GROUP # 115300-1

GROUP HEALTH PLAN AGREEMENT

HAWAII MEDICAL SERVICE ASSOCIATION
AND
GENESYS TELECOMMUNICATIONS LABORATORIES INC

Payment of dues to HMSA under this Agreement constitutes Client's full acceptance of this Agreement effective February 1, 2021 and terminates all prior group health plan agreements between Client and HMSA, except for agreements governing Medicare Advantage or Medicare Part D Plans.

HAWAII MEDICAL SERVICE ASSOCIATION

GROUP HEALTH PLAN AGREEMENT

This Group Health Plan Agreement ("**Agreement**") is effective as of February 1, 2021, by and between **GENESYS TELECOMMUNICATIONS LABORATORIES INC** ("**Client**") and Hawaii Medical Service Association ("**HMSA**"), a Hawaii mutual benefit society.

ARTICLE 1. DEFINITIONS

1.1 **ACA.** The Patient Protection and Affordable Care Act, as amended by the Health and Education Reconciliation Act of 2010, and its regulations, as amended.

1.2 **Benefit Documents.** The documents issued by HMSA or an HMSA affiliate that describe the Plan benefits available to Members enrolled in the Plan. Those documents, listed in the attached **Exhibit A** and provided by HMSA, are incorporated into this Agreement.

1.3 **COBRA.** The Consolidated Omnibus Budget Reconciliation Act of 1985, and its implementing regulations, as amended.

1.4 **Eligible Individual.** An individual who is eligible for coverage under Group Plan. If Client is a private employer group, this means a regular and direct employee of Client who meets the following minimum requirements as provided under Hawaii's Prepaid Health Care Act: (i) works at least 20 hours a week; (ii) is compensated at least the minimum wage required by law; and (iii) lives, works or resides in Hawaii. If Client is a union or trust fund managing benefits under a multiemployer plan, this means union members eligible for coverage under Client's Group Plan.

1.5 **Eligible Dependent.** A dependent eligible for benefits under the Group Plan as described in the Plan Documents.

1.6 **ERISA.** The Employee Retirement Income Security Act of 1974, and its implementing regulations, as amended.

1.7 **Group Plan.** Client's welfare benefit plan, either a group health and/or dental plan as established under ERISA as set forth in Section 4.1(a).

1.8 **HIPAA.** The Health Insurance Portability and Accountability Act of 1996, and its implementing regulations, as amended.

1.9 **HITECH.** The Health Information Technology for Economic and Clinical Health Act of 2009 and its implementing regulations, as amended.

1.10 **Members.** Subscribers and their Eligible Dependents enrolled in the Plan.

1.11 **Named Fiduciary.** Under ERISA, the fiduciary or fiduciaries named in the Plan Documents who are responsible for controlling and managing the operation and administration of the Group Plan.

1.12 **Plan.** The medical, drug, vision, dental or other benefit plans that HMSA insures for Client, in accordance with the Benefit Documents and this Agreement.

1.13 **Plan Administrator.** The Plan Administrator as defined under ERISA is Client for purposes of the benefits provided under and through the Group Plan, and/or such other person or entity named in the Plan Documents for the Group Plan. HMSA shall not be considered the Plan Administrator.

1.14 **Plan Documents.** The various documents required under ERISA under which the Plan Sponsor and Plan Administrator operate and manage the Group Plan, including but not limited to the Summary Plan Description, Form 5500 and Summary of Material Modifications.

1.15 **Plan Sponsor.** Client is Plan Sponsor as provided under ERISA.

1.16 **Protected Health Information.** Protected Health Information or "**PHI**" shall have the meaning given such term in HIPAA, but shall also include any other individually identifiable information about HMSA or Plan Sponsor's members, insureds or Eligible Individual.

1.17 **Subscribers.** Client's Eligible Individuals enrolled in the Plan.

ARTICLE 2. OBLIGATIONS OF HMSA

2.1 **Provision of Benefits.** HMSA shall provide or arrange for Plan benefits for Members enrolled in the Plan in accordance with the terms and conditions set forth in this Agreement, including the Benefit Documents, and any applicable laws.

2.2 **Plan Information.** HMSA shall prepare and provide Benefit Documents, as outlined in Exhibit A, to Client in electronic format.

2.3 **Benefit Administration.** HMSA shall pay benefits during each month of the term of this Agreement in accordance with the terms and conditions of the Plan except when a provider has made arrangements with HMSA to: (a) accept a negotiated payment from HMSA as payment in full instead of collecting the copayment described in the Benefit Document (such instances are primarily limited to anesthesiology, laboratory, and imaging services when provided by certain providers and may be changed by HMSA from time to time); and (b) accept a capitated or bundled payment under a managed care model.

