IN THE UNITED STATES COURT OF FEDERAL CLAIMS

HEALTH REPUBLIC INSURANCE COMPANY, Plaintiff, on behalf of itself and all others similarly situated, vs. THE UNITED STATES OF AMERICA, Defendant.	No. 1:16-cv-00259-MMS (Judge Sweeney)

DISPUTE SUBCLASS'S MOTION TO DISMISS THE GOVERNMENT'S COUNTERCLAIM

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For over half a decade, the federal government unlawfully failed to make risk corridor payments it promised to qualified health plan ("QHP") issuers to induce them to join Affordable Care Act marketplaces. For some QHP issuers, the government's dereliction of duty was harmful. For others, including the members of the Dispute Subclass, it was fatal. The government's failure to meet its obligations—to the tune of tens or hundreds of millions of dollars—rendered Dispute Subclass members insolvent and forced them into liquidation proceedings. The government now asserts counterclaims against the very entities its misconduct bankrupted. To add insult to injury, the government seeks interest on the Dispute Subclass's purported debts at an effective annual rate exceeding 15%. The government thus seeks to profit from the fact that its unlawful conduct rendered Dispute Subclass members unable to meet their financial obligations.

The government's counterclaims have no merit. Not only does this Court lack subject matter jurisdiction over the government's claims, but the government's claim for interest against

Meritus and Colorado HealthOp is foreclosed by both state and federal law; its claim against Colorado HealthOp has already been adjudicated and rejected by the Court of Federal Claims; and, finally, its claim against Meritus was paid by Meritus, in full, three years ago. The Court should therefore dismiss the government's counterclaims.

I. BACKGROUND

A. Risk Corridors Litigation

Section 1342 of the Affordable Care Act created the "risk corridor" program designed to mitigate the risks of QHP issuers that chose to participate in the ACA marketplaces. Under Section 1342, for the years 2014, 2015, and 2016, the government was required to make statutorily defined payments to QHP issuers whose costs exceeded certain thresholds. The program was designed to induce issuers to participate in the then-nascent marketplaces, notwithstanding the substantial uncertainties surrounding them. Based on the government's promises, the three members of the Dispute Subclass—Meritus Health Partners, Meritus Mutual Health Partners (collectively, "Meritus"), and Colorado Health Insurance Cooperative, Inc. ("Colorado HealthOp")[1]—sold policies on the Arizona (Meritus) and Colorado (Colorado HealthOp) ACA state exchanges in the 2014 and 2015 benefit years.

In late 2014, after the government induced Meritus and Colorado HealthOp to participate in ACA exchanges, the government attempted to reverse course with respect to risk corridor payments, passing an appropriations bill that purportedly prevented the Department of Health and Human Services from making payments beyond the amount the risk corridors program took in from QHP issuers. As a result, the government failed to meet its risk corridor obligations to Meritus and Colorado HealthOp. For Meritus Health Partners, this amounted to a loss of over

[1] While Freelancers Co-Op of New Jersey is currently a member of the Dispute Subclass, Freelancers and the government have agreed in principle to resolve their dispute, and the parties intend to file a motion to place Freelancers in a separate subclass.

$58 million. For Meritus Mutual, it was over $14 million. For Colorado HealthOp, it was over $111 million.

The government's failure to make nearly $200 million in payments it promised to Meritus and Colorado HealthOp had a predictable effect: all three entities became insolvent. Colorado HealthOp entered into liquidation in January 2016, while Meritus entered into liquidation in August 2016. The government filed proofs of claims in both the Meritus and Colorado HealthOp liquidation proceedings.

On April 27, 2020, the Supreme Court confirmed in an 8-1 decision that the government's failure to make risk corridor payments to QHP issuers was unlawful. *Maine Community Health Options*, 140 S. Ct. 1308 (2020). In a May 12, 2020 status report, the government for the first time in this four-plus-year litigation indicated that it may seek to assert an offset defense or counterclaim against unidentified class members. Dkt. 72.

On October 30, 2020, the government filed its amended answer in this matter. The amended answer conceded the Dispute Subclass's entitlement to full risk corridor payments for the years 2014 and 2015. Dkt. 101 at 1. The amended answer contained a single counterclaim against Colorado HealthOp and Meritus for breach of statutory and regulatory obligations to make payments under various provisions of the Affordable Care Act. *Id*. at 9-10. The counterclaims alleged that both Colorado HealthOp and Meritus owe the government under the ACA's risk adjustment and cost-sharing reduction reconciliation programs and for risk adjustment program user fees, and that Colorado HealthOp owes the government under the ACA's reinsurance program. The government further seeks over $7 million in interest from

Colorado HealthOp and over $18 million in interest from Meritus. The government's claimed interest reflects an effective annual rate exceeding 15%.[2]

B. The *Conway* Litigation

On October 19, 2018, Colorado HealthOp, through its liquidator, Michael Conway, filed suit in the Court of Federal Claims seeking to recover reinsurance program payments that the government unlawfully withheld. *See Conway v. United States*, No. 18-1623, Dkt. 1 (Fed. Cl. 2018). The *Conway* complaint alleged that instead of making required reinsurance payments to Colorado HealthOp, the government set off debts Colorado HeathOp purportedly owed to the government against the reinsurance payments. The government's setoff, according to the complaint, violated Colorado law, which prevents parties that owe money to an insolvent insurer from offsetting non-contractual debts against the funds owed to the insurer. The Court of Federal Claims agreed, and on October 3, 2019 ruled that Colorado HealthOp was entitled to its full reinsurance payment, as the government's offset violated Colorado law governing insurer insolvencies. *Conway v. United States*, 145 Fed. Cl. 514 (2019). The government's appeal of *Conway* is pending before the Federal Circuit. *See Conway v. United States*, No. 20-1292 (Fed. Cir.).

C. Meritus Insolvency Proceedings

On August 10, 2016, the Superior Court of Arizona, Maricopa County ("Liquidation Court") appointed a receiver for Meritus Health and Meritus Mutual, declaring both entities to be insolvent and placing each company under an order of liquidation. Meritus Liquidation Order

[2] *See* Department of Health and Human Services, Interest Rates on Overdue and Delinquent Debts, available at https://www.hhs.gov/about/agencies/asfr/finance/financial-policy-library/interest-rates/index.html (identifying applicable interest rates from 2010 to present as between 9.375% and 11.25%); 45 CFR § 30.18 (requiring the Department of Health and Human Services to charge a six percent penalty on debts delinquent over 90 days).

(Ex. 1).[3] The Liquidation Court subsequently established a proof of claim procedure for Meritus' alleged creditors. *See* Order Approving Liquidation Plan (Ex. 2). The government subsequently submitted three proofs of claim for:

- Claims by the Centers for Medicare and Medicaid Services ("CMS") against Meritus Health related to ACA programs in the total amount of $50,650,123.02, including each of the debts identified in the government's counterclaim. *See* Meritus Health CMS Proof of Claim (Ex. 3) at 2-6.

- Claims by CMS against Meritus Mutual related to ACA programs in the total amount of $94,581,998.78, which included each of the debts identified in the government's counterclaim, as well as debts arising from ACA Start-up and Solvency Loans. *See* Meritus Mutual CMS Proof of Claim (Ex. 4) at 1, 11.

- Claims by the Department of Justice in an undetermined amount which asserted that it included the same claims asserted by CMS. *See* DOJ Meritus Proof of Claim (Ex. 5).

Each of the three proof of claims asserted that the Government's claims were subject to set-off, and included a signed affirmation by a Government official that, among other things the claims were due and owing and the statements and documents submitted were true and correct to the signer's knowledge. *See* Ex. 3 at 2; Ex. 4 at 2-3; Ex. 5 at 3-4.

In two letters dated November 16, 2017, Meritus's receiver informed the government that it accepted certain offsets identified in the government's proofs of claim.[4] Specifically, Meritus Health notified the government that it offset $46,195,827.78 in risk adjustment payments, $3,899,178.47 in cost-sharing reduction reconciliation payments, and $44,141.47 in user fees

[3] Although motions to dismiss are generally based on the complaint's allegations, the Court may take judicial notice of any relevant public records. *See Ideal Innovations, Inc. v. United States*, 138 Fed. Cl. 244, 248 (2018) ("Although the materials the Court may consider is more limited under RCFC 12(b)(6) than under RCFC 12(b)(1), the Court may still go beyond the complaint's allegations. The Court, for example, may take judicial notice of any relevant public records."). Each of the exhibits to this motion is from the docket of the court overseeing Meritus's liquidation, and so the Court may take judicial notice of them. *See Pikulin v. United States*, 97 Fed. Cl. 71, 73 n. 3 (2011) (court may take judicial notice of court records in closely related litigation).

[4] In contrast to Colorado insurance law, Arizona insurance law contemplated an offset under these circumstances, which offset was applied by Meritus at the request of the government.

owed to the government against reinsurance and risk corridors payments owed to Meritus Health. *See* Meritus Health Offset Letter (Ex. 6) at 1-2. The letter further informed the government that the amount that the government owed to Meritus Health under the risk corridors and reinsurance programs had been reduced from $62,684,619.00 to $12,034,495.98, reflecting the payment of the aforementioned (and other) debts by offset. *Id*.

Meritus Mutual likewise informed the government that it offset $594,168.87 in risk adjustment payments, $115,649.36 in cost-sharing reduction reconciliation payments, and $7.76 in user fees owed to the government against risk corridor and reinsurance payments owed to Meritus Mutual. *See* Meritus Mutual Offset Letter (Ex. 7) at 1-3. The letter further informed the government that the amount that the government owed to Meritus Mutual under the risk corridors and reinsurance programs had been reduced from $16,221,332.00 to $15,465,414.47, reflecting the payment of the aforementioned (and other) debts by offset. *Id*.

The two offset letters told the government that no further claim to interest would be considered, as Meritus's debts to the government had been paid by offset. Ex. 6 at 2; Ex. 7 at 3. The letters also afforded the government an opportunity to respond to the offset. Ex. 6 at 3; Ex. 7 at 4. Having received no response from the Government, on December 11, 2018, Meritus's receiver filed a request with the Liquidation Court for approval of the offset, and a hearing was subsequently set on March 8, 2019. *See* Meritus Offset Petition (Ex. 8). The Government received a copy of the receiver's request and the notice of the hearing. As reported to the Liquidation Court, these documents were sent via hard copy and via email. *See* Ex. 8 at 20-24; Report on Notice to Claimants (Ex. 9). The Government did not file a response to the petition and did not appear at the hearing. *See* Order on Meritus Setoff Petition (Ex. 10) at 6.

After the hearing, the Liquidation Court approved the offset. The Liquidation Court indicated that, after the offset was effectuated, the net risk corridors amount owed to Meritus Health is $4,863,176.00, and the net risk corridors payment owed to Meritus Mutual is $12,182,140.00.[5] Ex. 10 at 7. The Liquidation Court's order confirmed that the net effect of the setoff of claims is that the government owed Meritus (diminished) risk corridor payments, while all the ACA debts owed to the government (aside from those arising from start-up and solvency loans) were satisfied. *Id* at 6. Meritus's balance sheets reflect this offset. *See* Dec. 31, 2018 Meritus Balance Sheet (Ex. 11) at 14. Notwithstanding the payment of Meritus's ACA debts by offset, the government now seeks a second payment of those exact debts, adding millions in interest that purportedly accrued in the years *after* the debts were paid.

II. ARGUMENT

A. Under Reverse Preemption, the Court Lacks Subject Matter Jurisdiction to Adjudicate the Government's Counterclaim

"[T]he Court of Federal Claims, like all inferior federal courts, is a court of jurisdiction limited by what Congress allows." *Massie v. United States*, 226 F.3d 1318, 1321 (Fed. Cir. 2000). The government relies on two federal statutes that it maintains give this Court jurisdiction to entertain its counterclaim: 28 U.S.C. §§ 1503 and 2508. *See* Am. Answer ¶ 4. The government is correct that it is typically the case that the Court of Federal Claims has jurisdiction to adjudicate the government's asserted offsets. In this instance, however, the federal statutes conflict with state statutes and the McCarran-Ferguson Act, 15 U.S.C. § 1012, limits the Court's ability to adjudicate the government's counterclaim. Specifically, the Act provides: "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a

[5] From the pleadings, there does not appear to be a material dispute regarding calculations of the amounts that the government owes Meritus under the ACA.

fee or tax upon such business, unless such Act specifically relates to the business of insurance." 15 U.S.C. § 1012(b). Under the Act, where a generally applicable federal law conflicts with a state insurance law, the federal law is "reverse pre-empted" and the state insurance law controls.

In *United States Department of Treasury v. Fabe*, the Supreme Court explained the McCarran-Ferguson Act's import with respect to the government's efforts to recover debts from insolvent insurers. 508 U.S. 491 (1993). In *Fabe*, the government asserted that, pursuant to 37 U.S.C. § 3713, it was entitled to a "superpriority" for the debts it was owed in an insurer insolvency proceeding. The federal superpriority statute conflicted with state insurance law, prioritizing the government's claims behind, among other claims, administrative expenses and policyholder claims. *Id*. at 495. The Court ruled that to the extent the state priority law serves to protect policyholders, it is a law enacted "for the purpose of regulating the business of insurance," and it reverse pre-empts conflicting federal laws that do not "specifically relate[] to the business of insurance." *Fabe*, 508 U.S. at 505-06. The Court subsequently ruled that 37 U.S.C. § 3713, the general federal superpriority statute, was reverse pre-empted by the state priority law to extent the state law prioritized the claims of policyholders (and administrative costs of the insolvency proceeding) above the government's claims. *Id*. at 508-09.

In this case, the McCarran-Ferguson Act and Arizona and Colorado law operate to preempt 28 U.S.C. §§ 1503 and 2508, the statutes the government relies on to establish subject matter jurisdiction. Both Arizona and Colorado law reserve the power to adjudicate an insolvent insurer's debts for the court overseeing the insurer's liquidation, and provide the liquidation court with exclusive jurisdiction over matters related to the insurer's liquidation. A.R.S. 20-612(a) ("The superior court is vested with exclusive original jurisdiction of delinquency proceedings under this article, and is authorized to make all necessary and proper orders to carry

out the purposes of this article."); A.R.S. 20-612(c) ("Delinquency proceedings pursuant to this article shall constitute the sole and exclusive method of liquidating . . . an insurer."); Colo. Rev. Stat. § 10-3-504(2) ("The district court in and for the city and county of Denver shall have jurisdiction to entertain, hear, or determine any complaint praying for the . . . liquidation . . . of any insurer, or praying for an injunction or restraining order or other relief preliminary to, incidental to, or relating to such proceedings other than in accordance with this part 5.").

The McCarran-Ferguson Act and *Fabe* require that 28 U.S.C. § 1503 and § 2508—the federal statutes allowing the government to pursue offsets in the Court of Federal Claims—yield to state laws vesting exclusive jurisdiction over offsets (and other matters related to liquidation) in state liquidation courts. Not only is this the law, but it makes sense. A "policy of placing ultimate control over all issues relating to the insolvency proceedings in a single court is aimed at protecting the relationship between the insurance company and its policyholder," and requires those proceedings be "shielded from federal interference by the McCarran-Ferguson Act" under *Fabe*. *Munich Am. Reinsurance Co. v. Crawford*, 141 F.3d 585, 593 (5th Cir. 1998); *see also Davister Corp. v. United Republic Life Ins. Co.*, 152 F.3d 1277, 1281 (10th Cir. 1998) ("The Utah statute consolidating all claims against a liquidating insurer, by its nature and express terms, was enacted to protect policyholders."). Indeed, consolidation of all claims against a liquidated insurer in a single forum "prevents the unnecessary and wasteful dissipation of the insolvent company's funds that would occur if the receiver had to defend unconnected suits in different forums across the country." *Munich*, 141 F.3d at 593. "Consolidation also eliminates the risk of conflicting rulings, piecemeal litigation of claims, and unequal treatment of claimants, all of which are of particular interest to insurance companies and policyholders[.]" *Id.* Perhaps most importantly, "[a]llowing a putative creditor to pluck from the entire liquidation proceeding one

discrete issue," would "directly impact the policyholders because it deals with a purported asset of the insurance company that could be apportioned to them." *Davister*, 152 F.3d at 1281. Consequently, federal appellate courts have repeatedly ruled that even where federal law otherwise requires that a claim be heard in a particular forum, that entitlement is trumped by the McCarran-Ferguson Act and state laws vesting exclusive jurisdiction over insurer liquidations in specific state courts. *Davister*, 152 F.3d at 1282 (holding that under McCarran-Ferguson Act and state insurer liquidation regimes, creditor was not entitled to pursue claim in arbitration against insolvent insurer even though the Federal Arbitration Act otherwise authorized arbitration); *Munich*, 141 F.3d at 595-96 ("We therefore hold that the FAA is reverse pre-empted under the McCarran–Ferguson Act, thereby leaving the district court without the power to compel arbitration in this case."); *Stephens v. American Int'l Ins. Co.*, 66 F.3d 41, 45 (2d Cir. 1995) (holding that Kentucky Liquidation Act superseded creditor's right to arbitrate under the FAA). So too here. Under the McCarran-Ferguson Act, the government's claims against insolvent insurers must be adjudicated in the state courts overseeing the Dispute Subclass's liquidations. As courts have repeatedly noted, any other outcome would substantially interfere with the carefully crafted insurer insolvency regimes established by the states.

In short, neither 28 U.S.C. § 1503 nor 28 U.S.C. § 2508 "specifically relates to the business of insurance," and so the McCarran-Ferguson Act provides that they are inoperative to the extent they conflict with state insurance laws. 15 U.S.C. § 1012(b). Because the two statutes that would typically give this Court jurisdiction to hear the government's counterclaim conflict with Arizona and Colorado laws vesting *exclusive* jurisdiction to determine claims against insolvent insurers in state liquidation courts, they cannot form the basis for this Court's jurisdiction. Absent any operative statutory basis for subject matter jurisdiction, the Court must

dismiss the government's counterclaims.[6] *See, e.g., In re PRS Ins. Grp., Inc.*, 294 B.R. 609, 613 (Bankr. D. Del. 2003) (holding bankruptcy court's subject matter jurisdiction was preempted under McCarran-Ferguson Act); *In re Amwest Sur. Ins. Co.*, 245 F. Supp. 2d 1038, 1045 (D. Neb. 2002) ("Nebraska's statute designating the state forum for adjudication of these claims regulates the business of insurance and, under the McCarran–Ferguson Act, cannot lawfully be 'invalidate[d], impair[ed], or supercede[d]' by permitting additional litigation in the federal court on the basis of diversity.").

B. The Government's Claim for Interest Against Both Meritus and Colorado HealthOp Should Be Dismissed

Even if the Court had subject matter jurisdiction to hear the government's counterclaims, the government's counterclaim fails on the merits. As an initial matter, the government's claim for interest against Meritus and Colorado HealthOp contravenes both state and federal law and should be dismissed.

[6] The Dispute Subclass does not dispute that the ACA is responsible for the existence of their purported debts. But the existence of a debt pursuant to the ACA is not inconsistent with Arizona or Colorado law; indeed, state insurer insolvency laws presuppose that the insurers have debts that have become too much to bear. The inconsistency between state and federal law in this case arises from the government's attempt to pursue its counterclaims in this court under 28 U.S.C. § 1503 and § 2508, which conflicts with state reservations of exclusive jurisdiction over liquidation matters for the state liquidation courts. It is 28 U.S.C. § 1503 and § 2508—which the government must concede are not specifically directed to the business of insurance—and not the Affordable Care Act that are reverse pre-empted by the McCarran-Ferguson Act under *Fabe*. It is likewise immaterial the government's asserted ability to offset arises from common law and not a statute. The question, for purposes of assessing subject matter jurisdiction, is not whether the government's right to offset conflicts with state law; it is whether the federal laws giving the Court the authority to hear the government's counterclaims are reverse pre-empted by state insurance laws under the McCarran-Ferguson Act. And those laws—28 U.S.C. § 1503 and § 2508—are undisputedly "Act[s] of Congress" subject to McCarran-Ferguson Act reverse pre-emption.

1. The Government May Not Claim Interest When the Government Is the Net Debtor

Applying federal law, the government is not entitled to pre-judgment interest under the well-established "interest on the balance" rule. Where two parties have claims that "arise out of related transactions,"[7] prejudgment interest "is available only on the net difference between the two claims at any point in time." *Local Oklahoma Bank v. United States*, 59 Fed. Cl. 713, 722-23 (2004) (*citing Ralston Purina Co. v. Parsons Feed & Farm Supply, Inc.*, 416 F.2d 207, 212 (8th Cir. 1969)). "The objective of the rule is to compensate for the loss of the use of money only to the extent of the difference between the two claims." *Id*. (internal quotation marks omitted). With respect to both Meritus and Colorado HealthOp, the government is the *net debtor*—excluding the government's claimed prejudgment interest, it owes *more* to Meritus[8] and Colorado HealthOp in risk corridor payments than the government asserts Meritus and Colorado HealthOp owe to it for other ACA obligations.[9] Consequently, the government has no entitlement to the interest it seeks.

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[7] The government's position across the risk corridor cases has been that the ACA "created several interrelated programs under which the Parties' respective claims arise." *See* Dkt. 80 at 1.

[8] As noted in Section II.D, Meritus's position is that the government's debt was paid in full in November 2017. But even if the Court finds otherwise, both Meritus Health and Meritus Mutual were owed millions more in risk corridor payments than the non-interest debts asserted in the government's counterclaim.

[9] The government seeks $19,588,835.69 in non-interest debts from Colorado HealthOp and 50,551,556.84 in non-interest debts from Meritus, Dkt. 101, but Colorado HealthOp is owed over $111 million in risk corridor payments and Meritus was owed over $68 million in risk corridor payments before it effectuated an offset of its debts to the government. *See* CMS, Risk Corridor Payments and Charge Amounts for Benefit Year 2014 (Nov. 19, 2015), available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RC-Issuer-level-Report.pdf; CMS, Risk Corridor Payments and Charge Amounts for Benefit Year 2015 (Nov. 18, 2016), available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-RC-Issuer-level-Report-11-18-16-FINAL-v2.pdf.

2. The Government May Not Claim Interest Accruing After the Dispute Subclasses' Insolvencies

As noted above, under black letter federal law, the government is not entitled to interest. Even if the interest-on-the-balance rule did not doom the government's claim for interest, however, the McCarran-Ferguson Act and Arizona and Colorado law would separately defeat the government's interest claim. For hundreds of years, the rule has been that interest on a debt ceases to accrue once an entity enters insolvency proceedings. *See In Re Liquidation of Pine Top Ins. Co.*, 322 Ill. App. 3d 693, 701-02 (2001) (holding that claims against insolvent insurers cannot include any post-allowance interest); *Vanston Bondholders Protective Committee v. Green*, 329 U.S. 156, 164 (1946) ("[t]he general rule in bankruptcy and in equity receivership has been that interest on the debtors' obligations ceases to accrue at the beginning of the proceedings"); *Sexton, as Trustee in Bankruptcy of Kessler & Co. v. Dreyfus*, 219 U.S. 339, 344 (1911) ("For more than a century and a half the theory of the English bankrupt system has been that everything stops at a certain date."). This prohibition is reflected in both the Arizona and Colorado insurer insolvency laws, which fix the rights and liabilities of an insolvent insurer upon issuance of an order of liquidation. *See* Ariz. Rev. Stat. § 20-635 ("The rights and liabilities of the insurer and of its creditors, policyholders, stockholders, members, subscribers and all other persons interested in its estate shall, unless otherwise directed by the court, be fixed as of the date on which the order directing the liquidation of the insurer is filed[.]"); Colo. Rev. Stat. § 10-3-517(2) ("Upon issuance of the order, the rights and liabilities of any such insurer and of its creditors, policyholders, shareholders, members, and all other persons interested in its estate shall become fixed as of the date of entry of the order of liquidation[.]") This fixing of rights is a key component of the priority system for insolvent insurers that is already expressly protected under *Fabe.*

The government's position is that it is entitled to interest that continues to accrue to this day at an effective rate exceeding 15% annually, pursuant to 31 U.S.C.§ 3717 and 45 CFR § 30.18. Needless to say, the government's position is inconsistent with the Arizona and Colorado laws fixing debts on the date a liquidation order is entered. And, under the McCarran-Ferguson Act and *Fabe*, Arizona and Colorado law reverse pre-empt the statutory bases for any assertion of post-liquidation order interest by the government. Taken to its logical conclusion, the government's position is that it (and no other creditor, including policyholders) can continue to accrue post-liquidation order interest at above-market rates until the government's claims consume the insurer's entire estate—or, at the very least, until it consumes the entirety of the government's obligation to the insurer, which is precisely what the government has done to Meritus Health. It is difficult to conceive of a federal law that would more powerfully interfere with the rights of policyholders than one which allows the government to usurp via delay the entirety of a multi-million-dollar asset that could be used to pay policyholder claims. *See Fabe*, 508 U.S. at 505-06 ("The primary purpose of a statute that distributes the insolvent insurer's assets to policyholders in preference to other creditors is identical to the primary purpose of the insurance company itself: the payment of claims made against policies."). Arizona and Colorado law thus reverse pre-empt the statutory bases for the government's interest claim.

C. Colorado Law Prohibits the Government's Counterclaim Against Colorado HealthOp

In *Conway*, Judge Hertling—evaluating the government's attempt to recoup from Colorado HealthOp by offset the same ACA debts at issue in the government's counterclaims here—ruled that the government's offset violated Colorado law, which in turn supplied the relevant federal rule of decision. *Conway*, 145 Fed. Cl. at 529. The same legal principles that

required judgment for Colorado HealthOp in *Conway* defeat the government's counterclaim as to Colorado HealthOp in this case.

1. Colorado Law Provides the Federal Rule of Decision

The government's asserted right to setoff sums purportedly owed it by the Dispute Subclass against their recovery in this case "arises under common law, not statute." Order Granting Government's Motion for Leave to Amend, Dkt. 96 at 9. Because the federal government "exercis[es] a constitutional function or power" when it "disburses funds or pays its debts," federal courts may need to supply "the governing rule of law" relating to these functions where federal statutes do not provide one. *Clearfield Tr. Co. v. United States*, 318 U.S. 363, 367 (1943). But while significant federal property interests may require "federal law governance," that "does not necessarily mean that federal courts should *create* the controlling law." *Am. Elec. Power Co., Inc. v. Conn.*, 564 U.S. 410, 422 (2011) (emphasis added). Rather, "[a]bsent a *demonstrated need* for a federal rule of decision, [federal courts have] taken 'the prudent course' of 'adopt[ing] the readymade body of state law as the federal rule of decision until Congress strikes a different accommodation.'" *Id.* (quoting *United States v. Kimbell Foods, Inc.*, 440 U.S. 715, 740 (1979)).

In *Kimbell*, faced with a similar situation to that presented here, the Supreme Court was called upon "to determine the rights of the United States as against private creditors" with respect to the relative priority of liens arising from federal lending programs. 440 U.S. at 740. The Court first decided that, even though "the statutes authorizing these federal lending programs do not specify the appropriate rule of decision," the "priority of liens stemming from federal lending programs must [nonetheless] be determined with reference to federal law," because the agencies in question were performing federal, constitutional functions. *Id.* at 726–27.

But just because federal law applied "d[id] not inevitably require resort to uniform

federal rules." *Id.* at 727–28. Instead, in order to determine whether to fashion such a rule or else "adopt[] the otherwise applicable state-law rule of decision[,] [t]he *Kimbell* court considered three factors . . . : '(1) the need for national uniformity, (2) whether state law would 'frustrate specific objectives' of the federal program; and (3) the extent to which federal rules might 'disrupt commercial relationships predicated upon state law.'" *Conway*, 145 Fed. Cl. at 527 (quoting *Montana v. United States*, 124 F.3d 1269, 1274 (Fed. Cir. 1997)). In *Kimbell*, each of these factors supported "'the prudent course' of 'adopt[ing] the readymade body of state law as the federal rule of decision." 440 U.S. at 740. The same result obtains here.

First, the government cannot credibly claim that any "need for national uniformity" requires that a uniform rule regarding the government's offset rights in insurance liquidation proceedings. In *Kimbell*, the Court rejected the government's "generalized pleas for uniformity," noting that the government operations in question were already "specifically and in great detail adapted to state law." 440 U.S. at 729–30. Because "[t]he programs already conform to each State's commercial standards," the Court concluded that "the agencies [already] function effectively without uniform procedures and legal rules," undermining any claim that uniformity was needed for effective administration. *Id.*

The absence of any need for uniformity is even clearer here, where state-by-state administration is baked into the ACA by design. As this Court noted in *Conway*, "[e]ven more than the [Small Business Administration program in *United States v. Yazell*, 382 U.S. 341 (1966)], the ACA's provision for separate exchanges, reinsurance, and risk-adjustment programs in all 50 states demonstrates that the ACA creates no requirement that could not be met by each state operating its own programs, presumably applying its own insurance liquidation priority scheme." 145 Fed. Cl. at 528. And "[l]ike the FHA loan-processing procedures in *Kimbell* . . .

the ACA does not require that HHS's obligations to reinsurance and risk-adjustment program participants issue forth as 'nationwide act[s] of the Federal Government, emanating in a single form from a single source.'" *Id.* (quoting *Kimbell*, 440 U.S. at 733). "The adaptability of the reinsurance and risk-adjustment programs, evident on the face of the statute creating them and from the fact that states like Connecticut and Massachusetts may operate both or one of them, suggest that Colorado's insurance liquidation priority scheme[s] [are] the appropriate federal rule[s] of decision here." *Id.*

Second, applying Colorado's insurance liquidation priority schemes would not "frustrate specific objectives" of the ACA. 440 U.S. at 729. Applying state law would merely place the government "in substantially the same position as private lenders,"[10] undermining any suggestion that a "special status it seeks is []necessary to safeguard the public fisc." *Kimbell*, 440 U.S. at 737. Further, the ACA specifically provides that "[n]othing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title." 42 U.S.C. § 18041(d). Given the ACA's stated policy of *non-preemption*, it makes scant sense to instead determine that the ACA's specific objectives would be frustrated unless this court displaces state regulation of insurance liquidation. *See Conway*, 145 Fed. Cl. at 528 ("The ACA non-preemption clause's title alone—'No Interference with State Regulatory Authority'—suggests that the reinsurance and risk-adjustment programs can be properly implemented in the face of potentially less favorable, but not outright incompatible state insurance liquidation law, like Colorado's priority scheme.").

Third, the "application of a federal rule would disrupt commercial relationships predicated on state law." *Kimbell*, 440 U.S. at 729. As the Supreme Court noted in *Kimbell*,

[10] In fact, in a *better* position than nearly all creditors except policyholders. *See* C.R.S.A. § 10-3-541.

announcing a new federal rule that would give the federal government greater priority over other creditors under preexisting state law would cause "[c]reditors who justifiably rely on state law . . . [to] have their expectations thwarted whenever a federal contractual security interest suddenly appeared and took precedence." *Id.* at 739. "Because the ultimate consequences of altering settled commercial practices are so difficult to foresee . . . the prudent course is to adopt the readymade body of state law as the federal rule of decision until Congress strikes a different accommodation." *Id.* at 739–40. This concern is even more pronounced here, where a uniform federal rule would not only threaten to disrupt the expectations of sophisticated business parties (who, after all, may at least have the benefit of legal advice), but also of ordinary policyholders. *See Conway*, 145 Fed. Cl. at 529 (noting that Colorado state law assures policyholders of a higher priority of payment than the Federal Government).

Consequently, Colorado law supplies the relevant federal rule of decision governing the government's right to pursue an offset against Colorado HealthOp.

2. Colorado Law Prohibits the Government From Offsetting Colorado HealthOp's Debts Against Its Risk Corridor Judgment

To provide maximal protection to policyholders, Colorado requires that their claims receive higher priority in the event of an insurer's liquidation insurer than all other creditor claims except those incurred through the liquidation process. *See* Colo. Rev. Stat. § 10-3-541(1)(b). The federal government receives the next-best treatment.[11] *Id.* § 10-3-541(1)(c). As Judge Hertling noted in *Conway* with respect to the exact debts the government presently asserts against Colorado HealthOp, allowing the government to claim this offset would "violate[] Colorado's insurance liquidation priority scheme by [allowing it to] leap-frog[] claimants with

[11] Of course, the federal government receives equal priority to other policyholders for any claims it asserts as a policyholder. *Id.* § 10-3-541(b).

higher priority." *Conway*, 145 Fed. Cl. at 524. Neither Colorado statutes nor Colorado common law permits this disruption.

Notwithstanding this order of priority, Colorado statutorily permits parties to set off "mutual debts or mutual credits" arising out of contracts between the insurer and creditor. Specifically, Colorado law provides:

> Notwithstanding any other provision of this title, mutual debts or mutual credits, whether arising out of one or more contracts between the insurer and another person in connection with any action or proceeding under this part 5, shall be set off, and the balance only shall be allowed or paid . . .

Colo. Rev. Stat. § 10-3-529(1). This statute does not authorize the government's efforts to offset Colorado HealthOp's debts because the debts at issue do not arise out of a contract.

As Judge Hertling held in *Conway*, Colorado's offset statute permits only those offsets that arise out of a contract between the insurer and creditor. This is plain from the statutory language, which permits offset of "mutual debts or mutual credits, whether arising out of *one or more contracts* between the insurer and another person." Colo. Rev. Stat. § 10-3-529(1) (emphasis added). This language does not permit offsets that do not arise out of a contract or contracts, because such offsets would not "aris[e] out of one or more contracts between the insure and another person." *Id.*[12]; *McCoy v. People*, 442 P.3d 379, 389 (Colo. 2019) (instructing courts to "read statutory words and phrases in context, and . . . construe them according to the rules of grammar and common usage."). Here, none of the debts identified in the counterclaim are contractual—the government identifies only risk adjustment payments, reinsurance payments, CSR reconciliation payments, user fees, and interest on those totals as the debts at issue. Dkt.

[12] To take an example: if one were to praise "the advocate's prodigious skill at oral advocacy, whether arising from one or several arguments before the Court of Federal Claims," the listener would have no basis to conclude the advocate acquired her skill by arguing before the Southern District of New York, much less that she was an accomplished college debater.

101 ¶¶ 52-56. To the extent the government argues that Colo. Rev. Stat. § 10-3-529(1) permits offsets of *non-contractual* debts, the government stretches the statute's meaning well past its breaking point. *Conway*, 145 Fed. Cl. at 525.

This view is reinforced when § 10-3-529(1) is read, as it must be, in its full statutory context. *See Martinez v. People*, 69 P.3d 1029, 1033 (Colo. 2003) (noting that "[t]he legislature is presumed to intend that the various parts of a comprehensive scheme are consistent with and apply to each other, without having to incorporate each by express reference in the other statutory provisions.") As Judge Hertling noted in *Conway*, "Subsection 5 of the offset statute permits certain offsets that are otherwise barred when 'the contracts' meet certain requirements." 145 Fed. Cl. at 525 (quoting Colo. Rev. Stat. § 10-3-529(5)). Further, Subsection 6 (the statute's effective date provision) provides:

> This section shall be effective January 1, 1993, and shall apply to all *contracts* entered into, renewed, extended, or amended on or after said date and to debts or credits arising from any business written or transactions occurring after January 1, 1993, pursuant to any *contract* including those in existence prior to January 1, 1993 . . . For purposes of this section, any change in the terms of, or consideration for, any *such contract* shall be deemed an amendment.

Colo. Rev. Stat. § 10-3-529(6).

As Judge Hertling explained, "[t]hese neighboring provisions" would make little sense if "in the context of the entire statute the Colorado legislature" intended to permit offsets of debts other than those arising through insurance contracts. 145 Fed. Cl. at 525. Read on its own terms and in the context of the statute to which it belongs, § 10-3-529(1) does not permit the government's asserted offsets because they do not arise out of a contract.

Nor does Colorado common law provide offset rights beyond those specifically codified at Colo. Rev. Stat. § 10-3-529(1). The Colorado Supreme Court held as much in *Bluewater Ins. Ltd. v. Balzano*, where it rejected various reinsurers' attempts to claim offsets against sums owed

to an insurer in liquidation. 823 P.2d 1365, 1374 (Colo. 1992). Whatever offset rights might exist as a matter of Colorado common law did not apply in the insurer liquidation context, where "any exercise of the right to offset here in effect would create a preference for the reinsurers over the policyholders in the distribution of Aspen's assets, contrary to public policy." *Id.* at 1376. The Court specifically "reject[ed] the reinsurers' argument that the insurance liquidation act was intended to preserve an equitable right to offset," concluding instead that the Act's order of priority in liquidation required abrogation of any such right. *Id.* at 1369; *Conway*, 145 Fed. Cl. at 526 ("The [Colorado Supreme] Court assumed without deciding that 'an equitable right to offset does obtain in the reinsurance context,' and concluded that the legislature had abrogated any such right. Then . . . the Court addressed whether a common law right of offset was implicit in the insurance liquidation priority statute. It answered that question in the negative." (quotations omitted). Accordingly, the government's proposed offsets violate Colorado law. The Court should dismiss the government's counterclaim as to Colorado HealthOp.

3. Federal Common Law Does Not Permit the Offset Sought By The Government

Though this court should look to state law to supply the federal rule of decision, the result would be no different even if this court chose instead to fashion a uniform federal rule governing the priority of the government's offset within a state's existing insurance liquidation scheme without reference to the content of any state's law. This is so because to the extent that any uniform rule of federal common law defines the scope of federal government's offset rights, that rule furnishes the government with *the same offset rights* as could be exercised by other creditors.

"As recognized by the Supreme Court since at least 1841, the United States has the same common law right to setoff as a private party." Order Granting Motion for Leave to Amend,

Dkt. 96 at 9 (citations omitted); *see also United States v. Munsey Trust Co. of Washington, D.C.*, 332 U.S. 234, 239 (1947) ("The government has the same right 'which belongs to every creditor, to apply the unappropriated moneys of his debtor, in his hands, in extinguishment of the debts due to him.'").[13] But here, as explained above, Colorado specifically restricts the offset right of "private part[ie]s" and other creditors under precisely these circumstances, so as to prevent them from "leap-frogging claimants with higher priority" and undermining the state's generally applicable insurance liquidation scheme. *Conway*, 145 Fed. Cl. at 524. Allowing the government to offset under these circumstances would grant it *greater* rights than private parties or other creditors, an outcome completely at odds with the holding of *Munsey* and the cases that preceded it that the federal government is entitled to *equal* treatment.

Certain Federal Circuit cases have noted that "the government retains its setoff right unless there is some explicit statutory or contractual provision that bars its exercise." *Johnson v. All-State Constr. Co.*, 329 F.3d 848, 854 (Fed. Cir. 2003) (citing cases). These cases reflect the axiom that "[i]n order to abrogate a common-law principle," a contract or statute "must 'speak directly' to the question addressed by the common law." *United States v. Texas*, 507 U.S. 529, 534 (1993). They have little relevance here, where Colorado has clearly acted to abrogate the common law of offset with respect to insurers in liquidation. None of these cases depart from *Munsey*'s holding that the federal government has neither lesser *nor greater* offset rights than either parties.

To the extent any uniform federal rule sets out the scope of the government's offset

[13] When the Supreme Court first recognized the federal government's "common right [of offset,] which belongs to every creditor," *Gratiot v. United States*, 40 U.S. 336, 370 (1841), it likely conceived of it as an element of the general "common law." *Swift v. Tyson*, 41 U.S. 1, 18 (1842), *overruled by Erie Ry. Co. v. Tompkins*, 304 U.S. 64 (1938). Because the "general common law" was subject to displacement by state statutes, *id.*, federal offset rights likely were as well.

rights, the rule is simply one of parity: the federal government shall be no better or worse treated than other creditors when it comes to offset rights. That rule does not allow the federal government to sweep away even-handed state regulation and instead demand for itself greater offset rights than those enjoyed by private parties. Accordingly, the federal common law right to offset, which provides the government with only the same rights available to other creditors, independently defeats the government's counterclaim against Colorado HealthOp.

D. Meritus Paid the Debts Identified in the Counterclaim in Full in 2017

Finally, Meritus already paid the amounts sought by the government in its counterclaims through offset implemented in accordance with Arizona insurance law at the request of the government. The government's insistence that Meritus pay borderline-usurious interest on amounts paid years ago, with the interest continuing to churn with no end in sight, reveals the hypocrisy of its position: while the government maintains that it is entitled to pursue the same right to offset that belongs to any party with mutual debts, it refuses to acknowledge that Meritus—***in 2017***—paid by offset the very debts the government now pursues. "This court recognizes the right of private entities to exercise the common law right of set-off against the United States." *Local Okla. Bank*, 59 Fed. Cl. at 721. A valid setoff requires "(i) a decision to effectuate a setoff, (ii) some action accomplishing the setoff, and (iii) a recording of the setoff." *Johnson v. All-State Const., Inc.*, 329 F.3d 848, 854 (Fed. Cir. 2003). In *Johnson*, for instance, the Federal Circuit ruled that a single notice satisfied each of these requirements where the notice states that the government "would not make [a payment] because 'the amount to be retained for liquidated damages exceeds the amount of the invoice." *Id*. at 854-55. The notice, according to the Federal Circuit, "reflected a decision to effectuate a setoff; [] reflected an act to accomplish the set-off; and [] recorded the set-off." *Id*. (internal quotation marks omitted).

Here, on November 16, 2017, Meritus—***at the government's request***—effectuated an offset of the very debts the government now seeks to collect (for a second time). The government filed proofs of claim with Meritus's receiver that expressly requested the government's Claim be treated "as a secured claim to the extent it is subject to set-off by a claim of the Debtor against the United States," and noted that "[t]he United States is a unitary creditor for purposes of set-off and recoupment." *See* Ex. 3 at ¶ 16; Ex. 4 at 3 ("The United States hereby expressly reserves its right to set-off or recoup any claim against debts owed to the Estate by the United States."). In the November 16, 2017 letters to the government, Meritus's receiver accepted the government's offset requests as part of the claims adjudication process. Specifically, the receiver sent the government a "Notice of Setoff and Claim Determination" for both Meritus Health and Meritus Mutual which identified (1) Meritus's debts to the government that were subject to offset and (2) the government's debts to Meritus, from which Meritus's debts would be offset, which included risk corridor and reinsurance payments. *See* Exs. 6, 7. The letters identified the amount of money the government owed to Meritus Health and Meritus Mutual "after application of the Setoff", and indicated that "[d]ue to the offset, no further entitlement to interest asserted by Claimant would be considered under the Claim." Ex. 6 at 2; Ex. 7 at 3. Meritus subsequently recorded the offset in its balance sheets, and the Liquidation Court ratified the offset. *See* Ex. 10 at 7; Ex. 11 at 14.

These steps more than met the three requirements to effectuate an offset: Meritus made the decision to take an offset; sent the November 16, 2017 letters to the government to accomplish the offset; and recorded the offset both in its November 16, 2017 letters and in its balance sheets. *See Local Okla. Bank,* 59 Fed. Cl. at 721 (2004) (correspondence reflected a proper offset directed at a government agency); *see also Johnson*, 329 F.3d at 854-55 (a single

notice successfully effectuated a setoff). The debts that were extinguished via offset in November 2017 are the exact same debts that the government now seeks to double-recover via its counterclaim. *Compare* Ex. 6 at 2 and Ex. 7 at 2-3 (identifying cost sharing reduction reconciliation payments, risk adjustment payments, and user fees owed to the government among the debts being setoff against risk corridor and reinsurance payments owed to Meritus), *with* Am. Ans. ¶¶ 57-59 (identifying those same debts as those the government now seeks to recover).[14] Accordingly, the government's counterclaim seeks to recover debts that have already been paid, plus interest that would continue to churn at the government's discretion. Because the debts at issue were paid in November 2017, the government does not have a plausible claim for interest—the government may not claim years of interest on non-existent debts.[15] The government's counterclaim should be dismissed in full as to Meritus.[16]

III. CONCLUSION

For the foregoing reasons, the Court should dismiss the government's counterclaim. The Court lacks subject matter jurisdiction to entertain the government's counterclaim, and even if it were properly before this Court, it fails on the merits in full, as to both Meritus and Colorado

[14] With the exception of the user fees, the amounts paid to the government by offset exceed the principal amounts identified in the Amended Answer. The Amended Answer requests $46,583,774.29 in risk adjustment payments, $3,920,461.72 in CSR reconciliation payments, and $47,320 in user fees. Dkt. 101 at 10. The amounts offset in November 2017, between Meritus Health and Meritus Mutual, include $46,789,996.65 in risk adjustment payments, $4,014,827.83 in CSR reconciliation payments, and $44,149.23 in user fees. Ex. 6 at 2; Ex. 7 at 2-3.

[15] As explained in Section II.B., *supra*, even if Meritus's debts to the government had not been extinguished in 2017, the government's claim for interest is prohibited by both the "interest on the balance" rule and the McCarran-Ferguson Act.

[16] As noted above, the Court may take judicial notice of the documents reflecting the offset, which are part of the public record in the Liquidation Court proceeding. If the Court, however, is disinclined to do so, it also may treat this portion of the motion as a motion for summary judgment under RCFC 12(d).

HealthOp. In the alternative, the Court should dismiss the government's counterclaim to the extent it seeks interest.

DATED: November 20, 2020

Respectfully submitted,

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PERMANENT ASSIGNMENT
TO JUDGE MARTIN ECB-412

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA

IN AND FOR THE COUNTY OF MARICOPA

STATE OF ARIZONA, *ex rel.* LESLIE R. HESS, Interim Director of Insurance,

Plaintiff,

vs.

COMPASS COOPERATIVE MUTUAL HEALTH NETWORK, INC. dba MERITUS MUTUAL HEALTH PARTNERS, an Arizona Corporation; and

COMPASS COOPERATIVE HEALTH PLAN, INC. dba MERITUS HEALTH PARTNERS, an Arizona Corporation

Defendants.

Cause No.: CV 2016-011872

ORDER FOR APPOINTMENT OF RECEIVER AND INJUNCTION

Plaintiff, STATE OF ARIZONA, *ex rel.* LESLIE R. HESS, Interim Director of Insurance, having filed a Complaint for Appointment of Receiver and for Injunction pursuant to A.R.S. §§ 20-611 through 20-616; the Defendants, Compass Cooperative Mutual Health Network, Inc. dba Meritus Mutual Health Partners ("Meritus Mutual") and Compass Cooperative Health Plan, Inc. dba Meritus Health Partners ("MHP"), having been duly served with process or accepted same, and a hearing

having been held before this Court, the Court makes the following Findings of Fact and Conclusions of Law and enters the following Order:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Plaintiff is the STATE OF ARIZONA, *ex rel.* LESLIE R. HESS, Interim Director of Insurance ("Director" or "Receiver"). The Director is charged with the enforcement of Title 20, Arizona Revised Statutes, relating to the transaction of insurance business in the State of Arizona.

2. Defendant Compass Cooperative Mutual Health Network, Inc. doing business as Meritus Mutual Health Partners ("Meritus Mutual") is an Arizona nonprofit corporation and was issued an Arizona certificate of authority to transact disability insurance business on May 28, 2013.

3. Defendant Compass Cooperative Health Plan, Inc. doing business as Meritus Health Partners ("MHP") is an Arizona nonprofit corporation which holds an Arizona certificate of authority to transact business as a health care services organization effective May 28, 2013 pursuant to Article 9, Chapter 4 of Title 20, A.R.S.

4. Defendant Meritus Mutual was approved to operate as a consumer operated and oriented health plan ("CO-OP") in the State of Arizona by the Center for Medicare & Medicaid Services ("CMS"), a division of the U.S. Department of Health & Human Services.

5. Defendants are under common control. Defendants have the same officers and directors, share the same home office, and share services for the adjudication and payment of claims. There are no other companies affiliated with Defendants. While one receivership is established for administrative efficiencies, all references to Defendant and/or Defendants are references to Defendant Meritus Mutual and/or Defendant MHP and the Director may take action collectively or individually under the circumstances.

