days after receipt of a request for an appeal. The appeal shall be conducted pursuant to chapter 4 of the administrative procedures act.

(3) In an appeal pursuant to this section, the relief available to a person, and the decision of an independent hearing officer hearing an appeal, shall be limited to the following:

(a) Affirming or reversing a determination of the commissioner under sections 509(1) and 510(1).

(b) Determining, based on the information and factors described in section 509(4) and the standards prescribed in section 516, 1 of the following:

(i) That the provider class plan prepared by the corporation under section 511(1) was prepared in compliance with that section and shall be retained as provided in section 506(4).

(ii) That the provider class plan prepared by the commissioner under section 513(2)(a) was prepared in compliance with that section and shall be retained as provided in section 506(4).

(iii) That a provider class plan described in subparagraph (i) or (ii) was not prepared in compliance with section 511(1) or 513(2)(a),

respectively, and shall not be retained as provided in section 506(4). In this case, the hearing officer shall order the corporation to prepare and submit a provider class plan as provided in subsection (4). Detailed findings must accompany the determination made by the hearing officer pursuant to this subdivision.

(4) Within 180 days after receipt of the hearing officer's determination made under subsection (3)(b)(iii), the health care corporation shall transmit to the hearing officer a provider class plan that is in conformance with the findings of the hearing officer and that substantially achieves the goals of a health care corporation as provided in section 504. In developing a provider class plan under this subsection, the corporation shall obtain advice and consultation from providers in the provider class and subscribers, using procedures established pursuant to section 505.

(5) After receipt of a provider class plan transmitted by the health care corporation pursuant to subsection (4), the hearing officer shall determine 1 of the following:

(a) That the provider class plan prepared by the corporation shall be retained as provided in section 506(4).

(b) That the provider class plan prepared by the corporation should not be retained as provided in section 506(4), and the commissioner may suspend or limit the corporation's certificate of authority until the corporation submits a provider class plan which the hearing officer determines should be retained as provided in section 506(4).

Sec. 516. (1) All provider class plans retained by the commissioner under section 513 or approved by the hearing officer shall maintain the following standards for all providers:

(a) Responsible cost controls shall exist that balance quality,

accessibility, and cost.

(b) The health care corporation shall promote programs and policies which encourage cost-effective behavior by providers in accordance with the provisions of this act, and in accordance with all of the following:

(i) There shall be a reasonable basis for believing that the programs will be effective.

(ii) The programs applicable to a provider class shall be reviewed to avoid duplication or inconsistency, to the extent practicable.

(c) There shall be a fair and reasonable appeals process established and maintained by the health care corporation for aggrieved providers.

(d) There shall be a reasonable period for implementation of changes.

(e) There shall be reasonably prompt payment by the health care corporation to providers who render covered health care services.

(2) In addition to the standards prescribed in subsection (1), the following standards shall apply to hospitals:

(a) To the extent practicable, reimbursement control shall be expressed in the aggregate to individual hospitals.

(b) No portion of the health care corporation's fair share of hospitals' reasonable financial requirements shall be borne by other health care purchasers. However, this subdivision shall not preclude reimbursement arrangements which include financial incentives and disincentives.

(c) The health care corporation's programs and policies shall not unreasonably interfere with the hospital's ability and responsibility to manage its operations.

Sec. 517. A health care corporation shall transmit an annual report for each provider class to the commissioner regarding the level of achievement of the goals provided in section 504. The report shall include data necessary

to a determination of the corporation's compliance or noncompliance with the goals, as prescribed in section 504, and compliance with objectives contained in the provider class plan. The report shall be in accordance with forms and instructions prescribed by the commissioner and shall include information as necessary to evaluate the considerations of section 509(4). The report may include other information the corporation deems relevant.

Sec. 518. The considerations set forth in section 509(4) and the standards set forth in section 516 shall only apply for purposes of this act and may be appealed only as specifically provided in this act. An appeal from a final determination of an independent hearing officer shall be conducted pursuant to chapter 6 of the administrative procedures act, except that the appeal shall be taken within 30 days after the final determination, upon leave granted, in the court of appeals.

PART 6

Sec. 601. (1) A health care corporation shall be subject to regulation and supervision by the commissioner as provided in this act.

(2) A designee of the commissioner shall not be authorized to act on behalf of the commissioner under this act unless prior written notice of the delegation of authority has been given to a health care corporation subject to that delegated authority.

Sec. 602. (1) Not later than March 1 each year, subject to a 30-day extension which may be granted by the commissioner, a health care corporation shall file in the office of the commissioner a sworn statement verified by at least 2 of the principal officers of the corporation showing its condition as of the preceding December 31. The statement shall be in a form, and contain those matters, which the commissioner prescribes for a health care corporation, including those matters contained in section 205. The statement shall include the number of members and the number of subscribers' certificates issued by the corporation and outstanding.

(2) The commissioner, by order, may require a health care corporation to submit statistical, financial, and other reports for the purpose of monitoring compliance with this act.

Sec. 603. (1) The commissioner shall have the power of visitation and examination into the affairs of a health care corporation. The corporation shall in every way facilitate an examination or visitation.

(2) The power of examination shall include free access to all of the books, papers, and documents that relate to the business of the corporation, except as provided in section 304(2)(d). Free access shall include the right to copy and reproduce at the place of business of the health care corporation and to require delivery of any materials to the office

of the commissioner in Lansing within 5 working days after the request is made. If the corporation is unable to respond to the request within 5 working days, the corporation shall specify a date certain by which the corporation will respond. However, the date certain shall not be later than 15 working days after the request is made unless the commissioner agrees to a longer period of time. Witnesses may be summoned and qualified under oath, and examination may be made of the corporation's officers, agents, or employees or of other persons having knowledge of the affairs, transactions, and conditions of the corporation. The per diem, traveling, reproduction, and other necessary expenses in connection with visitation and examination shall be paid by the corporation, and shall be credited to the general fund of the state.

(3) Information provided to the commissioner which is disclosable only to the commissioner under section 304(2) shall not be disclosed by the commissioner to other persons until such time as the minutes pertaining to that information may be disclosed under section 304(3).

(4) If it appears from any examination or report that this act or any other law of this state has been violated, the commissioner immediately shall report the violation to the attorney general in writing. The attorney general shall then take action on the alleged violation, as the facts warrant. Unless the public health, safety, or welfare otherwise clearly requires, before commencement of a proceeding against a health care corporation resulting from a report, the corporation shall be furnished a copy of the examination report and shall be given an informal opportunity to show compliance with law.

(5) Upon the request of the commissioner, the attorney general may petition for, and the circuit court may issue, an ex parte order from

the circuit court directing a corporation to comply with this section. The corporation shall be entitled to an expedited hearing to challenge the ex parte order.

