UNITED STATES BANKRUPTCY COURT
NORTHERN DISTRICT OF ALABAMA
SOUTHERN DIVISION

IN RE:	)	CASE NO.: 15-02741-TOM
	)	CHAPTER 11
WALTER ENERGY, INC., *et al*.,	)	
	)	JOINTLY ADMINISTERED
Debtors.[1]	)	

MOTION OF BLUE CROSS AND BLUE SHIELD OF ALABAMA FOR ADEQUATE PROTECTION OF PAYMENT OR IN THE ALTERNATIVE, FOR RELIEF FROM THE AUTOMATIC STAY

Comes now, Blue Cross and Blue Shield of Alabama ("Blue Cross"), by its undersigned counsel, and hereby requests that the Court enter an order granting adequate protection of payment pursuant to 11 U.S.C. § 363(e), or in the alternative, relief from the automatic stay pursuant to 11 U.S.C. § 362(d) and Rule 4001 of the Federal Rules of Bankruptcy Procedure. In support of the relief sought, the affidavit of Amanda Davis is attached to the Motion as **Exhibit "A"** and is incorporated herein by reference. In further support of this motion, Blue Cross avers as follows:

INTRODUCTION

Walter Energy, Inc. ("Walter Energy") provides health insurance and related benefits to eligible employees and their dependents through various benefit plans. Though Walter Energy now has few active employees, over 3,600 employees or former employees (and their dependents) remained as eligible participants under these plans as of January 29, 2016 according

[1] The Debtors in these cases, along with the last four digits of each Debtor's federal tax identification number are: Walter Energy, Inc. (9953); Atlantic Development and Capital, LLC (8121); Atlantic Leasco, LLC (5308); Blue Creek Coal Sales, Inc. (6986); Blue Creek Energy, Inc. (0986); J.W. Walter, Inc. (0648); Jeffers Warrior Railroad Company, Inc. (3200); Jim Walter homes, LLC (4589); Jim Walter Resources, Inc. (1186); Maple Coal Co., LLC (3791); Sloss-Sheffield Steel & Iron Company (4884); SP Machine, Inc. (9945); Taft Coal Sales & Associates, Inc. (8731); Tuscaloosa Resources, Inc. (4869); V Manufacturing Company (9790); Walter Black Warrior Basin LLC (5973); Walter Coke, Inc. (9791); Walter Energy Holdings, LLC (1596); Walter Exploration & Production LLC (5973); Walter Home Improvement, Inc. (1633); Walter Land Company (7709); Walter Minerals, Inc. (9714); and Walter Natural Gas, LLC (1198). The location of the Debtors' corporate headquarters is 3000 Riverchase Galleria, Suite 1700, Birmingham, Alabama 35244-2359.

to Walter Energy. Walter Energy and Blue Cross are parties to an administrative services agreement whereby Blue Cross administers claims of eligible participants under the plans on behalf of Walter Energy. Blue Cross's role is entirely administrative in nature and Blue Cross does not provide insurance coverage to Walter Energy's eligible participants. Health care providers submit claims to Blue Cross who in turn pays allowed claims and then is reimbursed by Walter Energy.

As the Court is well-aware, a sale of substantially all of Walter Energy's assets is expected to close on or around February 29, 2016. The purchaser is not assuming the agreement with Blue Cross, but the agreement has not been rejected by Walter Energy. Upon information and belief, once the sale closes, there will be few, if any, eligible participants under the benefit plans. This means that claims for health care services provided to these participants after the closing will not be covered by the benefit plans. However, after the closing, claims will continue to be submitted under the plan to Blue Cross by health care providers for services provided prior to and up to the closing. These claims commonly are referred to as "run out" claims. Blue Cross estimates that the run out claims will be approximately $3 million. Blue Cross has requested that Walter Energy provide assurance to Blue Cross that Walter Energy will fulfill its obligations to pay these run out claims under the ASA after the closing. Despite these requests, Walter Energy has not provided that assurance.

Blue Cross seeks adequate protection that Walter Energy will perform its payment obligations under its agreement with Blue Cross. Blue Cross does not want to see any of the eligible participants under Walter Energy's health plans to be without coverage. However, if Walter Energy does not provide Blue Cross with adequate protection of payment, Blue Cross seeks an order allowing Blue Cross to immediately terminate the agreement and cease processing

claims in order to limit the financial loss that will result from Walter Energy's failure to perform under the agreement.

THE ADMINISTRATIVE SERVICES AGREEMENT

1. Walter Energy, as employer, provides and has provided health care benefits to eligible employees and their dependents pursuant to various plans (collectively, the "Plan"), established by Walter Energy.

2. Blue Cross and Walter Energy are parties to an Administrative Service Agreement (the "ASA") dated as of January 1, 2001, pursuant to which Blue Cross, as claims administrator, provides certain administrative services to the Plan and on behalf of Walter Energy, including but not limited to administering benefits, providing application forms, issuing identification cards and, upon request by Walter Energy, providing claims costs projections and analyses and such other actuarial and statistical data as Walter Energy may request from time to time in connection with its management of the Plan. Blue Cross provides no insurance benefits to Walter Energy, the Plan or its eligible participants. A true and correct copy of the ASA is attached hereto as **Exhibit "B"** and is incorporated herein by reference.

3. The process works as follows: Eligible participants receive healthcare services from providers. Those providers then submit claims for healthcare services to Blue Cross, which pays approved costs to the providers. Blue Cross submits the costs to Walter Energy, which in turn pays to Blue Cross the amounts Blue Cross has paid to the providers.

4. According to the ASA, Walter Energy bears sole and exclusive financial responsibility for all eligible claims filed by employees of Walter Energy that are covered by the Plan. These obligations include (a) claims that are submitted to and paid by Blue Cross in accordance with the Plan, (b) claims for services that have been provided to eligible employees and their dependents for which no claim has yet been filed with Blue Cross, and (c) adjustments

to amounts previously paid by Blue Cross to hospital providers and others based upon estimated costs that are retroactively adjusted based upon the providers' actual costs as subsequently audited and determined.

5. Walter Energy is required to pay Blue Cross weekly deposits (as specified in Article III of the ASA) by the close of business each Thursday. At the end of each month, Blue Cross invoices Walter Energy for (a) the amount which Blue Cross is ultimately obligated to pay, as described above, plus (b) administrative charges payable to Blue Cross pursuant to the ASA, less (c) the weekly deposit fees paid to Blue Cross during the previous month. (ASA Article III.A).

6. If Walter Energy fails to make timely payments to Blue Cross under the ASA, Blue Cross is not obligated to pay any further claims under the ASA. (ASA Article II.S.2.c). The ASA states as follows:

> In recognition of [Blue Cross's] risk of reimbursement for the Cost of Claims (as defined below), it is agreed that if [Walter Energy] fails to transfer sufficient funds to pay the pending Cost of Claims, [Blue Cross] may at its discretion (i) suspend all pending Claims automatically without notice to [Walter Energy] or any Member until it has sufficient assurance that there has been transferred an amount into the account sufficient to pay [Blue Cross] for the Cost of Claims and (ii) recall payments for Claims already made but for which there is an insufficient amount in the account to pay the Cost of Claims.

(ASA Article III.A.2).

7. The ASA may be terminated by either party upon thirty (30) days' written notice to the other party (ASA Article VI). The ASA states that

> In the event of termination of this Agreement, [Walter Energy] will pay [Blue Cross] for the Cost of Claims on all claims that were incurred, but not paid by [Blue Cross] before the effective date of the termination of this Agreement.

(ASA Article III.D). These claims for services incurred prior to termination of the ASA that are not paid until after termination of the ASA commonly are referred to as "run out" claims.

8. Walter Energy is required to indemnify and hold Blue Cross harmless from and against any liability that Blue Cross may incur as a result of Blue Cross's reliance on instructions, communications, or directions from Walter Energy regarding the administration of benefits payable under the Plan. Walter Energy and Blue Cross further agreed to indemnify and hold each other harmless from and against any liability that the other party may incur as a result of the indemnifying party's (i) breach of the ASA or (ii) failure to comply with applicable law, provided however, that Walter Energy will in all cases remain responsible for payment of benefits under the Plan (ASA Article V).

9. As of January 29, 2016, there were over 3,600 active or inactive employees that were eligible participants under the Plan. This number does not include dependents of employees that also are eligible participants, thus increasing the total number of eligible participants under the Plan.

PROCEDURAL BACKGROUND

10. On June 25, 2015 (the "Petition Date"), Walter Energy and its affiliates named above filed a voluntary petition for relief under Chapter 11 of title 11 of the United States Code, 11 U.S.C. §§ 101 *et seq*. (the "Bankruptcy Code") in the United States Bankruptcy Court for the Southern District of Alabama (the "Court"), Case No. 15-02741.

11. On November 5, 2015, Walter Energy filed a motion seeking approval of sale procedures to sell substantially all of its assets [*Docket No. 993*] (the "Sale Motion"). On January 8, 2016, the Court entered an order granting the Sale Motion and approving the proposed sale [*Docket No. 1584*] (the "Sale Order").

12. On December 16, 2015, the Court entered an order [*Docket No. 1333*] regarding, among other things, benefits of what is referred to in the order as "Non-Union Retirees." Pursuant to this order, the Non-Union Retirees' benefits are terminated effective January 31,

2016. These benefits include health insurance administered by Blue Cross pursuant to the ASA. Under this order Walter Energy is to continue to process all claims of the Non-Union Retirees in the ordinary course of business through and including the closing date. This order also requires Walter Energy to deposit $400,000.00 into an escrow account to be used to pay claims for healthcare services provided to the Non-Union Retirees prior to January 31, 2016, but that are not processed until after the closing date (i.e., the "run out" claims).

13. A separate opinion and order then was entered by the Court on December 28, 2015 [*Docket No. 1333*], granting Walter Energy's motion for an order terminating retiree benefits for all union retirees, among other things. These benefits include health insurance administered by Blue Cross pursuant to the ASA. Based upon information and belief, these union retirees and their dependents remain eligible participants under the Plan until the sale closes.

