REQUEST FOR MODIFICATION
of the
Commissioner's Approving Determination and Order
(Order No. ID-RC-13-06)
Dated April 29, 2013

Filed with the

Pennsylvania Insurance Department
on behalf of

Highmark Health (f/k/a UPE)
Fifth Avenue Place
120 Fifth Avenue
Pittsburgh, PA 15222

October 16, 2023

Name, title, address, telephone number, and fax number of the individual to whom notices and correspondence concerning this Request for Modification should be addressed:

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ITEM 1: **IDENTITY OF PARTIES TO THE REQUEST FOR MODIFICATION**

(A) The party requesting modification is Highmark Health (f/k/a UPE) on behalf of itself and its affiliates, including Highmark Inc.

(B) The registered address and principal executive office address of Highmark Health is Fifth Avenue Place, 120 Fifth Avenue, Pittsburgh, PA 15222.

(C) Highmark Health is a Pennsylvania nonprofit corporation.

(D) Highmark Health operates an integrated healthcare delivery and financing system.

(E) Highmark Health is the sole corporate member of Highmark Inc., a Pennsylvania nonprofit health plan corporation.

(F) Highmark Health also is the sole corporate member of Allegheny Health Network (f/k/a UPE Provider Sub) ("AHN").

ITEM 2:

A. **BACKGROUND INFORMATION WITH RESPECT TO THE REQUEST FOR MODIFICATION**

On April 29, 2013, in Approving Determination and Order No. ID-RC-13-06 (the "Order"), the Pennsylvania Insurance Commissioner (the "Commissioner") approved the application of UPE (n/k/a Highmark Health) submitted to the Pennsylvania Insurance Department (the "Department") to acquire control of Highmark Inc. and of various subsidiaries thereof as identified in the Form A relating thereto, subject to certain conditions.

On July 28, 2017, the Commissioner, pursuant to Section 27 of the Order granted Highmark Health's request for modification to Conditions 10 and 11, as well as certain other Conditions. The current provisions of the Order, as modified, are set forth in Appendix A along with a comparison showing changes to the original Order. A compilation of the currently operative Conditions of the Order is attached hereto as Appendix A-1. A redline of the Order as modified in 2017 is attached hereto as Appendix A-2.

B. **REQUEST FOR MODIFICATION OF THE ORDER.**

Condition 27 of the Order provides as follows:

> Upon written request by a UPE Entity setting forth: (a) the specific Condition(s) for which such UPE Entity seeks relief; (b) the reason for which such relief is necessary and (c) an undertaking by such UPE Entity to provide all such further information as the Department shall require to evaluate the request, the Department may evaluate and, after evaluation of the request, the Commissioner, in the

> Commissioner's sole discretion, may grant relief, in whole or in part, from one or more of the Conditions as the Commissioner may be [sic] deem appropriate.

Pursuant to Condition 27, Highmark Health hereby requests that it, Highmark Inc., and any other impacted affiliates of Highmark Health be granted relief from the remaining Conditions in the Order for the reasons set forth herein.

Although the Order applies certain Conditions to Highmark Health, then known as UPE, Highmark Inc. is the insurer entity subject to regulation under the Department's authority and Highmark Health is subject to regulation by the Department, if at all, to the limited extent it is considered a domestic insurer under 40 Pa. Stat. § 991.1402.

C. REASON THE MODIFICATION IS NECESSARY

The Order has been in place for over 10 years, and at this point, there can be no doubt that Highmark Inc. continues to be a very strong, fiscally sound health insurance company and that healthcare competition in western Pennsylvania has been enhanced following the creation of Highmark Health as a blended health organization. For that core reason, among others discussed below, the Order has served its purpose and any competitive effects it sought to address have been remedied. Consistent with its limited statutory authority to address the potential anticompetitive effects of mergers, the Department should not continue to regulate Highmark Health through the Order. Highmark Inc. will remain subject to robust oversight from the Department, the antitrust laws, and other regulatory obligations, ensuring that Highmark Inc. remains a viable health insurer in the Commonwealth of Pennsylvania subject to the same regulatory regime as other similarly situated competitors. Therefore, the remaining Conditions of the Order should be lifted.

1. Highmark Health's Strategy is Procompetitive

The Order made possible the creation of Highmark Health as a blended health organization. Highmark Health's approach has been to operate a health system – Allegheny Health Network ("AHN") – through the lens of a large health insurer with a focus on reducing current and long-term costs of care by increasing health outcomes and quality at every step of the patient experience. Highmark Health's Living Health model is consumer centric and focused on patient and member outcomes with the goal of bending the arc of health care costs while providing better health results for our patients and members.

Highmark Health's ability to have deep insight into the operations of both a health insurer and a hospital system has been procompetitive. As an integrated healthcare company with a large health plan and vibrant competition in the regions of Pennsylvania where it offers health plans, Highmark Health does not have the incentive or ability to raise premiums or other costs for employer groups or individuals above competitive levels. Indeed, the incentives go the other way, because to remain competitive and sell more insurance, Highmark Inc. must maintain premiums at the lowest viable cost. Highmark Health likewise is not incentivized to pay rates that are above competitive levels to AHN or other providers because to do so would result in higher premiums charged by Highmark Inc., which would make Highmark Inc. less competitive in the market.

Highmark Inc.'s incentives are aligned with risk and value-based reimbursement, and therefore consistent with the path for healthcare as mapped out by the Center for Medicare and Medicaid

Innovation ("CMMI"). CMMI seeks to have 100 percent of original Medicare beneficiaries and the majority of Medicaid in accountable care by 2030, which means that operating margins will of necessity be driven by lower health care costs and improved health outcomes. Highmark Inc. intends to align with CMMI's goals not only in Medicare and Medicaid but also in commercial products by executing on its Living Health strategy.[1]

Because of Highmark Health's blended health approach, it is incentivized to deliver both high quality of care and low cost of care. One example of this is Highmark Inc.'s Together Blue products. Highmark Inc. has launched high performing network Together Blue products in the Affordable Care Act market, the Medicare Advantage market, and for small group clients. These products have high performing networks in which only AHN and select other providers are in-network. Together Blue products are offered at a lower cost because they are supported by a select group of lower cost and high-quality providers. For example, Highmark Inc.'s most recent Together Blue product is a Medicare Advantage (Part C) HMO plan for members in Allegheny, Butler, Erie, Washington, and Westmoreland counties. The product is offered at a $0 premium, and includes low copays, an over-the-counter card allowance, and exclusive access to a specialized customer service team that can help members identify doctors, schedule appointments, explain plan terms, and connect them with in-network providers. Consistent with its Together Blue experience, Highmark Inc.'s high performing network products yield approximately $100 greater cost savings than broad network products on a risk-adjusted total medical expenditure per member per month basis.

Competition on the health plan side of the market incentivizes Highmark Inc. to keep premiums low for this and other products. Competition on the provider side incentivizes Highmark Inc. to offer, as discussed below, high quality of care on an in-network basis so that it can attract members to its high performing network products.

It is also important to note here that Highmark Health has been able to continue to offer competitive products in the market and maintain a fiscally sound balance sheet and appropriate Risk Based Capital amounts, while providing funding to AHN through rates and other transfers permitted under the Order. Highmark Health and Highmark Inc. do not show any indications that they would suffer material financial challenges because of the transfers to AHN. If the transfers were excessive in terms of Highmark Health or Highmark Inc.'s financial viability, either the balance sheet and Risk Based Capital amounts would reflect that adverse fact, or the price of insurance/total medical costs would be too high to be competitive in the market. Neither of these outcomes has come to pass, because Highmark Health's strategy as articulated to the Department in 2013 has been successful. Highmark Health's performance over the last ten years should put to rest any implication that AHN is detrimental to the overall viability of Highmark Health and/or Highmark Inc.

2. The Current State of Healthcare Competition in Western Pennsylvania

Over the past 10 years, healthcare markets in western Pennsylvania have become more competitive. Competition is vigorous on the payer and provider sides of the market. Highmark

[1] *Value-Based Payments: Is the CMS's Vision for 2030 Within Reach?*, December 1, 2022, available at https://healthcare.rti.org/insights/value-based-payments-and-cms-vision-for-2030 (accessed October 16, 2023).

Inc. has faced stiffer competition on the insurance side of the market, and on the provider side of the market, AHN has thrived as a high quality, lower cost provider.

On the insurer side, there has been a clear increase in competition since the Order was issued in 2013. New and existing competitors have introduced new products in the market and gained market share since 2013.

With respect to cost of care, total medical expenditures for Highmark Inc. commercial, Medicare Advantage and ACA enrollees attributed to AHN providers has been lower relative to enrollees attributed to UPMC since at least 2019. Moreover, the number of Highmark Inc. commercial enrollees using AHN providers has increased from 14% in 2014 to 26% in 2022. Highmark Inc. members who utilize Physician Partners of Western PA, AHN's clinically integrated network, have a 3% lower cost of care than others in western Pennsylvania, which is a savings of approximately $215 per member annually. Underscoring the impact of the Order and of Highmark Health, Highmark Inc. sees lower total cost of care in its western Pennsylvania market as compared to other Pennsylvania markets saving $210 per member per year.

Highmark Health's analysis is consistent with that of the Department's economist, Compass Lexecon. Compass Lexecon's May 2023 Competitive Assessment of the Western Pennsylvania Insurance and Healthcare Markets (the "2023 Compass Lexecon Report") prepared for the Department concluded that, since the Order, competition has been "strengthened" in the insurer markets and "maintained" on the delivery side of the market.[2]

On the provider side, AHN has improved access to care and maintained strong quality of care. With respect to access, AHN has, among other things, created six multi-specialty Health + Wellness pavilions and six outpatient centers; reopened the West Penn Hospital emergency room and expanded inpatient services; and opened seven new cancer centers, including a major new academic and research hub at Allegheny General Hospital.

AHN's quality metrics are strong across the board. CMS Hospital Compare data from 2013-2022 show that AHN's patient safety indicators have improved every year since 2016. AHN's readmission score has improved since 2019, its mortality score has improved substantially since 2019, and its patient satisfaction scores have improved in recent years.

These metrics indicate that Highmark Health's integrated strategy of selling insurance at competitive rates and then having members access high-quality, cost-effective care at AHN is working. AHN is a vital component of how Highmark Inc. sells insurance in western Pennsylvania, and the continued overall financial success of Highmark Health in western Pennsylvania is a testament to the importance of AHN to its strategy. Without a strong competitor like AHN, Highmark Health was of the view that UPMC would have had limited competitive constraints on rate increases, which would have increased overall medical costs through the increased premiums necessary to pay those rates. With AHN, Highmark Health is able to provide outstanding medical care at the lowest total medical cost in the region and constrain the rates

[2] This is consistent with Compass Lexecon's July 2017 Assessment of Healthcare Competition Following Highmark Inc.'s Affiliation with West Penn Allegheny Health System, Inc. and other Healthcare Providers (the "2017 Compass Lexecon Report").

charged by UPMC to not only Highmark Inc. members but to all consumers in western Pennsylvania.

3. Relief from the Order is Appropriate and Procompetitive after 10 Years of Unique Regulatory Burdens Imposed on Highmark Health

The Order imposes requirements on Highmark Health that were meant to curb any anticompetitive effects from its affiliation with AHN. The federal antitrust enforcement agencies impose similar requirements, such as firewalls or notice requirements, as conditions for approval of certain vertical mergers. Unlike the Order, however, federal orders containing such requirements typically terminate after a set period of time – usually 10 years.[3] The 2023 Compass Lexecon Report notes that conditions such as these expire after 5-10 years, and the consent orders cited by Compass Lexecon were limited to 3, 5 or 10-year periods.[4] Accordingly, after a decade, it is time to grant Highmark Health relief from the remaining Conditions in the Order.

Highmark Health's position that the Order's Conditions should be removed is consistent with the Department's limited statutory authority to regulate mergers. Permanent regulation by order is not typical and would be inconsistent with a properly functioning regulatory scheme. While the Department may seek certain policy outcomes, there is no statutory or regulatory basis for imposing conditions to maintain such outcomes long after they have been achieved, and on only one regulated entity among several similarly situated entities.

The Department's relevant authority is set forth in 40 Pa. Stat. § 991.1402. The Department may disapprove a proposed transaction only on specifically enumerated grounds, including where the change in control would lessen competition.[5] Otherwise, the Department must approve the transaction.[6] This statutory grant of authority is a "clear directive" and the Department's ability to enact conditions on a transaction may last only so long as there is a risk of anticompetitive effects.[7] As set forth above, and consistent with the 2017 and 2023 Compass Lexecon Reports, there is no ongoing competitive threat from this decade-old transaction.

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[3] *See, e.g., FTC v. Sycamore Partners II L.P.* (January 28, 2019) (providing that company is subject to 10-year order requiring prior notification to the FTC of any acquisitions and compliance reports for firewall requirement); *FTC v. Broadcom Ltd.* (July 13, 2017) (terminating order after ten years that requires firewalls and monitor as conditions for merger); *FTC v. Teva Pharmaceuticals Industries Ltd.* (September 15, 2016) (requiring merging parties to file a written report for ten years setting forth in detail the manner and form in which it has complied with the order); *FTC v. Abbott Labs.* (2017) (approving acquisition on condition that acquiring party not acquire ownership in company or its assets without advanced notice for 10-year period); *Enforcement of Merger Consent Decrees*, GLOBAL COMPETITION REVIEW (Nov. 8, 2021) ("The DOJ's antitrust consent decrees typically last 10 years.").

[4] 2023 Compass Lexecon Report, at 66 (citing 10-year or less firewall conditions); *id.* at 68-69 (citing 10-year conditions prohibiting anti-tiering or anti-steering contract terms); *id.* at 61 (citing Tennessee COPA Terms of Certification. January 31, 2018 https://www.balladhealth.org/sites/default/files/documents/TN-COPA-Terms-of-Certification-Jan-31-2018.pdf) (3-year conditions for rural spending, 3-year conditions for capital compliance, and 10-year spending requirement).

[5] 40 Pa. Stat. § 991.1402(f).

[6] *Id.*

[7] *See, e.g.*, *Transp. Servs., Inc. v. Underground Storage Tank Indemnification Bd.*, 67 A.3d 142, 155 (Pa. Commw. Ct. 2013) (where regulatory rule operated as a binding standard of conduct and exceeded the clear directive of the enabling regulation, the rule must be promulgated as a regulation to be enforced); *Home Builders Ass'n of Chester v. Dep't. of Env. Protection*, 828 A.2d 446, 455 (Pa. Commw. Ct. 2003) ("[I]t is clear that an agency cannot create new

Where the transaction no longer poses a risk to competition and competition has been sufficiently enhanced, the Department lacks a clear statutory basis for continued regulation by order. Under 40 Pa. Stat. § 991.1402(f)(1), the Department "may only disapprove a filing [for a merger] for seven specified reasons."[8] Where the relevant one of those seven enumerated reasons has been addressed, the Department's statutory authority to control the conditions of the merger is no longer applicable. Indeed, the Department's authority to "condition the approval of the merger" arises under 40 Pa. Stat. § 991.1402(f)(1)(ii)(C), which is limited to conditions that would remove the "basis of disapproval" as related to whether the merger would "substantially lessen competition in insurance in this Commonwealth or tend to create a monopoly therein." 40 Pa. Stat. § 991.1402(f)(1)(ii)(C) further provides that the department may condition approval "on the removal of the basis of disapproval within a specified period of time." This statutory language does not support indefinite conditions and it does not support conditions not targeted to address any concentration in the insurance market in Pennsylvania.

The potential harm the Order sought to remedy, within the Department's statutory authority, has been addressed. Further, as noted by Compass Lexecon, Highmark Health's ability to compete on the same playing field as its competitors has been constrained.[9] The Order has accomplished its original goal, and with the passage of a decade, the Order now unduly limits Highmark Health's ability to compete with other integrated delivery systems not subject to the same conditions. Plainly, there is no risk from the formation of Highmark Health that there will be any reduction in "competition in insurance in this Commonwealth" or the creation of any "monopoly therein."[10] Other health insurers have been growing their enrollment shares significantly while not being subject to the same constraints that Highmark Inc. faces from the Order. The Order's Conditions place a unique burden on Highmark Inc.'s ability to vigorously compete with other insurers, and no longer serve a procompetitive purpose 10 years later. The Order should not prohibit legitimate competitive activities,[11] particularly where the Department's statutory purpose has been fulfilled.

Although Highmark Health may seek modifications or exceptions to the Conditions, the "desired flexibility" of the administrative modification procedure should not justify an Order that no longer

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regulation through negotiations that are binding on the agencies without formally adopting the regulation through the procedures set forth in the Commonwealth Documents Law; nor can an agency enter into settlement agreements that are *de facto* regulations."); *Dept. of Env. Resources v. Rushton Mining Co.*, 139 Pa. Commw. 648, 662 (Pa. Commw. Ct. 1991) ("While the statutes cited by the DER do provide the DER with the authority to attach terms and conditions to mining permits, and the Pennsylvania Code sections cited outline the types of conditions to be included in the permits, those sources do not give the DER the authority to mask regulations as standard conditions, nor relieve it from the obligation to promulgate those conditions when they are in the nature of regulations which are binding and have the force of law….Because we have determined that the general conditions in question in the permits were regulations which should have been promulgated and were not, we find that the DER did not have the authority to apply the conditions to all of the permittees as a matter of policy.").

[8] *Erie Ins. Exch. v. Pa. Ins. Dep't.*, 133 A.3d 102, 111 n.16 (Pa. Commw. Ct. 2016).

[9] *See* 2017 Compass Lexecon Report prepared for the Pennsylvania Insurance Department, at 53 ("Highmark legitimately asserts that, imposing these conditions on Highmark and AHN without also imposing the same competitive and consumer choice conditions on its rivals does not ensure a level playing field in competing for insureds or patients"); *id*. at 45 ("Since the implementation of the 2013 Order, Highmark has had a net loss of membership to its competitors.").

[10] 40 Pa. Stat. § 991.1402(f)(1)(ii).

[11] *See, e.g.*, *Mallet & Co. v. Lacayo*, 16 F.4th 364, 390 (3d Cir. 2021).

has "substantial evidence to support" its Conditions.[12] Courts have recognized that "the conditions of an individual case may not be ignored in favor of an administrative policy."[13] Because competitive circumstances have changed, the Order is no longer consistent with the competitive conditions that justified its imposition.[14] A decade of restrictions on Highmark Health have more than satisfied the Department's limited statutory mandate to curb the anticompetitive effects of the transaction.

The 2017 Compass Lexecon Report stated, "[i]n our view, Highmark legitimately asserts that, imposing these conditions on Highmark and AHN without also imposing the same competitive and consumer choice conditions on its rivals does not ensure a level playing field in competing for insureds or patients."[15] Compass Lexecon has suggested that the Department issue regulations like those in the Order on other integrated delivery systems in Pennsylvania, but the more straightforward and fair approach, and the approach consistent with the Department's statutory authority, is to grant the request for modification and relieve Highmark Health from the remaining Conditions.

4. The Remaining Conditions Impose Specific and Undue Burdens on Highmark Health and Highmark Inc.

The remaining Conditions each impose an undue burden on Highmark Health and Highmark Inc. that are inconsistent with market realities, the competitive landscape, and the comparative burdens on other similarly situated entities.

Conditions 1 and 2 (Highmark Cannot Prohibit Affiliated Providers from Contracting with Other Payors)

Highmark Health has no intention to prohibit affiliated providers from contracting with other payors and faces independent oversight for any such conduct under the antitrust laws and Pennsylvania and federal law governing charitable organizations.[16] This position also would not be economically viable for AHN. Further, these Conditions as imposed by the Department are not applicable to similarly situated payors and providers.

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[12] *Gradison Auto. Bus Co. v. Pennsylvania Public Utility Commission*, 184 A.2d 334, 336-38 (Pa. Super. Ct. 1962) (citing *Leaman Transportation Corporation v. Pennsylvania Public Utility Commission*, 33 A.2d 721 (Pa. Super. Ct. 1943)) (holding that an agency exceeded its authority in granting an order where there was no competent evidence to support it).

[13] *Duquesne Light v. Pennsylvania Public Utility Commission*, 715 A.2d 540, 546 (Pa. Commw. Ct. 1998) (where the Public Utility Commission failed to consider evidence of the impact on petitioner's ability to purchase utility in a competitive market, the Public Utility Commission did not consider the public interest).

[14] 2023 Compass Lexecon Report, at 12-13 ("Since 2017, the competitive dynamics in Pennsylvania and WPA have continued to change in the healthcare insurance markets. UPMC's Health Plan has grown significantly by focusing on health plans that reach the Medicaid, Medicare, and ACA (Affordable Care Act) communities, and by expanding its commercial health plans. Other national insurers, such as UnitedHealthcare and Aetna, have remained competitors and have slightly increased their share of the market since 2017. In addition, potential new competition from other BCBSA insurers may provide additional insurance choices in the near future as a result of the BCBSA Settlement.").

[15] 2017 Compass Lexecon Report at 53.

[16] *See, e.g.*, Rev. Rul. 69-545, 1969-2 C.B. 117 (holding that a tax-exempt hospital, such as AHN's hospitals, could fail to continue to qualify for exemption if it did not provide "hospital care for all those persons in the community able to pay the cost thereof either directly or through third party reimbursement.").

Condition 3 (No Provider/Payor Contracts Can Be Longer Than 5 Years)

This Condition limits innovation in a time when innovation is key. A limited 5-year contract has made Highmark Health reluctant to invest in innovative, pro-consumer arrangements with providers, as Highmark Health cannot obtain an appropriate return on investment. Short term contracts also discourage the collaboration needed for payors and providers to form the relationships needed for effective value-based care. This Condition poses particular competitive disadvantages for Highmark Inc. because other payors have the ability to enter into the long-term contracts necessary for risk and value-based arrangements, and Highmark Inc.'s competitors know its constraints under this Condition. This is also an example of where an ability to request a modification is not feasible because the opportunity to partner with a provider on innovative contracts may easily be lost to competitors who do not have the requirement to obtain a waiver. No other payor or provider is subject to this type of restriction under the Department's oversight to our knowledge, and the competitive disadvantage to Highmark Inc. is clear.

Conditions 5 and 6 (Highmark Provider Contracts May Not Contain Most Favored Nation Clauses)

Highmark Health's activities in this area are subject to robust federal and state antitrust oversight. Through earlier litigation involving UPMC, Highmark Inc., and the Pennsylvania Attorney General, it has become clear to Highmark Inc. that most favored nations provisions are disfavored by the Pennsylvania Attorney General's Office. These provisions are subject to independent federal and state regulatory oversight. Given the antitrust enforcement environment, particularly around healthcare, there is not sufficient incentive to seek such clauses. No other insurer in Pennsylvania is subject to this Condition.

Conditions 7 through 9 (Firewalls (Competitively Sensitive Information) and Related Reporting):

The Federal Price Transparency Rules require group health plans and insurance issuers to publish provider-specific reimbursement rates; hospitals must publish payor-specific rates for services and discounted cash prices. The intent of the Price Transparency Rules is to make health care pricing more accessible and useful to consumers.[17] Even when federal regulators impose comparable firewall conditions, the conditions generally last no more than 10 years, which also supports elimination of this Condition.[18] Similarly situated integrated delivery and finance systems are not subject to firewall restrictions, which creates an unlevel playing field in Pennsylvania. In addition,

[17] CENTERS FOR MEDICARE AND MEDICAID SERVICES, *Use of Pricing Information Published under the Transparency in Coverage Final Rule*, September 6, 2023, https://www.cms.gov/healthplan-price-transparency/public-data (accessed September 12, 2023). If the Department has concerns about the effectiveness of the Transparency Regulations, then it may evaluate whether comparable regulations applicable to all similarly situated insurers in Pennsylvania are appropriate.

[18] *See, e.g., FTC v. Sycamore Partners II L.P.* (January 28, 2019) (providing that company is subject to 10-year order requiring prior notification to the FTC of any acquisitions and compliance reports for firewall requirement); *FTC v. Broadcom Ltd.* (July 13, 2017) (terminating order after ten years that requires firewalls and monitor as conditions for merger).

as discussed in more detail below, sharing of competitively sensitive information is subject to enforcement under the antitrust laws.

Conditions 11 and 12 (Financial Commitment Limitations and Related Reporting):

The Limitations on Transfers Condition is comparable to the 10 percent of surplus limitation on dividends or other distributions in the PA Insurance Holding Companies law.[19] Highmark Inc. acknowledges it is subject to this provision in the Holding Companies Act. It is not the statutory constraint itself on the amount that Highmark Inc. may transfer to Highmark Health or AHN without Department approval at which Highmark Inc. balks. It is the reporting requirements, which are burdensome and unnecessary at the 10-year mark, particularly given the Department's authority to audit compliance or otherwise request additional information. Further, the Department has issued other constraints on the RBC requirements of Highmark Inc. as part of its regulation of BCBSA licensed entities in the Commonwealth, and thus any constraints related to RBC specifically with respect to transfers from Highmark Inc. to AHN are unnecessary. While the statutory and regulatory constraints on dividends and distributions is applicable to other insurers, the Condition itself and the reporting requirements are not applicable to other payors or providers.

Condition 13 (Highmark Health to File Annual Audited Financial Statements and Auditor Management Letters)

This is already required under existing statutory authority for both Highmark Health[20] and Highmark Inc.[21] AHN provides audited financials publicly through the Electronic Municipal Market Access (EMMA) system. Highmark Health provides audited financial publicly via its Form 990 filing with the IRS. There is no reason to maintain this as a Condition given that the Department already has the authority to obtain any financial information with respect to Highmark Health that it desires.

Condition 14 (Required Quarterly AHN Financial and Operational Information Reporting)

This additional reporting is burdensome and unnecessary. Public bondholders accept current reporting as sufficient for monitoring AHN financial position and, thus, the Department has the information from other sources. After 10 years, such financial oversight of AHN is no longer necessary. This requirement is not in place for similarly situated entities.

Condition 18 (Maintain Executive Compensation Program Tying Senior Executive Compensation to Benefits to Policyholders and Others to Implementation of IDN Strategy and AHN Strategic and Financial Plan)

[19] 40 Pa. Stat. § 459.8; 31 Pa. Code § 25.22.
[20] 26 U.S.C §§ 6001, 6033.
[21] 40 Pa. Stat. § 443.

The Highmark Health Board of Directors and applicable committees follow best practices with respect to their fiduciary duties concerning compensation issues. Such best practices require consideration of strategy and community outcomes in compensation discussions. The Highmark Health Board is guided by independent compensation consultants. The Department has access to actual compensation information through Forms 990 and annual compensation reports. After 10 years, this type of compensation oversight is no longer necessary to ensure that there is an incentive to implement the integrated strategy. As provided above, Highmark Health is fully committed to its strategy. This condition is not applicable to similarly situated entities.