2.4 **Reports.**

a. **Rate Renewal Proposal.** HMSA agrees to provide Client with a rate renewal proposal 30 days prior to the beginning of each one year term under this Agreement. The rate renewal(s) shall be incorporated as part of this Agreement.

b. **Confidentiality.** The information contained in the reports listed in this Section 2.4 shall be considered as HMSA's proprietary and non-public information ("**Confidential Information**"). Client agrees that Confidential Information will not be disclosed to any third party outside Client and its consultants, unless required by law. Further, any and all

Confidential Information shall only be used to administer the Plan and not be used to compete with HMSA.

c. **Additional Reports.** HMSA may provide such other reports as requested by Client, which can be reasonably accommodated by HMSA, and Client shall reimburse HMSA for expenses incurred in producing the same.

d. **Schedule A.** For clients with more than 100 Members, HMSA agrees to provide Client with the necessary information for Client to complete the Schedule A with respect to the Group Plan as contemplated by the annual reporting requirements (Form 5500) under ERISA.

ARTICLE 3. OBLIGATIONS OF CLIENT

3.1 **Client as Plan Administrator.** Client, for itself and as Plan Administrator (as defined under ERISA) for the Group Plan and Subscribers, shall enroll only Eligible Individuals and their Eligible Dependents as Members, unless otherwise specifically approved by HMSA in writing or required by federal or State of Hawaii statute. Client shall act as Plan Administrator for its Group Plan in accepting notices from HMSA concerning any aspect of the Group Plan.

3.2 **Distribution of Benefit Descriptions.** Client shall be solely responsible for distributing to Members and newly Eligible Individuals any descriptions of benefits, including the Benefit Documents and Summary of Benefits and Coverage (SBC), as required by federal law. Client shall keep these documents easily accessible to Subscribers. Client, as Plan Administrator under ERISA, retains full responsibility for ensuring that such benefit descriptions, including but not limited to, the Benefit Documents, Plan Documents, SBCs, and any other documentation related to the Group Plan are distributed to Members within the timeframes and in the manner required by law. Client shall indemnify and hold HMSA harmless from any losses, penalties, or liabilities arising out of any noncompliance with this Section.

3.3 **Underwriting Policies.**

a. **Eligibility of Group.**

1. Client represents and warrants that it: (a) is an *employing* unit with at least one Eligible Individual in its employment; and (b) engages in business in Hawaii and employs employees who live, work, or reside in Hawaii. HMSA may give special consideration to Eligible Individuals who work and reside out-of-state, but such out-of-state Eligible Individuals shall not be included as Subscribers in the Plan except with advance written consent of HMSA.

2. Client represents and warrants that it meets all state and federal requirements, including but not limited to:
   - Having a General Excise Tax License and Department of Labor Number.
   - Having Unemployment and Temporary Disability Insurance for each Eligible Individual, except that a group employing immediate family members (spouse, children or parents) need not provide Unemployment or Temporary Disability Insurance for immediate family members.

- Having Worker's Compensation Insurance for each employee, if applicable.
- Deducting FICA taxes from employees, if applicable.
- Having W-2 and W-4 Forms on file with the Department of Labor, if applicable.

3. At HMSA's request, Client agrees to provide the following:
   - Evidence that Client is complying with Section 3.3.a.2.
   - Current Federal Employer Identification Number.
   - Department of Labor Unemployment Insurance Account Number.
   - A detailed description and evidence of the nature of its business.

b. **Enrollment of Members**.

1. Client shall be solely responsible for determining eligibility of potential Members and enrolling them in the Plan. Client represents and warrants that only Eligible Individuals and their Eligible Dependents will be enrolled in the Plan. Client agrees that it will enroll Eligible Dependents consistent with the guidelines set forth in the Benefit Documents.

2. On a regular basis, Client shall provide HMSA or a vendor or designee of HMSA with enrollment information in a format acceptable to HMSA. Client must ensure the accuracy of the enrollment information it or its agent provides to HMSA and will be responsible for paying any costs associated with correcting enrollment errors.

   In the event that Client identifies an error in or changes necessary to the enrollment information that it submits to HMSA (including incorrect enrollment information that may necessitate a retroactive billing adjustment by HMSA), Client shall immediately (within thirty (30) calendar days) notify HMSA in writing of the error and/or change in order to facilitate any corrective action by HMSA. HMSA reserves the right, in its sole discretion, to make any retroactive billing adjustment applicable to Client. Retroactive enrollment changes shall be included in regular enrollment information that Client provides to HMSA in a format acceptable to HMSA.

3. Client represents that any eligibility conditions or waiting periods it imposes on potential Members are in accord with the requirements of applicable state and federal law, including the prohibition against waiting periods in excess of 90 days under Public Health Service Act Section 2708. Specifically, Client represents that it does not impose any waiting periods greater than 90 days, nor any other eligibility conditions that would violate Public Health Service Act section 2708 or the regulations issued thereunder (as may be amended from time to time). Client will notify HMSA immediately of any changes to such representation.

c. **Termination of Members**

1. **Prospective Terminations**. Client must submit to HMSA a membership report form, electronic report in a format acceptable to HMSA, or other written termination request containing the names of Members whose coverage is to be terminated on the first day of the following month. The membership report form, electronic report, or other written termination request must be received by HMSA before the close of HMSA's business hours on the last business day before the beginning of the month that the terminations are to take effect.