14. The Sale Order approved the assumption and assignment of certain executory contracts described in the Asset Purchase Agreement dated November 5, 2012. Section 2.5 of that agreement provides that contracts to be assumed shall be designated in writing, and otherwise shall automatically be deemed "excluded contracts."

15. On January 6, 2016, the contracts to be assumed under the Asset Purchase agreement were designated in writing, which do not include the ASA. Therefore, while the purchaser is assuming certain contracts and liabilities of Walter Energy, the ASA and the obligations thereunder are not included in those contracts and liabilities being assumed. However, at the same time the ASA is not being rejected.

16. Based upon information and belief, the sale approved by the Sale Order is expected to close on or around February 29, 2016.

17. Upon consummation of the proposed sale, Blue Cross understands that there will be few or no eligible participants under the Plan. However, Blue Cross expects run out claims after the closing of the sale to be approximately $3 million.

18. As of the date of this motion, Blue Cross continues in the performance of its duties under the ASA. Given their significance, Blue Cross has sought assurance from Walter Energy that the run out claims will be paid by Walter Energy (similar to the assurance provided for the Non-Union Retirees' run out claims). While Walter Energy does not dispute its liability under the ASA, Walter Energy has not provided Blue Cross with that assurance.

LEGAL ARGUMENT

I. Due to the Significant Financial Obligation Imposed Upon Blue Cross by the ASA, Walter Energy Should be Required to Provide Adequate Protection to Blue Cross

As explained above, the Plan provides coverage to Walter Energy's employees and their dependents (including non-active employees). Blue Cross pays the claims each week under the ASA, all of which Walter Energy is obligated to repay Blue Cross under the terms of the ASA. Whether or not Walter Energy will have the cash to satisfy its obligations under the ASA going forward (particularly after the sale closes) is questionable at best. Due to this substantial obligation imposed upon Blue Cross under the ASA and the resulting financial exposure, Walter Energy should be required to provide adequate protection of future performance under the ASA. 11 U.S.C. § 363(e); *see generally In re Continental Energy Assocs. Ltd. P'ship.*, 178 B.R. 405, 408 (Bankr. M.D. Penn. 1995) (recognizing importance of protecting the interests of non-debtor party to contract post-petition); *see also In re RB Furniture, Inc.* 141 B.R. 706, 713-14 (Bankr. Cent. Dist. Cal. 1992) (finding non-debtor party to executory contract is entitled to adequate protection of future performance by requiring debtor to deposit funds into a segregated account). This protection should come in the form of a deposit by Walter Energy in the amount of $3

million into an escrow account much the same way as the run out claims for the Non-Union Retirees were handled.

II. If Adequate Protection Is Not Provided, Blue Cross Should Be Granted Relief from the Automatic Stay to Terminate the ASA and Exercise Its Rights and Remedies Under the ASA, and all Amounts Paid by Blue Cross Post Petition Should be Deemed as Allowed Administrative Expenses.

Blue Cross is nothing more than an administrator of claims under Walter Energy's benefit plans. Blue Cross never agreed to pay for insurance coverage to Walter Energy's employees and Blue Cross should not now be required to do so simply because Walter Energy cannot. Again, Blue Cross does not want to see any of the eligible participants under Walter Energy's health plans to be without coverage. However, if the assurance requested above is not provided, Blue Cross should not be forced to continue to perform under the ASA and increase its exposure to financial loss. Instead, the automatic stay should be lifted immediately to allow Blue Cross immediately to (i) terminate the ASA, (ii) cease payment of claims under the ASA, and (iii) exercise its rights of recoupment against any refund amounts to which Walter Energy may be entitled under the ASA.

Consummation of the sale approved by the Sale Order effectively leaves Walter Energy with little to no tangible assets making reorganization unlikely. As such, the ASA is not necessary to an effective reorganization. Despite requests by Blue Cross, Walter Energy has not provided assurance that it will perform any of its obligations under the ASA after the closing occurs. The expected liability of Blue Cross is too great for Blue Cross to continue to perform under the ASA without such assurance. Blue Cross is entitled to relief from the automatic stay pursuant to section 362(d)(2)(B) of the Bankruptcy Code to terminate the ASA, cease all obligations of Blue Cross thereunder and exercise the rights and remedies made available to Blue Cross under the ASA. Further, Blue Cross is entitled to relief from the automatic stay pursuant

to section 362(d)(1) for cause, as there is no adequate protection — absent an adequate protection deposit — that Blue Cross will be paid for the claims it continues to pay under the ASA.

Whether or not sufficient funds will exist to satisfy administrative expense claims in this case is unknown. However, in the event the adequate protection sought by Blue Cross is not provided, Blue Cross is entitled to an administrative expenses claim. Section 503 of the Bankruptcy Code and applicable case law provide that all amounts owed by Walter Energy to Blue Cross under the ASA for services rendered and expenses incurred by Blue Cross post-petition should be treated as administrative expenses. 11 U.S.C. § 503(b)(1)(A)(i) (providing that allowed administrative expenses include "the actual, necessary costs and expenses of preserving the estate, including wages, salaries, and commissions for services rendered after the commencement of the case"); *see also Hartford Underwriters Ins. Co. v. Union Planters Bank, N.A.*, 530 U.S. 1, 4-5 (2000). Because Blue Cross is preserving the estate by paying obligations of Walter Energy for claims of its employees (both active and inactive) and their dependents under the Plan, all post-petition amounts owed to Blue Cross should be deemed as allowed administrative expenses. To be clear however, treating Blue Cross's claim as an administrative expense is not adequate protection given the uncertainty of whether such claims will be paid in full in this case. *See In re JW Aluminum Co.*, 200 B.R. 64, 67 (Bankr. M.D. Fla. 1996) (recognizing that administrative expense claims are not always satisfied in full).

WHEREFORE, PREMISES CONSIDERED, Blue Cross respectfully requests that the Court enter an order requiring Walter Energy to provide Blue Cross adequate protection by depositing into an escrow account an amount equal to the estimated run out liability of Blue Cross under the ASA.

In the alternative, Blue Cross respectfully requests that the Court enter an order (i) lifting the automatic stay to allow Blue Cross to immediately (a) terminate the ASA, (b) cease its obligations under the ASA including (but not limited to) paying claims immediately, and (c) exercise its rights and remedies under the ASA including but not limited to the recoupment of refund amounts that may be due to Walter Energy under the ASA and (ii) deeming as an allowed administrative expense, all amounts owed by Walter Energy to Blue Cross under the ASA for services rendered and expenses incurred by Blue Cross post-petition. Blue Cross requests that the Court waive the fourteen (14) day stay of relief pursuant to Federal Rule of Bankruptcy Procedure 4001(a)(3) and grant Blue Cross such other and different relief as the Court deems proper and just.

Dated: February 1, 2016.

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CERTIFICATE OF SERVICE

I certify that a copy of the foregoing has been filed and delivered via filing on the Court's CM/ECF system to all persons receiving notice thereunder and upon the following by U.S. mail, properly addressed and postage prepaid, on February 1, 2016.

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Wilmington Trust, National Association
Attn: Steven Cimalore
1100 N. Market Street
Wilmington, DE 19890

Winter McFarland, LLC
Ruth McFarland
205 McFarland Circle North
Tuscaloosa, AL 35406

/s/ Jeremy L. Retherford

Exhibit “A”

UNITED STATES BANKRUPTCY COURT
NORTHERN DISTRICT OF ALABAMA
SOUTHERN DIVISION

IN RE:	)	CASE NO.: 15-02741-TOM
	)	CHAPTER 11
WALTER ENERGY, INC., *et al.*,	)	
	)	JOINTLY ADMINISTERED
Debtors.[1]	)	

AFFIDAVIT

STATE OF ALABAMA)
)
JEFFERSON COUNTY)

Amanda Davis, being duly sworn, deposes and states as follows:

1. My name is Amanda Davis. I am above the age of 19 years and I make the statements contained herein based upon my own personal knowledge from my review of the records which are kept in the ordinary course of business and over which I maintain possession and control. I am employed by Blue Cross and Blue Shield of Alabama ("Blue Cross") as Unit Manager, Large Group Billing, and I am familiar with the business relationship between Blue Cross and Walter Energy, Inc. ("Walter Energy").

2. Walter Energy, as employer, provides and has provided health care benefits to eligible employees and their dependents pursuant to various plans (collectively, the "Plan"), established by Walter Energy.

[1] The Debtors in these cases, along with the last four digits of each Debtor's federal tax identification number are: Walter Energy, Inc. (9953); Atlantic Development and Capital, LLC (8121); Atlantic Leasco, LLC (5308); Blue Creek Coal Sales, Inc. (6986); Blue Creek Energy, Inc. (0986); J.W. Walter, Inc. (0648); Jeffers Warrior Railroad Company, Inc. (3200); Jim Walter homes, LLC (4589); Jim Walter Resources, Inc. (1186); Maple Coal Co., LLC (3791); Sloss-Sheffield Steel & Iron Company (4884); SP Machine, Inc. (9945); Taft Coal Sales & Associates, Inc. (8731); Tuscaloosa Resources, Inc. (4869); V Manufacturing Company (9790); Walter Black Warrior Basin LLC (5973); Walter Coke, Inc. (9791); Walter Energy Holdings, LLC (1596); Walter Exploration & Production LLC (5973); Walter Home Improvement, Inc. (1633); Walter Land Company (7709); Walter Minerals, Inc. (9714); and Walter Natural Gas, LLC (1198). The location of the Debtors' corporate headquarters is 3000 Riverchase Galleria, Suite 1700, Birmingham, Alabama 35244-2359.

3. Blue Cross and Walter Energy are parties to an Administrative Service Agreement (the "ASA") dated as of January 1, 2001, pursuant to which Blue Cross, as claims administrator, provides certain administrative services to the Plan and on behalf of Walter Energy, including but not limited to administering benefits, providing application forms, issuing identification cards and, upon request by Walter Energy, providing claims costs projections and analyses and such other actuarial and statistical data as Walter Energy may request from time to time in connection with its management of the Plan. Blue Cross provides no insurance benefits to Walter Energy, the Plan or its eligible participants. A true and correct copy of the ASA is attached hereto as **Exhibit "A"** and is incorporated herein by reference.