Sec. 604. (1) The commissioner shall ensure the confidentiality of records containing personal data which may be associated with identifiable individuals. Except as is necessary to comply with a court order, or for the purposes of claim adjudication or when required by law, the commissioner shall not disclose records containing personal data which may be associated with an identifiable individual without the prior informed consent of the individual to whom the data pertain. The individual's consent shall be in writing. If an individual has authorized the release of personal data to a specific person, that person shall not release the data to a third person unless the individual executes in writing another informed consent authorizing that additional release.

(2) The commissioner shall ensure the confidentiality of data which discloses reimbursement levels for specific procedures or services of specific providers and data which, if disclosed, can be used to calculate those reimbursement levels. This subsection shall apply only if the data are not already generally known to providers and if the disclosure of the data would be harmful to the achievement of the goals set forth in section 504. Only that portion of a record dealing with data described in this subsection shall be exempt from disclosure. A person, whose request for a hearing has been granted by the commissioner, may examine the data and shall be subject to the same confidentiality requirements as the commissioner under this subsection.

(3) The commissioner shall ensure the confidentiality of any trade secrets of the corporation, except for information required to be disclosed

under Act No. 442 of the Public Acts of 1976, as amended, being sections 15.231 to 15.246 of the Michigan Compiled Laws.

(4) Subject to the provisions of subsections (1) to (3), information which a health care corporation provides to or files with the commissioner shall be governed by Act No. 442 of the Public Acts of 1976, as amended, being sections 15.231 to 15.246 of the Michigan Compiled Laws.

(5) A person who violates the confidentiality provisions of this section is guilty of a misdemeanor, punishable by a fine of not more than $1,000.00 for each violation.

Sec. 605. (1) Upon due notice and an opportunity for an evidentiary hearing pursuant to the administrative procedures act, the commissioner may suspend or limit the certificate of authority of a health care corporation if the commissioner determines that any of the following circumstances exist:

(a) The health care corporation does not meet the requirements of this act respecting the adequacy of its reserves.

(b) The health care corporation is using methods or practices in the conduct of its business which render further transactions hazardous or injurious to subscribers of the corporation or the public.

(c) The health care corporation refuses or fails to comply with this act or with a lawful order of the commissioner.

(2) If the commissioner finds that the public health, safety, or welfare requires emergency action and incorporates this finding into an order, a summary suspension or limitation of a certificate of authority may be ordered. The suspension or limitation shall be effective on the date specified in the order or upon service of a certified copy of the order on the health care corporation, whichever is later, and shall be

effective during the proceedings. The corporation shall have the right to an administrative hearing within 5 days to show why the summary suspension or limitation should be terminated.

(3) An order of limitation may restrict the solicitation of certificates, the renewal of business in force, and the solicitation, offer, or acceptance of contracts, and may impose other conditions to continued authorization as are reasonably necessary to protect the subscribers of the corporation or the public. The commissioner shall terminate an order of limitation when the circumstance giving rise to the order ceases to exist.

(4) Upon suspension or limitation of a corporation's certificate of authority, if the commissioner considers it necessary or desirable for the protection of the subscribers of the corporation or the public, the commissioner may publish notice of the suspension or limitation in 1 or more newspapers of general circulation in the state.

(5) An emergency order by the commissioner which suspends or limits a corporation's certificate of authority shall be for a period not to exceed 1 year and, after opportunity of hearing, the commissioner for good cause may extend the period of suspension or limitation for additional periods not to exceed 1 year.

Sec. 606. (1) The commissioner shall have the same authority regarding the officers and directors of a health care corporation as the commissioner has with respect to the officers and directors of insurers under sections 249 and 250 of Act No. 218 of the Public Acts of 1956, being sections 500.249 and 500.250 of the Michigan Compiled Laws.

(2) The commissioner shall have the same authority with respect to the dissolution, taking over, or liquidation of corporations formed

or doing business under this act as is provided in chapter 78 of Act No. 218 of the Public Acts of 1956, as amended, being sections 500.7800 to 500.7868 of the Michigan Compiled Laws. For purposes of this subsection, a health care corporation shall be considered to be insolvent if its liabilities exceed its assets, unless otherwise defined in chapter 78 of Act No. 218 of the Public Acts of 1956, as amended.

Sec. 607. (1) A health care corporation shall submit a copy of any new or revised certificate to the commissioner along with applicable proposed rates and rate rationale. The certificates, and applicable proposed rates, shall be deemed approved and effective 30 days after filing with the commissioner, except as otherwise provided in this section. The commissioner may subsequently disapprove any certificate deemed approved.

(2) The commissioner shall exempt from prior approval certificates resulting from a collective bargaining agreement.

(3) The commissioner may disapprove, or approve with modifications, a certificate and applicable rates under 1 or more of the following circumstances:

(a) If the rate charged for the benefits provided is not equitable, not adequate, or excessive, as defined in section 609.

(b) If the certificate contains 1 or more provisions which are unjust, unfair, inequitable, misleading, deceptive, or which encourage misrepresentation of the coverage.

(c) If a certificate reduces the scope, amount, or duration of benefits so as to have the effect of reducing the comprehensiveness of existing health care benefits available to groups or to individuals. The commissioner may approve a certificate which reduces the scope, amount, or duration of health care benefits if the commissioner determines that the certificate

will be offered as an alternative in addition to an existing certificate which provides comprehensive health care benefits and if the commissioner determines that approval of the alternative certificate will not adversely affect the opportunity for groups or individuals to obtain comprehensive health care benefits.

(4) The commissioner shall approve a certificate and applicable proposed rates if all of the following conditions are met:

(a) If the rate charged for the benefits provided is equitable, adequate, and not excessive, as defined in section 609.

(b) If the certificate does not contain any provision which is unjust, unfair, inequitable, misleading, deceptive, or which encourages misrepresentation of the coverage.

(5) If the commissioner disapproves a certificate and any applicable proposed rates under this section, he or she shall issue a notice of disapproval which specifies in what respects a filing fails to meet the requirements of this act. The notice shall state that the filing shall not become effective.

(6) If the commissioner approves, or approves with modifications, a certificate and any applicable proposed rates under this section, he or she shall issue a notice of approval or approval with modifications. If the notice is of approval with modifications, the notice shall specify what modifications in the filing are required for approval under this act, and the reasons for the modifications. The notice shall also state that the filing shall become effective after the modifications are made and approved by the commissioner.

(7) Upon request by a health care corporation, the commissioner may allow certificates and rates to be implemented prior to filing to

allow implementation of a new certificate on the date requested.

Sec. 608. (1) The rates charged to nongroup subscribers for each certificate shall be filed in accordance with section 610 and shall be subject to the prior approval of the commissioner. Annually, the commissioner shall approve, disapprove, or modify and approve the proposed or existing rates for each certificate subject to the standard that the rates must be determined to be equitable, adequate, and not excessive, as defined in section 609. The burden of proof that rates to be charged meet these standards shall be upon the health care corporation proposing to use the rates.