   Termination requests for effective dates other than the first of the month must be in writing and received by HMSA before the close of HMSA's business hours one business day before the intended effective date. Termination requests received after the close of business shall be deemed received on the next business day. The termination will be effective on the first business day after the day that HMSA receives the written request. Client must give written notice to Members whose coverage under the Group Plan is to be terminated under this subsection at least ten (10) days prior to the effective date of termination.

2. **Retroactive Terminations by Client.** Client cannot retroactively terminate a Member unless (a) the termination is due to Member's separation from Client; (b) the Member is notified on or before the separation that his or her membership in the Plan ended at the time of separation; (c) Client retains records sufficient to document the notification of the Member; and (d) HMSA receives notice of the termination within sixty (60) days of the Member's separation from Client. If the Member incurred claims after their termination date and before retroactively terminated, those claims will be included in Client's utilization for future rating purposes.

d. **Other Group Coverage.** HMSA reserves the right to non-renew this Agreement if it is determined that, as to the Client's Eligible Individuals enrolled in Free Choice type plans (such as Preferred Provider Organizations and comprehensive Medical plans), that less than 100% of Client's employees are enrolled in HMSA's Free Choice Plan. HMSA also reserves the right to recalculate the Client's dues if during a contract term it is determined that of the employees enrolled in a Free Choice Plan, less than 100% of Client's employees are enrolled in HMSA's Free Choice Plan.

e. **Non-Compliance**. HMSA, at its discretion, reserves the right to audit Client for compliance with the above Underwriting Policies. This includes proof of employment and/or union membership, where applicable, and dependent relationships. Non-compliance with these requirements will result in cancellation of the Agreement. In the event it is determined that Client intentionally misrepresented or omitted a material fact that constitutes fraud, HMSA reserves the right to terminate this Agreement, effective as of the first day of the fraudulent act or intentional misrepresentation. Client also agrees to reimburse HMSA for any benefits paid for any Client or individual membership granted by reason of such misrepresentation or omission. If the Agreement is canceled for reason of non-compliance with HMSA's Underwriting

Policies, HMSA may re-enroll the Client under a new Agreement upon Client providing evidence satisfactory to HMSA of compliance.

3.4 **Payment.**

a. **Consideration**. Client shall pay to HMSA as consideration for HMSA's provision of the Plan and such other services specified in this Agreement all amounts specified herein. Payment shall be made on a monthly basis and no later than the first business day of the month for which benefits will be provided.

b. **Monthly Dues.** The monthly dues payable by Client shall be calculated by multiplying the rates listed in **Exhibit B** ("**Summary of Rates**"), attached hereto and incorporated herein, by the number of Subscribers enrolled in each category shown as of the first day of the month for which the dues are being prepaid. If payment of dues is not received by HMSA by the due date, the amount due shall accrue interest at the United States prime rate published in the Wall Street Journal that is in effect on the date that payments became delinquent, plus two percent (2%) per annum, calculated on a daily basis, commencing with the first day of such delinquency. If the prime rate changes and payments are still delinquent, interest will continue to accrue on the outstanding balance but based upon the new prime rate.

c. **Return of Dues.** Dues that HMSA receives from Client for Members will not be returned to Client by refund, credit against future payments of dues, or otherwise, except in the following instances: (i) prospective termination of a Member for which Client has already paid dues; or (ii) retroactive termination of Member as a result of separation from Client.

d. **Renewals**. HMSA will provide Client with an updated Summary of Rates and Benefit Documents for the new plan year(s), which are incorporated by reference into this Agreement.

3.5 **Acknowledgements.** Client acknowledges and agrees that this Agreement constitutes a contract solely between HMSA and Client, for itself and as Plan Administrator for the Group Plan and Subscribers. Further, Client acknowledges and agrees that HMSA is an independent entity operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans; that the Blue Cross and Blue Shield Association permits HMSA to use the Blue Cross and Blue Shield Service Marks in the State of Hawaii; and that HMSA is not contracting as the agent of the Blue Cross and Blue Shield Association. Client further agrees that it has not entered into this Agreement based upon representations by any person other than HMSA, and that no person, entity, or organization other than HMSA shall be held accountable or liable to Client for any of HMSA's obligations to Client created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of HMSA other than those obligations created under other provisions of this Agreement.