4. The process works as follows: Eligible participants receive healthcare services from providers. Those providers then submit claims for healthcare services to Blue Cross, which pays approved costs to the providers. Blue Cross submits the costs to Walter Energy, which in turn pays to Blue Cross the amounts Blue Cross has paid to the providers.

5. According to the ASA, Walter Energy bears sole and exclusive financial responsibility for all eligible claims filed by employees of Walter Energy that are covered by the Plan. These obligations include (a) claims that are submitted to and paid by Blue Cross in accordance with the Plan, (b) claims for services that have been provided to eligible employees and their dependents for which no claim has yet been filed with Blue Cross, and (c) adjustments to amounts previously paid by Blue Cross to hospital providers and others based upon estimated costs that are retroactively adjusted based upon the providers' actual costs as subsequently audited and determined.

6. Walter Energy is required to pay Blue Cross weekly deposits (as specified in Article III of the ASA) by the close of business each Thursday. At the end of each month, Blue

Cross invoices Walter Energy for (a) the amount which Blue Cross is ultimately obligated to pay, as described above, plus (b) administrative charges payable to Blue Cross pursuant to the ASA, less (c) the weekly deposit fees paid to Blue Cross during the previous month. (ASA Article III.A).

7. If Walter Energy fails to make timely payments to Blue Cross under the ASA, Blue Cross is not obligated to pay any further claims under the ASA. (ASA Article II.S.2.c). The ASA states as follows:

> In recognition of [Blue Cross's] risk of reimbursement for the Cost of Claims (as defined below), it is agreed that if [Walter Energy] fails to transfer sufficient funds to pay the pending Cost of Claims, [Blue Cross] may at its discretion (i) suspend all pending Claims automatically without notice to [Walter Energy] or any Member until it has sufficient assurance that there has been transferred an amount into the account sufficient to pay [Blue Cross] for the Cost of Claims and (ii) recall payments for Claims already made but for which there is an insufficient amount in the account to pay the Cost of Claims.

(ASA Article III.A.2).

8. The ASA may be terminated by either party upon thirty (30) days' written notice to the other party (ASA Article VI). The ASA states that

> In the event of termination of this Agreement, [Walter Energy] will pay [Blue Cross] for the Cost of Claims on all claims that were incurred, but not paid by [Blue Cross] before the effective date of the termination of this Agreement.

(ASA Article III.D). These claims for services incurred prior to termination of the ASA that are not paid until after termination of the ASA commonly are referred to as "run out" claims.

9. Walter Energy is required to indemnify and hold Blue Cross harmless from and against any liability that Blue Cross may incur as a result of Blue Cross's reliance on instructions, communications, or directions from Walter Energy regarding the administration of benefits payable under the Plan. Walter Energy and Blue Cross further agreed to indemnify and hold each other harmless from and against any liability that the other party may incur as a result

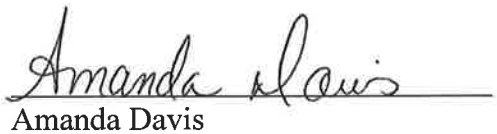
of the indemnifying party's (i) breach of the ASA or (ii) failure to comply with applicable law, provided however, that Walter Energy will in all cases remain responsible for payment of benefits under the Plan (ASA Article V).

10. As of January 29, 2016, over 3,600 active or inactive employees were eligible participants under the Plan. This number does not include dependents of employees that also are eligible participants, thus increasing the total number of eligible participants under the Plan.

11. Blue Cross understands that Walter Energy intends to sell substantially all of its assets and that the closing of this transaction is to occur on or around February 29, 2016. Upon consummation of the proposed sale, Blue Cross also understands that there will be few or no eligible participants under the Plan. However, Blue Cross expects run out claims after the closing of the sale to be approximately $3 million.

12. Blue Cross has requested that Walter Energy provide adequate assurance that Walter Energy will fully perform its obligations under the ASA, but Blue Cross has not been provided with that assurance.

Dated: February 1, 2016



Amanda Davis
Affiant

STATE OF ALABAMA)
)
COUNTY OF JEFFERSON)

I, the undersigned notary public in and for said county in said state, hereby certify that Amanda Davis, on behalf of Blue Cross and Blue Shield of Alabama, is signed to the foregoing instrument and who is known to me, acknowledged before me on this day that, being informed of the contents of the instrument, she, as such representative and with full authority, executed the same voluntarily for and as the act of said company.

Given under my hand this 1st day of February, 2016.

[NOTORIAL SEAL]

Kristi P. Todd
Notary Public
My Commission Expires:

Notary Public

My commission expires: 12/16/2018

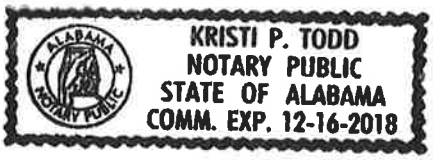


Exhibit “B”

REDACTED

Administrative Services Agreement
between
Blue Cross and Blue Shield of Alabama
and

Walter Energy
Group 02740, 13582-13585, 20555, 21529, 39053,
45636-45638, 45641, 60159-60162
Effective: January 1, 2014

Original Effective Date: January 1, 2001

ADMINISTRATIVE SERVICES AGREEMENT
between
BLUE CROSS AND BLUE SHIELD OF ALABAMA
450 Riverchase Parkway East
Birmingham, Alabama 35244-2858
(herein called the Claims Administrator)

and

Walter Energy
3000 Riverchase Galleria Towers, Suite 1700
Hoover, Alabama 35244
(herein called the Employer)

ARTICLE I - INTRODUCTION

The effective date of this Agreement is 12:01 a.m. on the date stated on the cover page of this Agreement, and from year to year thereafter unless and until terminated pursuant to Article VI. If there is any inconsistency between this Agreement and the Implementation or Enrollment Agreement between the parties, the terms of this Agreement shall control. This Agreement is issued and delivered in the State of Alabama, and is governed (subject to any applicable federal laws) by the laws of the state of Alabama. Article VII contains defined terms that are used in this Agreement. Unless the context clearly requires otherwise, any defined terms contained in the Plan, when used in this Agreement, shall have the same meaning as in the Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

The Claims Administrator has executed this Agreement and sent it to the Employer at the address appearing in the records of the Claims Administrator. The Claims Administrator intends to rely upon the terms of this document in its administration of the Plan. The Employer understands and acknowledges that, if it fails to respond to reasonable requests by the Claims Administrator for the Employer to return a signed copy of the Agreement or propose written changes, the Agreement shall be deemed binding and in full effect as of the effective date stated on the cover page.

ARTICLE II - ALLOCATION OF ADMINISTRATIVE DUTIES

The Employer and the Claims Administrator each agree to perform the administrative duties identified in this Article II. Each party shall perform these duties consistent with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA) and other applicable laws.

A. Eligibility and Enrollment

1. Claims Administrator's Duties. The Claims Administrator will furnish appropriate application forms and related material and will provide such assistance as may be reasonably necessary for the Employer to enroll its employees, former employees, and their eligible dependents in the Plan. The Claims Administrator will maintain up-to-date eligibility status records on all enrolled Members as submitted by the Employer. The Claims Administrator will issue identification cards to each Member who is enrolled in the Plan and who is certified as eligible by the Employer.

2. Employer's Duties. The Employer will determine whether and when employees, former employees, or dependents are eligible to enroll in the Plan. The Employer will provide timely and accurate data to the Claims Administrator that appropriately identifies all employees, former employees, and dependents who are enrolled or disenrolled in the Plan and the effective dates of such enrollment or disenrollment.

3. Other.

   a. The Claims Administrator will rely on eligibility information submitted by the Employer as satisfying the terms of the Plan and the requirements of the Medicare Secondary Payer

(MSP) statutes and regulations (42 U.S.C. Section 1395(y), and 42 CFR Part 411, Subparts B-H). If the Centers for Medicare and Medicaid Services (CMS) makes demand upon the Employer for repayment or other remedy in cases which CMS determines that the Plan should have paid primary, the Claims Administrator is authorized to repay CMS and add that amount to the next invoice for the Cost of Claims in Article III. Upon request, the Employer will promptly provide written authorization to the Claims Administrator to repay CMS. The Employer agrees that, if it fails to provide prompt written authorization, it will be responsible for interest and penalties, as applicable, that may be due to CMS.

b. If the Employer retroactively cancels coverage for one or more Members, the Claims Administrator will not request refunds of payments made more than 60 days before the date on which the Employer satisfactorily notifies the Claims Administrator of the retroactive cancellation. The Claims Administrator will credit any payments recovered for the 60-day retroactive cancellation period to the Cost of Claims pursuant to Article III. Prior to obtaining refunds, the Claims Administrator may request satisfactory assurance from the Employer that the Member has been properly retroactively terminated pursuant to the Affordable Care Act (including the completion of any appeals) and has been properly offered and declined to elect COBRA coverage. Any refund to the Employer of the Administrative Charge paid with respect to retroactively cancelled Members will not exceed the Administrative Charge paid or payable with respect to such Members for the 60-day retroactive cancellation period.

c. Without in any way limiting the generality of any other provision of the Agreement, Employer understands and acknowledges that Employer is solely and completely responsible for the Plan's compliance with COBRA, HIPAA, the Affordable Care Act and other applicable laws as such laws may affect any Member's retroactive loss of coverage under the Plan. Furthermore, and without in any way limiting the generality of Article V, Employer agrees to hold the Claims Administrator harmless, to the extent permitted by law, from and against any and all loss or liability that the Claims Administrator may incur as a result of any Member's retroactive loss of coverage under the Plan.