Condition 20 (No Contracts that Limit Consumer Choice Initiatives)

Highmark Health agrees that such limiting provisions are anti-consumer and anti-competitive and artificially and unnecessarily inflate the cost of health care. In discussions with the Pennsylvania Attorney General concerning litigation in 2019, Highmark Inc. agreed not to include anti-steering/tiering provisions in contracts. In fact, Highmark Inc. has implemented contracts in its product line that incentivize patients to utilize lower cost and high-quality providers because that is consistent with Highmark Health's risk/value-based model. This Condition is not applicable to similar entities and even when similar conditions are imposed by regulators, it is only for a 10-year period.[22]

Condition 21 (Highmark to Implement IDN Strategy in Manner that Supports Community Hospitals; Annual IDN Community Hospital Impact Reports Required; Corrective Actions Required if Implementation Results in Material Decrease in Community Hospital Discharges)

This Condition may have been defensible at the time the Order was entered as a mechanism to provide service protection to community hospitals. However, in light of the current state of the health insurer market, the effect and any threat to community hospitals has been mitigated because other payors also have significant membership volume at the community hospitals. Highmark Inc. should not be held to a standard to support hospitals to which other insurers are not held, particularly given the robust state of competition in the health insurance market. This requirement unnecessarily constrains Highmark Inc. from (and subjects Highmark Inc. to possible penalty for) designing and offering products that would be in the best interest of policyholders and subscribers. After 10 years, the community hospitals have had sufficient time to adjust to the market dynamics of a Highmark Inc./AHN affiliation.

In addition, reporting is burdensome and the 2023 Compass Lexecon Report notes that it is unaware of any other jurisdictions or transactions requiring this type of monitoring and reporting.[23] Furthermore, the Department has authority to request information and audit Highmark Inc.'s activities.[24]

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[22] 2023 Compass Lexecon Report, at 61 (citing Tennessee COPA Terms of Certification. January 31, 2018 https://www.balladhealth.org/sites/default/files/documents/TN-COPA-Terms-of-Certification-Jan-31-2018.pdf) (3-year conditions for rural spending, 3-year conditions for capital compliance, and 10-year spending requirement).
[23] 2023 Compass Lexecon Report, at 71.
[24] 31 Pa. Code § 147.3; 40 Pa. Stat. § 323.3.

Condition 23 (Community Health Reinvestment Requirement and Related Reporting)

Highmark Health recognizes both its commitment to the community and Highmark Inc.'s statutory obligation to report Community Health Reinvestment ("CHR") activities.[25] However, no other Pennsylvania payors are required to pay a specific dollar amount of CHR. Other regulators have required five-year financial investments in community benefit programs in similar transactions where there are competitive concerns of insurer or provider market concentration.[26] After 10 years, the requirements in this Condition are detrimental to Highmark Health, especially given that there is more intense competition in the market.

Condition 26 (Highmark to Pay Department Expenses Related to the Conditions)

Highmark Health acknowledges the appropriateness of incurring reasonable fees of the Department to study and evaluate the impacts of the creation of Highmark Health, but at this point – 10 years and more than $20 million later – the fees impose an excessive burden on the enterprise. After 10 years, Highmark Health should be treated by the Department as doing business as usual and Highmark Health should not be subjected to undue scrutiny and oversight that involves substantial fees payable by Highmark Health annually. Such fees are not imposed on any other entities to regularly evaluate their role in the market.

As set forth above, each Condition uniquely burdens Highmark Inc. in its ability to compete with other health insurers in the marketplace and should be terminated in favor of the continued regulatory oversight – both via antitrust law and the Department's regulatory authority.

5. The Department Will Continue to Have Robust Regulatory Oversight

The Department has the necessary levers, through its current authority and other applicable laws, to ensure that Highmark Inc. thrives and competition persists in healthcare markets in Pennsylvania. The Department continues to have significant oversight and regulatory authority with respect to Highmark Inc. and its interactions with Highmark Health and AHN (and others), including:

- Risk-Based Capital requirements, 40 Pa. Stat. § 221.2-B;
- filing requirements for intercompany agreements, 31 Pa. Code § 25.21;
- filing requirements around provider contracts, 40 Pa. Stat. § 3801.509;

[25] 40 Pa. Stat. § 991.2502.

[26] 2023 Compass Lexecon Report, at 72 (citing Attorney General Bonta Conditionally Approves Ownership Change of High Desert Hospital. 12/17/2021. Date accessed: 12/1/2022. https://oag.ca.gov/news/press-releases/attorney-general-bonta-conditionally-approves-ownership-change-high-desert. Attorney General's Summary List of Conditions. Date Accessed 12/1/2022. https://oag.ca.gov/system/files/media/smmc-conditions-packet-12172021.pdf) ("[T]he consent decree of *Kaiser and Providence St Mary* in 2021 required that $750,000 be allocated annually to St. Joseph Health Community Partnership Fund for five years to support low income and unmet populations in SMMC's and the new Victorville hospital's service areas.").

- CHR reporting activities, 40 Pa. Stat. § 991.2502;
- 10% of surplus limitation on the distributions from Highmark Inc., Pa. Stat. § 459.8; 31 Pa. Code § 25.22;
- market conduct exams, 40 Pa. Stat. § 323.3;
- examination and audit authority, 31 Pa. Code § 147.3; 40 Pa. Stat. § 323.3; and
- annual required filings, 40 Pa. Stat. § 443.

In addition to the Department, the antitrust laws, enforced by federal agencies and the Pennsylvania Attorney General's Office, place independent legal constraints on Highmark Health's ability to share competitively sensitive information ("CSI") between its affiliates. Under federal antitrust law, sharing of CSI between horizontal rivals could provide an opportunity for market coordination in violation of Section 1 of the Sherman Act, which prohibits agreements between two or more individuals or independent entities that unreasonably restrain trade. 15 U.S.C. § 1. Additionally, misuse of CSI within a vertically integrated firm runs the risk of violating Section 2 of the Sherman Act, which prohibits monopolization or attempted monopolization through willful or predatory conduct. 15 U.S.C. § 2. Outside of the federal antitrust laws, there is risk that misuse of CSI could give rise to a claim for unfair competition under Pennsylvania law.[27] Because the antitrust laws already regulate the conduct the Department Firewall Conditions are meant to address, the Firewall Conditions are superfluous and should not continue in perpetuity.

***

For the reasons set forth above, Highmark Health hereby respectfully requests that the Department grant its request for modification of the Conditions as set forth above.

ITEM 3: ADDITIONAL INFORMATION

Highmark Health will provide the Department with such further information as the Department may need to evaluate the requests contained in this Request for Modification.

[27] *See Larry Pitt & Assocs. v. Lundy Law, LLP*, 57 F. Supp. 3d 445, 456 (E.D. Pa. 2014) ("The Court will allow [plaintiff] to pursue its [unfair competition] claim that [defendant] . . . provided Lundy Law with competitively sensitive information regarding competitors' advertising budgets and practices.").

ITEM 4: SIGNATURE AND CERTIFICATION

Highmark Health has caused this Request for Modification to be duly signed on its behalf in the City of Pittsburgh and Commonwealth of Pennsylvania on the 16th day of October 2023.

(SEAL)

HIGHMARK HEALTH

By: _____ Title: Chief Operating Officer

Attest:

By: _____ Title: Secretary

CERTIFICATION

The undersigned deposes and says that he/she has duly executed the attached Request for Modification dated October 16, 2023 for and on behalf of Highmark Health; that he/she is the Chief Operating Officer of such company; and that he/she is authorized to execute and file such instrument. Deponent further says that he/she is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

Signature: _____

Typed Name: Karen Hanlon

Appendix A

Appendix
A-1

BEFORE THE INSURANCE DEPARTMENT
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:

Application of Highmark Health for Approval of the Request by Highmark Health to Acquire Control of Highmark Inc.; First Priority Life Insurance Company, Inc.; Gateway Health Plan, Inc.; Highmark Casualty Insurance Company; Highmark Senior Resources Inc.; HM Casualty Insurance Company; HM Health Insurance Company, d/b/a Highmark Health Insurance Company; HM Life Insurance Company; HMO of Northeastern Pennsylvania, Inc., d/b/a First Priority Health; Inter-County Health Plan, Inc.; Inter-County Hospitalization Plan, Inc.; Keystone Health Plan West, Inc.; United Concordia Companies, Inc.; United Concordia Dental Plans of Pennsylvania, Inc.; and United Concordia Life and Health Insurance Company	:	Pursuant to Sections 1401, 1402 and 1403 of the Insurance Holding Companies Act, Article XIV of the Insurance Company Law of 1921, Act of May 17, 1921, P.L. 682, as amended, 40 P.S. §§ 991.1401-991.1403; 40 Pa.C.S. Chapter 61 (relating to hospital plan corporations); 40 Pa.C.S. Chapter 63 (relating to professional health services plan corporations); and Chapter 25 of Title 31 of The Pennsylvania Code, 31 Pa. Code §§ 25.1-25.23 Order No. ID-RC-13-06

APPROVING DETERMINATION AND ORDER

Upon consideration of the information, presentations, reports, documents and comments received, as well as other inquiries, investigations, materials, and studies permitted by law,[1] the application (the "Application") of Highmark Health (the "Applicant") to acquire control (the "Change of Control") of Highmark Inc.; First Priority Life Insurance Company, Inc.; Gateway Health Plan, Inc.; Highmark Casualty Insurance Company; Highmark Senior Resources Inc.; HM Casualty Insurance Company; HM Health Insurance Company, d/b/a Highmark Health

[1] These materials include, but are not limited to, information submitted to the Department by Highmark Health and members of the public, and the reports prepared for the Department by The Blackstone Group, L.P. (the "Blackstone Report") and Margaret E. Guerin-Calvert, Senior Consultant, Compass Lexecon (the "Guerin-Calvert Report"). All of the publicly available materials submitted to the Department are available on the Department's website at: http://www.portal.state.pa.us/portal/server.pt/community/industry_activity/9276/highmark_west_penn_allegheny_health_system/982185

Insurance Company; HM Life Insurance Company; HMO of Northeastern Pennsylvania, Inc., d/b/a First Priority Health; Inter-County Health Plan, Inc.; Inter-County Hospitalization Plan, Inc.; Keystone Health Plan West, Inc.; United Concordia Companies, Inc.; United Concordia Dental Plans of Pennsylvania, Inc.; and United Concordia Life and Health Insurance Company (the "Highmark Insurance Companies") and all other transactions included in the Form A which are subject to the Department's jurisdiction and require approval of the Department are hereby approved, subject to the conditions set forth below (collectively the "Conditions").

Section 1402 of the Insurance Holding Companies Act requires the Department to approve an application for a change in control unless the Department has found that:

(i) After the Change of Control, the Highmark Insurance Companies would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which they are presently licensed;

(ii) The effect of the Change of Control would be to substantially lessen competition in insurance in this Commonwealth or tend to create a monopoly therein;

(iii) The financial condition of the Applicant is such as might jeopardize the financial stability of a one or more of the Highmark Insurance Companies or prejudice the interests of any policyholders;

(iv) The Change of Control, including but not limited to any material change in the business or corporate structure or management of the Applicant or the Highmark Insurance Companies as described in the Application is unfair and unreasonable to policyholders of the Highmark Insurance Companies and not in the public interest;

(v) The competence, experience and integrity of those Persons who would control the operation of any of the Highmark Insurance Companies are such that it would not be in the

interest of the policyholders of the Highmark Insurance Companies and the public to permit the Change of Control;

(vi) The Change of Control is likely to be, hazardous or prejudicial to the insurance buying public; and

(vii) The Change of Control is not in compliance with laws of the Commonwealth.

The burden is on the Department to show a violation of the standards. The standards are phrased in the negative and the Department is required to approve a transaction unless it finds that any of the standards are met.

The Department finds that, with the imposition of the Conditions set forth below to preserve and promote competition in insurance in the Commonwealth of Pennsylvania, to protect the public interest, and to protect the financial stability of the Highmark Insurance Companies, the Change of Control (and all other transactions included in the Application which are subject to the Department's jurisdiction and require approval of the Department) do not violate Section 1402 of the Insurance Holding Companies Act.

The form of the Second Amended and Restated Bylaws of Highmark Inc., as submitted to the Department in connection with the Application, meet the statutory standards of 40 Pa.C.S. § 6328(b).

This Approving Determination and Order shall be subject to the following Conditions, all of which must be complied with in order for the approval of the Application to be valid. This Approving Determination and Order is effective immediately.[2] The Department will issue further

[2] The captions, headings and preambles in this Approving Determination and Order are for convenience and general reference only and shall not be construed to describe, define or limit the scope, intent or meaning of any of the terms or conditions of this Approving Determination and Order.

full written findings and conclusions on or before May 31, 2013 that substantially reflect the factual conclusions reached in the Blackstone Report and the Guerin-Calvert Report.

Competitive Conditions

Preamble: Both the WPAHS Entities and the Domestic Insurers engage in confidential and competitively sensitive contract negotiations with each other's rivals that involve price and non-price terms and product design. Common ownership of the Domestic Insurers and the WPAHS Entities provides the opportunity for each to obtain and make use of Competitively Sensitive Information from rivals that could be used to the potential detriment of consumers and competition. The ability of rival insurers in the Western Pennsylvania area to develop and obtain the benefits of innovative products and pricing depend on their ability to contract with Highmark Health-affiliated providers without risk of disclosure to the Domestic Insurers. A risk to competition exists if a Domestic Insurer can adversely affect any rival's price and non-price contract terms or deter innovation or access or limit gains to innovation by obtaining and acting upon any rival's Competitively Sensitive Information. A risk to competition also exists if Health Care Insurers or Health Care Providers enter into contractual arrangements, including but not limited to arrangements (known as "most-favored nation" arrangements) that guarantee receipt of the best payment rate and/or terms offered to any other Health Care Insurer or Health Care Provider. The following Competitive Conditions are designed to mitigate potential adverse competitive effects on competition and on rivals contracting with the Domestic Insurers and/or the WPAHS Entities when under common ownership and to maximize market-based access opportunities of unrelated providers and community hospitals to the IDN and insurers to Highmark Health Health Care Providers.

Prohibition On Exclusive Contracting

1. No Domestic Insurer shall enter into a contract or arrangement with any Highmark Health Health Care Provider which contract or arrangement requires the UPE Health Care Provider to exclusively contract with one or more Health Care Insurers with respect to any Health Care Service.

2. No Highmark Health Entity shall, directly or indirectly, prohibit or limit the authority of any other Highmark Health Entity that is a Health Care Provider from entering into any contract or arrangement with any Health Care Insurer. Exclusive contracts with specialized providers, such as anesthesiologists or emergency room physicians, may be entered into by a Highmark Health Entity that is a Health Care Insurer with at least thirty

(30) days' prior written notice to the Department, so long as the Department does not advise the requesting Health Care Insurer that the Department either disapproves the request for approval or requests any further information or explanation regarding the request for approval within such thirty (30) day period.

Provider/Insurer Payment Contract Length Limitation

3. No Domestic Insurer shall enter into any contract or arrangement with any Health Care Provider where the length of the contract (including but not limited to the initial term and all renewal terms) is in excess of five (5) years, without the prior Approval of the Department. No Highmark Health Entity that is a Health Care Providershall enter into any contract or arrangement with any Health Care Insurer where the length of the contract (including but not limited to the initial term together with all renewal terms) is in excess of five (5) years, without the Approval of the Department.

Termination Of Current Health Care Insurer Contracts Other Than For Cause

4. Until December 31, 2015, no Highmark Health Entity that is a Health Care Provider shall terminate a Health Care Service reimbursement contract with any Health Care Insurer for a reason other than for cause.

Prohibition On Most Favored Nation Contracts Or Arrangements

5. No Domestic Insurer shall enter into any contract or arrangement with any Health Care Provider on terms which include a "most favored nation" or similar clause that guarantees or provides that a Domestic Insurer will receive the best payment rate and/or terms that such Health Care Provider gives any other purchaser or payor of the same or substantially the same product or service.

6. No Highmark Health Entity that is a Health Care Provider shall enter into any contract or arrangement with any Health Care Insurer which includes a "most favored nation" or similar clause that guarantees or provides that the Health Care Insurer will receive the best payment rate and/or terms that such Highmark Health Entity gives any other purchaser or payor of the same or substantially the same product or service.

Firewall Policy

7. Highmark Health shall develop, implement, monitor the operation of and enforce strict compliance with a Firewall Policy for Highmark Health, Allegheny Health Network, and each Highmark Health Entity that is a Health Care Provider or a Health Care Insurer (and for such other Highmark Health Entities as the Department may require). The Firewall Policy shall be in a form and substance acceptable to the Department. Within thirty (30) days after the issuance of this Approving Determination and Order, Highmark Health shall file with the Department, for the review and Approval of the Department, a comprehensive Firewall Policy that includes but is not limited to the elements set forth in Appendix 2 (Firewall Policy), which is attached hereto and is incorporated herein by reference. Different Firewall Policies may be submitted for separate Highmark Health

Entities or types of Highmark Health Entities, provided that each such separate policy shall substantially include all of the elements set forth in Appendix 2 (Firewall Policy) and be accompanied by an explanation that describes the need for a separate policy. Once Approved by the Department, each Firewall Policy ("Approved Firewall Policy") shall be made publicly available in accordance with the requirements of the Department. After Approval of the Department of the Approved Firewall Policy, Highmark Health shall cause each applicable Highmark Health Entity to maintain in full force the applicable Approved Firewall Policy. No Highmark Health Entity may make any material amendment, waive enforcement of or terminate any material provision of its Approved Firewall Policy without the Approval of the Department. Each Highmark Health Entity required to have and to maintain an Approved Firewall Policy shall give prompt notice to the Department of any other amendment, waiver or termination of its Approved Firewall Policy.

8. On or before May 1 of each year, Highmark Health shall file with the Department a report executed by Highmark Health's President and its Chief Privacy Officer. The report shall be a public record, shall be in a form and substance satisfactory to the Department and shall include the following certification to the best of the President's and Chief Privacy Officer's information, knowledge and belief: (i) at all times during the immediately preceding calendar year, each Highmark Health Entity subject to Condition 7 was governed by and operated in accordance with a Department Approved Firewall Policy; (ii) at all times in the prior calendar year each Approved Firewall Policy was fully implemented, monitored and enforced in accordance with its terms, except as fully described in subsection (vi) below; (iii) mandatory training of employees with access to any Competitively Sensitive Information (including both current employees and all new hires) has occurred in accordance with the terms of the applicable Approved Firewall Policy; (iv) each Highmark Health Entity that is subject to Condition 7 has obtained recertification biannually of each of its employees with access to any Competitively Sensitive Information stating that the employee has received a copy of the Approved Firewall Policy, understands the Approved Firewall Policy and agrees to abide by the Firewall Policy; (v) no individual with management oversight over all or part of both Highmark Health's provider and insurer business segments has used Competitively Sensitive Information obtained as part of his or her oversight function to competitively disadvantage a rival Health Care Provider or Health Care Insurer; (vi) each Highmark Health Entity that is subject to Condition 7 has undertaken an annual good faith review of the Highmark Health Entity's Approved Firewall Policy compliance for the prior calendar year and that either (a) there were no violations or other breaches of the applicable Approved Firewall Policy other than those for which the Highmark Health Entity had previously provided notice to the Department in accordance with the Approved Firewall Policy, or (b) the Department has been provided with the non-reported breaches report and corrective action plan required in Condition 9; and (vii) such other information as the Department shall require.

9. Highmark Health, Allegheny Health Network, and each Highmark Health Entity that is a Health Care Provider or a Health Care Insurer shall provide the Department with such information regarding its Approved Firewall Policy and its implementation and

enforcement as the Department shall from time to time request. In addition to other information to be provided to the Department, a report of non-reported breaches of the applicable Approved Firewall Policy, which shall not be a public record, shall accompany the annual certification along with a corrective action plan (which shall be satisfactory in form and substance to the Department) to assure the Department of future, timely compliance with the Approved Firewall Policy and to provide an explanation as to why prior notice of such breach had not been provided to the Department. Approved Firewall Policy implementation and enforcement shall be subject to review and/or examination by the Department, or consultants retained by the Department at the expense of the Highmark Health Entity, to the extent that the Department believes that such review and/or examination is in the public interest.

Financial Conditions

Preamble: The following financial conditions are intended to: (i) limit the amount of policyholder funds that may be transferred to any Domestic Insurer's new parent entity or other Affiliates of the parent; (ii) establish an enhanced standard of review and assessment that is required to be undertaken prior to any Domestic Insurer entering into additional material financial commitments; (iii) implement ongoing reporting and monitoring requirements related to a Domestic Insurer's investments into the WPAHS Entities; (iv) establish criteria for a plan of corrective action to be prepared by Highmark Health if the turnaround of WPAHS falls short of certain targets; and (v) enhance the level of transparency and accountability with respect to Highmark's stated goal of deriving tangible policyholder benefits, in the form of relative premium and cost of care savings, related to financial commitments made in connection with the Transaction.

Limitations On Donations

10. Effective as of July 28, 2017, Condition 10 is deleted; provided that the Commissioner reserves the right, in the Commissioner's sole discretion, to reinstate Condition 10, in whole or in part, with respect to one or more Domestic Insurers, upon written notice to Highmark.

Financial Commitment Limitations

11. Any Financial Commitment made or agreed to be made to or for any Person by any of the Highmark Health Entities designated in this Condition, directly or indirectly, shall satisfy the following requirements:

    A. **Due Diligence Standard**. For all Financial Commitments: (i) the Highmark Health Entity making or agreeing to make any Financial Commitment shall conduct a Commercially Reasonable Process to evaluate and assess the benefits and risks to policyholders, subscribers or other stakeholders, as applicable, and

whether the Financial Commitment furthers and is consistent with the Highmark Health Entity's nonprofit mission, if the Highmark Health Entity is exempt from Federal taxation pursuant to Section 501(c)(3) of the Internal Revenue Code); and (ii) the terms of any Financial Commitment shall satisfy the provisions of 40 P.S. § 991.1405, as if the Financial Commitment transaction were made or agreed to be made between or among members of the holding company system. Each Highmark Health Entity making or agreeing to make any Financial Commitment shall reasonably document the Commercially Reasonable Process undertaken pursuant to this Condition 11.A., shall provide to the Department upon any filing with the Department pursuant to this Condition 11, or whenever requested by the Department, a summary of the documentation supporting the performance of such Commercially Reasonable Process and shall provide such further information as requested by Department. Documentation evidencing such Commercially Reasonable Process shall be retained by the Highmark Health Entity for five (5) years after making the Financial Commitment to which the Commercially Reasonable Process relates.

B. **Transactions to or with Highmark Health Entities**. Without the Approval of the Department, no Domestic Insurer shall, directly or indirectly, make or agree to make: (i) any Financial Commitment to or with any Highmark Health Entity if in the calendar year commencing January 1, 2017, or in any subsequent calendar year after December 31, 2017, either (A) the amount thereof, together with all other Financial Commitments made or agreed to be made directly or indirectly by all of the Domestic Insurers to or with any Highmark Health Entity in such calendar year, equals or exceeds ten percent (10%) of Highmark's surplus as regards to policyholders as shown on its last annual statement on file with the Department; or (B) the RBC Rating of Highmark is, or as a result of the Financial Commitment is likely to be, 525% or below; or (ii) any Financial Commitment in the form or substance of a Loan to any Highmark Health Entity (other than Highmark or any direct or indirect subsidiary of Highmark) if at any time on or after January 1, 2017 the amount thereof, together with all other Financial Commitments in the form or substance of a Loan made or agreed to be made directly or indirectly by all of the Domestic Insurers to or with any Highmark Health Entity (other than Highmark or any direct or indirect subsidiary of Highmark) from or after January 1, 2017, reduced by any amount of principal repayments made with respect to such Loans, exceeds an aggregate amount of $200,000,000 or more. The calculation of the RBC Rating of Highmark for the purposes of this Condition 11.B. shall be made as provided in Condition 11.E. The calculation of the amount of the Financial Commitment shall be made as provided in Condition 11.F.

C. **Transactions to or with any Person other than Highmark Health Entities**. Without the Approval of the Department, no Domestic Insurer, directly or indirectly, shall make or agree to make any Financial Commitment to or with any Person other than a Highmark Health Entity in the calendar year commencing January 1, 2017, or any subsequent calendar year after December 31, 2017, if the

RBC Rating of Highmark is, or as a result of the Financial Commitment is likely to be, 525% or below. The calculation of the RBC Rating of Highmark for the purposes of this Condition 11.C. shall be made as provided in Condition 11.E. The calculation of the amount of the Financial Commitment shall be made as provided in Condition 11.F.

D. **Calculation of Financial Commitment Limitations**. If a Financial Commitment is made by a Domestic Insurer to a Highmark Health Entity and such Highmark Health Entity further makes a Financial Commitment to a Person other than a Highmark Health Entity, the Financial Commitment made by the Domestic Insurer to the Highmark Health Entity and by the Highmark Health Entity to the Person other than a Highmark Health Entity shall not be aggregated, but for the purposes of this Condition 11, such Financial Commitment made to the Highmark Health Entity shall be subject to the requirements of Condition 11.B.

E. **RBC Rating Calculation; Reports to the Department**.

(1) The calculation of the RBC Rating of Highmark to determine if the RBC Rating of Highmark is, or as a result of a Financial Commitment is likely to be, 525% or below shall be based upon the last annual statement of Highmark on file with the Department, adjusted for the impact of the proposed Financial Commitment and the most recently available information or data as shown in the latest Quarterly RBC Report filed pursuant to Condition 11.E.(3).

(2) Simultaneously with the submission to the Department of any request to approve any Financial Commitment pursuant this Condition 11, Highmark shall provide to the Department, in addition to all other information required or requested by the Department: (i) a calculation of the effect or impact of the proposed Financial Commitment on the RBC Rating of Highmark (determined as provided in Condition 11.E.(1)); (ii) a "downside" or "stress" analysis of such effect on the RBC Rating of Highmark; and (iii) a calculation of the effect or impact of the proposed Financial Commitment on the RBC Rating of Highmark based upon the last annual statement of Highmark on file with the Department prior to the applicable Financial Commitment.

(3) Highmark shall provide to the Department on a quarterly basis a report (the "Quarterly RBC Report"), in form and substance acceptable to the Department, that includes calculations of the RBC Rating of Highmark (i) based upon the last annual statement of Highmark on file with the Department, adjusted for the most recently available information or data as of the end of the quarter to which such Quarterly RBC Report relates; and (ii) based upon the last annual statement of Highmark on file with the Department. Along with the Quarterly RBC Report, Highmark shall provide the Department with all supporting documentation used to arrive at its estimates of the RBC Rating of Highmark, including but not limited

to, any models, analyses or other supporting documentation used in estimating the effect of a potential transaction on the RBC Rating of Highmark.