6. The certificates of authority of Defendant Meritus Mutual and of Defendant MHP were each suspended and each Defendant was placed under the supervision of the Arizona Department of Insurance ("Department") on October 30, 2015 in Order Summarily Suspending Certificate of Authority and Order for Supervision, Docket Nos. 15A-168-INS and 15A-169-INS ("Suspension and Supervision Orders").

7. In the Suspension and Supervision Orders, the Department determined that the continuation of the business of each Defendant was hazardous to the public or to holders of its policies pursuant to A.R.S. §20-220.01, and ordered that each Defendant suspend the issuance of new or renewed business including discontinuing all policies on or before midnight on December 31, 2015. In addition, each Defendant was placed under the Department's supervision pursuant to A.R.S. §20-169.

8. Since December 31, 2015, each Defendant has ceased writing all new and renewal business, discontinued all policies, and has continued to pay claims and wind down the operations of the business in accordance with the Supervision Order.

9. The risk-based capital level for each Defendant is at or below the authorized control level and the grounds for delinquency proceedings and an order of liquidation under A.R.S. §§ 20-616, 20-615(10) are satisfied.

10. Each Defendant is also impaired and/or insolvent under A.R.S. § 20-611(8) and the grounds for delinquency proceedings and an order of liquidation under A.R.S. §§ 20-616 and 20-615 are satisfied.

11. Impairment or insolvency means that the surplus of a mutual insurer shall be deemed to be impaired and the insurer shall be deemed to be insolvent when such insurer is not possessed of assets at least equal to all liabilities and required reserves together with minimum surplus. A.R.S. § 20-611(8).

12. Defendant MHP's current adjusted Capital and Surplus as of December 31, 2015 is $(43,339,133) and as of March 31, 2016 is $(45,537,854). Thus, under A.R.S. §20-611(8), MHP is insolvent.

13. Defendant Meritus Mutual's current adjusted Capital and Surplus as of December 31, 2015 is $(799,007) and as of March 31, 2016 is $(1,350,718). Thus, under A.R.S. § 20-611(8), Defendant Meritus Mutual is insolvent.

14. Grounds exist for these delinquency proceedings, entry of an order of liquidation with a finding of insolvency with respect to each Defendant and appointment of the Director as Receiver pursuant to A.R.S. § 20-616.

ORDER

IT IS THEREFORE ORDERED THAT:

1. This Court has sole and exclusive jurisdiction over this matter pursuant to A.R.S. § 20-612, is vested with exclusive original jurisdiction of delinquency proceedings for Defendants and is authorized to make all necessary and proper orders to carry out the purposes of A.R.S. §§ 20-611 through 20-650.

2. Venue for these delinquency proceedings is proper in this Court pursuant to A.R.S. § 20-612.

3. Defendant Compass Cooperative Mutual Health Network, Inc. doing business as Meritus Mutual Health Partners ("Meritus Mutual") is declared insolvent and placed under an order of liquidation.

4. Defendant Compass Cooperative Health Plan, Inc. doing business as Meritus Health Partners ("MHP") is declared insolvent and placed under an order of liquidation.

5. Interim Director of Insurance Leslie R. Hess ("Director") is appointed as receiver and liquidator of Defendant Meritus Mutual and Defendant MHP and ordered to administer the two separate but related liquidations in a single receivership proceeding. Pursuant A.R.S. §§ 20-621 and 20-624, the Director is ordered to take immediate possession of the assets of Defendant Meritus Mutual and the assets of Defendant MHP, to administer those assets under the orders of this Court, to liquidate the business of each Defendant, to take immediate possession of the property of each Defendant, to deal with each Defendant's property and business in the Director's own name as receiver or in the name of the Defendant, and to give notice to all creditors who have claims against the the Defendant to present such claims.

6. As receiver, the Director is vested by operation of law with the title to all of the property, contracts and rights of action and all of the books and records of each Defendant, wherever located, as of the date of entry of this order directing her to liquidate each Defendant. Director shall have the right to recover the assets and reduce them to possession.

7. Under A.R.S. § 20-623.01, the Director is authorized to appoint one or more special deputy receivers to act for the receiver and may employ counsel, clerks and assistants as she deems

necessary. Subject to the approval of the Court, the Director shall fix the compensation of the special deputies, counsel, clerks or assistants and all expenses of taking possession of each Defendant and of conducting the proceeding and shall use the funds or assets of each Defendant to pay the respective compensation and expenses as reasonably allocated under the circumstances.

8. The Director is ordered to liquidate the business of each Defendant and as Receiver, to:

a. Collect, receive and take exclusive custody, control and possession of all records, property and assets (including subsidiaries) of any kind or nature owned beneficially or otherwise by each Defendant, with full power to use for, collect, receive and take possession of all bank accounts, goods, chattels, rights, deposits, credits, monies, lands, books and records of account and other papers and property and causes of action of each Defendant;

b. Conserve, hold and manage all the property and assets subject to this receivership in order to prevent to the extent possible, loss, damage, and injury to creditors and others who have done business with each Defendant; to obtain an accounting thereof, and to adjust and protect the interest of such creditors and other persons doing business with each Defendant, as approved by the Court; the Receiver may maintain property and assets of each Defendant in the investments in which such property and assets are presently held or in similar investments consistent with the present investment policy of Defendants, or may reinvest such property or assets in another manner in her discretion;

c. Engage and employ attorneys, accountants, appraisers, consultants, actuaries, work-out specialists, investment bankers and other persons to evaluate the property and assets subject to this receivership, and to operate the business of each Defendant, as the Receiver may deem necessary in the performance of her duties and responsibilities in discharging the authority conferred by this Order. The Receiver may, at her discretion, retain or terminate the contracts of any such persons already engaged by Defendants. All such persons so engaged, employed or retained are to be paid out of the funds, property or assets of each Defendant in the possession of the Receiver or coming into her possession. The Receiver may also retain or discharge any employees at any time, in her sole discretion, by specifically advising such employees of the termination of their employment. The Receiver may implement measures related to the discharge or retention of employees and shall take any

action necessary to comply with applicable federal and state laws pertaining to discharge of employees and any benefit plans of Defendants. The Receiver may, in her discretion, make a payment of day to day expenses of Defendant on-going at the date of this Order;

d. Make such payments and disbursements from the property and assets subject to this receivership and to incur such expenses as may be necessary and advisable in discharging her duties as Receiver, and to present to the Court from time to time an accounting of all such payments, disbursements, and expenses;

e. Institute, prosecute, defend, compromise, intervene in, seek stays in, or become a party to, such suits, actions or proceedings at law or in equity as may, in the Receiver's opinion, be necessary for the collection, recovery, protection, maintenance, or preservation of the property or assets subject to this receivership; and

f. The Receiver, in her discretion, may affirm or disavow any executory contracts to which each Defendant is a party. The entry of this Order of Receiver shall not constitute an anticipatory breach of any such contracts.

9. Except by leave of this Court or upon the written direction or consent of the Receiver, during the pendency of this receivership, each Defendant and all customers, principals, investors, creditors, shareholders, lessors, and other persons, except for the Receiver or her agents, seeking to establish or enforce any claim, rights or interest against or on behalf of each Defendant, and all others acting for or on behalf of such persons including attorneys, trustees, agents, sheriffs, constables, marshals and other officers and their deputies and their respective attorneys, servants, agents, employees, be and hereby are enjoined from:

a. Commencing, prosecuting, continuing or enforcing any claim, suit or proceeding against each Defendant or against any of its assets (including subsidiaries) for a period of 180 days from entry of this Order; the Receiver may request an extension of this provision in her discretion.

b. Commencing, prosecuting, continuing or enforcing any suit or proceeding in the name or on behalf of each Defendant or any of its subsidiaries;

c. Accelerating the due date of any obligation or claimed obligation, enforcing any lien upon, or taking or attempting to take possession of, or retaining possession of, any property of each

Defendant, or attempting to foreclose, forfeit, alter or terminate any interest of each Defendant in any of its property or assets, whether such acts are part of a judicial or administrative proceeding or otherwise;

d. Using self-help or executing or issuing or causing the execution of any court attachment, subpoena, replevin, execution or other process for the purpose of impounding or taking possession of, or interfering with, or creating, or enforcing a lien upon, any property wherever located, owned by or in the possession of each Defendant, any of its subsidiaries, or the Receiver appointed pursuant to this Order or any agents appointed by said Receiver; and

e. Doing any act or thing whatsoever to interfere with the taking control of, possession or management by the Receiver appointed herein of the property and assets subject to this receivership, or to in any way harass or interfere with said Receiver, or to interfere, in any manner, with the exclusive jurisdiction of this Court over the property and assets of each Defendant.

10. No person may serve or cause to be served upon the Receiver and any Special Deputy Receiver any legal process, including attachments, garnishments, subpoenas, writs of replevin, writs of execution and every other form of process whether described specifically herein or not, without first securing the authorization of this Court or the specific written consent of the Receiver. Any process issued in violation of this Order is void. Persons endeavoring to secure documentation from the Receiver shall, in all instances, first attempt to secure such information by submitting a formal written request to the Receiver and, if such request has not been responded to within sixty (60) days, such person may thereafter seek an order of this Court with regard to the relief requested.

11. All attorneys, consultants, accountants, and others employed by each Defendant to represent Defendant or its insureds, within 30 days of notice of this Order or such other time period as the Receiver shall determine, shall report to the Receiver on the name, company claim number and status of each file they are handling on behalf of each Defendant. Said report shall also include an accounting of any funds received from or on behalf of each Defendant. All attorneys, consultants, accountants and others described herein may either be retained or discharged by the Receiver in the Receiver's sole discretion.

12. Any servicers, agents, brokers, third-party administrators or other persons having sold policies of insurance and/or collected premiums on behalf of each Defendant shall account for and pay

premiums and commissions due in the normal course of business owed to each Defendant directly to the Receiver within 30 days of the date of this Order or within such other time as determined by the Receiver. Persons failing to provide such status reports may be required to appear before this Court to show cause, if any they may have, as to why they should not be required to account to the Receiver or be held in contempt of court for violation of the provisions of this Order. No servicer, agent, broker, third party administrator, managing general agent, or other person shall use premium monies owed to each Defendant for the refund of unearned premium or for any purpose other than payment to the Receiver. No servicer, agent, broker, third party administrator, managing general agent, or other person shall exercise any form of set-off, alleged set-off, lien, any form of self-help whatsoever or refuse to transfer any funds or assets to the Receiver's control without the permission of this Court.

13. All claims adjusters and other third parties handling claims files relating to Defendants' policies, insurance contracts or bonds shall within thirty (30) days of the date of this Order, report to the Receiver on the name, company claim number, policy or other identifying number and status of each file they are handling on behalf of each Defendant. Persons failing to provide such status reports may be required to appear before this Court to show cause, if any they may have, as to why they should not be required to account to the Receiver or be held in contempt of court for violation of the provisions of this Order. All claims adjusters and other third parties handling claims files relating to Defendants' policies, insurance contracts or bonds may be retained by the Receiver at her sole discretion.

14. Any bank, savings and loan association, trustee, institution or other person or entity which has on deposit, in its possession, custody or control any funds, accounts, or any other property or assets of each Defendant or its subsidiaries shall immediately transfer title, custody and control of all such funds, property or assets to the Receiver and are hereby instructed that the Receiver has absolute control over such accounts, funds, property and other assets and the Receiver may change the name of such accounts, funds, property and other assets, withdraw them from such bank, savings and loan association, trustee, other institution, person or entity, or take any lesser action necessary for the proper conduct of this receivership. No bank, savings and loan association, trustee, other institution, person or entity shall exercise any form of set-off, alleged set-off, lien, any form of self-help whatsoever or refuse

to transfer any accounts, funds, property or assets to the Receiver's control without the permission of the Receiver or this Court.

15. Any data processing service which has custody or control of any data processing information and records including but not limited to source documents, data processing cards, input tapes, all types of storage information, master tapes or any other recorded or electronic information of any kind relating to claimants and insureds of each Defendant or any aspect of the business of each Defendant shall transfer custody and control of such records to the Receiver, upon demand.

16. Each Defendant and its respective officers, directors, agents, servants, employees, attorneys, successors, accountants and assigns and those persons in active concert or participation with them and each of them shall transfer to the Receiver within ten (10) calendar days after request from the Receiver all books, records, accounts, documents or any other data of any kind or nature relating to each Defendant's business, in whatever format, electronic or otherwise, including claims files, whether open or closed, and all policyholder files and correspondence relating to claimants and insureds, and shall immediately send to the Receiver all such documents received after the date the Receiver makes a request for files and give to the Receiver a list of third parties who may be in possession of such documents.

17. Each Defendant and its respective officers, directors, shareholders, members, subscribers, agents, servicers, trustees, creditors, lenders, financial institutions, servants, employees, attorneys, successors, accountants and assigns, and all other persons, and those persons in active concert or participation with them and each of them, be and hereby are enjoined during the pendency of this action from directly or indirectly:

a. Except through and at the direction of the Receiver, transacting any of each Defendant's or any of its subsidiaries business.

b. Wasting or disposing of each Defendant's and any of its subsidiaries, property or assets, or the obtaining of preferences, judgments, attachments, or other liens, or the making of any levy against each Defendant and its subsidiaries.

c. Destroying, secreting, defacing, transferring, or otherwise altering or disposing of any books, records, accounts or any other papers of any kind or nature of each Defendant.

d. Transferring, receiving, altering, selling encumbering, pledging, assigning, liquidating, or otherwise disposing of any assets, funds or property owned, controlled, or in the possession of, or in which an interest held or claimed by each Defendant, or the Receiver appointed herein.

e. Obstructing or interfering or refusing to cooperate with the Receiver appointed pursuant to this Order or her duly authorized agents, in the exercise of their lawful authority under the Orders of this Court.

DONE in Open Court this 10th day of August, 2016.

Judge of the Superior Court

5226242

Exhibit 2

Lewis Roca Rothgerber Christie LLP
201 East Washington Street, Suite 1200
Phoenix, Arizona 85004-2595

Joel A. Glover (CO Bar No. 20821) (*pro hac vice* pending)
Direct Dial: 303.628.9553
Direct Fax: 303.623.9222
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Direct Dial: 602.262.5738
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Attorneys for Receiver

SUPERIOR COURT OF ARIZONA

COUNTY OF MARICOPA

STATE OF ARIZONA, *ex rel.* LESLIE R. HESS, Interim Director of Insurance, Plaintiff, vs. COMPASS COOPERATIVE MUTUAL HEALTH NETWORK, INC., dba MERITUS MUTUAL HEALTH PARTNERS, an Arizona corporation; and COMPASS COOPERATIVE HEALTH PLAN, INC., dba MERITUS HEALTH PARTNERS, an Arizona corporation, Defendants.	No. CV2016-011872 **ORDER RE: PETITION NO. 7** **ORDER APPROVING LIQUIDATION PLAN** (Assigned to The Honorable Daniel Martin)

Leslie R. Hess, Interim Director of Insurance for the Arizona Department of Insurance, as Receiver (hereinafter "Receiver") of Compass Cooperative Mutual Health Network, Inc. doing business as Meritus Mutual Health Partners ("Meritus Mutual") and Compass Cooperative Health Plan, Inc. dba Meritus Health Partners ("MHP"), having filed Petition No. 7 ("Petition No. 7") to Petition for Order Approving Liquidation Plan, a hearing having been held before this Court on March 8, 2017, the Court being fully advised in the premises and good cause appearing therefor, IT IS ORDERED:

1. Background Filings and Orders.

a. The Liquidation Plan, dated January 11, 2017, was filed by the Receiver.

b. Also dated January 11, 2017, the Receiver filed Petition No. 8 – Petition to Set Hearing and Approve Notice of Hearing for Petition No. 7 – Petition for Order Approving Liquidation Plan.

c. Dated January 26, 2017, this Court entered its Order regarding Petition No. 8, the Order Approving Petition to Set Hearing and To Approve Notice of Hearing for Petition No. 8 – Petition for Order Approving Liquidation Plan.

d. Dated February 6, 2017, the Receiver filed its Certificate of Providing Notice of Hearing Regarding Petition for Order Approving Liquidation Plan confirming the method and dates by which notice of the hearing was provided.

e. The hearing regarding the Liquidation Plan took place on March 8, 2017. No objections to the Liquidation Plan were filed with this Court prior to the hearing. Likewise, no objections to the Liquidation Plan were made at the hearing.

f. At the hearing, counsel for the Receiver addressed the Liquidation Plan, the relief requested thereby and the basis for the Liquidation Plan.

2. Approval of the Liquidation Plan. The Liquidation Plan submitted by the Receiver is hereby approved. The Receiver is directed to implement the Liquidation Plan and to take all steps as reasonably necessary and/or appropriate to do so. As set forth more fully herein: (1) the Receiver shall coordinate Meritus Mutual claims' coverage from the Arizona Life and Disability Insurance Guaranty Fund ("AZ Guaranty Fund")

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subject to and in accordance with the Service Agreement previously approved by this Court; (2) the Receiver shall determine MHP claim amounts, taking into account in-network, out-of-network and network exception distinctions; (3) a temporary restraining order is entered prohibiting collections from enrollees and insureds unless and until an Explanation of Benefits ("EOB") notice (or similar documentation) has been issued by the Receiver; and (4) a proof of claim process is established that includes a claims bar deadline for non-Providers while allowing for Provider claims to be adjudicated and determined generally in accordance with the Meritus Companies' procedures.

3. Coordination of Coverage for Meritus Mutual Benefits.

a. In accordance with the Service Agreement previously approved by this Court, the Receiver and the AZ Guaranty Fund shall coordinate with the Providers having claims against Meritus Mutual to confirm the appropriate claim amount using the applicable effective date. After confirmation of the claim amounts, EOB notices (or similar documentation) will be sent to the applicable insureds and Providers. Among other things, the EOB notices will identify for the insured the correct amounts of any deductibles and/or copays from the insured to the Provider, whether paid or unpaid.

b. Benefits shall be provided by the AZ Guaranty Fund, subject to and in accordance with provisions and limitations provided for in the Arizona Life and Disability Insurance Guaranty Fund Act, A.R.S. 20-681, *et seq.*

c. To the extent there are any disputes regarding the claim amounts and/or the EOB notices and related calculations (including consideration of offsets and/or other amounts due from the Provider to Meritus Mutual), this Court shall have the sole and exclusive jurisdiction to resolve such disputes.

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4. Adjudication of Claims Related to MHP Benefits.

a. Claims for benefits associated with MHP policies are not subject to coverage by the AZ Guaranty Fund. The Receiver shall coordinate with the Providers having claims against MHP initially to confirm the appropriate claim amount using the applicable effective date. After confirmation of the claim amounts, EOB notices (or similar documentation) will be sent to the applicable insureds and Providers. Among other things, the EOB notices will identify for the insured the correct amounts of any deductibles and/or copays from the insured to the Provider, whether paid or unpaid.

b. While the claims shall be adjudicated, the Receiver shall not make any payments of any claims to or for the benefit of MHP Providers without additional notice, hearing and order of this Court in order for the Court to take into account, among other things, the statutory priority system (A.R.S. § 20-629) .

c. To the extent there are any disputes regarding the claim amounts and/or the EOB notices and related calculations (including consideration of offsets and/or other amounts due from the Provider to MHP), this Court shall have the sole and exclusive jurisdiction to resolve such disputes.

5. Claims Bar Deadline and Proof of Claim Process.

a. Pursuant to A.R.S. §§ 20-640 and 20-628, the Court establishes May 15, 2017 as the proof of claims bar deadline.

b. The Receiver shall notify all persons who may have claims against Meritus Mutual and/or MHP (other than Providers as specified below) by publishing on the web site maintained for Meritus Mutual and MHP the Proof of Claims Notice and

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instructions in substantially the same form as was attached as Exhibit A to the Petition No. 7 – Petition for Order Approving Liquidation Plan ("Exhibit A to the Petition") and by sending a copy of the Proof of Claims Notice via regular mail using the books and records of Meritus Mutual and/or MHP for the most recent and complete mailing addresses of such person. The Receiver shall file proof of publication and mailing after it has provided notice of Exhibit A to the Petition in the manner provided for herein.

c. Any and all persons (other than Providers as specified below) with claims against Meritus Mutual and/or MHP shall file the Proof of Claim form of Exhibit A to the Petition on or before May 15, 2017 or such claims shall be forever barred to the extent each does not otherwise qualify as a late-filed claim under the Arizona Insurer Receivership Act.

d. In the Receiver's discretion:

i.the Receiver may notify one or more creditors of a proposed deemed claim amount based on the books and records of Meritus Mutual and/or MHP which the creditor may dispute by means of submission of a separate Proof of Claim Form; and

ii.the Receiver may seek an extension of the Proof of Claims Bar Date under the circumstances and subject to this Court approval.

e. Providers are not required to use the Proof of Claim Form to submit a claim. Instead, Providers with claims for health care services provided must submit the claims to Meritus Mutual and/or MHP in the usual manner used in the normal course of business for processing and adjudicating claims. In addition: (1) the Receiver will communicate to each Provider a Notice of Claim Amount determined in accordance with the Arizona Insurer Receivership Act; (2) if a Provider objects to the

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claim amount in the Notice, that Provider must file a written notice of objection with the Receiver within thirty (30) days after the date of the Notice; (3) the Receiver will file with the Court notice of the Provider's objection to the claim amount, along with the Receiver's recommendation; and (4) any such disputed claim will be resolved by this Court subject to and in accordance with the Arizona Insurer Receivership Act. Providers whose claims have already been submitted to Meritus Mutual and/or MHP do not need to submit a duplicate claims and should not do so.

6. Temporary Restraining Order - Balance Billing and Enrollee Collections.

a. The Court hereby finds that the practice whereby Providers with unpaid claims for services provided under insurance policies issued by Meritus Mutual and/or MHP (including the Provider's agents, affiliates, and/or any others acting on their behalf, including but not limited to collection agencies) seek to recover balances due directly from enrollees and/or insureds of Merits Mutual or MHP ("Balance Billing and Enrollee Collections") interferes with the Receivership and creates the potential for improper preferences, judgments, attachments and liens.

b. The Court hereby imposes a Temporary Restraining Order enjoining Balance Billing and Enrollee Collections and prohibiting Providers with unpaid claims for services provided under insurance policies issued by Meritus Mutual and/or MHP (including the Provider's agents, affiliates, and/or any others acting on their behalf, including but not limited to collection agencies) from seeking to recover balances due directly from enrollees and/or insureds of Merits Mutual or MHP.

c. The Temporary Restraining Order will remain in full force and effect unless and until an EOB notice (or similar documentation) is produced and issued by the Receiver as part of the claim process subject to and in accordance with this Liquidation Plan. Additionally, at any time, a Provider may petition this Court for relief from the Temporary Restraining Order before issuance of an EOB notice (or

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similar documentation) for good cause shown, taking into account, among other things, alleged hardship that would be suffered by the Provider as compared to the potential for interference with the Receiver, interference with the proceeding and the obtaining of preferences in violation of A.R.S. § 20-614, and potential hardship to the enrollees. Before filing such petition, the Provider must confer with the Receiver to determine whether or to what extent the Receiver opposes the requested relief.

ENTERED this 8th day of March, 2017.

The Honorable Daniel Martin
Maricopa County Superior Court Judge

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Phoenix, Arizona 85004-2595

Exhibit 3

PROOF OF CLAIM FORM
MERITUS MUTUAL – MERITUS HEALTH PARTNERS

Read the enclosed instruction sheet carefully before completing this form. Complete each section of the form and attach documentation. **All Proof of Claim Forms must be presented or postmarked to the Receiver at the specified address by the Claims Filing Deadline of 11:59 p.m. on May 15, 2017.**

Address for Submitting Claims: Meritus, In Receivership
Attention: Proof of Claims
Raintree Corporate Center I
15333 North Pima Road, Suite 305
Scottsdale, AZ 85260

PLEASE PRINT – ATTACH SUPPORTING INFORMATION AS NECESSARY

Section One – Claimant Contact Information

Claimant's Full Legal Name: U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services

Social Security or EIN Number: N/A

Date of Birth: N/A

Claimant's Mailing Address: 7500 Security Boulevard, Mail Stop WB 22-75
Windsor Mill MD 21244

Phone Number: 301-492-4304 Fax Number: _____

Email: jeffrey.grant1@cms.hhs.gov

Attorney Representation:
If Claimant is represented by an attorney, please complete the following:

[___] Claimant is represented by an attorney. Please direct all communication regarding this Proof Claim to Claimant's attorney using the following contact information:

Attorney's Name: Angela M. Belgrove

Attorney's Mailing Address: Office of the General Counsel, Region IX
90 7th Street, Suite 4-500
San Francisco, CA 94103-6705

Phone Number: (415) 437-8156 Fax Number: (415) 437-8188

Email: Angela.Belgrove@HHS.GOV

Section Two – Information Regarding Claim

1. Company. This claim is filed against: [check appropriate box(es) below]
   [__] Compass Cooperative Mutual Health Network, Inc., dba Meritus Mutual Health Partners
   [X] Compass Cooperative Health Plan, Inc. dba Meritus Health Partners

2. Claim Type and Amount. [check appropriate box(es) below and indicate amount]
   Type:
   a. [__] Policyholder, Insured or Member.
   b. [__] Agent, Vendor or other Creditor for goods or services provided.
   c. [__] Shareholders and/or Owners.
   d. [X] All other claims.

   Amount: $50,650,123.02

   Explanation of the Nature of the Claim:
   Government claim, entitled to priority under Federal Law and 507c.42(3)

   [Attach additional sheets for explanation as necessary.]

   Identify Attached Documentation, if any:
   Proof of Claim summary and accompanying exhibits

3. Security. If you are asserting a secured claim or otherwise asserting rights to any security, you must complete this section:
   [X] Yes. I am asserting a secured claim.
   If so and you hold or exercise any control over the cash, securities, trust funds, letters of credit or other assets of Meritus Mutual or Meritus Health Partners, you must explain the nature of your control and provide supporting documentation.
   This Claim is entitled to treatment as a secured claim to the extent it is subject to set-off by a claim of the Debtor against the United States. The United States is a unitary creditor for purposes of set-off and recoupment.

Section Three – Affirmation of Claimant

I affirm: (i) that I have read the foregoing Proof of Claim and understand the contents thereof; (ii) that this claim is justly due and owing; (iii) that I am entitled to file this claim; (iv) that the matters set forth above and in any accompanying statements and documents are true and correct to my own knowledge; and (v) that no payment of or on account of the aforesaid claim has been made, except as otherwise state in my claim.

Signature of person (or authorized agent) making claims: 

Printed Name: Jeffrey Grant

Title: (if applicable): Director, Payment Policy & Financial Management Group

Date Signed: May 10, 2017

The Centers for Medicare & Medicaid Services' Proof of Claim Summary: Compass Cooperative Healthplan, Inc., d/b/a Meritus Health Partners

***State of Arizona, ex rel. Leslie R. Hess, Interim Director of Insurance, v. Compass Cooperative Mutual Health Network, Inc. et al.*, Ariz. Superior Ct., County of Maricopa, Cause No. CV 2016 -011872.**

1. The United States of America, on behalf of the United States Department of Health and Human Services' ("HHS") Centers for Medicare & Medicaid Services ("CMS") and CMS's Center for Consumer Information and Insurance Oversight ("CCIIO"), files this Proof of Claim ("Claim") against Compass Cooperative Healthplan, Inc., d/b/a Meritus Health Partners, (the "Debtor") based on the following facts and circumstances.

2. Prior to the appointment of Arizona's Interim Director of Insurance as statutory receiver of the Debtor on August 16, 2016, the Debtor offered "health insurance coverage" to individuals in the Arizona individual and small group markets as a "health insurance issuer," as those terms are defined under the Patient Protection and Affordable Care Act ("PPACA" or "Act"), 42 U.S.C. § 18021(b)(2).

PPACA Cost-Sharing Reduction Reconciliation Obligations

3. The PPACA created subsidies to reduce the cost-sharing expenses of low- and middle-income individuals who purchase health insurance through a health insurance exchange ("Exchange"). *See generally* 42 U.S.C. § 18071. These subsidies are known as "cost-sharing reductions" or "CSRs."

4. At the direction of Congress, CMS and the United States Department of the Treasury ("Treasury") established a program to advance subsidy payments (including the CSR portion of advance payments) to issuers on behalf of eligible insureds. *See* 42 U.S.C. § 18082. Under this program, the Treasury advances payments of CSRs to issuers of qualified health

plans ("QHPs") based on estimates.[1] Issuers, in turn, are required to apply the advance payments to the cost-sharing obligations of their enrollees. 45 C.F.R. § 156.410(a).

5. Because the monthly advances of CSRs are based on estimates, they are subject to annual reconciliation after issuers calculate the actual amount of CSRs provided to eligible enrollees using methodologies specified by CMS. *See id.* § 156.430(c)-(d). If, upon reconciliation, CMS determines that the CSR portion of advance payments exceeded the actual amount of CSRs provided to enrollees, the issuer must reimburse CMS (on behalf of the Treasury) for the difference. *Id.* § 156.430(e). Conversely, if CMS determines that the CSR portion of advance payments fell short of the actual amount of CSRs provided to enrollees, CMS (on behalf of the Treasury) must reimburse the issuer for the difference. *Id.*

6. Between April and June, 2016, CMS reconciled the CSR portion of advance payments made to issuers of QHPs for the 2014 and 2015 benefit years.

7. As a result of reconciliation, CMS determined that the CSR portion of advance payments for 2014 and 2015 made to the Debtor exceeded the actual amount of CSRs provided to enrollees, and therefore, the Debtor owes a principal balance to CMS of $159,731.96 for 2014 and $3,647,812.47 for 2015. *See* Exhibit A (Initial Invoice) and Exhibit B (Intent to Refer Letter.) As of May 3, 2017, the Debtor also owes interest in the amount of $91,619.04 on both debts and an administrative fee of $15, resulting in a total of amount owed of $3,899,178.47. *Id.* CMS's right to collect such overpayments is governed by applicable federal law.[2]

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[1] In 2014, these estimates were calculated from Exchange data showing a plan's actuarial value and expected allowed claims costs. In 2015, Exchanges calculated the advance amount using multipliers particular to the plan variation and premium for each policy. *See* 45 C.F.R. §§ 155.340(a), 155.1030(b)(3), 156.430(b).

[2] The law applicable to CMS's debt collection activities generally includes, but is not limited to, 31 U.S.C. § 3711, *et seq.*; 45 C.F.R. § 156.1215; 42 C.F.R. Part 401, Subpart F; 31 C.F.R. Part 901; and applicable common law (collectively, "Federal Debt Collection Law").

PPACA Reinsurance Obligations

8. Pursuant to section 1341 of the PPACA, health insurance issuers and other contributing entities are required to make annual reinsurance contributions to the PPACA transitional reinsurance program for the 2014, 2015, and 2016 benefit years. *See* 42 U.S.C. § 18061. CMS collects these contributions and generally uses the funds to reimburse eligible insurance companies for a portion of high claims costs incurred during the applicable benefit years. *See* 45 C.F.R. § 153.230(a)-(c). For the 2015 benefit year, health insurance issuers and contributing entities were required to: (1) submit enrollment data by November 16, 2015; (2) make an initial bifurcated or single, combined reinsurance contribution payment by January 15, 2016; and (3) make a second bifurcated reinsurance contribution payment (if applicable) no later than November 15, 2016. *See* 45 C.F.R. § 153.405(b)-(c); *see also* Key Dates for Calendar Year 2016: QHP Certification in the Federally-facilitated Marketplaces; Rate-Review; Risk Adjustment and Reinsurance, at 3, *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2016-key-dates-table-2-29-16.pdf. To the extent issuers and other contributing entities do not pay their mandatory reinsurance contribution(s) at the proper time, the deficiency constitutes a determination of a debt. *See* 45 C.F.R. §§ 153.400(c) and 156.1215(c).

9. The Debtor submitted its enrollment count for the 2015 benefit year on November 11, 2015, and elected a bifurcated payment schedule for its contribution obligations (which resulted in total reinsurance contributions due for the 2015 benefit year of $2,043,901.20). On January 14, 2016, the Debtor made an initial bifurcated payment of $1,532,925.90 for the 2015 benefit year. *See* Exhibit C (ACA Transitional Reinsurance Annual Enrollment and Contributions Submissions Form – First Collection). The Debtor's second bifurcated payment

of $510,975.30 remains outstanding and was due no later than November 15, 2016. *See* Exhibit D (ACA Transitional Reinsurance Annual Enrollment and Contributions Submissions Form – Second Collection) and Exhibit E (and ACH Debit Retired Transaction Document). *See* 45 C.F.R. § 153.405(c)(2). CMS's right to collect such payment is governed by Federal Debt Collection Law.

PPACA Risk Adjustment Obligations

10. Section 1343 of the PPACA established a permanent risk adjustment program to mitigate the impact of adverse selection on and stabilize premiums for issuers of PPACA-compliant coverage in the individual and small group markets. *See* 42 U.S.C. § 18063.[3] Under the program, issuers of qualifying plans that enroll policyholders with disproportionately low actuarial risk are assessed a fee or "charge" by CMS, whereas issuers that enroll policyholders with disproportionately high actuarial risk receive a payment.

11. Issuers subject to the CMS-administered risk adjustment program are required to establish a dedicated Distributed Data Environment ("DDE") to ensure that CMS is provided access to risk adjustment data in a timely fashion. 45 C.F.R. § 153.700(a). The submission deadline for risk adjustment data for the 2015 benefit year was May 2, 2016. Issuers that fail to establish a DDE and/or provide access to the required data, such that CMS cannot apply the Federally certified risk adjustment methodology to calculate the issuer's risk adjustment transfer amount in a timely fashion, are assessed a default risk adjustment charge. *See* 45 C.F.R. § 153.740(b); *see also* FAQ #14472, *available at* https://www.regtap.info/faq_viewe.php?i=14472.

[3] Although the PPACA permits states to operate their own risk adjustment programs, Arizona elected not to do so. Therefore, CMS presently administers the program in Arizona. *See* 42 U.S.C. § 18041(c).

12. Issuers of risk adjustment-covered plans also must pay a user fee to CMS based on their qualifying business in states where CMS administers the program. *See* 45 C.F.R. § 153.610(f). The user fee is a product of the monthly enrollment in the risk adjustment covered plan and a per-enrollee-per-month rate specified by CMS annually in its regulations.

13. As of May 3, 2017, CMS has calculated risk adjustment obligations remaining for the 2015 benefit year, and the Debtor owes CMS $46,195,827.78 in risk adjustment charges (which includes $174,354.00 in interest as of May 3, 2017 and a $15 administrative fee). *See* Exhibits F and G (Initial Invoices) and Exhibits I and J (Intent to Refer Letters). The Debtor also owes $44,141.47 for 2015 benefit year risk adjustment user fees (*see* Exhibit H (Initial Invoice) and Exhibit K (Intent to Refer Letter)), which results in a total of amount owed of $46,239,969.25. CMS's right to collect such payment is governed by Federal Debt Collection Law.

Conclusion

14. As of May 3, 2017, the Debtor owes CMS a total of $50,650,123.02, which represents $3,899,178.47 for reconciliation of the cost-sharing reduction portion of advance payments, $510,975.30 under the PPACA Reinsurance Program, and $46,239,969.25 under the PPACA Risk Adjustment Program (which includes $46,195,827.78 in risk adjustment charges and $44,141.47 for risk adjustment user fees). We note that the amounts owed by the Debtor are based on the current amounts due for each of the above-referenced programs reduced for any amounts collected through payment of invoices and netting under 45 C.F.R. § 156.1215(b). *See* Exhibit L (Account Receivables Owed by Debtor as of May 3, 2017).[4]

[4] Exhibit L does not include the amounts owed under the PPACA transitional reinsurance program, as these amounts are due in light of the ACH debit retiring as described in paragraph 9 above and the accompanying exhibits.

15. This Claim reflects the known liability of the Debtor to this instrumentality of the United States. The United States reserves its right to amend and/or supplement this Proof of Claim as necessary to assert any subsequently discovered liabilities.

16. This Claim is entitled to treatment as a secured claim to the extent it is subject to set-off by a claim of the Debtor against the United States. The United States is a unitary creditor for purposes of set-off and recoupment.

17. The filing of this Claim is not: (a) a waiver or release of the United States' rights against any person, entity or property; (b) a waiver or release of any right or claim of the United States, of any nature whatsoever, under any applicable law; (c) an election of any remedy to the exclusion, express or implied, of any other remedy; (d) an admission that this Claim encompasses debts that are subject to discharge in this or any other proceeding; (e) a consent to, ratification of, or admission regarding any obligation or liability based upon or arising out of any transaction between the United States and the Debtor; (f) an admission that the Arizona court presiding over the liquidation proceeding has jurisdiction over the United States with respect to any matter identified in this Claim, or a waiver or release of any rights related thereto; or (g) a waiver or release of any right of the United States to a trial by jury in any proceeding as to any and all matters so triable. All such rights are hereby expressly reserved by the United States without exception and without purpose of confessing or conceding any right or claim by this filing, or by any other participation in this proceeding.

EXHIBIT A

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
7500 Security Boulevard, Mail Stop WB-22-75
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF FINANCIAL MANAGEMENT

Date: 12-AUG-2016

COMPASS COOPERATIVE HEALTH PLAN INC
ATTN:MERITUS HEALTH PARTNERS
2005 W. 14TH STREET, SUITE 113
TEMPE, AZ 85281

DUNNING LETTER- FIRST REQUEST

Re:	Program	:	Advance Payment of Cost-Sharing Reductions
	Entity ID	:	A194001
	Invoice Number	:	R1608A194001003
	Invoice Date	:	12-AUG-2016
	Invoice Amount	:	$3,807,544.43
	Payment Due Date	:	27-AUG-2016

Dear Sir/Madam,

This letter is to notify you that the Centers for Medicare & Medicaid Services (CMS) has determined that COMPASS COOPERATIVE HEALTH PLAN INC owes the amount of $3,807,544.43 for the program referenced above. This determination is based on the calculations found in the Final HIX 820 report for the month of August, 2016. The charge amount noted above may reflect adjustments pursuant to 45 CFR 156.1215 that were applied from payments that were due to or from COMPASS COOPERATIVE HEALTH PLAN INC for other ACA programs.

Payment Instructions

Payment must be submitted electronically. To submit payment, you must visit www.pay.gov then select and complete the CMS Health Insurance Marketplace and Premium Stabilization Programs Payment Form. To avoid offset of future payments you must pay this amount in full within 15 calendar days of the date of this letter. If the full amount is not paid within 15 calendar days, future payments will be offset until the full amount of the debt is collected, if applicable.

Interest, Administrative Fees and Penalties

If the full amount owed is not paid within 30 calendar days from the date of this letter, your debt will be considered delinquent as of the date of this letter. Should your debt become delinquent CMS will assess interest, administrative costs, and late payment penalties in accordance with the Department of Health and Human Services (HHS) claims collection regulation at 45 CFR Section 30.18. Any amounts not paid within 30 calendar days from the date of this letter will be assessed interest at the rate of 9.625 percent per year, starting from the date of delinquency, i.e., from the date of this letter. Administrative costs incurred for processing and handling amounts not paid by the due date will be assessed. In addition, a penalty charge of 6 percent per year will be assessed on any principal amounts delinquent for more than 90 days. These charges will continue to accrue until the debt is paid in full or otherwise resolved.

Referral to the U.S Department of the Treasury for Collection

If your debt remains unpaid 90 days from the date of this letter your debt will be referred to the United States Department of the Treasury's (the Treasury) Debt Management Services for Cross Servicing and Offset of Federal Payments. Your debt will be referred under 31 U.S.C. Section 3711(g). The Treasury will add additional administrative fees of up to 30 percent and accrue the required penalty charge of 6 percent per year on any amount outstanding. Interest will continue to accrue.

The Treasury's Debt Management Services will use various tools to collect the debt, including offset of federal payments, demand letters, phone calls, referral to a private collection agency, and referral to the U.S. Department of Justice for litigation.

Right to Inspect Records Prior to Referral to Treasury

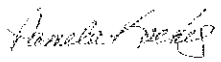
You have a right to present evidence that all or part of your debt is not past due or legally enforceable. In order to exercise your right to present evidence that all or part of your debt is not past due or legally enforceable, CMS must receive a copy of the evidence to support your position, along with a copy of this letter. You have the right to inspect and copy all records pertaining to your debt. In order to present evidence or review the HHS records, you must submit a written request to CCIIOInvoices@cms.hhs.gov. Your request must be received within 60 calendar days from the date of this letter. In response to a timely request for access to HHS records, you will be notified of the location and time when you can inspect and copy records related to this debt. Interest, administrative charges, and penalties will continue to accrue during any review period. Therefore, while review is pending, you will be liable for interest and related late payment charges on amounts not paid by the due date identified above.

Bankruptcy

If you have filed a petition for bankruptcy or you are involved in insolvency or liquidation proceedings in your state, please notify CMS at CCIIOInvoices@cms.hhs.gov. CMS financial obligations will be resolved in accordance with the applicable regulations and court process. Documentation supporting your status, along with a copy of this notice, must be submitted. When notifying us about the bankruptcy, insolvency or liquidation, please include the name the bankruptcy or other proceeding is filed under and the district or state court where it is filed and the docket number.

A debtor delinquent on a debt is ineligible for Government loans, loan guarantees, or loan insurance until the debtor resolves the debt. Knowingly making false statements or bringing frivolous actions may subject a debtor to civil or criminal penalties under 31 U.S.C. Section 3729-3731, 18 U.S.C. Section 286, Section 287, Section 1001 and Section 1002, or any other applicable statutory authority.

Sincerely,



Pamela Koenig
Director, Division of Financial Transfers & Operations
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services

EXHIBIT B

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
7500 Security Boulevard, Mail Stop WB-22-75
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF FINANCIAL MANAGEMENT

Date: 17-OCT-2016

COMPASS COOPERATIVE HEALTH PLAN INC
ATTN:MERITUS HEALTH PARTNERS
2005 W. 14TH STREET, SUITE 113
TEMPE, AZ 85281

DUNNING LETTER- FINAL REQUEST

Re:			
	Program	:	Advance Payment of Cost-Sharing Reductions
	Entity ID	:	A194001
	Invoice Number	:	R1608A194001003
	Invoice Date	:	12-AUG-2016
	Invoice Amount	:	$3,807,544.43
	Interest Charge	:	$61,079.36
	Administrative Fee	:	$15.00
	Total Amount Due	:	$3,868,638.79

Dear Sir/Madam,

Your debt owed to the Centers for Medicare and Medicaid Services (CMS) is delinquent and, by this letter, we are providing notice that your debt will be referred to the United States Department of the Treasury's (the Treasury) Debt Management Services for Cross Servicing and Offset of Federal Payments. Your debt will be referred under 31 U.S.C. Section 3711(g). The Treasury will add additional administrative fees of up to 30 percent and accrue the required penalty charge of 6 percent per year on any principal amounts delinquent for more than 90 days.

Interest and Administrative Fees

Simple interest at the rate of 9.625 percent is being assessed on the unpaid balance. Interest is assessed 30 calendar days from the date of the initial invoice for each 30-day period payment is delayed. In addition, an administrative fee of $15 has been added to the unpaid balance.

Referral to the U.S. Department of the Treasury for Collection

If the total amount due is not paid immediately your debt will be referred to the Treasury for collection. The Treasury will use various tools to collect the debt, including offset of federal payments, invoices, phone calls, referral to a private collection agency, and referral to the U.S. Department of Justice for litigation. The Treasury will add additional administrative fees of up to 30 percent and accrue the required penalty charge of 6 percent per year on any amount outstanding. Interest will continue to accrue.

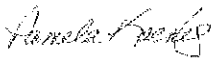
Payment Instructions

If you take immediate action and pay this debt in full, your debt will not be referred to the Treasury for collection. To submit payment, you must visit www.pay.gov then select and complete the CMS Health Insurance Marketplace and Premium Stabilization Programs Payment Form. If the full amount is not paid immediately, future payments will be offset pursuant to 45 CFR 156.1215(b) until the full amount of the debt is collected, if applicable.

Bankruptcy/Insolvency

If your organization has filed a petition for bankruptcy or if your organization is involved in insolvency or liquidation proceedings, please notify CMS at CCIIOInvoices@cms.hhs.gov. All financial obligations will be resolved in accordance with the applicable federal law. Documentation supporting your organization's status, along with a copy of this notice, must be submitted. When notifying us about the bankruptcy, insolvency or liquidation, please include the name the bankruptcy or other proceeding is filed under, the district or state court where it is filed and the docket number. A debtor delinquent on a debt is ineligible for Government loans, loan guarantees, or loan insurance until the debtor resolves the debt. Knowingly making false statements or bringing frivolous actions may subject a debtor to civil or criminal penalties under 31 U.S.C. Section 3729-3731, 18 U.S.C. Section 286, Section 287, Section 1001 and Section 1002, or any other applicable statutory authority.

Sincerely,



Pamela Koenig
Director, Division of Financial Transfers & Operations
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services

EXHIBIT C

ACA Transitional Reinsurance Program
Annual Enrollment and Contributions Submission Form

** Required Fields*

Current Date: 05/03/2017

* Legal Business Name (LBN): Compass Cooperative HP

* Federal Tax ID Number: 46-1509576

Billing Contact

* First Name: Tom * Last Name: Napolitano * Job Title: CFO

* Email Address: tnapolitano@meritusaz.com * Telephone: (602) 957-2113 Ext: 400

Billing Address

* Line 1: 2005 W, 14th Street, Suite 113 Line 2:

* City: Tempe * State: Arizona * Zip Code: 85281

Contact for Submission

* First Name: Kristen * Last Name: Hart * Job Title: Finance

* Email Address: khart@meritusaz.com * Telephone: (602) 957-2113 Ext:

* Are you reporting for more than three (3) Contributing Entities? ○ Yes ◉ No

* Are you both the Reporting Entity and Contributing Entity? ◉ Yes ○ No

ACA Transitional Reinsurance Program
Annual Enrollment and Contributions Submission Form

Contributing Entity 1:

* Legal Business Name (LBN): Compass Cooperative HP

* Federal Tax ID Number: 46-1509576 * Organization Type: Nonprofit

Billing Address

* Line 1: 2005 W, 14th Street, Suite 113 Line 2:

* City: Tempe * State: Arizona * Zip Code: 85281

* Domiciliary State: Arizona

* Benefit Year: 2015 * Annual Enrollment Count for the applicable benefit year: 46,452.30

* Indicate Type of Contributing Entity: Health Insurance Issuer

Other Type:

Contributing Entity 2:

* Legal Business Name (LBN):

* Federal Tax ID Number: * Organization Type:

Billing Address

* Line 1: Line 2:

* City: * State: * Zip Code:

* Domiciliary State:

* Benefit Year: 2015 * Annual Enrollment Count for the applicable benefit year:

* Indicate Type of Contributing Entity:

Other Type:

Contributing Entity 3:

* Legal Business Name (LBN):

* Federal Tax ID Number: * Organization Type:

Billing Address

* Line 1: Line 2:

* City: * State: * Zip Code:

* Domiciliary State:

* Benefit Year: 2015 * Annual Enrollment Count for the applicable benefit year:

* Indicate Type of Contributing Entity:

Other Type:

ACA Transitional Reinsurance Program
Annual Enrollment and Contributions Submission Form

* Type of Filing

(•) New ( ) Re-Filing ( ) Resubmission ( ) Invoice

* Type of Payment (All payment types must be filed and scheduled by November 15th of the Benefit Year)

- [x] First Collection - Contribution for Program Payments and Program Administration Funds (Regulatory Payment Due Date - January 15, 2016)
- [ ] Second Collection - Contribution for General Fund of the US Treasury (Regulatory Payment Due Date - November 15, 2016)
- [ ] Combined Collection - First Collection + Second Collection (as described above) (Regulatory Payment Due Date - January 15, 2016)

* Benefit Year for Reporting Gross Annual Enrollment Count	2015
Total Applicable Benefit Year Contribution Rate	44.00
* Annual Enrollment Count	46,452.30
* Verify Annual Enrollment Count	46,452.30
Contribution Rate for Program Payments and Program Administration Funds	33.00
Contribution Amount Due for Program Payments and Program Administration Funds	1,532,925.90
Contribution Rate for General Fund of the US Treasury	11.00
Contribution Amount Due for General Fund of the US Treasury	510,975.30
Total Contributions Due for the Applicable Benefit Year	2,043,901.20
Previous Pay.gov Tracking ID	
Invoice Number	
Verify Invoice Number	
Invoice Payment Amount	
Annual Enrollment Count	
Verify Annual Enrollment Count	

- [x] The Annual enrollment count entered in this Form is accurate and matches the aggregate enrollment count by entity in the Supporting Documentation, if applicable.