B. Customer Service

The Claims Administrator will provide Members with access to a toll-free Customer Service phone number during the hours of 8:00 a.m. to 5:00 p.m., central time, on days during which the Claims Administrator is open for business. Customer Service will respond to requests from Members concerning claims processing and adjudication and will coordinate - when necessary - requests for information that involve other departments of the Claims Administrator.

C. Benefit Booklet (Summary Plan Description)

1. Claims Administrator's Duties. The Employer requests the Claims Administrator to prepare a benefit booklet that will serve as a summary plan description (SPD) or summary of material modifications (SMM). Pending finalization of the benefit booklet, the Employer directs the Claims Administrator to process benefits and terms under the plan in accordance with the provisions of the Group Enrollment or Implementation Agreement, this Agreement, the standard benefit language maintained by the Claims Administrator for the type of plan established by the Employer herein, and any draft benefit booklets treated as "operative" by the Claims Administrator. A draft benefit booklet shall be considered operative by the Claims Administrator when the booklet serves as the primary, but not the sole, instrument upon which the Claims Administrator bases its administration of the Plan, without regard to whether the booklet is finalized or distributed to the Plan's participants. If there is any conflict between any of the foregoing documents, the Claims Administrator is directed to resolve such conflict in a manner that best effectuates the intent of the Employer and the Claims Administrator as of the date on which claims were incurred.

2. Employer's Duties. The Employer acknowledges and understands that it is the plan administrator and plan sponsor of the Plan under ERISA, other applicable law and/or the terms of the Plan. Among other things, this imposes upon the Employer the sole legal responsibility to (i) prepare the benefit booklet, (ii) determine whether the benefit booklet distributed to Plan participants satisfies ERISA's definition of an SPD or other applicable legal requirements, (iii) ascertain that the booklet accurately and fully describes the benefits that the Employer intends the Claims

Administrator to provide or administer, and (iv), distribute the booklet in a timely fashion and appropriate manner to Plan participants. Nothing in this Agreement and no actions taken by the Claims Administrator are intended to delegate any of the Employer's responsibilities under the Plan or applicable law to the Claims Administrator.

D. Summary of Benefits and Coverage (SBC) and Uniform Glossary

The Employer may prepare their own SBC and Uniform Glossary or may request the Claims Administrator to prepare both documents. At the request of the Employer, the Claims Administrator will prepare a draft SBC for the benefits that the Claims Administrator administers under the Plan that the Employer may use either as the SBC or in connection with the preparation of its own SBC. In either case, the Employer acknowledges and understands that the Affordable Care Act imposes upon the Employer the sole legal responsibility to (i) prepare the SBC and Uniform Glossary (ii) determine whether the SBC and Uniform Glossary distributed to Plan participants satisfies the requirements of the Affordable Care Act, and (iii), distribute the SBC and the Uniform Glossary in a timely fashion and appropriate manner to Plan participants. Nothing in this Agreement and no actions taken by the Claims Administrator are intended to delegate any of the Employer's responsibilities under the Plan or applicable law to the Claims Administrator.

E. Annual and Summary Annual Reports

1. Claims Administrator's Duties. The Claims Administrator will send to the Employer such information that the Claims Administrator has within its possession as will permit the Employer to prepare, file, and/or distribute appropriate annual reports (Forms 5500) and summary annual reports for the Plan.

2. Employer's Duties. The Employer will prepare, file, and/or distribute as required by law, appropriate annual reports (Forms 5500) and summary annual reports for the Plan.

F. Claims Processing and Adjudication

1. Claims Administrator's Duties. The Claims Administrator will exercise the discretionary fiduciary authority to process and adjudicate claims under the Plan. This authority encompasses all determinations and findings necessary to process and adjudicate claims, such as the discretionary authority to construe and apply the Plan, make findings of fact, and determine whether services or supplies are medically necessary (within the meaning of the Plan) or otherwise satisfy the medical standards or guidelines required for payment of benefits under the Plan (such as, for example, the requirement that medical services or supplies not be experimental or investigational). The Claims Administrator will include a description of its claims procedures in the draft benefit booklet prepared by the Claims Administrator in accordance with Section C above. The Employer will be responsible for making all eligibility determinations under the Plan.

2. Employer's Duties. The Employer may, in writing, instruct the Claims Administrator to prospectively pay or deny specified claims or a class of claims that the Employer has determined in its fiduciary discretion are, or are not, payable under the Plan. The Claims Administrator will comply with such instructions to the extent permissible under the Claims Administrator's provider contracts and to the extent the Claims Administrator has not relied to its detriment on prior practice or Plan interpretation.

G. Appeals

1. Administrative Appeals

   a. Claims Administrator's Duties The Claims Administrator will exercise the discretionary fiduciary authority to review denied claims under Section 503 of the Employee Retirement Income Security Act of 1974 ("ERISA") and if applicable, the Affordable Care Act. The Claims Administrator will serve as the appropriate named fiduciary responsible for providing the Member with a full and fair review of his or her denied claim. The Claims Administrator will include a description of its appeal procedures in the draft benefit booklet prepared by the Claims Administrator in accordance with Section C above. It shall be the responsibility and

duty of the Employer to comply with any applicable notice provisions, appeal provisions and other provisions of the Affordable Care Act related to Employer's initial Member eligibility determinations and retroactive cancellations.

b. Employer's Duties The Employer may, in writing, instruct the Claims Administrator to prospectively grant or deny specified appeals or a class of appeals that the Employer has determined in its fiduciary discretion are, or are not, consistent with the terms of the Plan. The Claims Administrator will comply with such instructions to the extent permissible under the Claims Administrator's provider contracts and to the extent that the Claims Administrator has not relied to its detriment on prior practice or Plan interpretation.

2. Affordable Care Act External Reviews

If the Plan is subject to the external review requirements under the Affordable Care Act, it is the desire and understanding of the Employer that, in order to comply with the applicable external review provisions under the Affordable Care Act (including applicable regulations, Technical Guidance and other guidance issued from time to time thereunder), the Claims Administrator has entered into, and will endeavor to enter into and to maintain agreements with at least three (3) independent review organizations to furnish external review services to Members in accordance with the provisions of the Affordable Care Act applicable to self-funded group health plans. If the Plan is subject to the external review requirements under the Affordable Care Act, Employer hereby authorizes and directs Claims Administrator to accept external review requests from Members and assign such requests to its independent review organizations to administer such external reviews in accordance with the provisions of the Affordable Care Act applicable to self-funded group health plans.

H. Managed Care Services

When applicable under the Plan, the Claims Administrator will exercise the discretionary fiduciary authority to make determinations that are necessary or appropriate for Case Management, Disease Management, Care Coordination, and other similar Managed Care Programs.

I. Actuarial Services

Upon reasonable request, the Claims Administrator will provide the Employer with Claims cost projections and analyses and such other actuarial and statistical data as may be reasonably requested by the Employer to perform its administrative and Plan design responsibilities.

J. COBRA

The Employer will determine whether a Member is entitled to continue coverage under COBRA and will provide the required notices and COBRA application form to a Member who is so entitled. The Employer will determine the amount of the monthly COBRA premium and be responsible for all other COBRA requirements including billing and collection of premiums.

K. Certificates of Creditable Coverage/HIPAA

1. Claims Administrator's Duties. The Claims Administrator will furnish certificates of creditable coverage to Members. These certificates will verify the duration of coverage administered by the Claims Administrator, and will be issued when there is a break in coverage of at least one day.

2. Employer's Duties. The Employer will issue supplemental certificates of creditable coverage as necessary to certify coverage under any additional benefit option under the Plan. The Employer is responsible for the Plan's compliance with the provisions of Title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

L. HIPAA Privacy and Security

1. Claims Administrator's Duties. The Claims Administrator will function as a business associate of the Plan in accordance with the privacy and security regulations issued by the Secretary of Health

and Human Services under HIPAA. The Claims Administrator will sign a separate business associate agreement with the Plan. In the event of any conflict between this Agreement and the Business Associate Agreement, the Business Associate Agreement shall control.

2. Employer's Duties. The Employer is responsible for the Plan's compliance with the HIPAA privacy and security regulations and for its own compliance, as Plan sponsor, with those regulations.

M. Qualified Medical Child Support Orders

1. Claims Administrator's Duties. The Claims Administrator will enroll a child as directed by the Employer pursuant to the terms of a qualified medical child support order (QMCSO).

2. Employer's Duties. The Employer will adopt a policy for determining whether a medical support order is a qualified medical child support order. The Employer will exercise the discretionary, fiduciary, discretion to determine whether a medical support order is a QMCSO and notify the Claims Administrator of its determination.

N. Subrogation

The Claims Administrator shall pursue subrogation and reimbursement recoveries where appropriate. Subrogation and reimbursement recoveries shall be credited to the Cost of Claims as provided for in Article III.

O. Litigation Involving the Plan

1. The Claims Administrator is authorized but not required to provide a defense against claims for benefits and other litigation involving the Plan. The Claims Administrator is further authorized to act on behalf of the Plan and the Employer with regard to settlement of any claims for which it provides a defense. The Claims Administrator is further authorized in its discretion to determine whether and when in its judgment the Plan should be added as a necessary party to litigation.

2. The Employer shall in all cases remain responsible for the cost of benefit payments under the Plan, regardless of whether such payments are made pursuant to settlement of litigation or court order and regardless of whether benefit payments are denominated as such or as some form of damages or other liability. The Employer's obligation to fund any such benefit payments shall survive the termination of this Agreement.

3. The Claims Administrator is authorized to act on behalf of the Plan and the Employer in litigating and settling cases or controversies that involve multiple plans and plan participants, whether arising in contract, tort or any other legal theory. Examples include, but are not limited to, cases arising out of defective medical devices or medicines, overpayments, and provider fraud or provider suits where the provider has sued multiple Blue Cross entities. Any amounts recovered, less all direct costs such as outside attorneys' fees, will be credited against the monthly charges in Article III. In some cases the applicable amount recovered may have to be estimated when, for example, a court will not release information that would allow identification of the plans and/or participants involved and the settlement is based upon the number of lives in all plans covered by the Claims Administrator compared to the total number of lives covered by the industry.