ARTICLE 4. FEDERAL AND STATE LAWS

4.1 **ERISA.**

a. The Group Plan constitutes an ERISA covered plan, or employer-provided employee welfare benefit plan governed by ERISA. Except as otherwise provided in subsection 4.1(b) below, the Client shall be the Plan Administrator, Named Fiduciary and Plan Sponsor for purposes of ERISA, and shall be solely responsible for compliance with all ERISA requirements applicable to the Group Plan, including but not limited to provision of Summary Plan Descriptions, summary of material modifications, and other communication and reporting requirements to Members and the U.S. Department of Labor or the Internal Revenue Service.

b. Client designates HMSA to be a fiduciary under the Group Plan solely for the purposes of: (i) determining the amount and type of benefits payable to any Members in accord with the Plan and (ii) interpreting the Plan provisions including those necessary to determine benefits. HMSA's determinations and interpretations, and its decisions on these matters are subject to *de novo* review by an impartial reviewer as provided in the Plan or as allowed by law.

4.2 **Prepaid Health Care Act.** This Plan is established by Client as a prepaid health care plan pursuant to the Hawaii Prepaid Health Care Act, Haw. Rev. Stat. Chapter 393. Client shall be solely responsible for compliance with all requirements of the Hawaii Prepaid Health Care Act, not expressly imposed by that Act on the health plan contractor (HMSA).

4.3 **Affordable Care Act.** Client shall be responsible for ensuring the Plan's compliance with any and all provisions of the ACA applicable to Client and the Plan.

a. **Medical Loss Ratio.** The Parties acknowledge and agree that pursuant to federal law and regulations, HMSA must provide a rebate to each "enrollee", as that term is defined under federal law, if HMSA's medical loss ratio ("**MLR**") does not exceed the minimum percentages required by the law. The Parties further acknowledge and agree that federal law allows HMSA to distribute any MLR rebate owed to Client, as the policyholder. Client represents and warrants that it shall use the proportion of any MLR Rebate attributable to Subscribers' contribution to premium for the benefit of Subscribers either through a cash refund or premium credit in accordance with the procedures set forth in the law and regulations. HMSA shall rely on Client's representation and warranty in distributing to Client any MLR rebate due. This Section shall survive the expiration or termination of this Agreement.

b. **Eligible Individual Count.** The Parties acknowledge that HMSA relies on information from Client to categorize Client as a small or large group for ACA purposes, including but not limited to MLR, risk corridor, and risk adjustment. By entering into this Agreement, Client represents that it has accurately disclosed to HMSA (i) the number of any non-Member Eligible Individuals who work at least twenty (20) hours per week for four (4) consecutive weeks, regardless of whether they live or work in Hawaii, and (ii) the number of full-time equivalents as described in 26 U.S.C. §4980H(c)(2) for the remaining non-Member Eligible Individuals not covered by (i) immediately above, if any.

c. **Grandfathered Status.** Client must attest in writing to HMSA that its plan qualifies for grandfathered status no later than 90 days prior to the beginning of each one year term under this Agreement. Failure to provide such attestation may result in the loss of grandfathered status for the plan and the addition of health care reform requirements under the ACA which may cause an increase to Client's premiums. If Client has elected to maintain (a) grandfathered plan(s) under ACA, Client shall: (i) ensure that the proper disclosures are made to Members that it believes the plan is a grandfathered plan within the meaning of section 1251 of ACA, along with the required contact information; (ii) maintain records documenting the terms of the plan in connection with the coverage in effect on March 23, 2010, and any other documents necessary to verify, explain or clarify its status as a grandfathered health plan; and (iii) not decrease its contribution rate towards the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percentage points below the contribution rate on March 23, 2010 for the Plan, and if Client does, notify HMSA at least 60 days in advance of the effective date of such change.

d. **Primary Care Provider and Obstetrical/Gynecological Services.** If Client has not elected to maintain (a) grandfathered plan(s) under ACA and offers an HMO Plan to its Members, Client agrees that it has the sole responsibility to: (i) ensure that the proper disclosures are made to HMO Plan Members of their rights to designate their Primary Care Provider (or Personal Care Physician); and (ii) ensure that the proper disclosures are made to HMO Plan Members of their rights to obtain obstetrical or gynecological services within their health center without a referral.

4.4 **Medicare Secondary Payer.** To enable HMSA's and Client's compliance with Medicare Secondary Payer laws, Client will furnish HMSA, in a manner set forth by HMSA, with information HMSA determines is sufficient to establish the appropriate primary payer for Medicare claims, both at HMSA's request and otherwise reasonably required to enable the parties' compliance with law.

4.5 **HIPAA.** Client acknowledges that under a fully-insured group health plan, HMSA is the covered entity and is responsible for complying with all applicable requirements for the protection of its members' PHI, including having adequate date security safeguards in place. Consequently, Client acknowledges that HMSA cannot disclose certain details of its security controls or allow access to or audit of its data systems.