(2) The methodology and definitions of each rating system, formula, component, and factor used to calculate rates for group subscribers for each certificate, including the methodology and definitions used to calculate administrative costs for administrative services only and cost-plus arrangements, shall be filed in accordance with section 610 and shall be subject to the prior approval of the commissioner. The definition of a group, including any clustering principles applied to nongroup subscribers or small group subscribers for the purpose of group formation, shall be subject to the prior approval of the commissioner. The commissioner shall approve, disapprove, or modify and approve the methodology and definitions of each rating system, formula, component, and factor for each certificate subject to the standard that the resulting rates for group subscribers must be determined to be equitable, adequate, and not excessive, as defined in section 609. In addition, the commissioner may from time to time review the records of the corporation to determine proper application of a rating system, formula, component, or factor with respect to any group. The corporation shall refile for approval under this subsection, every 3 years, the

methodology and definitions of each rating system, formula, component, and factor used to calculate rates for group subscribers, including the methodology and definitions used to calculate administrative costs for administrative services only and cost-plus arrangements. The burden of proof that the resulting rates to be charged meet these standards shall be upon the health care corporation proposing to use the rating system, formula, component, or factor.

(3) A proposed rate shall not take effect until a filing has been made with the commissioner and approved under section 607 or this section, as applicable, except as provided in subsections (4) and (5).

(4) Upon request by a health care corporation, the commissioner may allow rate adjustments to become effective prior to approval, for federal or state mandated benefit changes. However, a filing for these adjustments shall be submitted before the effective date of the mandated benefit changes. If the commissioner disapproves or modifies and approves the rates, an adjustment shall be made retroactive to the effective date of the mandated benefit changes or additions.

(5) Implementation prior to approval may be allowed when the health care corporation is participating with 1 or more health care corporations to underwrite a group whose employees are located in several states. Upon request from the commissioner, the corporation shall file with the commissioner, and the commissioner shall examine, the financial arrangement, formulae, and factors. If any are determined to be unacceptable, the commissioner shall take appropriate action.

Sec. 609. (1) A rate is not excessive if the rate is not unreasonably high relative to the following elements, individually or collectively; provision for anticipated benefit costs; provision for administrative

expense; provision for cost transfers, if any; provision for a contribution to or from the corporate contingency reserve that is consistent with the attainment or maintenance of the target contingency reserve level prescribed in section 205; and provision for adjustments due to prior experience of groups, as defined in the group rating system. A determination as to whether a rate is excessive relative to the elements listed above, individually or collectively, shall be based on the following: reasonable evaluations of recent claim experience; projected trends in claim costs; the allocation of administrative expense budgets; and the present and anticipated contingency reserve positions of the health care corporation. To the extent that any of these elements are considered excessive, the provision in the rates for these elements shall be modified accordingly.

(2) The administrative expense budget must be reasonable, as determined by the commissioner after examination of material and substantial administrative and acquisition expense items.

(3) A rate is equitable if the rate can be compared to any other rate offered by the health care corporation to its subscribers, and the observed rate differences can be supported by differences in anticipated benefit costs, administrative expense cost, differences in risk, or any identified cost transfer provisions.

(4) A rate is adequate if the rate is not unreasonably low relative to the elements prescribed in subsection (1), individually or collectively, based on reasonable evaluations of recent claim experience, projected trends in claim costs, the allocation of administrative expense budgets, and the present and anticipated contingency reserve positions of the health care corporation.

(5) Except for identified cost transfers, each line of business,

over time, shall be self-sustaining. However, there may be cost transfers for the benefit of senior citizens and group conversion subscribers. Cost transfers for the benefit of senior citizens, in the aggregate, annually shall not exceed 1% of the earned subscription income of the health care corporation as reported in the most recent annual statement of the corporation. Group conversion subscribers are those who have maintained coverage with the health care corporation on an individual basis after leaving a subscriber group.

Sec. 610. (1) Except as provided under section 608(4) or (5), a filing of information and materials relative to a proposed rate shall be made not less than 120 days before the proposed effective date of the proposed rate. A filing shall not be considered to have been received until there has been substantial and material compliance with the requirements prescribed in subsections (6) and (8).

(2) Within 30 days after a filing is made of information and materials relative to a proposed rate, the commissioner shall do either of the following:

(a) Give written notice to the corporation, and to each person described under section 612(1), that the filing is in material and substantial compliance with subsections (6) and (8) and that the filing is complete. The commissioner shall then proceed to approve, approve with modifications, or disapprove the rate filing 60 days after receipt of the filing, based upon whether the filing meets the requirements of this act. However, if a hearing has been requested under section 613, the commissioner shall not approve, approve with modifications, or disapprove a filing until the hearing has been completed and an order issued.

(b) Give written notice to the corporation that the corporation has not yet complied with subsections (5) and (8). The notice shall state

specifically in what respects the filing fails to meet the requirements of subsections (6) and (8).

(3) Within 10 days after the filing of notice pursuant to subsection (2)(b), the corporation shall submit to the commissioner such additional information and materials, as requested by the commissioner. Within 10 days after receipt of the additional information and materials, the commissioner shall determine whether the filing is in material and substantial compliance with subsections (6) and (8). If the commissioner determines that the filing does not yet materially and substantially meet the requirements of subsections (6) and (8), the commissioner shall give notice to the corporation pursuant to subsection (2)(b) or use visitation of the corporation's facilities and examination of the corporation's records to obtain the necessary information describ in the notice issued pursuant to subsection (2)(b). The commissioner shall use either procedure previously mentioned, or a combination of both procedures, in order to obtain the necessary information as expeditiously as possible. The per diem, traveling, reproduction, and other necessary expenses in connection with visitation and examination shall be paid by the corporation, and shall be credited to the general fund of the state.

(4) If a filing is approved, approved with modifications, or disapproved under subsection (2)(a), the commissioner shall issue a written order of the approval, approval with modifications, or disapproval. If the filing was approved with modifications or disapproved, the order shall state specifically in what respects the filing fails to meet the requirements of this act and, if applicable, what modifications are required for approval under this act. If the filing was approved with modifications, the order shall state that the filing shall take effect after the

modifications are made and approved by the commissioner. If the filing was disapproved, the order shall state that the filing shall not take effect.

(5) The inability to approve 1 or more rating classes of business within a line of business because of a requirement to submit further data or because a request for a hearing under section 613 has been granted shall not delay the approval of rates by the commissioner which could otherwise be approved or the implementation of rates already approved, unless the approval or implementation would affect the consideration of the unapproved classes of business.

(6) Information furnished under subsection (1) in support of a nongroup rate filing shall include the following:

(a) Recent claim experience on the benefits or comparable benefits for which the rate filing applies.

(b) Actual prior trend experience.

(c) Actual prior administrative expenses.

(d) Projected trend factors.

(e) Projected administrative expenses.

(f) Contributions for risk and contingency reserve factors.

(g) Actual health care corporation contingency reserve position.

(h) Projected health care corporation contingency reserve position.

(i) Other information which the corporation considers pertinent to evaluating the risks to be rated, or relevant to the determination to be made under this section.

(j) Other information which the commissioner considers pertinent to evaluating the risks to be rated, or relevant to the determination to be made under this section.