F. **Financial Commitment Calculation**.

(1) In determining the amount of a Financial Commitment in any applicable calendar year, the Financial Commitment shall be deemed to occur upon the date on which the Financial Commitment (or the portion thereof) is required be reflected in the financial statements of the Domestic Insurer in accordance with statutory accounting principles.

(2) The amount of the Financial Commitment for an applicable calendar year shall be all or that portion of the Financial Commitment that meets the test provided in Condition 11.F.(1) above; provided that if less than the entire amount of the Financial Commitment satisfies the test in Condition 11.F.(1) above, the remaining portion of the Financial Commitment shall be deemed to be a Financial Commitment once such remaining portion is required to be reflected in the financial statements of the Domestic Insurer in accordance with statutory accounting principles.

(3) Notwithstanding any other provision of this Approving Determination and Order, with respect to any Financial Commitment relating to any guaranty or surety arrangement, the amount of the Financial Commitment for a calendar year with respect to that guaranty or surety arrangement shall be equal to the maximum amount of the guaranty or surety as set forth in or determined by the applicable instrument or agreement of guaranty or surety (or any other documents relating thereto), if the obligations under such guaranty or surety at issuance or any time thereafter are collateralized, or required (whether immediately or upon the occurrence of any events or conditions) to be collateralized, directly or indirectly, by any assets or properties of any Domestic Insurer; provided that the foregoing shall not apply to any existing guaranty of a Domestic Insurer or to any extension of such guaranty hereafter entered into or agreed upon, if any such extension arrangement is acceptable to the Department in form and substance.

G. **Application to Certain Transactions**.

(1) Condition 11.B. shall not apply to Highmark's forgiveness of any indebtedness owed to it as of July 31, 2017 by Highmark Health and/or AHN and/or subsidiaries of Highmark Health or any alternative repayment method of such indebtedness acceptable to the Department in form and substance. This indebtedness, as of July 31, 2017, is estimated to be approximately $500,000,000 owed by AHN to Highmark and the $200,000,000 owed by Highmark Health to Highmark (collectively the "$700,000,000 Debt").

(2) No later than thirty (30) days after the RBC Rating of Highmark exceeds 650% as reflected in a Quarterly RBC Report required to be submitted to the Department pursuant to Condition 11.E.(3), Highmark shall forgive for statutory accounting purposes (or finalize an alternative repayment method acceptable to the Department in form and substance with respect to) the $700,000,000 Debt. Any time after November 30, 2019, the Department may require Highmark to forgive for statutory accounting purposes (or finalize an alternative repayment method satisfactory to the Department with respect to) the $700,000,000 Debt.

(3) Condition 11.B. shall not apply to: (i) the extension of Highmark's existing guarantee of the WPAHS term loan dated May 22, 2014 by and between WPAHS and certain lenders; and/or (ii) a successor guarantee by Highmark of such loan, if such extension or successor guaranty is acceptable to the Department in form and substance.

(4) Condition 11.B. shall not apply to a Financial Commitment that is: (i) otherwise in compliance with applicable Pennsylvania law, including but not limited to the Insurance Holding Company Act, which act shall at all times apply to Financial Commitments of Highmark and each direct or indirect subsidiary of Highmark and (ii) either (A) from Highmark to a direct or indirect subsidiary of Highmark; or (B) from a direct or indirect subsidiary of Highmark to Highmark or another direct or indirect subsidiary of Highmark; provided that any Financial Commitment made by a direct or indirect subsidiary of Highmark to any Person other than to Highmark or any other direct or indirect subsidiary of Highmark shall be treated for the purpose of this Condition 11 as if it were a Financial Commitment of Highmark on the date of such Financial Commitment by such direct or indirect subsidiary of Highmark.

H. **No Circumvention Mechanism**. No Domestic Insurer may undertake any action to delay any Financial Commitment or perform or agree to perform any Financial Commitment in stages or steps, or take any other action with respect to any Financial Commitment, the purpose, design or intent of which is, or could reasonably be construed to be, to evade any of the foregoing requirements or any Approval of the Department which otherwise would have been required.

I. **No Limitation on Other Obligations**. Nothing contained in this Approving Determination and Order shall limit or affect the obligations of each Highmark Health Entity to comply with applicable law, including without limitation the Insurance Holding Company Act. No Approval of the Department shall be required under this Condition 11 if Department approval for the Financial Commitment has been obtained under 40 P.S. § 991.1405.

Disclosure Of Financial Commitments And Financial And Operational Information

12. On or before May 1 of each year, Highmark Health shall file with the Department a report setting forth: (i) all Financial Commitments made or agreed to be made by any Highmark Health Entity within the immediately preceding calendar year; and (ii) specifying the section of this Condition pursuant to which such Financial Commitments were permitted to be made or agreed to be made. Highmark Health shall promptly and fully respond to questions or requests of the Department for information in connection with such report.

13. Each year, no later than the date on which the financial statements are required to be filed for the holding company system under Form B or otherwise filed pursuant to 40 P.S. § 991.1404 (a), Highmark Health shall file with the Department, as a public record, audited financial statements (including but not limited to all footnotes) of Highmark Health prepared in accordance with GAAP, for the immediately preceding calendar year. In addition, Highmark Health shall file with the Department any letters from auditor(s) to management and any other information requested by the Department. The audited financial statements of Highmark Health that are required to be filed annually pursuant to Condition 13 as a public record shall include a footnote (or disclosure in another manner as required by GAAP) that discloses the balance sheets and income statements of Highmark, AHN and Highmark Health (Parent Only) separately and shall provide consolidating adjustments totaling to the audited consolidated balance sheet and income statement of Highmark Health.

14. Highmark Health shall file with the Department a report setting forth the below listed financial and operational information for the WPAHS Entities (the "Required WPAHS Financial and Operational Information"). The Required WPAHS Financial and Operational Information shall be filed quarterly for each quarter through the period ended June 30, 2015 (within 30 days after the end of the quarter) and thereafter annually on July 1 of each year.

    A. The Required WPAHS Financial and Operational Information shall be presented on the same basis as the information was presented for the immediately preceding three (3) month period through the quarter ended June 30, 2015, or for each annual report on the same basis the information was presented for the preceding four (4) quarters of each year for which the annual report is required to be delivered. For each quarterly report, the information shall be compared to the WPAHS budget or forecast for such quarter and for each annual report, the information shall be compared to the WPAHS budget or forecast for such year and the Base Case financial projections. Highmark Health shall make members of its management team available to the Department on a timely basis for purposes of reviewing the Required WPAHS Financial and Operational Information with the Department and any consultants retained by the Department.

    B. The Required WPAHS Financial and Operational Information shall include for the WPAHS Entities:

(1) An income statement displaying a level of detail consistent with the Base Case Financial Projections for the WPAHS Entities as submitted by Highmark Health to the Department as part of Highmark Health's Form A filings (the "Base Case Financial Projections"). To the extent that the income statement submitted to the Department pursuant to this Condition differs from GAAP, a reconciliation shall be submitted as well.

(2) A cash flow statement displaying a level of detail consistent with the Base Case Financial Projections for the WPAHS Entities submitted by Highmark Health to the Department as part of Highmark Health's Form A. To the extent that the income statement and cash flow statements submitted to the Department pursuant to this Condition differ from GAAP, a reconciliation shall be submitted as well.

(3) A calculation of the WPAHS Entities' Days Cash on Hand as defined in the Master Trust Indenture (the "DCOH"), which shall present a level of detail sufficient to reconcile the components of the calculation to the income statement and balance sheets submitted as part of this Condition.

(4) A calculation of WPAHS Entities' Debt Service Coverage Ratio, as defined in the Master Trust Indenture, which shall present a level of detail sufficient to reconcile the components of the calculation to the income statement and balance sheets submitted as part of this Condition.

(5) A schedule of capital expenditures for all WPAHS Entities, and for each WPAHS Entity for which information is requested by the Department, during the applicable calendar quarter in question and grouped by significant project categories.

(6) A schedule of inpatient and outpatient discharge volume for the WPAHS Entities in total and for each primary WPAHS Entity facility.

(7) A schedule of occupancy rates for the WPAHS Entities in total and for each primary WPAHS facility.

(8) A schedule of salaried and non-salaried employees, including but not limited to physicians, on an FTE basis for the WPAHS Entities in total and for each primary WPAHS Entity operating segment (hospitals, physician organization, etc.).

(9) A schedule of occupied beds by each primary WPAHS Entity facility.

(10) A schedule of FTEs per occupied bed by each primary WPAHS Entity facility.

(11) Audited financial statements (including but not limited to all footnotes) of WPAHS and WPAHS Affiliates specified by the Department prepared in

accordance with GAAP, for the immediately preceding calendar year along with any letters from auditors to management.

(12) If WPAHS files consolidated financial statements with any Highmark Health Entity other than WPAHS Affiliates specified by the Department, then Highmark Health shall deliver WPAHS' consolidating financial statements showing its financial position, results of operations, changes in cash flow and related footnotes thereto of WPAHS and such specified WPAHS Affiliates on a standalone basis.

(13) Such other financial and operational information related to WPAHS and the IDN Strategy as may be requested, from time to time, by the Department.

C. Highmark Health shall continue to file quarterly with the Department the Required AHN Financial and Operational Information pursuant to this Condition 14 for each quarter through the period ended December 31, 2020 and thereafter annually on July 1 of each year; provided that the Department may extend the requirement to file the Required AHN Financial and Operational Information quarterly for up to an additional five (5) years if, in the judgment of the Department, such an extension is in the public interest. Highmark Health shall benchmark (the "Benchmark Report") the actual results for each such quarter and annually thereafter against the projections contained in the "Allegheny Health Network Strategic and Financial Plan (2017-2020)" ("AHN Strategic and Financial Plan"), as filed with the Department and as such plan may be updated or extended, if required by the Department pursuant to Condition 15. A public version of the AHN Financial and Operational Information and the Benchmark Report also shall be filed with the Department at the same time as these reports are filed with the Department.

WPAHS Corrective Action Plan

15. Highmark Health shall prepare and produce to the Department a plan of financial and operational corrective action for WPAHS (the "WPAHS Corrective Action Plan") if either:

A. (i) From the date hereof through June 30, 2015, the aggregate amount of Financial Commitments made or agreed to be made directly or indirectly by all Highmark Health Entities to the WPAHS Entities equals or exceeds $100,000,000 and (ii) the WPAHS Entities have issuer ratings from two (2) of the Credit Rating Agencies of less than investment grade; or

B. As of the quarter ended June 30, 2015, either (i) the WPAHS Entities' net income, as determined in accordance with GAAP ("Net Income"), has not been greater than $0.00 after adjusting for any material non-recurring or unusual income, including but not limited to all payments received from any Highmark Health Entity outside of the normal course of business and any Financial Commitments

to the extent included in such Net Income, for two (2) out of the previous four (4) consecutive quarters; or (ii) DCOH, after adjusting for any material non-recurring or unusual cash receipts and Financial Commitments, including but not limited to all payments received from any Highmark Health Entity outside of the normal course of business, has not been equal to or greater than a value of sixty-five (65) days for two (2) of the previous four (4) consecutive quarters.

C. Highmark Health shall submit to the Department a corrective action plan for AHN and its Affiliates setting forth the information required by this Condition 15.C., together with such information necessary to make such plan full, accurate and complete (the "AHN Corrective Action Plan"). The AHN Corrective Action Plan submitted may be in the form of (i) a confidential and a non-confidential (public) version of the AHN Corrective Action Plan; or (ii) one AHN Corrective Action Plan with appropriate redactions of confidential information; provided, however, that all information so redacted shall be provided to the Department. A preliminary version of the required AHN Corrective Action Plan (the "Preliminary AHN Corrective Action Plan") shall be filed with the Department no later than July 15, 2015 and the final and complete AHN Corrective Action Plan (the "Final AHN Corrective Action Plan") shall be filed with the Department no later than September 30, 2015.

(1) The AHN Corrective Action Plan shall provide, among other items:

(a) A description of the specific steps and investment of funds and changes to AHN and the AHN Entities that have already been taken to carry out or implement the IDN Strategy since the close of the Affiliation Agreement; specifically including: (A) a description of the category of the IDN program changes, projects or investments that have been incurred or implemented (the "Changes Implemented"); (B) the cost thereof; (C) the specific locations at which the Changes Implemented were made; (D) the reason(s) why such changes or investments were required or advisable;

(b) The specific results or benefits/cost savings sought to be obtained by the Changes Implemented, including a quantification of value, if available, and comparison of the actual benefits/cost savings obtained to date in comparison to those anticipated as of the date that such Changes Implemented were incurred or implemented;

(c) A description of any steps, initiatives or plans that were proposed, but not implemented, and the reasons for not implementing such plans or proposals;

(d) The specific objectives or goals of all strategies, plans and actions comprising the AHN Corrective Action Plan, including the timeline for the accomplishment of these objections (the "Plan Objectives"); and

(e) Detailed operating and financial projections on a quarterly basis for the period of July 1, 2015 through December 31, 2017 and the following operating and financial projections, together with a description of the assumptions underlying such projections which must be reasonable and likely attainable:

(i) Projected inpatient discharges and outpatient registration volume for each AHN Entity, along with projected occupancy rates and in connection therewith:

(A) Provide written commentary explaining why the Board of Directors of Highmark Health (the "Highmark Health Board") and the Board of Directors of AHN and their management believe these volumes to be achievable.

(B) Discuss the impact of the current University of Pittsburgh Medical Center Consent Decree upon these projections.

(ii) Projected income statements, displaying a level of detail consistent with the Base Case Financial Projections for the AHN Entities submitted by Highmark in connection with the 2013 Order.

(iii) Projected balance sheets, displaying a level of detail consistent with the Base Case Financial Projections for the AHN Entities.

(iv) Projected cash flow statements, displaying a level of detail consistent with the Base Case Financial Projections for the AHN Entities.

(v) A detailed schedule of anticipated capital expenditures for all of the AHN Entities' facilities, including:

(A) For each AHN facility, a specific list of significant projects and the timing of these projects, including each Specific Scheduled Use;

(B) A list of strategic initiatives, including potential acquisitions of other businesses or entities, including, hospitals, physician groups, laboratories or other enterprises; and

(C) A schedule of anticipated future spending by AHN or any AHN Entity for its or their affiliated

community hospitals and the strategic rationale for such spending.

(vi) A schedule of projected salaried and non-salaried employees on a full-time equivalent basis for the AHN Entities in total and for each primary AHN Entity operating segment or component, together with an explanation of how each primary operating segment or component is defined.

(vii) A description of any plans to downsize, close or repurpose, in whole or in part, any facility or operation owned or operated by any AHN Entity and provide a schedule of the timing and cost/benefit analysis associated with these plans.

(viii) A schedule of any anticipated future Financial Commitments from any Domestic Insurer to any direct or indirect AHN Entity along with the purpose of such Financial Commitments.

(ix) A calculation of AHN's projected Days Cash on Hand (the "DCOH") as defined in the Master Trust Indenture dated May 1, 2007, as amended, relating to the West Penn 2007A Series Bonds (the "Trust Indenture") for each quarter through December 31, 2017.

(x) A calculation of AHN's projected Debt Service Coverage Ratio as defined in the Trust Indenture for each quarter through December 31, 2017.

(xi) Provide functional excel backup to each set of financial projections requested in items C.(1)(e)(i) – (x) above.

(xii) A list of any projected future changes in Specific Scheduled Uses of the Financial Commitment of AHN.

(2) As part of the AHN Corrective Action Plan, Highmark Health shall provide a description of the diligence process that the Highmark Health Board pursued in order to ultimately approve the AHN Corrective Action Plan, including a description of the following:

(a) The manner in which the AHN Corrective Action Plan was prepared and how the projections were assessed or made at each facility;

(b) The material issues or concerns that the Highmark Health Board or management expressed with regard to earlier drafts of the AHN Corrective Action Plan; and

(c) The changes that were made to the AHN Corrective Action Plan in order to ultimately obtain approval by the Highmark Health Board.

(3) Prior to submission of the Final AHN Corrective Action Plan to the Department, Highmark Health shall have the Final AHN Corrective Action Plan reviewed at its sole cost and expense by an independent external financial expert experienced in these matters who was not involved with, and who did not otherwise participate in the preparation of or provide any analysis for, the Preliminary AHN Corrective Action Plan or the Final AHN Corrective Action Plan (the "Financial Commitment Reviewer"). The Financial Commitment Reviewer shall provide an opinion as to the reasonableness of the Final AHN Corrective Action Plan, the sufficiency of the Final AHN Corrective Action Plan to accomplish the Plan Objectives and the specific level of benefits and costs to be borne by Highmark's policyholders, as distinct from any franchise benefits accruing to Highmark in the form of higher enrollment, revenue and market share, and an opinion as to the reasonableness of the value assigned by Highmark Health and/or Highmark to Highmark's investments in AHN. A copy of such report shall be submitted to the Department as part of the Final AHN Corrective Action Plan and a public version of such report also shall be submitted to the Department.

(4) Highmark Health shall respond to all questions from the Department and its advisors relating to the Final AHN Corrective Action Plan and/or the AHN Strategic and Financial Plan, as such plans may be updated or extended from time to time, within the timeframe requested by the Department. The Department may impose, upon notice to Highmark Health, an obligation to update the Final AHN Corrective Action Plan or the AHN Strategic and Financial Plan or extend the period covered by the Final AHN Corrective Action Plan or the AHN Strategic and Financial Plan.

(5) The Final AHN Corrective Action Plan shall specifically identify any Financial Commitments (including Donations) contemplated by the Final AHN Corrective Action Plan. A review by the Department of the Preliminary AHN Corrective Action Plan and/or the Final AHN Corrective Action Plan shall not constitute an approval of any such Financial Commitments (including Donations, if any) unless: (i) Highmark specifically shall request approval of such Financial Commitments (including Donations, if any) and provide the information relating thereto to fully describe the nature and purposes for such Financial Commitment (including Donations, if any) and (ii) the Department shall specifically grant approval of such Financial

Commitments (including Donations, if any) pursuant to the approval requirements of the this Approving Determination and Order.

16. If a WPAHS Corrective Action Plan is required to be prepared and produced to the Department pursuant to Condition 15A or 15B, it shall be produced promptly upon request or order of the Department to Highmark Health and all such information when produced shall be treated as confidential pursuant to an examination process or proceeding under 40 PS § 991.1406.

17. The WPAHS Corrective Action Plan shall specify, in reasonable detail, Highmark Health's intended actions to be taken over the subsequent twelve to twenty-four (12-24) months that are designed and anticipated to: (i) facilitate repayment or refinancing of the bond obligations of the WPAHS Entities payable to Highmark (or any Highmark Health Entity) and on terms that would not require any Credit Enhancement Device from Highmark or other Highmark Health Entities; (ii) generate DCOH of at least sixty-five (65) days within eighteen (18) months and for the foreseeable future thereafter; and (iii) generate net income of no less than $0 within eighteen (18) months and for the foreseeable future thereafter.

    A. In addition, the WPAHS Corrective Action Plan shall specify the intended corrective actions that are proposed to be implemented, including but not limited to the following potential actions that were referenced in Highmark Health's Form A filing: (i) efficiency improvements and revenue opportunities; (ii) changes in employment, including but not limited to in the number of employed physicians; (iii) modifications to capital expenditure plans; (iv) reductions in unfunded research; (v) non-core asset sales; (vi) restructuring of compensation and benefits; and (vii) outsourcing.

    B. The WPAHS Corrective Action Plan shall include but not be limited to: (i) an estimate of total cost to adopt, implement and consummate the WPAHS Corrective Action Plan—including but not limited to write-downs, one-time or ongoing restructuring costs, anticipated litigation, consulting, legal and other advisory fees and any future capital commitments—specifying Highmark Health's estimated value for any WPAHS Entity-related investments held by Highmark or any other Highmark Health Entity, including but not limited to loans or bonds receivable, at the time of the WPAHS Corrective Action Plan's implementation and without consideration of potential contingency actions; and (ii) the amount of any funding needed by the WPAHS Entities to fully pay for and carry out the WPAHS Corrective Action Plan (the '"WPAHS Required Funding") and an acknowledgement that any Donations made pursuant to Condition 10 will be restricted for use in paying the WPAHS Required Funding to the extent of the amount of the WPAHS Required Funding.

    C. Prior to submission, Highmark Health shall have the WPAHS Corrective Action Plan reviewed at its sole expense by an external financial expert, who shall conclude as to the reasonableness of the plan and the sufficiency of the WPAHS Required Funding and Highmark Health's stated actions for the purposes of

limiting future WPAHS, Highmark and/or Highmark Health losses and/or the need for additional Financial Commitments. The financial expert also shall assess the specific level of benefits and costs to be borne by Highmark's policyholders, as distinct from any franchise benefits accruing to Highmark in the form of higher enrollment, revenue and market share, and shall conclude as to the reasonableness of the value assigned by Highmark Health to Highmark's investments in WPAHS.

Executive Compensation

18. Highmark Health and Highmark shall ensure and maintain in effect a policy that any senior executives of any Highmark Health Entity who have been responsible for designing, recommending and/or implementing the IDN Strategy and/or the AHN Strategic and Financial Plan, as filed with the Department and as such plan may be updated or extended, if required by the Department pursuant to Condition 15, have a meaningful portion of their long-term compensation tied to the achievement of quantifiable and tangible benefits to policyholders, if any, or to the charitable nonprofit entity, if the Highmark Health Entity is exempt from Federal taxation pursuant to Section 501(c)(3) of the Internal Revenue Code (the "IDN Compensation Policy"). By October 15, 2017 Highmark Health shall deliver to the Department a copy of the IDN Compensation Policy which satisfies the foregoing requirements in a form and substance acceptable to the Department. Any amendments to the IDN Compensation Policy shall be submitted to the Department accompanied by a certification by the President of Highmark Health that, to the best of his or her information, knowledge and belief, the amendment to the IDN Compensation Policy satisfies the requirements of this Condition. Highmark Health shall report annually by May 1 of each year the amount of the compensation paid to such senior executives and describe the manner in which such compensation is consistent with the IDN Compensation Policy.

Meeting IDN Savings Benchmarks

19. On or before May 1 of each year, Highmark Health shall file with the Department a report describing in detail whether each Benchmark contained in Appendix 3 (Benchmarks), which Appendix 3 is attached hereto and incorporated herein by reference, has been met or what progress has been made toward meeting each Benchmark. The report shall include but not be limited to a statement of savings achieved through implementation of the IDN Strategy (the "IDN Savings") during (i) the preceding calendar year; and (ii) in total since consummation of the Affiliation Agreement. Each annual report shall quantify: (i) the total savings realized by policyholders across all products and consumers compared to the estimate of the cost of care that would have been incurred by policyholders if the Affiliation Agreement had not been consummated (the "Total IDN Savings"); (ii) the relative savings realized by consumers on a per-member-per-month claims basis (the "PMPM IDN Savings"); (iii) a comparison of the Total IDN Savings and PMPM IDN Savings to the relevant projections provided in the Form A filing and shall provide a detailed description of variances between the projections and actual savings achieved; (iv) the annual and cumulative savings actually achieved by policyholders in the eight categories for which projected savings were provided to the Department in the Form A, which categories are set forth in Attachment 4

(Total IDN Savings Categories) or such other categories as the Department may approve. Highmark Health shall have the quantification of savings and related explanations of variances reviewed by an external actuarial consulting firm, which shall conclude as to the reasonableness of the methodologies used for quantifying the savings. Within ninety (90) days of closing of the Affiliation Agreement, Highmark Health shall submit to the Department a detailed plan for the measurement and reporting methodologies to be followed for compliance with this Condition. If the Benchmark has not been met or if satisfactory progress has not been made toward achievement of the Benchmark, the report shall specify what corrective actions will be taken in order to assure that the Benchmark is met in a timely fashion. Specifically, if, as of December 31, 2016, either the Total IDN Savings or the PMPM IDN Savings are less than the amounts projected as part of the Form A filing, then, by April 1, 2017, Highmark Health shall file with the Department a detailed corrective action plan to maximize IDN Savings in the future or otherwise generate tangible policyholder benefits in amounts sufficient to justify the continued investment of policyholder funds in the IDN Strategy.

Public Interest/Policyholder Protection Conditions

Consumer Choice Initiatives

Preamble: Consumer choice and other member cost-sharing initiatives, including but not limited to tiered network products based upon transparent, objective criteria that include quality and cost, are procompetitive. These initiatives are consistent with efforts to provide consumers with informed healthcare choices and to incentivize consumers to consider the costs of healthcare and quality of outcomes in choosing providers. The following consumer choice initiative Condition is designed to prohibit provider and insurer contracts that would prohibit or limit the ability of Health Care Insurers to implement such consumer choice initiatives.

20. After the issuance of this Approving Determination and Order, no Domestic Insurer shall enter into a contract or arrangement with a Health Care Provider that prohibits and/or limits the ability of any Domestic Insurer to implement Consumer Choice Initiatives, without the prior Approval of the Department. After the issuance of this Approving Determination and Order, no Highmark Health Entity that is a Health Care Provider shall enter into a contract or arrangement with a Health Care Insurer that prohibits and/or limits the ability of the Highmark Health Entity to implement Consumer Choice Initiatives, without the prior Approval of the Department. This Condition does not prohibit a Domestic Insurer or a Highmark Health Entity that is a Health Care Provider from entering into a contract that provides volume discounts, provided that such volume discounts are not conditioned upon or related to commitments not to implement Consumer Choice Initiatives.

Affiliation And IDN Impact On Community Hospitals

Preamble: Highmark Health indicates in its filings that vibrant and financially healthy community hospitals are a key component of the IDN Strategy. Community hospitals are viewed as high quality, lower cost alternatives for healthcare delivery; and, thus, are projected to be key partners. Highmark Health acknowledges that its efforts to reinvigorate the WPAHS Entities may result in some draw of inpatients away from community hospitals to the WPAHS Entities, but states that the IDN Strategy and Highmark Health's "Accountable Care Alliance" strategy overall will increase inpatient admissions at community hospitals, thereby resulting in a net increase in community hospital inpatient admissions. To address concerns that the Affiliation Agreement will adversely impact inpatient admissions at community hospitals and risk the financial viability of these community assets, the Department imposes Conditions that require the monitoring and reporting of Affiliation Agreement and IDN Strategy implementation impacts on community hospital discharges, and Conditions requiring Highmark Health to report any financial commitments and other efforts to deliver more cost-effective healthcare at community hospitals to further healthcare choices in the Western Pennsylvania area.