On occasion, HMSA may provide Client, in its roles as Plan Sponsor and Plan Administrator, access to PHI necessary to perform Client's plan administration functions. Client certifies to HMSA and agrees to do the following to the extent required by HIPAA:

a. **Privacy and Security of PHI.** Client will develop, implement, maintain, and use appropriate administrative, technical, and physical safeguards to protect the privacy of all PHI received, developed or maintained under this Agreement. The safeguards must reasonably protect said PHI from any intentional or unintentional use or disclosure in violation of the HIPAA.

b. **Amendments to Plan Documents.** Client agrees that it will not request access to any PHI that may be disclosed under this Agreement without first having adopted the amendments to the Plan Documents as required by 45 C.F.R. §§ 164.314(b) and 164.504(f)(1)(i) and (f)(2). Client further confirms, on its own behalf and on behalf of the Plan, that all applicable HIPAA provisions have been met.

4.6 **Non-Compliance with Laws.** Client agrees and acknowledges that if it fails to meet any of its obligations under Article 4, Client shall make no claims against, and shall indemnify and hold HMSA harmless from any losses, liabilities, penalties, costs, excise taxes or fees incurred by it that result from Client's failure to perform as provided in Article 4.

ARTICLE 5. COBRA AND USERRA SERVICES

5.1 **Client Responsibilities.** Client shall be solely responsible for meeting all requirements of COBRA and the Uniformed Services Employment and Reemployment Rights Act of 1994 ("**USERRA**") that are applicable to Client and the Group Plan. Client also shall be responsible for promptly notifying HMSA of Members who elect to continue HMSA coverage under COBRA or USERRA provisions and of when their eligibility ends.

5.2 **HMSA Services.** HMSA shall provide, at no additional cost to Client, the services specified below to assist Client in meeting its responsibilities with respect to providing the continuation of health care coverage under the Group Plan as required by COBRA. HMSA's responsibilities relating to providing continuation of coverage under the Plan for Members pursuant to this section shall be limited to the following:

a. Billing and collecting dues including any applicable service charges, directly from Members, if requested by Client;

b. Maintaining and reconciling Member accounts;

c. Answering inquiries from Members who continue plan coverage under COBRA or USERRA provisions;

d. Preparing reports for Client on COBRA and USERRA cases; and

e. Terminating coverage upon the earlier of (i) failure to make timely payment (if HMSA handles collecting dues), (ii) the end of the maximum coverage period, or (iii) upon such later date of termination of the COBRA period as determined by Client.

ARTICLE 6. QMCSO SERVICES

6.1 **Client Responsibilities.** Client shall be solely responsible for meeting all Medical Child Support Orders ("**MCSO**") requirements applicable to Client, including but not limited to all notification responsibilities with respect to MCSOs, the establishment and application of written procedures for determining whether such MCSOs are "qualified", and for the administration of benefits under such orders, including notification to Members and Alternate Recipients (as defined by ERISA) of MCSOs. Client shall also be responsible for promptly notifying HMSA of the receipt of an MCSO relating to the Plan, Client's determination as to whether such MCSO is

"qualified", the name and address of Alternate Recipients whom Client has determined are eligible to receive benefits under the Plan and the name and address of any custodial parent or court-appointed guardian designated to receive benefits on behalf of such Alternate Recipient.

6.2 **HMSA Services.** HMSA shall provide, at no additional cost to Client, the services specified below to help Client meet its responsibilities with respect to the receipt of MCSOs. HMSA's responsibilities shall be limited to the following:

a. Mailing benefit checks to the Alternate Recipient or designated custodial parent or court appointed guardian when required under the terms of the Plan and the MCSO.

b. Answering inquiries from Alternate Recipients or designated court-appointed guardians who receive benefits under the Plan.

c. Providing sample administrative procedures for Client for determining whether an MCSO is qualified.

d. Providing benefits in accordance with the applicable requirements of any Qualified Medical Child Support Orders ("**QMCSO**") as required by ERISA.

ARTICLE 7. BLUECARD PROGRAM

7.1 **Out-of-Area Services**

a. **Overview**

HMSA has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever Members access healthcare services outside of Hawaii, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below. Typically, when accessing care outside the geographic area HMSA serves, Members obtain care from healthcare providers that have a contractual agreement ("Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from healthcare providers in the Host Blue geographic area that do not have a contractual agreement ("Nonparticipating Providers") with the Host Blue. HMSA remains responsible for fulfilling our contractual obligations to Client. HMSA's payment practices in both instances are described below.

b. **Inter-Plan Arrangements Eligibility – Claim Types.**

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits except when paid as medical benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by HMSA to provide specific services.

c. **BlueCard® Program**

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access covered healthcare services outside the geographic area HMSA serves, the Host Blue will be responsible for contracting and handling all interactions with its participating healthcare providers. The financial terms of the BlueCard® Program are described generally below.