(7) A copy of the filing, and all supporting information, except for the information which may not be disclosed under section 604, shall be open to public inspection as of the date filed with the commissioner.

(8) The commissioner shall make available forms and instructions for filing for proposed rates under sections 608(1) and 608(2). The forms with instructions shall be available not less than 180 days before the proposed effective date of the filing.

Sec. 611. It is the intent of the legislature to promote uniformity of rates among subscribers to the greatest extent practicable.

Sec. 612. (1) Upon receipt of a rate filing under section 610, the commissioner immediately shall notify each person who has requested in writing notice of those filings within the previous 2 years, specifying the nature and extent of the proposed rate revision and identifying the location, time, and place where the copy of the rate filing described in section 610(7) shall be open to public inspection and copying. The notice shall also state that if the person has standing, the person shall have, upon making a written request for a hearing within 60 days after receiving notice of the rate filing, an opportunity for an evidentiary hearing under section 613 to determine whether the proposed rates meet the requirements of this act. The request shall identify the issues which the requesting party asserts are involved, what portion of the rate filing is requested to be heard, and how the party has standing. The corporation shall place advertisements giving notice, containing the information specified above, in at least 1 newspaper which serves each geographic area in which significant numbers of subscribers reside.

(2) The commissioner may charge a fee for providing, pursuant to subsection (1), a copy of the rate filing described in section 610(7).

The commissioner may charge a fee for providing a copy of the entire filing to a person whose request for a hearing has been granted by the commissioner pursuant to section 613. The fee shall be limited to actual mailing costs and to the actual incremental cost of duplication, including labor and the cost of deletion and separation of information as provided in section 14 of Act No. 442 of the Public Acts of 1976, being section 15.244 of the Michigan Compiled Laws. Copies of the filing may be provided free of charge or at a reduced charge if the commissioner determines that a waiver or reduction of the fee is in the public interest because the furnishing of a copy of the filing will primarily benefit the general public. In calculating the costs under this subsection, the commissioner shall not attribute more than the hourly wage of the lowest paid, full-time clerical employee of the insurance bureau to the cost of labor incurred in duplication and mailing and to the cost of separation and deletion. The commissioner shall use the most economical means available to provide copies of a rate filing.

Sec. 613. (1) If the request for a hearing under this section is with regard to a rate filing not yet acted upon under section 610(2)(a), no such action shall be taken by the commissioner until after the hearing has been completed. However, the commissioner shall proceed to act upon those portions of a rate filing upon which no hearing has been requested. Within 15 days after receipt of a request for a hearing, the commissioner shall determine if the person has standing. If the commissioner determines that the person has standing, the person may have access to the entire filing subject to the same confidentiality requirements as the commissioner under section 604, and shall be subject to the penalty provision of section 604(5). Upon determining that the person has standing, the commissioner

shall immediately appoint an independent hearing officer before whom the hearing shall be held. In appointing an independent hearing officer, the commissioner shall select a person qualified to conduct hearings, who has experience or education in the area of health care corporation or insurance rate determination and finance, and who is not otherwise associated financially with a health care corporation or a health care provider. The person selected shall not be currently or actively employed by this state. For purposes of this subsection, an employee of an educational institution shall not be considered to be employed by this state. For purposes of this section, a person has "standing" if any of the following circumstances exist:

(a) The person is, or there are reasonable grounds to believe that the person could be, aggrieved by the proposed rate.

(b) The person is acting on behalf of 1 or more named persons described in subdivision (a).

(c) The person is the commissioner, the attorney general, or the health care corporation.

(2) Not more than 30 days after receipt of a request for a hearing, and upon not less than 15 days' notice to all parties, the hearing shall be commenced. Each party to the hearing shall be given a reasonable opportunity for discovery before and throughout the course of the hearing. However, the hearing officer may terminate discovery at any time, for good cause shown. The hearing officer shall conduct the hearing pursuant to the administrative procedures act. The hearing shall be conducted in an expeditious manner. At the hearing, the burden of proving compliance with this act shall be upon the health care corporation.

(3) In rendering a proposal for a decision, the hearing officer

shall consider the factors prescribed in section 609.

(4) Within 30 days after receipt of the hearing officer's proposal for decision, the commissioner shall by order render a decision which shall include a statement of findings.

(5) The commissioner shall withdraw an order of approval or approval with modifications if the commissioner finds that the filing no longer meets the requirements of this act.

Sec. 614. (1) Not less than 75 days after a filing is received, as provided in section 610, the health care corporation may petition the commissioner, who shall make a determination with respect to interim rates and shall order interim rates in the amount prescribed in subsection (2). Interim rates shall not be implemented if the commissioner finds that the health care corporation has substantially contributed to the delay or that the health care corporation has not provided information requested by the commissioner relative to a determination under this section. The interim rate determination shall not be a contested case under chapter 4 of the administrative procedures act.

(2) The commissioner shall grant an interim rate, in an amount as determined by the commissioner, if the commissioner makes a finding that the corporation has made a convincing showing that there is probable cause to believe that the failure to grant the interim rate will result in an underwriting loss for that line of business for the period for which rates are being requested. As used in this subsection, "underwriting loss" means the difference between income from current rates plus investment income, and projected claims plus projected administrative expenses.

(3) If the final rate determination results in approval of a lower rate, appropriate refunds or adjustments, as determined by the commissioner.

shall be made to reflect payments made in excess of the approved rate.

(4) The order establishing an interim rate adjustment made pursuant to this section shall be limited to adjusting rates for certificates then in effect, and shall not be used to alter certificates or implement new certificates.

(5) This section shall apply only to rates subject to section 608(1) for which a hearing has been requested.

Sec. 615. Any final order or decision made, issued, or executed by the commissioner under this act after a hearing held before the commissioner or a deputy commissioner pursuant to the administrative procedures act shall be subject to review as provided in chapter 6 of the administrative procedures act without leave by the circuit court for Ingham county.

Sec. 616. (1) If a document required or permitted to be filed with the commissioner under this act substantially conforms to the requirements of this act, the commissioner shall endorse upon it the word "filed" with the commissioner's official title and the dates of receipt and of filing, and shall file and index the document or a microfilm or other reproduced copy of the document in his or her office. If so requested at the time of delivery of the document to his or her office, the commissioner shall include the hour of filing in his or her endorsement on the document.

(2) If the commissioner fails promptly to file a document, other than an annual report or a supplemental statement, submitted for filing under this act, the commissioner shall, within 10 days after receipt from the person submitting the document for filing of a written request for the filing of the document, give written notice of the refusal to file to that person, specifying the reasons for the failure to file the document. From the disapproval the person may seek judicial review pursuant to sections

103, 104, and 106 of the administrative procedures act.