21. On or before May 1 of each year, Highmark Health shall submit a document (the "IDN-Community Hospital Report"), which IDN-Community Hospital Report shall describe in detail for the immediately preceding calendar year: (a) the number of discharges for each Domestic Insurer at each hospital in the WPA service area, as such area is defined in connection with the Form A (the "WPA Service Area"); (b) the number of discharges for each Domestic Insurer at each hospital in its WPA Service Area for calendar year ended 2012 ("Base Year Discharge Data"); (c) a comparison of the discharge information in the current IDN-Community Hospital Report against: (i) the discharge information provided by Highmark Health under the IDN-Community Hospital Report for the immediately preceding year; and (ii) the Base Year Discharge Data; (d) an analysis of whether and to what extent Highmark's affiliation with WPAHS and the implementation of the IDN Strategy resulted in a net decrease in the Domestic Insurers' discharges at its WPA Service Area community hospitals; and (e) the amount and nature of any Financial Commitments by any and all Highmark Health Entities in community-based facilities and service in community hospitals that any such Highmark Health Entities have undertaken with each hospital (excluding any hospitals of WPAHS and UPMC or their respective subsidiaries), including but not limited to efforts to identify opportunities to deliver more cost-effective healthcare to ensure a robust and vibrant network with meaningful choice in key service lines.

A. Within sixty (60) days after the date of an IDN-Community Hospital Report, the Domestic Insurers shall submit to the Department a plan of operational corrective

action ("IDN Corrective Action Plan") if the analysis set forth in the IDN-Community Hospital Report for the year in question reflects a net decrease of 10% or more in all of the Domestic Insurers' discharges at their WPA Service Area community hospitals with which they have a contract or arrangement. The IDN Corrective Action Plan shall specify, in reasonable detail, the Domestic Insurers' intended commercially reasonable actions to be taken over the subsequent twelve (12) months that are designed and anticipated to address the reasons for the decrease in discharges relating to the Affiliation Agreement and the IDN Strategy. The IDN Corrective Action Plan shall include but not be limited to an estimate of total cost to adopt, implement and consummate the IDN Corrective Action Plan.

B. The Domestic Insurers shall use commercially reasonable efforts to implement the IDN Strategy in a manner that utilizes and enhances the role of community hospitals in their respective WPA Service Areas to provide continued services to the communities they serve.

Transition Plan Regarding UPMC Contract

Preamble: The Department recognizes that Highmark's contract with UPMC is scheduled to terminate on December 31, 2014, and new or extended provider contracts may or may not be entered into between the parties. The Department also recognizes that the Application's Base Case is premised on a non-continuation of the UPMC Contract and that continuation of such contract may, based on the Applicant's projections, delay WPAHS' financial recovery. The potential termination of these provider contracts may be disruptive to the Domestic Insurers' enrollees and consumers of UPMC healthcare services as that termination date is reached. In the event of a contract termination and to minimize any adverse impact on healthcare consumers and protect the public interest, the Department imposes a transition plan condition on all Domestic Insurers that have contract(s) with UPMC. The Condition focuses on issues such as continuation of care and access options available to the Domestic Insurers' enrollees; adequacy of the Domestic Insurers' remaining provider networks; and appropriate communications, as necessary, to inform healthcare consumers of any issues with continued access to certain UPMC facilities and practice areas.

22. With respect to the possibility of a contract between or among one or more of the Domestic Insurers and UPMC after December 31, 2014, the following shall apply:

A. If a Domestic Insurer secures UPMC's assent to a new contract, combination, affiliation, or arrangement (or an extension of the current contract that expires on December 31, 2014) ("New UPMC Contract"), Highmark Health shall notify the Department in advance of the execution of the New UPMC Contract and provide

the Department with updated information, based on reasonable assumptions and credible projections, on the impact of the terms of any New UPMC Contract on the financial performance of WPAHS, as well as an independent analysis of an expert on the impact of the New UPMC Contract on both the insurance and provider markets in the region including but not limited to any effects on competition.

B. If, however, one or more of the Domestic Insurers and UPMC do not enter into a New UPMC Contract by July 1, 2014, then Highmark Health shall file with the Department and with the Pennsylvania Department of Health: (i) an update of the status of negotiations between UPMC and such Domestic Insurer(s), including but not limited to reasons that the parties have been unable to enter into a New UPMC Contract; and (ii) a formal transition plan (the "UPMC Contract Transition Plan") no later than July 31, 2014 that sets forth such information as shall be required by the Department and the Department of Health and which addresses such issues as continuation of care; options available to subscribers to access Health Care Providers; appropriate communication, as necessary, to subscribers, providers and others regarding adequacy and changes in cost or scope of coverage. The Highmark Health Entities shall fully cooperate with the Department and the Department of Health in coordinating with UPMC for the further development and, if necessary, implementation of the UPMC Contract Transition Plan with the goal of minimizing any disruption to consumers and the marketplace and ensuring that such consumers continue to have access to quality healthcare in a competitive marketplace.

Community Health Reinvestment

Preamble: Preamble: This Condition requires Highmark to continue its commitment to non-profit activities directed to the betterment of overall community healthcare by fixing and expressly making permanent a percentage of Highmark's direct written premiums that will be dedicated to Community Health Reinvestment endeavors.

23. Commencing with calendar year 2014, Highmark shall annually dedicate to and pay for Community Health Reinvestment Activities ("CHR") an amount equal to 1.25% of all of Highmark's aggregate direct written premiums, as reported in the annual statement filed by Highmark pursuant to Condition 23B (the "Annual CHR Payment Obligation") for the immediately preceding year.

A. The Annual CHR Payment Obligation shall be calculated on a calendar year basis. Notwithstanding the foregoing, (i) Highmark's minimum Annual CHR Payment Obligation (the "Minimum Annual CHR Payment Obligation") shall be equal to 1.25% of all of Highmark's aggregate direct written premiums for the 2013 calendar year; and (ii) Highmark shall not be required to fund or commit to fund Community Health Reinvestment Activities for 2014 in an amount in excess of 105% of the Minimum Annual CHR Payment Obligation, and thereafter in an

amount in excess of 105% of the actual CHR Payment made (but in no event less than the Minimum Annual CHR Payment Obligation) for the immediately preceding calendar year. Highmark shall not be required to fund or commit to fund any Community Health Reinvestment Activities to the extent that, at the time of such funding or commitment, or after giving effect thereto, its RBC Rating level is, or is reasonably expected to be, less than 525%. If Highmark fails to meet its Annual CHR Payment Obligation in any calendar year, the deficiency in such payment obligation shall be paid by Highmark by May 1 of the following calendar year into the Insurance Restructuring Restricted Receipt Account.

B. On or before March 31 of each calendar year, Highmark shall provide to the Department a report, in form and substance acceptable to the Department, of Highmark's Community Health Reinvestment Activities for the prior calendar year.

C. The provisions of this Condition supersede and replace in their entirety any obligation by Highmark pursuant to Condition 4 of the Department's Decision and Order dated November 27, 1996 (Docket No. MS96-04-098) (the "1996 Department Order").

Miscellaneous Conditions

Modification Of Prior Orders

24. Except as expressly provided in this Approving Determination and Order, nothing in this Approving Determination and Order shall be construed to modify or repeal any term or condition of any prior order or approval of the Department, including, but not limited to, the 1996 Department Order.

25. The Department shall determine whether and to what extent any conflict or inconsistency exists between or among this Approving Determination and Order and any term or condition in any prior order(s) or approval(s) of the Department, and the Department shall have the authority to determine what term or condition controls.

Department Costs And Expenses

26. The Department may retain at the reasonable expense of the Highmark Health Entities, as determined by the Department, any attorneys, actuaries, accountants and other experts not otherwise part of the Department's staff as, in the judgment of the Department, may be necessary to assist the Department, regardless whether retained before, on or after the date of this Approving Determination and Order, in or with respect to: (i) evaluation and assessment of any certifications, reports submissions, or notices given or required to be given in connection with this Approving Determination and Order; (ii) compliance by any of the Highmark Health Entities with this Approving Determination and Order; (iii) the enforcement, or any challenge or contest to enforcement or validity, of the Conditions or otherwise of this Approving Determination and Order, including, but not limited to, reviewing and analyzing any certifications, reports, submissions or notices by or for any

Highmark Health Entity or auditing and reviewing any books and records of any Highmark Health Entity to determine compliance with any of the Conditions; (iv) litigation, threatened litigation or inquiries or investigations regarding, arising from or related to the Form A filing, the process surrounding the approval of the Form A filing and/or this Approving Determination and Order; and/or (v) the defense of any request or action to require public disclosure of information that Highmark Health or the Department deems confidential. The obligations of the Highmark Health Entities to the Department for all such costs and expenses shall be joint and several obligations.

Modification Of Approving Determination And Order

27. Upon written request by a Highmark Health Entity setting forth: (a) the specific Condition(s) for which such Highmark Health Entity seeks relief; (b) the reason for which such relief is necessary and (c) an undertaking by such Highmark Health Entity to provide all such further information as the Department shall require to evaluate the request, the Department may evaluate and, after evaluation of the request, the Commissioner, in the Commissioner's sole discretion, may grant relief, in whole or in part, from one or more of the Conditions as the Commissioner may be deem appropriate.

28. The Commissioner reserves the right to impose additional conditions upon the approval of the Transaction or modify the Conditions in this Approving Determination and Order if, in his reasonable judgment (i) the consolidated financial position or results of operation of the WPAHS Entities suffer or incur, or are reasonably likely to suffer or incur, a material deterioration or material adverse change and the Commissioner finds that such material deterioration or material adverse change might jeopardize the financial stability of a Domestic Insurer or prejudice the interest of the policyholders of a Domestic Insurer; (ii) the Commissioner finds that actions taken or proposed to be taken by any Highmark Health Entity might jeopardize the financial stability of a Domestic Insurer or prejudice the interest of policyholders of a Domestic Insurer; and/or (iii) the Commissioner finds that actions taken or proposed to be taken by any Highmark Health Entity would substantially lessen competition in insurance in this Commonwealth or tend to create a monopoly therein.

Settlement Of Litigation

29. Without the prior approval of the Commissioner, Highmark Health and each Highmark Health Entity agrees that it will not settle, enter into a settlement agreement or otherwise consent to terminate litigation where the result of such settlement or termination of litigation will be to affect or impair in any way the objective or purpose sought by the Department in imposing or establishing any Condition in this Approving Determination and Order.

Modification Of Affiliation Agreement

30. No Highmark Health Entity which is a party to the Affiliation Agreement may amend, waive enforcement of, modify, or enter into any other agreement or arrangement having

the effect of terminating, waiving or modifying, in any material respect, the terms or conditions of the Affiliation Agreement, without the prior approval by the Commissioner.

Sunset Of Conditions

31. The Conditions contained in this Approving Determination and Order shall expire as follows:

    A. The following Conditions shall not expire: Conditions 1 and 2 (Prohibition on Exclusive Contracting); 3 (Provider/Insurer Contract Length); 5 and 6 (Prohibition on Most Favored Nation Contracts or Arrangements); 7, 8, and 9 (Firewall Policy); 10 (Donations); 11 (Financial Commitment Limitations); 12 and 13 (Public Disclosure of Financial Commitments and Financial and Operational Information Conditions); 20 (Consumer Choice Initiatives); 23 (Community Health Reinvestment); 26 (Department Cost and Expenses); 27 and 28 (Modification of Approving Determination and Order); 29 (Settlement of Litigation); 31 (Sunset of Conditions); 32 (Required Record Retention); 33, 34, and 35 (Enforcement); and 36 (Post Closing Obligations).

    B. Condition 19 (Meeting IDN Savings Benchmarks) and Condition 37 (Post-Closing Obligations of Highmark Health regarding closing documents) shall expire on December 31, 2017, provided that the Department may extend any of these Conditions for up to an additional five (5) years if, in the judgment of the Department, such an extension is in the public interest; and further provided that any expiration of any Condition shall not affect or limit the obligations arising under such Condition prior to its expiration.

    C. Unless a Condition is listed in Condition 31.A. or 31.B. or contains a specific expiration date, the Condition shall expire on December 31, 2020, provided that the Department may extend any of these Conditions for up to an additional five (5) years if, in the judgment of the Department, such an extension is in the public interest; and further provided that any expiration of any Condition shall not affect or limit the obligations arising under such Condition prior to its expiration.

Required Record Retention

32. The books, accounts and records of each Highmark Health Entity shall be so maintained and be accessible to the Department as to clearly and accurately disclose the precise nature and details of the transactions between and/or among any Highmark Health Entity and/or other Person, and to permit the Department to establish compliance with the Conditions or otherwise of this Approving Determination and Order, including, but not limited to, such accounting information as is necessary to support the reasonableness of any charges or fees to a Person.

Enforcement

33. Each of the Highmark Health Entities shall be subject to the jurisdiction of the Department for the purpose of enforcing the terms or the Conditions or otherwise of this Approving Determination and Order. Nothing in this Approving Determination and Order is intended to create or enlarge the right of any Person to enforce, seek enforcement of, and/or seek compliance by the Highmark Health Entities with the terms and conditions of this Approving Determination and Order.

34. To the maximum extent provided by law, a violation of any Condition shall constitute a violation of 40 Pa.C.S. § 6105 (relating to penalties), which provides that any person who violates a Department order made pursuant to 40 Pa.C.S. Chapter 61 (relating to hospital plan corporations) or hinders or prevents the Department in the discharge of its duties under that statute shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine of not more than $ 3,000 or to be imprisoned for not more than six months, or both, in the discretion of the court. This statute also provides that any act or default by any corporation, association, or common law trust who violates a Department order made pursuant to 40 Pa.C.S. Chapter 61 (relating to hospital plan corporations) shall be deemed to be the act or default of the officers or directors who participated in authorizing or effecting such act or default or who knowingly permitted it.

35. In addition to its powers otherwise available under applicable law, the Department may apply to the Commonwealth Court for an order enjoining any Highmark Health Entity or any director, officer, employee or agent thereof from violating or continuing to violate any term or condition of this Approving Determination and Order and for such other equitable relief as the nature of the case and the interest of any Domestic Insurer's policyholders, creditors, shareholders, members or the public may require,

Post Closing Obligations Of Highmark Health

36. If Highmark Health proceeds with closing the Transaction and implements the Change of Control as contemplated by Form A, Highmark Health shall have been deemed to have agreed expressly to fully and promptly comply with each Condition set forth in this Approving Determination and Order. Highmark Health shall have the obligation and responsibility to cause all Highmark Health Entities to comply with their respective obligations under this Approving Determination and Order, including but not limited to the Conditions.

37. Highmark shall provide to the Department a list of closing documents for the Affiliation Agreement and the JRMC Affiliation Agreement within five (5) days after consummation of the Transaction and shall maintain the listed documents and make them available to the Department for a period of not less than five (5) years from the date of this Approval Determination and Order.

This Approving Determination and Order is effective immediately. The Department will issue further full written findings and conclusions on or before May 31, 2013 that substantially reflect the factual conclusions reached in the Blackstone Report and the Guerin-

Michael F. Consedine
Insurance Commissioner
Commonwealth of Pennsylvania

Date: April 29, 2013

Appendix 1 (Definitions)

In addition to the words or terms otherwise defined in the Approving Determination and Order, as used in this Approving Determination and Order and the appendices thereto, the following terms have the following meanings:

"1996 Department Order" shall have the meaning set forth in Condition 23C.

"Addendum 1" means Addendum No. 1 to Amendment No. 1 to Form A dated August 24, 2012.

"Affiliate" means any present Person or any Future Person that, directly or indirectly through one or more intermediaries, Controls, is Controlled by, or is under Common Control with any other Highmark Health Entity and their successors and assigns. "Affiliate" includes but is not limited to all Persons in which any Highmark Health Entity, directly or indirectly, has a membership interest.

"Affiliation Agreement" means the contract entered into between Highmark Health, Allegheny Health Network, Highmark, WPAHS and certain subsidiaries of WPAHS as specified therein dated October 31, 2011, as amended by that certain Amendment No. 1 to Affiliation Agreement entered into as of January 22, 2013, relating to the affiliation between or among the parties thereto.

"Annual CHR Payment Obligation" shall have the meaning set forth in Condition 23A.

"Approval of the Department" or "Approved by the Department" means, except as otherwise provided in this definition: either (1) the Department expressly grants its written approval to a written request by the applicable requesting party for Department approval; or (2) within thirty (30) days after the receipt by the Department of the written request for approval, the Department does not advise the requesting party that the Department either disapproves the request for approval or requests any further information or explanation regarding the request for approval. With respect to Condition 3 (Provider/Insurer Payment Contract Length Limitation), Condition 7 (Firewall Policy) and Condition 21 (Consumer Choice Initiatives), "Approval of the Department" means when the Department expressly grants its written approval to a written request by the applicable requesting party for Department approval.

"Approved Firewall Policy" shall have the meaning set forth in Condition 7.

"Base Case Financial Projections" means the WPAHS financial projections for fiscal years 2013-2017 as prepared by Highmark, dated January 16, 2013 and submitted by Highmark Health to the Department as Exhibit K to Amendment No. 2 to Form A.

"Base Year Discharge Data" shall have the meaning set forth in Condition 21.

"Benchmark" shall have the meaning set forth in Appendix 3 (Benchmarks).

"Commercially Reasonable Process" means such due diligence and evaluative process that would be customarily performed by parties to an arm's length transaction in the geographic

area in which the Financial Commitment is to be made in order to assess the merits and risks of a Financial Commitment and the financial, operational and policy effects to the involved Highmark Health Entity. This includes but is not limited to obtaining, where commercially appropriate and reasonable or to the extent required by law, of a third party fairness opinion or fair market value analysis of such Financial Commitment or other financial analysis and/or stakeholder cost-benefit assessment as may be customarily or reasonably expected to be performed in connection with such a transaction.

"Competitively Sensitive Information" means any information that is not available publicly that could potentially affect competitive innovation and/or pricing between or among one or more Highmark Health Entities and the rivals of such Highmark Health Entities at the provider and/or insurer levels. At a minimum, "Competitively Sensitive Information" includes but is not limited to: (i) present and future reimbursement rates by payor; (ii) payor-provider reimbursement contracts; (iii) terms and conditions included in agreements or arrangements between payors and providers, including but not limited to discounts in reimbursements in agreements; (iv) reimbursement methodologies including but not limited to provisions relating to performance, pay for performance, pay for value, tiering of providers; and (v) specific cost and member information, and revenue or discharge information specific to the payor.

"Community Health Reinvestment Activity" means community health services and projects that improve health care or make health care more accessible. The term includes funding, subsidization or provision of the following: (i) health care coverage for persons who are determined by recognized standards as determined by the Department to be unable to pay for coverage; (ii) health care services for persons who are determined by recognized standards to be uninsured and unable to pay for services; (iii) programs for the prevention and treatment of disease or injury, including but not limited to mental retardation, mental disorders, mental health counseling or the promotion of health or wellness; and (iv) such other services or programs as the Department may approve, including but not limited to health or mental health services for veterans, and the prevention of other conditions, behaviors or activities that are adverse to good health as well as donations to or for the benefit of health care providers in furtherance of any of the foregoing purposes. "Community Health Reinvestment Activity" does not include expenditures for advertising, public relations, sponsorships, bad debt, administrative costs associated with any Domestic Insurer, programs provided as an employee benefit, use of facilities for meetings held by community groups, or expenses for in-service training, continuing education, orientation or mentoring of employees.

"Consumer Choice Initiatives" mean tools and methods that assist consumers in making informed healthcare decisions that reflect differences in the price, cost and quality of care provided. These initiatives may include but are not limited to tools that enable consumers to compare quality and cost-efficiency of medical treatments, healthcare goods and services and providers, and incentives such as tiered network health plan benefit designs that reward patients who choose to use healthcare resources more efficiently. The term "Consumer Choice Initiatives" specifically includes but is not limited to products that include Tiering and Steering as part of their product design.

"Control," "Controlling," "Controlled by" or "under Common Control with" have the meaning given to those terms in 40 P.S. § 991.1401,

"Credit Enhancement Device" means any letter of credit, guaranty, line of credit, insurance or any other device, arrangement or method, financial or otherwise, given or provided as security or assurance for the payment of the principal of, premium, if any, or interest on, the applicable debt.

"Department" means the Insurance Department of the Commonwealth of Pennsylvania.

"Domestic Insurers" means the following Pennsylvania domestic insurers to which the Form A applies: Highmark Inc.; Highmark Casualty Insurance Company, a Pennsylvania stock insurance company; Highmark Senior Resources Inc., a Pennsylvania stock insurance company; HM Casualty Insurance Company, a Pennsylvania stock insurance company; HM Health Insurance Company, d/b/a Highmark Health Insurance Company, a Pennsylvania stock insurance company; HM Life Insurance Company, a Pennsylvania stock insurance company; Keystone Health Plan West, Inc., a Pennsylvania business corporation and licensed health maintenance organization; United Concordia Companies, Inc., a Pennsylvania stock insurance company; United Concordia Dental Plans of Pennsylvania, Inc., a Pennsylvania business corporation and licensed risk-assuming PPO; United Concordia Life And Health Insurance Company, a Pennsylvania stock insurance company; First Priority Life Insurance Company, Inc.; HMO of Northeastern Pennsylvania, Inc., d/b/a First Priority Health; Highmark Benefits Group Inc.; Highmark Coverage Advantage Inc. and Highmark Senior Health Company. "Domestic Insurers" also includes but is not limited to any Health Care Insurer hereafter formed, acquired or organized directly or indirectly by or for any of the foregoing or by any other Highmark Health Entity. The term "Domestic Insurers" shall not include Gateway Health Plan, Inc.; Inter-County Health Plan, Inc.; or Inter-County Hospitalization Plan, Inc. to the extent that those entities are not used, directly or indirectly, to circumvent, affect or impair the purpose or intent of any Condition.

"Domestic Insurer Competitively Sensitive Information" means Competitively Sensitive Information originated by, received and/or held, directly or indirectly, in any form by or for any Domestic Insurer.

"Donation" means any contribution, grant, donation, distributions under 40 P.S. § 991.1405 or other transfer or payment of funds, property or services (or a commitment to make a Donation), whether made directly or indirectly, in cash or in kind, by any Highmark Health Entity to any other Highmark Health Entity or to any other Person; provided, however, that "Donation" shall not include any transfer or payment made in exchange for the fair value of goods or services received by the transferring or paying Person. An expenditure made for a Community Health Reinvestment Activity is not a "Donation", so long as the expenditures are for the direct provision of community health services and direct funding of projects that improve health care or make health care more accessible. Donations that are in furtherance of the Affiliation Agreement, the JRMC Affiliation Agreement and any affiliation agreement with SVHS; and/or are capital expenditures related to the IDN or the IDN Strategy are not to be considered as Community Health Reinvestment Activity for the purposes of this definition of "Donation." For the avoidance of doubt, the term "Donation" shall also include: (i) any dividends, howsoever denominated; and/or (ii) any distribution made to (A) AHN; (B) any direct or indirect subsidiary of AHN; and/or (C) any direct or indirect subsidiary of Highmark Health that is not a wholly-owned direct or indirect subsidiary of Highmark.

"Financial Commitment" means any direct or indirect payment or transfer of any cash or other property, any Donation as defined herein, provision of services, encumbrance upon or granting of any security interest in or to any assets or properties, or the direct or indirect guaranty or incurrence of any contractual obligation or liability. The term "Financial Commitment" includes, but is not limited to, the acquisition of any assets or properties of or interests in, the merger, consolidation or affiliation with, or the entering into of any financial or contractual relationship with, any Person, except for: (a) any Financial Commitment made in the ordinary and usual course of the Highmark Health Entity's business; or (b) any amounts expressly required to be paid without any further consent of any Person and pursuant to the current provisions of the Affiliation Agreement, JRMC Affiliation Agreement and/or any affiliation agreement between Highmark and SVHS acceptable to the Department. Without limiting the generality of the foregoing, (i) until December 31, 2020, a Financial Commitment shall include but is not limited to (A) any advance payment by a Domestic Insurer to a AHN Entity pursuant to or in connection with a contract or arrangement for the payment or reimbursement for Health Care Services; or (B) an increase in contractual rates pursuant to or in connection with a contract or arrangement for the payment or reimbursement for Health Care Services between or among any Domestic Insurer and any AHN Entity in excess of amounts to be determined on the basis of a method of calculation to be submitted to the Department by Highmark by September 15, 2017, which method of calculation shall be acceptable to the Department in form and substance; and (ii) in no event shall any Financial Commitment relating to the acquisition of any assets or properties of or interests in, the merger, consolidation or affiliation with, or any Donation to or investment in, any Person in connection with the IDN Strategy, as it may be renamed, modified or replaced, be considered to be in the ordinary course of business.

"Financial Commitment Notice" shall have the meaning set forth in Condition 11B.

"Firewall Policy" means a written course of action that governs the use, disclosure, release, dissemination or sharing of Competitively Sensitive Information between and/or among each Highmark Health Entity and the employees, contractors, officers, directors, managers or other personnel of other Highmark Health Entities. Without limiting the scope of any Firewall Policy, a Firewall Policy shall restrict each Domestic Insurer's and its directors', officers', employees' and agents' knowledge and ability to influence, directly or indirectly, the negotiations of other Highmark Health Entities with rival insurers, and, conversely, shall restrict other Highmark Health Entities' and their directors', officers', employees' and agents' knowledge and ability to influence, directly or indirectly, any Domestic Insurer's negotiations with rival Health Care Providers.

"Form A" means the Form A filed by Highmark Health, as applicant, with the Department on November 7, 2011, as amended and supplemented by filings made by Highmark Health with the Department.

"GAAP" means generally accepted accounting principles, consistently applied.

"Health Care Insurer" means the Highmark Insurance Companies or any other related or unrelated insurance company, health plan corporation, professional health services plan corporation, health maintenance organization, preferred provider organization or other Person in the business of insurance that finances or pays for health care goods and/or services.

"Health Care Provider" means a Person licensed, certified or otherwise authorized or permitted by the laws of the Commonwealth of Pennsylvania or any other state to provide or perform a Health Care Service in the ordinary course of business or practice of a profession and any other Person who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to a physician, dentist, hospital, nursing home, assisted living provider, home health agency or any other Person that would constitute a "health care provider" pursuant to Federal HIPAA privacy laws (45 C.F.R. § 160.103).

"Health Care Service" means any medical or health care service including but not limited to the treatment or care of an individual or administration of any medical service or medical goods or supplies or dispensing of any medical goods or supplies.

"Highmark" means Highmark Inc., a Pennsylvania nonprofit corporation licensed to operate a hospital plan and a professional health services plan and its successors and assigns.

"Highmark Affiliates" means all Affiliates of Highmark. The term includes but is not limited to all of the Domestic Insurers (other than Highmark).

"Highmark Entities" or "Highmark Entity" means, individually and/or collectively, Highmark and Highmark Affiliates.

"Highmark Insurance Companies" shall have the meaning as set forth in the first paragraph of this Approving Determination and Order.