- [x] Acknowledgment: My acknowledgment is on behalf of my organization and the contributing entity or entities for which the data and accompanying payment(s) are being submitted. My acknowledgment legally and financially binds my organization and each contributing entity to the applicable laws, regulations and program instructions of the Affordable Care Act (ACA). By my submission, I certify that the data are true, correct and complete. If my organization or any contributing entity becomes aware that data are untrue, incorrect or incomplete, CMS shall be promptly informed. If CMS identifies a discrepancy or has questions about the data being submitted, I agree to be the contact for responding to such questions. I acknowledge that the provisions of the Affordable Care Act specifically make payments made by or in connection with an Exchange subject to the False Claims Act if those payments include any Federal funds. This includes, but is not limited to, the transitional reinsurance program established under Section 1341 of the Affordable Care Act.

Authorizing Official for Reporting Entity's Acknowledgment

* First Name: Tom * Last Name: Napolitano * Job Title: CFO

* Email Address: tnapolitano@MeritusAZ.com * Telephone: (602) 957-2113 Ext: 400

EXHIBIT D

ACA Transitional Reinsurance Program
Annual Enrollment and Contributions Submission Form

** Required Fields*

Current Date: 04/26/2017

* Legal Business Name (LBN): Compass Cooperative HP

* Federal Tax ID Number: 46-1509576

Billing Contact

* First Name: Tom * Last Name: Napolitano * Job Title: CFO

* Email Address: tnapolitano@meritusaz.com * Telephone: (602) 957-2113 Ext: 400

Billing Address

* Line 1: 2005 W, 14th Street, Suite 113 Line 2:

* City: Tempe * State: Arizona * Zip Code: 85281

Contact for Submission

* First Name: Kristen * Last Name: Hart * Job Title: Finance

* Email Address: khart@meritusaz.com * Telephone: (602) 957-2113 Ext:

* Are you reporting for more than three (3) Contributing Entities? ○ Yes ◉ No

* Are you both the Reporting Entity and Contributing Entity? ◉ Yes ○ No

ACA Transitional Reinsurance Program
Annual Enrollment and Contributions Submission Form

Contributing Entity 1:

* Legal Business Name (LBN): Compass Cooperative HP

* Federal Tax ID Number: 46-1509576 * Organization Type: Nonprofit

Billing Address

* Line 1: 2005 W, 14th Street, Suite 113 Line 2:

* City: Tempe * State: Arizona * Zip Code: 85281

* Domiciliary State: Arizona

* Benefit Year: 2015 * Annual Enrollment Count for the applicable benefit year: 46,452.30

* Indicate Type of Contributing Entity: Health Insurance Issuer

Other Type:

Contributing Entity 2:

* Legal Business Name (LBN):

* Federal Tax ID Number: * Organization Type:

Billing Address

* Line 1: Line 2:

* City: * State: * Zip Code:

* Domiciliary State:

* Benefit Year: 2015 * Annual Enrollment Count for the applicable benefit year:

* Indicate Type of Contributing Entity:

Other Type:

Contributing Entity 3:

* Legal Business Name (LBN):

* Federal Tax ID Number: * Organization Type:

Billing Address

* Line 1: Line 2:

* City: * State: * Zip Code:

* Domiciliary State:

* Benefit Year: 2015 * Annual Enrollment Count for the applicable benefit year:

* Indicate Type of Contributing Entity:

Other Type:

ACA Transitional Reinsurance Program
Annual Enrollment and Contributions Submission Form

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

* Type of Filing

(•) New ( ) Re-Filing ( ) Resubmission ( ) Invoice

* Type of Payment (All payment types must be filed and scheduled by November 15th of the Benefit Year)

- [ ] First Collection - Contribution for Program Payments and Program Administration Funds
  (Regulatory Payment Due Date - January 15, 2016)
- [x] Second Collection - Contribution for General Fund of the US Treasury
  (Regulatory Payment Due Date - November 15, 2016)
- [ ] Combined Collection - First Collection + Second Collection (as described above)
  (Regulatory Payment Due Date - January 15, 2016)

* Benefit Year for Reporting Gross Annual Enrollment Count	2015
Total Applicable Benefit Year Contribution Rate	44.00
* Annual Enrollment Count	46,452.30
* Verify Annual Enrollment Count	46,452.30
Contribution Rate for Program Payments and Program Administration Funds	33.00
Contribution Amount Due for Program Payments and Program Administration Funds	1,532,925.90
Contribution Rate for General Fund of the US Treasury	11.00
Contribution Amount Due for General Fund of the US Treasury	510,975.30
Total Contributions Due for the Applicable Benefit Year	2,043,901.20
Previous Pay.gov Tracking ID	
Invoice Number	
Verify Invoice Number	
Invoice Payment Amount	
Annual Enrollment Count	
Verify Annual Enrollment Count	

- [x] The Annual enrollment count entered in this Form is accurate and matches the aggregate enrollment count by entity in the Supporting Documentation, if applicable.

- [x] Acknowledgment: My acknowledgment is on behalf of my organization and the contributing entity or entities for which the data and accompanying payment(s) are being submitted. My acknowledgment legally and financially binds my organization and each contributing entity to the applicable laws, regulations and program instructions of the Affordable Care Act (ACA). By my submission, I certify that the data are true, correct and complete. If my organization or any contributing entity becomes aware that data are untrue, incorrect or incomplete, CMS shall be promptly informed. If CMS identifies a discrepancy or has questions about the data being submitted, I agree to be the contact for responding to such questions. I acknowledge that the provisions of the Affordable Care Act specifically make payments made by or in connection with an Exchange subject to the False Claims Act if those payments include any Federal funds. This includes, but is not limited to, the transitional reinsurance program established under Section 1341 of the Affordable Care Act.

Authorizing Official for Reporting Entity's Acknowledgment

* First Name: Tom * Last Name: Napolitano * Job Title: CFO

* Email Address: tnapolitano@MeritusAZ.com * Telephone: (602) 957-2113 Ext: 400

EXHIBIT E

ACH Debit Transaction Detail

Report Generated on 04/26/2017 03:57 PM ET

Agency: HHSCMS Application: Transitional Reinsurance Contributions

Transaction Information

Label	Value	Label	Value
Pay.gov Tracking ID:	25OBL6HT	Collection Status:	Retired
Agency Tracking ID:	74905831905	Effective Date:	11/15/2016 12:00 AM ET
Account Holder Name:	Compass Cooperative Health Plan	Deposit Ticket:	010161
Transaction Date:	11/11/2015 06:15 PM ET	Debit Voucher:	010216
Transaction Amount:	$510,975.30	Return Reason Code:	29 - CORPORATE CUSTOMER ADVISES NOT AUTHORIZED
Frequency:	OneTime	ACH Type:	
Payment:	1 of 1	Username:	MeritusHealth
Email Address:	khart@meritusaz.com		
Account Type:	BusinessChecking		
Bank Account:	**********8721		
Routing Number:	121137522		
Street Address:			
City:			
Country:			
State/Province:			
Zip/Postal Code:			
Tax Identification Number:			
Date of Birth:			

Classification Data

Label	SP	ATA	AID	BPOA	EPOA	A	MAIN	SUB	Credit BETC	Debit BETC	Amount
Reinsurance Contribution			075			X	5735	001	COLL	COLLAJ	$510,975.30

EXHIBIT F

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
7500 Security Boulevard, Mail Stop WB-22-75
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF FINANCIAL MANAGEMENT

Date: 12-AUG-2016

COMPASS COOPERATIVE HEALTH PLAN INC
ATTN:MERITUS HEALTH PARTNERS
2005 W. 14TH STREET, SUITE 113
TEMPE, AZ 85281

DUNNING LETTER- FIRST REQUEST

Re:	Program	:	Risk Adjustment Program
	Entity ID	:	A194001
	Invoice Number	:	L15AZ160860761003
	Invoice Date	:	12-AUG-2016
	Invoice Amount	:	$788,993.84
	Payment Due Date	:	11-SEP-2016

Dear Sir/Madam,

This letter is to notify you that the Centers for Medicare & Medicaid Services (CMS) has determined that COMPASS COOPERATIVE HEALTH PLAN INC owes the amount of $788,993.84 for the program referenced above. Section 1343 of the Affordable Care Act and implementing regulations, specifically 45 CFR 153.610(d), requires an entity with lower than average actuarial risk to make risk adjustment payments or, under 45 CFR 153.740(b), to pay a default risk adjustment charge.

This determination is based on the calculated payments and charges stemming from data submitted to your EDGE server for the ACA HHS-operated Risk Adjustment Program for the applicable benefit year, or your failure to submit such data as required. The amount noted above as owed for risk adjustment may reflect further adjustments pursuant to 45 CFR 156.1215 that were applied from payments that were due to or from COMPASS COOPERATIVE HEALTH PLAN INC for other ACA programs.

Payment Instructions

Payment must be submitted electronically. To submit payment, you must visit www.pay.gov and then select and complete the CMS Health Insurance Marketplace and Premium Stabilization Programs Payment Form. To avoid offset of future payments you must pay this amount in full within 30 calendar days of the date of this letter. If the full amount is not paid within 30 calendar days, future payments will be offset until the full amount of the debt is collected, if applicable.

Interest, Administrative Fees and Penalties

If the full amount owed is not paid within 30 calendar days from the date of this letter, your debt will be considered delinquent as of the date of this letter. Should your debt become delinquent CMS will assess interest, administrative costs, and late payment penalties in accordance with the Department of Health and Human Services (HHS) claims collection regulation at 45 CFR Section 30.18. Any amounts not paid within 30 calendar days from the date of this letter will be assessed interest at the rate of 9.625 percent per year, starting from the date of delinquency, i.e., from the date of this letter. Administrative costs incurred for processing and handling amounts not paid by the due date will be assessed. In addition, a penalty charge of 6 percent per year will be assessed on any principal amounts delinquent for more than 90 days. These charges will continue to accrue until the debt is paid in full or otherwise resolved.

Referral to the U.S Department of the Treasury for Collection

If your debt remains unpaid 90 days from the date of this letter your debt will be referred to the United States Department of the Treasury's (the Treasury) Debt Management Services for Cross Servicing and Offset of Federal Payments. Your debt will be referred under 31 U.S.C. Section 3711(g). The Treasury will add additional administrative fees of up to 30 percent and accrue the required penalty charge of 6 percent per year on any amount outstanding. Interest will continue to accrue.

The Treasury's Debt Management Services will use various tools to collect the debt, including offset of federal payments, demand letters, phone calls, referral to a private collection agency, and referral to the U.S. Department of Justice for litigation.

Right to Inspect Records Prior to Referral to Treasury

You have a right to present evidence that all or part of your debt is not past due or legally enforceable. In order to exercise your right to present evidence that all or part of your debt is not past due or legally enforceable, CMS must receive a copy of the evidence to support your position, along with a copy of this letter. You have the right to inspect and copy all records pertaining to your debt. In order to present evidence or review the HHS records, you must submit a written request to CCIIOInvoices@cms.hhs.gov. Your request must be received within 60 calendar days from the date of this letter. In response to a timely request for access to HHS records, you will be notified of the location and time when you can inspect and copy records related to this debt. Interest, administrative charges, and penalties will continue to accrue during any review period. Therefore, while review is pending, you will be liable for interest and related late payment charges on amounts not paid by the due date identified above.

Bankruptcy

If you have filed a petition for bankruptcy or you are involved in insolvency proceedings in your state, please notify CMS at CCIIOInvoices@cms.hhs.gov. CMS financial obligations will be resolved in accordance with the applicable bankruptcy process. Documentation supporting your bankruptcy status, along with a copy of this notice, must be submitted. When notifying us about the bankruptcy, please include the name the bankruptcy is filed under and the district where the bankruptcy is filed and the docket number.

A debtor delinquent on a debt is ineligible for Government loans, loan guarantees, or loan insurance until the debtor resolves the debt. Knowingly making false statements or bringing frivolous actions may subject a debtor to civil or criminal penalties under 31 U.S.C. Section 3729-3731, 18 U.S.C. Section 286, Section 287, Section 1001 and Section 1002, or any other applicable statutory authority.

Sincerely,

Pamela Koenig
Director, Division of Financial Transfers & Operations
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services

EXHIBIT G

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
7500 Security Boulevard, Mail Stop WB-22-75
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF FINANCIAL MANAGEMENT

Date: 12-AUG-2016

COMPASS COOPERATIVE HEALTH PLAN INC
ATTN:MERITUS HEALTH PARTNERS
2005 W. 14TH STREET, SUITE 113
TEMPE, AZ 85281

DUNNING LETTER- FIRST REQUEST

Re:	Program	:	Risk Adjustment Program
	Entity ID	:	A194001
	Invoice Number	:	I15AZ160860761003
	Invoice Date	:	12-AUG-2016
	Invoice Amount	:	$45,232,464.94
	Payment Due Date	:	11-SEP-2016

Dear Sir/Madam,

This letter is to notify you that the Centers for Medicare & Medicaid Services (CMS) has determined that COMPASS COOPERATIVE HEALTH PLAN INC owes the amount of $45,232,464.94 for the program referenced above. Section 1343 of the Affordable Care Act and implementing regulations, specifically 45 CFR 153.610(d), requires an entity with lower than average actuarial risk to make risk adjustment payments or, under 45 CFR 153.740(b), to pay a default risk adjustment charge.

This determination is based on the calculated payments and charges stemming from data submitted to your EDGE server for the ACA HHS-operated Risk Adjustment Program for the applicable benefit year, or your failure to submit such data as required. The amount noted above as owed for risk adjustment may reflect further adjustments pursuant to 45 CFR 156.1215 that were applied from payments that were due to or from COMPASS COOPERATIVE HEALTH PLAN INC for other ACA programs.

Payment Instructions

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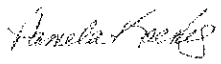
Bankruptcy

If you have filed a petition for bankruptcy or you are involved in insolvency proceedings in your state, please notify CMS at CCIIOInvoices@cms.hhs.gov. CMS financial obligations will be resolved in accordance with the applicable bankruptcy process. Documentation supporting your bankruptcy status, along with a copy of this notice, must be submitted. When notifying us about the bankruptcy, please include the name the bankruptcy is filed under and the district where the bankruptcy is filed and the docket number.

A debtor delinquent on a debt is ineligible for Government loans, loan guarantees, or loan insurance until the debtor resolves the debt. Knowingly making false statements or bringing frivolous actions may subject a debtor to civil or criminal penalties under 31 U.S.C. Section 3729-3731, 18 U.S.C. Section 286, Section 287, Section 1001 and Section 1002, or any other applicable statutory authority.

Sincerely,



Pamela Koenig
Director, Division of Financial Transfers & Operations
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services

EXHIBIT H

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
7500 Security Boulevard, Mail Stop WB-22-75
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF FINANCIAL MANAGEMENT

Date: 12-AUG-2016

COMPASS COOPERATIVE HEALTH PLAN INC
ATTN:MERITUS HEALTH PARTNERS
2005 W. 14TH STREET, SUITE 113
TEMPE, AZ 85281

DUNNING LETTER- FIRST REQUEST

Re:	Program	:	User Fees for the Risk Adjustment Program
	Entity ID	:	A194001
	Invoice Number	:	D1608A194001003
	Invoice Date	:	12-AUG-2016
	Invoice Amount	:	$43,089.64
	Payment Due Date	:	27-AUG-2016

Dear Sir/Madam,

This letter is to notify you that the Centers for Medicare & Medicaid Services (CMS) has determined that COMPASS COOPERATIVE HEALTH PLAN INC owes the amount of $43,089.64 for the program referenced above. Section 1343 of the Affordable Care Act and implementing regulations, specifically 45 CFR 153.610(d), requires an entity with lower than average actuarial risk to make risk adjustment payments or, under 45 CFR 153.740(b), to pay a default risk adjustment charge.

This determination is based on the calculated payments and charges stemming from data submitted to your EDGE server for the ACA HHS-operated Risk Adjustment Program for the applicable benefit year, or your failure to submit such data as required. The amount noted above as owed for risk adjustment may reflect further adjustments pursuant to 45 CFR 156.1215 that were applied from payments that were due to or from COMPASS COOPERATIVE HEALTH PLAN INC for other ACA programs.

Payment Instructions

Payment must be submitted electronically. To submit payment, you must visit www.pay.gov then select and complete the CMS Health Insurance Marketplace and Premium Stabilization Programs Payment Form. To avoid offset of future payments you must pay this amount in full within 15 calendar days of the date of this letter. If the full amount is not paid within 15 calendar days, future payments will be offset until the full amount of the debt is collected, if applicable.

Interest, Administrative Fees and Penalties

If the full amount owed is not paid within 30 calendar days from the date of this letter, your debt will be considered delinquent as of the date of this letter. Should your debt become delinquent CMS will assess interest, administrative costs, and late payment penalties in accordance with the Department of Health and Human Services (HHS) claims collection regulation at 45 CFR §30.18. Any amounts not paid within 30 calendar days from the date of this letter will be assessed interest at the rate of 9.625 percent per year, starting from the date of delinquency, i.e., from the date of this letter. Administrative costs incurred for processing and handling amounts not paid by the due date will be assessed. In addition, a penalty charge of 6% per year will be assessed on any principal amounts delinquent for more than 90 days. These charges will continue to accrue until the debt is paid in full or otherwise resolved.

Referral to the U.S Department of the Treasury for Collection

If your debt remains unpaid 90 days from the date of this letter your debt will be referred to the United States Department of the Treasury's (the Treasury) Debt Management Services for Cross Servicing and Offset of Federal Payments. Your debt will be referred under 31 U.S.C. § 3711(g). The Treasury will add additional administrative fees of up to 30 percent and accrue the required penalty charge of 6% per year on any amount outstanding. Interest will continue to accrue.
The Treasury's Debt Management Services will use various tools to collect the debt, including offset of federal payments, demand letters, phone calls, referral to a private collection agency, and referral to the U.S. Department of Justice for litigation.

Right to Inspect Records Prior to Referral to Treasury

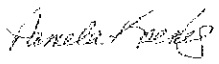
You have a right to present evidence that all or part of your debt is not past due or legally enforceable. In order to exercise your right to present evidence that all or part of your debt is not past due or legally enforceable, CMS must receive a copy of the evidence to support your position, along with a copy of this letter. You have the right to inspect and copy all records pertaining to your debt. In order to present evidence or review the HHS records, you must submit a written request to CCIIOInvoices@cms.hhs.gov. Your request must be received within 60 calendar days from the date of this letter. In response to a timely request for access to HHS records, you will be notified of the location and time when you can inspect and copy records related to this debt. Interest, administrative charges, and penalties will continue to accrue during any review period. Therefore, while review is pending, you will be liable for interest and related late payment charges on amounts not paid by the due date identified above.

Bankruptcy

If you have filed a petition for bankruptcy or you are involved in insolvency or liquidation proceedings in your state, please notify CMS at CCIIOInvoices@cms.hhs.gov. CMS financial obligations will be resolved in accordance with the applicable regulations and court process. Documentation supporting your status, along with a copy of this notice, must be submitted. When notifying us about the bankruptcy, insolvency or liquidation, please include the name the bankruptcy or other proceeding is filed under and the district or state court where it is filed and the docket number.

A debtor delinquent on a debt is ineligible for Government loans, loan guarantees, or loan insurance until the debtor resolves the debt. Knowingly making false statements or bringing frivolous actions may subject a debtor to civil or criminal penalties under 31 U.S.C. Section 3729-3731, 18 U.S.C. Section 286, Section 287, Section 1001 and Section 1002, or any other applicable statutory authority.

Sincerely,



Pamela Koenig
Director, Division of Financial Transfers & Operations
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services

EXHIBIT I

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
7500 Security Boulevard, Mail Stop WB-22-75
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF FINANCIAL MANAGEMENT

Date: 17-OCT-2016

COMPASS COOPERATIVE HEALTH PLAN INC
ATTN:MERITUS HEALTH PARTNERS
2005 W. 14TH STREET, SUITE 113
TEMPE, AZ 85281

DUNNING LETTER- FINAL REQUEST

Re:			
	Program	:	Risk Adjustment Program
	Entity ID	:	A194001
	Invoice Number	:	L15AZ160860761003
	Invoice Date	:	12-AUG-2016
	Invoice Amount	:	$788,993.84
	Interest Charge	:	$12,656.78
	Administrative Fee	:	$15.00
	Total Amount Due	:	$801,665.62

Dear Sir/Madam,

Your debt owed to the Centers for Medicare & Medicaid Services (CMS) is delinquent and, by this letter, we are providing notice that your debt will be referred to the United States Department of the Treasury's (the Treasury) Debt Management Services for Cross Servicing and Offset of Federal Payments. Your debt will be referred under 31 U.S.C. §3711(g). The Treasury will add additional administrative fees of up to 30 percent and accrue the required penalty charge of 6 percent per year on any principal amounts delinquent for more than 90 days.

Interest and Administrative Fees

Simple interest at the rate of 9.625 percent is being assessed on the unpaid balance. Interest is assessed 30 calendar days from the date of the initial invoice for each 30-day period payment is delayed. In addition, an administrative fee of $15 has been added to the unpaid balance.

Referral to the U.S. Department of the Treasury for Collection

If the total amount due is not paid immediately your debt will be referred to the Treasury for collection. The Treasury will use various tools to collect the debt, including offset of federal payments, invoices, phone calls, referral to a private collection agency, and referral to the U.S. Department of Justice for litigation. The Treasury will add additional administrative fees of up to 30 percent and accrue the required penalty charge of 6 percent per year on any amount outstanding. Interest will continue to accrue.

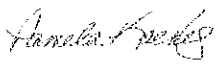
Payment Instructions

If you take immediate action and pay this debt in full, your debt will not be referred to the Treasury for collection. To submit the payment, you must visit www.pay.gov and then select and complete the CMS Health Insurance Marketplace and Premium Stabilization Programs Payment Form. If the full amount is not paid immediately, future payments will be offset pursuant to 45 CFR 156.1215(b) until the full amount of the debt is collected, if applicable.

Bankruptcy/Insolvency

If your organization has filed a petition for bankruptcy or if your organization is involved in insolvency or liquidation proceedings, please notify CMS at CCIIOInvoices@cms.hhs.gov. All financial obligations will be resolved in accordance with the applicable federal law. Documentation supporting your organization's status, along with a copy of this notice, must be submitted. When notifying us about the bankruptcy, insolvency or liquidation, please include the name the bankruptcy or other proceeding is filed under, the district or state court where it is filed and the docket number. A debtor delinquent on a debt is ineligible for Government loans, loan guarantees, or loan insurance until the debtor resolves the debt. Knowingly making false statements or bringing frivolous actions may subject a debtor to civil or criminal penalties under 31 U.S.C. Section 3729-3731, 18 U.S.C. Section 286, Section 287, Section 1001 and Section 1002, or any other applicable statutory authority.

Sincerely,



Pamela Koenig
Director, Division of Financial Transfers & Operations
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services

EXHIBIT J

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
7500 Security Boulevard, Mail Stop WB-22-75
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF FINANCIAL MANAGEMENT

Date: 17-OCT-2016

COMPASS COOPERATIVE HEALTH PLAN INC
ATTN:MERITUS HEALTH PARTNERS
2005 W. 14TH STREET, SUITE 113
TEMPE, AZ 85281

DUNNING LETTER- FINAL REQUEST

Re:			
	Program	:	Risk Adjustment Program
	Entity ID	:	A194001
	Invoice Number	:	I15AZ160860761003
	Invoice Date	:	12-AUG-2016
	Invoice Amount	:	$45,232,464.94
	Interest Charge	:	$718,245.94
	Administrative Fee	:	$0.00
	Total Amount Due	:	$45,950,710.88

Dear Sir/Madam,

Your debt owed to the Centers for Medicare & Medicaid Services (CMS) is delinquent and, by this letter, we are providing notice that your debt will be referred to the United States Department of the Treasury's (the Treasury) Debt Management Services for Cross Servicing and Offset of Federal Payments. Your debt will be referred under 31 U.S.C. §3711(g). The Treasury will add additional administrative fees of up to 30 percent and accrue the required penalty charge of 6 percent per year on any principal amounts delinquent for more than 90 days.

Interest and Administrative Fees

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Referral to the U.S. Department of the Treasury for Collection

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Sincerely,

Pamela Koenig
Director, Division of Financial Transfers & Operations
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services

Ambercity Hospice Inc.
3590 Central Ave, Suite 207
Riverside, CA, 92506

Attention: Dekki Mawikere

Sender Name: Elizabeth Mgbam
Sender Phone Number: (650) 316-2720

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EXHIBIT K

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
7500 Security Boulevard, Mail Stop WB-22-75
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF FINANCIAL MANAGEMENT

Date: 17-OCT-2016

COMPASS COOPERATIVE HEALTH PLAN INC
ATTN:MERITUS HEALTH PARTNERS
2005 W. 14TH STREET, SUITE 113
TEMPE, AZ 85281

DUNNING LETTER- FINAL REQUEST

Re:			
	Program	:	User Fees for the Risk Adjustment Program
	Entity ID	:	A194001
	Invoice Number	:	D1608A194001003
	Invoice Date	:	12-AUG-2016
	Invoice Amount	:	$43,089.64
	Interest Charge	:	$691.22
	Administrative Fee	:	$15.00
	Total Amount Due	:	$43,795.86

Dear Sir/Madam,

Your debt owed to the Centers for Medicare & Medicaid Services (CMS) is delinquent and, by this letter, we are providing notice that your debt will be referred to the United States Department of the Treasury's (the Treasury) Debt Management Services for Cross Servicing and Offset of Federal Payments. Your debt will be referred under 31 U.S.C. §3711(g). The Treasury will add additional administrative fees of up to 30 percent and accrue the required penalty charge of 6 percent per year on any principal amounts delinquent for more than 90 days.

Interest and Administrative Fees

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Bankruptcy/Insolvency

If your organization has filed a petition for bankruptcy or if your organization is involved in insolvency or liquidation proceedings, please notify CMS at CCIIOInvoices@cms.hhs.gov. All financial obligations will be resolved in accordance with the applicable federal law. Documentation supporting your organization's status, along with a copy of this notice, must be submitted. When notifying us about the bankruptcy, insolvency or liquidation, please include the name the bankruptcy or other proceeding is filed under, the district or state court where it is filed and the docket number. A debtor delinquent on a debt is ineligible for Government loans, loan guarantees, or loan insurance until the debtor resolves the debt. Knowingly making false statements or bringing frivolous actions may subject a debtor to civil or criminal penalties under 31 U.S.C. Section 3729-3731, 18 U.S.C. Section 286, Section 287, Section 1001 and Section 1002, or any other applicable statutory authority.

Sincerely,

Pamela Koenig
Director, Division of Financial Transfers & Operations
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services

EXHIBIT L

Compass Cooperative Healthplan, Inc., d/b/a Meritus Health Partners, 60761/A194001

AR's

Total	Transaction Type	Customer Number	Customer Name	Transaction Number	First Dunning Letter Date	Remaining Amount	Intent to Refer Letter Date
	CSR-RECV	FEPS1-A194001	COMPASS COOPERATIVE HEALTH PLAN INC	R1608A194001003	12-Aug-16	3,807,544.43	17-Oct-16
	CSR-RECV	FEPS1-A194001	COMPASS COOPERATIVE HEALTH PLAN INC	R1608A194001003ADM		15	
	CSR-RECV	FEPS1-A194001	COMPASS COOPERATIVE HEALTH PLAN INC	R1608A194001003INT		91,619.04	
Total	**CSR-RECV**	**FEPS1-A194001**	**COMPASS COOPERATIVE HEALTH PLAN INC**			**3,899,178.47**	
	RA-COLL-RECV	FEPS1-A194001	COMPASS COOPERATIVE HEALTH PLAN INC	I15AZ160860761003	12-Aug-16	45,232,464.94	17-Oct-16
	RA-COLL-RECV	FEPS1-A194001	COMPASS COOPERATIVE HEALTH PLAN INC	I15AZ160860761003INT		155,368.83	
	RA-COLL-RECV	FEPS1-A194001	COMPASS COOPERATIVE HEALTH PLAN INC	L15AZ160860761003	12-Aug-16	788,993.84	17-Oct-16
	RA-COLL-RECV	FEPS1-A194001	COMPASS COOPERATIVE HEALTH PLAN INC	L15AZ160860761003ADM		15	
	RA-COLL-RECV	FEPS1-A194001	COMPASS COOPERATIVE HEALTH PLAN INC	L15AZ160860761003INT		18,985.17	
Total	**RA-COLL-RECV**	**FEPS1-A194001**	**COMPASS COOPERATIVE HEALTH PLAN INC**			**46,195,827.78**	
	RA-USERFEE-RECV	FEPS1-A194001	COMPASS COOPERATIVE HEALTH PLAN INC	D1608A194001003	12-Aug-16	43,089.64	17-Oct-16
	RA-USERFEE-RECV	FEPS1-A194001	COMPASS COOPERATIVE HEALTH PLAN INC	D1608A194001003ADM		15	
	RA-USERFEE-RECV	FEPS1-A194001	COMPASS COOPERATIVE HEALTH PLAN INC	D1608A194001003INT		1,036.83	
Total	**RA-USERFEE-RECV**	**FEPS1-A194001**	**COMPASS COOPERATIVE HEALTH PLAN INC**			**44,141.47**	

Exhibit 4

PROOF OF CLAIM FORM

MERITUS MUTUAL – MERITUS HEALTH PARTNERS

Read the enclosed instruction sheet carefully before completing this form. Complete each section of the form and attach documentation. **All Proof of Claim Forms must be presented or postmarked to the Receiver at the specified address by the Claims Filing Deadline of 11:59 p.m. on May 15, 2017.**

Address for Submitting Claims: Meritus, In Receivership
Attention: Proof of Claims
Raintree Corporate Center I
15333 North Pima Road, Suite 305
Scottsdale, AZ 85260

PLEASE PRINT – ATTACH SUPPORTING INFORMATION AS NECESSARY

SECTION ONE – Claimant Contact Information

Claimant Name & Address		
Full Legal Name: U.S. Dept. of Health and Human Services, CMS		
Social Security or EIN Number:		
Meritus Member ID #:		Date of Birth:
Mailing Address: 7500 Security Blvd., WB-22-75		
City: Baltimore	State: MD	Zip: 21244
Phone: 410-786-9655	Fax:	Email: Leslie.Stafford@hhs.gov
Attorney Representation: If Claimant is represented by an attorney, please direct all communication regarding this Proof of Claim to Claimant's attorney using the following contact information:		
Attorney's Name: Marc S. Sacks, Trial Attorney, Civil Division		
Attorney's Mailing Address: U.S. Dept. of Justice, 1100 L. St. NW, Rm. 10058		
City: Washington, D.C.	State:	Zip: 20005
Phone: 202-307-1104	Fax:	Email: Marcus.S.Sacks@usdoj.gov

SECTION TWO – Information Regarding Claim

Company: This claim is filed against: [check appropriate box(es) below]

[ ] Compass Cooperative Health Plan, Inc. dba Meritus Health Partners (HMO)

[X] Compass Cooperative Mutual Health Network, Inc., dba Meritus Mutual Health Partners (PPO)

Claim Type and Amount: [check appropriate box(es) below and indicate amount]

[ ] Policyholder, Insured or Member

[ ] Shareholders/Owners

[ ] Agent, Vendor or other Creditor for goods or services provided

[X] All other Claims

Amount of Claim: $ 94,581,998.78 plus amounts to be determined

10

Explanation of the Nature of the Claim
Attach additional sheets for explanation as necessary. Identify Attached Documentation, if any:

See Proof of Claim summary and Exhibits.

Security
If you are asserting a secured claim or otherwise asserting rights to any security, you must complete this section:

[__] Yes. I am asserting a secured claim.

If so and you hold or exercise any control over the cash, securities, trust funds, letters of credit or other assets of Meritus Mutual or Meritus Health Partners, you must explain the nature of your control and provide supporting documentation.

_____

_____

SECTION THREE – Affirmation of Claimant

I affirm: (i) that I have read the foregoing Proof of Claim and understand the contents thereof; (ii) that this claim is justly due and owing; (iii) that I am entitled to file this claim; (iv) that the matters set forth above and in any accompanying statements and documents are true and correct to my own knowledge; and (v) that no payment of or on account of the aforesaid claim has been made, except as otherwise stated in my claim.

Signature of person (or authorized agent) making claims

Signature: _____

Printed Name: Matthew Lynch

Title: (if applicable): Director, Insurance Program Group
Center for Consumer Information and Insurance Oversight

Date Signed: 5/9/17

For Internal Office Use Only: POC # _____ Claim Type: _____ Postmarked Date: _____

Attachment to Proof of Claim of the Centers for Medicare & Medicaid Services

Nature of Claim: Recovery of amounts owed to the United States of America and/or any federal agency or entity (collectively, the "United States").

Set-offs: The United States reserves the right to amend these claims to assert subsequently discovered liabilities. The United States may hold estimated debts owed to the Estate that are subject to set-off and/or recoupment rights. The United States hereby expressly reserves its right to set-off or recoup any claim against debts owed to the Estate by the United States.

Security for Claim: These claims are entitled to treatment as secured claims to the extent they are subject to set-off by a claim of the Estate against the United States. The United States is a unitary creditor for purposes of set-off and recoupment.

The Centers for Medicare & Medicaid Services' Proof of Claim Summary
Compass Cooperative Mutual Health Network, Inc., d/b/a Meritus Mutual Health Partners

Superior Court of Arizona, County of Maricopa, CV2016-011872,
State of Arizona, ex rel. Leslie R. Hess, Interim Director of Insurance v. Compass Cooperative Mutual Health Network, Inc., d/b/a Meritus Mutual Health Partners

1. The United States of America, on behalf of the United States Department of Health and Human Services' ("HHS") Centers for Medicare & Medicaid Services ("CMS") and CMS's Center for Consumer Information and Insurance Oversight ("CCIIO"), files this Proof of Claim ("Claim") against Compass Cooperative Mutual Health Network, Inc., d/b/a Meritus Mutual Health Partners (the "Debtor"), based on the following facts and circumstances.

The Start-Up Loan and the Solvency Loan

2. Section 1322 of the Patient Protection and Affordable Care Act (the "PPACA") authorized CMS to extend loans to qualified applicants to foster the creation of new non-profit, member-governed insurance entities known as Consumer Oriented and Operated Plans or "CO-OPs." *See generally* 42 U.S.C. § 18042. The CO-OP program is intended to improve consumer choice and plan accountability, promote integrated models of care, and enhance competition in the insurance exchanges established by the Act. 42 U.S.C. § 18042; Establishment of Consumer Operated and Oriented Plan (CO-OP) Program, 76 Fed. Reg. 77392-01. The program established two types of CO-OP loans: (1) "loans to provide assistance to [CO-OPs] in meeting [their] start-up costs" and (2) loans "to provide assistance to [CO-OPs] in meeting any solvency requirements of States in which [they] seek to be licensed to issue qualified health plans." 42 U.S.C. § 18042(b)(1).

3. On June 7, 2012, the Debtor and CMS entered into a loan agreement ("Loan Agreement") under which the Debtor received a start-up loan ("Start-up Loan") in the principal amount of $20,890,333.00 and a solvency loan ("Solvency Loan") in the principal amount of

$72,422,900.00. *See generally* Exhibit A (Loan Agreement, dated June 7, 2012, and Appendices 1-5); 42 U.S.C. § 18042(b)(1).

4. The Start-up Loan (which was converted to a surplus note, see Exhibit A at Second Amendment to Loan Agreement) is evidenced by a promissory note on which payments were required to commence no later than 2017. *See* Exhibit A (Loan Agreement and First Amendment to Loan Agreement, showing Debtor's name change). Between June 2014 and August 2015, CMS disbursed the funding available under the Start-up Loan to the Debtor in its entirety. *See* Exhibits A and B (Loan Agreement, dated June 7, 2012 and Start-up Loan Promissory Note dated August 12, 2015).

5. The Solvency Loan is evidenced by a promissory note on which payments were required to commence no later than 2019 and be completed within 15 years of disbursement. *See* Exhibit A at Appendix 4 (Solvency Loan Promissory Note); *see also* 42 U.S.C. § 18042(b)(3). Between March 2013 and August 2015, CMS disbursed the funding available under the Solvency Loan to the Debtor in its entirety. *See* Exhibit C (Disbursement Records).

6. On October 30, 2015, the Arizona Department of Insurance notified CMS that it issued the Debtor an Order of Supervision and suspended the Debtor's Certificate of Authority, which immediately prohibited the issuance of new and renewal health insurance plans in Arizona by the Debtor. *See* Loan Agreement § 15.1. On December 18, 2015, CMS terminated the Loan Agreement, effective December 31, 2015. *See* Exhibit D (Termination Letter). Upon the termination of the Loan Agreement, "the unpaid Principal amount of the Loans, together with all Interest accrued" became "immediately due and payable" to CMS. *Id.* at 1; *see also* Loan Agreement § 15.3.

7. The Debtor presently owes CMS a total of $20,890,333.00 under the Start-up Loan, consisting entirely of principal.[1]

8. The Solvency Loan accrued interest at a rate of 0.25% per year. *See* Exhibit A (Loan Agreement § 4.3 & Appendix 6); 45 C.F.R. § 156.520(c). Between the first disbursement of the Solvency Loan on March 21, 2013 and May 15, 2017, the Solvency Loan accrued a total of $513,028.25 interest. *See* Exhibit E (Interest Calculations).

9. The Debtor presently owes CMS a total of $72,935,928.25 under the Solvency Loan, consisting of $72,422,900.00 in principal and $513,028.25 in aggregate interest to date.

10. CMS's right to collect these debts is governed by (1) the Loan Agreements; (2) applicable Federal law[2]; and (3) "the laws of the State of Arizona to the extent the same do not conflict with applicable Federal law." Loan Agreement § 19.2.

PPACA Cost-Sharing Reduction Reconciliation Obligations

11. The PPACA created subsidies to reduce the cost-sharing expenses of low- and middle-income individuals who purchase health insurance through a health insurance exchange ("Exchange"). *See generally* 42 U.S.C. § 18071. These subsidies are known as "cost-sharing reductions" or "CSRs."

12. At the direction of Congress, CMS and the United States Department of the Treasury ("Treasury") established a program to advance subsidy payments (including the CSR portion of advance payments) to issuers on behalf of eligible insureds. *See* 42 U.S.C. § 18082. Under this program, the Treasury advances payments of CSRs to qualified health plans (QHPs)

[1] The Start-up Loan accrued interest at a rate of 0% per year. *See* Loan Agreement § 4.3 and Appendix 6; 45 C.F.R. § 156.520(c).

[2] The law applicable to CMS's debt collection activities generally includes, but is not limited to, 31 U.S.C. § 3711, *et seq.*; 45 C.F.R. § 156.1215; 42 C.F.R. Part 401, Subpart F; 31 C.F.R. Part 901; and applicable common law (collectively, "Federal Debt Collection Law").

based on estimates.[3] Issuers, in turn, are required to apply the advance payments to the cost-sharing obligations of their enrollees. 45 C.F.R. § 156.410(a).

13. Because the monthly advances of the CSR portion of advance payments are based on estimates, they are subject to annual reconciliation after issuers calculate the actual amount of CSRs provided to eligible enrollees using methodologies specified by CMS. *See id.* § 156.430(c)-(d). If, upon reconciliation, CMS determines that the CSR portion of advance payments exceeded the actual amount of CSRs provided to enrollees, the issuer must reimburse CMS (on behalf of the Treasury) for the difference. *Id.* § 156.430(e). Conversely, if CMS determines that the CSR portion of advance payments fell short of the actual amount of CSRs provided to enrollees, CMS (on behalf of the Treasury) must reimburse the issuer for the difference. *Id.*

14. Between April and June, 2016, CMS reconciled the CSR portion of advance payments made to issuers of QHPs for the 2014 and 2015 benefit years.

15. As a result of reconciliation, CMS determined that the CSR portion of advance payments for 2014 and 2015 made to the Debtor exceeded the actual amount of CSRs provided to enrollees, and therefore, the Debtor owes a principal balance to CMS of $112,917.29 for 2015, and as of May 3, 2017, interest in the amount of $2,717.07 and an administrative fee of $15), for a total of amount owed of $115,649.36. *See* Exhibits F and G (Invoice and Intent to Refer Letter for this debt). CMS's right to collect such overpayments is governed by Federal Debt Collection Law.

[3] In 2014, these estimates were calculated from Exchange data showing a plan's actuarial value and expected allowed claims costs. In 2015, Exchanges calculated the advance amount using multipliers particular to the plan variation and premium for each policy. *See* 45 C.F.R. §§ 155.340(a), 155.1030(b)(3), 156.430(b).

PPACA Reinsurance Obligations

16. Pursuant to Section 1341 of the PPACA, health insurance issuers and other contributing entities are required to make annual reinsurance contributions to the PPACA transitional reinsurance program for the 2014, 2015, and 2016 benefit years. *See* 42 U.S.C. § 18061. CMS collects these contributions and generally uses the funds to reimburse eligible insurance companies for a portion of high claims costs incurred during the applicable benefit years. *See* 45 C.F.R. § 153.230(a)-(c). For the 2015 benefit year, health insurance issuers and contributing entities were required to: (1) submit enrollment data by November 16, 2015; (2) make an initial bifurcated or single, combined reinsurance contribution payment by January 15, 2016; and (3) make a second bifurcated reinsurance contribution payment (if applicable) no later than November 15, 2016. *See* 45 C.F.R. § 153.405(b)-(c); *see also* Key Dates for Calendar Year 2016: QHP Certification in the Federally-facilitated Marketplaces; Rate-Review; Risk Adjustment and Reinsurance, at 3, *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2016-key-dates-table-2-29-16.pdf. To the extent issuers and other contributing entities do not pay their mandatory reinsurance contribution(s) at the proper time, the deficiency constitutes a determination of a debt. 45 C.F.R. §§ 153.400(c) and 156.1215(c).

17. The Debtor submitted its enrollment count for the 2015 benefit year on November 11, 2015, and elected a bifurcated payment schedule for its contribution obligations (which resulted in total reinsurance contributions due for the 2015 benefit year of $184,366.16). On January 14, 2016, the Debtor made an initial bifurcated payment of $138,274.62 for the 2015 benefit year. *See* Exhibit H (ACA Transitional Reinsurance Annual Enrollment and Contributions Submissions Form, First Collection). The Debtor's second bifurcated payment of

$46,091.54 remains outstanding and was due no later than November 15, 2016. *See* Exhibits I and J (ACA Transitional Reinsurance Annual Enrollment and Contributions Submissions Form, Second Collection and ACH Debit Retired Transaction Document). *See* 45 C.F.R. § 153.405(c)(2). CMS's right to collect such payment is governed by Federal Debt Collection Law.

PPACA Risk Adjustment Obligations

18. Section 1343 of the PPACA established a permanent risk adjustment program to mitigate the impact of adverse selection on and stabilize premiums for issuers of PPACA-compliant coverage in the individual and small group markets. *See* 42 U.S.C. § 18063.[4] Under the program, issuers of qualifying plans that enroll policyholders with disproportionately low actuarial risk are assessed a fee or "charge" by CMS, whereas issuers that enroll policyholders with disproportionately high actuarial risk receive a payment.

19. Issuers subject to the CMS-administered risk adjustment program are required to establish a dedicated Distributed Data Environment ("DDE") to ensure that CMS is provided access to risk adjustment data in a timely fashion. 45 C.F.R. § 153.700(a). The submission deadline for risk adjustment data for the 2015 benefit year was May 2, 2016. Issuers that fail to establish a DDE and/or provide access to the required data such that CMS cannot apply the Federally certified risk adjustment methodology to calculate the issuer's risk adjustment transfer amount in a timely fashion are assessed a default risk adjustment charge. *See* 45 C.F.R. § 153.740(b); *see also* FAQ #14472, *available at* https://www.regtap.info/faq_viewe.php?i=14472.

[4] Although the PPACA permits states to operate their own risk adjustment programs, Arizona elected not to do so. Therefore, CMS presently administers the program in Arizona. *See* 42 U.S.C. § 18041(c).

20. Issuers of risk adjustment-covered plans also must pay a user fee to CMS based on their qualifying business in states where CMS administers the program. *See* 45 C.F.R. § 153.610(f). The user fee is a product of the monthly enrollment in the risk adjustment covered plan and a per-enrollee-per-month rate specified by CMS annually in regulation.

21. CMS has calculated risk adjustment obligations for the 2015 benefit year, and as of May 3, 2017, the Debtor owes CMS $589,820.86 in risk adjustment charges (which represents the amount of risk adjustment charges currently owed as of May 3, 2017, a charge of $346,561.95 and $243,258.91). As of May 3, 2017, the Debtor has currently paid the interest and administrative fee owed on the risk adjustment charges. *See* Exhibits K-N (Initial Risk Adjustment Invoices and Intent to Refer Letters) and (See Exhibit R – Account Receivables Owed by Debtor as of May 3, 2017). The Debtor also owes $4,348.01 in risk adjustment user fees (which includes $101.82 for interest and $15 for an administrative fee), resulting in a total amount owed of $594,168.87. *See* Exhibits O and P (Initial Risk Adjustment Fees Invoice and Intent to Refer Letter) and (See Exhibit R – Account Receivables Owed by Debtor as of May 3, 2017). CMS's right to collect such payments is governed by Federal Debt Collection Law.

PPACA User Fees under Federally-facilitated Exchange Program

22. CMS collects a user fee from participating issuers to fund Federally-facilitated Exchange operations. For 2014 and 2015, the user fee rate was set at 3.5 percent of the monthly premium charged by the issuer. Based on enrollment and premium projections, CMS estimated that the 2016 user fee rate will also be set at 3.5 percent of the monthly premium charged by the issuer. The Debtor owes CMS $7.76 for user fees under the PPACA Federally-facilitated Exchange program. *See* Exhibit Q (Initial User Fees Invoice).