(3) If a document relating to a health care corporation filed with the commissioner under this act is an inaccurate record of the corporation action referred to in the document or was defectively or erroneously executed, the document may be corrected by filing with the commissioner a certificate of correction on behalf of the corporation. A certificate, entitled "certificate of correction of ... (correct title of document and name of corporation)" shall be signed as provided in this act with respect to the document being corrected and filed with the commissioner. The certificate shall set forth the name of the corporation, the date the document to be corrected was filed by the commissioner, the provision in the document as corrected or eliminated, and if the execution was defective, the proper execution. The corrected document is effective in its corrected form as of its original filing date except as to a person who relied upon the inaccurate portion of the document and was, as a result of the inaccurate portion of the document, adversely affected by the correction.

(4) This section shall not apply with respect to documents filed pursuant to part 5 or this part.

Sec. 617. The commissioner may promulgate rules which the commissioner considers necessary to carry out the purposes of, and to execute and enforce this act. The rules shall be promulgated pursuant to the administrative procedures act.

Sec. 618. Whenever any section of this act requires a health care corporation to implement any new procedure, provide any new benefit, or enter into any new contract, the commissioner shall give the health care corporation a reasonable time to comply with the requirements.

Sec. 619. (1) The attorney general may bring an action, or apply

to the circuit court for a court order, to enjoin a health care corporation from transacting business, receiving, collecting, or disbursing money, or acquiring, holding, protecting, or conveying property if that corporate activity is not authorized under this act.

(2) The attorney general may apply to the circuit court for a court order enjoining an alleged violation of this act or other equitable or extraordinary relief to enforce this act.

(3) A political subdivision of this state, an agency of this state, or any person may bring an action in the circuit court for Ingham county for declaratory and equitable relief against the commissioner or to compel the commissioner to enforce this act or rules promulgated under this act.

PART 7

Sec. 701. (1) Each health care corporation on the effective date of this act shall be subject to this act without formal reorganization under this act, and shall be considered to exist under this act. However, within 120 days following the effective date of this act, the health care corporation shall do all of the following:

(a) Amend its articles of incorporation and bylaws to conform to the requirements of this act, subject to the certification of the attorney general, as provided in subsection (2).

(b) Restructure its board of directors to conform with the requirements of this act. The restructuring shall be described, shall be in writing, and shall be subject to the certification of the attorney general, as provided in subsection (2).

(c) After complying with subdivisions (a) and (b), obtain from the commissioner a new certificate of authority.

(2) Relative to the changes required by this act, amendments to the articles and bylaws, and a written description of the board restructuring shall be submitted to the attorney general and to the commissioner. If the attorney general finds that the amendments and restructuring conform to all statutory requirements, and that they comply with this act and ensure fair and equitable representation of the subscribers of the corporation, the attorney general shall certify these findings to the commissioner. In reviewing the amendments and description of the board restructuring, the attorney general may consult with the board of directors, officers, or employees of a corporation, and with any other individual or organization.

(3) If the attorney general approves the amendments and restructuring, the attorney general shall certify his or her approval to the board.

The amendments, and restructuring as described, shall take effect 10 days after the certification. If the attorney general disapproves all or any part of the amendments or restructuring, or both, the attorney general shall return the disapproved amendments or the written description of the restructuring, or both, to the board with a written statement setting forth the reasons for the disapproval and any recommendations for change which he or she may wish to suggest.

(4) If the amendments, written description of restructuring, or both, required by this act are not submitted to the attorney general and the commissioner within 120 days after the effective date of this act, or if the amendments, written description, or both, are disapproved as provided in this section, the commissioner and the attorney general shall, and the corporation may, seek judicial remedies as provided for by law in the circuit court in this state.

(5) If a health care corporation fails to comply with this section, the commissioner may issue an order suspending the right and privilege of the corporation to sell or issue new certificates until this section has been fully complied with.

(6) The corporate existence of each health care corporation operating in this state shall be considered to be extended, and its powers in all other respects undiminished, during the 120-day implementation period prescribed in subsection (1).

Sec. 702. Rules which were promulgated under former Act No.108 or 109 of the Public Acts of 1939, shall not continue in effect under this act. Orders issued and approvals granted by the commissioner under former Act No. 108 or 109 of the Public Acts of 1939, shall continue in effect until rescinded or withdrawn by the commissioner under this act.

Sec. 703. The following acts and parts of acts are repealed:

(a) Act No. 108 of the Public Acts of 1939, as amended, being sections 550.301 to 550.316 of the Compiled Laws of 1970.

(b) Act No. 109 of the Public Acts of 1939, as amended, being sections 550.501 to 550.517 of the Compiled Laws of 1970.

Sec. 704. This act shall take effect April 3, 1981.

4088 '79 - Sub. (S-1) - CR-1

Blue Cross
Blue Shield
of Michigan

600 Lafayette East
Detroit, Michigan 48226-2998

March 5, 1986

TO: Board of Directors and Corporate Membership

FROM: Franz Topol, Corporate Secretary

SUBJECT: Bylaw Amendments

The Board of Directors on February 5, 1986 adopted amendments to the current bylaws, substituting a Gubernatorial Appointees Component for the Consumers/Appointed Component, as part of the 1980 PA 350 implementation process.

These bylaw amendments were approved by the Attorney General on March 5, 1986, under Section 302 of 1980 PA 350, and therefore are in effect as of that date.

A set of the current bylaws, as amended, is enclosed. They will be in force until the new PA 350 bylaws take effect, except where superseded by more stringent PA 350 provisions which are not identified for specific inclusion in the new bylaws.

FT/ms
Enclosures

BLUE CROSS AND BLUE SHIELD OF MICHIGAN

B Y L A W S

As adopted by the Corporate Membership on February 12, 1975; as amended by the Board of Directors on April 14, 1976; as amended by the Board of Directors on June 9, 1976 to be effective on September 1, 1976; as amended by the Board of Directors on June 9, 1976 and by the Corporate Membership on August 6, 1976 to be effective on February 1, 1977; as amended by the Board of Directors on October 30, 1980 to be effective on January 1, 1981; as amended by the Board of Directors on June 5, 1985; as amended by the Corporate Membership on July 27, 1985; and as amended by the Board of Directors on February 5, 1986 and effective on March 5, 1986.

ARTICLE I

Membership

Section 1. The membership of the Corporation shall consist of ninety-three (93) persons, a majority of whom shall represent consumers.

Section 2. The membership of the Corporation shall consist of the following component groups and respective numbers of representatives:

(a) Consumers/Groups: Twenty-eight (28) representatives of substantial group purchasers of Blue Cross and Blue Shield coverage.

(b) Consumers/Labor: Ten (10) representatives of labor unions which have substantial membership segments enrolled in Blue Cross and Blue Shield of Michigan.

(c) Consumers/At Large: Twelve (12) consumers who shall be subscribers influential in community affairs but not representative of other components of the corporate membership.

(d) Gubernatorial Appointees: Four (4) representatives of the public appointed as directors by the governor by and with the advice and consent of the senate, two (2) of whom shall be retired individuals sixty-two (62) years of age or older.

(e) Doctors of Medicine: Fourteen (14) doctors of medicine.

(f) Doctors of Osteopathy: Four (4) doctors of osteopathy.