"IDN" means all aspects of and all Persons involved or to be involved with the integrated delivery network proposed by Highmark Health referred to in Addendum 1 and which is referenced on page 1 of Addendum 1 (wherein Highmark Health states that ". . . Highmark Health proposed the change in control as part of a strategy to implement an integrated delivery network (IDN)"). The IDN is further described throughout the Form A and elsewhere in documents filed by Highmark Health. The IDN includes but it's not limited to the Affiliation Agreement, the JRMC Affiliation Agreement, and proposed affiliation agreement with SVHS, the expansion of the provider network (physicians, community hospitals and medical malls), infrastructure development (including but not limited to the acquisition, expansion, development, improvement or construction of Health Care Services, Health Care Providers, facilities, physician practice management companies and group purchasing organizations), other relationships with individuals or Persons included in the Provider Group and any other activity that has been, is being or is expected to be included in the IDN when the IDN is fully implemented.

"IDN Compensation Policy" shall have the meaning set forth in Condition 18.

"IDN Savings" shall have the meaning set forth in Condition 19.

"IDN Strategy" refers to Highmark Health's strategy to implement the IDN.

"Insurance Restructuring Restricted Receipt Account" means the restricted receipt account in the Pennsylvania State Treasury established by Section 7 of Act 62, 40 P.S. § 991.1403b.

"JRMC" means Jefferson Regional Medical Center, its successors and assigns.

"JRMC Affiliates" means all Affiliates of JRMC.

"JRMC Affiliation Agreement" means that certain affiliation agreement by, between and among Highmark Health, Allegheny Health Network, Highmark, JRMC, the subsidiaries of JRMC and Jefferson Regional Medical Center Foundation dated as of August 13, 2012.

"Loan" means any loan, advance or other transfer or conveyance of cash or property from a Person to another Person in which the Person so receiving (or to receive) such cash or property promises to repay all or portion of the amount so received, regardless of whether such amount to be repaid is secured or unsecured, provides for interest or no interest or is evidenced by any agreement, writing, note or other evidence of indebtedness. In determining the amount of the Loan, the amount of the Loan shall equal the principal amount of the Loan plus the aggregate interest that would accrue on the outstanding amount of the Loan over the term thereof in excess of the commercially reasonable rate of interest that would be charged to a similarly situated borrower which is not affiliated with the Person making the Loan.

"Master Trust Indenture" shall have the meaning set forth in the Affiliation Agreement.

"Minimum Annual CHR Payments Obligation" shall have the meaning set forth in Condition 23A.

"Net Income" shall have the meaning set forth in Condition 15B.

"New UPMC Contract" shall have the meaning set forth in Condition 22A.

"Person" means any individual, corporation, partnership, limited liability company, trust, association, employee pension plan or stock trust or other entity or organization, including but not limited to any governmental or political subdivision or any agency or instrumentality thereof.

"PMPM IDN Savings" shall have the meaning set forth in Condition 19.

"Provider Group" refers to the Persons included or to be included in the "Provider Group" shown on the Proposed Corporate Structure after Tab N to Addendum 1.

"RBC Rating" means the risk-based capital level of a Health Care Insurer determined in accordance with the insurance laws and requirements of the Commonwealth of Pennsylvania as amended from time to time and in a manner acceptable to the Department.

"Required WPAHS Financial and Operational Information" shall have the meaning set forth in Condition 14.

"Steering" means any practice, process or arrangement the effect of which is directly or indirectly to encourage, direct or maneuver a Person into a course of action, e.g., choice of healthcare, by offering structured economic incentives that vary by their value to the consumer or other Person.

"SVHS" means Saint Vincent Health System, a Pennsylvania nonprofit corporation, its successors and assigns.

"SVHS Affiliates" means all Affiliates of SVHS.

"SVHS Entities" or "SVHS Entity" means SVHS and all SVHS Affiliates, collectively and individually.

"Tiering" means a method or design of a health care plan in which a Health Care Providers are assigned to different benefit tiers based on the Health Care Insurer's application of criteria to Health Care Providers' relative costs and/or quality, and in which enrollees pay the cost-sharing (co-payment, co-insurance or deductible) associated with a Health Care Provider's assigned benefit tier(s).

"Total IDN Savings" shall have the meaning set forth in Condition 19.

"Transaction" means the proposed Change of Control relating to the Highmark Insurance Companies as reflected in the Form A, together with all other related transactions and all aspects of the IDN Strategy, including but not limited to the Affiliation Agreement, the JRMC Affiliation Agreement, the expansion of the provider network (physicians, community hospitals and medical malls), the development of infrastructure (physician practice management companies and group purchasing organizations), formation of other relationships with individuals or entities included in the Provider Group, and any other activity that has been, is being or is expected to be included in the IDN when the IDN Strategy is fully implemented.

"Highmark Health" means the Pennsylvania nonprofit corporation of that name formed on October 20, 2011, being the ultimate parent entity, and its successors and assigns.

"Highmark Health Entity" or "Highmark Health Entities" means individually and/or collectively Highmark Health and Affiliates of Highmark Health, including, but not limited to, Allegheny Health Network, Highmark, all Highmark Affiliates, WPAHS, and all WPAHS Affiliates, JRMC, and all of JRMC Affiliates, SVHS and all SVHS Affiliates, any entity Controlled by any of the foregoing, and their respective successors and assigns.

"Highmark Health Health Care Provider Competitively Sensitive Information" means Competitively Sensitive Information originated by and/or held in any form by each business unit, e.g., each hospital (including, but not limited to, WPAHS and JRMC), each physician group, and other Highmark Health Entities on the IDN side of Highmark Health's business.

"Allegheny Health Network" means the Pennsylvania nonprofit corporation of that name formed on October 20, 2011 as referenced on page 7 of the Form A, its successors and assigns.

"UPMC" means University of Pittsburgh Medical Center and/or any and/or all of its Affiliates, its successors and assigns.

"UPMC Contract Transition Plan" shall have the meaning set forth in Condition 22B.

"WPA Service Area" shall have the meaning set forth in Condition 21.

"WPAHS" means West Penn Allegheny Health System, Inc., a Pennsylvania nonprofit corporation, its successors and assigns.

"WPAHS Affiliates" means all Affiliates of WPAHS.

"WPAHS Corrective Action Plan" shall have the meaning set forth in Condition 15.

"WPAHS Due Diligence Information" shall have the meaning set forth in the Affiliation Agreement.

"WPAHS Entities" or "WPAHS Entity" means, individually and/or collectively, WPAHS and all WPAHS Affiliates.

"WPAHS Tax-Exempt Bonds" shall have the meaning set forth in the Affiliation Agreement.

Appendix 2 (Firewall Policy)

Firewalls are a class of provisions that govern both the dissemination and/or sharing of Competitively Sensitive Information between and/or among the formerly independent operations of each Highmark Health Entity and the personnel from each such entity that can be involved in decision-making and engaged with its rivals (who are suppliers or customers) at other Highmark Health Entities. The purpose of developing and implementing a firewall policy is to avoid the inadvertent or intentional disclosure of Competitively Sensitive Information that could potentially reduce substantially competitive innovation or pricing between and/or among the vertically integrated entities and their rivals at the provider and insurer levels.

With respect to each Highmark Health Entity, it is also imperative from a competitive perspective to establish firewalls that prevent persons with influence over managed care contracts and related reimbursements on the health plan side from obtaining information on rival managed contracts and related reimbursements on the provider side.

With this Condition, each Highmark Health Entity shall develop and submit a firewall policy to the Department for approval. Different Firewall Policies may be submitted for separate Highmark Health Entities or types of Highmark Health Entities.

At a minimum, the Firewall Policy shall incorporate each of the following factors:

- Highmark Health, Allegheny Health Network, Highmark, WPAHS, JRMC, and SVHS senior management involvement and support;
- Corporate firewall compliance policies and procedures;
- Mandatory training and education of current and new employees;
- Monitoring, auditing and reporting mechanisms;
- Consistent disciplinary procedures for violation of the Firewall Policy and incentives to ensure compliance; and
- A recusal policy to reduce the risk of senior management's involvement in the review and approval of contracts or arrangements containing Competitively Sensitive Information to which they should otherwise not have access.

From a competitive perspective, the following principles shall guide the development and implementation of an effective Firewall Policy among the Highmark Health Entities' vertically integrated hospitals/providers and its insurers relating to personnel and decision-making:

- Separate managed care contracting information and activity of the hospital and of the insurer segments, including but not limited to the personnel who engage in decision-making and contracting with suppliers (customers);

- Firewall mechanisms that prevent sharing of Competitively Sensitive Information among persons at the hospital and insurer entities, with clear definition of what constitutes Competitively Sensitive Information; and

- Clear confidentiality policies, procedures and protocols that describe the specific persons and positions that can have access to Competitively Sensitive Information with clear policies and procedures for monitoring or auditing compliance with established firewalls, reporting of violations, and remedial actions taken in the event of a violation of the firewall.

Firewalls to prevent the dissemination of competitively sensitive information are common among vertically integrated firms, particularly integrated hospitals and insurance entities. At a minimum, each Highmark Health Entity's Firewall Policy shall prohibit the exchange of Competitively Sensitive Information, including but not limited to:

- Present and future reimbursement rates by payor;

- Payor-provider reimbursement contracts;

- Terms and conditions included in agreements or contracts between payors and providers including but not limited to discounts in reimbursements in agreements;

- Reimbursement methodologies including but not limited to provisions relating to performance, pay for performance, pay for value, tiering of providers; and

- Specific cost and member information and revenue or discharge information specific to the payor.

Each Highmark Health Entity's Firewall Policy shall incorporate monitoring, auditing and reporting mechanisms and provide consistent disciplinary procedures for violation of the Firewall Policy and incentives to ensure compliance, including but not limited to acknowledgement and certification by each employee or independent contractor with access to Competitively Sensitive Information of the employee's or independent contractor's responsibility to report actual or potential violations with the understanding that such reporting will not result in retribution. Employees also shall be required to affirmatively acknowledge that failure to report such information may subject the employee to disciplinary action and independent contractors shall be required to acknowledge that failure to report such information shall constitute cause for termination of such independent contractor's contract.

Highmark Health's Firewall Policy shall include but not be limited to a whistleblower protection/anti-retaliation policy acceptable to the Department that specifically includes but is not limited to reports of Firewall Policy violations. The Firewall Policy may reference a whistleblower protection/anti-retaliation policy of Highmark Health or another Highmark Health Entity so long as that whistleblower/anti-retaliation policy is acceptable to the Department.

Appendix 3 (Benchmarks)

The following are the benchmarks (the "Benchmarks") referred to in Condition 19:

☐ $3,000 lower yearly premiums for a family of four by Fiscal Year 2016 relative to a "no transaction scenario" as described in the Form A.

☐ 10% cost savings on inpatient spend on enrollees that remain with the Domestic Insurers that are Health Care Insurers.

☐ 10% cost savings on outpatient spend on enrollees that remain with the Domestic Insurers that are Health Care Insurers.

☐ Achieve estimated IDN cost savings relative to a "no transaction scenario" as described in the Form A in the following amounts:

Period	With UPMC at Non-Par after 12/31/2014			With UPMC at Par after 12/31/2014		
	TOTAL	Utilization Shift	IDN Implementation	TOTAL	Utilization Shift	IDN Implementation
*CY14	$12M	$80M	($68M)	($91M)	$33M	($215M)
*CY15	($233M)	$4M	($238M)	($298M)	($15M)	($283M)
*CY16	($261M)	$14M	($275M)	($447M)	($15M)	($432M)

* "CY" means calendar year

Attachment 4 (Total IDN Savings Categories)

1) Oncology Shift
2) Utilization Shift
3) Reimbursement
4) Healthier Population
5) Right Setting
6) Right Treatment
7) Cost/Quality
8) Other

Appendix
A-2

BEFORE THE INSURANCE DEPARTMENT
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:

Application of ~~UPE~~Highmark Health for Approval of the Request by ~~UPE~~Highmark Health to Acquire Control of Highmark Inc.; First Priority Life Insurance Company, Inc.; Gateway Health Plan, Inc.; Highmark Casualty Insurance Company; Highmark Senior Resources Inc.; HM Casualty Insurance Company; HM Health Insurance Company, d/b/a Highmark Health Insurance Company; HM Life Insurance Company; HMO of Northeastern Pennsylvania, Inc., d/b/a First Priority Health; Inter-County Health Plan, Inc.; Inter-County Hospitalization Plan, Inc.; Keystone Health Plan West, Inc.; United Concordia Companies, Inc.; United Concordia Dental Plans of Pennsylvania, Inc.; and United Concordia Life and Health Insurance Company	:	Pursuant to Sections 1401, 1402 and 1403 of the Insurance Holding Companies Act, Article XIV of the Insurance Company Law of 1921, Act of May 17, 1921, P.L. 682, as amended, 40 P.S. §§ 991.1401-991.1403; 40 Pa.C.S. Chapter 61 (relating to hospital plan corporations); 40 Pa.C.S. Chapter 63 (relating to professional health services plan corporations); and Chapter 25 of Title 31 of The Pennsylvania Code, 31 Pa. Code §§ 25.1-25.23 Order No. ID-RC-13-06

APPROVING DETERMINATION AND ORDER

Upon consideration of the information, presentations, reports, documents and comments received, as well as other inquiries, investigations, materials, and studies permitted by law,[1] the application (the "Application") of ~~UPE~~Highmark Health (the "Applicant") to acquire control (the "Change of Control") of Highmark Inc.; First Priority Life Insurance Company, Inc.; Gateway Health Plan, Inc.; Highmark Casualty Insurance Company; Highmark Senior Resources Inc.; HM Casualty Insurance Company; HM Health Insurance Company, d/b/a Highmark Health

[1] These materials include, but are not limited to, information submitted to the Department by ~~UPE~~Highmark Health and members of the public, and the reports prepared for the Department by The Blackstone Group, L.P. (the "Blackstone Report") and Margaret E. Guerin-Calvert, Senior Consultant, Compass Lexecon (the "Guerin-Calvert Report"). All of the publicly available materials submitted to the Department are available on the Department's website at:
http://www.portal.state.pa.us/portal/server.pt/community/industry_activity/9276/highmark_west_penn_allegheny_health_system/982185

Insurance Company; HM Life Insurance Company; HMO of Northeastern Pennsylvania, Inc., d/b/a First Priority Health; Inter-County Health Plan, Inc.; Inter-County Hospitalization Plan, Inc.; Keystone Health Plan West, Inc.; United Concordia Companies, Inc.; United Concordia Dental Plans of Pennsylvania, Inc.; and United Concordia Life and Health Insurance Company (the "Highmark Insurance Companies") and all other transactions included in the Form A which are subject to the Department's jurisdiction and require approval of the Department are hereby approved, subject to the conditions set forth below (collectively the "Conditions").

Section 1402 of the Insurance Holding Companies Act requires the Department to approve an application for a change in control unless the Department has found that:

(i) After the Change of Control, the Highmark Insurance Companies would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which they are presently licensed;

(ii) The effect of the Change of Control would be to substantially lessen competition in insurance in this Commonwealth or tend to create a monopoly therein;

(iii) The financial condition of the Applicant is such as might jeopardize the financial stability of a one or more of the Highmark Insurance Companies or prejudice the interests of any policyholders;

(iv) The Change of Control, including but not limited to any material change in the business or corporate structure or management of the Applicant or the Highmark Insurance Companies as described in the Application is unfair and unreasonable to policyholders of the Highmark Insurance Companies and not in the public interest;

(v) The competence, experience and integrity of those Persons who would control the operation of any of the Highmark Insurance Companies are such that it would not be in the

interest of the policyholders of the Highmark Insurance Companies and the public to permit the Change of Control;

(vi) The Change of Control is likely to be, hazardous or prejudicial to the insurance buying public; and

(vii) The Change of Control is not in compliance with laws of the Commonwealth.

The burden is on the Department to show a violation of the standards. The standards are phrased in the negative and the Department is required to approve a transaction unless it finds that any of the standards are met.

The Department finds that, with the imposition of the Conditions set forth below to preserve and promote competition in insurance in the Commonwealth of Pennsylvania, to protect the public interest, and to protect the financial stability of the Highmark Insurance Companies, the Change of Control (and all other transactions included in the Application which are subject to the Department's jurisdiction and require approval of the Department) do not violate Section 1402 of the Insurance Holding Companies Act.

The form of the Second Amended and Restated Bylaws of Highmark Inc., as submitted to the Department in connection with the Application, meet the statutory standards of 40 Pa.C.S. § 6328(b).

This Approving Determination and Order shall be subject to the following Conditions, all of which must be complied with in order for the approval of the Application to be valid. This Approving Determination and Order is effective immediately.[2] The Department will issue further

[2] The captions, headings and preambles in this Approving Determination and Order are for convenience and general reference only and shall not be construed to describe, define or limit the scope, intent or meaning of any of the terms or conditions of this Approving Determination and Order.

full written findings and conclusions on or before May 31, 2013 that substantially reflect the factual conclusions reached in the Blackstone Report and the Guerin-Calvert Report.

Competitive Conditions

Preamble: Both the WPAHS Entities and the Domestic Insurers engage in confidential and competitively sensitive contract negotiations with each other's rivals that involve price and non-price terms and product design. Common ownership of the Domestic Insurers and the WPAHS Entities provides the opportunity for each to obtain and make use of Competitively Sensitive Information from rivals that could be used to the potential detriment of consumers and competition. The ability of rival insurers in the Western Pennsylvania area to develop and obtain the benefits of innovative products and pricing depend on their ability to contract with ~~UPE~~Highmark Health-affiliated providers without risk of disclosure to the Domestic Insurers. A risk to competition exists if a Domestic Insurer can adversely affect any rival's price and non-price contract terms or deter innovation or access or limit gains to innovation by obtaining and acting upon any rival's Competitively Sensitive Information. A risk to competition also exists if Health Care Insurers or Health Care Providers enter into contractual arrangements, including but not limited to arrangements (known as "most-favored nation" arrangements) that guarantee receipt of the best payment rate and/or terms offered to any other Health Care Insurer or Health Care Provider. The following Competitive Conditions are designed to mitigate potential adverse competitive effects on competition and on rivals contracting with the Domestic Insurers and/or the WPAHS Entities when under common ownership and to maximize market-based access opportunities of unrelated providers and community hospitals to the IDN and insurers to ~~UPE~~Highmark Health Health Care Providers.

Prohibition On Exclusive Contracting

1. No Domestic Insurer shall enter into a contract or arrangement with any ~~UPE~~Highmark Health Health Care Provider which contract or arrangement requires the UPE Health Care Provider to exclusively contract with one or more Health Care Insurers with respect to any Health Care Service.

2. No ~~UPE~~Highmark Health Entity shall, directly or indirectly, prohibit or limit the authority of any other ~~UPE~~Highmark Health Entity that is a Health Care Provider from entering into any contract or arrangement with any Health Care Insurer. Exclusive contracts with specialized providers, such as anesthesiologists or emergency room physicians, may be entered into by a ~~UPE~~Highmark Health Entity that is a Health Care

Insurer with at least thirty (30) days' prior written notice to the Department, so long as the Department does not advise the requesting Health Care Insurer that the Department either disapproves the request for approval or requests any further information or explanation regarding the request for approval within such thirty (30) day period.

Provider/Insurer Payment Contract Length Limitation

3. No Domestic Insurer shall enter into any contract or arrangement with any Health Care Provider where the length of the contract (including but not limited to the initial term and all renewal terms) is in excess of five (5) years, without the prior Approval of the Department. No ~~UPE~~Highmark Health Entity that is a Health Care ~~Insurer domiciled in Pennsylvania~~ Provider shall enter into any contract or arrangement with any Health Care ~~Provider~~Insurer where the length of the contract (including but not limited to the initial term together with all renewal terms) is in excess of five (5) years, without the Approval of the Department.

Termination Of Current Health Care Insurer Contracts Other Than For Cause

4. Until December 31, 2015, no ~~UPE~~Highmark Health Entity that is a Health Care Provider shall terminate a Health Care Service reimbursement contract with any Health Care Insurer for a reason other than for cause.

Prohibition On Most Favored Nation Contracts Or Arrangements

5. No Domestic Insurer shall enter into any contract or arrangement with any Health Care Provider on terms which include a "most favored nation" or similar clause that guarantees or provides that a Domestic Insurer will receive the best payment rate and/or terms that such Health Care Provider gives any other purchaser or payor of the same or substantially the same product or service.

6. No ~~UPE~~Highmark Health Entity that is a Health Care Provider shall enter into any contract or arrangement with any Health Care Insurer which includes a "most favored nation" or similar clause that guarantees or provides that the Health Care Insurer will receive the best payment rate and/or terms that such ~~UPE~~Highmark Health Entity gives any other purchaser or payor of the same or substantially the same product or service.

Firewall Policy

7. ~~UPE~~Highmark Health shall develop, implement, monitor the operation of and enforce strict compliance with a Firewall Policy for ~~UPE~~Highmark Health, ~~UPE Provider Sub~~Allegheny Health Network, and each ~~UPE~~Highmark Health Entity that is a Health Care Provider or a Health Care Insurer (and for such other ~~UPE~~Highmark Health Entities as the Department may require). The Firewall Policy shall be in a form and substance acceptable to the Department. Within thirty (30) days after the issuance of this Approving Determination and Order, ~~UPE~~Highmark Health shall file with the Department, for the review and Approval of the Department, a comprehensive Firewall Policy that includes but is not limited to the elements set forth in Appendix 2 (Firewall Policy), which is attached hereto and is incorporated herein by reference. Different Firewall Policies may

be submitted for separate ~~UPE~~Highmark Health Entities or types of ~~UPE~~Highmark Health Entities, provided that each such separate policy shall substantially include all of the elements set forth in Appendix 2 (Firewall Policy) and be accompanied by an explanation that describes the need for a separate policy. Once Approved by the Department, each Firewall Policy ("Approved Firewall Policy") shall be made publicly available in accordance with the requirements of the Department. After Approval of the Department of the Approved Firewall Policy, ~~UPE~~Highmark Health shall cause each applicable ~~UPE~~Highmark Health Entity to maintain in full force the applicable Approved Firewall Policy. No ~~UPE~~Highmark Health Entity may make any material amendment, waive enforcement of or terminate any material provision of its Approved Firewall Policy without the Approval of the Department. Each ~~UPE~~Highmark Health Entity required to have and to maintain an Approved Firewall Policy shall give prompt notice to the Department of any other amendment, waiver or termination of its Approved Firewall Policy.

8. On or before May 1 of each year, ~~UPE~~Highmark Health shall file with the Department a report executed by ~~UPE~~Highmark Health's President and its Chief Privacy Officer. The report shall be a public record, shall be in a form and substance satisfactory to the Department and shall include the following certification to the best of the President's and Chief Privacy Officer's information, knowledge and belief: (i) at all times during the immediately preceding calendar year, each ~~UPE~~Highmark Health Entity subject to Condition 7 was governed by and operated in accordance with a Department Approved Firewall Policy; (ii) at all times in the prior calendar year each Approved Firewall Policy was fully implemented, monitored and enforced in accordance with its terms, except as fully described in subsection (vi) below; (iii) mandatory training of employees with access to any Competitively Sensitive Information (including both current employees and all new hires) has occurred in accordance with the terms of the applicable Approved Firewall Policy; (iv) each ~~UPE~~Highmark Health Entity that is subject to Condition 7 has obtained recertification biannually of each of its employees with access to any Competitively Sensitive Information stating that the employee has received a copy of the Approved Firewall Policy, understands the Approved Firewall Policy and agrees to abide by the Firewall Policy; (v) no individual with management oversight over all or part of both ~~UPE~~Highmark Health's provider and insurer business segments has used Competitively Sensitive Information obtained as part of his or her oversight function to competitively disadvantage a rival Health Care Provider or Health Care Insurer; (vi) each ~~UPE~~Highmark Health Entity that is subject to Condition 7 has undertaken an annual good faith review of the ~~UPE~~Highmark Health Entity's Approved Firewall Policy compliance for the prior calendar year and that either (a) there were no violations or other breaches of the applicable Approved Firewall Policy other than those for which the ~~UPE~~Highmark Health Entity had previously provided notice to the Department in accordance with the Approved Firewall Policy, or (b) the Department has been provided with the non-reported breaches report and corrective action plan required in Condition 9; and (vii) such other information as the Department shall require.

9. ~~UPE~~Highmark Health, ~~UPE Provider Sub~~Allegheny Health Network, and each ~~UPE~~Highmark Health Entity that is a Health Care Provider or a Health Care Insurer shall provide the Department with such information regarding its Approved Firewall Policy

and its implementation and enforcement as the Department shall from time to time request. In addition to other information to be provided to the Department, a report of non-reported breaches of the applicable Approved Firewall Policy, which shall not be a public record, shall accompany the annual certification along with a corrective action plan (which shall be satisfactory in form and substance to the Department) to assure the Department of future, timely compliance with the Approved Firewall Policy and to provide an explanation as to why prior notice of such breach had not been provided to the Department. Approved Firewall Policy implementation and enforcement shall be subject to review and/or examination by the Department, or consultants retained by the Department at the expense of the ~~UPE~~Highmark Health Entity, to the extent that the Department believes that such review and/or examination is in the public interest.

Financial Conditions

Preamble: The following financial conditions are intended to: (i) limit the amount of policyholder funds that may be transferred to any Domestic Insurer's new parent entity or other Affiliates of the parent; (ii) establish an enhanced standard of review and assessment that is required to be undertaken prior to any Domestic Insurer entering into additional material financial commitments; (iii) implement ongoing reporting and monitoring requirements related to a Domestic Insurer's investments into the WPAHS Entities; (iv) establish criteria for a plan of corrective action to be prepared by ~~UPE~~Highmark Health if the turnaround of WPAHS falls short of certain targets; and (v) enhance the level of transparency and accountability with respect to Highmark's stated goal of deriving tangible policyholder benefits, in the form of relative premium and cost of care savings, related to financial commitments made in connection with the Transaction.