Conclusion

23. As of May 3, 2017, the Debtor owes CMS $20,890,333.00 under the Start-up note, $72,935,928.25 under the Solvency note (including accrued interest); $115,469.36 for reconciliation of the cost-sharing reduction portion of advance payments; $46,091.54 under the PPACA Reinsurance Program; $594,168.87 under the PPACA Risk Adjustment Program (which includes $589,820.86 in risk adjustment charges and $4,348.01 for risk adjustment user fees); and $7.76 under the PPACA Federally-facilitated Exchange user fee program, for a total debt of $94,581,998.78. We note that the amounts owed by the Debtor are based on the current amounts due for each of the above-referenced programs reduced for any amounts collected through payment of invoices and netting under 45 C.F.R. § 156.1215(b). (See Exhibit R – Account Receivables Owed by Debtor as of May 3, 2017).[5]

24. CMS will amend and/or supplement this Proof of Claim as necessary. The filing of this Claim is not: (a) a waiver or release of the United States' rights against any person, entity or property; (b) a waiver or release of any right or claim of the United States, of any nature whatsoever, under any applicable law; (c) an election of any remedy to the exclusion, express or implied, of any other remedy; (d) an admission that this Claim encompasses debts that are subject to discharge in this or any other proceeding; (e) a consent to, ratification of, or admission regarding any obligation or liability based upon or arising out of any transaction between the United States and the Debtor; (f) an admission that the Arizona court presiding over the rehabilitation proceeding has jurisdiction over the United States with respect to any matter identified in this Claim, or a waiver or release of any rights related thereto; or (g) a waiver or release of any right of the United States to a trial by jury in any proceeding as to any and all

[5] Exhibit R does not include the amounts owed under the PPACA transitional reinsurance program, as these amounts are due in light of the ACH debit retiring as described in paragraph 17 above and the accompanying exhibits.

matters so triable. All such rights are hereby expressly reserved by the United States without exception and without purpose of confessing or conceding any right or claim by this filing, or by any other participation in this proceeding.

Exhibit A

LOAN AGREEMENT

Series A-$ 20,890,333 (Maximum) CO-OP Start-up Loan

Series B - $72,422,900 (Maximum) CO-OP Solvency Loan

US DEPARTMENT OF HEALTH AND HUMAN SERVICES,
CENTERS FOR MEDICARE & MEDICAID SERVICES

the "Lender"

Compass Cooperative Health Network

the "Borrower",
a non-profit corporation duly existing and operating
under the laws of the State of Arizona

Closing Date:

June 7, 2012

APPENDICES

Section 1. STATEMENT OF PURPOSE

1.1. Prefatory Statements

Whereas, Congress has directed the Secretary of the Department of Health and Human Services ("HHS") to establish a Consumer Operated and Oriented Plan (CO-OP) Program, the purpose of which is to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets through the provision of loans to qualified applicants for the purpose of financing start-up costs and insurance reserves [see the Affordable Care Act, Section 1322(a)]; and

Whereas, "Borrower," a not-for-profit member organization identified on the Title Page and Signature Page of this Agreement, duly existing and operating under the laws of the State/Commonwealth identified on such pages, has applied to the Centers for Medicare & Medicaid Services (the "Lender" or "CMS"), an operating division of HHS, to obtain such financing; and

Whereas, Lender has selected Borrower's application and agreed to provide such financing upon such terms and conditions as are more particularly described in this Agreement and its appendices (the "Appendices"); and

Whereas, Borrower understands and agrees that as a condition of accepting funding under this Agreement, it will adhere to all terms, conditions and other provisions of this Agreement and applicable CO-OP Program regulations.

1.2. Binding Intent

Accordingly, in consideration of the mutual agreements contained herein and for other good and valuable consideration, the receipt of which is hereby acknowledged, Lender and Borrower agree to the terms hereinafter set forth in this Agreement.

Section 2. DEFINITIONS

2.1. Defined Terms

The following terms and words shall have the stated meanings when used in this Agreement (including the recitals). Terms not otherwise defined in this Agreement shall have the meanings attributed them in the normal course of business.

"Accrual Period" means, (a) initially, the period from and including the Closing Date but excluding the first Loan payment date and (b) thereafter, each subsequent period from and including a Loan payment date but excluding the next Loan payment date.

"Affiliated Party" means an organization other than a Pre-Existing Issuer or a Related Entity that shares common ownership or control with Borrower, including an affiliate, subsidiary or parent thereof.

"Affordable Care Act" means the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, enacted on March 23, 2010, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, the Department of Defense and Full-Year Continuing Appropriations Act, 2011, Pub. L. No. 112-10, and the Consolidated Appropriations Act, 2012, Pub. L. No. 112-74, and as from time to time hereafter amended.

"Agreement" means this Loan Agreement, as from time to time hereafter amended in accordance with the terms hereof, together with all attached Appendices.

An" **Appendix"** to this Agreement means any appendix, schedule, exhibit or other document attached to this Agreement and incorporated by reference herein.

"Basic Operating Expenses" means the ordinary and necessary expenses incurred by Borrower in can-ying out its day-to-day business activities that are permitted under Section 3 of this Agreement, including but not necessarily limited to such expenses as non-medical services provider payroll, employee benefits and pension contributions, business related transportation, travel and training expenses and other similar non-clinical personnel expenses, as well as general business and administrative expenses such as those associated with renting space for administrative operations, utilities, telecommunications, business equipment, fixtures, leasehold improvements, licenses, permitted CO-OP marketing and adve1tising, professional services, business insurance, and taxes other than income taxes.

"Borrower" shall be the entity described as Borrower on the Title Page of this Agreement.

Borrower's **"Business Plan"** means Botrnwer's formal business plan submitted in response to the CO-OP FOA, a true copy of the most-cun-ent approved version of which is attached hereto and incorporated herein by reference as Appendix 7 hereto, and as from time to time hereafter amended by mutual agreement of the pmties.

"Business Day" means a day which is not a Saturday, Sunday or legal holiday under the laws of the United States of America.

"Closing Date" means the date of execution of this document, as noted on the Title Page of this Agreement.

"CMS" means Centers for M dicare & Medicaid Services, an Operating Division of the United States Depmtment of Health and Human Services.

"Contingency Funding" means that portion of the Solvency Loan specifically reserved to offset increased costs to Borrower or changes in Bon-ower's Business Plan caused by higher than expected enrollment or claims, expansions into additional servicing areas within the same State or States in which Borrower is operating, or changes in Federal law and/or changes in State Insurance Laws or State Reserve Requirements. **"Contingency Funds"** means any and all Funds provided to Bon-ower from Lender from the Contingency Funding. All Contingency Funding available under this Agreement is included in the total amount available for the Solvency Loan indicated on the facing page of this Agreement, and is the portion thereof indicated in the Solvency Loan Disbursement Agreement (Appendix 3).

"CO-OP" means the consumer governed, private, nonprofit health insurance entity established by Borrower that satisfies the standards in section 1322(c) of the Affordable Care Act and 45 CFR Section 156.515.

"CO-OP FOA" means Funding Opportunity Announcement Number: OO-C0 0 -11-001, CFDA No. 93.545, published by CMS on July 28, 2011 and as thereafter amended including on December 9, 2011, and as may be from time to time thereafter iimended.

"CO-OP Program" means the Consumer Operated and Oriented Plan (CO-OP) Program authorized by and established under Section 1322(a) of the Affordable Care Act.

"CO-OP Qualified Health Plan" or "CO-OP QHP" means a health plan that has in effect a certification that it meets the standards established by CMS pursuant to Section 1311(c) of the Affordable Care Act, except that the plan can be deemed certified by CMS or an entity designated by CMS as described in 45 CFR 156.520(e).

"Date of Award" means the date that occurred 30 days after applications were due in response to the CO-OP FOA.

"Disbursements" means the Funds Borrower will receive from Lender in accordance with the terms and conditions of this Agreement.

"Disbursement Agreement" means the agreement between Borrower and Lender governing the disbursement, use and repayment of Start-Up or Solvency Loan Funds (including Contingency Funds), as applicable, initial copies of which are attached to and incorporated hereto as Appendices 1 and 7, as from time to time hereafter modified by mutual written agreement of the parties.

"Disbursement Plan" means the schedule for Disbursements of Start-Up or Solvency Loan Funds, as applicable, initial copies of which are attached to and incorporated hereto as of Appendices 1, 2, 3 and 7, as from time to time hereafter modified by mutual written Schedule A agreement of the parties

"Event(s) of Default" means the occurrence or happening, from time to time, of one or more of the events identified in Section 15.1 below.

"Exchange" means a governmental agency or non-profitentity that meets the applicable requirements established by CMS, pursuant to sections 1311 and 1321 of the Affordable Care Act, and makes qualified health plans available to qualified individuals and qualified employers. Unless otherwise identified, this term refers to State Exchanges, regional Exchanges, subsidiary Exchanges, and a Federally-facilitated Exchange.

"Final Solvency Loan Disbursement Date" means the last date that any Disbursement of Solvency Loan Funds is or was made to Borrower.

"Financing Period" means the period measured from the Closing Date and to the date that Bon-ower makes the final repayment of all Principal and accrued Interest on the Loans, except for and not including any Improvements or Workout Periods.

"Gold Benefit Level" and **"Silver Benefit Level"** mean levels of coverage with a CO-OP QHP that provide benefits that are actuarially equivalent to 80% of the full actuarial value of benefits under the CO-OP QHP and 70% of the full actuarial value of benefits under the CO-OP QHP, respectively.

"GAAP" means generally accepted accounting principles applicable to a qualified nonprofit health insurance issuer, and **"GAAS"** means generally accepted auditing standards applicable to the same.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, enacted on August 21, 1996, as from time to time thereafter amended.

"Improvement Periods" means the time during periods in which the CO-OP may be experiencing difficulties in meeting full responsibilities under this Agreement, including minor or technical Events of Default, which are deemed resolvable by Lender.

"Interest" or "Interest Amount" means, with respect to any Loan payment date, the amount of interest accrued on the Principal of a Loan from time to time during the preceding Accrual Period, including any recapitalized interest on unpaid Obligations hereunder.

"IRC" means the Internal Revenue Code of 1986, as codified in Title 26 of the United States Code, as from time to time amended.

"Lender" means the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services.

"Loan" means the total amount of all outstanding Start-Up Loan disbursements, or the total amount of all outstanding Solvency Loan disbursements, respectively and individually, as the context or usage requires; **"Loans"** means both of them together.

"Loan Funds" or "Funds" means the Disbursements received under this Agreement as from time to time amended for Statt-Up and Solvency Loans, including accrued Interest thereon under the Maximum Amounts of Loan Principal described on the Title Page.

"Material Adverse Effect" means any occmTence, condition, event, change, consequence or effect that is or could reasonably be expected to be materially adverse to or othe1wise detrimentally effect the business, operations, results of operations, assets, liabilities, or financial condition of Borrower or the CO-OP.

"Maximum Disbursement Amount for Solvency Loan" means the maximum amount that is available for Disbursement to Borrower under the Solvency Loan as more patticularly described in Section 5.2 below.

"Member" means an individual covered under health insurance policies issued by Borrower.

"Member Grievance" means a written or oral expression of dissatisfaction regarding the CO-OP QHP and/or Borrower, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration, or appeal made by a Member or the Member's representative. When Borrower is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

"Monitoring Period" means the time during which Borrower is subject to oversight by Lender, including site visits and requests for information initiated by Lender that supplement any required periodic reports. The Monitoring Period will run simultaneously with the Performance Period.

"Obligations" means the Principal and Interest due on each of the Loans, together with any and all other obligations of Borrower arising under this Agreement pertaining to the Loans, whether now existing or arising in the future, as more specifically described in Section 3.3 below.

"Organizational Change" means any material or significant change to Borrower's corporate or governance structure, or any transfer of all or a significant portion of Borrower's assets, the implementation of which specifically requires the prior written approval of Lender in accordance with the terms of Section 18.2 of this Agreement.

"Performance Period" means the period beginning on the Closing Date and ending on the tenth (I O'h) anniversary of the date that Borrower makes the final repayment of all Principal and accrued Interest on the Loans. The Performance Period includes the Financing Period, the Improvement Period and the Workout Period, as applicable.

The **"PHSA"** means the Public Health Service Act, as codified in Title 42, Chapter 6A of the United States Code, as from time to time amended.

"PresExisting Issuer" means a health insurance issuer that was in existence on July 16, 2009.

"Related Entity" means an entity that shares common ownership, control, or governance structure (including management team or Board members) with a Pre-Existing Issuer, and satisfies at least one of the following conditions: (i) retains responsibilities for the services to be provided by the Pre-Existing Issuer; (ii) furnishes services to the Pre-Existing Issuer's enrollees under an oral or written agreement; or (iii) performs some of the Pre-Existing Issuer's management functions under contract or delegation.

"Repayment Schedule" means the agreed-upon plan or schedule for repayment of Statt-Up or Solvency Loan Funds, as applicable, copies of which are attached to and incorporated hereto as numbered Appendices, as from time to time hereafter amended by mutual agreement of the parties

"Reporting Period" means the time during which the recipient must submit program and financial reports to CMS. The Reporting Period runs simultaneously with the Performance Period.

"Risk-Based Capital Reserves" means the amount of required capital that the Borrower must maintain to remain in compliance with State Reserve Requirements. These risks may include asset depreciation risk, credit receivables risk, underwriting risk, and off-balance-sheet risk.

"SAP" means Statutory Accounting Principles, the rules for insurance accounting codified by the National Association of Insurance Commissioners (NAIC) or as promulgated by a State as rules to be used in reporting an insurer's results to regulators.

"Secretary" shall refer to the Secretary of HHS.

"SHOP" means a small business health options program operated by an Exchange through which a qualified employer can provide its employees and their dependents with access to one or more qualified health plans.

"Social Security Act" shall refer to the Social Security Act, as amended, as codified in Chapter 7 (§§ 301 et. seq.) of Title 42 of the United States Code.

"Solvency Loan" means the Loan provided to Borrower in order to meet State solvency and State Reserve Requirements that is governed by this Agreement, and the particular requirements of Appendix 4 - Solvency Loan Promissory Note.

"Sponsor" means an organization or individual that is involved in the development, creation, or organization of the CO-OP or provides 40 percent or more in total funding to a CO-OP (excluding any loans received from the CO-OP Program) as described in 45 CFR Part 156.

"Start-Up Loan" means the Loan to Borrower for costs associated with establishing a CO-OP that is governed by this Agreement, and the particular requirements of Appendix 2 - Start-Up Loan Promissory Note.

"State" means and includes each of the 50 sovereign States or Commonwealths within the United States of America and includes for purposes of this Agreement the District of Columbia.

"State Insurance Laws" means those State insurance laws and regulations that will govern Borrower in delivering the CO-OP QHP(s) for and within the particular State.

"State Reserve Requirements" means the financial reserve requirements that Borrower must meet under applicable State Insurance Laws for the delivery of health insurance under a CO-OP and to issue CO-OP QHPs and any non-CO-OP QHP coverage to be offered by the CO-OP. A statement of compliance from the host state will be milestone of Start-Up and ongoing operations.

"State Solvency Payment Restriction" means a State Insurance Law provision or regulatory action by a State insurance agency or department that enforcement or implementation of which creates an actual legal impediment or restriction on repayment of Loan funds pursuant to the terms of this Agreement.

"Subcontract" means any contract or other formal agreement entered into by Borrower with a third patty or Affiliated Party to furnish supplies or services to Borrower in furtherance of

Bolmwer's responsibilities, obligations or undertakings under this Agreement, as more specifically described in Section 8.2 below.

"Treasury" means the United States Department of the Treasury.

"Workout Period" means the period arising after an occurrence ofan Event of Default which is not cured within the time limits set forth in Section 15.l and 15.2 below.

Section 3. DESCRIPTION OF FINANCING

3.1. General

Under this Agreement, Lender is providing to Borrower funds for CO-OP Program purposes through two Loans, each of which shall be on par with the other for security purposes, .and each of which shall be governed and controlled for all purposes by this Agreement, including its Appendices.

3.2. Purpose of the Loan

The Loans are being provided by Lender to Borrower for the establishment of a CO-OP. The Loans are intended to permit Borrower to offer health plans primarily in the individual and small group markets as described in 45 CFR Part 156. Borrower agrees to perform all functions necessary to design, implement and operate a CO-OP QHP as set forth in the in the CO-OP FOA and consistent with its FOA proposal and approved Business Plan. Subject to the terms and conditions of this Agreement, Lender will loan an amount not to exceed $20, 890,333 for the Start-Up Loan and $72,422,900 for the Solvency Loan to Borrower.

3.3. Parity of Loans; Cross-Collateralization

Borrower hereby covenants and agrees that each of the Loans and all Obligations of Borrower arising under this Agreement pettaining to the Loans, whether now existing 6r arising in the future, shall be and are hereby expressly cross-defaulted and cross-ccillateralized with each other, such that the occurrence of any Event of Default under any of the Obligations shall be a default under all of the Obligations and under all documents and instruments evidencing and/or securing the Obligations.

3.4. Security for the Loans

The Loans and other Obligations will be general obligations of Borrower. Because the intent of the Loans, and the Solvency Loan in particular, is to provide financing to Borrower that meets the definition of"risk based capital" for State Insurance Laws purposes, the Loans will have a claim on cash flow and reserves of Borrower that is subordinate to (a) claims payments, (b) Basic Operating Expenses, and (c) maintenance of required reserve funds while Borrower is operating as a CO-OP under State Insurance Laws.

3.5. Permitted Use of Loan Funds

Borrower must use the Loan Funds only for the following purposes:

(a) Costs identified in the Business Plan and Disbursement Plans;
(b) Costs associated with establishing the CO-OP as an operating business;

(c) Costs associated with the initial operations of a CO-OP QHP, including but not limited to:

i. Renting space for issuer administrative operations;
ii. Renting or developing information technology systems;
ul. Renting or developing provider networks;
lv. Hiring a management team with adequate insurance expertise and other administrative personnel;
v. Hiring counsel and consultants to assist with State Insurance Laws and other licensure requirements;
vl. Negotiating, and contracting with providers and vendors;
vii. Hiring actuaries;
vul. Conducting community and prospective member education and educating CO-OP members on the rights and responsibilities of member governance;
lx. Developing strategic plans to build enrollment;
x. Establishing and participating in a private purchasing council; and
xi. Paying for the initial costs of operational and administrative staff.

(d) Cost associated with establishing and maintaining capital reserves for Borrower (including Risk-Based Capital Reserves) consistent with State Reserve Requirements;

(e) Investments petmitted from Funds held in appropriate accounts approved by State regulators; and

(f) Other expenditures as authorized in writing by Lender.

3.6. Prohibited Uses of Loan Funds

Notwithstanding any other provision of this Agreement to the contrary, in no event shall Borrower use any patt of Loan Funds for any of the following purposes or activities:

(a) To carry on propaganda and other activities attempting to influence legislation at the Federal, State, or local level of government;

(b) To conduct marketing. As used herein, "marketing" means activities that promote the purchase of a specific health care plan or explain a product's benefit structure to a specific customer. However "marketing" does not include activities related to community outreach, membership development, and membership education. Loan Funds may be used to provide information to Members regarding their coverage, rights, and responsibilities;

(c) To meet the matching requirements of any other Federal program;

(d) To cover or pay excessive executive compensation as determined by Lender in its sole but reasonable discretion;

(e) To fund activities unrelated to CO-OP planning and establishment, including but not limited to staff retreats and promotional giveaways;

(f) To fund activities associated with construction of facilities, including clinical facilities;

(g) To pay clinical expenses for Stalt-up Loans such as medical services provider salaries or payments, provider clinical space or administrative staff associated with clinical functions, and clinical equipment (excluding clinical information technology).

(h) To pay for services described in section 1303(b)(l)(B)(i) of the Affordable Care Act.

Nothing in this Agreement shall be construed to allow a person to take any action prohibited by IRC Section 50l(c) (29).

3.7. Differences in Servicing Regimes

During the Performance Period, the Loans will be managed under different sets of rules ("Servicing Regimes") corresponding to the status of the CO-OP's operations and finances. These rules are applicable during such Servicing Regimes and are generally described as follows:

(a) Performance Period. Throughout the entire Performance Period, Borrower will be required to make repayments of Principal and Interest and other Obligations in accordance with the terms of this Agreement.

(b) Financing Period. During the Financing Period, Borrower will be required to make repayments of Principal and Interest and other Obligations in accordance with the Repayment Schedule for each Loan, subject to applicable grace periods as hereinafter set forth in this Agreement.

(c) Improvement Period. During any Improvement Periods, Borrower will be required to agree to an Improvement Plan with Lender until either the problem is resolved, or a more serious Event of Default occurs that triggers a transition to a Workout Period.

(d) Workout Period. During a Workout Period, Lender will be entitled to pursue any and all remedies available to Lender under and in accordance with the telms of this Agreement. Borrower and Lender nonetheless agree to work in good faith to resolve any differences and correct any deficiencies which caused or led to the Loans to be in the Workout Period; provided that Lender shall have no obligation to take any actions to resolve any such issues if Lender has cause to believe that Borrower or a Affiliated Party has engaged in criminal or fraudulent activities, or in other deleterious activities that have caused or may cause material hmm to the CO-OP's Members or the CO-OP Program.

3.8. Conditions Precedent for Loan Disbursement

To receive any Funds under this Agreement, Borrower must (i) meet the specific conditions and milestones for each Disbursement as set forth in its Disbursement Plans (Schedule A of Appendices I and 7); (ii) remain in compliance with the CO-OP Program Requirements set forth in Section 7 below; and (iii) continuously meet the following specific conditions:

(a) Meet the eligibility criteria for the CO-OP as defined at 45 CFR 156.51O;

(b) Certify to Lender in writing that it possesses and has implemented policies and procedures to avoid insurance industry involvement and interference;
(c) As a condition precedent to Closing of this Agreement, Borrower must submit an "Affirmation of Regulatory Acceptance of CO-OP Loans as Regulatory Capital," to be attached as Appendix I 0, signed by the Superintendent of the Arizona Insurance Commissioner.

To receive Contingency Funds under this Agreement Borrower must, in addition to the conditions set forth above in this Section 3.8, submit to Lender adequate documentation that Borrower meets one of the following criteria or justifications for Contingency Funding:

(a) Borrower's enrollment levels have been higher than anticipated in its Business Plan as demonstrated by automated enrollment figures provided to Lender within 90 days of the close of the open enrollment period or within 60 days of the close of any special enrollment period;
(b) Borrower's claim costs have been significantly higher than anticipated in its Business Plan as demonstrated by the claims history of the preceding calendar quarter;
(c) Changes in State Solvency Requirements or other applicable State or Federal health insurance company solvency requirements have resulted in significant cost increases that were unanticipated under Borrower's Business Plan as demonstrated by State regulatory publications or a letter from the agency or official responsible in the State for the regulation of health insurance issuers.
(d) Borrower has a viable plan to expand its service area within the State or States in which it is already operating.

Contingency Funds shall not be disbursed to Borrower until all non-Contingency Funds have been disbursed to Borrower.

In the event Borrower had previously existed as or was converted from a multiple employer welfare arrangement (as such term is defined in ERISA Section 3(40), 29 U.S.C. §1002(40)), or multiple employer trust ("MEWA"), Borrower must first deposit, credit or apply and thereafter use any and all existing solvency, reserve or risk capital funds from such MEWA for the benefit of the CO-OP and its Members before seeking any Loan Disbursements hereunder. No Loan Funds (whether Contingency Funds or otherwise) will be disbursed hereunder unless and until such existing MEWA funds are deposited, credited or applied for the benefit of the CO-OP (as verified pursuant to standard audit and accounting procedures), and the Borrower establishes a bona fide need for Start-Up or Solvency Funds despite the availability of such MEWA funds for use by the CO-OP.

Section 4. START-UP LOAN - BASE PROVISIONS

4.1. Use

Start-Up Loan Funds must only be used in accordance with the Business Plan, the Start-Up Loan Disbursement Plan and the CO-OP FOA. Start-Up Loan Funds cannot be used to pay for costs

associated with purchase of land and construction of facilities, including construction or clinical costs such as the costs of actual medical services provider salaries and contracts or payment, provider clinical space, and clinical equipment.

4.2. Disbursement for Start-Up Loan

Any and all Start-Up Loan Disbursements shall be made in accordance with the terms and conditions set forth in the Disbursement Agreement attached hereto and incorporated herein by reference as Appendix 1. As a condition precedent to the making of any Disbursement, Borrower must satisfy the requirements of Section 3.8 above, including but not limited to the requirement that it demonstrate that it has met the specific conditions milestones for each such Disbursement as set forth in its Disbursement Plan (Appendix 1, Schedule A). Disbursements, at Lender's discretion, may not be provided during any Improvement or Workout Periods.

4.3. Interest

The Interest rate for the Start-Up Loan and any individual Disbursement thereof shall be fixed for the life of the Loan at the amount in Appendix 6, which represents the Treasury rate on five year securities in effect on the initial Date of Award minus one percentage point ("Interest Rate"); provided, however, that in this event this Agreement is earlier terminated for cause under Section 16.3 below, the Interest Rate for the Start-Up Loan shall be fixed at the rate in Appendix 6, which is equal to the Treasury rate on five year securities based on the Date of Award. Interest on the Start-Up Loan and each individual Disbursement thereof shall accrue on a monthly basis using a 360-day year and 30-day month for actual days elapsed. Interest shall be payable according to the Repayment Schedule attached to this Agreement and incorporated herein by reference as Schedule A of Appendix I. Accrued and unpaid Interest will be capitalized on an annual basis during the period prior to the first scheduled Interest payment date, and will be capitalized on any scheduled payment date on which Borrower does not pay the full amount of the accrued Interest due.

4.4. Repayment of Start-Up Loan

Borrower shall make Principal and Interest payments as described in the Start-Up Loan Promissory Note attached hereto and incorporated herein by reference as Appendix 2, with normal loan servicing activities to be contemporaneously undertaken by Lender or its designee. Principal repayments on the Start-Up Loan will be as stated in the Stait-Up Loan Promissory Note for the Start-Up Loan, but in any event no later than 5 years from the respective Disbursement date of the individual Loan Disbursement installments, subject to Borrower's ability to meet State Reserve Requirements and other solvency regulations or requisite surplus note arrangements.

Unless Lender terminates this Agreement for cause under Section 16.3 below, Borrower shall be obligated to repay I 00% of the Start-Up Loan amount disbursed, plus any capitalized Interest to Lender in accordance with the Repayment Schedule for the Start-Up Loan, subject to its ability to meet State Reserve Requirements and other solvency regulations, or requisite surplus note arrangements.

If Lender terminates this Agreement for cause under Section 16.3 below, Bon:ower shall be obligated to repay 110% of the Sta1t-Up Loan Principal disbursed, plus any capitalized Interest

and any accrued Interest recalculated for the life of the Start-Up Loan at the higher Interest Rate as described in Section 4.3 above.

Instructions regarding the process for submitting payments to Lender are provided in Appendix 8 attached hereto and incorporated herein by reference. Changes to the process for submitting payment will be made available to Borrower as pa1i of CO-OP Program guidance.

4.5. Prepayment of Start-Up Loan

Borrower may prepay the outstanding Principal of the Start-Up Loan, in whole, or in part, at any time, without penalty, upon giving 30 days written notice to Lender of its intent to so prepay. A revised Repayment Schedule will be prepared by Lender following receipt of any acceptable partial prepayment, and will be delivered to Borrower within 30 business days thereafter.

4.6. Disposition of Unused Funds

Borrower must repay any unused Start-Up Loan Funds to Lender. Every three years (as measured from the date of Disbursement of Funds), B01rnwer must determine the amount of Staii-Up Loan Funds received for use that was not used as outlined in the Business Plan and is not anticipated to be used in the following three year period. This unused funding must be returned to Lender within 60 days of such determination unless Borrower presents plans acceptable to Lender for the anticipated use of the unused Start-Up Loan Funds in the following three years.

If Start-Up Loan Funds are not disbursed to Borrower within five years of when projected in the Business Plan, the unused Loan Funds will be defunded and cancelled.

Section 5. SOLVENCY FINANCING - BASE PROVISIONS

5.1. Use

Solvency Loan Funds must only be used to establish Risk-Based Capital Reserves to be held by Borrower and other capital reserves necessary to meet State Reserve Requirements and other State Insurance Laws, and then only in strict accordance with the Business Plan and Disbursement Plan. Borrower must notify Lender in writing if Borrower determines that its expenses have exceeded its premium revenue for three consecutive months, which notice shall be delivered within 30 calendar days of such dete1mination.

5.2. Structure of Solvency Loan

The Solvency Loan will be structured so as to comply with applicable State Insurance Laws and the terms of Appendix 4. Solvency Loans will be disbursed to meet the reserve level established in the Disbursement Agreement for the Solvency Loan.

5.3. Disbursements for Solvency Loan

Borrower will receive Solvency Loan Disbursements under the process described in the Solvency Loan Disbursement Procedures attached hereto and incorporated herein by reference as Appendix 5. Disbursements, at Lender's discretion, may not be provided during any Improvement or Workout Periods, and may be held in escrow for the benefit of Borrower at

Lender's option prior to receipt by Borrower of all necessary and applicable State Insurance Law licenses and permits.

An initial Disbursement will be made in timing and amount as described in the Disbursement Plan (Schedule A of Appendix 3). Lender will disburse the initial installment of the Solvency Loan within 30 days of receiving a written request for Disbursement of Loan Funds in accordance with the procedures desctibed in Appendix 5, so that Botrnwer can fund its required capital reserves (including Risk-Based Capital Reserves) in order to obtain licensure in a timely way.

Thereafter and until the Final Solvency Loan Disbursement Date, Borrower may draw additional Disbursements as needed (consistent with the Disbursement Agreement and the Solvency Loan Disbursement Procedures, and up to the maximum stated on the Title Page of this Agreement) for any of the following reasons:

(a) To meet the regulatory capital requirements of the State(s) in which B01rnwer seeks to be licensed to issue CO-OP QHPs; and
(b) To ensure that Borrower is in good standing under applicable State Insurance Laws and State Reserve Requirements.

In making any Disbursement request, Bo1rnwer shall deliver to Lender a written request for the Disbursement of Loan Funds in accordance with the procedures described in Appendix 5. By signing a request for Disbursement, Borrower shall be certifying that the Funds of such Disbursement will be used in compliance with the provisions of Section 3.4 regarding Permitted Uses of Loan Funds, and not in violation of the provisions of Section 3.5 regarding Prohibited Uses of Loan Funds.

In no event may the aggregate amount of Solvency Loan Disbursements exceed the Maximum CO-OP Solvency Loan award amount shown on the cover of this Agreement and described in Section 3.2 above.

Contingency Funds shall not be disbursed to Borrower unless and until all non-Contingency Funds available under this Agreement have been disbursed to Botrnwer, and Borrower otherwise meets the specific condition precedent requirements of Section 3.8 with respect to Contingency Funding.

5.4. Final Solvency Loan Disbursement Date

While there is available funding remaining in the Solvency Loan (that is, the difference between the Maximum CO-OP Solvency Loan award amount stated on the cover of this Agreement and indicated in Section 3.2 above, and the sum of all Disbursements made as of a given date), such Funds will be available for Disbursement up to the date specified in Appendix 5 as the Final Solvency Loan Disbursement Date.

5.5. Interest

The Interest rate for the Solvency Loan and any individual Disbursement thereof is fixed for the life of the loan at the amount in Appendix 6, which represents the interest rate on United States Treasury securities of similar maturity in effect on the Date of Award minus 2 percentage points,

("Interest Rate"); provided, however, that in the event this Agreement is earlier terminated for cause under Section 16.3 below, the Interest Rate for the Solvency Loan shall be fixed for the remaining life of the Loan at the rate reflected in Appendix 6, which is the interest rate on Treasury securities of similar maturity that was in effect on the initial Date of Award. Interest on the Solvency Loan shall accrue on a monthly basis using a 360-day year and 30-day month for actual days elapsed. Interest shall accrue to Principal during the Financing, Improvement and Workout Periods and be payable according to the Solvency Loan Promissory Note attached to this Agreement and incorporated herein by reference as Appendix 4. Accrued and unpaid Interest will be capitalized on an annual basis during the period prior to the first scheduled Interest payment date, and will be capitalized on any scheduled payment date on which Bon-ower does not pay the full amount of the accrued Interest due.

5.6. Repayment Provisions

Bon-ower shall make Principal and Interest payments as described in Schedule A of the Solvency Loan Promissory Note, with normal loan servicing activities to be undeltaken by Lender or its designee. Principal repayments of the Solvency Loan will be as stated in Schedule A of the Solvency Loan Promissory Note, but in any event no later than 15 years from the respective Disbursement date of the individual Loan Disbursement installments, subject to B01rnwer's ability to meet State Reserve Requirements and other solvency regulations or requisite surplus note an·angements.

Unless Lender terminates this Agreement for cause under Section 16.3 below, Bon-ower shall be obligated to repay I 00% of the Solvency Loan amount disbursed, plus any capitalized Interest to Bon-ower in accordance with the Repayment Schedule for the Solvency Loan, subject to its ability to meet State Reserve Requirements and other solvency regulations, or requisite surplus note an-angements.

If Lender terminates this Agreement for cause under Section 16.3 below, B01rnwer shall be obligated to repay 110% of the Solvency Loan Principal disbursed, plus any capitalized Interest and any accrued Interest recalculated for the life of the Sta1t-Up Loan at the higher Interest Rate as described in Section 5.6 above.

Instructions regarding the process for submitting payments to Lender are provided in Appendix 8 attached hereto and incorporated herein by reference. Changes to the process for submitting payment will be made available to Borrower as pa1t of CO-OP Program guidance.

5.7. Prepayment of Solvency Loan

Borrower may prepay the outstanding Principal of the Solvency Loan, in whole, or in part, at any time, without penalty, upon giving 30 days written notice to Lender of its intent to so prepay. A revised Repayment Schedule will be prepared by Lender following receipt of any acceptable partial prepayment; and will be delivered to Borrower within 30 business days thereafter.

5.8. Disposition ofUndisbursed Solvency Loan Funds

Should Solvency Loan Funds be set aside for future use under this Agreement (including, but not necessarily limited to Contingency Funds), but not disbursed within fifteen years of when projected in the Business Plan, the undisbursed Loan Funds will be defunded and cancelled.

5.9. Accounts

Lender shall receive evidence of the establishment of a solvency fund established according to the procedure of the applicable State's insurance commissioner prior to the initial Disbursement of Solvency Loan Funds.

5.10. Review and Supervision

Lender shall have the right to review and supervise the solvency fund established by Solvency Loan Funds provided under this Agreement; provided, however, that nothing in this Agreement shall be interpreted or construed to limit or supersede the authority of the responsible State's insurance commissioner in establishing the amount of solvency funds B01TOwer must maintain at any given time.

Section 6. PAYMENTS- DESCRIPTION

6.1. Application ofPayments

All payments made by Borrower hereunder will be applied by Lender in accordance with the following procedure:

(a) First to pay any outstanding Obligations ofBon-ower as defined in Section 2.1 that are due to Lender other than Interest or Principal;
(b) Second to pay any accrued Interest then due and owing under the Loans or any other outstanding Obligations of Borrower, with payment of Interest on the Start Up Loan having priority over payment of Interest on Solvency Loan;
(c) Third with the balance to pay outstanding Principal on the Loans, with payment of Principal on the Start-Up Loan having priority over payment of Principal on the Solvency Loan.

Payment by Borrower of a lesser amount than that which shall be then due shall be deemed to be payment on account, and shall not constitute an accord and satisfaction with respect to the underlying Obligation. The acceptance by Lender of a payment for a lesser amount which is delivered with an endorsement or statement to the effect that such lesser amount is payment in full shall be given no effect, and Lender may accept such payment without prejudice to any other rights or remedies which it may have against Borrower.

6.2. Payment Due Dates

All payments due under this Agreement shall be due on the scheduled payment date, irrespective of any other provision of the Agreement or any Appendix, Attachment or Schedule hereof. Notwithstanding the foregoing, Borrower's failure to make any payment of Principal or Interest due under the Loans on the due date thereof shall not be deemed an Event of Default under Section 15.I below unless the same remains delinquent for more than 60 calendar days after the due date thereof., or unless such delinquency is due to a State Solvency Payment Restriction, State Reserve Requirements, other State Insurance Laws or other solvency regulations, or requisite surplus note arrangements. In the latter event, the provisions of Section 6.5 shall apply.

6.3. Outstanding Delinquencies

In the event that any payment due under this Agreement is more than 60 calendar days late, Lender shall have the right, at its sole and absolute discretion, to exercise any right or remedy specified hereunder or available under applicable law, including the right to discontinue further Loan Disbursements or terminate this Agreement. In the event any payment due under this Agreement is delinquent for more than 180 days after the due date thereof, Lender shall refer the matter to the United States Department of Justice for processing and other Federal action, in accordance with the terms of applicable Federal law.

6.4. Notice of Inability to Make Payment

Borrower hereby covenants and agrees to notify Lender in writing at least 90 days in advance, whenever possible, if it will be unable to make any scheduled payment due hereunder, or immediately upon becoming aware or having reason to know or reasonably suspect or anticipate that it will be unable to make a scheduled payment hereunder if less than 90 days remain prior to the date of such scheduled payment.

6.5. Solvency Issues Preventing Payment; Additional Obligation

If Borrower is unable to make a payment as a result of a State Solvency Payment Restriction, State Reserve Requirements, other State Insurance Laws or other solvency regulations, or requisite surplus note arrangements, and a notice is provided to Lender with sufficient documentation to verify the claim, Lender will provide Borrower with a 60-day grace period to remedy the deficiency. Should the 60-day-delayed payment be missed, the missed payment and accrued Interest thereon may, at the option of Lender, be added to the last scheduled payment due as an additional Obligation payable in full on the last scheduled payment date.

Borrower's notice under this Section 6.5 should include a citation to or specific description of the State Reserve Requirement or other legal impediment which is then preventing payment, a description of how and why such legal impediment is preventing Borrower from making payment and a statement of the expected duration of said impediment.

Section 7. PROGRAM REQUIREMENTS

7.1. General

Borrower must at all times during the Term of this Agreement satisfy and meet all applicable requirements of the Affordable Care Act, and regulations promulgated thereunder, including but not necessarily limited to the regulations codified at 45 CFR Part 156, as well as terms of the CO-OP FOA and any and all additional CO-OP Program guidance as may be issued or released by Lender from time to time, including the following requirements:

(a) Borrower must meet all the State Insurance Laws and other standards for licensure that other issuers of Qualified Health Plans must meet in any State where Borrower offers a QHP, including State Reserve Requirements and other solvency and licensure requirements described in Section 1324(b) of the Affordable Care Act.
(b) Borrower cannot offer a health plan in any State until such State has in effect (or Lender has implemented for the State) the market reforms outlined in Part A of Title XXVII of

the Public Health Service Act (as amended by Subtitles A and C of Title I of the Affordable Care Act).

(c) Within the earlier of thirty-six months following the initial Disbursement of the Start-Up Loan, or one year following the initial Disbursement of the Solvency Loan, Bon-ower must be licensed in the State and must offer throughout the remainder of the Term of this Agreement the following CO-OP QHPs:

1. At least two CO-OP Q.HPs, one at the Silver Benefit Level and one at the Gold Benefit Level, in every individual market Exchange that serves the geographic regions in which Bon-ower is licensed and intends to provide health care coverage.

11. If offering at least one plan in the small group market, Bon-ower must offer at least two CO-OP QHPs, one at the Silver Benefit Level and one at the Gold Benefit Level, in each SHOP that serves the geographic regions in which it offers coverage in the small group market.

(d) Bon-ower must meet the standards of 45 CFR §156.515 no later than 5 years following initial Disbursement of the Start-Up Loan or 3 years following the initial Disbursement of the Solvency Loan. By that time, at least two-thirds of the policies or contracts for health insurance coverage issued by Bo1rnwer in each State in which it is licensed must be CO-OP QHPs as defined in 45 CFR §156.505 that are offered in the individual and small group markets.

(e) Borrower may only begin offering plans and accepting enrollment in the Exchanges for new CO-OP QHPs dming the open enrollment period and any other special enrollment period for each applicable Exchange.

(f) B01rnwer cannot convert or sell to a for-profit or non-consumer operated entity at any time after receiving a Loan (including after full repayment of the Loans). Thus, Bon-ower cannot sell a substantial portion of its enrollment to a for-profit or non-consumer operated entity. Bo1rnwer cannot undertake any transaction that would result in Borrower implementing a governance structure that does not meet the governance standards in 45 CFR §l 56.5l 5(b).

(g) Bon-ower must use any surplus funds (revenue in excess of its expenses) to repay the Loans, lower premiums, to improve benefits, to meet State Reserve Requirements, to accumulate reasonable and sufficient reserves to provide for enrollment growth, financial stability, and stable coverage for its Members, or for other programs intended to improve the quality of health care delivered to its Members.

7.2. Additional Program Requirements

(a) Bo1rnwer must at all times during the Term of this Agreement be a duly licensed company in good standing under the laws of the State(s) in which Bo1rnwer transacts business and be, or actively endeavoring to become, duly authorized to offer health insurance and provide health insurance coverage to the general public pursuant to applicable State Insurance Laws.

(b) The surplus reserves held by Bon-ower cannot be more than 10% below the RBC level stated in the Business Plan for the applicable year at any time (e.g. lfthe reserve level established in the Business Plan and funded by the Solvency Loan for a particular year is 300% of risk based capital ("RBC"), the surplus reserves held by Borrower shall not fall below 270% of RBC at any time during such applicable year).

(c) Borrower must ensure that any Member Grievances, appeals of adverse decisions or of coverage decisions received by Borrower are addressed in a timely and appropriate manner, including but not necessarily limited to satisfying applicable requirements of Section 2719 of the PHSA and any applicable requirements of State Insurance Laws that do not otherwise conflict with Section 2719 of the PHSA.

(d) Borrower must implement appropriate good practice measures to prevent, detect, correct, and report to Lender any actual or potential fraud, waste, and abuse committed by Borrower, its employees, agents, directors, officers, contractors and/or subcontractors in a manner consistent with CO-OP Program guidance.

(e) Before implementing any Organizational Change, Botrnwer must receive confirmation from Lender that the proposed changes are permitted under Section 1322 of the Affordable Care Act, and regulations promulgated thereunder, including but not necessarily limited to the regulations codified 45 CFR Part 156, the CO-OP FOA and any and all additional CO-OP Program guidance as may be issued or released by Lender from time to time in accordance with the provisions of Section 17.2 below.

Section 8. ADMINISTRATION

8.1. No Administrative Fees

No administrative fees or loan servicing fees will be charged to Borrower.

8.2. CO-OP Contracts

Borrower must ensure that all contracts or other formal agreements that Borrower enters into during the Performance Period with a third party or Affiliated Party to furnish supplies or services to Borrower in furtherance of Borrower's responsibilities, obligations or undertakings hereunder ("CO-OP Contracts") comply with Borrower's obligations under this Agreement and the CO-OP Program. In furtherance of this obligation, Borrower shall require the contracted entity under such CO-OP Contract to comply with Borrower's obligations under this Agreement and the CO-OP Program to the maximum extent practicable. Botrnwer shall further ensure that any Subcontract into which it enters for administrative, information technology or clinical services protects consumer control of the organization, to the maximum extent practicable.

All CO-OP Contracts into which Borrower enters for services that affect B01rnwer's activities that are integral to the provision of health care coverage must be approved in advance by Borrower's Board of Directors. The foregoing obligation includes but is not limited to third party administrative services, enrollment and call center services, provider services, claims payment, and grievance and appeal functions.

Notwithstanding any arrangements between or among Botrnwer and its Members, providers and suppliers, and contracted entities, Borrower must have ultimate responsibility for adhering to and otherwise fully complying with all CO-OP Program requirements and the terms and conditions of this Agreement.

8.3. Records Retention

Borrower agrees, and must require its providers, suppliers, and contracted entities performing services or functions on behalf of Borrower to agree, that U.S. Department of Health and Human Services, the Comptroller General, the HHS Office of Inspector General or their designees have the right to audit, inspect, evaluate, examine, and make excerpts, transcripts, and copies of any books, records, documents, and other evidence of Borrower, and its Members, providers and suppliers, and contracted entities related to their scope of work that pertain to:

(a) Borrower's compliance with CO-OP Program requirements; and
(b) The ability of Borrower to repay Loan Funds to Lender.

Borrower must comply with audit requirements of the Office of Management and Budget (0MB) Circular A-133. Information on the scope, frequency, and other aspects of the audits can be found on the Internet at http://www.whitehouse.gov/omb/circulars.

Borrower further agrees, and must include in its CO-OP Contracts a requirement causing its providers, suppliers, and contracted entities performing functions or services on behalf of Borrower to agree to the following:

(a) To maintain and give the U.S. Department of Health and Human Services, the Comptroller General, the HHS Office of Inspector General, or their designees access to all books, contracts, records, documents, and other evidence related to Borrower's scope of work sufficient to enable the audit, evaluation, and inspection of Borrower's compliance with program requirements and the terms of this Agreement;
(b) To maintain such books, contracts, records, documents, and other evidence related to Borrower's CO-OP Program throughout the last day of the Performance Period or from the date of completion of any audit, evaluation, or inspections, whichever is later, unless:
    i. Lender determines there is a special need to retain a particular record or group of records for a longer period and notifies Borrower at least 30 calendar days before the normal disposition date; or
    ii. There has been a termination, dispute, or allegation of fraud or similar fault committed by Borrower, its providers, suppliers, or contracted entities that perform functions or services on its behalf, in which case Borrower must retain records for an additional 6 years from the date of any resulting final resolution of the termination, dispute, or allegation of fraud or similar fault.

8.4. Right to Review Books and Records

Borrower shall document all uses of Loan proceeds, and maintain adequate books and, accounts, computer or other electronic payment and disbursements in accordance with generally accepted accounting principles consistently applied. The financial accounting system and/or methods employed by the Borrower must establish and leave a clear audit trail of all financial transactions and records executed and maintained. Borrower shall maintain all financial records consistent with industry standards for comparable health insurance carriers, and shall clearly identify all business revenue and disbursements by type of transaction. Borrower shall permit any representative of Lender, at any reasonable time and upon reasonable notice, to inspect, audit and examine such books and inspect the properties of Borrower. Borrower shall maintain documentation on the use of the Loan proceeds for a minimum of ten (I 0) years after the

completion of the inquiry response action supported by the Loan, or until the last day of the Performance Period, whichever is later. Borrower must obtain written approval from Lender prior to destroying any books or records required under this Agreement.

Section 9. LOAN MODIFICATION

9.1. Modification at Borrower's Request

Borrower may at any time after the initial Disbursement of a Loan request a loan modification for any or all of the following purposes:

(a) To obtain additional Loan Funds, if funding is available; or
(b) To materially revise the Business Plan, Disbursement Plans or Repayment Schedules.

It is understood and agreed that Disbursement Plans and Repayment Schedules will be revised and substituted by the patties in the ordinary course during the Financing Period to comport with the business realities of the CO-OP, and such revisions shall not necessarily require a written Loan Modification under this Section 9 unless the same are specifically requested by Borrower.

9.2. Modification Procedure

To request a loan modification, Borrower must submit a formal request, signed by its CFO or CEO, to Lender. The request must provide, at a minimum, (i) a detailed description of the requested modification; (ii) the reason for the request; (iii) sufficient evidence of hardship or other documentation justifying the request; and (iv) a detailed description of Borrower's plan for becoming a viable CO-OP under the requested modification with the capacity to repay the Loans.

Lender will review Borrower's request and make a written dete1mination regarding the request within 90 calendar days of receipt, which determination shall be granted, in whole or part, conditioned or denied in the sole and absolute discretion of Lender. In the event Lender has not made a written determination within such 90-day period, the request shall be deemed denied. All requests for loan modifications shall be contingent on B01rnwer's substantial compliance with the other material covenants, agreements, duties and obligations hereunder, and shall be subject to applicable statutory, regulatory, or other legal and administrative requirements.

The parties agree that no fees or other charges shall be required in conjunction with the submission and consideration of loan modification requests.

Section 10. DATA REPORTING AND MONITORING

10.1. Data Reporting and Monitoring

Borrower must submit financial reports, enrollment data, quality data, governance and election information, annual independently audited financial statements, and other reports and data required by Lender to monitor the performance of Borrower within the timeframes and formats established by Lender in CO-OP Program guidance. Instructions regarding data submission will be provided in CO-OP Program guidance.