Liability Calculation Method Per Claim

Unless subject to a fixed dollar copayment, the calculation of the Member liability on claims for covered healthcare services will be based on the lower of the participating provider's billed covered charges or the negotiated price made available to HMSA by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to HMSA by the Host Blue may be represented by one of the following:

i. An actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or

ii. An estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

iii. An average price. An average price is a percentage of billed covered charges in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e. prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to providers or refunds received or anticipated to be received from providers). However, the BlueCard® Program requires that the amount paid by the member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by HMSA in determining Client's premiums.

d. **Special Cases: Value-Based Programs**

BlueCard® Program - HMSA has included a factor for bulk distributions from Host Blues in Client's premium for Value-Based Programs when applicable under this Agreement.

e. **Return of Overpayments**

Recoveries from a Host Blue or its participating and nonparticipating providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recovery amounts determined in the ways noted above will be applied, in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to HMSA, they will be credited to Client's account. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be charged to HMSA as a percentage of the recovery.

f. **Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees**

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If applicable, HMSA will include any such surcharge, tax or other fee in determining Client's premium.

g. **Nonparticipating Providers Outside HMSA's Service Area**

1. Member Liability Calculation

When covered healthcare services are provided outside of HMSA's service area by nonparticipating providers, the amount(s) a member pays for such services will generally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, the member may be responsible for the difference between the amount that the nonparticipating provider bills and the payment HMSA will make for the covered services as set forth in this paragraph. Payments for out-of-network emergency services are governed by applicable federal and state law.

2. Exceptions

In some exception cases, HMSA may pay claims from nonparticipating healthcare providers outside of HMSA's service area based on the provider's billed charge. This may occur in situations where a member did not have reasonable access to a participating provider, as determined by HMSA in HMSA's sole and absolute discretion or by applicable state law. In other exception cases, HMSA may pay such claims based on the payment HMSA

would make if HMSA were paying a nonparticipating provider inside of HMSA's service area as described elsewhere in this agreement. This may occur where the Host Blue's corresponding payment would be more than HMSA's in-service area nonparticipating provider payment. HMSA may choose to negotiate a payment with such a provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the member may be responsible for the difference between the amount that the nonparticipating healthcare provider bills and payment HMSA will make for the covered services as set forth in this paragraph.

h. **Blue Cross Blue Shield Global Core**

- **General Information**
  If members are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing covered healthcare services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when members receive care from providers outside the BlueCard service area, the members will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

- **Inpatient Services**
  In most cases, if members contact the Service Center for assistance, hospitals will not require members to pay for covered inpatient services, except for their cost-share amounts, deductibles, coinsurance, etc. In such cases, the hospital will submit member claims to Service Center to initiate claims processing. However, if the member paid in full at the time of service, the member must submit a claim to obtain reimbursement for covered healthcare services.

- **Outpatient Services**
  Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for covered healthcare services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**
  When members pay for covered healthcare services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, members should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the Service Center address on the form to initiate claims processing. The claim form is available from HMSA, the Service Center or online at www.bcbsglobalcore.com. If members need assistance with their claim submissions, they should call the Service Center at

1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

ARTICLE 8. TERM AND TERMINATION

8.1 **Term.** This Agreement shall be for a five (5) month term beginning February 1, 2021 and automatically renew for successive one (1) year periods unless terminated earlier in accord with this Article.

8.2 **Termination by Client.** Client may terminate this agreement with or without cause upon thirty (30) calendar days advance written notice to HMSA.

8.3 **Termination by HMSA.**

a. Unless prohibited by state or federal law, HMSA reserves the right not to renew this Agreement at the end of the then-current term upon sixty (60) calendar days advance written notice to Client.

b. In the event the Client fails to pay monthly dues by their due dates, HMSA may terminate this Agreement for failure to pay dues, to be effective as of the first date for which dues were not received, unless all dues are brought current within ten (10) days of HMSA's providing written notice of default to Client in writing. Client shall have the right to reinstate the Agreement upon Client's payment of: (1) all dues in arrears calculated from the first date for which dues were unpaid until the date of reinstatement; (2) any penalties that may have been incurred pursuant to the late payment provisions of Section 3.4 of the Agreement; and (3) a reinstatement fee in the amount of either One Thousand dollars ($1,000) or two percent (2%) of the monthly dues in arrears as of the date the Agreement terminates, whichever is greater. Health plan coverage shall be reinstated under the Agreement, retroactive to the date of termination, and shall continue from the date of reinstatement at the then current rate of dues. Client's right to reinstate shall survive termination of the Agreement, but shall expire if not exercised within thirty (30) days of the effective date of termination of the Agreement.

c. HMSA may prospectively or retroactively terminate Client to the extent HMSA determines that, in its sole discretion, Client committed fraud or made an intentional misrepresentation in its dealings with HMSA.

d. HMSA may terminate Client immediately if HMSA determines, in its sole and absolute discretion, that Client fails to comply with the Underwriting Guidelines provided in Section 3.3 above.