(g) Hospitals: Eighteen (18) representatives of participating hospitals.

(h) Pharmacists: Two (2) pharmacists who shall be members of the Michigan State Pharmaceutical Association.

(i) The Chief Executive Officer of the Corporation, ex officio.

Section 3. The terms of office of the first Members of the Consolidated Corporation, designated to serve as such in accordance with the Plan of Consolidation, shall commence on the date on which the consolidation of Michigan Hospital Service and Blue Shield of

Michigan becomes legally effective and shall end with the Annual Meeting of the Members of the Corporation in 1976.

Section 4. At the Annual Meeting of the Members of the Corporation in 1976, thirty (30) Members shall be elected for one-year terms of office, thirty-one (31) for two-year terms of office and thirty-one (31) for three-year terms of office, exclusive of ex officio Members. Thereafter, all terms of office shall be for periods of three (3) years, exclusive of ex officio Members, so that at least thirty (30) Members of the Corporation shall be elected each year, except as provided in Section 7., below.

Section 5. Nominees for Members to fill terms of office expiring with an Annual Meeting shall be provided by the respective component groups of the membership, acting either as a whole or through a nominating committee and, where appropriate, after consultation with respective external designating entities, and shall be elected by the corporate membership as a whole, except as provided in Section 7., below.

Section 6. Nominees for Members to fill interim vacancies shall be provided by the respective component groups of the Board of Directors, acting either as a whole or through a nominating committee and, where appropriate, after consultation with respective external designating entities, shall be elected by the Board of Directors at any of its meetings, and shall serve

the unexpired term of office for which elected, except as provided in Section 7., below.

Section 7. Gubernatorial Appointees shall serve terms of office of two (2) years, and until respective successors are appointed and qualified. If a vacancy occurs before the conclusion of such a two-year term, the appointment of a gubernatorial appointee to complete the term shall be made in the same manner as the original appointment.

ARTICLE II

Hospital Representatives

Section 1. The State of Michigan shall be divided into six (6) districts for the purpose of designating the Members of the Corporation representing participating hospitals, as follows:

District I:	Allegan, Barry, Eaton, Ingham, Van Buren, Kalamazoo, Lenawee, Calhoun, Jackson, Berrien, Cass, St. Joseph, Hillsdale, Branch, and Clinton Counties.
District II:	Livingston, Oakland, Macomb, Washtenaw, Wayne, Monroe, and St. Clair Counties.
District III:	Manistee, Mason, Lake, Osceola, Oceana, Newaygo, Muskegon, Montcalm, Ottawa, Kent, Mecosta, and Ionia Counties.

District IV:	Clare, Gladwin, Iosco, Arenac, Isabella, Midland, Shiawassee, Genesee, Lapeer, Bay, Huron, Tuscola, Sanilac, Saginaw, and Gratiot Counties.
District V:	Emmett, Cheboygan, Presque Isle, Leelanau, Antrim, Otsego, Montmorency, Wexford, Alpena, Benzie, Grand Traverse, Kalkaska, Crawford, Oscoda, Alcona, Missaukee, Roscommon, Charlevoix, and Ogemaw Counties.
District VI:	All Counties of the Northern Peninsula.

Section 2. The participating hospitals located in the respective districts shall be entitled to designate eighteen (18) Members of the Corporation as follows:

District I:	Two (2) Members
District II:	Eight (8) Members
District III:	Two (2) Members
District IV:	Two (2) Members
District V:	Two (2) Members
District VI:	Two (2) Members

Subsequent to such designation, the participating hospitals of each district shall designate, from the above designated Corporate Members of their respective districts, nine (9) Directors of the Corporation, as follows:

District I:	One (1) Director
District II:	Four (4) Directors
District III:	One (1) Director
District IV:	One (1) Director

District V: One (1) Director

District VI: One (1) Director

ARTICLE III

Meetings of the Members

Section 1. The Annual Meeting of the Members of Blue Cross and Blue Shield of Michigan shall be held in the month of April of each year, beginning in 1976, on a day and in a place fixed by the Board of Directors.

Section 2. Special Meetings of the Members may be called at any time by the Chairman of the Board, and shall be called by him on written request of twenty-five (25) Members of the Corporation, in which request shall be stated the business to be transacted at such meeting.

Section 3. Notice of each meeting shall be sent to the Members at least ten (10) days prior to the date of each Special Meeting and at least twenty (20) days prior to the date of each Annual Meeting, in form satisfactory to the Chairman of the Board. Any Member may waive any notice required to be given by law or under these Bylaws. Attendance at any meeting, without objection to the manner in which notice of the meeting has been given, shall be deemed a waiver of notice thereof.

Section 4. Thirty-five (35) Members, present in person or represented by proxy, shall constitute a quorum at any Annual or Special Meeting of the Members. No action taken at such a meeting, except by the adoption of a resolution for adjournment, shall be valid unless passed by an affirmative vote of a majority of those present at the meeting, or of twenty-five (25) members, whichever number shall be the greater.

Section 5. The procedure at any meeting of the Members shall in the first instance be as prescribed by the chairman of the meeting, subject to appeal to and direction by the persons present.

ARTICLE IV

Board of Directors

Section 1. The business, property and affairs of this Corporation shall be managed by a Board of Directors, consisting of forty-nine (49) Corporate Members, a majority of whom shall represent consumers.

Section 2. Except as the initial Board of Directors is provided for in the Plan of Consolidation, the Board of Directors shall consist of the following component groups and respective numbers of Corporate Members:

(a) Consumers/Groups: Fourteen (14)

(b) Consumers/Labor: Five (5)

(c) Consumers/At Large: Six (6)

(d) Gubernatorial Appointees: Four (4)

(e) Doctors of Medicine: Seven (7)

(f) Doctors of Osteopathy: Two (2)

(g) Hospitals: Nine (9)

(h) Pharmacists: One (1)

(i) The Chief Executive Officer of the Corporation, ex officio.

Section 3. The terms of office of the first Board of Directors elected by the Members of the Consolidated Corporation shall commence on the date on which the consolidation of Michigan Hospital Service and Blue Shield of Michigan becomes legally effective and shall end with the Annual Meeting of the Members of the Corporation in 1976.

Section 4. At the Annual Meeting of the Members of the Corporation in 1976, fifteen (15) Directors shall be elected for one-year terms of office, fifteen (15) for two-year terms of office and sixteen (16) for three-year terms of office, exclusive of ex officio Directors. Thereafter, all terms of office shall be for periods of three (3) years, exclusive of ex officio Directors, so that at least fifteen (15) Directors shall be elected each year, except as provided in Section 7., below.

Section 5. Nominees for Directors to fill terms of office expiring with an Annual Meeting of the Members of the Corporation shall be provided by the respective component groups of the membership, acting either as a whole or through a nominating committee and, where appropriate, after consultation with respective external designating entities, and shall be elected by the corporate membership as a whole, except as provided in Section 7., below. If a Corporate Member is elected for a Director's term of office which exceeds his or her term of office as a Corporate Member, then the term of office as Director shall be only for the unexpired term as a Member.