In order to reduce duplication in data submission, Borrower consents to (i) Lender accessing any data submitted by Borrower to applicable Exchanges and State Departments of Insurance and (ii) Lender sharing any data submitted by Borrower with applicable Exchanges and State Departments of Insurance.

Borrower must submit the reports listed below in a manner and format consistent with CO-OP Program guidance until its Loans are fully repaid. Borrower shall initially follow the fo1mat reflected in the report formats as may be from time to time provided to Borrower by Lender. Lender has the discretion to start or stop the collection of these reports at any time, provided Borrower is given advance 30-day notice. Failure to submit the reports listed below may result in corrective action, the inability to access Loan Funds, and/or termination of this Agreement.

(a) Qumterly Federal Financial Repo1t (FFR): Borrower must submit a qumterly electronic SF 425. The report identifies cash transactions and expenditures against the authorized Funds for the Loan(s).
(b) Quarterly Financial Report: Borrower must submit a quarterly financial report including info1mation such as, but not limited to, a statement that Bo1rnwer is in compliance with all relevant State Insurance Laws and other licensure requirements appropriate for its stage of development or an explanation of any deficiencies and steps being taken to resolve them; financial statements including balances sheets, revenue and expense statements, and statements of cash flow, that include premium, administrative costs, salaries, claims expenses, and claims incurred but not reported (IBNR); an aging analysis of claims unpaid report and an aging analysis of premiums due and unpaid report.
(c) Semi-annual Progress Rep01t: Borrower must submit information such as, but not limited to: 1) progress on the goals, objectives, milestones, and activities identified in the Business Plan, Disbursement Plan, and Repayment Schedule; 2) accomplishments, bmTiers, and lessons learned; 3) data on Borrower's responsiveness to Member Grievance, maintenance of consumer control, and quality of care once Borrower begins providing health care coverage; 4) updated financial projections and proforma repo1ts; 5) enrollment reports listing CO-OP subscribers by each CO-OP QHP and market segment; 6) plan loss ratio for each CO-OP QHP and market segment (SHOP, group health coverage, etc.); 7) an updated Business Plan including supporting actuarial analyses; and 8) one of the semi-annual reports submitted each year must include an independently audited financial annual report.
(d) Annual audited financial statements performed in accordance with GAAS and prepared by an independent certified auditor.

All financial statements required hereunder must be prepared in accordance with GAAP and/or SAP. Borrower must certify (in a manner consistent with CO-OP Program guidance) that all information submitted to Lender is accurate, complete, and truthful based on its best knowledge, information, and belief. Failure to submit the reports required under this Section 10.1 may result in corrective action under Section 12 below, the inability to access Loan Funds, or other remedial or corrective actions permitted hereunder including termination of this Agreement.

10.2. Ownership of Data

Lender will own any and all data submitted by Borrower. Officers, employees, and contractors of Lender may only use the information disclosed or obtained from Borrower, for the purposes

of, and to the extent necessary in (1) carrying out the CO-OP Program, including but not limited to the awarding of CO-OP Loans, CO-OP Program monitoring and oversight, and CO-OP Program integrity activities; and (2) for complying with other requirements of Federal law. This restriction does not limit Lender's Office of Inspector General's authority to fulfill the Inspector General's responsibilities in accordance with applicable Federal law. This restriction does not limit the authority of other departments of the Federal Government to conduct program oversight and program evaluation activities.

Section 11. PROGRAM MONITORING

11.1. Program Monitoring

Borrower will be subject to monitoring by Lender to ensure that it complies with the requirements of the CO-OP Program, the Business Plan, Disbursement Plans, Repayment Schedules, and this Agreement throughout the Performance Period. In addition, Lender will monitor Borrower's financial management, responsiveness to Member Grievances, maintenance of consumer control, and quality of care. A memorandum describing the terms of such monitoring activities in more detail is attached hereto and incorporated herein by reference as Appendix 9 hereto.

Borrower must cooperate with and facilitate any monitoring or CO-OP Program oversight conducted by Lender including audits, performance reviews, site visits, and corrective action plans. The timing and frequency of audits, site visits, and performance reviews are at Lender's sole and absolute discretion. Lender will notify Borrower at least 15 calendar days in advance of any audit or site visit, unless fraud or other malfeasance is suspected, or unless Lender otherwise determines in its reasonable discretion that it has due cause to instigate an earlier investigation.

Lender may use a range of methods to monitor and assess the performance of Borrower including but not limited to:

Section 1. Analysis of data submitted to Lender by Borrower including aggregated annual and quarterly reports
Section 2. Site visits
Section 3. Analysis of member and/or provider complaints
Section 4. Background checks of personnel
Section 5. Audits.

11.2. Enhanced Oversight

Borrower may be placed on an enhanced oversight plan ("EOP") if Borrower fails to meet the milestones in its Disbursement Plan repeatedly, consistently underperforms relative to the Business Plan, or repeatedly fails to meet the requirements of this Agreement. Under an EOP, Lender conducts stronger and more frequent review of Borrower's operations and financial status, and may provide technical assistance to improve Borrower's performance.

Section 12. IMPROVEMENT PLAN

12.1. Improvement Period

Bo1rnwer shall enter an Improvement Period if, based upon the monitoring activities described in Section 11, Lender (i) has determined that Borrower has not complied with CO-OP Program requirements, has not achieved required performance levels under any previous approved and implemented corrective action plan (CAP), has failed to meet milestones in the Disbursement Plan, has failed to meet its Repayment Schedule, or has not otherwise met the terms and conditions of this Agreement in any material respect; and (ii) Lender believes that the violation is nonetheless resolvable.

12.2. Improvement Plan

During the Improvement Period, Borrower shall be placed under the requirements of an Improvement Plan that may consist of one, several, or all of the following in Lender's sole and absolute discretion:

(a) Warning notice: Borrower may receive a letter from Lender warning Borrower of a specific performance issue.

(b) Corrective Action Plan ("CAP"): Borrower may be placed on a CAP, which will be a plan developed by Borrower and approved by Lender to correct any failure to meet a CO-OP Program requirement or te1m and condition of this Agreement. The CAP include the following aspects:

1. If placed on a CAP, Borrower must submit, for Lender approval, a CAP by the deadline indicated on the notice of violation.
11. The CAP must specify what actions Borrower will take to correct the failure and remain in compliance with CO-OP Program requirements and the terms and conditions of this Agreement.
111. Borrower must implement the CAP as approved by Lender.
iv. Failure to submit, obtain approval for, or implement a CAP, or failure to achieve the required level of performance upon completion of the CAP, may result in termination of this Agreement or other corrective actions provided for in this Agreement.

(c) EOP: Borrower may be placed on a EOP, under which Lender shall conduct stronger and more frequent review of Borrower's operations and financial status.

(d) Technical Assistance: Lender may identify and provide resources to assist Borrower improve performance, meet program requirements, or fulfill the te1ms and conditions of the loan agreement. Lender may require Borrower to take specific actions to protect the interests of the Federal government.

(e) Discontinuance of Loan Disbursements: If Borrower fails to comply with CO-OP Program requirements or the terms and conditions of this Agreement, Lender may withhold further Disbursement of Loan Funds until such time as Borrower has corrected the failure and is in full compliance with CO-OP Program Requirements and the terms and conditions of this Agreement.

Section 13. COVENANTS

13.1. Affirmative Covenants

Borrower covenants and agrees that, from the Closing Date until the date that Principal and Interest on each Loan and all other Obligations shall have been indefeasibly paid in full and the commitment of Lender under Section 3.I to make the Loans has terminated:

13.1.1. Payment of Obligations

Borrower and its Affiliated Parties will comply with and pay, discharge or otherwise satisfy at or before maturity or before they become delinquent, its obligations of whatever nature. This includes:

(a) Material taxes, assessments and governmental charges or levies imposed on it or its income or profits or on any of its property
(b) Any other contractual obligations arising outside of this Agreement, in each case before the same shall become delinquent or in default, except where:
   i. The validity or amount thereof is being contested in good faith by appropriate proceedings
   ii. Borrower or such Affiliated Party has set aside on its books adequate reserves with respect thereto in accordance with GAAP and SAP.
   iii. The failure to make payment pending such contest could not reasonably be expected to result in a Material Adverse Effect. Borrower and its Affiliated Parties shall file on a timely basis all Federal, state and local tax and information returns, reports and any other information statements or schedules required to be filed by or in respect of it where the failure to file could reasonably be expected to have a Material Adverse Effect.

13.1.2. Notice of Material Adverse Effect

Borrower will promptly furnish written notice to Lender of:

(a) The occurrence of any default or event of default under any contractual agreement of Borrower or a Affiliated Party; or
(b) The instigation or pendency of any litigation, including:
   i. Any litigation or proceeding of which Borrower has knowledge that may exist at any time in which Borrower or a Affiliated Pa1 1y is a named party and which, if adversely determined could reasonably be expected to have a Material Adverse Effect, and the outcome, when resolved, of any such litigation or proceeding;
   ii. The commencement of any formal investigation of which Borrower becomes aware by any Governmental Authority that involves an allegation of a material violation of law by Borrower or an Affiliated Party, and the outcome, when resolved, of any such investigation; and
   iii. Any litigation or proceeding of which Bo1rnwer has knowledge affecting Borrower or any Affiliated Party in which (i) the amount involved is $100,000 or more, or (ii) injunctive or other similar equitable relief is sought.

(c) Proposed Change of Public Accountants. A proposed change of Borrower's accounting firm, including the name of the new accounting firm, which firm shall be an nationally recognized accounting firm reasonably acceptable to Lender;
(d) Disabling Event. The occurrence of any Disabling Event of which it has knowledge;
(e) Material Adverse Effect. Any development or event of which Borrower has knowledge that has had or could reasonably be expected to have a Material Adverse Effect;
(f) Licensure Status. Any change in licensure status or any adverse action or detelmination made by State insurance regulators against Borrower.

Each notice pursuant to this Section 13.1.1.2 shall be accompanied by a certificate of a responsible officer of Borrower setting forth details of the occurrence referred to therein and stating what action, if any, Borrower proposes to take with respect thereto.

13.1.3. Existence; Conduct of Business

Borrower will, and will cause each of its Affiliated Parties to, do or cause to be done all things necessary to preserve, renew and keep in full force and effect its legal existence and take all reasonable action to maintain all material rights, licenses, permits, privileges and franchises necessary or desirable in the normal conduct of the business of Borrower and its Affiliated Parties; provided, however, that in so doing, Borrower and its Affiliated Parties shall not make or attempt to make any Organization Changes without the prior written consent of Lender as required under Section 18.2 below.

13.1.4. Books and Records; Inspection

Borrower will, and will cause of each of its Affiliated Parties to, keep or cause to be kept complete, accurate and appropriate books and records in accordance with the requirements of this Agreement, including but not necessarily limited to the requirements of Sections 8, IO and 11 above.

13.1.5. Compliance with Laws

Bo1rnwer will, and will cause each of its Affiliated Parties to comply with any and all applicable laws, statutes, regulations or ordinances of the United States of America and each State in which it transacts business, as well as any Federal Government agency or other state or local governmental agency, or other administrative or regulatory agencies, board or court that are applicable to the conduct of the activities that are the subject of this Agreement and or its status as a non-profit insurance company, including but expressly not limited to the requirements of the Public Health Service Act and HIPAA privacy rules and regulations, and will further take all action, or refrain from taking any action, which may be required for unconditional compliance with the same.

13.1.6. Notice of Formation of Affiliated Parties

Prior to the formation or acquisition of any new Affiliated Party, Borrower will provide Lender with a minimum written notice of such formation or acquisition at least 30 days prior to such formation or acquisition, together with any and all such additional information related to such Affiliated Party as may thereafter be reasonably requested by Lender.

13.1.7. Use of Proceeds

Borrower shall use the Funds and proceeds of the Loans solely for the purposes permitted under Sections 3.4 above and applicable law.

13.1.8. Indemnification

Borrower will indemnify and hold harmless Lender and its officers and employees from and against any and all damages, losses or liabilities, including litigation costs, fees, and settlement costs, arising out of, or in any way connected with the use of the Loan Funds and the repayment of the Loans. Borrower will further indemnify and hold harmless Lender and its officers and employees from and against any and all damages, losses or liabilities, attributable to any actions taken by Lender in good faith to carry out the transactions contemplated by this Agreement, to safeguard Lender's interest or to ascertain, determine or carry out Lender's obligations under this Agreement or any law or contract applicable to this Agreement. Borrower will further indemnify, defend and hold harmless its Members and its officers, directors, incorporators, managing partners or other similar key or controlling persons (the foregoing other than the Members being collectively referred to as "Controlling Persons") from and against any and all suits, claims, actions, costs and expenses (including attorney's fees) arising out of or by reason of such Member or Controlling Person being or having been such Member or Controlling Person of the CO-OP, except in relation to matters involving malfeasance, intentional fraud or criminal activity or other misconduct committed by such indemnified party. The CO-OP may obtain and maintain commercial reasonable liability insurance policies to meet the foregoing indemnification obligations.

13.1.9.Discrimination

Borrowers must comply with all applicable Federal laws relating to nondiscrimination including, but not limited to:

(a) Title VI of the Civil Rights Act of 1964;
(b) Section 504 of the Rehabilitation Act of 1973;
(c) The Age Discrimination Act of 1975; and
(d) Title II, Subtitle A of the Americans with Disabilities Act of 1990.

13.1.10. Maintenance of Property.

Borrower will, and will cause its Affiliated Parties to, keep and maintain all property useful and necessary to the conduct of the business of Borrower and its Affiliated Parties in good working order and condition, ordinary wear and tear and casualty excepted.

13.2. Negative Covenants

Borrower covenants and agrees that, from the Closing Date and until the date that Principal and Interest on each Loan and all other Obligations hereunder shall have been paid in full and the commitment of Lender under Section 3.1 to make the Loans has terminated:

13.2.1. Indebtedness

Borrower will not, nor will it permit any of its Affiliated Parties to, create, issue, incur, assume, become liable in respect of or suffer to exist any indebtedness that was not otherwise specifically identified and provided for under the Business Plan, without the express prior written consent of

Lender, which consent may be withheld, conditioned or delayed in Lender's sole and absolute discretion.

13.2.2. Liens

Unless otherwise specifically identified or provided for under the Business Plan, Bolrnwer will not, nor will it permit any of its Affiliated Parties to, create, incur, assume or suffer to exist any lien on any real or personal property now owned or hereafter acquired by Borrower that has a market value in excess of $100,000 nor assign, transfer, convey or sell any income or revenues (including accounts receivable) or rights in respect thereof, without the express prior written consent of Lender, which consent may be withheld, conditioned or delayed in Lender's sole and absolute discretion.

13.2.3. Investments

Borrower will not, nor will it permit any of its Affiliated Parties to, acquire, make or enter into, or hold, any investments that are inconsistent with or in violation of State investment guidelines or mies for or pertaining to insurance providers.

13.2.4. Use of Proceeds

Borrower shall not use Loan Funds or and proceeds of the Loans for any of the purposes specified in Section 3.5 above, or as otherwise contrary to or in violation of applicable law.

13.2.5. Non-Discrimination

Borrower shall not discriminate, with respect to its CO-OP QHPs, on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

13.2.6. Screening of Key Personnel

Individuals that are debarred from Federal programs are not permitted to participate in the CO-OP Program. Borrower must therefore conduct on-going checks to ensure that all employees, contractors, and subcontractors are not excluded or debarred from Federal programs. In addition, to other sources, Borrower must consult the list of excluded individuals and entities (LEIE) database available at www.oig.hhs.gov/exclusions/ and the excluded parties list system (EPLS) available at www.epls.gov to identify individuals and entities excluded from Federal programs.

Section 14. REPRESENTATIONS AND WARRANTIES

14.1. Representations and Warranties of Borrower

Bolrnwer represents and warrants to Lender that as of the Closing Date:

(a) Borrower is duly formed or incolporated and in good standing under, and/or otherwise duly qualified and authorized to do business in, the State of Arizona.
(b) Borrower has full right and authority to enter into and perform under this Agreement; and that all persons signing on behalf of Borrower were authorized to do so by appropriate corporate or organizational action.
. (c) Borrower has taken all other actions necessary to authorize the execution and delively of this Agreement and assume the obligations hereunder.

(d) The execution and delively of this Agreement will not violate any applicable law, nor lead to default under or conflict with any of its other agreements.

(e) To the best of its knowledge and belief after full and adequate investigation, Borrower is in full compliance with all applicable laws in all material respects.

(f) To the best of its knowledge and belief after full and adequate investigation, Borrower is not part of an action, suit, claim, arbitration, or legal, administrative, or other investigation before any governmental authority, arbitrator or board; it is not in default with respect to any order or award of any arbitrator, government depattment, commission or agency; it is not in default under any term of its other agreements or instruments to which it is bound.

(g) Borrower has no other obligations or liabilities than those disclosed in the Business Plan and the financial statements delivered to Lender.

(h) Borrower has consistently maintained and will continue to maintain its books and records with full, true, and correct entries in accordance with applicable GAAP, SAP and all applicable other financial reporting laws.

(i) Borrower has filed all tax returns required and correctly reported all income and other amounts required, paid all taxes, interest, and penalties, if any. To the best of its knowledge and belief after full and adequate investigation, there are no actions, audits, assessments, reassessments, suits, proceedings, investigations, or claims pending or threatened against Borrower in respect of any taxes.

(j) Borrower has good and marketable title to all real properties and all other properties and assets owned by it, in each case free from liens (including, without limitation, liens for taxes), encumbrances, claims and defects that would affect their value or interfere with their usage.

(k) There has been no change in the financial status of Borrower since the date of its application and response to the CO-OP FOA that would adversely affect its ability to do business or to perfo1m its obligations hereunder.

(l) Upon execution, this Agreement shall be a legal and fully binding agreement duly enforceable against Borrower.

(m)Borrower intends to become a CO-OP and believes that it can develop a viable and sustainable CO-OP.

(n) None of Borrower's or any of its Affiliated Parties' funds or other assets constitute property of, or are beneficially owned, directly or indirectly, by any person subject to trade restrictions under U.S. law ("Embargoed Person"), including but not limited to:

i. the International Emergency Economic Powers Act, 50 U.S.C. §§ 1701 et seq.,

ii. the Trading with the Enemy Act, 50 U.S.C. App. 1 et seq. (the "Trading With the Enemy Act"),

iii. any of the foreign assets control regulations of the Treasury (31 C.F.R., Subtitle B, Chapter V, as amended) (the "Foreign Assets Control Regulations") or any enabling legislation or regulations promulgated thereunder or executive order relating thereto (which for the avoidance of doubt shall include but shall not be limited to (i) Executive Order No. 13224, effective as of September 24, 2001 and relating to Blocking Property and Prohibiting Transactions With Persons Who Commit, Threaten to Commit, or Support Terrorism (66 Fed. Reg. 49079 (2001)) (the "Executive Order") and (ii) the USA PATRIOT Act), with the result that the investment in Borrower or any of its Affiliated Parties (whether directly or

indirectly), is prohibited by applicable law or any Loan made by Lender is in violation of applicable law.

(o) No Embargoed Person has any interest of any nature whatsoever in Borrower or any of its Affiliated Parties with the result that the Investment in Borrower or any of its Affiliated Parties (whether directly or indirectly), is prohibited by applicable law or any Loan made by Lender is in violation of applicable law.

(p) None of Borrower's or any of its Affiliated Parties' funds have been derived from any unlawful activity with the result that the investment in Borrower or any of its Affiliated Parties (whether directly or indirectly), is prohibited by applicable law or any Loan made by Lender is in violation of applicable law.

(q) Neither Borrower, any of its Affiliated Parties, or any of their respective Affiliated Parties

i. is a "blocked person" as described in the Executive Order, the Trading With the Enemy Act or the Foreign Assets Control Regulations or

ii. engages in any dealings or transactions, or be otherwise associated, with any such "blocked person."

(r) For purposes of determining whether a representation with respect to any indirect ownership is true under this section, neither Borrower nor any Affiliated Party shall be required to make any investigation into (a) the ownership of publicly traded stock or other publicly traded securities or (b) the ownership of assets by a collective investment fund that holds assets for employee benefit plans or retirement arrangements.

Section 15. DEFAULT; EVENTS OF DEFAULT

15.1. Events of Default

As used in this Agreement, the term "Event(s) of Default" means the occurrence or happening, from time to time, of one or more of the following:

(a) Borrower, for reasons other than a States Solvency Payment Restriction, fails to pay any installment of Principal or Interest on a Loan or other Obligation for more than 60 days after the date the same is due, and such delinquent payment in not subsequently recapitalized in accordance with the terms hereof.

(b) Any representation or warranty made by Borrower under or pursuant this Agreement or any Related Documents shall prove to have been false or misleading in any material respect as of the date on which such representation or warranty was made.

(c) Borrower defaults in the performance or observance of any covenant contained in this Agreement or any of the Appendices hereof, or shall breach any of its representations, warranties or other duties contained in this Agreement or any of the Appendices hereof, and, in each case such default continues for at least 30 calendar days after written notice thereof from Lender to Borrower; provided, however, that such condition shall not constitute an Event of Default hereunder if Borrower commences action to cure such default with such 30 day period in a manner approved by Lender and thereafter diligently pursues such cure to completion.

(d) If, in the sole judgment of Lender, Borrower ceases to be solvent, admits in writing its inability to pay its debts, declares bankruptcy or instigates or prosecutes any case, proceeding or other action under any existing or future law of any jurisdiction, domestic

or foreign relating to bankruptcy, insolvency, reorganization or relief with respect to Bonower, or seeking reorganization, a1rnngement, adjustment, winding-up liquidation, dissolution, composition or other relief with respect to Borrower or Bonower's debts, or the making by Bonower of an assignment or any other anangement for the general benefit of creditors under any state statute.

(e) Bonower has been notified by Lender of a failure to be in compliance with any provision of this Agreement or the CO-OP Program, has been given an opportunity to correct the non-compliance through an Improvement Plan, and has failed to correct the failure and comply with the Improvement Plan.

(f) Bonower makes, or anyone acting on Bonower's behalf makes, a materially false or misleading representation to Lender or any branch; department or agency of the United States Government.

(g) Borrower defaults on any loan or agreement with another creditor, if Lender believes the default may materially affect Bmrnwer's ability to pay the obligation under this Agreement.

(h) Bonower fails to pay any taxes when and as due.

(i) Bonower implements or makes an Organizational Change in violation of the terms of Section 18.2 below.

(j) Borrower becomes the subject of a civil or criminal action that Lender believes may materially affect Bonower's ability to pay the obligation under this Agreement.

(k) Borrower does not otherwise preserve or account to Lender's satisfaction for any of the material provisions of this Agreement.

(1) Bonower has its State license to operate the CO-OP and/or to offer health insurance coverage suspended, terminated or revoked.

15.2. Notice of Events of Default

Upon the occurrence or happening of one or more of Events of Default identified in Section 15.1 above, Borrower must promptly notify Lender of the same in writing (but in any event not later than 10 business days after the occurrence or happening of such Event of Default), describing in such notice the circumstances sunounding the Event(s) of Default and any proposed or plans of Bmrnwer to remedy or cure such default. Borrower shall have a period of 30 days following the delivery of such notice to Lender to remedy any non-monetary default, and shall thereafter be obligated to diligently take and pursue (or refrain for taking or pursuing, as the case may be), all actions necessary to remedy such default. Failure to comply with the provisions of this Section 15 .2 shall entitle Lender to declare any or all outstanding payments of Principal and Interest and other Obligations to be immediately due and payable, at its option, and to proceed to pursue and enforce any and all rights and remedies hereinafter set forth in this Agreement or available under operative law.

15.3. Rights and Remedies of Lender

Upon the occurrence of an Event of Default which is not cured within the time limits set fo11h in Section 15.1 and 15.2 above, Bo1rnwer and the Loans hereunder shall automatically be deemed to be within a Workout Period. At Lender's option, Lender may thereafter declare, among other things, that:

(a) All obligations of Lender are immediately terminated.

(b) The unpaid Principal amount of the Loans, together with all Interest accrned thereon, and all fees, costs, expenses, indemnities and other amounts payable under this Agreement, are immediately due and payable, without further notice or cure oppo1tunities to Borrower, which notice and rights to cure in such Workout Period are hereby irreparably waived.
(c) Borrower must immediately repay any unused Loan Funds to Lender following the resolution of any outstanding debts and rnn out of outstanding claim obligations, consistent with State Insurance Laws.

It is understood and agreed that Lender may pursue any and all such remedies and any and all such other further rights or remedies available under applicable law as and to the extent it deems appropriate in its sole and absolute discretion, and no failure of Lender to take any or all of such actions shall be deemed a waiver of future rights to take further actions, or give rise to any other claims of waiver or estoppel.

All sums expended by Lender under this Section 15.3 shall be deemed to be disbursement of the account of Borrower, and all such sums shall be deemed additional Obligations of Borrower hereunder.

No action taken by Lender pursuant to this Section shall relieve Borrower from its other obligations pursuant to this Agreement. Borrower must further comply with all State Insurance Laws relevant to its termination from the CO-OP Program at its sole cost and expense, and shall not be entitled to use any Loan Funds or proceeds for such purposes unless and only to the extent that such use is mandated by a State Solvency Payment Restriction.

Section 16. TERMINATION RIGHTS

16.1. Termination of Agreement by Borrower

Provided that Borrower strictly adheres to the procedures hereinafter set forth in this Section 16.1, Borrower shall have the right to terminate this Agreement if it no longer believes that it can create a viable and sustainable CO-OP and Lender approves the termination.

16.1.1. Borrower's Termination Request

To request a termination of this Agreement, Borrower must first submit a formal request signed by its CFO or CEO. The request must, at a minimum:

(a) Assert that Borrower no longer believes that it can create a viable and sustainable CO-OP;
(b) Explain with particularity the facts and circumstances which formed the basis of Borrower's conclusion;
(c) Provide evidence and documentation in support of such assertion; and
(d) Describe what efforts Borrower has made to attempt to create a viable and sustainable CO-OP.

The request must also include an affidavit signed by the CFO, CEO, and two-thirds of the directors on Borrower's Board of Directors indicating that they collectively no longer believe

that BoJTower can create a viable and sustainable CO-OP. The request must also include a description ofBoJTower's plan to protect Lender' assets, subject to State Insurance Laws, and repay its Loan(s) should Lender approve its request.

16.1.2. Lender Response

Lender will review the response and provide a determination within 90 calendar days after receipt ofBoJTower's termination request, which determination may be withheld, conditioned or delayed in the sole and absolute discretion of Lender. In the event Lender has not made a written determination within such 90-day period, the request shall be deemed denied.

16.1.3 BoJTower's Duties Upon Voluntary Termination

If Lender agrees to pelmit Borrower to terminate this Agreement in accordance with the procedures set forth in this Section 16.1:

(a) BoJTower must comply with all applicable Federal requirements and State Insurance Laws relevant to its termination from the CO-OP Program.
(b) BoJTower forfeits all unused Loan Funds received under the Disbursement Plans and the CO-OP Program. Any unused disbursed Loan Funds must be repaid to Lender within 60 calendar days following the resolution of any outstanding debts and payment or other accommodation of outstanding claim obligations, consistent with applicable Federal requirements and State Insurance Laws.
(c) Any remaining Principal and Interest must be repaid in accordance with Borrower's Repayment Schedules. If BoJTower intends to dissolve, all Principle and Interest must be repaid prior to dissolution consistent with S.tate Insurance Laws unless and only to the extent that such payment is otherwise prevented, restricted or delayed by a State Solvency Payment Restriction.

16.2. Termination for Program Viability Reasons

Lender may elect to terminate this Agreement if it determines in its sole and absolute discretion that Borrower will not be likely to be able to establish a viable and sustainable CO-OP that serves the interests of its community and the goals of the CO-OP Program in accordance with the following procedure:

(a) Lender shall provide Borrower with a written notice of its intent to terminate under this provision. The request will provide an explanation for Lender's determination that telmination of this Agreement is in the best interests of the CO-OP Program.
(b) BoJTower may submit a formal response, signed by Bolrnwer's CFO or CEO, to Lender's request within 30 calendar days from the date of receipt of Lender's initial notice. The response must include, at a minimum, documentation demonstrating the viability of Borrower's Business Plan and a justification for why BoJTower should be permitted to continue participating in the CO-OP Program.
(c) Lender will review the response and provide a determination within 60 calendar days, which response may be withheld, conditioned, delayed or denied in Lender's sole and absolute discretion.
(d) Lender may terminate this Agreement without BoJTower's consent if Lender determines in its sole and absolute discretion that the documentation and justification

provided by Borrower is insufficient or inadequate to persuade or convince Lender that Bo1rnwer can establish a viable and sustainable CO-OP that serves the interests of its community and the goals of the CO-OP program. In such event, Lender will provide a notice of termination to Botrnwer that provides an explanation for the termination.

If this Agreement is terminated under this Section 16.2, Bo1rnwer shall:

(a) Immediately cease its operations under the CO-OP Program and thereafter comply with all applicable Federal requirements and State Insurance Laws relevant to its termination from the CO-OP Program.
(b) Forfeit all unused Loan Funds received under the Disbursement Plans and the CO-OP Program. Any unused Loan Funds must be repaid to Lender within 60 calendar days following the resolution of any outstanding debts and payment or other accommodation of outstanding claim obligations, consistent with applicable Federal requirements and State Insurance Laws.
(c) Notify the Internal Revenue Service of the termination and any other program non-compliance that may result in the termination of a Borrower's tax-exempt status under IRC Section 501 (c) (3) or (29).
(d) Inform State regulators of any action by Lender to terminate Borrower's participation in the program; and
(e) Notify the relevant Exchanges that the health plans offered by the CO-OP in the relevant Exchanges are no longer deemed to be CO-OP QHPs.
(f) Repay any remaining Principal and Interest in accordance with Borrower's Repayment Schedules. If Borrower intends to dissolve, all Principal and Interest must be repaid prior to dissolution consistent with applicable Federal requirements and State Insurance Laws, unless and only to the extent that that such payment is otherwise prevented, restricted or delayed by a State Solvency Payment Restriction

16.3. Termination for Cause by Lender

Lender may terminate the Loan Agreement upon written notice to Borrower in Lender's sole discretion if the organization, its providers and suppliers, or contracted entities performing services on its behalf:

(a) Fail to meet quality and performance standards, including implementation milestones, enrollment targets, consumer governance and responsiveness requirements, as specified in this Agreement, or any other contractual obligation with Lender;
(b) Engage in improper use of Federal funds;
(c) Fail to reinvest profits for the benefit of its Members;
(d) Engage in material noncompliance, or demonstrate a pattern of noncompliance with repo1ting requirements and other CO-OP Program requirements;
(e) Fail to submit an approvable CAP, fail to implement an approved CAP, or fail to improve performance after the implementation of a CAP;
(f) Violate any applicable laws, rules, or regulations that are relevant to Borrower's operations; or

(g) Knowingly submit to Lender false, inaccurate, or misleading data or information related to the CO-OP application, governance information, quality data, financial data, and enrollment data.

Lender may further immediately terminate this Agreement if Lender has cause to believe that Borrower or a Affiliated Party engages in, or has engaged in, criminal or fraudulent activities or activities that cause material harm to the CO-OP's Members or the CO-OP Program. In such event, Lender shall have the additional right, at its option, to suspend or debar Borrower from further participation in any Government program administered by Lender and notify other departments and agencies of such suspension and default.

If this Agreement is terminated under this Section 16.3, Borrower shall:

(a) Immediately cease its operations under the CO-OP Program consistent with all applicable Federal requirements and State Insurance Laws relevant to its te1mination from the CO-OP Program.
(b) Forfeit all unused Loan Funds received under the Disbursement Plans and the CO-OP Program. Any unused Loan Funds must be repaid to Lender within 60 calendar days following the resolution of any outstanding debts and payment or other accommodation of outstanding claim obligations, consistent with applicable Federal requirements and State Insurance Laws.
(c) Notify the Internal Revenue Service of the te1mination and any other program non-compliance that may result in the termination of a Borrower's tax-exempt status under IRC Section 501 (c)(3) or (29).
(d) Info1m State regulators of any action by Lender to terminate BmTOwer's participation in the program; and
(e) Notify the relevant Exchanges that the health plans offered by the CO-OP in the relevant Exchanges are no longer deemed to be CO-OP QHPs.
(f) Repay any remaining Principal and Interest must be repaid in accordance with Borrower's Repayment Schedules and the te1ms of this Agreement. If Borrower intends to dissolve, all Principal and Interest must be repaid prior to dissolution consistent with applicable Federal requirements and State Insurance Laws, unless and only to the extent that such payment is otherwise prevented, restricted or delayed by a State Solvency Payment Restriction.

16.4. Borrower's Right to Appeal

Bo1TOwer has the right to appeal Lender's decision to terminate this Agreement. In order for such appeal to be timely, Borrower must submit a formal request for appeal signed by the CEO or CFO to Lender within 30 days of Borrower's receipt of the notice of termination. Borrower's failure to file its request for appeal within such 30 day period may be deemed a waiver of all termination appeal rights in Lender's sole and absolute discretion. Borrower's appeal request must include, at a minimum, Borrower's statement of justification for why Lender should not terminate this Agreement and its proposal plan for promptly and adequately curing the condition that resulted in the decision to terminate.

Section 17. ACCOMMODATIONS AND DISPUTES

17.1. Accommodations for Changes in Law

In the event of statutory and regulatory changes to the law that may necessitate an Organization Change or other structural change in Borrower, Borrower and Lender agree to promptly enter negotiations in good faith for the purposes of transferring the Loan(s) to a new legal structure or other accommodation, consistent with Borrower's obligation to repay any disbursed Loan Funds.

17.2. Disputes

Disputes under this Agreement shall be decided in accordance with applicable Federal law and any applicable HHS policies.

Section 18. ASSIGNMENTS; ORGANIZATIONAL CHANGES

18.1. Assignments

Except for any Organizational Changes permitted under Section 18.2 below, Borrower may not assign this Agreement in whole or in part, whether by merger, acquisition, consolidation, reorganization or otherwise, nor otherwise delegate any of its obligations under this Agreement, without the express, prior written consent of Lender, which consent may be withheld, conditioned, granted or denied in Lender's sole and absolute discretion. If Borrower attempts to make an assignment or otherwise delegate its obligations hereunder in violation of this provision, such assignment or delegation shall be deemed void *ab initio* and of no force or effect, and Borrower shall remain legally bound hereto and responsible for all obligations under this Agreement. Borrower shall further be thereafter subject to such compliance actions as are otherwise described herein, or that may otherwise be provided for under applicable law.

18.2. Condition Precedent to Organizational Changes

In the event that Borrower seeks to (i) implement or make any material or significant changes to its corporate or governance structure or (ii) otherwise transfer all or a significant portion of its' assets to an Affiliated Party or other third party (an "Organizational Change") during the Performance Period of this Agreement, Borrower must request and receive the prior written approval of Lender (which consent may be withheld, conditioned, granted or denied in Lender's sole and absolute discretion), confirming that the proposed change(s) or transaction(s) is or are permitted under Section 1322 of the Affordable Care Act, and the regulations promulgated thereunder, including but not necessarily limited to the regulations codified in 45 CFR Part 156, or any other CO-OP Program guidance as may be issued or released by Lender from time to time, before proceeding with such Organizational Change. The procedure applicable to such prior approval is as follows:

(a) Borrower must notify Lender at least 30 Business Days in advance of any proposed Organizational Changes.

(b) Lender will review the proposed Organizational Change(s) and provide a determination to Borrower within 21 Business Days thereafter.

(d) In the event Lender has not approved Borrower's request within such 21-Day period, the request shall be deemed denied, and Bon-ower shall not thereafter implement the proposed Organizational Change(s) unless Lender otherwise subsequently so approves such request in writing.

In no event will any Organizational Change be permitted which causes or effectuates, or purports to cause or effectuate, a conversion or sale ofa substantial portion of Borrower's or an Affiliated Party's assets or enrollments to a for-profit or non-consumer operated entity, nor will any Organizational Change be permitted that would result in Bo1rnwer or an Affiliated Party implementing a governance structure that does not meet the governance standards codified 45 CFR §156.S IS(b), as from time to time hereafter amended.

18.3. Future Indebtedness

Except to the extent specifically identified in the Business Plan or otherwise specifically required by State Insurance Laws, Bon-ower shall not create or grant any mortgage, security interest, lien or other encumbrance upon its assets, or those of any Affiliated Party, that would have priority over or purport to have priority over or pari passu with the rights of Lender hereunder without the express, advanced written consent of Lender, which consent may be conditioned on the receipt by Lender of a commercially reasonable subordination agreement acknowledging Lender's priority position. Any failure ofBon-ower to comply with the provisions of this Section 18.3 may result in corrective action under Section 12 above, the inability to access further Loan Funds, or other remedial or corrective actions permitted hereunder including te lmination of this Agreement.

Section 19. MISCELLANEOUS

19.1. Notices

All notices specifically required under this Agreement shall be in writing and shall be delivered by hand or overnight courier service, mailed by certified or registered mail, or sent by facsimile to the addresses or facsimile numbers specified on the signature pages to this Agreement. Notices sent by hand or overnight courier service, or mailed by certified or registered mail, shall be deemed to have been given when received; notices sent by facsimile shall be deemed to have been given when the appropriate confirmation of receipt has been received; provided, that notices not given on a Business Day between 9:00 a.m. and 5:00 p.m. local time where the recipient is located shall be deemed to have been given at 9:00 a.m. on the next Business Day for the recipient. Lender of Bon-ower may change its address or facsimile number for notices and other communications.

19.2. Governing Law, Choice of Law and Forum

This Agreement will be governed by the laws and common law of the United States, including without limitation such regulations as may be promulgated from time to time by HHS, without regard to any conflict of laws statutes or rules, and by the laws of the State of Arizona to the extent the same do not conflict with applicable Federal law. The parties further agree that they consent to the jurisdiction of the Federal Courts located within such State and the courts of appeal therefrom, and waive any claim of lack of jurisdiction or *forum non conveniens.*

19.3. Counterparts

This Agreement may be executed in one or more counterparts, each of which shall constitute an original and all of which taken together shall constitute one and the same Agreement. The parties may sign facsimile copies of this Agreement, which shall each be deemed originals.

19.4. Integration

This Agreement, together with the Appendices attached hereto, represents the entire integrated agreement and understanding between the Parties with respect to matters set f01th herein, and the Parties acknowledge that they have not relied upon any representations by any other party apart from those set forth in this Agreement. No amendment or modification of this Agreement shall be binding or valid unless expressed in a written document executed by both parties hereto. All Appendices that form or constitute a part of this Agreement are incorporated herein by reference.

19.5. Binding Precedence

In the event of any conflict, inconsistency, ambiguity or difference between the provisions of this Agreement, and the provisions of any other related or collateral document, the provisions of this Agreement shall prevail, and any conflicting provisions in the related documents shall be deemed modified to eliminate the conflict; provided, however, that the foregoing shall not apply with respect to the terms of any applicable law, rule or regulation pe1taining to the CO-OP Program. In the event of conflict between the provisions contained in the numbered Sections of this Agreement and the provisions contained in the Appendices, the provisions of the Appendices shall prevail over those in the numbered Sections. In the event of a conflict between any provision of this Agreement as originally drafted and the provisions of any subsequent amendment, the provisions of the amendment shall control and prevail.

19.6. Statutory References; Accounting Terms

Unless otherwise stated, any reference in this Agreement to any act or statute or section thereof shall be deemed to be a reference to such act or statute or section, as amended, restated or replaced from time to time. All accounting te1ms not specifically defined in this Agreement shall be interpreted in accordance with GAAP and SAP.

19.7. Treatment of Certain Information; Confidentiality

Borrower acknowledges that this Agreement and all documents related thereto are subject to and governed by the provisions of the Freedom of Information Act, 5 U.S.C. § 552, and may be subject to full or partial release thereunder.

19.8. No Waiver

No term or condition of this Agreement shall be deemed waived, and no breach shall be deemed excused, unless such waiver or excuse is in writing and is executed by the party against whom such waiver or excuse is claimed. No delay or omission of Lender to exercise any right or power arising upon the occun-ence of any Event of Default shall impair any such right or power or shall be construed to be a waiver of any such Default or an acquiescence therein; and every power and remedy given by this Agreement to Lender may be exercised from time to time and as often as may be deemed expedient in the sole discretion of Lender.

19.9. Further Assurances

B01rnwer agrees to take whatever steps are necessary to fulfill the responsibilities assigned to it in this Agreement, and further agree to cooperate with Lender in that regard. Borrower further agrees to cooperate with any reasonable requirements of any Lender for access to relevant books and records, including, without limitation, books and records described in Sections 8, IO and 11 above.

19.10. Severability

The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement. In the event that any provision of this Agreement is determined to be invalid, unenforceable or otherwise illegal, such provision shall be deemed restated, in accordance with applicable law, to reflect as nearly as possible the original intention of the parties, and the remainder of the Agreement shall be in full force and effect.

19.11. No Third Party Beneficiaries

This Agreement is entered into by and between Lender and Borrower and for their benefit only. Except as specifically provided herein, there is no intent by any party to create or establish third paity beneficiary status or rights in any third person, and no such third party shall have any right to enforce any right or enjoy any benefit created or established under this Agreement.

19.12. Right of Set-Off

Notwithstanding any other provisions of this Agreement to the contra1y, in the event any Event of Default is not cured or another accommodation permissible under this Agreement is not otherwise reached within applicable notice and cure periods, Lender shall have at its disposal the full range of available rights, remedies and techniques to collect delinquent debts, such as those found in the Federal Claims Collection Standards and applicable Treasury regulations, as appropriate, including demand letters, administrative offset, salary offset, tax refund offset, private collection agencies, cross-servicing by the Treasury, and litigation.

19.13. Borrower Authority

The individual who executes and delivers this Agreement on behalf of B01rnwer represents and warrants to Lender that (i) that he or she is duly authorized to do so; (ii) that Borrower is a duly organized corporation or validly formed partnership or other legal entity in good standing under the laws of the jurisdiction of its incorporation or formation; (iii) that Borrower is qualified to do business and is in good standing in the jurisdiction in which Borrower is authorized to conduct business and has the power and authority to enter into this Agreement; and (iv) that all corporate or paitnership action requisite to authorize Borrower to enter into this Agreement has been duly taken.

19.14. Survival

All matters that relate to the expiration or earlier termination of this Agreement, or that relate to the representations, warranties and indemnities contained in this Agreement, as well as any rights and obligations of the parties pertaining thereto, shall survive the expiration or earlier termination of this Agreement and shall be given full force and effect notwithstanding any expiration or termination of this Agreement.

19.15. Construction of Language

The Table of Contents and the Article and Section headings of this Agreement are for reference only, and shall not be treated as a part of this Agreement or as affecting the true meaning of the provisions hereof. All references in this Agreement to designated "Articles," "Sections" and other subdivisions are, unless otherwise specified, to the designated Articles, Sections and subdivisions of this Agreement as originally executed. The words "herein," "hereof," "hereunder" and other words of similar import refer to this Agreement as a whole and not to any particular Article, Section or other subdivision. Any words of the masculine gender shall be deemed and construed to include correlative words of the feminine and neuter genders. Unless the context shall otherwise indicate, words importing the singular number shall include the plural and vice versa, and words importing persons shall include firms, associations and corporations, including public bodies, as well as natural persons.

19.16. Borrower's Authorized Representative

Borrower shall at all times have appointed a Borrower's Authorized Representative by designating such person or persons from time-to-time to act on the Borrower's behalf pursuant to a written certificate signed by Borrower and furnished to Lender and any loan servicer acting on Lender's behalf.

IN WITNESS WHEREOF, Lender and Borrower have executed this Agreement as of the date indicated by each signature.

Address: U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, 200 Independence Avenue, SW, Washington, D.C., 20201 Attention: Kevin Kendrick Telephone No.: (301) 492-4134 E-Mail: Kevin.kendrick@cms.hhs.gov	**U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services ("Lender")** Per: _____ Name: [illegible] Dept: [illegible]enter for Consumer Information and Insurance Oversight Date: ----"£4-'(J+-'-'{/J-"------

Address: Compass Cooperative Health Network 1496 North Higley Road Suite 102 - #300 Gilbert, AZ 85234 Attention: Kathleen Oestreich Project Officer Telephone No.: (520) 404-9639 E-Mail: Kathyo@eastwickstrategy.com	**[Borrower]** Per: Name: Kathleen Oestreich Title: Interim CEO Date:----------

IN WITNESS WHEREOF, Lender and Borrower have executed this Agreement as of the date indicated by each signature.

Address: U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, 200 Independence Avenue, SW, Washington, D.C., 20201 Attention: Kevin Kendrick Telephone No.: (301) 492-4134 E-Mail: Kevin.kendrick@cms.hhs.gov	**U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services ("Lender")** Per: _____ Name: Timothy Hill Deputy Director, Center for Consumer Information and Insurance Oversight Date:_____

Address: Compass Cooperative Health Network 1496 North Higley Road Suite 102 - #300 Gilbert, AZ 85234 Attention: Kathleen Oestreich Project Officer Telephone No.: (520) 404-9639 E-Mail: Kathyo@eastwickstrategy.com	**[Borrower]** Per: _____ Name: Kathleen Oestreich Title: Interim CEO Date: 6/6/2012

Appendix 1

START-UP LOAN DISBURSEMENT AGREEMENT

DISBURSEMENT AGREEMENT
FOR START-UP LOAN FUNDS

This Disbursement Agreement ("Agreement") dated June 7, 2012 ("Closing Date"), by and between the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services ("CMS") and Compass Cooperative Health Network ("Borrower"),

WITNESSETH THAT:

WHEREAS, CMS and Borrower have entered into a Loan Agreement ("Loan Agreement") contemporaneously herewith for the purposes of fostering the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets through the provision of loans to qualified applicants for the purpose of financing stat1-up costs and insurance reserves [see the Affordable Care Act, Section 1322(a)]; and

WHEREAS, pursuant to the terms of the Loan Agreement, CMS has agreed to make a Start-up Loan to Borrower in the maximum principal sum of$20,890,333; and

WHEREAS, CMS contemplates that there will be multiple loan disbursements ("Disbursements") and such Disbursements may occur at irregular intervals related to Borrower's bona fide CO-OP business requirements; and

WHEREAS, CMS and Borrower wish to enter into this Agreement to memorialize their understanding about the timing and procedures related to the Disbursements and to further ensure that Disbursements are made only for the uses intended under the Loan Agreement and the CO-OP Prograin authorized under the Affordable Care Act.

NOW, THEREFORE, in consideration of the mutual agreements contained herein and for other good and valuable consideration, the receipt of which is hereby acknowledged, CMS and Borrower agree to the terms hereinafter set forth in this Agreement.

I. Disbursement Guidelines

(i) Disbursement. Disbursements will be made according to the following schedule of "Draws:"

For First Draw: Within approximately one week of the Closing Date, and upon receipt of a complete cost breakdown, in form and content reasonably acceptable to CMS, and ce1tified by Borrower, showing all costs estimated for completing all Stait-Up activities, the first Disbursement will be made in the amount of $2,840,904.

For Subsequent Draws: The next fourteen (14) draws will be conditioned on the submission of evidence of Borrower's successful completion of the milestones and achievement of ongoing activities as described in Borrower's Business Plan (a copy of which is attached to the Loan Agreement as Appendix 7 thereof) and the disbursement schedule ("Disbursement Plan") attached hereto and incorporated herein by reference as Schedule A, in accordance with CO-OP Program (as such term is defined in the Loan Agreement) guidance. Prior to any Draw, Borrower must notify CMS of all successfully completed milestones and describe its projected ongoing activities prior to receiving any further subsequent Disbursements.

For Emergency Draws: This Draw will be disbursed if Borrower encounters eligible costs not outlined in B01TOwer's Business Plan. These costs must comply with eligible use of Funds provisions outlined in Section 3.5 of the Loan Agreement.