Limitations On Donations

10. Effective as of July 28, 2017, Condition 10 is deleted; provided that the Commissioner reserves the right, in the Commissioner's sole discretion, to reinstate Condition 10, in whole or in part, with respect to one or more Domestic Insurers, upon written notice to Highmark. ~~Without the Approval of the Department, no Domestic Insurer shall make, or agree to make, directly or indirectly, any Donation, which together with all other Donations made or agreed to be made by that Domestic Insurer within the twelve (12) consecutive months immediately preceding such Donation equals or exceeds the lesser of: (i) 3% of the Domestic Insurer's surplus as regards policyholders, as shown on its latest annual statement on file with the Department; or (ii) 25% of the Domestic Insurer's net income as shown on its latest annual statement; provided, however, if UPE has filed pursuant to Condition 15 a WPAHS Corrective Action Plan, any Donation made or agreed to be made by any Domestic Insurer to any UPE Entity shall be restricted solely for use in connection with implementing the Financial Commitments under and to the extent provided in the WPAHS Corrective Action Plan, until such time as all Financial Commitments related to the WPAHS Corrective Action Plan are satisfied. A Domestic~~

~~Insurer may not make or agree to make a Donation which is part of a plan or series of like Donations and/or other transactions with other UPE Entities, the purpose, design or intent of which is, or could reasonably be construed to be, to evade the threshold amount set forth in this Condition and thus avoid the review that would occur otherwise. Notwithstanding the foregoing, and in addition to the requirements of (i) and (ii) of this Condition 10, in no event shall Highmark have any right, directly or indirectly, to make any Donation under this Condition if the RBC Rating of Highmark is, or as a result of the Donation is likely to be, 525% or below. This Condition 10 shall not apply to a Donation made from a Domestic Insurer that is a direct or indirect subsidiary of Highmark to Highmark or any subsidiary of Highmark. No Approval of the Department shall be required under this Condition if Department approval for the Financial Commitment has been obtained under 40 P.S. § 991.1405.~~

Financial Commitment Limitations

11. Any Financial Commitment made or agreed to be made to or for any Person by any of the Highmark Health Entities designated in this Condition, directly or indirectly, shall satisfy the following requirements:~~Any Financial Commitment made or agreed to be made to or for any Person by any of the UPE Entities designated in this Condition, directly or indirectly, shall satisfy the following requirements:~~

    A. **Due Diligence Standard**. For all Financial Commitments: (i) the Highmark Health Entity making or agreeing to make any Financial Commitment shall conduct a Commercially Reasonable Process to evaluate and assess the benefits and risks to policyholders, subscribers or other stakeholders, as applicable, and whether the Financial Commitment furthers and is consistent with the Highmark Health Entity's nonprofit mission, if the Highmark Health Entity is exempt from Federal taxation pursuant to Section 501(c)(3) of the Internal Revenue Code); and (ii) the terms of any Financial Commitment shall satisfy the provisions of 40 P.S. § 991.1405, as if the Financial Commitment transaction were made or agreed to be made between or among members of the holding company system. Each Highmark Health Entity making or agreeing to make any Financial Commitment shall reasonably document the Commercially Reasonable Process undertaken pursuant to this Condition 11.A., shall provide to the Department upon any filing with the Department pursuant to this Condition 11, or whenever requested by the Department, a summary of the documentation supporting the performance of such Commercially Reasonable Process and shall provide such further information as requested by Department. Documentation evidencing such Commercially Reasonable Process shall be retained by the Highmark Health Entity for five (5) years after making the Financial Commitment to which the Commercially Reasonable Process relates.~~**Due Diligence Standard**. For all Financial Commitments: (i) the UPE Entity making or agreeing to make any Financial Commitment shall conduct a Commercially Reasonable Process to evaluate and assess the benefits and risks to policyholders, subscribers or other stakeholders, as applicable, and whether the Financial Commitment furthers and is consistent with the UPE Entity's nonprofit mission, if the UPE Entity is exempt from Federal taxation pursuant to Section 501(c)(3) of the Internal Revenue Code); and (ii) the~~

~~terms of any Financial Commitment shall satisfy the provisions of 40 P.S. § 991.1405, as if the Financial Commitment transaction were made or agreed to be made between or among members of the holding company system.~~

B. **Transactions to or with Highmark Health Entities**. Without the Approval of the Department, no Domestic Insurer shall, directly or indirectly, make or agree to make: (i) any Financial Commitment to or with any Highmark Health Entity if in the calendar year commencing January 1, 2017, or in any subsequent calendar year after December 31, 2017, either (A) the amount thereof, together with all other Financial Commitments made or agreed to be made directly or indirectly by all of the Domestic Insurers to or with any Highmark Health Entity in such calendar year, equals or exceeds ten percent (10%) of Highmark's surplus as regards to policyholders as shown on its last annual statement on file with the Department; or (B) the RBC Rating of Highmark is, or as a result of the Financial Commitment is likely to be, 525% or below; or (ii) any Financial Commitment in the form or substance of a Loan to any Highmark Health Entity (other than Highmark or any direct or indirect subsidiary of Highmark) if at any time on or after January 1, 2017 the amount thereof, together with all other Financial Commitments in the form or substance of a Loan made or agreed to be made directly or indirectly by all of the Domestic Insurers to or with any Highmark Health Entity (other than Highmark or any direct or indirect subsidiary of Highmark) from or after January 1, 2017, reduced by any amount of principal repayments made with respect to such Loans, exceeds an aggregate amount of $200,000,000 or more. The calculation of the RBC Rating of Highmark for the purposes of this Condition 11.B. shall be made as provided in Condition 11.E. The calculation of the amount of the Financial Commitment shall be made as provided in Condition 11.F.~~**Transactions Requiring Only Notice**. If the amount of any Financial Commitment made or agreed to be made by one or more of the Domestic Insurers equals or exceeds $100,000,000 in the aggregate (or if such Financial Commitment, together with all other Financial Commitments made by one or more of the Domestic Insurers, directly or indirectly, within twelve (12) consecutive months immediately preceding the making of the Financial Commitment causes the total to exceed $100,000,000), the Domestic Insurer(s) making or agreeing to make such Financial Commitment shall deliver to the Department written notice 30 days in advance of making or agreeing to make such Financial Commitment (the "Financial Commitment Notice"). The Financial Commitment Notice shall describe such Financial Commitment, and provide such information as is required by 31 Pa. Code § 27.3 relating to material transactions, together with such other information as the Department shall request. No notice is required under this Condition if notice of the Financial Commitment is provided to the Department pursuant to 40 P.S. § 991.1405.~~

C. **Transactions to or with any Person other than Highmark Health Entities**. Without the Approval of the Department, no Domestic Insurer, directly or indirectly, shall make or agree to make any Financial Commitment to or with any Person other than a Highmark Health Entity in the calendar year commencing January 1, 2017, or any subsequent calendar year after December 31, 2017, if the

RBC Rating of Highmark is, or as a result of the Financial Commitment is likely to be, 525% or below. The calculation of the RBC Rating of Highmark for the purposes of this Condition 11.C. shall be made as provided in Condition 11.E. The calculation of the amount of the Financial Commitment shall be made as provided in Condition 11.F. ~~**Transactions Requiring Department Approval**. Without the Approval of the Department, no Domestic Insurer shall make or agree, directly or indirectly, to make any Financial Commitment if: (i) the amount thereof, together with all other Financial Commitments made or agreed to be made directly or indirectly by all of the Domestic Insurers within the immediately preceding consecutive twelve (12) months, equals or exceeds $250,000,000; (ii) the amount thereof is made in connection with a Financial Commitment made or agreed to be made to a Person (including but not limited to any Affiliates), together with all other Financial Commitments between or among one or more of the UPE Entities, on the one hand, and such Person (including but not limited to any Affiliates), on the other hand, aggregate $250,000,000 or more; or (iii) the RBC Rating of Highmark is, or as a result of the Financial Commitment is likely to be, 525% or below.~~

D. **Calculation of Financial Commitment Limitations**. If a Financial Commitment is made by a Domestic Insurer to a Highmark Health Entity and such Highmark Health Entity further makes a Financial Commitment to a Person other than a Highmark Health Entity, the Financial Commitment made by the Domestic Insurer to the Highmark Health Entity and by the Highmark Health Entity to the Person other than a Highmark Health Entity shall not be aggregated, but for the purposes of this Condition 11, such Financial Commitment made to the Highmark Health Entity shall be subject to the requirements of Condition 11.B. ~~**No Circumvention Mechanism**. No Domestic Insurer may undertake any action to delay any Financial Commitment or perform or agree to perform any Financial Commitment in stages or steps, or take any other action with respect to any Financial Commitment, the purpose, design or intent of which is, or could reasonably be construed to be, to evade any of the foregoing requirements.~~

E. **RBC Rating Calculation; Reports to the Department**.

(1) The calculation of the RBC Rating of Highmark to determine if the RBC Rating of Highmark is, or as a result of a Financial Commitment is likely to be, 525% or below shall be based upon the last annual statement of Highmark on file with the Department, adjusted for the impact of the proposed Financial Commitment and the most recently available information or data as shown in the latest Quarterly RBC Report filed pursuant to Condition 11.E.(3).

(2) Simultaneously with the submission to the Department of any request to approve any Financial Commitment pursuant this Condition 11, Highmark shall provide to the Department, in addition to all other information required or requested by the Department: (i) a calculation of the effect or impact of the proposed Financial Commitment on the RBC Rating of

Highmark (determined as provided in Condition 11.E.(1)); (ii) a "downside" or "stress" analysis of such effect on the RBC Rating of Highmark; and (iii) a calculation of the effect or impact of the proposed Financial Commitment on the RBC Rating of Highmark based upon the last annual statement of Highmark on file with the Department prior to the applicable Financial Commitment.

(3) Highmark shall provide to the Department on a quarterly basis a report (the "Quarterly RBC Report"), in form and substance acceptable to the Department, that includes calculations of the RBC Rating of Highmark (i) based upon the last annual statement of Highmark on file with the Department, adjusted for the most recently available information or data as of the end of the quarter to which such Quarterly RBC Report relates; and (ii) based upon the last annual statement of Highmark on file with the Department. Along with the Quarterly RBC Report, Highmark shall provide the Department with all supporting documentation used to arrive at its estimates of the RBC Rating of Highmark, including but not limited to, any models, analyses or other supporting documentation used in estimating the effect of a potential transaction on the RBC Rating of Highmark.

F. **Financial Commitment Calculation**.

(1) In determining the amount of a Financial Commitment in any applicable calendar year, the Financial Commitment shall be deemed to occur upon the date on which the Financial Commitment (or the portion thereof) is required be reflected in the financial statements of the Domestic Insurer in accordance with statutory accounting principles.

(2) The amount of the Financial Commitment for an applicable calendar year shall be all or that portion of the Financial Commitment that meets the test provided in Condition 11.F.(1) above; provided that if less than the entire amount of the Financial Commitment satisfies the test in Condition 11.F.(1) above, the remaining portion of the Financial Commitment shall be deemed to be a Financial Commitment once such remaining portion is required to be reflected in the financial statements of the Domestic Insurer in accordance with statutory accounting principles.

(3) Notwithstanding any other provision of this Approving Determination and Order, with respect to any Financial Commitment relating to any guaranty or surety arrangement, the amount of the Financial Commitment for a calendar year with respect to that guaranty or surety arrangement shall be equal to the maximum amount of the guaranty or surety as set forth in or determined by the applicable instrument or agreement of guaranty or surety (or any other documents relating thereto), if the obligations under such guaranty or surety at issuance or any time thereafter are collateralized, or required (whether immediately or upon the occurrence of

any events or conditions) to be collateralized, directly or indirectly, by any assets or properties of any Domestic Insurer; provided that the foregoing shall not apply to any existing guaranty of a Domestic Insurer or to any extension of such guaranty hereafter entered into or agreed upon, if any such extension arrangement is acceptable to the Department in form and substance.

G. **Application to Certain Transactions**.

(1) Condition 11.B. shall not apply to Highmark's forgiveness of any indebtedness owed to it as of July 31, 2017 by Highmark Health and/or AHN and/or subsidiaries of Highmark Health or any alternative repayment method of such indebtedness acceptable to the Department in form and substance. This indebtedness, as of July 31, 2017, is estimated to be approximately $500,000,000 owed by AHN to Highmark and the $200,000,000 owed by Highmark Health to Highmark (collectively the "$700,000,000 Debt").

(2) No later than thirty (30) days after the RBC Rating of Highmark exceeds 650% as reflected in a Quarterly RBC Report required to be submitted to the Department pursuant to Condition 11.E.(3), Highmark shall forgive for statutory accounting purposes (or finalize an alternative repayment method acceptable to the Department in form and substance with respect to) the $700,000,000 Debt. Any time after November 30, 2019, the Department may require Highmark to forgive for statutory accounting purposes (or finalize an alternative repayment method satisfactory to the Department with respect to) the $700,000,000 Debt.

(3) Condition 11.B. shall not apply to: (i) the extension of Highmark's existing guarantee of the WPAHS term loan dated May 22, 2014 by and between WPAHS and certain lenders; and/or (ii) a successor guarantee by Highmark of such loan, if such extension or successor guaranty is acceptable to the Department in form and substance.

(4) Condition 11.B. shall not apply to a Financial Commitment that is: (i) otherwise in compliance with applicable Pennsylvania law, including but not limited to the Insurance Holding Company Act, which act shall at all times apply to Financial Commitments of Highmark and each direct or indirect subsidiary of Highmark and (ii) either (A) from Highmark to a direct or indirect subsidiary of Highmark; or (B) from a direct or indirect subsidiary of Highmark to Highmark or another direct or indirect subsidiary of Highmark; provided that any Financial Commitment made by a direct or indirect subsidiary of Highmark to any Person other than to Highmark or any other direct or indirect subsidiary of Highmark shall be treated for the purpose of this Condition 11 as if it were a Financial Commitment of Highmark on the date of such Financial Commitment by such direct or indirect subsidiary of Highmark.

H. **No Circumvention Mechanism**. No Domestic Insurer may undertake any action to delay any Financial Commitment or perform or agree to perform any Financial Commitment in stages or steps, or take any other action with respect to any Financial Commitment, the purpose, design or intent of which is, or could reasonably be construed to be, to evade any of the foregoing requirements or any Approval of the Department which otherwise would have been required.

~~E.~~I. **No Limitation on Other Obligations**. Nothing contained in this Approving Determination and Order shall limit or affect the obligations of each Highmark Health Entity to comply with applicable law, including without limitation the Insurance Holding Company Act. No Approval of the Department shall be required under this Condition 11 if Department approval for the Financial Commitment has been obtained under 40 P.S. § 991.1405.

Disclosure Of Financial Commitments And Financial And Operational Information

12. On or before May 1 of each year, ~~UPE~~Highmark Health shall file with the Department a report setting forth: (i) all Financial Commitments made or agreed to be made by any ~~UPE~~Highmark Health Entity within the immediately preceding calendar year; and (ii) specifying the section of this Condition pursuant to which such Financial Commitments were permitted to be made or agreed to be made. ~~UPE~~Highmark Health shall promptly and fully respond to questions or requests of the Department for information in connection with such report.

13. Each year, no later than the date on which the financial statements are required to be filed for the holding company system under Form B or otherwise filed pursuant to 40 P.S. § 991.1404 (a), ~~UPE~~Highmark Health shall file with the Department, as a public record, audited financial statements (including but not limited to all footnotes) of ~~UPE~~Highmark Health prepared in accordance with GAAP, for the immediately preceding calendar year. In addition, ~~UPE~~Highmark Health shall file with the Department any letters from auditor(s) to management and any other information requested by the Department. The audited financial statements of Highmark Health that are required to be filed annually pursuant to Condition 13 as a public record shall include a footnote (or disclosure in another manner as required by GAAP) that discloses the balance sheets and income statements of Highmark, AHN and Highmark Health (Parent Only) separately and shall provide consolidating adjustments totaling to the audited consolidated balance sheet and income statement of Highmark Health.

14. ~~UPE~~Highmark Health shall file with the Department a report setting forth the below listed financial and operational information for the WPAHS Entities (the "Required WPAHS Financial and Operational Information"). The Required WPAHS Financial and Operational Information shall be filed quarterly for each quarter through the period ended June 30, 2015 (within 30 days after the end of the quarter) and thereafter annually on July 1 of each year.

A. The Required WPAHS Financial and Operational Information shall be presented on the same basis as the information was presented for the immediately preceding

three (3) month period through the quarter ended June 30, 2015, or for each annual report on the same basis the information was presented for the preceding four (4) quarters of each year for which the annual report is required to be delivered. For each quarterly report, the information shall be compared to the WPAHS budget or forecast for such quarter and for each annual report, the information shall be compared to the WPAHS budget or forecast for such year and the Base Case financial projections. ~~UPE~~Highmark Health shall make members of its management team available to the Department on a timely basis for purposes of reviewing the Required WPAHS Financial and Operational Information with the Department and any consultants retained by the Department.

B. The Required WPAHS Financial and Operational Information shall include for the WPAHS Entities:

(1) An income statement displaying a level of detail consistent with the Base Case Financial Projections for the WPAHS Entities as submitted by ~~UPE~~Highmark Health to the Department as part of ~~UPE~~Highmark Health's Form A filings (the "Base Case Financial Projections"). To the extent that the income statement submitted to the Department pursuant to this Condition differs from GAAP, a reconciliation shall be submitted as well.

(2) A cash flow statement displaying a level of detail consistent with the Base Case Financial Projections for the WPAHS Entities submitted by ~~UPE~~Highmark Health to the Department as part of ~~UPE~~Highmark Health's Form A. To the extent that the income statement and cash flow statements submitted to the Department pursuant to this Condition differ from GAAP, a reconciliation shall be submitted as well.

(3) A calculation of the WPAHS Entities' Days Cash on Hand as defined in the Master Trust Indenture (the "DCOH"), which shall present a level of detail sufficient to reconcile the components of the calculation to the income statement and balance sheets submitted as part of this Condition.

(4) A calculation of WPAHS Entities' Debt Service Coverage Ratio, as defined in the Master Trust Indenture, which shall present a level of detail sufficient to reconcile the components of the calculation to the income statement and balance sheets submitted as part of this Condition.

(5) A schedule of capital expenditures for all WPAHS Entities, and for each WPAHS Entity for which information is requested by the Department, during the applicable calendar quarter in question and grouped by significant project categories.

(6) A schedule of inpatient and outpatient discharge volume for the WPAHS Entities in total and for each primary WPAHS Entity facility.

(7) A schedule of occupancy rates for the WPAHS Entities in total and for each primary WPAHS facility.

(8) A schedule of salaried and non-salaried employees, including but not limited to physicians, on an FTE basis for the WPAHS Entities in total and for each primary WPAHS Entity operating segment (hospitals, physician organization, etc.).

(9) A schedule of occupied beds by each primary WPAHS Entity facility.

(10) A schedule of FTEs per occupied bed by each primary WPAHS Entity facility.

(11) Audited financial statements (including but not limited to all footnotes) of WPAHS and WPAHS Affiliates specified by the Department prepared in accordance with GAAP, for the immediately preceding calendar year along with any letters from auditors to management.

(12) If WPAHS files consolidated financial statements with any ~~UPE~~Highmark Health Entity other than WPAHS Affiliates specified by the Department, then ~~UPE~~Highmark Health shall deliver WPAHS' consolidating financial statements showing its financial position, results of operations, changes in cash flow and related footnotes thereto of WPAHS and such specified WPAHS Affiliates on a standalone basis.

(13) Such other financial and operational information related to WPAHS and the IDN Strategy as may be requested, from time to time, by the Department.

C. Highmark Health shall continue to file quarterly with the Department the Required AHN Financial and Operational Information pursuant to this Condition 14 for each quarter through the period ended December 31, 2020 and thereafter annually on July 1 of each year; provided that the Department may extend the requirement to file the Required AHN Financial and Operational Information quarterly for up to an additional five (5) years if, in the judgment of the Department, such an extension is in the public interest. Highmark Health shall benchmark (the "Benchmark Report") the actual results for each such quarter and annually thereafter against the projections contained in the "Allegheny Health Network Strategic and Financial Plan (2017-2020)" ("AHN Strategic and Financial Plan"), as filed with the Department and as such plan may be updated or extended, if required by the Department pursuant to Condition 15. A public version of the AHN Financial and Operational Information and the Benchmark Report also shall be filed with the Department at the same time as these reports are filed with the Department.

WPAHS Corrective Action Plan

15. ~~UPE~~Highmark Health shall prepare and produce to the Department a plan of financial and operational corrective action for WPAHS (the "WPAHS Corrective Action Plan") if either:

A. (i) From the date hereof through June 30, 2015, the aggregate amount of Financial Commitments made or agreed to be made directly or indirectly by all ~~UPE~~Highmark Health Entities to the WPAHS Entities equals or exceeds $100,000,000 and (ii) the WPAHS Entities have issuer ratings from two (2) of the Credit Rating Agencies of less than investment grade; or

B. As of the quarter ended June 30, 2015, either (i) the WPAHS Entities' net income, as determined in accordance with GAAP ("Net Income"), has not been greater than $0.00 after adjusting for any material non-recurring or unusual income, including but not limited to all payments received from any ~~UPE~~Highmark Health Entity outside of the normal course of business and any Financial Commitments to the extent included in such Net Income, for two (2) out of the previous four (4) consecutive quarters; or (ii) DCOH, after adjusting for any material non-recurring or unusual cash receipts and Financial Commitments, including but not limited to all payments received from any ~~UPE~~Highmark Health Entity outside of the normal course of business, has not been equal to or greater than a value of sixty-five (65) days for two (2) of the previous four (4) consecutive quarters.

C. Highmark Health shall submit to the Department a corrective action plan for AHN and its Affiliates setting forth the information required by this Condition 15.C., together with such information necessary to make such plan full, accurate and complete (the "AHN Corrective Action Plan"). The AHN Corrective Action Plan submitted may be in the form of (i) a confidential and a non-confidential (public) version of the AHN Corrective Action Plan; or (ii) one AHN Corrective Action Plan with appropriate redactions of confidential information; provided, however, that all information so redacted shall be provided to the Department. A preliminary version of the required AHN Corrective Action Plan (the "Preliminary AHN Corrective Action Plan") shall be filed with the Department no later than July 15, 2015 and the final and complete AHN Corrective Action Plan (the "Final AHN Corrective Action Plan") shall be filed with the Department no later than September 30, 2015.

(1) The AHN Corrective Action Plan shall provide, among other items:

(a) A description of the specific steps and investment of funds and changes to AHN and the AHN Entities that have already been taken to carry out or implement the IDN Strategy since the close of the Affiliation Agreement; specifically including: (A) a description of the category of the IDN program changes, projects or investments that have been incurred or implemented (the "Changes Implemented"); (B) the cost thereof; (C) the specific locations at

which the Changes Implemented were made; (D) the reason(s) why such changes or investments were required or advisable;

(b) The specific results or benefits/cost savings sought to be obtained by the Changes Implemented, including a quantification of value, if available, and comparison of the actual benefits/cost savings obtained to date in comparison to those anticipated as of the date that such Changes Implemented were incurred or implemented;

(c) A description of any steps, initiatives or plans that were proposed, but not implemented, and the reasons for not implementing such plans or proposals;

(d) The specific objectives or goals of all strategies, plans and actions comprising the AHN Corrective Action Plan, including the timeline for the accomplishment of these objections (the "Plan Objectives"); and

(e) Detailed operating and financial projections on a quarterly basis for the period of July 1, 2015 through December 31, 2017 and the following operating and financial projections, together with a description of the assumptions underlying such projections which must be reasonable and likely attainable:

(i) Projected inpatient discharges and outpatient registration volume for each AHN Entity, along with projected occupancy rates and in connection therewith:

(A) Provide written commentary explaining why the Board of Directors of Highmark Health (the "Highmark Health Board") and the Board of Directors of AHN and their management believe these volumes to be achievable.

(B) Discuss the impact of the current University of Pittsburgh Medical Center Consent Decree upon these projections.

(ii) Projected income statements, displaying a level of detail consistent with the Base Case Financial Projections for the AHN Entities submitted by Highmark in connection with the 2013 Order.

(iii) Projected balance sheets, displaying a level of detail consistent with the Base Case Financial Projections for the AHN Entities.

(iv) Projected cash flow statements, displaying a level of detail consistent with the Base Case Financial Projections for the AHN Entities.

(v) A detailed schedule of anticipated capital expenditures for all of the AHN Entities' facilities, including:

(A) For each AHN facility, a specific list of significant projects and the timing of these projects, including each Specific Scheduled Use;

(B) A list of strategic initiatives, including potential acquisitions of other businesses or entities, including, hospitals, physician groups, laboratories or other enterprises; and

(C) A schedule of anticipated future spending by AHN or any AHN Entity for its or their affiliated community hospitals and the strategic rationale for such spending.

(vi) A schedule of projected salaried and non-salaried employees on a full-time equivalent basis for the AHN Entities in total and for each primary AHN Entity operating segment or component, together with an explanation of how each primary operating segment or component is defined.

(vii) A description of any plans to downsize, close or repurpose, in whole or in part, any facility or operation owned or operated by any AHN Entity and provide a schedule of the timing and cost/benefit analysis associated with these plans.

(viii) A schedule of any anticipated future Financial Commitments from any Domestic Insurer to any direct or indirect AHN Entity along with the purpose of such Financial Commitments.

(ix) A calculation of AHN's projected Days Cash on Hand (the "DCOH") as defined in the Master Trust Indenture dated May 1, 2007, as amended, relating to the West Penn 2007A Series Bonds (the "Trust Indenture") for each quarter through December 31, 2017.

(x) A calculation of AHN's projected Debt Service Coverage Ratio as defined in the Trust Indenture for each quarter through December 31, 2017.

(xi) Provide functional excel backup to each set of financial projections requested in items C.(1)(e)(i) – (x) above.

(xii) A list of any projected future changes in Specific Scheduled Uses of the Financial Commitment of AHN.

(2) As part of the AHN Corrective Action Plan, Highmark Health shall provide a description of the diligence process that the Highmark Health Board pursued in order to ultimately approve the AHN Corrective Action Plan, including a description of the following:

(a) The manner in which the AHN Corrective Action Plan was prepared and how the projections were assessed or made at each facility;

(b) The material issues or concerns that the Highmark Health Board or management expressed with regard to earlier drafts of the AHN Corrective Action Plan; and

(c) The changes that were made to the AHN Corrective Action Plan in order to ultimately obtain approval by the Highmark Health Board.

(3) Prior to submission of the Final AHN Corrective Action Plan to the Department, Highmark Health shall have the Final AHN Corrective Action Plan reviewed at its sole cost and expense by an independent external financial expert experienced in these matters who was not involved with, and who did not otherwise participate in the preparation of or provide any analysis for, the Preliminary AHN Corrective Action Plan or the Final AHN Corrective Action Plan (the "Financial Commitment Reviewer"). The Financial Commitment Reviewer shall provide an opinion as to the reasonableness of the Final AHN Corrective Action Plan, the sufficiency of the Final AHN Corrective Action Plan to accomplish the Plan Objectives and the specific level of benefits and costs to be borne by Highmark's policyholders, as distinct from any franchise benefits accruing to Highmark in the form of higher enrollment, revenue and market share, and an opinion as to the reasonableness of the value assigned by Highmark Health and/or Highmark to Highmark's investments in AHN. A copy of such report shall be submitted to the Department as part of the Final AHN Corrective Action Plan and a public version of such report also shall be submitted to the Department.

(4) Highmark Health shall respond to all questions from the Department and its advisors relating to the Final AHN Corrective Action Plan and/or the AHN Strategic and Financial Plan, as such plans may be updated or extended from time to time, within the timeframe requested by the Department. The Department may impose, upon notice to Highmark Health, an obligation to update the Final AHN Corrective Action Plan or

the AHN Strategic and Financial Plan or extend the period covered by the Final AHN Corrective Action Plan or the AHN Strategic and Financial Plan.