8.4 **Termination by Either Party.** Either party may terminate this Agreement, effective immediately, if the other party:

a. Is unable to pay its debts generally as they become due;

b. Makes a voluntary assignment for the benefit of creditors;

c. Is declared insolvent in any proceeding;

d. Commences a voluntary case or other proceeding seeking liquidation, reorganization or other relief with respect to itself, any of its property, assets or debts under any bankruptcy, insolvency, readjustment of debt, liquidation, or dissolution law of any jurisdiction now or hereafter in effect; or

e. Is named as a debtor party in such petition, application, case or proceeding and it indicates its approval thereof, consents thereto, acquiesces therein or acts in furtherance thereof, or if such petition, application, case or proceeding is not dismissed or stayed for a period of sixty (60) calendar days after it is commenced, or is the subject of any order appointing any such receiver, liquidator, custodian or trustee or approving the petition in any such case or proceeding.

8.5 **Effect of Termination.** The termination of this Agreement shall not relieve either party of any obligation or liability it may have to the other party in respect of any period prior to such termination or in respect of any obligations hereunder that, by their terms, survive the termination of this Agreement. The rights granted for and upon termination of this Agreement are not exclusive and each party shall have all of the cumulative rights and remedies under this Agreement or at law or in equity.

8.6 **Notification to Members.** Client must give written notice to Members whose coverage under the Group Plan is to be terminated pursuant to Section 8.2 and 8.4 of this Article at least ten (10) days prior to the effective date of termination.

ARTICLE 9. MODIFICATIONS

9.1 **HMSA Modifications.** HMSA shall provide written notice to Client of any material modifications to the Plan and/or any amendments to this Agreement at least sixty (60) calendar days in advance of the effective date of such modification and/or amendment, unless a longer period of time is required by applicable law. The modification and/or amendment shall take effect on the later of (i) the first calendar day after the notice period, or (ii) the date specified in the written notice.

9.2 **Modifications Required By Law.** Notwithstanding any other provision in this Agreement, any change, including any addition and/or deletion, to any provision(s) of the Plan and/or this Agreement that is required by duly-enacted law or regulation shall be deemed to be part of this Agreement effective immediately without right to object or further action required to be taken by either party to amend this Agreement to effect such change(s) for as long as such law or regulation is in effect and applicable to this Agreement.

9.3 **Change in Dues.** Notwithstanding anything to the contrary in this Agreement, HMSA reserves the right to adjust the dues required of Client, the retention, and/or the rates applicable to Members to the extent: (1) those dues or fees are not approved by the Insurance Division; and/or (2) the state or federal government imposes fees and assessments onto HMSA's fully insured policies that were not taken into account when calculating Client's dues under this Agreement. HMSA shall provide notice of changes in dues to Client as soon as feasible.

Changes in dues resulting from benefit modifications that are requested by Client shall apply on the date the modification becomes effective.

ARTICLE 10. INDEMNIFICATION AND ARBITRATION

10.1 **Indemnification.** Client shall defend, indemnify and hold HMSA, its directors, officers, agents, employees and affiliates harmless from any and all claims, demands, liabilities, damages, losses, suits, costs (including reasonable legal costs) and judgments (collectively, "**Losses**") arising out of this Agreement, including as provided pursuant to Section 12.1, or the performance by HMSA of its duties under the Plan or under the Agreement except that the foregoing shall not apply to Losses arising from (i) the gross negligence or willful misconduct of HMSA; (ii) acts or omissions of third-parties, including Members, or (iii) Members' claims for benefits.

10.2 **Arbitration.** If any dispute arises between the parties to this Agreement, the parties shall settle the dispute by binding arbitration in Hawaii pursuant to the Hawaii Uniform Arbitration Act, HRS ch.658A and the arbitration service's arbitration rules (or such other arbitration rules as the parties may mutually agree); to the extent not inconsistent with the arbitration provisions in this Agreement.

a. The arbitrator may hear and determine motions for summary disposition pursuant to HRS 658A-15(b). The arbitrator shall also hear and determine any challenges to the arbitration agreement and any disputes regarding whether a controversy is subject to an agreement to arbitrate. In order to make the arbitration hearing fair, expeditious and cost-effective, discovery by both parties shall be limited to requests for production of documents material to the claims or defenses in the arbitration. Limited depositions for use as evidence at the arbitration hearing may occur as authorized by HRS §658A-17(b).

b. All expenses of the arbitration including the arbitrator's fee, any costs of a reporter and transcript and the fees of an arbitration service, will be shared equally by the parties. Each party shall pay its own attorney and witness fees, provided that the arbitrator may award attorney fees and costs in an amount authorized by law to a prevailing party related to any claim or contention of a non-prevailing party, that the arbitrator determines was frivolous or wholly without merit.

c. The decision of the arbitrator shall be binding on both parties and judgment shall be entered thereon upon timely motion by either party in a court of competent jurisdiction. No action may be brought in any court in connection with this decision except as stated in the Hawaii Uniform Arbitration Act. There shall be no consolidation of parties in the arbitration proceeding. The arbitrator may award any remedy that can be granted by a court in like circumstances, provided that no award of punitive damages or exemplary damages shall be made.