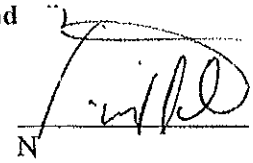
For Final Draw: This Draw will be disbursed after all milestones have been met and ongoing activities accomplished as described in Borrower's Business Plan and the Disbursement Plan in accordance with CO-OP Program guidance.

(ii) Failure to Meet Milestones. Borrower must notify CMS in writing (consistent with CO-OP Program guidance) at least 30 calendar days in advance, when possible, if it will be unable to meet a milestone.

II. Funding Requests

Method of Disbursement. Ifno Event of Default (as such term is defined in the Loan Agreement) has occurred that has not been cured within applicable grace and cure periods, and all of the terms and conditions of this Agreement have been complied with to the satisfaction of CMS, CMS shall pay to Borrower, via wire transfer, the principal amount of funding Draw requested, subject to and in accordance with the terms and conditions set forth in the Loan Agreement. Notwithstanding the foregoing, CMS reserves the right to partially or incrementally fund Borrower's Draw request(s) in circumstances where Borrower has not successfully completed milestones or adequately accomplished or achieved ongoing activities to the satisfaction of CMS.

IN WITNESS WHEREOF, CMS and Borrower have executed this Agreement as of the date indicated by each signature.

Address: U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, 200 Independence Avenue, SW, Washington, D.C., 20201 Attention: Kevin Kendrick Telephone No.: (301) 492-4134 E-Mail: Kevin.kendrick@cms.hhs.gov	**U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services ("Lend ")** Per:  N De uty Director, Center for Consumer Information and Insurance Oversight Date: 6/7/12

Address: Compass Cooperative Health Network 1496 North Higley Road Suite I 02 - #300 Gilbe1t, AZ 85234 Attention: Kathleen Oestreich Project Officer Telephone No.: (520) 404-9639 E-Mail: Kathyo@eastwickstrategy.com	**[Borrower]** Per: Name: Kathleen Oestreich Title: Interim CEO Date:_____6_/6_1_2_0_12

Appendix 1 - Schedule *A*

START-UP DISBURSEMENTS AND MILESTONES

Excel Spreadsheet Attached

CO-OP Start -up Loan Disbursement Schedule

Complete the detailed disbursement schedule below. List the proposed milestones for your requested Start-up loan. Each must detail the proposed milestones, documentation required to confirm completion of each milestone, milestones that must be completed before (pre-decessor tasks) and after (successor tasks) each milestone. See Attachment 5 for the list of core milestones and the list of categories. Please note that loan funding cannot be used for marketing activities. Therefore, marketing milestones should not be included in the detailed disbursement schedule.

For each milestone, funding associated with core contracts should be segregated in a separate column. Core Contract to the right of the other milestone funding. For these core contracts, the CO-OP must submit the contracts to CMS for review and approval prior to the disbursement of any funding associated with the milestones. For non-Core Contract milestone the associated funding amount should be provided in the "Cost" column.

If a milestone will take multiple Quarters to complete, it should be listed with in each applicable Quarter with related numbering (for example: 12a in Quarter 1, 12b in Quarter 2, and 12c in Quarter 3.) Funding should be linked to the milestone per quarter as relevant for the specific milestone based on necessary funding for timing during the completion of the milestone. For example, if one milestone has associated funding of $200,000 with 1t, and will take three quarters to complete, the $200,000 should be divided amongst the quarters as relevant to funding required for completion.

CO-OP Name	Compass Cooperative Health Network (CCHN)
Date	06/03/2012
Start-up Loan Amount	$20,890,333
Total Funding from Milestones (Non-Core Contracts)	$14,676,975
Total Funding from Core Contracts	$6,213,358

Quarter	Total Funding (Non-Core Contract)	Total Core Contracts	Total Estimated by Quarter
Q1 2012	$0	$0	$0
Q2 2012	$1,243,990	$354,433	$1,598,423
Q3 2012	$1,596,914	$723,100	$2,320,014
Q4 2012	$1,389,039	$858,100	$2,247,139
Q1 2013	$2,549,426	$686,200	$3,235,626
Q2 2013	$1,952,126	$686,200	$2,638,326
Q3 2013	$1,628,493	$821,300	$2,449,793
Q4 2013	-$1,614,293	$821,300	$2,435,593
Q1 2014	$2,519,361	$1,262,725	$3,782,086
Q2 2014	$0	$0	$0
Q3 2014	$0	$0	$0
Q4 2014	$133,333	$0	$133,333
Q1 2015	$0	$0	$0
Q2 2015	$0	$0	$0
Q3 2015	$0	$0	$0
Q4 2015	$50,000	$0	$50,000
Total	$14,676,975	$6,213,358	$20,890,333

Task#	CONTINGENT FUNDING: Core Contract Milestone	Short Task Description	Objectives/Milestones	Documentation Required	Predecessor Tasks	Successor Tasks	Category	Start Date	Due Date	Cost	CONTINGENT FUNDING: CO<e Contract
93		Disburse funds for application fees	Actuary: $25K, Legal: $25K, Project Officer: $25K, Application Advisor $25K	Invoices for services			Business Structure	Q42011	Q22012	$100,000	$0
1a		Develop CO-OP project plan	Construct detailed project plan using loan funding as start date	Project plan		10	Business Structure	Q2 2012	Q32012	$50,000	$0
2		Establish bank accounts	Open all operating accounts needed for the CO-OP	Bank statement		6	Business Structure	Q2 2012	Q2 2012	$25,000	$0
3		Establish legal representation	Retain legal firm that will provide legal support to CO-OP	Letter from firm confirming retainer		15	Business Structure	Q2 2012	Q2 2012	$100,000	$0
4a		Additional capital funding for CO-OP creation	Identify other sources of capital funding available to CO-OP	List of identified sources of additional funding			Business Structure	Q2 2012	Q3 2012	$40,000	$0
5a	Yes	Establish physical facilities	Core Contract: Lease office space, set-up utilities, purchase eQuipment and furniture, move into facility	Office lease, utility statements, purchase receipts	2	7	Business Operations	Q2 2012	Q1 2014	$65,690	$10,000
6a		Obtain insurance	Obtain all insurances required to operate the CO-OP (i.e., liability, D&O, etc.)	Insurance policy statements	2,3		Business Operations	Q2 2012	Q3 2012	$100,000	$0
7a	Yes	Establish computer network system	Core Contract: Agreements with Vendors, Purchase and install hardware and software to support the CO-OP's daily business functions	Receipts for servers, computers, printers and software, set contracts with IT Design Team	5		Business Operations	Q2 2012	Q3 2012		$279,700
8a		Establish HIPAA systems security plan	Develop systems security plan compliant with HIPAA	Security plan			Business Operations	Q2 2012	Q3 2012	$150,000	$0

Task#	CONTINGENT FUNDING - Core Contract Milestone	Short Task Description	Objectives/Milestones	Documentation Required	Predecessor Tasks	Successor Tasks	Category	Start Date	Due Date	Cost	CONTINGENT FUNDING: Core Contract
9a	Yes	Finalize staffing Schedule. Engage Temporary Staff	Core Contract: interimmgmt agreements: Develop plan for hiring management and staff for CO-OP, hire interimmanagement	Staffing schedule, interim management contracts for CEO,CFO,CHRO, Prem Contract for President		15, 21	Business Operations	02 2012	03 2012	$37,500	$64,733
91		Solicit bids for accounting system	Identify at least 3 vendors toprovide accounting system and support and conduct competitive bid	Bidder list and RFP	1		BusinessOperations	02 2012	03 2012	$115,000	$0
11a		Develop provider network strategy	Develop provider network contracting strategy	Provider network plan		24	Business Operations	02 2012	03 2012	$169,700	$0
12		Establishmentof Conflicts of Interest Policy	Develop and finalize a Conflicts of Interest Policy	Final Conflict of Interest Policy :Board approval of conflict of interest policy.			Business Operations	022012	02 2012	$75,000	$0
13		Consultant Contracts	Finalize consulting contracts for various initiativ es, including network management, technology, branding, public relations, product design, among others	Signed contracts			Business Operations	02 2012	02 2012	$216,100	$0
Tou t Funding for Q2 2012										$1,243,990	$354,433
1b		Develop CO-OP projectplan	Construct detailed project plan using loan fundi ng as start date	Project plan		10	Business Structure	02 2012	032012	$50,000	$0
4b		Additional capital funding for CO-OP creation	Identify othersources of capital funding available to CO-OP	List of identified sources of additional funding			Business Structure	022012	03 2014	$50,000	$0
5b	Yes	Establish physical facilities	Core Contract-Lease:Rent office space; set-up utilities, purchase equipment and furniture, move into facility	Officelease, utility statements, purchase receipts		7	Business Operations	02 2012	01 2014	$58,814	$90,000
6b		Obtaininsurance	Obtain all insurances required to operate the CO-OP (i.e., liability, D&O, etc.)	Insurance policy statements	2,3		Business Operations	02 2012	03 2012	$50,000	$0
7b		Establish computer network system	Core Contract: Agreements with vendors. Purchase and install hardware and software to support the CO-OP's dailybusiness functions	Receipts for servers, computers, printers and software	11		Business Operations	02 2012	03 2012	$50,000	$0
8b		Establish HIPM systems security plan	Develop systems security plan compliant with HIPM	Security plan			Business Operations	02 2012	03 2012	$70,000	$0
9b	Yes	Finalize staffing Schedule Engage Temporary Staff	Core Contract: interim mgmt agreements: Develop plan for hiringmanagement and staff for CO-OP, hireinterim management	Staffing schedule, interim management contracts for CEO,CFO,CHRO, Prem Contract for President		15,21	Business Operations	02 2012	03 2012	$37,500	$0
92		Select/implement accounting system vendor	Select mostcompetitive vendor consistent with CO-OP's business requirements	Contract	1		Business Operations	02 2012	03 2012	$50,000	$0
11b		Develop provider network strategy	Develop provider network contracting strategy	Provider network plan		24	Business Operations	02 2012	03 2012	$50,000	$0
14a		Clinical Care Guidelines	Develop and complete Clinical Careguidelines for Care Models	Completed Guidelines		20	Plan Operations	032012	04 2012	$37,500	$0
15a	Yes	Hire plan management staff	Core Contract: employment contracts. Hire plan management staff	Resumes and employment contracts for planmanagement staff (CEO, CFO, CTO, COO, CMO and employment of Directors)	9	23	Business Operations	032012	012014	$0	$353,400
16		Develop plan for achieving licensure	Develop plan for achieving licensure	Licensureplan		17a	Licensure and Certification	032012	032012	$100,000	$0
17a		Implement licensure plan	Beginimplementationof plan for achieving licensure	Application for licensure	16	36	Licensure and Certification	03 2012	04 2012	$50,000	$0
18a		Develop compliance and reporting plan	Develop plan for ensuring compliance with Federal, State, and Exchange requirements and reporting potential violations as wellas fraud and abuse	Compliance and reporting plan			Business Operations	03 2012	04 2012	$37,500	$0
19		Develop quality assurance plan	Develop quality assurance plan	Quality Assurance plan		42	Business Operations	03 2012	03 2012	$75,000	$0
20		Care Models	Develop Care Models to be included in PCP PCMHContract requirements	Models Completed	14		Plan Operations	032012	032012	$75,000	$0
21a		Focus Groups	Provider Focus Groups - discuss caremodels, payment models, clinical analytics and peer analysis	Summary of focus group feedback			Plan Operations	03 2012	04 2012	$37,500	$0

Task#	CONTINGENT FUNDING: Core Contract Milestone	Short Task Description	Objectives/Milestones	Documentation Required	Predecessor Tasks	Successor Tasks	Category	Start Date	Due Date	Cost	CONTINGENT FUNDING: Core Contract
22a		Conductprocurement process for operations outsourcing	Identify at least 3 potential vendors for operations outsourcing (e.g., data storage) as wellas review criteria for vendor selection	Description of vendor selection process, RFP and evaluation criteria (not allemployees willhave contracts, willindicate on chart status of employee"	27	34	Plan Operations	032012	04 2012	$50,000	$0
23		Hiringof HR Staff and Training	Complete Hiring of HR and Training Staff	Employment Contracts	15		Business Operations	03 2012	032012	$25,000	$0
24a		Develop provider network	Begin discussions and recruitment of providers for participation in CO-OP network	Signed provider contracts and updated provider directO<)'	11		Business Operations	032012	012013	$100,000	$0
25a		Implement clinical integration strategy	Implement the programs, systems and processes needed to support the integrated clinical caremodel	Policies, procedures, list Of tools and systems to support integrated care management			Business Operations	032012	012013	$75,000	$0
26a	Yes	Implement systems/IT strategy	Core Contract with Vendor. Implement/build the systems required to support the CO-OP's health plan management functions	Operational systems and related documentation			Business Operations	03 2012	01 2013		$279,700
27		Develop outsourcing plan	Identify other operational components to be outsourced	Outsourcing plan		34	Plan Operations	0 3 2012	03 2012	$75,000	$0
28		Develop education communicationsplan	Develop planto create CO-OP brandand community awareness of non-profit CO-OPs	Education communications plan			Member Communications and Customer Service	032012	03 2012	$100,000	$0
30		Develop web site	Establish and test website	Operational web site	29		Member Communications and Customer Service	03 2012	032012	$118100	$0
31		Develop customer service and Dcommunity outreach plans	Develop plans that will guide customer service and community outreach delivery, tools and service levels	Completed Plans for Customer Service and Community Outreach		38, 39	Member Communications and Customer Service	032012	032012	$175000	$0
Total Funding for Q3 2012										**$1,598,914**	**$723,100**
5c	Yes	Establish physical facilities	Core Contract-Lease. Rent office space, setup utilities, purchase equipment and furniture, moveinto facility	Office lease, utility statements, purchase receipts		7	Business Operations	02 2012	01 2014	$84,750	$100,000
14b		Clinical Care Guidelines	Develop and complete Clinical Care guidelines for Care Models	Completed Guidelines		20	Plan Operations	032012	042012	$37,500	$0
15b	Yes	Theplan management staff	Core Contract: employment contracts; hire plan management staff	Resumes and employment contracts for plan management staff (CEO, CFO, CTO, COO, CMO and employment of Directors)	9	23	Business Operations	0 3 2012	01 2014	$0	$350,400
17b		Implement licensure plan	Implementationof plan for achieving licensure	Application for licensure		30	Licensure and Certification	03 2012	04 2012	$100,000	$0
18b		Develop compliance and reporting plan	Develop plan for ensuring compliance with Federal, State, and Exchange requirements and reporting potential violations as wellas fraud and abuse	Compliance and reporting plan			Business Operations	0 3 2012	04 2012	$37,500	$0
21b		Focus Groups	Provider Focus Groups: discuss caremodels, payment models, clinical analytics and peer analysis	Summary of focus group feedback			Plan Operations	03 2012	04 2012	$37,500	$0
22b		Conduct procurement process for operations outsourcing	Identify at least 3 potential vendors for operations outsourcing (e.g., data storage) as well as review criteria for vendor selection	Description of vendor selection process, RFP and evaluation criteria		34	Plan Operations	032012	04 2012	$100,000	$0
24b		Develop provider network	Begin discussions and recruitment Ofproviders for participation in CO-OP network	Signedprovider contracts and updated provider directory	11		Business Operations	032012	01 2013	$100,000	$0
25b		Implement clinical integration strategy	Implement the programs, systems and processes needed to support the integrated clinical caremodel	Policies, procedures, list of tools andsystemstosupportintegrated care management			Business Operations	032012	012013	$75,00	$0
26b	Yes	Implement systems/IT strategy	Core Contract with Vendor. Implement/build the systems required to support the CO-OP's health planmanagement functions	Operational systems and related documentation	7		Business Operations	0 3 2012	012013		$279,700
97		Develop Materials for Policies and Procedures Training	Implement employee training policies and procedures	Training Materials	9		Business Operations	04 2012	04 2012	$55,000	$0
33		Develop vendor management and monitoring plan	Develop vendor management and monitoring plan to ensure high performance	Vendor monitoring plan		35	Plan Operations	04 2012	04 2012	$100,000	$0
34	Yes	Contract with vendor for outsourced operations services	CoreContract with Vendor, Contract with vendor for outsourced operations services	Vendor contract	22, 27		Plan Operations	04 2012	04 2012		$125,000

Task#	CONTINGENT FUNDING. Core Contract Milestone	Short Task Description	Objectives/Milestones	Documentation Required	Predecessor Tasks	Succ essor Tasks	Category	Start Date	Due Date	Cost	CONTINGENT FUNDING: CoreContract
35a		Vendor management, monitoring and communications	Implement active vendor management and monitoring processes/procedures with all vendors	Quarterly results from vendor performance review process	33		Plan Operations	Q4 2012	032013	$37,500	$0
3c		Achieve licensure	Complete licensure process with the State Insurance Department	License	17	61	licensure and Certification	Q4 2012	Q4 2012	$75,000	$0
37a		Implement education communications plan	Engage with general business community to create brand and community awareness of non-profit CO-OPs	Documentation of communication meetings	29		Member Communications and Customer Service	Q4 2012	Q2 2013	$50,000	$0
38a		Implement community outreach plan	Engage with community leaders representing small business, individuals, the uninsured and other stakeholders to educate and build awareness of the CO-OP and its mission	Documen tation of communication meetings	31		Member Communications and Customer Service	Q4 2012	032013	$37,500	$0
39a		Develop community outreach materials	Develop material that is targeted to educate and build awareness of the CO-OP	Web site and hardcopy material	31		Member Communications and Customer Service	Q4 2012	02 2013	$50,000	$0
40a		Develop patient education/literacy content	Develop material to be handed out post enrollment and pre-effective date to promote healthy lifestyles and patient/physician communication	Web site and hardcopy material		73	Member Communications and Customer Service	Q4 2012	01 2013	$100,000	$0
41a		Develop and implement disaster recovery plan	Develop disaster recovery plan to safeguard Co OP operations and data in the event of a catastrophic event	Disaster recovery plan			Business Operations	Q4 2012	012013	$37,500	$0
42a		Implement quality assurance plan	Integrate elements of the QA plan into all aspects of system development, policies/procedures and training	Documentation	19		Business Operations	Q4 2012	02 2013	$88,900	$0
43a		Develop underwriting/rating models, policies and procedures	Develop underwriting/rating models, policies and procedures	Models, policies and procedures			Business Operations	Q4 2012	012013	$85,400	$0
48a		Develop benefit plans	Develop benefit plans and plan rates ensuring compliance with Exchange requirements for QHPs	Proposed benefit plans and rates. Approved benefit plans and rates		61	Plan Operations	Q4 2012	02 2013	$100,000	$0
Total Funding for Q4 2012										$1,389,039	$858,100
5d	**Yes**	Establish physical facilities	Core Contract-Lease;Rent office space; set-up utilities, purchase equipment and furniture, move into facility	Office lease, utility statements, purchase receipts		7	Business Operations	Q2 2012	Q1 2014	$100,226	$50,000
15c	Yes	Hire plan management staff	Core Contract: employment contracts. Hire plan management staff	Resumes and employment contracts for plan management staff (CEO, CFO, CTO, COO, CMO and employement of Directors)	9	23	Business Operations	Q3 2012	012014	**$0**	$199,900
24c		Develop provider network	Begin discussions and recruitment of providers or participation in CO-OP network	Signed provider contracts and updated provider directory	11		Business Operations	032012	012013	**$138,000**	$0
25c		Implement clinical integration **strategy**	Implement the programs, systems and processes needed to support the integrated clinical care model	Policies, procedures, list of tools and systems to support integrated care management			Business Operations	Q3 2012	012013	$200,000	$0
26c	Yes	Implement systems/IT strategy	Core Contract with Vendor; Implement/build the systems required to support the CO-OP's health plan management functions	Operational systems and related documentation	7		Business Operations	032012	Q1 2013		**$436,300**
32a		Policies and procedures training	Implement employee training policies and procedures	List of individuals completing training			Business Operations	Q12013	032013	**$175,000**	$0
35b		Vendor management, monitoring and communications	Implement active vendor management and monitoring processes/procedures with all vendors	Quarterly results from vendor performance review process			Plan Operations	Q4 2012	032013	**$87,500**	**SO**
37b		Implement education communications plan	Engage with general business community to create brand and community awareness of non-profit CO-OPs	Documentation of communication meetings	29		Member Communications and Customer Service	Q4 2012	02 2013	**$50,000**	$0
38b		Implement community outreach plan	Engage with community leaders representing small business, individuals, the uninsured and other stakeholders to educate and build awareness of the CO-OP and its mission	Documentation of communication meetings	31		Member Communications and Customer Service	Q4 2012	03 2013	**$50,000**	$0

Task#	CONTINGENT FUNDING. Core Contract Milestone	Short Task Description	Objectives/Milestones	Documentation Required	Predecessor Tasks	Successor Tasks	Category	Start Date	Due Date	Cost	CONTINGENT FUNDING. Core Contract
39b		Develop community outreach materials	Develop material that is targeted to educate and buildawareness of the CO-OP	Web site andhardcopy material	31		Member Communication and Customer Service	04 2012	02 2013	$112,500	$0
40b		Develop patient education/literacy content	Develop material to be handed out post enrollment and pre-effective date to promote healthy l estyles and patient,physician communication	Web site and hardcopy material		73	Member Communication and Customer Service	04 2012	012013	$200,000	$0
41b		Develop and implement disaster recovery plan	Develop disaster recovery plan to safeguard CO OP operations and data in the event of a catastrophic event	Disaster recoveryplan			Business Operations	04 2012	012013	$111,200	$0
42b		Implement quality assurance plan	Integrate elements of the QA planinto all aspects of system development, policies/procedures and training	Documentation	19		Business Operations	04 2012	02 2013	$100,000	$0
43b		Develop underwriting/rating models, policies and procedures	Develop underwriting/rating models, policies and procedures	Models, policies and procedures			Business Operations	04 2012	012013	$200,000	$0
44		Develop policies and procedures	All policies and procedures developed and approved	Policies and procedures manual	20		Business Operations	0 1 2013	012013	$200,000	$0
45a		Care Effectiveness Assessments	Develop Clinical Analytical and Care Model effectiveness assessments with U of Arizone College of Public Health	Affiliation Agreement Completed			Plan Operations	012013	02 2013	$50,000	$0
46a		Hospital Partner Care Model Stralegy	Development of Hospital Partner Care Model Strategy to align hospitals with care models and goals of Compass	Completed Plan	44	69	Plan Operations	012013	02 2013	$87,500	$0
47a		Apply to participate in the Exchange	Achieve certification to participate in the Exchange	Confirmation application submission for certification,Certification			Licensure and Certification	012013	02 2013	$200,000	$0
48b		Develop benefit plans	Develop benefit plans and planrates ensuring compliance with Exchange requirements for OHP's	Proposed benefit plans and rates, Approved benefit plans and rates		61	Plan Operations	04 2012	02 2013	$100,000	$0
49		Develop provider communicationsstrategy	Develop provider network training and communicationsstrategy	Web siteandhardcopy material		52	Establishmentof Provider Network<	012013	012013	$112,500	$0
52		Finalize Provider Network	Agreement with Core Providers in Primary Network<Area	Contacts, Provider directory	49		Establishment of Provider Network<	012013	01 2013	$225,000	$0
61a		Develop grievance and appeal processes	Grievance and appealprocesses in place and training has beendesigned	Policies and procedures manual			Member Communications and Customer Service	012013	022013	$50,000	$0
Total Funding for Q1 2013										$2,549,426	$680, 200
5e	Yes	Establish physical facilities	Core Contract-Lease;Rent office space; set-up utilities, purchase equipment and furniture, moveinto facility	Office lease, utility statements, purchase receipts		7	Business Operations	02 2012	01 2014	$75,226	$50,000
15d	Yes	Hire plan management staff	Core Contract: employment contracts. Hire plan management staff	Resumes and employment contracts for plan management staff (CEO, CFO, CTO, COO, CMO and employment of Directors)	9	23	Business Operations	032012	012014	$0	$199,900
34		Finalize clinicalintegration strategy	Finalize the implementationof programs, systems and processes needed to support the intPOrated clinicalcaremodel	Policies, procedures, list of tools and systems to support integrated care management			Business Operations	02 2013	02 2013	$175,000	$0
35	Yes	Firstlevel testing of Implement systems/IT strategy	Core Contract with Vendor; Implement/build the systems required to support the CO-OP's health planmanagement functions	Interim results and testing of Operational systems and related documentation	7, 26	75	Business Operations	02 2013	02 2013		$436,300
32b		Policies and procedures training	Implement employee training policies and procedures	List of individuals completing training			Business Operations	01 2013	0 3 2013	$75,000	$0
35c		Vendor management, monitoring and communications	Implement active vendor management and monitoring processes/procedures withall vendors	Quarterly results from vendor performance review process			Plan Operations	04 2012	02 2013	$37,500	$0
37c		Implement education communications plan	Engagewithgeneral business community to create brand and community awareness of non-profit CO-OPs	Documentation of communication meetings	29		Member Communications and Customer Service	04 2012	02 2013	$50,000	$0

Task #	CONTINGENT FUNDING: Co-op Contract Milestone	Short Task Description	Objectives/Milestones	Documentation Required	Predecessor Tasks	Successor Tasks	Category	Start Date	Due Date	Cost	CONTINGENT FUNDING: Co-op Contract
38c		Implement community outreach plan	Engage with community leaders representing smallbusiness, individuals, the uninsured, brokers andother stakeholders to educate and buildawareness of the CO-OP and its mission	Documentation of communication meetings	31		Member Communications and CustomerService	04 2012	0 3 2013	$25,000	$0
39c		Develop community outreach materials	Develop material that is targeted to educate and buildawareness of the CO-OP	Web site andhardcopy material	31		Member Communications and Customer Service	04 2012	02 2013	$37,500	$0
42c		Implement quality assurance plan	Integrate elements of the QA planinto all aspects of systemdevelopment, policies/proced'ures and training	Documentation of results	19		Business Operations	04 2012	02 2013	$25,000	$0
45b		Care Effectiveness Assessments	Develop Clinical Analytical and Care Model effectiveness assessments with U of Arizona College of Public Health	Affiliation Agreement Completed			Plan Operations	0 1 2013	02 2013	$50,000	$0
46b		Hospital Partner CareModel Strategy	Development of Hospital Partner CareModel Strategy to align hospitals with care models and Inoals of Comnass	Completed Plan	44	69	Plan Operations	01 2013	02 2013	$87,500	$0
47b		Apply to participate in the Exchange	Achieve certification to participate in the Exchange	Confirmation application submission for certification,Certification			Licensure and Certification	012013	02 2013	$75,000	$0
48c		Develop benefit plans	Develop benefit plans and plmrates ensuring compliance with Exchange requirementsfor OHPs	Proposed benefit plans and rates, Approved benefit plans and rates		53	Plan Operations	04 2012	02 2013	$100,000	$0
53		Approvals from Department of Insurance	Approval of plan rates and benefit plans by Department of Insurance	Approval letters	48		Plan Operations	Q2 2013	02 2013	$75,000	$0
54		Develop summary of benefits	Develop summary of benefits	Approved summary of benefits			Member Communications and CustomerService	02 2013	02 2013	$75,000	$0
55		Exchangecertification	Deemed certified toparticipate in the Exchange	Certification			Licensure and Certification	02 2013	02 2013	$75,000	$0
56		Meet Federal, state and Exchange reporting requirements	Establish and test Federal, state and Exchange reporting requirements	Approvals			Plan Operations	02 2013	02 2013	$75,000	$0
57a		Provider network training	Begin implementation of provider network trainingplan	Documentation of training meetings	52	67	Establishment of Provider Network	02 2013	04 2013	$75,000	$0
58a		Ongoingprovider communication	All lines of communication (web, newsletters, meetings, 800 numbers) with providern are open	Communication tracking log			Establishment of Provider Network	02 2013	04 2013	$75,000	$0
59a		System interoperability	Systems checks for interoperability	Documentation of test results			Plan Operations	Q2 2013	04 2013	$100,000	$0
60a		System tests	All information Technology systems tested and in operation	Documentation of test results		76	Plan Operations	02 2013	032013	$100,000	$0
61b		Develop grievance andappeal processes	Grievance and appeal processes in place and training hasbeen designed	Policies and procedures manual			Member Communications and Customer Service	01 2013	02 2013	$50,000	$0
62a		Member communication materials	Developmentof member communication content anddistribution channels	Communication materials		73	Member Communications and Customer Service	02 2013	03 2013	$125,000	$0
64a		Hirecustomer service staff	Beginimplementationofcustomer service staffingplan	Resumesforhiredservicestaff		65	Member Communications and Customer Service	02 2013	0 3 2013	$88,800	$0
65a		Traincustomer service staff	Train customer service staff on the full range of products, systems and procedures	Documentation of training meetings, Training materials	55		Member Communications and Customer Service	02 2013	04 2013	$50,000	$0
67a		Provider network maintenance and training	Maintain provider recruitment effort andongoing communication with participating providers	Changes toprovider directory and training materials	57		Establishment of Provider Network	02 2013	04 2013	$25,000	$0
68		Complex Member Outreach Plan	Develop Complex Member Outreach and Education Plan forcomplex clinical members	Member Outreach Plan			Plan Operations	02 2013	Q2 2013	$50,000	$0

Task#	CONTINGENT FUNDING: Core Contract Milestone	Sh ort Task Description	Objectives/Milestones	Docu mentation Required	Predecessor Tasks	Successor Tasks	Category	Start Date	Due Date	Cost	CONTINGENT FUNDING: Core Contract
69		*Develop* Materials for Clinical Care Training	Training of Clinical Care guidelines (i.e. Millman Care Guidelines) with Hospitals and Providers	Completed Training Materials	46		Plan Operations	02 2013	02 2013	$50.000	$0
98		File Application for Accreditation	Complete Application for State Accrededitation with State Insurance Department	Filed Application			Plan Operations	02 2013	02 2013	$50,000	$0
Total Funding for Q2 2013										**$1,952,126**	**$686,200**
51	Yes	Establish physical facilities	Core Contract-Lease;Rent office space; set-up utilities, purchase equipment and furniture; move into facility	Office lease, utility statements, purchase receipts		7	Business Operations	Q22012	01 2014	$85,226	$50,000
15e	Yes	Hire plan management staff	Core Contract: employment contracts. Hire plan management staff	Resumes and employment contracts for plan management staff (CEO, CFO, CTO, COO, CMO and employment of Directors)	9	23	Business Operations	032012	01 2014	$0	$199,900
32c		Policies and procedures training	Implement employee training policies and procedures	List Of individuals completing training			Business Operations	0 1 2013	032013	$69,000	$0
35d		Vendor management, monitO<ing and communications	Implem ent active vendor management and monitoring processes/procedures withall vendors	Quarter1y results from vendor performance review process			Plan Operations	04 2012	03 2013	$50,000	$0
96a		Implement Broker education communications plan	Engage with broker and insurance community to create brand and community awareness of non-profit CO-OPs	Documentation of communication **meetings**	29		Member Communications and Custome - Service	032013	04 2013	$80,000	$0
38d		Implement community outlreach plan	Engage with community leaders representing small business, individuals, the uninsured, brokers and other stakeholders to educate and build awareness of the CO-OP and its mission	Documentation of communication meetings	31		Member Communications and Customer Service	04 2012	032013	$50,000	$0
57b		Provider netw-or1c.training	Begin implementation of provider network trainingplan	Documentation of training meetings	52	67	Establishment of Provider **Network**	Q22013	04 2013	$100,000	$0
58b		Ongoing provider communication	All lines of communication (web, newsletters, meetings, 800 numbers) with providers are o=	Communication tracking log			Establishment of Provider **Network**	02 2013	04 2013	$100,000	$0
59b		System interoperability	Systems checks for interoperability	Documentation of test results			Plan Operations	02 2013	04 2013	$75,000	$0
60b		**System tests**	All Information Technology systems tested and in operation	Documentation of test results		76	Plan Operations	02 2013	04 2013	$75,000	$0
62b		Member communication materials	Development of member communication content and distribution channels	Communication materials		73	Member Communications and Customer Service	2 2013	0 3 2013	$150,000	$0
64b		Hire customer service staff	Begin implementationof customer service staffing plan	Resumes for hired customer service staff		65	Member Communication and Customer Service	02 2013	03 2013	$150,000	$0
65b		Train customer service staff	Train customer service staff on the full range of products , systems and procedures	Documentation of training meetings, Training materials	64		Member Communications and Customer Service	02 2013	04 2013	$75,000	$0
67b		Provider networ1c. maintenance and training	Maintain provider recruitment effort and ongoing communication withparticipating providers	Changes to provider directory and trainingmaterials	57		Establishment of Provider Network	02 2013	04 2013	$75,000	$0
71a		Outsourced vendors fully functional	All Non-IT systems fully loaded and tested	Documentation of test results	60		Plan Operations	03 2013	04 2013	$107,600	$0
73a		Update patient literacy material	Keep material current with evol ving information and evidence-basedpractice	Updated patient literacy materials	40		Member Communication and Customer Service	032013	04 2013	$100,000	$0
74a		Finalize clinical integration **strategy**	Finalize the programs, systems and processes needed to support the integrated clinical care model	Completed Policies, procedures, tools and systems to support integrated caremanagement			Business Operations	032013	04 2013	$150,000	$0
75a	**Yes**	Finalize systems/IT strategy	t oreContract: with Vendors and contract staff; completion of build-out of systems required to support the CO-OP's health plan management functions	System Operating and completed documentation	95		Business Operations	0 3 2013	012014		$436,300

Task #	CONTINGENT FUNDING: Core Contract Milestone	Short Task Description	Objectives/Milestones	Documentation Required	Predecessor Tasks	Successor Tasks	Category	Start Date	Due Date	Cost	CONTINGENT FUNDING Core Contract
76		Regional Network	Finalize arrangements with Core Providers in regional network, including surrounding states	Contracts with Providers or Provider Group	52		Establishment of Provider Network	03 2013	03 2013	$75,000	$0
77		National Network	Finalize arrangements with provider to deliver national network of provider services	Contracts with Provider	52		Establishment of Provider Network	03 2013	032013	$75,000	$0
87a	Yes	Engage UM and OM Partners	Core Contract: UM Partner, OM Partner; Submit RFPs for UM and OM contractors, finalize and execute contracts	Contract with UM Partner, OM Partner			Business Operations	032013	01 2014		$135,100
90a		Training of Clinical Care Guidelines	Training of Clinical Care guidelines (i.e. Minimum Care Guidelines) with Hospitals and Providers	List of completed training members			Plan Operations	03 2013	0 1 2014	$16,667	$0
Total Funding for 03 2013										**$1,628,493**	**$821,300**
6g	Yes	Establish physical facilities	Core Contract-Lease; Rent office space; set-up utilities, purchase equipment and furniture, move into facility	Office lease, utility statements purchase receipts		7	Business Operations	02 2012	01 2014	$60,226	$50,000
15f	Yes	Hire plan management staff	Core Contract: employment contracts, Hire plan management staff	Resumes and employment contracts for plan management staff (CEO, CFO, CTO, COO, CMO and employment of Directors)	9	23	Business Operations	032012	01 2014	$0	$199,900
56b		Implement Broker education communications plan	Engage with broker and insurance community to create brand and community awareness of non-profit CO-OPs	Documentation of communication meetings	29		Member Communications and Customer Service	03 2013	04 2013	$50,000	$0
57c		Provider network training	Begin implementation of provider network training plan	Documentation of training meetings	52	67	Establishment of Provider Network	02 2013	04 2013	$100,000	$0
58c		Ongoing provider communication	Series of communication (web, newsletters, meetings, 800 numbers) with providers are open	Communication tracking log			Establishment of Provider Network	0 22 013	04 2013	$125,000	$0
59c		System interoperability	Systems checks for interoperability	Documentation of test results			Plan Operations	02 2013	04 2013	$100,000	$0
60c		System tests	All Information Technology systems tested and in operation	Documentation of test results		78	Plan Operations	02 2013	032013	$125,000	$0
65c		Train customer service staff	Train customer service staff on the full range of products, systems and procedures	Documentation of training meetings, Training materials	64	80	Member Communications and Customer Service	02 2013	04 2013	$125,000	$0
67c		Provider network maintenance and training	Maintain provider recruitment effort and ongoing communication with participating providers	Changes to provider directory and training materials	57		Establishment of Provider Network	02 2013	04 2013	$100,000	$0
71b		Outsourced vendors fully functional	All Non-IT systems fully loaded and tested	Documentation of test results			Plan Operations	03 2013	04 2013	$75,000	$0
73b		Update patient literacy material	Keep material current with evolving information and evidence-based practice	Updated patient literacy materials	40		Member Communications and Customer Service	03 2013	04 2013	$100,000	$0
74b		Finalize clinical integration strategy	Finalize the programs, systems and processes needed to support the integrated clinical care model	Completed Policies, procedure, s tools and systems to support integrated care management			Business Operations	032013	04 2013	$250,000	$0
75b	Yes	Finalize systems/IT strategy	Core Contract with Vendors and contract staff; Completion of build-out of systems required to support the CO-OP's health plan management functions	System Operating and completed documentation	95		Business Operations	032013	012014		$436,300
78		Enroll individuals and groups	Process enrollment information provided by the Exchange, brokers/navigators or consumers	Monthly enrollment counts		79,80,81	Plan Operations	0 4 2013	04 2013	$75,000	$0
79		Implement member communications strategy	Send out member welcome packages that include all necessary information	Count of welcome packages distributed, model welcome package materials	72		Member Communications and Customer Service	04 2013	04 2013	$75,000	$0
80		Respond to member inquiries	Customer service is fully operational and taking calls and responding to correspondence from members with questions	Count of calls/letters received	65		Member Communications and Customer Service	04 2013	04 2013	$50,000	$0

Task#	CONTINGENT FUNDING Core Contract Milestone	Short Task Description	Objectives/Milestones	Documentation Required	Predecessor Tasks	Successor Tasks	Category	Start Date	Due Date	Cost	CONTINGENT FUNDING: Core Contract
81		Distribute ID cards	Provide ID cards tomembers effective 1/1/14	Count of cards distributed	78		Member Communications and Customer Service	04 2013	04 2013	560,000	$0
82		Monitor enrollment	Reviewinitial salesresultsagainstsalesbudget andtargets	Enrollment count	78	53	Business Operations	04 2013	04 2013	$60,000	$0
83		Adjust business strategies	Adjust operations and sales strategies based on initial enrollment experience	Corrective actionplans(if necessary)	80		BusinessOperations	04 2013	042013	$57,400	$0
87b	Yes	Engage UM andDMPartners	Ca<e Contract: UM Partner, DM Partner, Submit RfPs for UM and OM contractors, finalize and execute contracts	Contact withUM Partner, DM Partner			Business Operations	032013	012014		$135,100
90b		Training of Clinical Care Guidelines	Training of ClinicalCare guidelines (i.e. Milliman Care Guidelines) withHospitals and Providers	List of completed training members			Plan Operations	03 2013	012014	$16,667	$0
Total Funding for Q<I-2013										**$1,614, 293**	**$821 ,300**
5h	Yes	Establish physical facilities	Core Contract-Lease;Rent office space; set-up utilities, purchase equipment and furniture, move intofacility	Office lease, utility statements, purchase receipts		7	Business Operations	022012	01 2014	$189 022	$50,000
15g	Yes	Hire planmanagement staff	Core Contract: employment contracts. Hireplan management staff	Resumes and employment contracts /a< plan management staff (CEO, CFO,CTO,COO, CMO and employment of Directors)	9	23	Business Operations	032012	01'2014	$0	$199,900
75c	Yes	Finalize systems/IT strategy	Core Contract: with Vendors andcontract staff; Completion of build-out of systems required to support the CO-OP's health plan management functions	System Operating and completed documentation	95		Business Operations	032013	0 12014		$301,725
86	Yes	Engage HealthPlan Operations	Core Contract: with healthplan partner; Identify Healthplan partner RFP for mangement of member churn; TPA functions of enrollment, claims, medical management,wellness	Contract withhealthplan partner			Business Operations	0 1 2014	012014		$676,000
87c	Yes	Engage UM and DMPartners	C0<e Contract: UM Partner, DMPartner, Subm;t RFPs for UM and OMcontractors, finalize and execute contracts	Contract with UM Partner, OM Partner			Business Operations	032013	01 2014		$135,100
88		Launch of CO-OP	Start-up completed - funds to support first quarter operations, including additional salary, business insurance,other operating expenses.	Initial Performance Reports			Business Operations	012014	0 1 2014	$2,263,672	$0
89		Implement member-elected Operational Board	Scheduled Election, meeting and vote for Board of Directors	Results from Election			Member Communications and Customer Service	0 12014	012014	$50,000	$0
90c		Training of Clinical Care Guidelines	Training of Clinical Care guidelines (i.e. Milliman Care Guidelines) with Hospitals andProviders	List of completed training members			Plan Operations	032013	01 2014	$16,667	$0
Total Funding for Q1 2014										**$2,618,381**	**$1,262, 725**
99		Implement member-elected Operational Board	Scheduled Election, meeting and vote for Board of Directors	Results from Election			Member Communications and Customer Service	04 2014	04 2014	533,333	$0
85		Implement transitional Board of Directors	Transitional plan andimplementation of plan	Documentation	89		Member Communications and CustomerService	04 2014	0 4 2014	$100,000	$0
Total Fundingfor Q4 2014										**$133,333**	**$0**
100		Implement member-elected Operational Board	Scheduled Election, meeting and vote forBoard of Directors	Results from Election			Member Communications and Customer Service	04 2015	04 2015	$50,000	$0
Total Funding for Q4 2015										**$50,000**	**$0**

Appendix 2

START-UP LOAN PROMISSORY NOTE

U.S. Department of Health and Human Services,
Centers for Medicare & Medicaid Services

CO-OP Loan Borrower's Start-Up Loan, Series A, Dated Juue 7, 2012

PROMISSORY NOTE

Loan #: Start Up Loan Series A

This 7th day of June, 2012
By: Kathleen Oestreich

Title: Interim CEO

Compass Cooperative Health Network
1496 North Higley Road
Suite 102 - #300
Gilbert, AZ 85234

("Borrower")

Borrower promises, agrees and covenants to pay to the order of the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services (and its successors) the amounts specified in Schedule A below (this amount is called "Principal"), plus interest.

Payments made hereunder shall be applied first to any unpaid "Obligations" (as such term is defined in the Loan Agreement) other than Principal and interest, then to accrued and unpaid interest due and the remainder to the unpaid balance of Principal.

Borrower agrees to pay Principal and interest in the installments listed in Schedule A below, as may be amended from time to time.

Borrower hereby waives the rights of presentment (meaning the right to require CMS to demand payment) and notice of dishonor (meaning the right to require CMS to give notice to other persons that amounts due hereunder have not been paid).

This Note is attached to and expressly incorporated by reference in the Loan Agreement dated June 7, 2012 (as amended, supplemented or otherwise modified and in effect from time to time, the "Loan Agreement"), by and among Borrower and CMS, and evidences the "Start-Up Loan" made by CMS thereunder.

The terms and conditions of the Loan Agreement are hereby incorporated in their entirety by reference as though fully set forth herein.

Address: Compass Cooperative Health Network 1496 North Higley Road Suite 102 - #300 Gilbert, AZ 85234 Attention: Kathleen Oestreich Project Officer Telephone No.: (520) 404-9639 E-Mail: Kathyo@eastwickstrategy.com	**[Borrower]** Per: Kathleen Oestreich Name: Kathleen Oestreich Title: Interim CEO Date: 6/6/2012

SCHEDULE A:

RECORD OF START-UP DISBURSEMENTS AND PRINCIPAL DUE

DISBURSEMENT DATE	DISBURSEMENT AMOUNT ("PRINCIPAL")	DATE FOR REPAYMENT OF PRINCIPAL AND INTEREST	SERIES DESIGNATION
TBD	TBD	TBD	A-01

No interest or principal payments are due before 5 years from the disbursement for which they constitute an instance of repayment. All interest will accrue on a monthly basis using a 360 day year and a 30 day month for actual days elapsed. Any accrued interest during the grace period will be capitalized into the outstanding principal balance on an annual basis until repayment is due. A single lump sum payment of principal and interest will be made at the end of 5 years from the date of a specific disbursement.

Appendix 3

SOLVENCY LOAN DISBURSEMENT AGREEMENT

DISBURSEMENT AGREEMENT
FOR SOLVENCY LOAN FUNDS

This Disbursement Agreement ("Agreement") dated ("Closing Date"), by and between the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services ("CMS") and Compass Cooperative Health Network ("Borrower"),

WITNESSETH THAT:

WHEREAS, CMS and Borrower have entered into a Loan Agreement ("Loan Agreement") contemporaneously herewith for the purposes of fostering the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets through the provision of loans to qualified applicants for the purpose of financing start-up costs and insurance reserves [see the Affordable Care Act, Section 1322(a)]; and

WHEREAS, pursuant to the terms of the Loan Agreement, CMS has agreed to make a Solvency Loan to Borrower in the maximum principal sum of$72,422,900, of which $6,583,900 is Contingency Funding; and

WHEREAS, CMS contemplates that there will be multiple loan disbursements ("Disbursements") at irregular intervals related to levels of enrollment or claims, or as necessary to remain compliant with State insurance law solvency requirements; and

WHEREAS, CMS and Borrower wish to enter into this Agreement to memorialize their understanding about the timing and procedures related to the Disbursements and to further ensure that Disbursements are made only for the uses intended under the Loan Agreement and the CO-OP Program authorized under the Affordable Care Act.

NOW, THEREFORE, in consideration of the mutual agreements contained herein and for other good and valuable consideration, the receipt of which is hereby acknowledged, CMS and Borrower agree to the terms hereinafter set forth in this Agreement.

I. Disbursement Guidelines

(i) ***Disbursement.*** Whenever the Borrower desires to obtain Solvency Loan Funds, the Borrower shall submit to the CMS an updated Disbursement Schedule and adhere to procedures described in the Loan Agreement, Section 5.3 and in Appendix 5 thereof.

(ii) ***Failure to Meet Milestones.*** The Borrower must notify CMS (Consistent with CO-OP Program guidance) at least 90 days in advance, whenever possible, ifit will be unable to make any scheduled payment due hereunder, or immediately upon becoming aware or having reason to know or reasonably suspect or anticipate that it will be unable to make a scheduled payment hereunder if less than 90 days remain prior to the date of such scheduled payment.

II. Funding Requests

(i) ***Method of Disbursement.*** Ifno Event of Default (as such term is defined in the Loan Agreement) has occurred that has not been cured within applicable grace and cure periods, and all of the terms and conditions of this Agreement have been complied with to the satisfaction of

CMS, CMS shall pay to Borrower, via wire transfer, the principal amount of funding Draw requested, subject to and in accordance with the terms and conditions set forth in the Loan Agreement.

IN WITNESS WHEREOF, CMS and Borrower have executed this Agreement as of the date indicated by each signature.

Address: U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, 200 Independence Avenue, SW, Washington, D.C., 20201 Attention: Kevin Kendrick Telephone No.: (301) 492-4134 E-Mail: Kevin.kendtick@cms.hhs.gov	**U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services ("Lender")** Per: Na,ffill Deputy Director, Center for Consumer Information and Insurance Oversight Date: f|--'-+-'\]

Address: Compass Cooperative Health Network 1496 North Higley Road Suite 102 -#300 Gilbe1t, AZ 85234 Attention: Kathleen Oestreich Project Officer Telephone No.: (520) 404-9639 E-Mail: Kathyo@eastwickstrategy.com	**[Borrower]** Per: _____ Name: Kathleen Oestreich Title: Interim CEO Date:----------

CMS, CMS shall pay to Borrower, via wire transfer, the principal amount of funding Draw requested, subject to and in accordance with the terms and conditions set forth in the Loan Agreement.