~~(1)~~(5) The Final AHN Corrective Action Plan shall specifically identify any Financial Commitments (including Donations) contemplated by the Final AHN Corrective Action Plan. A review by the Department of the Preliminary AHN Corrective Action Plan and/or the Final AHN Corrective Action Plan shall not constitute an approval of any such Financial Commitments (including Donations, if any) unless: (i) Highmark specifically shall request approval of such Financial Commitments (including Donations, if any) and provide the information relating thereto to fully describe the nature and purposes for such Financial Commitment (including Donations, if any) and (ii) the Department shall specifically grant approval of such Financial Commitments (including Donations, if any) pursuant to the approval requirements of the this Approving Determination and Order.

16. If a WPAHS Corrective Action Plan is required to be prepared and produced to the Department pursuant to Condition 15A or 15B, it shall be produced promptly upon request or order of the Department to ~~UPE~~Highmark Health and all such information when produced shall be treated as confidential pursuant to an examination process or proceeding under 40 PS § 991.1406.

17. The WPAHS Corrective Action Plan shall specify, in reasonable detail, ~~UPE~~Highmark Health's intended actions to be taken over the subsequent twelve to twenty-four (12-24) months that are designed and anticipated to: (i) facilitate repayment or refinancing of the bond obligations of the WPAHS Entities payable to Highmark (or any ~~UPE~~Highmark Health Entity) and on terms that would not require any Credit Enhancement Device from Highmark or other ~~UPE~~Highmark Health Entities; (ii) generate DCOH of at least sixty-five (65) days within eighteen (18) months and for the foreseeable future thereafter; and (iii) generate net income of no less than $0 within eighteen (18) months and for the foreseeable future thereafter.

A. In addition, the WPAHS Corrective Action Plan shall specify the intended corrective actions that are proposed to be implemented, including but not limited to the following potential actions that were referenced in ~~UPE~~Highmark Health's Form A filing: (i) efficiency improvements and revenue opportunities; (ii) changes in employment, including but not limited to in the number of employed physicians; (iii) modifications to capital expenditure plans; (iv) reductions in unfunded research; (v) non-core asset sales; (vi) restructuring of compensation and benefits; and (vii) outsourcing.

B. The WPAHS Corrective Action Plan shall include but not be limited to: (i) an estimate of total cost to adopt, implement and consummate the WPAHS Corrective Action Plan—including but not limited to write-downs, one-time or ongoing restructuring costs, anticipated litigation, consulting, legal and other

advisory fees and any future capital commitments—specifying ~~UPE~~Highmark Health's estimated value for any WPAHS Entity-related investments held by Highmark or any other ~~UPE~~Highmark Health Entity, including but not limited to loans or bonds receivable, at the time of the WPAHS Corrective Action Plan's implementation and without consideration of potential contingency actions; and (ii) the amount of any funding needed by the WPAHS Entities to fully pay for and carry out the WPAHS Corrective Action Plan (the '"WPAHS Required Funding") and an acknowledgement that any Donations made pursuant to Condition 10 will be restricted for use in paying the WPAHS Required Funding to the extent of the amount of the WPAHS Required Funding.

C. Prior to submission, ~~UPE~~Highmark Health shall have the WPAHS Corrective Action Plan reviewed at its sole expense by an external financial expert, who shall conclude as to the reasonableness of the plan and the sufficiency of the WPAHS Required Funding and ~~UPE~~Highmark Health's stated actions for the purposes of limiting future WPAHS, Highmark and/or ~~UPE~~Highmark Health losses and/or the need for additional Financial Commitments. The financial expert also shall assess the specific level of benefits and costs to be borne by Highmark's policyholders, as distinct from any franchise benefits accruing to Highmark in the form of higher enrollment, revenue and market share, and shall conclude as to the reasonableness of the value assigned by ~~UPE~~Highmark Health to Highmark's investments in WPAHS.

Executive Compensation

18. ~~UPE~~Highmark Health and Highmark shall ensure and maintain in effect a policy that any senior executives of any ~~UPE~~Highmark Health Entity who have been responsible for designing, recommending and/or implementing the IDN Strategy and/or the AHN Strategic and Financial Plan, as filed with the Department and as such plan may be updated or extended, if required by the Department pursuant to Condition 15, have a meaningful portion of their long-term compensation tied to the achievement of quantifiable and tangible benefits to policyholders, if any, or to the charitable nonprofit entity, if the ~~UPE~~Highmark Health Entity is exempt from Federal taxation pursuant to Section 501(c)(3) of the Internal Revenue Code (the "IDN Compensation Policy"). ~~Within ninety (90) days after the date hereof, UPE~~By October 15, 2017 Highmark Health shall deliver to the Department a copy of the IDN Compensation Policy which satisfies the foregoing requirements in a form and substance acceptable to the Department. Any amendments to the IDN Compensation Policy shall be submitted to the Department accompanied by a certification by the President of ~~UPE~~Highmark Health that, to the best of his or her information, knowledge and belief, the amendment to the IDN Compensation Policy satisfies the requirements of this Condition. ~~UPE~~Highmark Health shall report annually by May 1 of each year the amount of the compensation paid to such senior executives and describe the manner in which such compensation is consistent with the IDN Compensation Policy.

Meeting IDN Savings Benchmarks

19. On or before May 1 of each year, ~~UPE~~Highmark Health shall file with the Department a report describing in detail whether each Benchmark contained in Appendix 3 (Benchmarks), which Appendix 3 is attached hereto and incorporated herein by reference, has been met or what progress has been made toward meeting each Benchmark. The report shall include but not be limited to a statement of savings achieved through implementation of the IDN Strategy (the "IDN Savings") during (i) the preceding calendar year; and (ii) in total since consummation of the Affiliation Agreement. Each annual report shall quantify: (i) the total savings realized by policyholders across all products and consumers compared to the estimate of the cost of care that would have been incurred by policyholders if the Affiliation Agreement had not been consummated (the "Total IDN Savings"); (ii) the relative savings realized by consumers on a per-member-per-month claims basis (the "PMPM IDN Savings"); (iii) a comparison of the Total IDN Savings and PMPM IDN Savings to the relevant projections provided in the Form A filing and shall provide a detailed description of variances between the projections and actual savings achieved; (iv) the annual and cumulative savings actually achieved by policyholders in the eight categories for which projected savings were provided to the Department in the Form A, which categories are set forth in Attachment 4 (Total IDN Savings Categories) or such other categories as the Department may approve. ~~UPE~~Highmark Health shall have the quantification of savings and related explanations of variances reviewed by an external actuarial consulting firm, which shall conclude as to the reasonableness of the methodologies used for quantifying the savings. Within ninety (90) days of closing of the Affiliation Agreement, ~~UPE~~Highmark Health shall submit to the Department a detailed plan for the measurement and reporting methodologies to be followed for compliance with this Condition. If the Benchmark has not been met or if satisfactory progress has not been made toward achievement of the Benchmark, the report shall specify what corrective actions will be taken in order to assure that the Benchmark is met in a timely fashion. Specifically, if, as of December 31, 2016, either the Total IDN Savings or the PMPM IDN Savings are less than the amounts projected as part of the Form A filing, then, by April 1, 2017, ~~UPE~~Highmark Health shall file with the Department a detailed corrective action plan to maximize IDN Savings in the future or otherwise generate tangible policyholder benefits in amounts sufficient to justify the continued investment of policyholder funds in the IDN Strategy.

Public Interest/Policyholder Protection Conditions

Consumer Choice Initiatives

Preamble: Consumer choice and other member cost-sharing initiatives, including but not limited to tiered network products based upon transparent, objective criteria that include quality and cost, are procompetitive. These initiatives are consistent with efforts to provide consumers with informed healthcare choices and to incentivize consumers to consider the costs of healthcare and quality of outcomes in choosing providers. The following consumer choice initiative Condition is designed to prohibit provider and

insurer contracts that would prohibit or limit the ability of Health Care Insurers to implement such consumer choice initiatives.

20. After the issuance of this Approving Determination and Order, no Domestic Insurer shall enter into a contract or arrangement with a Health Care Provider that prohibits and/or limits the ability of any Domestic Insurer to implement Consumer Choice Initiatives, without the prior Approval of the Department. After the issuance of this Approving Determination and Order, no ~~UPE~~Highmark Health Entity that is a Health Care Provider shall enter into a contract or arrangement with a Health Care Insurer that prohibits and/or limits the ability of the ~~UPE~~Highmark Health Entity to implement Consumer Choice Initiatives, without the prior Approval of the Department. This Condition does not prohibit a Domestic Insurer or a ~~UPE~~Highmark Health Entity that is a Health Care Provider from entering into a contract that provides volume discounts, provided that such volume discounts are not conditioned upon or related to commitments not to implement Consumer Choice Initiatives.

Affiliation And IDN Impact On Community Hospitals

Preamble: ~~UPE~~Highmark Health indicates in its filings that vibrant and financially healthy community hospitals are a key component of the IDN Strategy. Community hospitals are viewed as high quality, lower cost alternatives for healthcare delivery; and, thus, are projected to be key partners. ~~UPE~~Highmark Health acknowledges that its efforts to reinvigorate the WPAHS Entities may result in some draw of inpatients away from community hospitals to the WPAHS Entities, but states that the IDN Strategy and ~~UPE~~Highmark Health's "Accountable Care Alliance" strategy overall will increase inpatient admissions at community hospitals, thereby resulting in a net increase in community hospital inpatient admissions. To address concerns that the Affiliation Agreement will adversely impact inpatient admissions at community hospitals and risk the financial viability of these community assets, the Department imposes Conditions that require the monitoring and reporting of Affiliation Agreement and IDN Strategy implementation impacts on community hospital discharges, and Conditions requiring ~~UPE~~Highmark Health to report any financial commitments and other efforts to deliver more cost-effective healthcare at community hospitals to further healthcare choices in the Western Pennsylvania area.

21. On or before May 1 of each year, ~~UPE~~Highmark Health shall submit a document (the "IDN-Community Hospital Report"), which IDN-Community Hospital Report shall describe in detail for the immediately preceding calendar year: (a) the number of discharges for each Domestic Insurer at each hospital in the WPA service area, as such area is defined in connection with the Form A (the "WPA Service Area"); (b) the number of discharges for each Domestic Insurer at each hospital in its WPA Service Area for calendar year ended 2012 ("Base Year Discharge Data"); (c) a comparison of the

discharge information in the current ~~IDN Certification~~ IDN-Community Hospital Report against: (i) the discharge information provided by ~~UPE~~Highmark Health under the ~~IDN Certification~~ IDN-Community Hospital Report for the immediately preceding year~~, if any was required to be provided~~; and (ii) the Base Year Discharge Data; (d) an analysis of whether and to what extent Highmark's affiliation with WPAHS and the implementation of the IDN Strategy resulted in a net decrease in the Domestic Insurers' discharges at its WPA Service Area community hospitals; and (e) the amount and nature of any Financial Commitments by any and all ~~UPE~~Highmark Health Entities in community-based facilities and service in community hospitals that any such ~~UPE~~Highmark Health Entities have undertaken with each hospital (excluding any hospitals of WPAHS and UPMC or their respective subsidiaries), including but not limited to efforts to identify opportunities to deliver more cost-effective healthcare to ensure a robust and vibrant network with meaningful choice in key service lines.

A. Within sixty (60) days after the date of an IDN-Community Hospital Report, the Domestic Insurers shall submit to the Department a plan of operational corrective action ("IDN Corrective Action Plan") if the analysis set forth in the IDN-Community Hospital Report for the year in question reflects a net decrease of 10% or more in all of the Domestic Insurers' discharges at their WPA Service Area community hospitals with which they have a contract or arrangement. The IDN Corrective Action Plan shall specify, in reasonable detail, the Domestic Insurers' intended commercially reasonable actions to be taken over the subsequent twelve (12) months that are designed and anticipated to address the reasons for the decrease in discharges relating to the Affiliation Agreement and the IDN Strategy. The IDN Corrective Action Plan shall include but not be limited to an estimate of total cost to adopt, implement and consummate the IDN Corrective Action Plan.

B. The Domestic Insurers shall use commercially reasonable efforts to implement the IDN Strategy in a manner that utilizes and enhances the role of community hospitals in their respective WPA Service Areas to provide continued services to the communities they serve.

Transition Plan Regarding UPMC Contract

Preamble: The Department recognizes that Highmark's contract with UPMC is scheduled to terminate on December 31, 2014, and new or extended provider contracts may or may not be entered into between the parties. The Department also recognizes that the Application's Base Case is premised on a non-continuation of the UPMC Contract and that continuation of such contract may, based on the Applicant's projections, delay WPAHS' financial recovery. The potential termination of these provider contracts may be disruptive to the Domestic Insurers' enrollees and consumers of UPMC healthcare services as that termination date is reached. In the event of a contract termination and to minimize any adverse impact on healthcare consumers and protect the public interest,

the Department imposes a transition plan condition on all Domestic Insurers that have contract(s) with UPMC. The Condition focuses on issues such as continuation of care and access options available to the Domestic Insurers' enrollees; adequacy of the Domestic Insurers' remaining provider networks; and appropriate communications, as necessary, to inform healthcare consumers of any issues with continued access to certain UPMC facilities and practice areas.

22. With respect to the possibility of a contract between or among one or more of the Domestic Insurers and UPMC after December 31, 2014, the following shall apply:

A. If a Domestic Insurer secures UPMC's assent to a new contract, combination, affiliation, or arrangement (or an extension of the current contract that expires on December 31, 2014) ("New UPMC Contract"), ~~UPE~~Highmark Health shall notify the Department in advance of the execution of the New UPMC Contract and provide the Department with updated information, based on reasonable assumptions and credible projections, on the impact of the terms of any New UPMC Contract on the financial performance of WPAHS, as well as an independent analysis of an expert on the impact of the New UPMC Contract on both the insurance and provider markets in the region including but not limited to any effects on competition.

B. If, however, one or more of the Domestic Insurers and UPMC do not enter into a New UPMC Contract by July 1, 2014, then ~~UPE~~Highmark Health shall file with the Department and with the Pennsylvania Department of Health: (i) an update of the status of negotiations between UPMC and such Domestic Insurer(s), including but not limited to reasons that the parties have been unable to enter into a New UPMC Contract; and (ii) a formal transition plan (the "UPMC Contract Transition Plan") no later than July 31, 2014 that sets forth such information as shall be required by the Department and the Department of Health and which addresses such issues as continuation of care; options available to subscribers to access Health Care Providers; appropriate communication, as necessary, to subscribers, providers and others regarding adequacy and changes in cost or scope of coverage. The ~~UPE~~Highmark Health Entities shall fully cooperate with the Department and the Department of Health in coordinating with UPMC for the further development and, if necessary, implementation of the UPMC Contract Transition Plan with the goal of minimizing any disruption to consumers and the marketplace and ensuring that such consumers continue to have access to quality healthcare in a competitive marketplace.

Community Health Reinvestment

Preamble: Preamble: This Condition requires Highmark to continue its commitment to non-profit activities directed to the betterment of overall community healthcare by fixing and expressly making permanent a percentage of Highmark's direct written

premiums that will be dedicated to Community Health Reinvestment endeavors.

23. Commencing with calendar year 2014, Highmark shall annually dedicate to and pay for Community Health Reinvestment Activities ("CHR") an amount equal to 1.25% of all of Highmark's aggregate direct written premiums, as reported in the annual statement filed by Highmark pursuant to Condition 23B (the "Annual CHR Payment Obligation") for the immediately preceding year.

A. The Annual CHR Payment Obligation shall be calculated on a calendar year basis. Notwithstanding the foregoing, (i) Highmark's minimum Annual CHR Payment Obligation (the "Minimum Annual CHR Payment Obligation") shall be equal to 1.25% of all of Highmark's aggregate direct written premiums for the 2013 calendar year; and (ii) Highmark shall not be required to fund or commit to fund Community Health Reinvestment Activities for 2014 in an amount in excess of 105% of the Minimum Annual CHR Payment Obligation, and thereafter in an amount in excess of 105% of the actual CHR Payment made (but in no event less than the Minimum Annual CHR Payment Obligation) for the immediately preceding calendar year. Highmark shall not be required to fund or commit to fund any Community Health Reinvestment Activities to the extent that, at the time of such funding or commitment, or after giving effect thereto, its RBC Rating level is, or is reasonably expected to be, less than 525%. If Highmark fails to meet its Annual CHR Payment Obligation in any calendar year, the deficiency in such payment obligation shall be paid by Highmark by May 1 of the following calendar year into the Insurance Restructuring Restricted Receipt Account.

B. On or before March 31 of each calendar year, Highmark shall provide to the Department a report, in form and substance acceptable to the Department, of Highmark's Community Health Reinvestment Activities for the prior calendar year.

C. The provisions of this Condition supersede and replace in their entirety any obligation by Highmark pursuant to Condition 4 of the Department's Decision and Order dated November 27, 1996 (Docket No. MS96-04-098) (the "1996 Department Order").

Miscellaneous Conditions

Modification Of Prior Orders

24. Except as expressly provided in this Approving Determination and Order, nothing in this Approving Determination and Order shall be construed to modify or repeal any term or condition of any prior order or approval of the Department, including, but not limited to, the 1996 Department Order.

25. The Department shall determine whether and to what extent any conflict or inconsistency exists between or among this Approving Determination and Order and any term or

condition in any prior order(s) or approval(s) of the Department, and the Department shall have the authority to determine what term or condition controls.

Department Costs And Expenses

26. The Department may retain at the reasonable expense of the ~~UPE~~Highmark Health Entities, as determined by the Department, any attorneys, actuaries, accountants and other experts not otherwise part of the Department's staff as, in the judgment of the Department, may be necessary to assist the Department, regardless whether retained before, on or after the date of this Approving Determination and Order, in or with respect to: (i) evaluation and assessment of any certifications, reports submissions, or notices given or required to be given in connection with this Approving Determination and Order; (ii) compliance by any of the ~~UPE~~Highmark Health Entities with this Approving Determination and Order; (iii) the enforcement, or any challenge or contest to enforcement or validity, of the Conditions or otherwise of this Approving Determination and Order, including, but not limited to, reviewing and analyzing any certifications, reports, submissions or notices by or for any ~~UPE~~Highmark Health Entity or auditing and reviewing any books and records of any ~~UPE~~Highmark Health Entity to determine compliance with any of the Conditions; (iv) litigation, threatened litigation or inquiries or investigations regarding, arising from or related to the Form A filing, the process surrounding the approval of the Form A filing and/or this Approving Determination and Order; and/or (v) the defense of any request or action to require public disclosure of information that ~~UPE~~Highmark Health or the Department deems confidential. The obligations of the ~~UPE~~Highmark Health Entities to the Department for all such costs and expenses shall be joint and several obligations.

Modification Of Approving Determination And Order

27. Upon written request by a ~~UPE~~Highmark Health Entity setting forth: (a) the specific Condition(s) for which such ~~UPE~~Highmark Health Entity seeks relief; (b) the reason for which such relief is necessary and (c) an undertaking by such ~~UPE~~Highmark Health Entity to provide all such further information as the Department shall require to evaluate the request, the Department may evaluate and, after evaluation of the request, the Commissioner, in the Commissioner's sole discretion, may grant relief, in whole or in part, from one or more of the Conditions as the Commissioner may be deem appropriate.

28. The Commissioner reserves the right to impose additional conditions upon the approval of the Transaction or modify the Conditions in this Approving Determination and Order if, in his reasonable judgment (i) the consolidated financial position or results of operation of the WPAHS Entities suffer or incur, or are reasonably likely to suffer or incur, a material deterioration or material adverse change and the Commissioner finds that such material deterioration or material adverse change might jeopardize the financial stability of a Domestic Insurer or prejudice the interest of the policyholders of a Domestic Insurer; (ii) the Commissioner finds that actions taken or proposed to be taken by any ~~UPE~~Highmark Health Entity might jeopardize the financial stability of a Domestic Insurer or prejudice the interest of policyholders of a Domestic Insurer; and/or (iii) the Commissioner finds that actions taken or proposed to be taken by any ~~UPE~~Highmark

Health Entity would substantially lessen competition in insurance in this Commonwealth or tend to create a monopoly therein.

Settlement Of Litigation

29. Without the prior approval of the Commissioner, ~~UPE~~Highmark Health and each ~~UPE~~Highmark Health Entity agrees that it will not settle, enter into a settlement agreement or otherwise consent to terminate litigation where the result of such settlement or termination of litigation will be to affect or impair in any way the objective or purpose sought by the Department in imposing or establishing any Condition in this Approving Determination and Order.

Modification Of Affiliation Agreement

30. No ~~UPE~~Highmark Health Entity which is a party to the Affiliation Agreement may amend, waive enforcement of, modify, or enter into any other agreement or arrangement having the effect of terminating, waiving or modifying, in any material respect, the terms or conditions of the Affiliation Agreement, without the prior approval by the Commissioner.

Sunset Of Conditions

31. The Conditions contained in this Approving Determination and Order shall expire as follows:

A. The following Conditions shall not expire: Conditions 1 and 2 (Prohibition on Exclusive Contracting); 3 (Provider/Insurer Contract Length); 5 and 6 (Prohibition on Most Favored Nation Contracts or Arrangements); 7, 8, and 9 (Firewall Policy); 10 (Donations); 11 (Financial Commitment Limitations); 12 and 13 (Public Disclosure of Financial Commitments and Financial and Operational Information Conditions); 20 (Consumer Choice Initiatives); 23 (Community Health Reinvestment); 26 (Department Cost and Expenses); 27 and 28 (Modification of Approving Determination and Order); 29 (Settlement of Litigation); 31 (Sunset of Conditions); 32 (Required Record Retention); 33, 34, and 35 (Enforcement); and 36 (Post Closing Obligations).~~The following Conditions shall not expire: Conditions 1 and 2 (Prohibition on Exclusive Contracting); 3 (Provider/Insurer Contract Length); 5 and 6 (Prohibition on Most Favored Nation Contracts or Arrangements); 7, 8, and 9 (Firewall Policy); 10 (Donations); 11 (Financial Commitment Limitations); 13 (one of the Public Disclosure of Financial Commitments and Financial and Operational Information Conditions); 20 (Consumer Choice Initiatives); 23 (Community Health Reinvestment); 26 (Department Cost and Expenses); 27 and 28 (Modification of Approving Determination and Order); 29 (Settlement of Litigation); 32 (Required Record Retention); 33, 34, and 35 (Enforcement); and 36 (Post Closing Obligations).~~

B. Condition 19 (Meeting IDN Savings Benchmarks) and Condition 37 (Post-Closing Obligations of Highmark Health regarding closing documents) shall

expire on December 31, 2017, provided that the Department may extend any of these Conditions for up to an additional five (5) years if, in the judgment of the Department, such an extension is in the public interest; and further provided that any expiration of any Condition shall not affect or limit the obligations arising under such Condition prior to its expiration.~~Unless a Condition is listed in Condition 31A or contains a specific expiration date, the Condition shall expire on December 31, 2018, provided that the Department may extend any of these Conditions for up to an additional five (5) years if, in the judgment of the Department, such an extension is in the public interest, and further provided that any expiration of any Condition shall not affect or limit the obligations arising under such Condition prior to its expiration.~~

C. Unless a Condition is listed in Condition 31.A. or 31.B. or contains a specific expiration date, the Condition shall expire on December 31, 2020, provided that the Department may extend any of these Conditions for up to an additional five (5) years if, in the judgment of the Department, such an extension is in the public interest; and further provided that any expiration of any Condition shall not affect or limit the obligations arising under such Condition prior to its expiration.

Required Record Retention

32. The books, accounts and records of each ~~UPE~~Highmark Health Entity shall be so maintained and be accessible to the Department as to clearly and accurately disclose the precise nature and details of the transactions between and/or among any ~~UPE~~Highmark Health Entity and/or other Person, and to permit the Department to establish compliance with the Conditions or otherwise of this Approving Determination and Order, including, but not limited to, such accounting information as is necessary to support the reasonableness of any charges or fees to a Person.

Enforcement

33. Each of the ~~UPE~~Highmark Health Entities shall be subject to the jurisdiction of the Department for the purpose of enforcing the terms or the Conditions or otherwise of this Approving Determination and Order. Nothing in this Approving Determination and Order is intended to create or enlarge the right of any Person to enforce, seek enforcement of, and/or seek compliance by the ~~UPE~~Highmark Health Entities with the terms and conditions of this Approving Determination and Order.

34. To the maximum extent provided by law, a violation of any Condition shall constitute a violation of 40 Pa.C.S. § 6105 (relating to penalties), which provides that any person who violates a Department order made pursuant to 40 Pa.C.S. Chapter 61 (relating to hospital plan corporations) or hinders or prevents the Department in the discharge of its duties under that statute shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine of not more than $ 3,000 or to be imprisoned for not more than six months, or both, in the discretion of the court. This statute also provides that any act or default by any corporation, association, or common law trust who violates a Department order made pursuant to 40 Pa.C.S. Chapter 61 (relating to hospital plan corporations)

shall be deemed to be the act or default of the officers or directors who participated in authorizing or effecting such act or default or who knowingly permitted it.

35. In addition to its powers otherwise available under applicable law, the Department may apply to the Commonwealth Court for an order enjoining any ~~UPE~~Highmark Health Entity or any director, officer, employee or agent thereof from violating or continuing to violate any term or condition of this Approving Determination and Order and for such other equitable relief as the nature of the case and the interest of any Domestic Insurer's policyholders, creditors, shareholders, members or the public may require,

Post Closing Obligations Of ~~UPE~~Highmark Health

36. If ~~UPE~~Highmark Health proceeds with closing the Transaction and implements the Change of Control as contemplated by Form A, ~~UPE~~Highmark Health shall have been deemed to have agreed expressly to fully and promptly comply with each Condition set forth in this Approving Determination and Order. ~~UPE~~Highmark Health shall have the obligation and responsibility to cause all ~~UPE~~Highmark Health Entities to comply with their respective obligations under this Approving Determination and Order, including but not limited to the Conditions.

37. Highmark shall provide to the Department a list of closing documents for the Affiliation Agreement and the JRMC Affiliation Agreement within five (5) days after consummation of the Transaction and shall maintain the listed documents and make them available to the Department for a period of not less than five (5) years from the date of this Approval Determination and Order.

This Approving Determination and Order is effective immediately. The Department will issue further full written findings and conclusions on or before May 31, 2013 that substantially reflect the factual conclusions reached in the Blackstone Report and the Guerin-

Michael F. Consedine
Insurance Commissioner
Commonwealth of Pennsylvania

Date: April 29, 2013

Appendix 1 (Definitions)

In addition to the words or terms otherwise defined in the Approving Determination and Order, as used in this Approving Determination and Order and the appendices thereto, the following terms have the following meanings:

"1996 Department Order" shall have the meaning set forth in Condition 23C.