P. Stop-Loss Insurance

1. Claims Administrator's Duties. Upon written request, the Claims Administrator will provide stop-loss reports to the Employer on adjudicated claims.

2. Employer's Duties. The Employer is responsible for selecting and maintaining in force, if desired, suitable stop-loss insurance coverage and for giving all required notifications to the stop-loss insurer.

Q. ERISA

1. The Employer is the Plan administrator and sponsor within the meaning of Sections 3(1)(A) and (B) of ERISA. As such, it remains responsible of all obligations of Plan administrators and sponsors under ERISA, including the exercise of discretionary, fiduciary, authority to manage and administer the Plan except to the extent delegated to the Claims Administrator hereunder. Without limiting the foregoing, the Employer is responsible for notifying Members of any lapse or loss of coverage or changes to or termination of this Agreement to the extent required by law.

2. The Employer also serves as the Plan's sponsor within the meaning of Section 3(16)(B) of ERISA. This means that the Employer exercises non-fiduciary discretion concerning the design of the Plan. The Employer acknowledges that changes in Plan design may be limited by the capabilities of the Claims Administrator's claims processing systems or prior medical necessity certifications that the Claims Administrator may have provided in reliance on the existing Plan design. The Employer therefore agrees that it will not implement a change in Plan design or communicate a change to Members unless the Employer gives the Claims Administrator a reasonable period of time - prior to implementation of the proposed change - to review and comment on the proposed change and its effective date. If, after consultation with the Employer, the Claims Administrator determines that it will be unable to administer the proposed change as of the desired or any later effective date, it shall so advise the Employer and the Employer shall assume full responsibility for administration of the change.

R. National Dental Network

The Claims Administrator will provide the Plan's eligible members with access to a national dental network through a contract with DenteMax. DenteMax providers have agreed to provide services to members in accordance with guidelines established by the Claims Administrator for claims review and payment. The provision of dental services to members through the DenteMax network shall be governed by (i) the terms of the agreements between participating dentists and DenteMax, and (ii), the Claims Administrator's agreement with DenteMax for access to the DenteMax network. Pursuant to the terms of these agreements, DenteMax may amend from time to time the fee schedule that the Claims Administrator will use to reimburse DenteMax providers, and such changes will become effective as of such date specified by DenteMax.

S. Health and Dependent Care Flexible Spending Arrangements

1. Claims Administrator's Duties. The Claims Administrator will provide the following services with respect to the Employer's Health Flexible Spending Account (Health FSA) and Dependent Care Account (DCA):

   a. Establishment of Accounts. Based upon election information provided to the Claims Administrator by the Employer prior to the beginning of the calendar year or prior to the commencement of participation for new employees, the Claims Administrator will establish reimbursement accounts for participating employees. The Claims Administrator will assist the Employer in identifying and resolving any discrepancies regarding contributions, deposits, and Requests for Reimbursement paid.

   b. Requests for Reimbursement. The Claims Administrator will pay Requests for Reimbursement submitted in accordance with the Flex Plan based on Participant elections at the time Requests for Reimbursement are submitted. The Claims Administrator will pay Requests for Reimbursement filed with the Claims Administrator for medical expenses which are only partially covered or eligible for reimbursement under the Employer's group health plan from the Participant's Health FSA generally without requiring the Participant to submit a separate Request for Reimbursement. For other medical expenses, the Claims Administrator will require the Participant to submit a Request for Reimbursement with supporting documentation that the expenses are not covered or eligible for reimbursement under the group health plan or from another third party payor (with limited exceptions, as applicable, for situations in which the medical services or supplies forming the basis for the Request for Reimbursement are covered under the Flex Plan and under a Health Reimbursement Arrangement (HRA) maintained by the Employer).

For Requests for Reimbursement under the DCA, the Claims Administrator will require a Participant to submit a Request for Reimbursement for payment of expenses along with supporting documentation including a bill from the care provider and the taxpayer identification number of the care provider. The minimum amount which the Claims Administrator will reimburse is $10.00, with the exception of payments at the end of the calendar year or upon exhaustion of the Participant's account. Requests for Reimbursement for amounts less than $10.00 under the Plan will be held until the accumulated Requests for Reimbursement of the Participant under the Plan reach $10.00. The Claims Administrator will mail reimbursement checks to Participants on a daily basis, enclosing with each check a Statement of Account form indicating the amount of funds reimbursed from the Participant's account(s) to date and the amount remaining in the account(s).

c. Preferred Flex Cards. If elected by the Employer, Participants will be issued stored-value cards which are called Preferred Flex Cards. Participants are not required to use the Preferred Flex Card. The Preferred Flex Card is accepted by merchants and health care providers that have been approved by the Claims Administrator and that accept MasterCard®. The Claims Administrator will be responsible for the administration of the Preferred Flex Card program. Terms governing participants' use of Preferred Flex Cards and payment of benefits upon proper use are set forth in the Plan.

d. Account Summaries. The Claims Administrator will provide to the Employer monthly summaries of all accounts of Participants on an individual and group basis. Detailed quarterly summaries will also be provided to each Participant.

e. Funding. The Claims Administrator will send to the Employer periodically a statement reflecting the pending amount of Requests for Reimbursement plus the administrative charges specified in paragraph f. below.

(i) The Employer will transfer funds for Requests for Reimbursement into an account designated by the Claims Administrator by the close of business on the business day next following its receipt of the statement. In recognition of the Claims Administrator's risk of reimbursement for the cost of Requests for Reimbursement, it is agreed that if the Employer fails to transfer sufficient funds to pay the pending cost of Requests for Reimbursement, the Claims Administrator may at its discretion (i) suspend all pending Requests for Reimbursement automatically without notice to the Employer or any Participant until it has sufficient reassurance that there has been transferred an amount into the account sufficient to pay the Claims Administrator for the cost of Requests for Reimbursement and (ii) recall payments for Requests for Reimbursement already made but for which there is an insufficient amount in the account to pay the amount due.

(ii) The Claims Administrator will provide the Employer with a statement reconciling the amount of Requests for Reimbursement paid plus administrative charges versus deposits at the end of each month. A detailed listing of paid Requests for Reimbursement will accompany the reconciliation statement.

(iii) The Claims Administrator's charge to the Employer for Requests for Reimbursement will be the amount which the Claims Administrator is ultimately obligated to pay for such Requests for Reimbursement. For example, the Employer must pay the Claims Administrator for Requests for Reimbursement incurred before the termination of the Agreement but paid after it terminates. Such Requests for Reimbursement will be reflected in the detail listings supporting each monthly statement.

f. Administrative Charges. The Employer will reimburse the Claims Administrator for a monthly administrative charge of per participant per month.

2. Employer's Duties. The Employer will have the following responsibilities with respect to the Employer's Health FSA and DCA arrangements:

a. Enrollment. The Employer will distribute enrollment forms to eligible individuals prior to the beginning of each Plan year and for new employees upon satisfaction of all eligibility requirements for the Flex Plan. The Employer will forward enrollment data, along with a certification of eligibility of those employees, to the Claims Administrator at least thirty (30) days prior to the date the employees are to begin participating in the Flex Plan.

b. Payroll Deductions. At the Claims Administrator's request, the Employer will provide to the Claims Administrator a confirmation of the payroll deductions made for each Participant each pay period. In the event of any error or inaccuracy in the Employer's payroll deduction reports, upon which the Claims Administrator has relied in making payments, the Employer will make the Claims Administrator whole for any shortfall, as determined by the Claims Administrator and communicated to the Employer.

c. Payments to the Claims Administrator. The Employer will pay to the Claims Administrator on a periodic basis the amount of Requests for Reimbursement paid or payable for Participants under the Plan as reflected on a statement submitted to the Employer by the Claims Administrator. The frequency of such statements shall be mutually agreed on by the Employer and the Claims Administrator. In the event the Employer does not pay the amount specified by the Claims Administrator, the Claims Administrator will not be required to pay any further Requests for Reimbursement, and the Employer will indemnify the Claims Administrator and its vendors for any liability arising from such refusal to pay Requests for Reimbursement.

d. Administrative Charge. The Employer will pay the Claims Administrator the administrative charge specified in paragraph 1.f. above.

e. Cessation of Eligibility. The Employer will notify the Claims Administrator when a Participant ceases to be eligible to participate in the Flex Plan (to include a Participant who ceases to be eligible due to the expiration of the COBRA continuation coverage period).

f. COBRA. The Employer shall determine whether COBRA applies to the Flex Plan and, if so, shall provide all required notices, shall function as the Plan Administrator for purposes of COBRA, and shall determine the amount of a participant's account that is available for continued coverage under COBRA and the period of time for which such coverage may continue. The Employer shall determine the applicable premium for COBRA coverage and shall collect such premium directly from eligible participants and dependents who have elected to continue coverage under COBRA. Without in any way limiting the foregoing, the Employer has made the following determinations with respect to the Health FSA and instructs the Claims Administrator as follows:

(i) The Employer has determined that the Health FSA of a Participant shall be subject to COBRA only if the maximum reimbursement available to the Participant for the remainder of the calendar year exceeds the "applicable premium" that the Participant is obligated to pay for the remainder of the calendar year. The Employer shall determine when this condition applies and, if it does, shall offer COBRA coverage to the appropriate qualified beneficiaries.

(ii) If more than one qualified beneficiary is entitled to purchase COBRA coverage, all such beneficiaries shall be covered under one family Health FSA. If Requests for Reimbursement are received and processed by the Claims Administrator with incurred dates preceding the loss of coverage under the Employer's group health plan, but following the date on which the Claims Administrator has established the COBRA-FSA at the Employer's direction, the Claims Administrator shall not recalculate the opening balance of the COBRA-FSA. Rather, the Claims Administrator shall process any such Requests for Reimbursement against the Health FSA of the Participant who did not have a qualifying event, or in some cases, against the COBRA-FSA.