ARTICLE 11. SUBROGATION RULES

11.1 **HMSA's Rights.** Client, for itself and as Plan Administrator for the Group Plan and Subscribers, grants HMSA (or its agent or assignee) the exclusive right to recover amounts paid to a

Member by any person, insurance company, or entity, where the payment is related to any accident, injury, or condition for which the Member has received or will receive benefits under the Plan portion of the Group Plan. HMSA shall be subrogated to all claims, actions, requests, demands, rights or remedies that a Member may have against any person, corporation or other entity who has or may have caused, contributed to, or aggravated an accident, injury, or condition for which the Member has received, will receive, or may claim an entitlement to benefits under the Plan portion of the Group Plan (such rights to be deemed "**Rights of Recovery**"). HMSA shall have the complete authority and discretion to investigate and pursue a Right of Recovery. All amounts recovered under a Right of Recovery, shall be retained by HMSA. Recoveries shall be treated as having been received in the year that HMSA paid the underlying claim.

11.2 **Client's Responsibilities.** Client will take reasonable and appropriate efforts to inform Members of the Rights of Recovery described herein. Client agrees to promptly notify HMSA in writing of any circumstances known to it where a Right of Recovery may exist.

ARTICLE 12. GENERAL PROVISIONS

12.1 **Compliance With Laws.** Each party shall comply with all applicable laws. Each party shall provide to the other any and all information requested in order for the requesting party to comply with applicable law, including, without limitation, COBRA, ERISA, HIPAA and ACA. Notwithstanding the foregoing, Client shall be solely responsible for ensuring that any and all wellness programs offered under the Plan are compliant with any and all applicable state or federal laws and regulations, including ACA, and shall indemnify and hold harmless HMSA, its officers, directors, agents, employees, and affiliates from any and all Losses arising out of any alleged or actual noncompliance with such laws.

12.2 **Assignment.** Client shall not assign or otherwise convey its rights, duties and/or obligations under this Agreement to any entity, without the prior written consent of HMSA. This Agreement shall be binding upon and inure solely to the benefit of the parties, their successors, and their permitted assignees.

12.3 **Governing Law.** This Agreement, its construction and interpretations shall be governed by and enforced in accordance with the laws of the State of Hawaii, except to the extent federal law supersedes or preempts state law.

12.4 **Severability.** The provisions of this Agreement are severable. If any provision of this Agreement is held or declared to be illegal, invalid or unenforceable, the remainder of the Agreement will continue in full force and effect as though the illegal, invalid or unenforceable provision had not been contained in the Agreement.

12.5 **Notice.** Except as otherwise specifically provided in this Agreement or otherwise in writing by the parties, any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be sent to the address or addresses set forth below unless the sender has been otherwise instructed in writing or unless otherwise provided by law. Such notice shall be deemed to have been given or made when actually received or seventy-two (72) hours after being sent, whichever occurs first.

HMSA:	Client:
Attn: 8-Account Management & Sales Hawaii Medical Service Association Blue Cross Blue Shield of Hawaii P.O. Box 860 Honolulu, HI 96808-0860 GroupPlanContracts@hmsa.com	GENESYS TELECOMMUNICATIONS LABORATORIES INC 2001 JUNIPERO SERRA BLVD DALY CITY, CA 94014 ANITA.WATTS@GENESYS.COM

12.6 **Non-Waiver.** No course of dealing or failure of either party to enforce any term, right or condition of the Agreement shall be construed as a waiver of such term, right or condition. No waiver or discharge shall be valid unless in writing signed by an authorized representative of the party against whom such waiver or discharge is sought to be enforced.

12.7 **Complete Agreement.** This Agreement (including the exhibits and Benefit Documents) constitutes the entire agreement between the parties, and no other statements, representations, warranties or obligations shall bind the parties unless expressly set forth in writing and signed by both parties or implemented pursuant to Article 9.

Payment of dues to HMSA under this Agreement constitutes Client's full acceptance of this Agreement effective February 1, 2021 and terminates all prior group health plan agreements between Client and HMSA, except for agreements governing Medicare Advantage or Medicare Part D Plans.

GROUP # 115300-1

EXHIBIT A

BENEFIT DOCUMENTS FOR GENESYS TELECOMMUNICATIONS LABORATORIES INC

The following plan information is available online for your convenience:
https://hmsa.com/Contracts/2021GTB-203/

1. HMSA's Preferred Provider Plan 2010 Guide to Benefits (762), July 2021.

2. Prescription Drug Rider Plan Certificate (972), July 2021.

3. Vision Care Rider Plan Certificate (DU), January 2021.

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EXHIBIT B

SUMMARY OF RATES FOR GENESYS TELECOMMUNICATIONS LABORATORIES INC

EFFECTIVE: FEBRUARY 1, 2021 THROUGH JUNE 30, 2021

Small Group Plus $30K GTL/AD&D - PPP 2010

Single	Two Party	Family
$779.90	$1,549.60	$2,319.30