IN WITNESS WHEREOF, CMS and Borrower have executed this Agreement as of the date indicated by each signature.

Address: U.S. Depmtment of Health and Human Services, Center for Medicare and Medicaid Services, 200 Independence Avenue, SW, Washington, D.C., 20201 Attention: Kevin Kendrick Telephone No.: (301) 492-4134 E-Mail: Kevin.kendrick@cms.hhs.gov	**U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services ("Lender")** Per: _____ Name: Timothy Hill Deputy Director, Center for Consumer Information and Insurance Oversight Date:_____

Address: Compass Cooperative Health Network 1496 North Higley Road Suite I 02 - #300 Gilbe1t, AZ 85234 Attention: Kathleen Oestreich Project Officer Telephone No.: (520) 404-9639 E-Mail: Kathyo@eastwickstrategy.com	**[Borrower]** Per: Name: Kathleen Oestreich Title: Interim CEO Date:_____6_16_12_0_1_2_ _

Schedule *A* - Scheduled Solvency Disbursements

Date	Amount	Reason / Justification
TBD	TBD	Initial Solvency Draw

Any Solvency Disbursements beyond this amount requires notice to CMS and successful completion of the procedures described in the Loan Agreement, Section 5.3, and Appendix 5, Solvency Loan Disbursement Procedures.

Appendix4

SOLVENCY LOAN PROMISSORY NOTE

U.S. Department of Health and Human Services,
Centers for Medicare & Medicaid Services
CO-OP Loan Borrower's Solvency Loan, Series B, Dated June 7, 2012

PROMISSORY NOTE

The Solvency Loan provided pursuant to the Loan Agreement of which this Promissory Note is a part, and is incorporated into as Appendix 4, is a Surplus Note. Accordingly, Borrower promises, agrees and covenants to pay to the order of Lender, the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services (and its successors) the amounts specified in Schedule A below (this amount is called "Principal"), plus interest. Notwithstanding any conflicting provisions contained in the Loan Agreement, payment shall be on the terms and subject to the conditions set forth in this Surplus Note. Interest shall not compound and shall be computed annually for the twelve (12) months ending on the anniversary of each disbursement on the basis of a year of twelve thirty-day months.

Payments made hereunder shall be applied first to any unpaid "Obligations" (as such term is defined in the Loan Agreement) other than Principal and interest, then to accrned and unpaid interest due and the remainder to the unpaid balance of Principal.

Borrower agrees to pay Principal and interest in the installments listed in Schedule A below, as may be amended from time to time.

PROVIDED, HOWEVER, that payment of Principal and interest shall be subject to the following conditions:

1. This surplus note shall not be a liability or claim against Borrower or any of its assets, except as provided in this Surplus Note. This Surplus Note does not confer any rights upon the Lender, as Note Holder, other than the right to receive payment of principal and interest on the terms and subject to the conditions set forth in this Surplus Note.

2. This Surplus Note shall be repaid only out of the surplus earnings of Borrower and, as to each payment, only with the prior approval of the Arizona Insurance Commissioner or his designee. Subject to the approval requirements set forth herein, Borrower at its option may repay all or any part of this Surplus Note at any time after issuance at the outstanding principal amount plus the interest accrned thereon to the date of repayment.

3. By acceptance of this Surplus Note, the Note Holder agrees that the payment of principal and interest hereunder is expressly subordinated to claims of creditors and members of Borrower. If Borrower is dissolved and there are insufficient assets to pay in full the principal amount of and interest on all outstanding Surplus Notes, then Borrower shall pay on the Surplus Notes pro rata on the basis of the outstanding principal amount of each Surplus Note and the interest

accrued thereon. Regardless of the issuance date of this Surplus Note or any other surplus note of Borrower this Surplus Note shall be of equal rank with any other surplus note, unless such other surplus note is expressly subordinated to this Surplus Note.

Subject to the conditions for payment, repayment, discharge, and retirement of this Promissory Note set forth above, Borrower may, at its option, prepay this Promissory Note in whole or in part at any time without penalty.

No recourse under or upon any obligation, covenant, or agreement contained in this Promissory Note, or for any claim based thereon or otherwise in respect thereof, shall be had against any member, officer, or director, as such, past, present, or future, of Borrower or of any successor corporation, either directly or through any trustee, receiver, or any other person; it being expressly understood that this Promissory Note is solely a corporate obligation ofB01rnwer, and that any and all personal liability, and any and all rights and claims against every such member, officer, or director, as such, are hereby expressly waived and released by every holder hereof by the acceptance of this Promissory Note and as a part of the consideration for the issue hereof.

The obligation of Borrower under this Promissory Note may not be offset or be subject to recoupment with respect to any liability or obligation owed to Bmrnwer. No security agreement or interest, whether existing on the date of this Note or subsequently entered into, applies to the obligation under this Note.

No modification of this obligation is effective and no other agreement may modify or supersede the te1ms of this obligation, whether existing on the date of this Note or subsequently entered into, unless the modification or agreement is approved in writing by the Commissioner.

Borrower hereby waives the rights of presentment (meaning the right to require CMS to demand payment) and notice of dishonor (meaning the right to require CMS to give notice to other persons that amounts due hereunder have not been paid).

This Note is attached to and expressly incorporated by reference in the Loan Agreement dated June 7, 2012, as amended, supplemented or otherwise modified and in effect from time to time (the "Loan Agreement"), by and among Borrower and CMS, and evidences the "Solvency Loan" made by CMS thereunder.

The terms and conditions of the Loan Agreement are hereby incorporated in their entirety by reference as though fully set forth herein.

Address: Compass Cooperative Health Network 1496 North Higley Road Suite I 02 - #300 Gilbe11, AZ 85234 Attention: Kathleen Oestreich Project Officer Telephone No.: (520) 404-9639 E-Mail: Kathyo@eastwickstrategy.com	**[Borrower]** ,/;xJ...w...,_J Li.4.tu, ,i..) Per: _____ Name: Kathleen Oestreich Title: Interim CEO Date: 6/6/2012

SCHEDULE A:

RECORD OF SOLVENCY DISBURSEMENTS AND PRINCIPAL DUE

DISBURSEMENT DATE	DISBURSEMENT AMOUNT ("PRINCIPAL")	DATEFOR FIRST INTERST PAYMENT	DATE FOR FINAL PRINCIPAL ANDINTERST PAYMENT	SERIES DESIG-NATION
TBD	TBD	TBD	TBD	B-01

For each drawdown of the Solvency Loan, payment of principal and interest is calculated as follows: for disbursements made on or after 2014 but no later than 2018, the interest-only period begins in 2019 and ends 5 years from the date of the disbursement. During this period, interest payments are due annually, staiting in 2019. For disbursements made after 2018, the interest-only period begins one year after the disbursement date, and ends 5 years after the disbursement date. During this period, 5 annual interest payments are due, starting in the first year of the interest-only period. The amortization period begins 6 years after each disbursement, and ends 15 years thereafter. During this period, 10 equal, annual payments that include principal and interest are due each year based on the remaining unpaid principal balance.

For disbursements made prior to 2014, there will be no interest only period. The amortization period will begin in 2019 and run through final repayment, 15 years after disbursement.

Appendix 5

Solvency Loan Disbursement Procedures

I. INITIAL INSTALLMENT

For Borrower to receive the initial installment disbursement of Solvency Loan funds Borrower shall provide to Lender a written request that conforms to the following requirements:

a. The request is in writing and specifies a fixed dollar sum.

b. The request, by explicit terms, states that the signatories to the request thereby certify as follows:

1) The stated sum represents an amount sufficientto meet reserve capital and solvency requirements, as determined by a State insurance regulator or regulatory entity, as the case may be, for the purpose of becoming licensed, and/or authorized, to engage in the business of insuranceas an issuer of health insurance policies that include, at a minimum, all business lines specified in the Business Plan, within the entire geographicalarea specified in the Business Plan;

2) The stated sum is sufficient for the purpose satisfying any risk based capital reserve requirement imposed under this Agreement with Borrower, including the reserve level established in the Disbursement Agreement to meet the initial reserve level, and

3) The determination as to the necessity and sufficiency of the request has been developed, reviewed, and approved, with all appropriate actuarial certification and/or attestation, and in a manner consistent with industry standards and sound business practice.

c. The request must be signed by both the Borrower's CEO and CFO.

d. The request must include evidence acceptable to Lender that the sum requested is not excessive for purposes of initial licensure asa health insurance issuer and is in all other respects consistent with sound business practice and fair dealing, and the spirit and purpose of this Agreement.

e. After the initial Solvency Loan disbursement, Lender shall provide promptly to Borrower Schedule A to Appendix 4 to accurately record the making of the initial disbursement, and the schedule of its repayment, consistent with all terms of this Agreement.

IL DISBURSEMENT SUBSEQUENT TO THE INITIAL INSTALLMENT

Bo1rnwer may draw additional disbursements of Solvency Loan Funds as needed, subsequent to the initial disbursement, and consistent with all terms, conditions, requirements, and limitations of this Agreement, up to the maximum amount stated on the Title Page of the Agreement, for either of the following purposes:

I. To meet the regulatory capital requirements of a State in which Borrower seeks to be or remain licensed to issue CO-OP QHPs; and

2. To ensure that Borrower is in good standing under applicable State Insurance Laws and State Reserve Requirements, as well as in compliance with all terms of this Agreement.

The procedure for requesting disbursements of Solvency Loan Funds subsequent to the initial disbursement is to submit to Lender a written request that conforms to the following requirements:

a. The request specifies a fixed dollar sum.

b. The request, by explicit terms, states that the signatories to the request thereby certify that:

1) The stated sum represents an amount necessary to satisfy State reserve capital and solvency requirements in a State in which Borrower is licensed and/or authorized to engage in the business of insurance as an issuer of health insurance policies that include business lines specified in the Business Plan, and/or

2) The stated sum is sufficient and necessary to maintain any additional risk based capital reserve requirement imposed under this Agreement;

3) The subsequent disbursement is necessary due to change in circumstances, such as: emollment growth; unanticipated claims experience; network growth or change; change to State law or other regulatory requirements, or other cause, and

4) The determination as to the necessity and sufficiency of the request has been developed, reviewed, and approved, with all appropriate actuarial certification and/or attestation, and in a manner consistent with industry standards and sound business practice.

c. The request is signed by both the Borrower's CEO and CFO.

d. Any Contingency Funds shall be requested using the procedures specified in this Section II.

e. After any subsequent Solvency Loan disbursement, Lender shall provide promptly to Bo1rnwer a superseding Schedule A to Appendix 4, revised so as to accurately record the making of that subsequent disbursement, and the schedule of its repayment, in addition to all prior disbursements, including the initial disbursement.

f. Notwithstanding any other provision of the Loan Agreement to the contrary, no Solvency Loan Funds shall be disbursed to Borrower later than fifteen (15) years after the date of the initial draw of solvency funds, exclusive of the day of the initial draw. The date that is the last day of the fifteenth year following the date of the initial draw referenced in the preceding sentence is the Final Solvency Loan Disbursement Date (FSLDD).

Appendix 6

Interest Rates

Loan Interest Rate Start-Up: 0.00%

Loan Interest Rate Solvency: 0.25%

Post Default Interest Rate Start-Up: 0.71%

Post Default Interest Rate Solvency: 2.25%

For an explanation on Interest Rate calculation refer to Section 4.3 for Start-Up Loans and Section 5.5 for Solvency Loans.

Appendix 7

Business Plan

[Incorporated by reference; original on file]

Appendix 8

Payment Instructions

At least 90 days prior to the first payment due date CMS will contact Borrower to provide payment instructions for the first payment and subsequent payments. Those instructions and the contact information below are subject to change over time upon reasonable notice and without formal amendment to the Agreement.

CMS and Borrower contact information for payment arrangements is as follows:

Address:

U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, D.C. 20201

Attention: Reed Cleary

Telephone Number: (301) 492-4390

E-Mail: reed.cleary@cms.hhs.gov

Address:

Compass Cooperative Health Network
1496 North Higley Road
Suite 102 - #300
Gilbert, AZ 85234

Attention: Kathleen Oestreich
Project Officer

Telephone No.: (520) 404-9639

E-Mail: Kathyo@eastwickstrategy.com

Appendix 9

Administration of Compliance Monitoring

Lender will monitor and assess the performance of Borrower in meeting the terms and parameters of the Loan Agreement and to ensure that the Borrower uses Federal funds in a manner consistent with section 1322 of the Affordable Care Act, the provisions of 45 CFR part 156 subpart F. To meet these requirements, Lender will monitor Borrower's:

1. Financial management;
2. Responsiveness to Member Grievances;
3. Maintenance of consumer control; and
4. Quality of care.

Borrower must, upon written request, submit financial reports, enrollment data, quality data, governance and election information, annual independently audited financial statements in accordance with any State financial reporting requirements, the employment contracts of the senior management of the CO-OP including the Chief Executive Officer, the Chief Operating Officer, the Chief Financial Officer, and the senior Executive Vice-President and other data required by Lender to monitor the performance of Borrower.

Lender may use a range of methods to monitor and assess the performance of Borrower including but not limited to any of the following:

1. Analysis of specific financial data required by the Loan Agreement and provided by Borrower, including aggregated annual and quarterly reports;
2. Site visits;
3. Analysis of Member Grievances and/or provider complaints;
4. Background checks of CO-OP personnel; and/or
5. On-site review of financial systems and documents up to and including Agreed Upon Procedures and/or Audits.

Borrower must cooperate with and facilitate any monitoring or program oversight conducted by Lender including audits, performance reviews, site visits, and corrective action plans. The timing of audits, site visits, and performance reviews are at Lender's discretion. Lender will notify Borrower 15 calendar days in advance of any audit or site visit, unless fraud or other malfeasance is suspected.

To maintain compliance with provisions of the CO-OP Program, Borrower will submit to Lender the following periodic reports on or prior to the specified due dates, or upon written request from Lender, dming the Performance Period, as defined in section 2 of this Loan Agreement:

Report/ Information	Data/Collection Period	Date(s) Due
Quarterly Federal Financial Report (FFR) - SF 425	Quarterly	30 days following the last day of the quarter
Quarterly Financial Report	Quarterly	30 days following the last day of the quarter
Semi-annual Progress Report	Semi-annually	90 days following the last day of the second and fourth quarters

The Quaiterly Financial Repmt must include information such as, but not limited to:

1. A statement that Borrower is in compliance with all relevant State licensure requirements appropriate for its stage of development or an explanation of any deficiencies and steps being taken to resolve them, and
2. Financial statements including a balance sheet, income statement, and statement of cash flows.

The Semi-annual Progress Report must provide information such as, but not limited to:

1. Progress on the goals, objectives, milestones, and activities identified in Borrower's Business Plan and the Loan Agreement;
2. Accomplishments, barriers, and lessons learned;
3. Data on the Borrower's responsiveness to Member Grievances, maintenance of consumer control, and quality of care once enrollment begins;
4. An updated Business Plan including supporting actuarial analyses; and
5. One of the semi-annual repo1ts must include audited financial statements by an independent auditor.

In addition to the requirements above, Borrower must maintain documentation of the following provisions and provide evidence of compliance upon request from Lender during the Performance Period:

I. Section 501(c)(29) private nonprofit member organization status, if such status has been sought and obtained;
2. Offering of at least one CO-OP QHP at the silver level of benefits and one at the gold level of benefits in every individual Exchange that serves the geographic area in which it is licensed and intends to provide health care coverage;
3. If offering at least one plan in the small group market outside the Exchange, offering of a CO-OP QHP at both the silver and gold benefit levels in each SHOP that serves the geographic regions in which the organization offers coverage in the small group market; and
4. At least two-thirds of the contracts written by a CO-OP must be CO-OP QHPs offered in the individual and small group markets of the States in which the CO-OP is licensed.

Borrower agrees, and must require its providers, suppliers, and contracted entities perfo1ming services or functions on behalf of Borrower to agree, that Lender, the Comptroller General, the OIG or their designees have the right to audit, inspect, evaluate, examine, and make excerpts, transcripts, and copies of any books, records, documents, and other evidence of Borrower, and its members, providers and suppliers, and contracted entities related to their scope of work that pertain to Borrower's compliance with CO-OP Program requirements, and the ability of Borrower to repay loan funds to Lender. Lender will own any and all data submitted by Borrower.

Appendix 10
Affirmation of State Regulatory Acceptance of CO-OP Loans as Regulatory Capital

Department of Insurance
State of Arizona
Financial Affairs Division
Telephone: (602) 364-3999
Facsimile: (602) 364-3989

JANICE K. BREWER
Governor

2910 North 44th Street, Suite 210
Phoenix, Arizona 85018-7269
www.id.state.az.us

CHRISTINA URIAS
Director of Insurance

May 31, 2012

Mr. David Edwards
Chairman & Vice President - Legal
Gaen Healthcare Advisors LLC
8770 W. Bryn Mawr Ave., Suite 1300
Chicago, IL 60631

RE: **Compass Cooperative Health Network ("Compass CO-OP")**

Dear Mr. Edwards:

You asked our Department to review a form of promissory note ("Solvency Surplus Note") in connection with a loan program ("Solvency Loan") offered by the US Department of Health and Human Services, Centers for Medicare & Medicaid Services ("CMS"), providing for the funding of a consumer operated and oriented health plan in Arizona pursuant to Section 1322 of the Affordable Care Act. You asked us to determine whether the Solvency Surplus Note the Compass CO-OP intends to issue qualifies as a "surplus note" under Arizona Revised Statutes (A.R.S.) § 20-725. We have discussed same with Mr. Kevin Kendrick of CMS.

Based on our review of the Solvency Surplus Note, Solvency Loan, and our discussions with Mr. Kendrick, we believe that should Compass CO-OP issue the Solvency Surplus Note, it will qualify as a surplus note under A.R.S. § 20-725, and as such, the funds related to the Solvency Surplus Note could be used as surplus for reserve and solvency purposes. We discussed the following with Mr. Kendrick:

(i) the use of Solvency Surplus Note proceeds is not permitted for initial capitalization or "start up" costs;
(ii) the Solvency Surplus Note proceeds must be invested in eligible assets qualified under Arizona insurance statutes that meet the liquidity needs of Compass CO-OP;
(iii) an Arizona court-appointed receiver for Compass CO-OP (acting in lieu of the department or agency), enforcing or implementing a state insurance law provision or taking a regulatory action, is within the definition of State Solvency Payment Restriction;
(iv) the Department's approval authority over any proposed payments under the Solvency Surplus Note; and
(v) the requirement that the Solvency Surplus Note comply with SSAP No. 41.

Surplus notes are recognized as surplus because of their highly restrictive nature. The holder of the surplus note agrees to the lowest priority for repayment in the event of a receivership, and payments under a surplus note can only be made from earned surplus upon the prior approval of the Department.

The Department will require compliance with SSAP No. 41, and it is our position that SSAP No. 41 does not permit the recapitalization of interest. Under the terms of the Solvency Surplus Note, interest may accumulate; however, the Compass CO-OP shall not record interest as a liability nor an expense until the Director grants specific approval for any individual interest payment. Further, Compass CO-OP shall not report unapproved interest through operations, shall not represent interest as an addition to principal or notional amount of the Solvency Surplus Note, and shall not accrue further interest, i.e. interest on interest.

Compass CO-OP does not currently have a certificate of authority in Arizona nor have they filed an application with us so we cannot issue a formal approval to allow Compass CO-OP to issue the Solvency Surplus Note. Please be aware that we are only issuing this letter prior to Compass CO-OP applying for an Arizona certificate of authority because of the unique provisions under the Affordable Care Act that require Compass CO-OP to seek our determination.

Please let me know if you have any questions. Thank you.

Sincerely,

Kurt Regner
Assistant Director
Financial Affairs Division

cc: Gerrie Marks, Deputy Director
Cary Cook, Chief Financial Compliance Officer
Alex Shafer, Assistant Director, Life & Health Division
Leslie Hess, Deputy Receiver/Legal Analyst

AMENDMENT TO LOAN AGREEMENT

I. Purpose

The purpose of this Amendment is to amend the Loan Agreement dated June 7, 2012 ("Agreement"), between Compass Cooperative health Network ("Borrower") and the Centers for Medicare and Medicaid Services ("Lender") (Lender and Borrower together are "the Parties"), pursuant to Section 19 of the Agreement, and in particular Section 19.4 thereof, to reflect a change of Borrower's name.

II. Modifications

Accordingly, the Parties hereby agree to the following specific modifications to the Agreement:

a. Each reference in the Agreement to "Compass Cooperative Health Network" shall be replaced and superseded by "Compass Cooperative Mutual Health Network, Inc."

b. Each and every reference in the Agreement to "Borrower" shall be deemed to refer to, and shall refer to, Compass Cooperative Mutual Health Network, Inc.

III. Effective Date and Counterparts

This Amendment shall take effect on the date on which Lender executes this Amendment, and shall be retroactive to the date the name change it reflects became legally effective. This Amendment may be executed in counterparts.

IV. No Other Change

Except as expressly modified herein, all other terms and conditions of the Agreement shall remain in full force and effect, and are hereby ratified, endorsed and reaffirmed by the Parties hereto, as witnessed by their respective signatures below. In conjunction therewith, each Party

hereby expressly agrees to abide by and be legally bound by the covenants, terms and conditions of the Agreement, as the same be modified hereby. In the event of a conflict between any provision of the Agreement as originally drafted and the provisions of this Amendment, the provisions of this Amendment shall control.

IN WITNESS WHEREOF, Lender and Borrower have executed this Amendment as of the date indicated by each signature.

For Lender:

Per: _____
Name: James T. Kerr
Title: Deputy Director, Center for Consumer Information and Insurance Oversight

Date: _____

For Borrower:

Kathleen Oestreich

Per: _____
Kathleen Oestreich
Title: Chief Executive Officer

Date: _____

SECOND AMENDMENT TO LOAN AGREEMENT

I. Purpose

The purpose of this Second Amendment ("Amendment") is to amend the Loan Agreement dated **June 7, 2012** ("Agreement"), between **Meritus Mutual Health Partners, f/k/a Compass Cooperative Health Network** ("Borrower"), and the Centers for Medicare & Medicaid Services ("Lender") (Lender and Borrower together are "the Parties"), through a written amendment consistent with Section 19.4 thereof. This Amendment shall serve the purpose of, among other things, replacing Appendix 2 of the Agreement with that Appendix 2 attached as Attachment 1 hereto, for the purpose of enabling the outstanding balance of the Start-up Loan to be treated as the proceeds of a surplus note pursuant to National Association of Insurance Commissioners Statement of Statutory Accounting Principles No. 41 (SSAP 41). The Parties intend that this Amendment is necessary to advance the Parties' mutual interest, and that the Director of Insurance of the State of Arizona acknowledges the promissory note contained in Appendix 2 of the Agreement as a surplus note within the meaning of SSAP 41, and thus accept the proceeds of the Start-Up Loan (designated as "Series A" on the facing page of the Agreement) provided pursuant to the Agreement as an asset for purposes of determining and acknowledging regulatory capital and surplus.

II. Amendment

Accordingly, the Parties hereby agree to amend the Agreement as follows:

1. By replacing the version of Appendix 2 to the Agreement that existed prior to the execution of this Amendment with that new Appendix 2 attached as Attachment 1 to this Amendment.

2. In the Definition section, under the defined terms "Interest" or "Interest Amount," inserting a period after the phrase "Accrual Period" and deleting the remainder of the text.

3. Deleting the text of the section entitled "4.3 Interest" in its entirety and replacing it with the following text:

The Interest rate for the Start-Up Loan and any individual Disbursement thereof shall be fixed for the life of the Loan at the amount in Appendix 6, which represents the Treasury rate on five year securities in effect on the initial Date of Award minus one percentage point ("Interest Rate"); provided, however, that in the event this Agreement is earlier terminated for cause under Section 16.3 below, the Interest Rate for the Start-Up Loan shall be fixed at the rate in Appendix 6, which is equal to the Treasury rate on five year securities based on the Date of Award. Interest on the Start-Up Loan and each individual Disbursement thereof shall, subject to all terms and limitations in the Start-up Loan Promissory attached hereto and incorporated herein by reference as Appendix 2, accrue on a monthly basis using a 360-day year and 30-day month for actual days elapsed. Interest shall be payable according to the Repayment Schedule attached to this Agreement and incorporated herein by reference as Schedule A of Appendix 2.

4. Deleting the text of the second paragraph of the section entitled "4.4 Repayment of Start-Up Loan" in its entirety and replacing it with the following text:

Unless Lender terminates this Agreement for cause under Section 16.3 below, Borrower shall, subject to all terms and limitations in the Start-up Loan Promissory attached hereto and incorporated herein by reference as Appendix 2.1 be obligated to repay 100 percent of the Start-Up Loan amount disbursed, plus any Interest due to Lender in accordance with the Repayment Schedule for the Start-Up Loan, subject to its ability to meet State Reserve Requirements and other solvency regulations, or requisite surplus note arrangements.

5. Deleting in its entirety the last sentence of the section entitled "5.5 Interest".

6. Deleting the text of paragraph (a) of the section entitled "15.1 Events of Default" in its entirety and replacing it with the following text:

Borrower, for reasons other than a State's Solvency Payment Restriction, fails to pay any installment of Principal or Interest on a Loan or other Obligation for more than 60 days after the date the same is due, subject to any applicable surplus note limitations in the Start-up Loan Promissory Note or the Solvency Loan Promissory Note attached hereto and incorporated herein by reference as Appendices 2 and 4, respectively, and such delinquent payment is not subsequently recapitalized in accordance with the terms hereof.

7. Replacing all occurrences of the phrase "capitalized interest," in section 5.6 or otherwise throughout the Agreement, with the phrase "interest due."

8. Deleting in its entirety the second sentence of the text below the table in Schedule A to Appendix 2.

III. Execution and Effective Date

This Amendment may be executed by the Parties in any order and is effective upon execution by the last of the two Parties to so execute. This Amendment may be executed in counterparts.

IV. No Other Change

Except as expressly modified herein, all other terms and conditions of the Agreement shall remain in full force and effect, and are hereby ratified, endorsed and reaffirmed by the Parties hereto, as witnessed by their respective signatures below. In conjunction therewith, each Party hereby expressly agrees to abide by and be legally bound by all covenants, terms and conditions of the Agreement, as the same be modified hereby. In the event of a conflict between any provision of the Agreement as originally drafted and the provisions of this Amendment, the provisions of this Amendment shall control.

IN WITNESS WHEREOF, Lender and Borrower have executed this Amendment as of the date indicated by each signature.

For Lender:

Per: _____
Name: Kevin Gaunihan
Title: Director, Center for Consumer Information and Insurance Oversight Marketplace CEO

Date: 9/30/15

For Borrower:

Per: _____
Name: Tom Zumtobel
Title: Chief Executive Officer

Date: _____

ATTACHMENT 1

Appendix 2

START-UP LOAN PROMISSORY NOTE

U.S. Department of Health and Human Services,
Centers for Medicare & Medicaid Services

CO-OP Loan Borrower's Start-Up Loan, Series A, Dated June 7, 2013

PROMISSORY NOTE

Loan #: Start Up Loan Series A
This 30th day of September, 2015
By: Tom Zumtobel
Title: Chief Executive Officer
Meritus Mutual Health Partners
2005 W. 14th Street, Suite 113, Tempe, AZ 85281
("Borrower")

The Start-up Loan provided pursuant to the Loan Agreement of which this Promissory Note is a part, and is incorporated into as Appendix 2, is a Surplus Note. Accordingly, Borrower promises, agrees, and covenants to pay to the order of Lender, the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services (and its successors) the amounts specified in Schedule A below (this amount is called "Principal"), plus interest. Notwithstanding any conflicting provisions contained in the Loan Agreement, other than Section 3.4 of the Loan Agreement which is incorporated herein by reference. Payment shall be on the terms and subject to the conditions set forth in this Surplus Note. Interest shall not compound and shall be computed annually for the twelve (12) months ending on the anniversary of each disbursement on the basis of a year of twelve thirty-day months.

Borrower agrees to pay Principal and interest in the installments listed in Schedule A below, as may be amended from time to time.

PROVIDED, HOWEVER, that payment of Principal and interest shall be subject to the following conditions:

1. This surplus note shall not be a liability or claim against Borrower or any of its assets, except as provided in this Surplus Note. This Surplus Note does not confer any rights upon the Lender, as Note Holder, other than the right to receive payment of principal and interest on the terms and subject to the conditions set forth in this Surplus Note.

2. Principal and interest due under this Surplus Note are payable only in compliance with the Statements of Statutory Accounting Principles No. 41 and No. 72, the provisions of Section 20-725, Arizona Revised Statutes, and with the prior written approval of the Director of Insurance of the State of Arizona. Borrower shall pay any amounts due and owing to the extent provided. No payments, however, whether principal or interest, shall be made if thereby the surplus of the Borrower is reduced below the minimum (or stated amount above that minimum) statutory requirements of the State of Arizona. Subject to the approval requirements set

forth herein, Borrower at its option may repay all or any part of this Surplus Note at any time after issuance at the outstanding principal amount plus the interest accrued thereon to the date of repayment.

3. By acceptance of this Surplus Note, the Note Holder agrees that the payment of principal and interest hereunder is expressly subordinated to claims of creditors and members of Borrower, including a) policyholders of Borrower; b) claimant and beneficiary claims of policies issued by Borrower; c) all other classes of creditors other than surplus note holders; d) Operating expenses of Borrower, and e) reserve and solvency requirements as determined by applicable State law. If Borrower is dissolved and there are insufficient assets to pay in full the principal amount of and interest on all outstanding Surplus Notes, then Borrower shall pay on the Surplus Notes pro rata on the basis of the outstanding principal amount of each Surplus Note and the interest accrued thereon, unless and only to the extent that such payment is otherwise prevented, restricted or delayed by a State Solvency Payment Restriction. Regardless of the issuance date of this Surplus Note or any other surplus note of Borrower this Surplus Note shall be of equal rank with any other surplus note, unless such other surplus note is expressly subordinated to this Surplus Note.

Subject to the conditions for payment, repayment, discharge, and retirement of this Promissory Note set forth above, Borrower may, at its option, prepay this Promissory Note in whole or in part at any time without penalty.

The obligation of Borrower under this Promissory Note may not be offset or be subject to recoupment with respect to any liability or obligation owed to Borrower. No security agreement or interest, whether existing on the date of this Note or subsequently entered into, applies to the obligation under this Note.

No modification of this obligation is effective and no other agreement may modify or supersede the terms of this obligation, whether existing on the date of this Note or subsequently entered into, unless the modification or agreement is approved by the Director of Insurance of the State of Arizona.

Borrower hereby waives the rights of presentment (meaning the right to require CMS to demand payment) and notice of dishonor (meaning the right to require CMS to give notice to other persons that amounts due hereunder have not been paid).

This Note is attached to and expressly incorporated by reference in the Loan Agreement dated **June 7, 2012**, as amended, supplemented or otherwise modified and in effect from time to time, the "Loan. Agreement"), by and among Borrower and CMS, and evidences the "Solvency Loan" made by CMS thereunder.

The terms and conditions of the Loan Agreement are hereby incorporated in their entirety by reference as though fully set forth herein.

Address: 2005 W. 14th Street, Suite 113 Tempe, AZ 85281 Attention: Telephone No.: 602.957.2113 x___ E-mail:	Meritus Mutual Health Partners Per: _____ Name: Tom Zumtobel Title: Chief Executive Officer Date: _____

Exhibit B

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

OFFICE OF INSURANCE PROGRAMS

August 12, 2015

Compass Cooperative Health Plan, Inc.
Attn: Tom Zumtobel
2005 West 14th St, Suite 113
Tempe, AZ, 85281

Re: Amended Schedule A to Appendix 2 – Series A Start-up Loan, Promissory Note

Dear Borrower:

Consistent with the Loan Agreement in force between Compass Cooperative Health Plan, Inc. and CMS, dated June 7, 2012, (Agreement), and the Promissory Note attached to, and incorporated into, the Loan Agreement as Appendix 2, CMS is providing the accompanying revised Schedule A, which fully reflects all loan disbursements made through the date of this letter, and which is attached in final form to this letter as Attachment 1 for illustrative purposes. Accordingly, the amended Schedule A to the Start-up Loan's Promissory Note is hereby incorporated into the Agreement as Schedule A to Appendix 2, and as of the date of this letter supersedes any preceding version of Schedule A to Appendix 2 to the Loan Agreement.

This act constitutes a revision and substitution by the Parties in the ordinary course of business during the Financing Period, to comport with the business realities of Compass Cooperative Health Plan, Inc. Accordingly, this event does not require a Loan Modification or other amendment to the Agreement.

Sincerely,

Meghan Elrington-Clayton
CO-OP Team

Attachment

Attachment 1

SCHEDULE A:

RECORD OF START-UP DISBURSEMENTS AND PRINCIPAL DUE

DISBURSEMENT DATE	DISBURSEMENT AMOUNT ("PRINCIPAL")	DATE FOR REPAYMENT OF PRINCIPAL AND INTEREST	REPAYMENT AMOUNT DUE	SERIES DESIGNATION
06/14/2012	$2,840,904.00	06/14/2017	$2,840,904.00	A-01
08/22/2012	$1,389,039.00	08/22/2017	$1,389,039.00	A-02
09/26/2012	$2,569,426.00	09/26/2017	$2,569,426.00	A-03
01/23/2013	$2,836,443.00	01/23/2018	$2,836,443.00	A-04
03/22/2013	$2,023,543.00	03/22/2018	$2,023,543.00	A-05
06/21/2013	$1,955,643.00	06/21/2018	$1,955,643.00	A-06
09/20/2013	$3,817,283.00	09/20/2018	$3,817,283.00	A-07
11/13/2013	$450,300.00	11/13/2018	$450,300.00	A-08
12/20/2013	$16,667.00	12/20/2018	$16,667.00	A-09
02/20/2014	$2,607,752.00	02/20/2019	$2,607,752.00	A-10
06/20/2014	$133,333.00	06/20/2019	$133,333.00	A-11
06/20/2015	$50,000.00	06/22/2020	$50,000.00	A-12
08/12/2015	$200,000.00	08/12/2020	$200,000.00	A-13

Exhibit 5

PROOF OF CLAIM FORM
MERITUS MUTUAL – MERITUS HEALTH PARTNERS

Read the enclosed instruction sheet carefully before completing this form. Complete each section of the form and attach documentation. **All Proof of Claim Forms must be presented or postmarked to the Receiver at the specified address by the Claims Filing Deadline of 11:59 p.m. on May 15, 2017.**

Address for Submitting Claims: Meritus, In Receivership
Attention: Proof of Claims
Raintree Corporate Center I
15333 North Pima Road, Suite 305
Scottsdale, AZ 85260

PLEASE PRINT – ATTACH SUPPORTING INFORMATION AS NECESSARY

Section One – Claimant Contact Information

Claimant's Full Legal Name: __The United States_____

Social Security or EIN Number: ___N/A_____

Date of Birth: _____N/A_____

Claimant's Mailing Address: Sharon C. Williams, 1100 L St, N.W., Room 10016, Washington, D.C. 20005_____
_____
_____

Phone Number: __(202) 353-0530_____ Fax Number: __(202)307-0494_____

Email: ___sharon.williams@usdoj.gov _____

Attorney Representation:
If Claimant is represented by an attorney, please complete the following:

[x] Claimant is represented by an attorney. Please direct all communication regarding this Proof Claim to Claimant's attorney using the following contact information:

Attorney's Name: _Sharon C. Williams_____

Attorney's Mailing Address: __1100 L St., Room 10016, Washington, D.C. 20005_____
_____
_____

Phone Number: _(202) 353-0530_____ Fax Number: ___(202) 307-0494 _____

Email: ___sharon.williams@usdoj.gov_____

Section Two – Information Regarding Claim

1. Company. This claim is filed against: [check appropriate box(es) below]
   [_x_] Compass Cooperative Mutual Health Network, Inc., dba Meritus Mutual Health Partners [_x_] Compass Cooperative Health Plan, Inc. dba Meritus Health Partners

2. Claim Type and Amount. [check appropriate box(es) below and indicate amount]
   Type:
   a. [_x_] Policyholder, Insured or Member.
   b. [__] Agent, Vendor or other Creditor for goods or services provided.
   c. [__] Shareholders and/or Owners.
   d. [_x_] UNKNOWN All other claims.

   Amount: __UNKNOWN_____

   Explanation of the Nature of the Claim:
   _____UNKNOWN_____
   _____
   _____
   [Attach additional sheets for explanation as necessary.]
   Identify Attached Documentation, if any:
   _____
   _____

3. Security. If you are asserting a secured claim or otherwise asserting rights to any security, you must complete this section:
   [__] Yes. I am asserting a secured claim.
   If so and you hold or exercise any control over the cash, securities, trust funds, letters of credit or other assets of Meritus Mutual or Meritus Health Partners, you must explain the nature of your control and provide supporting documentation.
   _____UNKNOWN_____
   _____

Section Three – Affirmation of Claimant

I affirm: (i) that I have read the foregoing Proof of Claim and understand the contents thereof; (ii) that this claim is justly due and owing; (iii) that I am entitled to file this claim; (iv) that the matters set forth above and in any accompanying statements and documents are true and correct to my own knowledge; and (v) that no payment of or on account of the aforesaid claim has been made, except as otherwise state in my claim.

Signature of person (or authorized agent) making claims: SCWilliams

Printed Name: Sharon C. WIlliams _____

Title: (if applicable): Trial Attorney, United States Department of Justice_____

Date Signed: 5/9/17

Attachment to Proof of Claim

Nature of claim: Recovery of amounts owed to the United States and/or any federal agency or entity. These claims are entitled to first priority treatment pursuant to 31 U.S.C. § 3713.

Set-offs: The United States reserves the right to amend these claims to assert subsequently discovered liabilities. The United States may hold estimated debts owed to the estate that are subject to set-off and/or recoupment rights. The United States hereby expressly reserves its right to set-off or recoup any claim against debts owed to the estate by any federal agency or entity.

Security for claim: These claims are entitled to treatment as secured claims to the extent they are subject to set-off by a claim of the estate against any United States agency or entity. The United States is a unitary creditor for purposes of set-off and recoupment.

Exhibit 6

Lewis Roca
ROTHGERBER CHRISTIE

Lewis Roca Rothgerber Christie LLP
1200 Seventeenth Street
Suite 3000
Denver, CO 80202

303.623.9000 main
303.623.9222 fax
lrrc.com

Joel A. Glover
Admitted in Arizona, Colorado and Wyoming
303.628.9553 direct
303.623.9222 fax
jglover@lrrc.com

Sent Via Email and Overnight Delivery

November 16, 2017

Jeffrey Grant (Jeffrey.grant1@cms.hhs.gov)
Director, Payment Policy & Financial Management Group
U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop WB 22-75
Windsor Mill, MD 21244

Angela M. Belgrove (Angela.Belgrove@HHS.gov)
Office of the General Counsel, Region IX
90 7th Street, Suite 4-500
San Francisco, CA 94103-6705

Re: Compass Cooperative Health Plan, Inc. dba Meritus Health Partners, in Receivership ("**MHP**")

Notice of Setoff and Claim Determination

Dear Mr. Grant and Ms. Belgrove:

This letter is sent in our capacity as counsel for the Receiver of MHP. It provides notice of a Setoff and Claim Determination and seeks a response on or before Monday, December 18, 2017.

The Proof of Claim (the "Claim") submitted by the U.S. Dept. of Health and Human Services and the Centers for Medicare and Medicaid Services ("CMS") dated May 10, 2017 has been received and adjudicated by the Receiver subject to and in accordance with A.R.S. § 20-601 et seq. (the "Receivership Act") and applicable Court Orders entered by the Superior Court of Arizona in the County of Maricopa in *State of Arizona, ex. rel.*, Leslie R. Hess, Interim Director of Insurance, vs. Compass Cooperative Mutual Health Network, Inc., dba Meritus Mutual Health Partners, an Arizona corporation; and Compass Cooperative Health Plan, Inc., dba Meritus Health Partners, an Arizona corporation in action no. CV2016-011826 (the "Receivership Court").

The Receiver's determination of the Claim is as follows:

Setoff – Debts and Obligations Related to the Affordable Care Act

The Receivership Act (A.R.S. § 20-638) expressly provides for setoff of mutual debts under these circumstances and provides as follows:

> A. In all cases of mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this article, such credits and debts shall be set off and the balance only shall be allowed or paid, except as provided in subsection B of this section.
>
> B. No offset shall be allowed in favor of any such person where the obligation of the insurer to such person would not at the date of the entry of any liquidation order or otherwise as provided in section 20-635, entitle him to share as a claimant in the assets of the insurer, ***

The Claim asserted the following claims related to the Affordable Care Act ("ACA"):

CSR:	$ 3,899,178.47
PPACA Reinsurance:	$ 510,975.30
Risk Adjustment:	$ 46,195,827.78
PPACA Fee:	$ 44,141.47
Total:	$ 50,650,123.02

At the same time, a mutual debt is owed to MHP related to the ACA as follows:

Risk Corridor Claims:	$ 55,513,299
Reinsurance:	$ 7,171,320
Total:	$ 62,684,619

After application of the Setoff, the remaining debt owed to MHP is:

$12,034,495.98

After setoff, this remains as a net amount due to Meritus Mutual and the claim for that amount is being litigated in the pending class action styled as *Health Republic Ins. Co. v. United States*, U.S. Court of Federal Claims, Case No. 16-cv-00259 MMS.

Due to the offset, no further entitlement to interest asserted by Claimant would be considered under the Claim.

Response Opportunity and Hearing Date

On or before Monday, December 18, 2017, please notify the Receiver of your response to the Receiver's determination. To the extent you object to such determinations, please support your position.

A hearing will be scheduled at least 60 days after the date of this letter. We will send you notice of the hearing after it is scheduled. At that hearing, the Receiver will ask the Receivership Court to approve the Receiver's determination.

We look forward to hearing from you.

Sincerely,

Joel A. Glover
Lewis Roca Rothgerber Christie LLP

JAG

cc: Darren Ellingson, Special Deputy Receiver of the Meritus Companies
(darren.ellingson@icloud.com)
Marc S. Sacks, Esq., Trial Attorney, Civil Division
(Marcus.S.Sacks@usdoj.gov)
Matthew Lynch, Director, Insurance Program Group
(Matthew.Lynch@cms.hhs.gov and Leslie.Stafford@hhs.gov)
Sharon C. Williams, Esq.
(Sharon.williams@usdoj.gov)

Exhibit 7

Lewis Roca
ROTHGERBER CHRISTIE

Lewis Roca Rothgerber Christie LLP
1200 Seventeenth Street
Suite 3000
Denver, CO 80202

303.623.9000 main
303.623.9222 fax
lrrc.com

Joel A. Glover
Admitted in Arizona, Colorado and Wyoming
303.628.9553 direct
303.623.9222 fax
jglover@lrrc.com

Sent Via Email and Overnight Delivery

November 16, 2017

Matthew Lynch (Matthew.Lynch@cms.hhs.gov and Leslie.Stafford@hhs.gov)
Director, Insurance Program Group
Center for Consumer Information and Insurance Oversight
U.S. Dept. of Health and Human Services, CMS
7500 Security Blvd., WB-22-75
Baltimore, MD 21244

Marc S. Sacks, Esq. (Marcus.S.Sacks@usdoj.gov)
Trial Attorney, Civil Division
U.S. Dep't of Justice
1100 L. St. NW. Rm. 10058
Washington, DC 20005

Re: Compass Cooperative Mutual Health Network, Inc. dba Meritus Mutual Health Partners, in Receivership ("**Meritus Mutual**")

Notice of Setoff and Claim Determination

Dear Mr. Lynch and Mr. Sacks:

This letter is sent in our capacity as counsel for the Receiver of Meritus Mutual. It provides notice of a Setoff and Claim Determination and seeks a response on or before Monday, December 18, 2017.

The Proof of Claim (the "Claim") submitted by the U.S. Dept. of Health and Human Services and the Centers for Medicaid and Medical Services ("CMS") dated May 11, 2017 has been received and adjudicated by the Receiver subject to and in accordance with A.R.S. § 20-601 et seq. (the "Receivership Act") and applicable Court Orders entered by the Superior Court of Arizona in the County of Maricopa in *State of Arizona, ex. rel.*, Leslie R. Hess, Interim Director of Insurance, vs. Compass Cooperative Mutual Health Network, Inc., dba Meritus Mutual Health Partners, an Arizona corporation; and Compass Cooperative Health Plan, Inc., dba Meritus Health Partners, an Arizona corporation in action no. CV2016-011826 (the "Receivership Court").

The Receiver's determination of the Claim is as follows:

Start-Up Loan and Solvency Loan – Class 10 Priority Claims:

Under the Receivership Act, surplus notes are accorded Class 10 priority, as follows:

> In a delinquency proceeding against an insurer domiciled in this state, the priority of distribution of claims from the general assets of the insurer shall be determined pursuant to this section. Every claim in each class shall be paid in full or adequate funds shall be reserved for the payment before the members of the next class may receive any payment. Subclasses may not be established within any class. The order of distribution is as follows:
> ***
>
> > 10. Claims of surplus note or certificate of contribution holders or other similar obligations and for premium refunds on assessable policies.

The Claim asserted a claim for a Start-Up Loan in the amount $20,890,333.00

The Start-Up Loan was amended and converted to a surplus note. Its terms require that it be treated as a "surplus note pursuant to National Association of Insurance Commissioners Statement of Statutory Accounting Principles No. 41." Additionally, the repayment obligations were subject to the Co-Op's "ability to meet State Reserve Requirements and other solvency regulations, or requisite surplus note arrangements." Accordingly, the claim for the Start-Up Loan is accorded Class 10 priority level.

The Claim asserted a claim for a Solvency Note in the amount of $72,935,928.25, which included an assertion of interest owed in the amount of $513,028.25.

The express language of the Solvency Note acknowledged that, in the event of insolvency, any claims for payment under the solvency note would be of equal rank with claims of other surplus note holders. Moreover, the solvency note was not subject to security, offset or any form of recoupment. Accordingly, the claim for the Solvency Note is accorded Class 10 priority.

Pursuant to the Receivership Court's Order Accepting Status Report on Claims Adjudication and Granting Order Regarding Future Claims Reports dated September 25, 2017, the Receiver is not making a determination on the amount of the Class 10 claims but reserves the right to do so. At this time, it does not appear reasonably likely that there would be a distribution of assets at the Class 10 priority level. If such a distribution appears likely, then the amount of the Class 10 claims will be addressed.

Setoff – Debts and Obligations Related to the Affordable Care Act

The Receivership Act (A.R.S. § 20-638) expressly provides for setoff of mutual debts under these circumstances and provides as follows:

> A. In all cases of mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this article, such credits and debts shall be set off and the balance only shall be allowed or paid, except as provided in subsection B of this section.

B. No offset shall be allowed in favor of any such person where the obligation of the insurer to such person would not at the date of the entry of any liquidation order or otherwise as provided in section 20-635, entitle him to share as a claimant in the assets of the insurer, ***

The Claim asserted the following claims related to the Affordable Care Act ("ACA"):

CSR:	$115,649.36
PPACA Reinsurance:	$ 46,091.54
Risk Adjustment:	$594,168.87
Exchange User-Fee:	$ 7.76
Total:	$755,917.53

At the same time, a mutual debt is owed to Meritus Mutual related to the ACA as follows:

Risk Corridor Claims:	$12,938,057
Reinsurance:	$3,283,275
Total:	$16,221,332

After application of the Setoff, the remaining debt owed to Meritus Mutual is:

$15,465,414.47

After setoff, this remains as a net amount due to Meritus Mutual and the claim for that amount is being litigated in the pending class action styled as *Health Republic Ins. Co. v. United States*, U.S. Court of Federal Claims, Case No. 16-cv-00259 MMS.