(iii) The Employer shall identify for the benefit of the Claims Administrator when Participants under the plan are continuing coverage as a result of COBRA. The Employer shall also advise the Claims Administrator when the COBRA coverage of Participants in the Health

FSA is due to expire. The Employer shall reimburse the Claims Administrator for any benefits paid in error as a result of the Employer's failure to provide timely written notice to the Claims Administrator of the events specified in this paragraph or in the Flex Plan.

g. Testing Obligations. The Employer acknowledges and understands that it is responsible for performing any and all testing of the Flex Plan necessary to comply with all nondiscrimination and qualification requirements under the Internal Revenue Code of 1986, as amended. The Claims Administrator is under no obligation to advise, assist in, or perform such testing.

h. Election Changes. The Employer acknowledges and understands that it is responsible for determining if and when Participants may make mid-year changes in elections under Section 125 of the Internal Revenue Code of 1986. The Claims Administrator has no responsibility to make such determinations. Upon permitting a Participant to make a mid-year change in election, the Employer will promptly notify the Claims Administrator of the new election amount in writing.

3. Definitions. The following definitions are applicable with respect to the Health FSA and DCA provided for under this portion of the Agreement:

a. Request for Reimbursement means a request for reimbursement of an expense covered under the Flex Plan that is incurred after the effective date of this Agreement and for which the date of service or treatment (incurred date) is prior to the date of the Participant's cessation of participation in the Flex Plan.

b. Participant means any employee or former employee eligible to participate in the Flex Plan.

c. Flex Plan means the Employer's Health Flexible Spending Account (Health FSA) and Dependent Care Account (DCA))maintained by the Employer under Sections 125 and 106(c)(2) of the Internal Revenue Code, the terms of which are set forth in one or more written documents adopted by the Employer as constituting the terms of the Flex Plan. The trade name of the Flex Plan is the Preferred Blue Flexible Spending Plan.

ARTICLE III - FINANCIAL ARRANGEMENT

A. Payment Procedures

1. The Claims Administrator will call and/or fax the Employer by 2:00 p.m. central time each Wednesday of the week to advise of the pending Cost of Claims level specified below in this Article III.

2. The Employer will transfer funds for the Cost of Claims and Administrative Charges into an account designated by the Claims Administrator by the close of business each Thursday. In recognition of the Claims Administrator's risk of reimbursement for the Cost of Claims (as defined below), it is agreed that if the Employer fails to transfer sufficient funds to pay the pending Cost of Claims, the Claims Administrator may at its discretion (i) suspend all pending Claims automatically without notice to the Employer or any Member until it has sufficient reassurance that there has been transferred an amount into the account sufficient to pay the Claims Administrator for the Cost of Claims and (ii) recall payments for Claims already made but for which there is an insufficient amount in the account to pay the Cost of Claims.

3. The Claims Administrator will provide the Employer with a statement reconciling the level of Cost of Claims paid plus Administrative Charges versus deposits at the end of each month. Following the reconciliation, any amount due to or from the Employer will be adjusted on a subsequent wire transfer.

B. Cost of Claims

The Claims Administrator's charge to the Employer for Claims will be the amount which the Claims Administrator is ultimately obligated to pay for such Claims including, but not limited to, retroactive adjustments or supplemental payments required by various provider agreements. For example, the Employer must pay the Claims Administrator for Claims incurred before the termination of the Agreement but paid after it terminates, as provided under "Run-out" below. Such Claims will be reflected in a monthly detail listing sent to the Employer.

The Cost of Claims will be adjusted upwards or downwards, as applicable, by the following:

1. Net Subrogation Recoveries: The net amount recovered through Subrogation will be credited against the Cost of Claims.

2. Access Fees: Access fees, if applicable under Article V, will be added to the Cost of Claims.

3. Credit for Multi-Plan Litigation: The Claims Administrator will reduce the Cost of Claims by the amount of any applicable recovery allocated to the Employer as a result of awards, settlements, or judgments involving multi-plan litigation as described in Article II.

C. Administrative Charges

Effective January 1, 2014 through December 31, 2014. the Employer will pay the Claims Administrator a monthly Administrative Charge of per covered contract holder or former contract holder for health and $ per covered contract holder or former contract holder for dental (excluding any charges for access fees). Effective January 1, 2015 through December 31, 2015, the Employer will pay the Claims Administrator a monthly Administrative Charge of per covered contract holder or former contract holder for health (excluding any charges for access fees).

The Employer will pay the Claims Administrator a separate commission amount of $ and per contract per month for consultant fees. This commission will be passed on the consultant.

D. Run-out

In the event of termination of this Agreement, the Employer will pay the Claims Administrator for the Cost of Claims on all claims that were incurred, but not paid by the Claims Administrator before the effective date of the termination of this Agreement. This provision will apply to all claims originally filed within the timely filing period set forth in the Plan as in effect prior to termination of this Agreement. The Cost of Claims will be paid on the same basis as set forth in Article III.A. The Employer is not required to pay an Administrative Charge for health and dental claims paid under this run-out provision.

E. Air Medical Services

The Claims Administrator contracts with a third party to provide air medical services. The Employer will pay the Claims Administrator a separate monthly charge o per covered contract holder (including COBRA contracts) for this service.

F. Performance Standards

Please refer to Exhibit 1 for the Performance Standards Agreement.

ARTICLE IV - CLAIMS AUDITS

A. Purpose

The following rules are designed to:

1. Establish a procedure by which the Employer or its authorized representatives may conduct comprehensive audits and reviews of the accuracy of the Claims Administrator's processing of Claims under the Plan in order to identify any improperly processed Claims;

2. Establish the procedure that the Claims Administrator will follow to correct any identified Claims errors;

3. Protect the legitimate business interest of the Claims Administrator; and,
4. Facilitate the protection of individually identifiable health information.

B. Employer's Audit Rights

1. The Employer may engage the services of any person or entity (hereinafter referred to as "Auditor") to audit the accuracy of the Claims Administrator's payment of Claims under the Plan. Except as provided for in the next paragraph, all costs of an audit or review shall be borne by the Employer. For purposes of this Agreement, the term "audit" means the examination of a sample of Claims consistent with generally accepted auditing standards. Sample size will be determined in a fashion consistent with generally accepted auditing standards, not to exceed a size that would be selected using statistically valid sampling techniques. If any questions should arise concerning the audit sample size, the parties will negotiate in good faith to reach a mutually agreed upon resolution. The agreed upon sample size shall not preclude the subsequent review and correction of all Claims affected by any systematic error identified during the audit.

2. The Claims Administrator will provide appropriate staff to support Plan audits (as defined above), the costs of which are included in the Employer's administrative fees. If the Employer or Auditor wishes to conduct a review of paid Claims on any basis other than generally accepted auditing standards, the Employer and Claims Administrator will negotiate a mutually agreed upon fee, to be paid by the Employer, necessary to cover the additional costs incurred by the Claims Administrator for such a review. Prior to undertaking the audit, the Employer shall require the Auditors to execute a confidentiality agreement in a form satisfactory to the Claims Administrator.

3. Audits of Claims must be (i) commenced within 24 months of the date the Claims were paid, and (ii) completed and submitted to the Claims Administrator within 36 months of the date the Claims were paid. The Employer will be deemed to have accepted as correct the processing of all Claims with respect to which an audit is not commenced, completed, and submitted to the Claims Administrator within the foregoing time frames.

4. The Employer understands and acknowledges that information, data, documentation, or software disclosed by the Claims Administrator in the course of or related to the audit contains individually identifiable health information about Plan Members ("Member Health Data") as well as information that is proprietary to the Claims Administrator's business operations ("Proprietary Data"). The Employer further understands and acknowledges that all Proprietary Data is confidential and a valuable trade secret of the Claims Administrator, and that any disclosure or use of such data for any purpose other than to evaluate the accuracy of the Claims Administrator's processing of Claims under this Agreement will cause irreparable harm and loss to the Claims Administrator. Proprietary Data includes, but is not limited to, UCR limits, negotiated provider payments, hospital per-diems, retroactive reimbursement mechanisms, and other negotiated terms between the Claims Administrator and hospital and medical providers. In view of the foregoing, the Employer agrees that neither it nor the Auditors shall release or disclose to any third party any data or information obtained from the Claims Administrator during the course of the audit without first affording the Claims Administrator the opportunity to determine whether such data or information includes any Proprietary Data. If it does, the Claims Administrator may require the removal of Proprietary Data from the material to be released or disclosed.

5. The Employer warrants that the Plan will enter into a suitable business associate agreement with the Auditors prior to the commencement of the audit. This agreement will authorize the Claims Administrator to release Member Health Data to the Auditors.

C. Procedures for Audits of Claims

1. The Employer shall provide prior written notice to the Claims Administrator regarding its intention to perform an audit or review of the Claims Administrator's accuracy of Claims payments.

2. The Auditors may contact the hospital or medical providers with whom Blue Cross and Blue Shield of Alabama or another Blue Cross/Blue Shield Plan has a contract without written consent of the Claims Administrator only in order to confirm payment of the audited Claims. All other contact with providers regarding Blue Cross or Blue Shield payments must first receive written consent of Blue Cross and Blue Shield of Alabama.

3. The Employer will furnish the Claims Administrator a copy of the completed audit report. Upon receipt of the audit report, the Claims Administrator will provide a written statement to the Employer of any disputed findings or conclusions.

4. Should the Auditors identify disputed Claim payments under the Plan, the Employer and the Claims Administrator shall in good faith determine if the claims payments are in error and allocate responsibility for such errors among themselves, based on the relative degree of fault of each party. With respect to Claims errors that the parties determine are the responsibility of the Claims Administrator, the Claims Administrator will make a refund to the Employer of such erroneous payments and may thereafter, for its own account, recover the amount of the refund from the provider or the Member. In all other cases, the Claims Administrator will request a refund of the Claim (to the extent permitted by law) from the provider, Member, or in the case of claims paid through the BlueCard Program, the Host Plan, except to the extent that the retroactive eligibility adjustment provisions of Article II provide otherwise. Upon receipt of the refund, the Claims Administrator will credit the Employer with the amount of the refund.