Section 6. Nominees for Directors to fill interim vacancies shall be provided by the respective component groups of the Board of Directors, acting either as a whole or through a nominating committee and, where appropriate, after consultation with respective external designating entities, shall be elected by the Board of Directors at any of its meetings, and shall serve the unexpired term of office for which elected, but not beyond their own terms of office as Corporate Members, except as provided in Section 7., below.

Section 7. Gubernatorial Appointees shall serve terms of office of two (2) years, and until respective successors are appointed and qualified. If a vacancy occurs before the conclusion of such a two-year term, the appointment of a gubernatorial appointee to complete the term shall be made in the same manner as the original appointment.

ARTICLE V

Meetings of Board of Directors

Section 1. The Board of Directors shall, by resolution, provide for Regular Meetings of the Board which shall be held not more frequently than monthly nor less frequently than quarterly.

Section 2. Special Meetings of the Board of Directors may be called by the Chairman of the Board and shall be called by him at the request in writing of any twelve (12) of the Directors.

Section 3. The meetings of the Board of Directors shall be held at such place and at such time as shall be selected by the Chairman of the Board.

Section 4. Written notice of the time and place of each Regular and Special Meeting of the Board of Directors shall be given to each Director by mail or telegraph, directed to his last address appearing on the records of the Corporation, at least ten (10) days before the date of such meeting. Any Director may waive any notice required to be given by law or under these Bylaws. Attendance at any meeting, without objection to the manner in which notice of the meeting has been given, shall be deemed a waiver of notice thereof.

Section 5. Twenty-five (25) Directors shall constitute a quorum at any meeting of the Board of Directors. Any meeting at which less than a quorum is present may, however, be adjourned to a further date by those who attend, without further notice other than announcement at such meeting. When a quorum shall be present upon any such adjourned date, any business may be transacted which might have been transacted at the meeting as originally called.

Section 6. The procedure at any meeting of the Board of Directors shall in the first instance be as prescribed by the chairman of the meeting, subject to appeal to and direction by the persons present.

ARTICLE VI

Committees of the Board of Directors

Section 1.

The Board of Directors shall establish four Standing Committees consisting of an Executive Committee, a Finance Committee, an Audit Committee and a Nominating Committee. The composition of each Standing Committee shall be representative of the composition of the Board, as nearly as possible, and may include Corporate Members except as otherwise provided.

Section 2.

Executive Committee. The Executive Committee shall consist solely of Directors and shall include the Chairman and Vice Chairman of the

Board. The Executive Committee shall be vested with the powers of the Board of Directors when the Board is not in session, except that policies of the Board cannot be changed without prior approval or subsequent ratification by the Board.

Section 3.

Finance Committee. The Finance Committee shall consist of a majority of Directors and shall include the Chairman of the Board. The Finance Committee shall oversee all financial matters concerning the Corporation except those specifically reserved by these bylaws, or specifically delegated by the Board of Directors, to another committee.

Section 4.

Audit Committee. The Audit Committee shall consist of non-management Directors. The Audit Committee shall oversee all matters relating to independent audits of the Corporation and may direct or approve special audits at any time.

Section 5.

Nominating Committee. The Nominating Committee shall consist of a majority of Directors. The Nominating Committee shall recommend sufficient candidates to fill vacancies occurring in the corporate membership or the Board and shall nominate candidates for election as officers pursuant to Article VII of these Bylaws.

Section 6.

The Board, by resolution, may at any time, establish Special Committees which shall have such composition, authority, responsibility and duration as the Board, in its discretion, may authorize.

Section 7.

Subject to confirmation by the Board, the Chairman of the Board shall appoint those persons who shall serve as members of any Standing or Special Committee and shall designate who shall serve as officers thereof; only a Director may be designated to chair a committee. Each member of a committee shall serve for one year, more or less, but may be reappointed for successive terms. Interim vacancies on any committee shall be filled in the same manner as specified herein, except that the person appointed shall only serve the balance of the unexpired term.

Section 8.

Unless otherwise provided in Rules adopted by the Board, a majority of the members of a committee shall constitute a quorum for the transaction of business at any meeting thereof. The action of a majority of those present, if a quorum is present, shall constitute the action of the committee. Except as otherwise provided in these Bylaws, or by resolution of the Board, no action by a committee shall be deemed the action of the Corporation unless adopted by the Board. Each committee will keep regular minutes of its proceedings and report the same at the next meeting of the Board; all directors shall receive copies.

Section 9.

Any committee or component of a joint committee established pursuant to a contract or other instrument adopted by the Board shall be considered a Special Committee and shall be subject to all of the provisions of these Bylaws, except as otherwise specifically provided in the instrument.

Section 10.

With the approval of the Chairman of the Board, a committee may establish one or more subcommittees which shall have such composition, authority, responsibility and duration as the Chairman of the Board and the committee may authorize. Except as approved by the Board, no subcommittee shall have or exercise any powers greater than those of the committee by which it is established.

ARTICLE VII

Officers

Section 1. The Board of Directors shall select a Chief Executive Officer who shall be a Director and also serve as Chairman of the Board. He shall be a salaried employee of the Corporation under such terms as shall be fixed by the Board. The Board of Directors shall further elect a Vice Chairman who shall be a Director; a President; a Secretary; a Treasurer; and such other officers as it may deem necessary. All officers elected by the Board of Directors, unless Directors, shall be salaried employees

of the Corporation. Each officer shall have such authority and perform such duties as may be prescribed by the Board of Directors, and may be removed by the Board of Directors whenever, in its judgment, the interests of the Corporation will be served thereby. The Board of Directors may secure the fidelity of any officer by bond or otherwise.

Section 2. The Chairman of the Board shall preside at all meetings of the Members of the Corporation and the Board of Directors. In his capacity as the Chief Executive Officer of the Corporation, he shall, subject to the Board, have general and active management of the business and affairs of the Corporation as necessary. He shall see that all orders and resolutions of the Board of Directors are carried into effect. He shall have the general powers usually vested in the Chief Executive Officer of a corporation. He shall also perform such other duties as may be required by law or as may be delegated to him by the Board of Directors or are provided elsewhere in these bylaws.

Section 3. The Vice Chairman shall, in the absence of the Chairman, preside at meetings of the Members of the Corporation and the Board of Directors and perform all of the other Board duties of the office of Chairman of the Board.

Section 4. The President and any other officers of the Corporation shall be salaried employees, subject to assignment of duties and responsibilities by the Chairman of the Board and Chief Executive Officer.

Section 5. The Secretary shall, in general, perform all duties usually incident to that office, and such other duties as may be assigned to him by the Board of Directors or Chairman; shall be responsible for the recording of the minutes of meetings of the Members of the Corporation and of the Board of Directors; shall have the custody of the corporate seal; and shall affix the same to any instrument requiring the seal.