"Addendum 1" means Addendum No. 1 to Amendment No. 1 to Form A dated August 24, 2012.

"Affiliate" means any present Person or any Future Person that, directly or indirectly through one or more intermediaries, Controls, is Controlled by, or is under Common Control with any other ~~UPE~~Highmark Health Entity and their successors and assigns. "Affiliate" includes but is not limited to all Persons in which any ~~UPE~~Highmark Health Entity, directly or indirectly, has a membership interest.

"Affiliation Agreement" means the contract entered into between ~~UPE~~Highmark Health, ~~UPE Provider Sub~~Allegheny Health Network, Highmark, WPAHS and certain subsidiaries of WPAHS as specified therein dated October 31, 2011, as amended by that certain Amendment No. 1 to Affiliation Agreement entered into as of January 22, 2013, relating to the affiliation between or among the parties thereto.

"Annual CHR Payment Obligation" shall have the meaning set forth in Condition 23A.

"Approval of the Department" or "Approved by the Department" means, except as otherwise provided in this definition: either (1) the Department expressly grants its written approval to a written request by the applicable requesting party for Department approval; or (2) within thirty (30) days after the receipt by the Department of the written request for approval, the Department does not advise the requesting party that the Department either disapproves the request for approval or requests any further information or explanation regarding the request for approval. With respect to Condition 3 (Provider/Insurer Payment Contract Length Limitation), Condition 7 (Firewall Policy) and Condition 21 (Consumer Choice Initiatives), "Approval of the Department" means when the Department expressly grants its written approval to a written request by the applicable requesting party for Department approval.

"Approved Firewall Policy" shall have the meaning set forth in Condition 7.

"Base Case Financial Projections" means the WPAHS financial projections for fiscal years 2013-2017 as prepared by Highmark, dated January 16, 2013 and submitted by ~~UPE~~Highmark Health to the Department as Exhibit K to Amendment No. 2 to Form A.

"Base Year Discharge Data" shall have the meaning set forth in Condition 21.

"Benchmark" shall have the meaning set forth in Appendix 3 (Benchmarks).

"Commercially Reasonable Process" means such due diligence and evaluative process that would be customarily performed by parties to an arm's length transaction in the geographic

area in which the Financial Commitment is to be made in order to assess the merits and risks of a Financial Commitment and the financial, operational and policy effects to the involved ~~UPE~~Highmark Health Entity. This includes but is not limited to obtaining, where commercially appropriate and reasonable or to the extent required by law, of a third party fairness opinion or fair market value analysis of such Financial Commitment or other financial analysis and/or stakeholder cost-benefit assessment as may be customarily or reasonably expected to be performed in connection with such a transaction.

"Competitively Sensitive Information" means any information that is not available publicly that could potentially affect competitive innovation and/or pricing between or among one or more ~~UPE~~Highmark Health Entities and the rivals of such ~~UPE~~Highmark Health Entities at the provider and/or insurer levels. At a minimum, "Competitively Sensitive Information" includes but is not limited to: (i) present and future reimbursement rates by payor; (ii) payor-provider reimbursement contracts; (iii) terms and conditions included in agreements or arrangements between payors and providers, including but not limited to discounts in reimbursements in agreements; (iv) reimbursement methodologies including but not limited to provisions relating to performance, pay for performance, pay for value, tiering of providers; and (v) specific cost and member information, and revenue or discharge information specific to the payor.

"Community Health Reinvestment Activity" means community health services and projects that improve health care or make health care more accessible. The term includes funding, subsidization or provision of the following: (i) health care coverage for persons who are determined by recognized standards as determined by the Department to be unable to pay for coverage; (ii) health care services for persons who are determined by recognized standards to be uninsured and unable to pay for services; (iii) programs for the prevention and treatment of disease or injury, including but not limited to mental retardation, mental disorders, mental health counseling or the promotion of health or wellness; and (iv) such other services or programs as the Department may approve, including but not limited to health or mental health services for veterans, and the prevention of other conditions, behaviors or activities that are adverse to good health as well as donations to or for the benefit of health care providers in furtherance of any of the foregoing purposes. "Community Health Reinvestment Activity" does not include expenditures for advertising, public relations, sponsorships, bad debt, administrative costs associated with any Domestic Insurer, programs provided as an employee benefit, use of facilities for meetings held by community groups, or expenses for in-service training, continuing education, orientation or mentoring of employees.

"Consumer Choice Initiatives" mean tools and methods that assist consumers in making informed healthcare decisions that reflect differences in the price, cost and quality of care provided. These initiatives may include but are not limited to tools that enable consumers to compare quality and cost-efficiency of medical treatments, healthcare goods and services and providers, and incentives such as tiered network health plan benefit designs that reward patients who choose to use healthcare resources more efficiently. The term "Consumer Choice Initiatives" specifically includes but is not limited to products that include Tiering and Steering as part of their product design.

"Control," "Controlling," "Controlled by" or "under Common Control with" have the meaning given to those terms in 40 P.S. § 991.1401,

"Credit Enhancement Device" means any letter of credit, guaranty, line of credit, insurance or any other device, arrangement or method, financial or otherwise, given or provided as security or assurance for the payment of the principal of, premium, if any, or interest on, the applicable debt.

"Department" means the Insurance Department of the Commonwealth of Pennsylvania.

"Domestic Insurers" means the following Pennsylvania domestic insurers to which the Form A applies: Highmark Inc.; Highmark Casualty Insurance Company, a Pennsylvania stock insurance company; Highmark Senior Resources Inc., a Pennsylvania stock insurance company; HM Casualty Insurance Company, a Pennsylvania stock insurance company; HM Health Insurance Company, d/b/a Highmark Health Insurance Company, a Pennsylvania stock insurance company; HM Life Insurance Company, a Pennsylvania stock insurance company; Keystone Health Plan West, Inc., a Pennsylvania business corporation and licensed health maintenance organization; United Concordia Companies, Inc., a Pennsylvania stock insurance company; United Concordia Dental Plans of Pennsylvania, Inc., a Pennsylvania business corporation and licensed risk-assuming PPO; ~~and~~ United Concordia Life And Health Insurance Company, a Pennsylvania stock insurance company; First Priority Life Insurance Company, Inc.; HMO of Northeastern Pennsylvania, Inc., d/b/a First Priority Health; Highmark Benefits Group Inc.; Highmark Coverage Advantage Inc. and Highmark Senior Health Company. "Domestic Insurers" also includes but is not limited to any Health Care Insurer hereafter formed, acquired or organized directly or indirectly by or for any of the foregoing or by any other ~~UPE~~Highmark Health Entity. The term "Domestic Insurers" shall not include ~~First Priority Life Insurance Company, Inc.;~~ Gateway Health Plan, Inc.; ~~HMO of Northeastern Pennsylvania, Inc., d/b/a First Priority Health;~~ Inter-County Health Plan, Inc.; or Inter-County Hospitalization Plan, Inc. to the extent that those entities are not used, directly or indirectly, to circumvent, affect or impair the purpose or intent of any Condition.

"Domestic Insurer Competitively Sensitive Information" means Competitively Sensitive Information originated by, received and/or held, directly or indirectly, in any form by or for any Domestic Insurer.

"Donation" means any contribution, grant, donation, distributions under 40 P.S. § 991.1405 or other transfer or payment of funds, property or services (or a commitment to make a Donation), whether made directly or indirectly, in cash or in kind, by any Highmark Health Entity to any other Highmark Health Entity or to any other Person; provided, however, that "Donation" shall not include any transfer or payment made in exchange for the fair value of goods or services received by the transferring or paying Person. An expenditure made for a Community Health Reinvestment Activity is not a "Donation", so long as the expenditures are for the direct provision of community health services and direct funding of projects that improve health care or make health care more accessible. Donations that are in furtherance of the Affiliation Agreement, the JRMC Affiliation Agreement and any affiliation agreement with SVHS; and/or are capital expenditures related to the IDN or the IDN Strategy are not to be considered as Community Health Reinvestment Activity for the purposes of this definition of

"Donation." For the avoidance of doubt, the term "Donation" shall also include: (i) any dividends, howsoever denominated; and/or (ii) any distribution made to (A) AHN; (B) any direct or indirect subsidiary of AHN; and/or (C) any direct or indirect subsidiary of Highmark Health that is not a wholly-owned direct or indirect subsidiary of Highmark.~~means any contribution, grant, donation, distributions under 40 P.S. § 991.1405 or other transfer or payment of funds, property or services (or a commitment to make a Donation), whether made directly or indirectly, in cash or in kind, by any UPE Entity to any other UPE Entity or to any other Person; provided, however, that "Donation" shall not include any transfer or payment made in exchange for the fair value of goods or services received by the transferring or paying Person. An expenditure made for a Community Health Reinvestment Activity is not a "Donation", so long as the expenditures are for the direct provision of community health services and direct funding of projects that improve health care or make health care more accessible. Donations that are in furtherance of the Affiliation Agreement, the JRMC Affiliation Agreement and any affiliation agreement with SVHS; and/or are capital expenditures related to the IDN or the IDN Strategy are not to be considered as Community Health Reinvestment Activity for the purposes of this definition of "Donation."~~

"Financial Commitment" means any direct or indirect payment or transfer of any cash or other property, any Donation as defined herein, provision of services, encumbrance upon or granting of any security interest in or to any assets or properties, or the direct or indirect guaranty or incurrence of any contractual obligation or liability. The term "Financial Commitment" includes, but is not limited to, the acquisition of any assets or properties of or interests in, the merger, consolidation or affiliation with, or the entering into of any financial or contractual relationship with, any Person, except for: (a) any Financial Commitment made in the ordinary and usual course of the Highmark Health Entity's business; or (b) any amounts expressly required to be paid without any further consent of any Person and pursuant to the current provisions of the Affiliation Agreement, JRMC Affiliation Agreement and/or any affiliation agreement between Highmark and SVHS acceptable to the Department. Without limiting the generality of the foregoing, (i) until December 31, 2020, a Financial Commitment shall include but is not limited to (A) any advance payment by a Domestic Insurer to a AHN Entity pursuant to or in connection with a contract or arrangement for the payment or reimbursement for Health Care Services; or (B) an increase in contractual rates pursuant to or in connection with a contract or arrangement for the payment or reimbursement for Health Care Services between or among any Domestic Insurer and any AHN Entity in excess of amounts to be determined on the basis of a method of calculation to be submitted to the Department by Highmark by September 15, 2017, which method of calculation shall be acceptable to the Department in form and substance; and (ii) in no event shall any Financial Commitment relating to the acquisition of any assets or properties of or interests in, the merger, consolidation or affiliation with, or any Donation to or investment in, any Person in connection with the IDN Strategy, as it may be renamed, modified or replaced, be considered to be in the ordinary course of business.~~means any direct or indirect payment or transfer of any cash or other property, any Donation, provision of services, encumbrance upon or granting of any security interest in or to any assets or properties, or the direct or indirect guaranty or incurrence of any contractual obligation or liability. The term "Financial Commitment" includes, but is not limited to, the acquisition of any assets or properties of or interests in, the merger, consolidation or affiliation with, or the entering into of any financial or contractual relationship with, any Person, except for: (i) any Financial Commitment made in the ordinary and usual course of the UPE Entity's business; or (ii) any~~

~~amounts expressly required to be paid without any further consent of any Person and pursuant to the current provisions of the Affiliation Agreement, JRMC Affiliation Agreement and/or any affiliation agreement between Highmark and SVHS acceptable to the Department. Without limiting the generality of the foregoing, (i) until June 30, 2017, a Financial Commitment shall include but is not limited to (A) any advance payment by a Domestic Insurer to a WPAHS Entity pursuant to or in connection with a contract or arrangement for the payment or reimbursement for Health Care Services; or (B) an increase in contractual rates pursuant to or in connection with a contract or arrangement for the payment or reimbursement for Health Care Services between or among any Domestic Insurer and any WPAHS Entity in excess of the level of increase set forth in the Base Case Financial Projections; and (ii) in no event shall any Financial Commitment relating to the acquisition of any assets or properties of or interests in, the merger, consolidation or affiliation with, or any Donation to or investment in, any Person in connection with the IDN Strategy, as it may be renamed, modified or replaced, be considered to be in the ordinary course of business.~~

"Financial Commitment Notice" shall have the meaning set forth in Condition 11B.

"Firewall Policy" means a written course of action that governs the use, disclosure, release, dissemination or sharing of Competitively Sensitive Information between and/or among each ~~UPE~~Highmark Health Entity and the employees, contractors, officers, directors, managers or other personnel of other ~~UPE~~Highmark Health Entities. Without limiting the scope of any Firewall Policy, a Firewall Policy shall restrict each Domestic Insurer's and its directors', officers', employees' and agents' knowledge and ability to influence, directly or indirectly, the negotiations of other ~~UPE~~Highmark Health Entities with rival insurers, and, conversely, shall restrict other ~~UPE~~Highmark Health Entities' and their directors', officers', employees' and agents' knowledge and ability to influence, directly or indirectly, any Domestic Insurer's negotiations with rival Health Care Providers.

"Form A" means the Form A filed by ~~UPE~~Highmark Health, as applicant, with the Department on November 7, 2011, as amended and supplemented by filings made by ~~UPE~~Highmark Health with the Department.

"GAAP" means generally accepted accounting principles, consistently applied.

"Health Care Insurer" means the Highmark Insurance Companies or any other related or unrelated insurance company, health plan corporation, professional health services plan corporation, health maintenance organization, preferred provider organization or other Person in the business of insurance that finances or pays for health care goods and/or services.

"Health Care Provider" means a Person licensed, certified or otherwise authorized or permitted by the laws of the Commonwealth of Pennsylvania or any other state to provide or perform a Health Care Service in the ordinary course of business or practice of a profession and any other Person who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to a physician, dentist, hospital, nursing home, assisted living provider, home health agency or any other Person that would constitute a "health care provider" pursuant to Federal HIPAA privacy laws (45 C.F.R. § 160.103).

"Health Care Service" means any medical or health care service including but not limited to the treatment or care of an individual or administration of any medical service or medical goods or supplies or dispensing of any medical goods or supplies.

"Highmark" means Highmark Inc., a Pennsylvania nonprofit corporation licensed to operate a hospital plan and a professional health services plan and its successors and assigns.

"Highmark Affiliates" means all Affiliates of Highmark. The term includes but is not limited to all of the Domestic Insurers (other than Highmark).

"Highmark Entities" or "Highmark Entity" means, individually and/or collectively, Highmark and Highmark Affiliates.

"Highmark Insurance Companies" shall have the meaning as set forth in the first paragraph of this Approving Determination and Order.

"IDN" means all aspects of and all Persons involved or to be involved with the integrated delivery network proposed by ~~UPE~~Highmark Health referred to in Addendum 1 and which is referenced on page 1 of Addendum 1 (wherein ~~UPE~~Highmark Health states that ". . . ~~UPE~~Highmark Health proposed the change in control as part of a strategy to implement an integrated delivery network (IDN)"). The IDN is further described throughout the Form A and elsewhere in documents filed by ~~UPE~~Highmark Health. The IDN includes but it's not limited to the Affiliation Agreement, the JRMC Affiliation Agreement, and proposed affiliation agreement with SVHS, the expansion of the provider network (physicians, community hospitals and medical malls), infrastructure development (including but not limited to the acquisition, expansion, development, improvement or construction of Health Care Services, Health Care Providers, facilities, physician practice management companies and group purchasing organizations), other relationships with individuals or Persons included in the Provider Group and any other activity that has been, is being or is expected to be included in the IDN when the IDN is fully implemented.

"IDN Compensation Policy" shall have the meaning set forth in Condition 18.

"IDN Savings" shall have the meaning set forth in Condition 19.

"IDN Strategy" refers to ~~UPE~~Highmark Health's strategy to implement the IDN.

"Insurance Restructuring Restricted Receipt Account" means the restricted receipt account in the Pennsylvania State Treasury established by Section 7 of Act 62, 40 P.S. § 991.1403b.

"JRMC" means Jefferson Regional Medical Center, its successors and assigns.

"JRMC Affiliates" means all Affiliates of JRMC.

"JRMC Affiliation Agreement" means that certain affiliation agreement by, between and among ~~UPE~~Highmark Health, ~~UPE Provider Sub~~Allegheny Health Network, Highmark, JRMC,

the subsidiaries of JRMC and Jefferson Regional Medical Center Foundation dated as of August 13, 2012.

"Loan" means any loan, advance or other transfer or conveyance of cash or property from a Person to another Person in which the Person so receiving (or to receive) such cash or property promises to repay all or portion of the amount so received, regardless of whether such amount to be repaid is secured or unsecured, provides for interest or no interest or is evidenced by any agreement, writing, note or other evidence of indebtedness. In determining the amount of the Loan, the amount of the Loan shall equal the principal amount of the Loan plus the aggregate interest that would accrue on the outstanding amount of the Loan over the term thereof in excess of the commercially reasonable rate of interest that would be charged to a similarly situated borrower which is not affiliated with the Person making the Loan.

"Master Trust Indenture" shall have the meaning set forth in the Affiliation Agreement.

"Minimum Annual CHR Payments Obligation" shall have the meaning set forth in Condition 23A.

"Net Income" shall have the meaning set forth in Condition 15B.

"New UPMC Contract" shall have the meaning set forth in Condition 22A.

"Person" means any individual, corporation, partnership, limited liability company, trust, association, employee pension plan or stock trust or other entity or organization, including but not limited to any governmental or political subdivision or any agency or instrumentality thereof.

"PMPM IDN Savings" shall have the meaning set forth in Condition 19.

"Provider Group" refers to the Persons included or to be included in the "Provider Group" shown on the Proposed Corporate Structure after Tab N to Addendum 1.

"RBC Rating" means the risk-based capital level of a Health Care Insurer determined in accordance with the insurance laws and requirements of the Commonwealth of Pennsylvania as amended from time to time and in a manner acceptable to the Department.

"Required WPAHS Financial and Operational Information" shall have the meaning set forth in Condition 14.

"Steering" means any practice, process or arrangement the effect of which is directly or indirectly to encourage, direct or maneuver a Person into a course of action, e.g., choice of healthcare, by offering structured economic incentives that vary by their value to the consumer or other Person.

"SVHS" means Saint Vincent Health System, a Pennsylvania nonprofit corporation, its successors and assigns.

"SVHS Affiliates" means all Affiliates of SVHS.

"SVHS Entities" or "SVHS Entity" means SVHS and all SVHS Affiliates, collectively and individually.

"Tiering" means a method or design of a health care plan in which a Health Care Providers are assigned to different benefit tiers based on the Health Care Insurer's application of criteria to Health Care Providers' relative costs and/or quality, and in which enrollees pay the cost-sharing (co-payment, co-insurance or deductible) associated with a Health Care Provider's assigned benefit tier(s).

"Total IDN Savings" shall have the meaning set forth in Condition 19.

"Transaction" means the proposed Change of Control relating to the Highmark Insurance Companies as reflected in the Form A, together with all other related transactions and all aspects of the IDN Strategy, including but not limited to the Affiliation Agreement, the JRMC Affiliation Agreement, the expansion of the provider network (physicians, community hospitals and medical malls), the development of infrastructure (physician practice management companies and group purchasing organizations), formation of other relationships with individuals or entities included in the Provider Group, and any other activity that has been, is being or is expected to be included in the IDN when the IDN Strategy is fully implemented.

"~~UPE~~Highmark Health" means the Pennsylvania nonprofit corporation of that name formed on October 20, 2011, being the ultimate parent entity, and its successors and assigns.

"~~UPE~~Highmark Health Entity" or "~~UPE~~Highmark Health Entities" means individually and/or collectively ~~UPE~~Highmark Health and Affiliates of ~~UPE~~Highmark Health, including, but not limited to, ~~UPE Provider Sub~~Allegheny Health Network, Highmark, all Highmark Affiliates, WPAHS, and all WPAHS Affiliates, JRMC, and all of JRMC Affiliates, SVHS and all SVHS Affiliates, any entity Controlled by any of the foregoing, and their respective successors and assigns.

"~~UPE~~Highmark Health Health Care Provider Competitively Sensitive Information" means Competitively Sensitive Information originated by and/or held in any form by each business unit, e.g., each hospital (including, but not limited to, WPAHS and JRMC), each physician group, and other ~~UPE~~Highmark Health Entities on the IDN side of ~~UPE~~Highmark Health's business.

"~~UPE Provider Sub~~Allegheny Health Network" means the Pennsylvania nonprofit corporation of that name formed on October 20, 2011 as referenced on page 7 of the Form A, its successors and assigns.

"UPMC" means University of Pittsburgh Medical Center and/or any and/or all of its Affiliates, its successors and assigns.

"UPMC Contract Transition Plan" shall have the meaning set forth in Condition 22B.

"WPA Service Area" shall have the meaning set forth in Condition 21.

"WPAHS" means West Penn Allegheny Health System, Inc., a Pennsylvania nonprofit corporation, its successors and assigns.

"WPAHS Affiliates" means all Affiliates of WPAHS.

"WPAHS Corrective Action Plan" shall have the meaning set forth in Condition 15.

"WPAHS Due Diligence Information" shall have the meaning set forth in the Affiliation Agreement.

"WPAHS Entities" or "WPAHS Entity" means, individually and/or collectively, WPAHS and all WPAHS Affiliates.

"WPAHS Tax-Exempt Bonds" shall have the meaning set forth in the Affiliation Agreement.

Appendix 2 (Firewall Policy)

Firewalls are a class of provisions that govern both the dissemination and/or sharing of Competitively Sensitive Information between and/or among the formerly independent operations of each ~~UPE~~Highmark Health Entity and the personnel from each such entity that can be involved in decision-making and engaged with its rivals (who are suppliers or customers) at other ~~UPE~~Highmark Health Entities. The purpose of developing and implementing a firewall policy is to avoid the inadvertent or intentional disclosure of Competitively Sensitive Information that could potentially reduce substantially competitive innovation or pricing between and/or among the vertically integrated entities and their rivals at the provider and insurer levels.

With respect to each ~~UPE~~Highmark Health Entity, it is also imperative from a competitive perspective to establish firewalls that prevent persons with influence over managed care contracts and related reimbursements on the health plan side from obtaining information on rival managed contracts and related reimbursements on the provider side.

With this Condition, each ~~UPE~~Highmark Health Entity shall develop and submit a firewall policy to the Department for approval. Different Firewall Policies may be submitted for separate ~~UPE~~Highmark Health Entities or types of ~~UPE~~Highmark Health Entities.

At a minimum, the Firewall Policy shall incorporate each of the following factors:

- ~~UPE~~Highmark Health, ~~UPE Provider Sub~~Allegheny Health Network, Highmark, WPAHS, JRMC, and SVHS senior management involvement and support;
- Corporate firewall compliance policies and procedures;
- Mandatory training and education of current and new employees;
- Monitoring, auditing and reporting mechanisms;
- Consistent disciplinary procedures for violation of the Firewall Policy and incentives to ensure compliance; and
- A recusal policy to reduce the risk of senior management's involvement in the review and approval of contracts or arrangements containing Competitively Sensitive Information to which they should otherwise not have access.

From a competitive perspective, the following principles shall guide the development and implementation of an effective Firewall Policy among the ~~UPE~~Highmark Health Entities' vertically integrated hospitals/providers and its insurers relating to personnel and decision-making:

- Separate managed care contracting information and activity of the hospital and of the insurer segments, including but not limited to the personnel who engage in decision-making and contracting with suppliers (customers);

- Firewall mechanisms that prevent sharing of Competitively Sensitive Information among persons at the hospital and insurer entities, with clear definition of what constitutes Competitively Sensitive Information; and

- Clear confidentiality policies, procedures and protocols that describe the specific persons and positions that can have access to Competitively Sensitive Information with clear policies and procedures for monitoring or auditing compliance with established firewalls, reporting of violations, and remedial actions taken in the event of a violation of the firewall.

Firewalls to prevent the dissemination of competitively sensitive information are common among vertically integrated firms, particularly integrated hospitals and insurance entities. At a minimum, each ~~UPE~~Highmark Health Entity's Firewall Policy shall prohibit the exchange of Competitively Sensitive Information, including but not limited to:

- Present and future reimbursement rates by payor;

- Payor-provider reimbursement contracts;

- Terms and conditions included in agreements or contracts between payors and providers including but not limited to discounts in reimbursements in agreements;

- Reimbursement methodologies including but not limited to provisions relating to performance, pay for performance, pay for value, tiering of providers; and

- Specific cost and member information and revenue or discharge information specific to the payor.

Each ~~UPE~~Highmark Health Entity's Firewall Policy shall incorporate monitoring, auditing and reporting mechanisms and provide consistent disciplinary procedures for violation of the Firewall Policy and incentives to ensure compliance, including but not limited to acknowledgement and certification by each employee or independent contractor with access to Competitively Sensitive Information of the employee's or independent contractor's responsibility to report actual or potential violations with the understanding that such reporting will not result in retribution. Employees also shall be required to affirmatively acknowledge that failure to report such information may subject the employee to disciplinary action and independent contractors shall be required to acknowledge that failure to report such information shall constitute cause for termination of such independent contractor's contract.

~~UPE~~Highmark Health's Firewall Policy shall include but not be limited to a whistleblower protection/anti-retaliation policy acceptable to the Department that specifically includes but is not limited to reports of Firewall Policy violations. The Firewall Policy may reference a whistleblower protection/anti-retaliation policy of ~~UPE~~Highmark Health or another ~~UPE~~Highmark Health Entity so long as that whistleblower/anti-retaliation policy is acceptable to the Department.

Appendix 3 (Benchmarks)

The following are the benchmarks (the "Benchmarks") referred to in Condition 19:

☐ $3,000 lower yearly premiums for a family of four by Fiscal Year 2016 relative to a "no transaction scenario" as described in the Form A.

☐ 10% cost savings on inpatient spend on enrollees that remain with the Domestic Insurers that are Health Care Insurers.

☐ 10% cost savings on outpatient spend on enrollees that remain with the Domestic Insurers that are Health Care Insurers.

☐ Achieve estimated IDN cost savings relative to a "no transaction scenario" as described in the Form A in the following amounts:

Period	With UPMC at Non-Par after 12/31/2014			With UPMC at Par after 12/31/2014		
	TOTAL	Utilization Shift	IDN Implementation	TOTAL	Utilization Shift	IDN Implementation
*CY14	$12M	$80M	($68M)	($91M)	$33M	($215M)
*CY15	($233M)	$4M	($238M)	($298M)	($15M)	($283M)
*CY16	($261M)	$14M	($275M)	($447M)	($15M)	($432M)

* "CY" means calendar year

Attachment 4 (Total IDN Savings Categories)

1) Oncology Shift
2) Utilization Shift
3) Reimbursement
4) Healthier Population
5) Right Setting
6) Right Treatment
7) Cost/Quality
8) Other