Notwithstanding anything in this Article IV to the contrary, no adjustments or refunds shall be made on the basis of statistical projections of sample dollar errors.

ARTICLE V - GENERAL PROVISIONS

A. Delegation of Discretionary Authority

The Employer hereby delegates to the Claims Administrator the discretionary responsibility and authority to process and adjudicate Claims under the Plan, to construe, interpret, and administer the Plan, and to perform every other act necessary or appropriate in connection with the Claims Administrator's provision of administrative services hereunder. Whenever the Claims Administrator makes reasonable determinations that are neither arbitrary nor capricious in its administration of the Plan, those determinations will be final and binding on the Plan's participants or beneficiaries, subject only to applicable rights of review under the Plan and thereafter to judicial review to determine whether the Claims Administrator's determination was arbitrary or capricious.

B. Allocation of ERISA Duties

The Employer is the Plan's administrator within the meaning of Section 3(16)(A) of ERISA. To the extent not delegated to the Claims Administrator in this Agreement or pursuant to the terms of the Plan, the Employer retains the discretionary fiduciary authority to manage and administer the Plan.

C. Indemnification and Reliance on Employer Directions

Each party agrees to indemnify, defend, and hold the other harmless from and against any liability that the other party may incur as a result of the indemnifying party's breach of this Agreement or failure to comply with applicable law; provided that the Employer will in all cases remain responsible for payment of benefits under the Plan.

The Claims Administrator is entitled to rely on instructions, communications, or directions from the Employer concerning Plan design, eligibility determinations, benefit changes, and other areas of Plan administration for which the Employer is responsible. The Claims Administrator has no obligation or responsibility to question or refuse to follow such instructions, communications, or directions. The

Employer will indemnify, defend, and hold the Claims Administrator harmless from any liability arising from the Claims Administrator's reliance on such instructions, communications, or directions.

D. Late Payment

If the Administrative Charges specified in Article III are not paid by the last day of the month in which such Charges are due, the Employer shall pay the Claims Administrator a penalty for each day such Charges are deemed late. The amount of the penalty will be calculated daily and will be based on the overnight repurchase rate that was in effect on the last day of the month in which the charges were due. This rate is published in the Money Rates section of the Wall Street Journal.

Charges are "late" each day a wire transfer in the proper amount is not received by the Claims Administrator.

E. Premium Taxes

The Claims Administrator will not invoice for any state premium taxes; provided that if a portion of Plan benefits are provided through separate, underwritten, arrangements (such as Expanded Psychiatric Services), the Employer understands and acknowledges that premium taxes attributable to such underwritten arrangements will be billed to the Employer as a part of the premium or as a part of the Administrative Charge.

F. Affordable Care Act Fees and Taxes

Employer is responsible for calculating, remitting and paying to the appropriate federal agencies all Affordable Care Act fees and taxes that apply to the Plan.

G. Changes in Agreement

1. The Employer and the Claims Administrator may amend this Agreement at any time without notice to any employee or dependent through the mutual written agreement of the Claims Administrator (duly executed by its officer authorized to do so) and of the Employer (duly executed by its officer authorized to do so). Amendments to the Enrollment or Implementation Agreement that are duly adopted after the effective date of this Agreement that affect the financial arrangement between the parties shall be deemed to amend the financial provisions of this Agreement.

2. Notwithstanding the foregoing, payment by the Employer of Administrative Charges following the effective date of an amendment to or restatement of this Agreement proposed in writing and duly executed by the Claims Administrator and sent to the Employer at its most recent address as reflected in the Claims Administrator's records shall constitute the Employer's binding acceptance of the terms of the amendment or restatement.

3. No representative or employee of the Claims Administrator is authorized to amend or vary the terms and conditions of this Agreement or to make any agreement or promise not specifically contained herein or to waive any provision hereof other than by the means prescribed above in this Article V.

H. Notices

1. Any notice given by the Claims Administrator under this Agreement shall be sufficient and effective for all purposes if and when mailed to the Employer at its address as appearing in the records of the Claims Administrator.

2. Any notice given to the Claims Administrator by the Employer shall be sufficient if mailed to the Claims Administrator at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858.

3. All notices by or to the Claims Administrator shall be in writing.

I. Out-of-Area Services

Blue Cross and Blue Shield of Alabama has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever Members access healthcare services outside the geographic area Blue Cross and Blue Shield of Alabama serves, the claims for those services may be processed through one of these Inter-Plan Programs and presented to Blue Cross and Blue Shield of Alabama for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Members under this agreement are described generally below.
Typically, Members, when accessing care outside the geographic area we serve, obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from non-participating healthcare providers. Our payment practices in both instances are described below.

J. BlueCard® Program

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

1. Liability Calculation Method Per Claim

The calculation of Member liability on Claims for covered healthcare services processed through the BlueCard® Program will be based on the lower of the participating healthcare provider's billed covered charges or the negotiated price made available to us by the Host Blue.

The calculation of your liability on Claims for covered healthcare services processed through the BlueCard® Program will be based on the negotiated price made available to us by the Host Blue. Sometimes, this negotiated price may be greater than billed charges if the Host Blue has negotiated with its participating healthcare provider(s) an inclusive allowance (e.g., per case or per day amount) for specific healthcare services.

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

(a) the actual price. An actual price is a negotiated payment without any other increases or decreases, or

(b) an estimated price. An estimated price is a negotiated payment increased or reduced by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives, or

(c) an average price. An average price is a percentage of billed covered charges 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 Plans using either the Estimated Price or Average Price, will, in accordance with InterPlan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid

to or received from providers). However, the amount paid by the Member and you is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard® Program requires that the price submitted by a Host Blue to us is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

If a Host Blue uses either an estimated price or an average price on a claim, it may also hold some portion of the amount that you pay in a variance account, pending settlement with its participating healthcare providers. Because all amounts paid are final, neither variance account funds held to be paid, nor the funds expected to be received, are due to or from you. Such payable or receivable would be eventually exhausted by healthcare provider settlements and/or through prospective adjustment to the negotiated prices. Some Host Blues may retain interest earned, if any, on funds held in variance accounts.

A small number of states require Host Blues either (i) to use a basis for determining Member liability for covered healthcare services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge.

Should the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, we would then calculate Member liability and your liability in accordance with applicable law.

2. Returns of Overpayments

Under the BlueCard® Program, recoveries from a Host Blue or from participating healthcare providers can arise in several ways including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a Claim-by-Claim or prospective basis.

3. BlueCard® Program Fees and Compensation

Employer understands and agrees to reimburse Blue Cross and Blue Shield of Alabama for certain fees and compensation which we are obligated under the BlueCard® Program to pay to the Host Blues, to the Blue Cross and Blue Shield Association (BCBSA), and/or to BlueCard® Program vendors, as described below. Fees and compensation under the BlueCard® Program may be revised in accordance with the Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by any groups. Such revisions typically are made annually as a result of Program policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with your benefit period under this agreement.

Blue Cross and Blue Shield of Alabama will charge these fees as follows:

Only the BlueCard® Program access fee may be charged separately each time a claim is processed through the BlueCard® Program. If one is charged, it will be a percentage of the discount/differential Blue Cross and Blue Shield of Alabama receives from the Host Blue, based on the current rate in accordance with the Program's standard procedures for establishing the access fee rate. The access fee will not exceed for any claim. All other BlueCard® Program-related fees are included in our general administrative fee.

In addition to the access fee described above, the applicable general administrative fee is noted in Article III C.

4. Negotiated National Account Arrangements

As an alternative to the BlueCard® Program, your Member claims for covered healthcare services may be processed through a negotiated National Account arrangement with a Host Blue.

If Blue Cross and Blue Shield of Alabama and you have agreed that (a) Host Blue(s) shall make available (a) custom healthcare provider network(s) in connection with this agreement, then the terms and conditions set forth in Blue Cross and Blue Shield of Alabama negotiated National Account arrangement(s) with such Host Blue(s) shall apply. Employer agrees that the relevant participation agreement describes Blue Cross and Blue Shield of Alabama's responsibility in connection with the processing and payment of claims when Blue Cross and Blue Shield of Alabama Members access such networks.

Member Liability Calculation

Member liability calculation will be based on the negotiated price/lower of either billed covered charges or negotiated price (refer to the description of negotiated price under Section I.1.) made available to Blue Cross and Blue Shield of Alabama by the Host Blue that allows your Members access to negotiated participation agreement networks of specified participating healthcare providers outside of Blue Cross and Blue Shield of Alabama service area.

Fees and Compensation

Employer understands and agrees to reimburse Blue Cross and Blue Shield of Alabama for certain fees and compensation which we are obligated under applicable Inter-Plan Programs requirements to pay to the Host Blues, to the Blue Cross and Blue Shield Association, and/or to Inter-Plan Programs vendors. Fees and compensation under applicable Inter-Plan Programs may be revised in accordance with the Programs' standard procedures for revising such fees and compensation, which do not provide for prior approval by any groups. Such revisions typically are made annually as a result of Inter-Plan Programs policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with your benefit period under this agreement.

In addition, the participation agreement with the Host Blue may provide that Blue Cross and Blue Shield of Alabama must pay an administrative and/or a network access fee to the Host Blue, and you further agree to reimburse Blue Cross and Blue Shield of Alabama for any such applicable administrative and/or network access fees. For this type of negotiated participation arrangement, any such administrative and/or network access fees will not be greater than the comparable fees that would be charged under the BlueCard® Program.

5. Non-Participating Healthcare Providers Outside Claims Administrator's Service Area

Member Liability Calculation

a. In general, when covered healthcare services are provided outside of the Blue Cross and Blue Shield of Alabama service area by non-participating healthcare providers, the amounts a Member pays for such services will generally be based on either the Host Blue's non-participating healthcare 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 non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this paragraph.

b. Exceptions. In some exception cases, we may pay such claims based on the payment we would make if we were paying a non-participating provider inside of our service area, as described elsewhere in this agreement, where the Host Blue's corresponding payment would be more than our in-service area non-participating provider payment, or in our sole and absolute discretion, we may negotiate a payment with such a provider on an exception basis. In other exception cases, Blue Cross and Blue Shield of Alabama may pay claims from non-participating healthcare providers outside of our service area based on the provider's billed charge, such as in situations where a Member did not have reasonable access to a participating provider, as determined by us in our sole and absolute discretion or by applicable state law. In any of these exception situations, the Member may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this paragraph.