Section 6. The Treasurer shall supervise the care and custody of the funds and securities of the Corporation. He shall direct the deposits of corporate funds in depositories as authorized by the Board of Directors, and shall cause to be made an annual report of the finances of the Corporation and such other financial reports as may from time to time be required by the Board of Directors. He shall perform such other duties as directed by the Board of Directors or Chairman.

Section 7. Assistant Secretaries and Assistant Treasurers, if any, shall perform such duties as the Board of Directors, the Chairman, or the Secretary or Treasurer, respectively, shall from time to time direct.

Section 8. The Board of Directors may in any instance designate the officers and agents who shall have authority to execute any checks, drafts, demands for money, notes, contracts, conveyance or other instrument on behalf of the Corporation, or may ratify or confirm any execution. When the execution of any instrument has

been authorized without specification of the executing officers or agents, the Chairman of the Board, the President, or a Vice President, and the Secretary or an Assistant Secretary, or Treasurer or an Assistant Treasurer, may execute the same in the name and on behalf of the Corporation and may have the corporate seal affixed thereto.

ARTICLE VIII.

Indemnification

Section 1. The Corporation shall indemnify any and all of its Corporate Members, Directors, and Officers, including all classifications of Vice Presidents, and thei Heirs, Executors, and Administrators against expenses actually and necessarily incurred by them in connection with the defense of any action, suit, or proceeding in which they or any of them are made parties or a party by reason of being or having been a Corporate Member, Director, or Officer, including a Vice President of any classification, or by reason of any action of commission or omission, vote, decision, statement or writing which they or any of them in good faith do or make in the course of the discharge of their duties to the Corporation, reasonably believing that their conduct, act, vote, decision, statement, or writing is lawful and in the best interest of the Corporation.

Section 2. The Corporation, acting by its Board of Directors, shall have the power to indemnify any and all of its Employees not

entitled to indemnification by Section 1, above, and their Heirs, Executors, and Administrators against expenses actually and necessarily incurred by them in connection with the defense of any action, suit, or proceeding in which they or any of them are made parties or a party by reason of being or having been an Employee or by reason of any action of commission or omission, vote, decision, statement or writing which they or any of them in good faith do or make in the course of the discharge of their duties to the Corporation, reasonably believing that their conduct, act, vote, decision, statement, or writing is lawful and in the best interest of the Corporation.

Section 3. The Corporation, acting by its Board of Directors, shall have power to purchase and maintain insurance on behalf of any of the persons above mentioned in this Article VIII, against the liability above described or otherwise.

Section 4. The rights of indemnification under this Article VIII shall inure to the benefit of individuals covered thereby for any action, suit, or proceeding maintained against them because of their past association with Blue Shield of Michigan or Michigan Hospital Service prior to the consolidation of those two corporations into this Corporation.

Section 5. The Corporation may employ competent counsel to defend any individual entitled to indemnification hereunder in any action, suit, or proceeding and defray all fees, costs, awards, and

judgments as may follow with respect to such proceedings or litigation, provided, however, that the Corporation shall not exonerate any such individual from any liability, costs or expenses which he or she shall have incurred or may incur by settlement between parties, unless the Corporation shall agree to such settlement in advance.

ARTICLE IX

Amendments

The Board of Directors may amend, alter or repeal these Bylaws, except for Articles I, II, IV, and IX, at any of its meetings. Any change by the Board of Directors shall require a minimum affirmative vote of twenty-five (25) Directors or a two-thirds (2/3) majority of the Directors in attendance, whichever is greater. The corporate membership may amend, alter or repeal any portion of these Bylaws at any of its meetings by an affirmative vote of the majority of the total membership.

DEC 2 8 1978

BLUE CROSS AND BLUE SHIELD OF MICHIGAN
RESTATED ARTICLES OF INCORPORATION

We, the undersigned, Chairman of the Board, President and Secretary of Blue Cross and Blue Shield of Michigan, the Consolidated corporation under a Plan for Consolidation filed pursuant to Acts Nos. 331 and 332, Michigan Public Acts of 1974, for the consolidation of Michigan Hospital Service, a corporation under the provisions of Act 109 of Public Acts of Michigan 1939, incorporated December 8, 1938 as Michigan Society for Group Hospitalization, and Blue Shield of Michigan, a corporation under the provisions of Act 108 of the Public Acts of Michigan of 1939, incorporated December 15, 1939, as Michigan Medical Service, the corporate existence of which corporations continues in Blue Cross and Blue Shield of Michigan, do hereby certify that at the first meeting of the members of said corporation, held at Detroit, Michigan on the twelfth day of February, 1975, the following restated Articles were duly adopted by the members:

ARTICLE I

The name of the corporation is "Blue Cross and Blue Shield of Michigan".

ARTICLE II

The purposes of the corporation are as follows:

To carry out the objects of the Plan of Consolidation filed in accordance with Acts Nos. 331 and 332, Public Acts of Michigan 1974;

To exercise all of the powers of a medical care corporation organized under Act No. 108 of the Public Acts of Michigan of 1939 as now or hereafter amended, and of a hospital service corporation organized under the provisions of Act No. 109 of the Public Acts of Michigan of 1939 as now or hereafter amended;

To have and exercise all the rights, powers, privileges, immunities and franchises, public and private, of the consolidating corporations under said Act No. 108, Public Acts of Michigan of 1939, as amended, and said Act No. 109 of the Public Acts of Michigan of 1939, as amended, and in general, to do all acts and things, and to carry on all businesses in connection and incident thereto, not violative of the laws of the State of Michigan.

ARTICLE III

The location of the principal office of the corporation shall be

600 East Lafayette
Detroit, Michigan 48226

or such other place as the Board of Directors may from time to time determine.

ARTICLE IV

The present members of the corporation shall be persons named in accordance with the provisions of the Plan of Consolidation aforesaid. Successor members shall be chosen in accordance with the provisions of the Bylaws of the corporation. Thirty-Five (35) Members, present in person or represented by proxy, shall constitute a quorum at any meeting of the Members.

ARTICLE V

The present Board of Directors of the corporation shall be persons named in accordance with the provisions of the Plan of Consolidation aforesaid. Successor directors shall be chosen in accordance with the provisions of the Bylaws of the corporation.

ARTICLE VI

The term of existence of the corporation shall be in perpetuity.

ARTICLE VII

The Board of Directors may adopt, alter or amend the Bylaws of the corporation, as provided therein.

ARTICLE VIII

These Articles may be amended at any meeting of the members in the manner provided by Section 4 of Act 108, Public Act of Michigan of 1939, as amended, and Section 5 of Act 109, Public Acts of Michigan of 1939, as amended, aforesaid.

ARTICLE IX

The annual meeting of the members of the corporation shall be held at such time and place as the Board of Directors may from time to time determine, or as the Bylaws may provide.

ARTICLE X

The corporation may, by Bylaw, limit the liability of directors and members and provide for their indemnification.

IN WITNESS WHEREOF, we hereunto sign our names this 12 day of February, 1975.

Chairman of the Board

President

Secretary