Fees and Compensation

No additional fees would apply for utilization of a non-participating provider. All non-par associated fees are included in the general administrative fee.

K. Blue Distinction Centers and Blue Distinction Centers+

Blue Distinction Centers and Blue Distinction Centers+ (BDC and BDC+) are national programs administered by the Blue Cross and Blue Shield Association for the provision of certain specialty care services by participating BDC and BDC+ providers to Plan members. The Employer will pay the Claims Administrator an access fee when Plan members use the BDC or BDC+ global contracted arrangements outside of the Claims Administrator's exclusive service area (state of Alabama). The access fee is billed regularly throughout the year.

These charges are in addition to the Administrative Charge listed in Article III C.

ARTICLE VI - TERMINATION OF AGREEMENT

This Agreement and all rights hereunder may be terminated at any time by either the Employer or the Claims Administrator upon 30 days written notice to the other given in the manner prescribed by Article V; provided however, that termination of this Agreement shall not terminate either party's indemnification rights under Article V, nor shall it terminate the Employer's obligation to pay the Claims Administrator for the Cost of Claims and Administrative Charges related to Claims incurred before the effective date of termination of this Agreement. Other provisions of this Agreement that survive termination are specified elsewhere herein.

ARTICLE VII - DEFINITIONS

The defined terms in this Agreement are as follows:

"Administrative Charges" means the monthly charges specified in Article III.

"Affordable Care Act" means The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 and regulations thereunder.

"Agreement" means this Administrative Services Agreement between the Claims Administrator and the Employer, any amendment to or any revisions of this Administrative Services Agreement made in accordance with Article V.

"Claim" means benefits provided under the Plan after the effective date of this Agreement or its termination, and for which the date of service or treatment (incurred date) is prior to the date of termination of this Agreement.

"Cost of Claims" means the amount described in Article III.

"Employer" means Walter Energy (including subsidiaries) and any corporate successor thereto.

"Member" means a subscriber or eligible dependent who has coverage under the Plan.

"Net Amount Recovered Through Subrogation" means the net amount, if any, which the Claims Administrator recovers from any other party less all direct costs and expenses of the recovery such as attorneys' fees and court costs. "Direct costs" and "expenses" do not include the salaries, benefits or administrative expenses of employees of the Claims Administrator.

"Plan" means the Walter Energy Group Medical Plan and Group Dental Plan established by Walter Energy having an effective date of January 1, 2001, as said Plan may be amended from time to time. The written instruments evidencing the benefits and terms of the Plan to be administered by the Claims Administrator consist of this Agreement, the Group Enrollment or Implementation Agreement, and the

benefit booklet prepared by the Claims Administrator that will serve as the Summary Plan Description in accordance with Article II, Section C. Pending finalization of the benefit booklet, the written instruments evidencing the benefits and terms of the Plan to be administered by the Claims Administrator will also consist of the standard benefit language maintained by the Claims Administrator for the type of plan established by the Employer, and any draft benefit booklets treated as operative by the Claims Administrator in accordance with Article II, Section C.

ARTICLE VIII - EXECUTION

IN WITNESS WHEREOF, the following parties have caused their respective duly authorized representative to execute this Administrative Services Agreement as of the effective date of this Agreement.

BLUE CROSS AND BLUE SHIELD OF ALABAMA

By Jim Sexton Date _____

Tim Sexton, Senior Vice President and Chief Marketing Officer

Walter Energy, Inc.

By _____ Date 7/29/2014

Title VP - Compensation & Benefits

EXHIBIT I

PERFORMANCE STANDARDS FOR WALTER ENERGY, INC. PERFORMANCE GUARANTEES

A. PERFORMANCE STANDARDS

1. The performance standards and penalties shall be administered and calculated by the Claims Administrator in accordance with accepted statistical techniques utilizing random samples.

2. **Financial Accuracy Rate**

   (a) The Claims Administrator's standard is that, during each Calendar Year, it shall maintain the financial accuracy rate (hereinafter referred to as the "Financial Accuracy Rate") of at least with respect to the payment of Claims hereunder.

   (b) If the Financial Accuracy Rate is less than in any Calendar Year, the Employer shall be entitled to a credit of of the Administrative Charges.

   (c) The Claims Administrator's Financial Accuracy Rate for a Calendar Year shall be calculated by the following:

$$1 - \frac{\text{(Amount Over Paid + Amount Under Paid)}}{\text{Amount Should Have Paid}} \times 100$$

   Financial Errors shall include, but are not limited to, the following:

   1. Incorrect application of deductibles and co-payments.
   2. Payment for non-covered services under the Plans.
   3. Overpayment of covered services under the Plans.
   4. Failure to apply or incorrect application of any coordination of benefits provisions of the Plans.
   5. Duplicate payments.
   6. Incorrect application of limits.

   (d) Notwithstanding the foregoing, financial errors shall not include errors made in reasonable reliance upon the information provided by the Employer, participants or providers of services in connection with a claim.

3. **Claims Processing Timeliness Standard**

   (a) The Claims Administrator's standard is that, during each Calendar Year, ninety percent (90%) of all non-investigated Claims received by it during such calendar year shall be processed within 14 calendar days of the Claims Administrator's receipt thereof, and during each Calendar Year ninety-five percent of all Claims received by it during such calendar year

shall be processed within 30 calendar days of the Claims Administrator's receipt thereof; provided that the Claims Administrator shall not be deemed to have failed to process any claim if its failure to process such claim within 14 calendar days or 30 calendar days of its receipt thereof was the direct result of the Employer's failure, or the failure of any third party providing services for or on behalf of the Employer or its Members to furnish required information in a timely manner. For the purpose of this, a claim shall be deemed to have been processed when the Claims Administrator either adjudicates a Claim for payment or denial or generates correspondence requesting pertinent information which it must receive before it can fully process a Claim.

(b) If the Claims Administrator fails to process at least _ _ of all non-investigated Claims, received by it during such calendar year, within 14 calendar days, the Employer shall be entitled to a credit of ____ of the Claims Administrator's Administrative Charges hereunder for such calendar year.

(c) If the Claims Administrator fails to process at least _ , of all Claims, received by it during such calendar year, within 30 calendar days, the Employer shall be entitled to a credit of ___ of the Claims Administrator's Administrative Charges hereunder for such calendar year.

4. Frequency Accuracy Standard

(a) The Claims Administrator's standard is that, during each Calendar Year service, its frequency accuracy rate for Claims processed during such calendar year shall be at least ninety-seven percent (

(b) If the Claims Administrator fails to achieve at least a _ _ frequency accuracy rate, the Employer shall be entitled to a credit equal to _ _ of the Claims Administrator's annual Administrative Charges hereunder.

(c) The Claims Administrator's frequency accuracy rate for any Calendar Year shall be determined by (i) dividing the number of sampled Claims processed hereunder during such calendar year without any frequency errors by the total number of sampled Claims processed hereunder during such calendar year, (ii) multiplying the result by one hundred (100).

Frequency Errors shall include, but are not limited to, the following:

1. Payment to an incorrect provider of services.
2. Sending of a payment to an incorrect address, unless the Employer, the participant, or the provider furnished the incorrect address.
3. Payment made on behalf of the wrong Employee or the wrong dependent.
4. Payment of an incorrect amount.
5. Failure to honor a proper assignment of benefits.
6. Any financial errors described in A2.

(d) Notwithstanding the foregoing, payment errors shall not include errors made in reasonable reliance upon the information provided by the Employer, participants or providers of services in connection with a claim.

B. CUSTOMER SERVICE ACCESSIBILITY AND INQUIRY RESPONSE

1. Telephone Response Time

The Claims Administrator's standard is that, the average speed of answer will not exceed seconds on an annual basis. If the Claims Administrator fails to achieve the seconds speed of answer, the Employer shall be entitled to a credit of _ __ of the Administrative Charges.

2. Call Abandonment Rate

The Claims Administrator's standard is that, the percentage of calls received that are terminated by a participant before a live person answers will not exceed during any one calendar year. If the Claims Administrator Call Abandonment Rate exceeds the Employer shall be entitled to a credit of __ of the Administrative Charges.

3. Timeliness of Inquiry Resolution

The Claims Administrator's standard is that during each calendar year, of all inquiries received during such calendar year, either written or telephonic, will be resolved within 14 calendar days.

(a) If the Claims Administrator fails to resolve to of all inquiries in 14 calendar days, the Employer shall be entitled to a credit of ___ of the Administrative Charges.

C. PERFORMANCE REPORTING

If the Employer requests Performance Standards other than the Claims Administrator's Industry Standards, the Employer shall pay an additional fee; this fee shall be added to the Administrative Charges.

D. CONDITIONS FOR ALL PENALTIES

The following conditions apply to all the foregoing penalties

(a) All calculations shall aggregate the data on all Members of the Employer.

(b) The total penalties shall not exceed __ of the annual Administrative Charges.

(c) A one-quarter performance guarantee moratorium will be in effect for all Performance Guarantee measures after a significant benefit change or enrollment of new states or enrollment of acquisitions involving new or existing states.

(d) In the performance guarantee areas where interface between the Claims Administrator and the Employer and/or Employer's vendor's is required, the applicable penalties shall apply to the Claims Administrator if and only if the errors or lack of timeliness is caused entirely by the Claims Administrator. Penalties shall not apply to the Claims Administrator due to errors caused by the Employer and/or one or more of the Employer's vendors.

(e) Any exception paid claims shall be excluded from the performance standards.

(f) Claims arrive via an electronic medium in a format that meets all statutory and regulatory requirement that apply at the time of receipt and the requirement of any applicable state or federal privacy/confidentiality laws and regulations.