Due to the offset, no further entitlement to interest asserted by Claimant would be considered under the Claim.

Response Opportunity and Hearing Date

On or before Monday, December 18, 2017 please notify the Receiver of your response to the Receiver's determination. To the extent you object to such determinations, please support your position.
A hearing will be scheduled at least 60 days after the date of this letter. We will send you notice of the hearing after it is scheduled. At that hearing, the Receiver will ask the Receivership Court to approve the Receiver's determination.

We look forward to hearing from you.

Sincerely,

Joel A. Glover
Lewis Roca Rothgerber Christie LLP

JAG

cc: Darren Ellingson, Special Deputy Receiver of the Meritus Companies
(darren.ellingson@icloud.com)
Angela M. Belgrove, Esq., Office of the General Counsel, Region IX
(Angela.Belgrove@HHS.gov)
Jeffrey Grant, Director
(Jeffrey.grant1@cms.hhs.gov)
Sharon C. Williams, Esq.
(Sharon.williams@usdoj.gov)

Exhibit 8

FAEGRE BAKER DANIELS LLP
1700 Lincoln Street, Suite 3200
Denver, Colorado 80203

Joel A. Glover (State Bar No. 034018)
Direct Dial: 303.607.3648
Direct Fax: 303.607.3600
Email: Joel.Glover@FaegreBD.com

Attorneys for Receiver

SUPERIOR COURT OF ARIZONA

COUNTY OF MARICOPA

STATE OF ARIZONA, *ex rel.* KEITH SCHRAAD, Interim Director of Insurance, Plaintiff, vs. COMPASS COOPERATIVE MUTUAL HEALTH NETWORK, INC., dba MERITUS MUTUAL HEALTH PARTNERS, an Arizona corporation; and COMPASS COOPERATIVE HEALTH PLAN, INC., dba MERITUS HEALTH PARTNERS, an Arizona corporation, Defendants.	No. CV2016-011872 **PETITION NO. 26** **REQUEST FOR HEARING, CLAIM DETERMINATION AND SETOFF RELATED TO CLAIMS OF THE UNITED STATES** (Assigned to The Honorable Daniel Martin)

Keith Schraad, Interim Director of Insurance, as Receiver (hereinafter "Receiver") of Compass Cooperative Mutual Health Network, Inc. doing business as Meritus Mutual Health Partners ("Meritus Mutual") and Compass Cooperative Health Plan, Inc. dba Meritus Health Partners ("MHP") (collectively referred to as the "Meritus Companies"), appointed pursuant to A.R.S. § 20-611, *et seq*., hereby submits this Request for Hearing, Claim Determination and Setoff Related to Claims of the United States ("Petition for Setoff") for the reasons set forth herein.

1. **Introduction**. Subject to and in accordance with the procedures established by this Court in the Order Approving Liquidation Plan dated March 8, 2017, claims have been submitted against the Meritus Companies by and on behalf of the United States

Department of Health and Human Services, Centers for Medicare & Medicaid Services ("CMS") and by the United States Department of Justice ("DOJ") in three separate proofs of claim ("POC's"). At the same time, the Meritus Companies have claims against CMS. With this Petition for Setoff, the Receiver seeks: (i) scheduling a hearing at a date and time determined by the Court in the form of the attached proposed order; [1] (ii) a declaration as to claim priority level with respect to certain claims asserted by CMS and DOJ; and (iii) an Order from this Court approving a setoff of certain specified claims involving the Meritus Companies and CMS/DOJ.

2. **Background – Affordable Care Act**. The mutual claims between the Meritus Companies and CMS/DOJ are based upon the Affordable Care Act. [2]

a. **The ACA and Co-Ops**. In March of 2010, Congress passed the Affordable Care Act ("ACA") in a dramatic overhaul of the nation's healthcare system, reshaping the health insurance market through a series of "interlocking reforms" and programs designed to expand coverage in the individual and small group health insurance market. *King v. Burwell*, 135 S. Ct 2480, 2485 (U.S. 2015). The ACA prohibits insurers from denying coverage or setting premiums based on a person's health; generally requires individuals to maintain health insurance coverage or make a payment to the Internal Revenue Service; and provides subsidies to low-income insurance purchasers through refundable tax credits. *Id.* at 2486-87. In conjunction with these reforms, the ACA created a network of "Health Benefit Exchanges" ("Exchanges") on which insurers would offer "Qualified Health Plans" ("QHP"s) to eligible purchasers.[3] It also created the Consumer Operated and

[1] In order to provide a full opportunity for responses and/or objections, if any, the Receiver requests that the hearing be scheduled at least seventy-five (75) days after the date of this filing.

[2] The Affordable Care Act has been the subject of extensive litigation and numerous petitions and court orders from around the country. A brief discussion is included here. For more thorough discussions of the Affordable Care Act, and related disputes, see, among others, *Moda Health Plan, Inc. v. United States*, 130 Fed. Cl. 436 (2017); *Molina Healthcare of California, Inc. et al. v. United States*, (United States Court of Federal Claims, No. 17-97C, filed August 4, 2017); and *Liquidator's Brief in Support of Motion to Approve the First Accounting and Status Report of the Liquidation Proceeding and the Acts Reported Therein*, filed on March 3, 2017 in The Matter of HealthyCT, Inc., in Liquidation, (Superior Court, Judicial District of Hartford, Docket No. HHD-CV16-6072516-S) (seeking approval of proposed set off under the ACA).

[3] Qualified Health Plans refers to those plans that met the criteria to be sold on the exchange. Only enrollees who purchased on the exchange were entitled to ACA Cost Share Reduction assistance. 45 CFR 155.20, Part 156, 155.1000, Part 156, subpart C. Eligible purchasers refers to those purchasers that provided financial information in order to qualify for Cost Share Reduction.

Oriented Plans Program (the "Co-Op Program"), which issued loans to help establish non-profit insurers to bring new competition into the insurance market in the form of Co-Ops, the creators of which had little or no experience with starting or running a health insurance company. 42 U.S.C. §§ 18031, 18041, 18042. The Meritus Companies were Co-Ops that offered QHPs on the exchange. They also offered health plans off the exchange in certain circumstances, though in those cases the enrollee would not qualify for Cost Share Reduction. Most Co-Op states had one C-Op that sold both PPO and HMO plans. However, due to Arizona's licensing requirements, the Meritus Companies were affiliates, but had distinct insurance licenses. Meritus Mutual operated as a Preferred Provider Organization ("PPO") while MHP operated as a Health Care Services Organization ("HCSO").[4] The distinction in licenses drives important differences in the liquidation of the two companies. For example, a PPO would be covered by the Arizona Guaranty Fund while an HMO would not.[5] Also, in-network (or contract) providers of an HCSO have a lower priority level for claims than do out of network HCSO provider or PPO providers.[6]

b. **Federal Regulators – HHS and CMS**. The United States Department of Health and Human Services ("HHS") is responsible for overseeing implementation of major provisions of the ACA and for administering certain programs thereunder, including the Co-Op Program. *See, e.g.*, 42 U.S.C. §§ 18041(a)(1), 18042(a)(1). HHS delegated many of its responsibilities under the ACA to CMS.

c. **Surplus Notes**. Section 1322 of the ACA authorized CMS to extend loans to qualified applicants to foster the creation of new Co-Ops.[7] The program was intended to improve consumer choice and plan accountability, promote integrated models of care, and enhance competition in the insurance market place, including on the exchanges established by the Act and off the Exchanges. *See* 42 U.S.C. § 18042. The program established two types of Co-Op loans: start-up loans, which were loans to provide

[4] While it is referred to as an HCSO in Arizona statutes and regulations, the more common term for the license is an HMO.
[5] See A.R.S. § 20-681(9)(d).
[6] See A.R.S.§ 20-629(A)(7).
[7] While CMS "qualified" the applicants, CMS knew that the applicants had no experience creating or running a health insurance company.

assistance to Co-Ops in meeting their start-up costs; and solvency loans, which were loans to assist Co-Ops in meeting any state solvency requirements. In some cases, including here, the start-up loan was subsequently converted to a surplus note. The surplus notes (also referred to as converted start-up notes) and the solvency loans contained significant restrictions and limitations on repayment.

i. With respect to the surplus note, the purpose of amending the start-up note and converting it to a surplus note was to ensure that it was treated as a "surplus note pursuant to National Association of Insurance Commissioners Statement of Statutory Accounting Principles No. 41." Among other things, that requires that any debt under the loan be subordinated to policyholders, claimant and beneficiary claims, and to all other classes of creditors other than surplus note holders. Additionally, the repayment obligations were subject to the Co-Op's "ability to meet State Reserve Requirements and other solvency regulations, or requisite surplus note arrangements."[8]

ii. With respect to the solvency loan, it was originally structured as a surplus note and was "expressly subordinated to claims of creditors and members" of the Co-Op. The solvency loan acknowledged that, in the event of insolvency, the solvency loan would be of equal rank with other surplus note holders (unless those surplus note holders agreed otherwise). Moreover, the solvency loan was not subject to security, offset or any form of recoupment.

d. **The "3Rs" Generally**. The changes to the health insurance market brought by the ACA created significant uncertainty for health insurers, particularly with respect to setting premium rates. Health insurers could no longer engage in medical underwriting and lacked data regarding millions of new consumers, including those with pre-existing health conditions, that were entering the health insurance market. To mitigate pricing risk, the ACA established three premium stabilization programs, known informally as the

[8]In Arizona, those solvency requirements include, among other things, that the holder's interest is "subordinate to the claims of policyholders, claimants and beneficiaries and to all other classes of creditors other than surplus note holders and that interest payments and principal payments require prior approval of the director." A.R.S. § 20-725. Additionally, in an insurance delinquency proceeding, the distribution priority for surplus note holders is Class 10, above only shareholders. A.R.S. § 20-629.

"3Rs": a temporary risk corridor program ("Risk Corridor"); a permanent risk adjustment program ("Risk Adjustment"); and a transitional reinsurance program ("Reinsurance"). 42 U.S.C. §§ 18061-18063. In addition, the ACA established premium subsidy and cost-sharing programs and imposed various fees (collectively, the "Affordable Care Act Fees") on QHPs. The result of these programs is that at any given time, QHPs (including those sold by the Meritus Companies) may owe money to the United States under some programs and be owed money from the United States under other programs.

i. **Risk Corridor Program**. Section 1343 of the ACA established a temporary Risk Corridor program that applied to insurers who offered QHPs on an exchange for years 2014, 2015 and 2016. The Risk Corridor program provided that QHP issuers would receive compensation from the United States if their losses exceeded a certain defined amount due to higher-than-expected utilization and medical costs for the issuer's insureds. At the same time, the Risk Corridor program provided that QHP issuers would pay the government a percentage of any unexpectedly high profits they made over similarly-defined amounts.[9] In appropriations acts for 2015 and 2016, Congress prohibited CMS and HHS from making risk corridor payments from funds appropriated under those acts. HHS and CMS adopted a "budget neutral" approach to the program in which only risk corridor collections from QHP issuers would be used to make risk corridor payments out to other QHP issuers. HHS also stated that distributions under the Risk Corridor program would be reduced pro rata to the extent of any shortfall. As a result, QHP issuers received less than 15% of amounts owed them for 2014 and nothing for amounts owed them for 2015. In response, there have been numerous lawsuits filed seeking payments under the Risk Corridor program. With Court approval, the Receiver (on behalf of Meritus and MHP) opted into a class action related to the Risk Corridor program. *See Health Republic Ins. Co. v. United States*, Case No. 1:16-cv-00259-MMS, United States Court of Federal Claims (the "Risk Corridor Class Action"). The Risk Corridor Class Action is

[9] QHPs collectively incurred compensable losses under the Risk Corridor Program of almost $2.9 billion in 2014 and $5.8 billion in 2015. *See Class Action Notice* from *Health Republic Ins. Co. v. United States*, Case No. 1:16-cv-00259-MMS, United States Court of Federal Claims.

currently stayed pending appeals of two other matters that had been brought in the Federal Claims Court and are on appeal before the Federal Circuit Court of Appeals. *See Moda Health Plan, Inc. v. United States*, Case No. 17-1994; *Land of Lincoln Mutual Health Ins. Co.*, Case No. 16-1224, and *see also Blue Cross and Blue Shield of North Carolina v. United States*, Case No. 17-2154.

ii. **Risk Adjustment Program**. Section 1343 of the ACA established a permanent Risk Adjustment program designed to protect against adverse selection by spreading the risk of insuring comparatively less healthy populations among insurers in a given state and to stabilize premiums for issuers of ACA-compliant coverage in the individual and small group markets. *See* 42 U.S.C. § 18063. Under the Risk Adjustment program, insurers are charged more if their actuarial risk is less than the average actuarial risk of all plans in that state for that year (that is, with plans whose populations are comparatively healthier) while insurers whose average actuarial risk is greater than average (that is, with plans whose populations are comparatively less healthy) receive payments from the program. The program is administered by CMS because Arizona elected not to do so. *See* 42 U.S.C. § 18041(c). As a result, the Risk Adjustment program also includes a user fee based on qualifying business in states such as Arizona where CMS administers the program. *See* 45 C.F.R. § 153.610(f).

iii. **Reinsurance Program**. The Reinsurance program is addressed under section 1341 of the ACA (42 U.S.C. § 18061) and under 45 C.F.R. § 153.200 and provides for circumstances under which insurers with QHPs might be required to make payments (generally referred to as "required contributions") to a designated reinsurance entity and also might be entitled to receive Reinsurance payments. With respect to required contributions, HHS established a methodology to collect a per enrollee amount based on plan enrollment. 45 C.F.R. § 153.400. With respect to receiving payments, 45 C.F.R. § 153.200 provides that, under certain circumstances, health insurance issuers would be eligible to receive Reinsurance payments when claims costs for an individual enrollee's covered benefits in a benefit year exceed an attachment point. Essentially, if an

enrollee's total claims exceed a specified level (the "attachment point"), the insurer would be paid a proportion of claims costs (the "coinsurance rate") beyond the attachment point until total claims costs reached a cap (the "reinsurance cap"). HHS has previously published attachment points, coinsurance rates, and reinsurance caps, the payment parameters of the Reinsurance program.

iv. **Cost-Sharing Reduction Reconciliation Program**. While not typically included in the "3-Rs," a reconciliation associated with the Cost-Sharing Reductions ("CSR") also contributes to debts owing between insurers that offered QHPs and the United States.[10] The CSR is a subsidy created by the ACA to reduce the cost-sharing expenses of low- and middle-income individuals who purchase health insurance through a health insurance Exchange. *See generally* 42 U.S.C. § 18071. Because the monthly advances of CSRs are based on estimates, they are subject to reconciliation after calculation of the actual amount of CSRs provided to eligible enrollees, with payment amounts payable to/from the United States and/or the QHP. *See* 45 C.F.R. § 156.430(c)-(e).

3. **United States Claims against the Meritus Companies**. Three Proofs of Claims ("POC"s) were submitted by or on behalf of the United States in the receivership proceedings, including: (i) a POC filed by HHS/CMS against MHP for a total amount of $50,650,123.02 (the "CMS-MHP Claims"); (ii) a POC filed by HHS/CMS against Meritus Mutual for a total amount of $94,581,998.78 (the "CMS-Meritus Mutual Claims") and (iii) a POC filed by the DOJ against both MHP and Meritus Mutual for an undetermined amount essentially seeking recovery of all amounts owed to the United States ("DOJ Claims").

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[10] As noted in the CMS claims, there are other smaller programs under the ACA generating amounts due that are also included in the setoff analysis herein and addressed in Exhibits 5 and 6.

a. **Claims against MHP**. With respect to the CMS-MHP Claims, the asserted claim amounts attributable to the specific ACA Risk-Sharing Programs[11] referenced herein are as follows (see Exhibit 1):

CSR:	$ 3,899,178.47
PPACA Reinsurance:[12]	$ 510,975.30
Risk Adjustment:	$ 46,195,827.78
PPACA Fee:	$ 44,141.47
Total:	$ 50,650,123.02

b. **Claims against Meritus Mutual.** With respect to the CMS-Meritus Mutual Claims, the asserted claim amounts were attributable to the loan and note claims and to the ACA Risk-Sharing Programs as follows (see Exhibit 2):

Loan/Note Claims:

Start-Up Loan:	$ 20,890,333.00
Solvency Note:	$ 72,935,928.25
Total:	$ 93,826,261.25

ACA Related Claims:

CSR:	$ 115,649.36
PPACA Reinsurance:[13]	$ 46,091.54
Risk Adjustment:	$ 594,168.87
Exchange User-Fee:	$ 7.76
Total:	$ 755,917.53

c. **DOJ Claims**. With respect to the DOJ Claims, no claim amount was specified. However, the claimant identified the nature of the claim and asserted rights associated with set-offs and security, with the following statements (see Exhibit 3):[14]

[11] For purposes of this Petition, ACA Risk-Sharing Programs that are the subject of the setoff include the Risk Corridor, Reinsurance, CSR, PPACA Reinsurance, Risk Adjustment, and Exchange User-Fee/PPACA Fee. The ACA Risk-Sharing Programs as defined herein do not include the surplus note claims which by their terms are not subject to setoff.

[12] As explained in Exhibits 1 and 2, the PPACA Reinsurance claim asserted by CMS differs from the transitional Reinsurance program. This distinction is noted, but not explained in footnote 4 of the CMS-MHP Claims and in footnote 5 of the CMS-Meritus Mutual Claims.

[13] Same as above reinsurance comment.

[14] Essentially identical statements were incorporated in the CMS-MHP Claims and the CMS-Meritus Mutual Claims.

i. With respect to the nature of the claim, the DOJ Claim states:

> Recovery of amounts owed to the United States and/or any federal agency or entity. These claims are entitled to first priority treatment pursuant to 31 U.S.C. § 3713.

ii. With respect to set-offs, the DOJ Claim states:

> The United States reserves the right to amend these claims to assert subsequently discovered liabilities. The United States may hold estimated debts owed to the estate that are subject to set-off and/or recoupment rights. The United States hereby expressly reserves its right to set-off or recoup any claim against debts owed to the estate by any federal agency or entity.

iii. With respect to security for the claim, the DOJ Claim states:

> These claims are entitled to treatment as secured claims to the extent they are subject to set-off by a claim of the estate against any Untied States agency or entity. The United States is a unitary creditor for purposes of set-off and recoupment.

4. **Jurisdiction**.

a. This Court is vested with exclusive original jurisdiction of insurer receiverships and is authorized to make all necessary and proper orders to carry out the purposes of A.R.S. § 20-601, *et seq*. (the "Arizona Receivership Act"). A.R.S. § 20-612(A). Among other things, one of the purposes of the Arizona Receivership Act is to provide an exclusive forum to hear and determine claims against the Meritus Companies. *See* A.R.S. § 30-628.

b. CMS and DOJ have filed POCs against MHP and Meritus Mutual in these receivership proceedings asserting claims for amounts due under the ACA and in response to the POC process ordered by this Court. As a result, this Court has jurisdiction with respect to the determination and adjudication of those claims under the Arizona Receivership Act. Courts have concluded that insurance insolvency proceedings "are analogous to proceedings in bankruptcy" and thus those Courts have looked to "federal

bankruptcy law for guidance," particularly regarding jurisdictional issues. *Garamendi v. Executive Life Ins. Co.*, 17 Cal. App. 4th 504, 516, 21 Cal. Rptr. 2d 578, 585 (1993). The jurisdictional rule consistently followed by courts applying bankruptcy law to questions of jurisdiction associated with a proof of claim filing is as follows:

> [A] creditor who files a proof of claim against the estate of a bankrupt consents to the jurisdiction of the bankruptcy court for a full determination of the claims between the creditor and the estate. Indeed, the Supreme Court has held that filing a proof of claim waives such entitlements as a creditor's Seventh Amendment right to a jury trial; the right of a state or commonwealth to invoke sovereign immunity under the Eleventh Amendment; and of relevance here, the right to have private claims heard by an Article III court as established in Katchen." *In re Applied Thermal Systems, Inc. v. Zeeco, Inc.*, 294 B.R. 784, 788 (Bankr. N.D. Okla. 2003) (*citing Wiswall v. Campbell*, 93 U.S. 347, 351, 23 L. Ed. 923 (1876); *Gardner v. New Jersey*, 239 U.S. 565, 573, 91 L. Ed. 504, 67 S. Ct. 467 (1947); *Katchen v. Landy*, 382 U.S. 323, 15 L. Ed. 2d 391, 86 S. Ct. 467 (1966); and *Langenkamp v. Culp*, 498 U.S. 42, 44, 112 L. Ed. 2d 343, 111 S. Ct. 330 (1990)).

5. **Surplus Notes – Class 10 Priority Level Determination**. The first item to be addressed in the claims asserted by CMS is the priority level of the claims for notes (start-up note and solvency note) against Meritus Mutual, which combined total $93,826,261.25 (collectively, the "CMS Surplus Notes"). It is well-established under Arizona law that surplus notes must be assigned a Class 10 priority level and the CMS Surplus Notes are no different.[15] Section 20-629(A)(10), A.R.S., provides as follows:

> In a delinquency proceeding against an insurer domiciled in this state, the priority of distribution of claims from the general assets of the insurer shall be determined pursuant to this section. Every claim in each class shall be paid in full or adequate funds shall be reserved for the payment before the members of the next class may receive any payment. Subclasses may not be established within any class. The order of distribution is as follows:
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[15] This low recovery priority level is consistent with Arizona law which requires that, with respect to surplus notes, the holder's interests shall be "subordinate to the claims of policyholders, claimants and beneficiaries and to all other classes of creditors other than surplus note holders and that interest payments and principal payments require prior approval of the director." A.R.S. § 20-725.

10. Claims of surplus note or certificate of contribution holders or other similar obligations and for premium refunds on assessable policies

a. **Converted Start-Up Note**. The first of the two notes that were the basis for the CMS claims is referred to as the start-up note and was asserted to have an amount due of $20,890,333.00. A copy of the start-up note was included with the CMS-Meritus Mutual Claim. (See Exhibit 2.) As acknowledged by CMS in its claim, the start-up note was amended and converted to a surplus note. (See Exhibit 2.) As amended, the start-up note requires that it be treated as "surplus note pursuant to National Association of Insurance Commissioners Statement of Statutory Accounting Principles No. 41." Among other things, that requires that any debt under the loan be subordinated to policyholders, claimant and beneficiary claims, and to all other classes of creditors other than surplus note holders. Additionally, the repayment obligations were subject to the Co-Op's "ability to meet State Reserve Requirements and other solvency regulations, or requisite surplus note arrangements." Thus, the plain language of the note, agreed to and signed by CMS, requires that the start-up note be determined to be a Class 10 priority level claim against Meritus Mutual.[16]

b. **Solvency Note**. The second note that forms the basis of the CMS claim is referred to as the solvency note and was asserted to have an amount due of $72,935,928.25. A copy of the solvency note was included with the CMS-Meritus Mutual Claim. (See Exhibit 2.) Similar to the converted start-up note, the solvency note acknowledged that, in the event of insolvency, any claims for payment under the solvency note would be of equal rank with claims of other surplus note holders (unless those surplus note holders agreed otherwise). Moreover, the solvency note was not subject to security, offset or any form of recoupment. Thus, just like the converted start-up note, the plain language of the solvency loan indisputably requires that any claims be categorized at the Class 10 priority level against Meritus Mutual.

[16] Consistent with this Court's Order dated September 25, 2017, if it ever appears that there could be a distribution to Class 10 level claimants, then it would be necessary to determine the amount of the Class 10 claim. Until that time, the amount of the Class 10 claim need not be determined.

c. **Notice to CMS**. In accordance with A.R.S. § 20-628, the Receiver has provided CMS with notice of its claim determination regarding the surplus notes as Class 10 Claims against Meritus Mutual. See Exhibit 6. As part of that notice, the Receiver asked CMS to notify it if it had any objection and, in that event, to provide all available support for CMS's position. To date, there has been no substantive response. The Receiver shall also send notice to CMS of the hearing after it is scheduled.

d. **Requested Declaration – Class 10 Claims**. In light of the express language from the converted start-up note and the solvency note, the Receiver requests that the Court enter an Order that establishes CMS's claims under the converted start-up note and the solvency note as Class 10 priority level claims with the amount of such claims to be determined only if it appears likely that a distribution will be made to Class 10 priority level claimants.

6. **Claims of the Meritus Companies against CMS**. As noted above in the discussion of debts and obligations under the ACA, in addition to the Meritus Companies owing debts to CMS, CMS owes substantial debts to the Meritus Companies. Specifically, CMS owes MHP $55,513,299 under the Risk Corridor program and $7,171,320 under the Reinsurance program. Likewise, CMS owes Meritus Mutual 12,938,057 under the Risk Corridor program and $3,283,275 under the Reinsurance program. (See Exhibit 4.) The Receiver has been vested by operation of law with title to all of the property of the Meritus Companies (including rights of action for unpaid claims due under the ACA) and has been ordered to liquidate and reduce the assets to possession. A.R.S. § 20-624(B).

a. **Risk Corridor**. Efforts by insurers to collect payments due under the Risk Corridor program has generated substantial litigation. Currently, the U.S. Court of Federal Claims is adjudicating at least 26 claims for payment under the Risk Corridor program. *See Molina Healthcare of California, Inc., et al. v. United States*, U.S. Court of Federal Claims, Case No. 17-97C, Order dated August 4, 2017, page 17. Among the 26 lawsuits is a class action against the United States for payments under the Risk Corridor program. *See Health Republic Ins. Co. v. United States*, U.S. Court of Federal Claims, Case No. 16-cv-

00259 MMS. In accordance with this Court's May 4, 2017 Order Re Petition No. 10 Approving Contingency Fee Arrangement for Risk Corridor Suit, Meritus Mutual and MHP are participating in the Risk Corridor Class Action, which is currently stayed pending appeals before the Federal Circuit involving other Risk Corridor lawsuits.[17] MHP's Risk Corridor claims against CMS total $55,513,299 while Meritus Mutual's Risk Corridor claims against CMS total $12,938,057. (Exhibit 4.) After the setoff contemplated herein is implemented, the Receiver currently anticipates that recovery efforts associated with the remaining balance due to the Meritus Companies would continue to be prosecuted in the Risk Corridor Class Action.

b. **Reinsurance**. In addition to amounts due under the Risk Corridor claims, CMS also owes MHP and Meritus Mutual significant amounts under the Reinsurance programs described above. Specifically, MHP has an unpaid claim against CMS under the Reinsurance program in the amount of $7,171,320. (Exhibit 4.) Likewise, Meritus Mutual has an unpaid claim against CMS under the Reinsurance program in the amount of $3,283,275. (Exhibit 4.) Other insurers and receivers of insolvent insurers have similar debts and have pursued different strategies in an attempt to recover those amounts.

i. For example, in two recent cases, liquidators have filed Complaints in the United States Court of Federal Claims including causes of actions for payments under the Reinsurance program. *See, e.g., Vullo (as Liquidator of Health Republic Ins. Of New York) v. United States*, U.S. Court of Federal Claims, Case No. 17-1185C, filed on September 1, 2017, Complaint, Second Cause of Action; and *Atkins (as Liquidator of Kentucky Health Cooperative) v. United States*, U.S. Court of Federal Claims, Case No. 17-1108C, filed on August 16, 2017, Complaint Paragraphs 63-68.

[17] The Risk Corridor Class Action has been stayed pending certain appeals to the United States Court of Appeals for the Federal Circuit ("Federal Circuit"). On June 14, 2018, the Federal Circuit entered an Order in *Moda Health Plan, Inc. v. United States*, 2017-1994. The Federal Circuit ruled that the United States is obligated to pay participants in the health benefit exchanges the full amount indicated by the statutory formula for payments out under the risk corridors program. *Id.*, Document 87-1. Page 19. However, the Federal Circuit also ruled that Congress temporarily suspended payments on the risk corridors program beyond the sum of payments in. *Id.*, Document 87-1. Pages 20-31. That decision remains subject to motions to reconsider.

ii. Alternatively, in a recent petition, a liquidator sought to have the receivership court impose a set-off related to payments due under the Reinsurance Program. *See Motion to Approve the First Accounting and Status Report of the Liquidation Proceeding and the Acts Reported Therein*, in *In re HealthyCT, Inc., in Liquidation*, Superior Court, Judicial District of Hartford, Connecticut, Docket No. HHD0CV16-6072516-S, filed on February 17, 2017.

iii. After the setoff contemplated herein is implemented, the Receiver anticipates seeking recovery of the amounts due under the Reinsurance Program, including but not limited to by means of commencing a judicial action, depending on the circumstances.

7. **Liquidation Act Authority for Offsets**. Under the Arizona Liquidation Act, A.R.S. § 20-638, setoff of mutual debts or mutual credits as contemplated in this Petition is expressly authorized, as follows:

> A. In all cases of mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this article, such credits and debts shall be set off and the balance only shall be allowed or paid, except as provided in subsection B of this section.
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> B. No offset shall be allowed in favor of any such person where the obligation of the insurer to such person would not at the date of the entry of any liquidation order or otherwise as provided in section 20-635,[18] entitle him to share as a claimant in the assets of the insurer,
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8. **Setoff – ACA Risk-Sharing Programs.**

a. **Setoff and Notice to CMS**. CMS asserts that each claim is entitled to treatment as a secured claim to the extent it is subject to set-off by claims of the Meritus

[18] A.R.S. § 20-635 provides: "The rights and liabilities of the insurer and of its creditors, policyholders, stockholders, members, subscribers and all other persons interested in its estate shall, unless otherwise directed by the court, be fixed as of the date on which the order directing the liquidation of the insurer is filed in the office of the clerk of the court which made the order, subject to the provisions of this article with respect to the rights of claimants holding contingent claims."

companies.[19] (See Exhibits 1 and 2). As set forth in the chart below, the Receiver has set off amounts due and owed under the ACA Risk-Sharing Programs, subject to this Court's approval, that would leave approximately $17 million still due to the Meritus Companies under the Risks Corridor program and approximately $10 million still due to the Meritus Companies under the Reinsurance program. (See Exhibit 4 for additional details and support regarding the following charts.) In accordance with A.R.S. § 20-628, the Receiver has provided CMS and DOJ with notice of its setoff of these amounts. See Exhibits 5, 6 and 7. As part of that notice, the Receiver asked CMS and DOJ to notify it if it had any objection and, in that event, to provide all available support for their position. To date, there has been no substantive response. The Receiver shall provide a copy of this Petition and also provide notice to CMS and DOJ of the hearing after it is scheduled.

b. **MHP Setoff - Generally**. With respect to MHP, the setoff analysis associated with the ACA Risk-Sharing Programs is as follows (see Exhibit 5):

The following amounts are owed by CMS to MHP:

Risk Corridor Claims:	$ 55,513,299.00
Reinsurance:	$ 7,171,320.00
Total:	$ 62,684,619.00

The following amounts were submitted as claims by the United States against MHP:

CSR:	$ 3,899,178.47
PPACA Reinsurance:	$ 510,975.30
Risk Adjustment:	$ 46,195,827.78
PPACA Fee:	$ 44,141.47
Total:	$ 50,650,123.02

After application of a setoff, the remaining debt owed by CMS to MHP is $12,034,495.98 with all related mutual debts and credits setoff and otherwise deemed satisfied.

[19] Under A.R.S. § 20-629(E), the "owner of a secured claim *** may surrender the owner's security and file the owner's claim as a general creditor, or the claim may be discharged by resort to the security, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors."

c. **MHP Setoff – Specific Programs.** With respect to the specific ACA Risk-Sharing Programs, the setoff allocation proposed by the Receiver is set forth below.

Risk Corridor Claims due from CMS to MHP:	$55,513,299.00
(MINUS) Total Due from MHP to CMS:	$50,650,123.00
(EQUALS) Net Risk Corridor Claims due from CMS to MHP:	$4,863,176.00

The total amount of the Risk Corridor Claims exceeds the amount due to CMS under the ACA Risk-Sharing Programs. As a result, there is no setoff applicable to reduce the amount of the Reinsurance Claims.

Reinsurance Claims due from CMS to MHP:	$ 7,171,320.00
(MINUS) Balance Due from MHP to CMS:	$ 0.00
(EQUALS) Net Reinsurance Claims due from CMS to MHP:	$ 7,171,320.00

d. **Meritus Mutual Setoff - Generally**. With respect to Meritus Mutual, the setoff analysis associated with the ACA Risk-Sharing Programs claims is as follows (see Exhibit 6):

The following amounts are owed by CMS to Meritus Mutual:

Risk Corridor Claims:	$ 12,938,057.00
Reinsurance:	$ 3,283,275.00
Total:	$ 16,221,332.00

The following amounts were submitted as claims by the United States against Meritus Mutual:

CSR:	$ 115,649.36
PPACA Reinsurance:	$ 46,091.54

Risk Adjustment:	$594,168.87
Exchange User-Fee:	$ 7.76
Total:	$755,917.53

After application of a setoff, the remaining debt owed to Meritus Mutual is $15,465,414.47 with all related mutual debts and credits setoff and otherwise deemed satisfied.

e. **Meritus Mutual Setff – Specific Programs.** With respect to the specific ACA Risk-Sharing Programs, the setoff allocation proposed by the Receiver is set forth below.

Risk Corridor Claims due from CMS to Meritus Mutual:	$12,938,057.00
(MINUS)	
Total Due from Meritus Mutual to CMS:	$ 755,917.00
(EQUALS)	
Net Risk Corridor Claims due from CMS to Meritus Mutual:	$12,182,140.00

The total amount of the Risk Corridor Claims exceeds the amount due to CMS under the ACA Risk-Sharing Programs. As a result, there is no setoff applicable to reduce the amount of the Reinsurance Claims.

Reinsurance Claims due from CMS to Meritus Mutual:	$ 3,283,275.00
(MINUS) Balance Due from Meritus Mutual to CMS:	$ 0.00
(EQUALS) Net Reinsurance Claims due from CMS to Meritus Mutual:	$ 3,283,275.00

9. **Continuing Participation in Risk Corridor Class Action.** After the setoff has been implemented, MHP and Meritus Mutual will have claims against CMS under the Risk Corridor program in the following amounts, respectively:

Net Risk Corridor Claims due to MHP:	$ 4,863,176.00
Net Risk Corridor Claims due to Meritus Mutual:	$ 12,182,140.00

The net amount due under the Risk Corridor program would continue to be prosecuted in the Risk Corridor Class Action currently stayed in the Federal Claims Court.

10. **Prosecution of Reinsurance Claims.** After the setoff has been implemented, MHP and Meritus Mutual will have claims against CMS under the Reinsurance program in the following amounts, respectively:

Net Reinsurance Claims due to MHP:	$ 7,171,320.00
Net Reinsurance Claims due to Meritus Mutual:	$ 3,283,275.00

The Receiver, in his discretion, may seek to prosecute the claims of MHP and of Meritus Mutual under the Reinsurance program against CMS in the Federal Claims Court or such other forum determined by the Receiver as reasonable and appropriate under the circumstances, and/or to negotiate the potential resolution of such claims, if possible.

11. **Limit to CMS Claims**. This Petition is limited to the claims related to the surplus notes and the ACA Risk-Sharing Programs as asserted by CMS under the two POCs, including the CMS-MHP Claim and the CMS-Meritus Mutual Claim. It is not intended to address or resolve issues unrelated to the ACA Risk-Sharing Programs and/or to the surplus notes that were raised in the DOJ Claim. The Receiver reserves the right to proceed with the existing DOJ program that allows for a Receiver to request a release from the United States (for matters other than tax) before closing an estate, subject to any setoff orders that may be entered by this Court.

WHEREFORE, the Receiver requests that the Court enter an Order:

(1) Approving the Receiver's Request for Claim Determination and Setoff Related to Claims of the United States and granting the relief requested therein;

(2) Determining that CMS's claims for payment from Meritus Mutual under the converted start-up note and the solvency note are Class 10 priority level claims under A.R.S. § 20-629;

(3) Deferring any determination as to the amount of CMS's claims for payment from Meritus Mutual under the converted start-up note and the solvency note unless and until such time as the Receiver reasonably anticipates that there may be a distribution for Class 10 level claimants;

(4) Approving the setoff of all claims as between MHP and CMS under the ACA Risk-Sharing Programs, including but not limited to CSR, Reinsurance, Risk Adjustment, and Risk Corridor, so that the net effect is that the remaining amount that CMS owes MHP under the ACA Risk-Sharing Programs (with all related mutual debts and credits setoff and otherwise deemed satisfied) is as follows:

Net Risk Corridor Claims
due to MHP: $ 4,863,176.00

Net Reinsurance Claims
due to MHP: $ 7,171,320.00

(5) Approving the setoff of all claims as between Meritus Mutual and CMS under the ACA Risk-Sharing Programs, including but not limited to CSR, Reinsurance, Risk Adjustment, and Risk Corridor, so that the net effect is that the remaining amount that CMS owes Meritus Mutual under the ACA Risk-Sharing Programs (with all related mutual debts and credits setoff and otherwise deemed satisfied) is as follows:

Net Risk Corridor Claims
due to Meritus Mutual: $ 12,182,140.00

Net Reinsurance Claims
due to Meritus Mutual: $ 3,283,275.00

(6) Ordering that, pursuant to A.R.S. § 20-624 and paragraphs 8 and 10 of the August 10, 2016 Order for Appointment of Receiver and Injunction (the "Receivership Order"), the Receiver may institute, prosecute and/or compromise any suits, actions and/or

claims related to the Risk Corridor Claims, including the continued participation as a class member in the Risk Corridor Class Action;

(7) Ordering that, pursuant to A.R.S. § 20-624 and paragraphs 8 and 10 of the Receivership Order, the Receiver may institute, prosecute and/or compromise any suits, actions, and/or claims related to the Reinsurance Claims, including but not limited to prosecution of claims of MHP and Meritus Mutual against CMS in the Federal Court of Claims or such other forum determined by the Receiver as reasonable and appropriate under the circumstances, and/or to negotiate the resolution of such claims; and

(8) Granting such further relief as the Court deems reasonable and necessary under the circumstances.

Dated this 11th day of December, 2018.

FAEGRE BAKER DANIELS LLP

By: /s/ Joel Glover (#034018)
Joel A. Glover

Attorneys for Receiver

COPY of the foregoing mailed this 11th day of December, 2018 to the attached Master Service List

/s/ Brenda McHenry
Brenda McHenry

SUPERIOR COURT OF ARIZONA

COUNTY OF MARICOPA

No. CV2016-011872 (Assigned to The Honorable Daniel Martin)

MASTER SERVICE LIST

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Arizona Department of Insurance
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Phoenix, Arizona 85007

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Patient Financial Services
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Attorneys for Sarah McMahon

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Bullhead City, Arizona 86442

Justin J. Henderson
Lewis Roca Rothgerber Christie LLP
201 East Washington Street, Suite 1200
Phoenix, Arizona 85004-2595
Attorneys for Receiver

Exhibit 9

FAEGRE BAKER DANIELS LLP
1700 Lincoln Street, Suite 3200
Denver, Colorado 80203

Joel A. Glover (State Bar No. 034018)
Direct Dial: 303.607.3648
Direct Fax: 303.607.3600
Email: Joel.Glover@FaegreBD.com

Attorneys for Receiver

SUPERIOR COURT OF ARIZONA

COUNTY OF MARICOPA

STATE OF ARIZONA, *ex rel.* KEITH SCHRAAD, Interim Director of Insurance, Plaintiff, vs. COMPASS COOPERATIVE MUTUAL HEALTH NETWORK, INC., dba MERITUS MUTUAL HEALTH PARTNERS, an Arizona corporation; and COMPASS COOPERATIVE HEALTH PLAN, INC., dba MERITUS HEALTH PARTNERS, an Arizona corporation, Defendants.	No. CV2016-011872 **PETITION NO. 26** **REPORT ON NOTICE TO CLAIMANTS** (Assigned to The Honorable Daniel Martin)

Keith Schraad, Interim Director of Insurance, as Receiver (hereinafter "Receiver") of Compass Cooperative Mutual Health Network, Inc. doing business as Meritus Mutual Health Partners ("Meritus Mutual") and Compass Cooperative Health Plan, Inc. dba Meritus Health Partners ("MHP") (collectively referred to as the "Meritus Companies"), appointed pursuant to A.R.S. § 20-611, *et seq*., hereby submits this Report on Notice Claimants.

1. On or about December 11, 2018, the Receiver filed Petition No. 26, the Request for Hearing and Setoff Related to Claims of the United States, along with Exhibit 1 through 7 and a Proposed Order Scheduling Hearing Regarding Requested Claim

Determination and Setoff Related to Claims of the United States (collective "Petition No. 26").

2. Notice of Petition 26 was provided to the Master Service List via regular mail.

3. Additionally, under these specific circumstances, the Receiver provided further notice of Petition No. 26 to claimants that submitted the specific Proofs of Claim that are the subject of Petition No. 26 via emails and via overnight deliveries sent on December 13, 2018, December 14, 2018 and December 21, 2018, consistent with the emails attached in Exhibit A.

Dated this 21st day of December, 2018.

FAEGRE BAKER DANIELS LLP

By: /s/ Joel Glover (#034018)
Joel A. Glover

Attorneys for Receiver

COPY of the foregoing mailed this 21st day of December, 2018 to the attached Master Service List

/s/ Brenda McHenry
Brenda McHenry

SUPERIOR COURT OF ARIZONA

COUNTY OF MARICOPA

No. CV2016-011872 (Assigned to The Honorable Daniel Martin)

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Interim Director
Arizona Department of Insurance
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Justin J. Henderson
Lewis Roca Rothgerber Christie LLP
201 East Washington Street, Suite 1200
Phoenix, Arizona 85004-2595
Attorneys for Receiver

Exhibit A

Glover, Joel A.

From:	Glover, Joel A.
Sent:	Thursday, December 13, 2018 11:48 AM
To:	Elizabeth.parish@cms.hhs.gov; Angela.Belgrove@hhs.gov; Marcus.S.Sacks@usdoj.gov; Matthew.Lynch@cms.hhs.gov; Leslie.Stafford@hhs.gov; Sharon.Williams@usdoj.gov
Subject:	Meritus Mutual and Meritus Health Plans - Notice Regarding Proof of Claim
Attachments:	Petition No. 26 - Petition for Claims Determination and Setoff.pdf; Meritus Setoff Petition exhibits.zip; Petition No. 26 - Petition for Claims Determination and Setoff.pdf

This firm is legal counsel to the Receiver of Compass Cooperative Health Plan, Inc., dba Meritus Health Partners, in Receivership (MHP) and Compass Cooperative Mutual Health Network, Inc. dba Meritus Mutual Health Partners, in Receivership (Meritus Mutual).

In order to provide notice to you regarding the Proofs of Claim you have submitted in the receivership, we are sending the following to you via email and overnight delivery.

Petition No. 26

Request for Hearing, Claim Determination and Setoff Related to Claims of the United States (PDF file)

Exhibits 1 through 7 (zip file)

Proposed Order Scheduling Hearing Regarding Requested Claim Determination and Setoff Related to Claims of the United States (PDF file)

If you have any questions or would like to discuss, please feel free to contact me.

Sent via email to:

Elizabeth E. Parish (Elizabeth.parish@cms.hhs.gov)

(While Jeffrey Grant was identified in the Proof of Claim, pursuant to instructions from an email dated November 17, 2017, we have substituted Ms. Parish for Mr. Jeffrey Grant. Let us know if that is not correct.)

Angela M. Belgrove (Angela.Belgrove@hhs.gov)

Marc S. Sacks, Esq., Trial Attorney, Civil Division (Marcus.S.Sacks@usdoj.gov)

Matthew Lynch, Director, Insurance Program Group (Matthew.Lynch@cms.hhs.gov and Leslie.Stafford@hhs.gov)

Sharon C. Williams, Esq. (Sharon.Williams@usdoj.gov)

Sent via overnight delivery to:

Elizabeth E. Parish
Acting Director, Payment Policy & Financial Management Group

U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop WB 22-75
Windsor Mill, MD 21244

Angela M. Belgrove
Office of the General Counsel, Region IX
90 7th Street, Suite 4-500
San Francisco, CA 94103-6705

Matthew Lynch (and Leslie Stafford)
Director, Insurance Program Group
Center for Consumer Information and Insurance Oversight
U.S. Department of Health and Human Services, CMS
7500 Secuirty Blvd., WB-22-75
Baltimore, MD 21244

Marc S. Sacks, Esq.
Trial Attorney, Civil Division
U.S. Dep't of Justice
1100 L. St. NW Rm. 10058
Washington, DC 20005

The United States
Sharon C. Williams, Esq.
1100 L St., N.W., Room 10016
Washington, DC 20005

Glover, Joel A.

From:	Glover, Joel A.
Sent:	Friday, December 14, 2018 1:40 PM
To:	Elizabeth.parish@cms.hhs.gov; Angela.Belgrove@hhs.gov; Marcus.S.Sacks@usdoj.gov; Matthew.Lynch@cms.hhs.gov; Leslie.Stafford@hhs.gov; Sharon.Williams@usdoj.gov
Subject:	RE: Meritus Mutual and Meritus Health Plans - Notice Regarding Proof of Claim
Attachments:	Order re Petition 26 Scheduling Hearing.pdf

Attached is a copy of the Order Re Petition No. 26 Scheduling Hearing Regarding Requested Claim Determination and Setoff Related to Claims of the United States. The hearing is scheduled for March 8, 2019.

A copy is also being sent via overnight delivery.

From: Glover, Joel A.
Sent: Thursday, December 13, 2018 11:48 AM
To: Elizabeth.parish@cms.hhs.gov; Angela.Belgrove@hhs.gov; Marcus.S.Sacks@usdoj.gov; Matthew.Lynch@cms.hhs.gov; Leslie.Stafford@hhs.gov; Sharon.Williams@usdoj.gov
Subject: Meritus Mutual and Meritus Health Plans - Notice Regarding Proof of Claim

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Elizabeth E. Parish (Elizabeth.parish@cms.hhs.gov)

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Matthew Lynch, Director, Insurance Program Group (Matthew.Lynch@cms.hhs.gov and Leslie.Stafford@hhs.gov)

Sharon C. Williams, Esq. (Sharon.Williams@usdoj.gov)

Sent via overnight delivery to:

Elizabeth E. Parish
Acting Director, Payment Policy & Financial Management Group
U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop WB 22-75
Windsor Mill, MD 21244

Angela M. Belgrove
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The United States
Sharon C. Williams, Esq.
1100 L St., N.W., Room 10016
Washington, DC 20005

Glover, Joel A.

From: Glover, Joel A.
Sent: Friday, December 21, 2018 12:40 PM
To: Elizabeth.parish@cms.hhs.gov; Angela.Belgrove@hhs.gov; Marcus.S.Sacks@usdoj.gov; Matthew.Lynch@cms.hhs.gov; Leslie.Stafford@hhs.gov; Sharon.Williams@usdoj.gov
Subject: RE: Meritus Mutual and Meritus Health Plans - Notice Regarding Proof of Claim
Attachments: Petition 26 - Minute Order - Hearing March 8, 2019.pdf; Order as Entered - Petition No. 26 - Claims Determination and Setoff.pdf

Attached please find copies of the following orders:

Minute Order dated 12/18/2018

Amended Order Re Petition No. 26 – Scheduling Hearing Regarding Requested Claim Determination and Setoff Related to Claims of the United States

We are also sending these via overnight delivery. It appears that there may have been a delivery error with respect to the prior overnight delivery to Ms. Parish so we are including another copy of Petition 26, with exhibits, in that delivery.

Sincerely,

Joel A. Glover
Partner
joel.glover@FaegreBD.com Download vCard
D: +1 303 607 3648

Faegre Baker Daniels LLP
3200 Wells Fargo Center | 1700 Lincoln Street | Denver, CO 80203-4532, USA

From: Glover, Joel A.
Sent: Friday, December 14, 2018 1:40 PM
To: Elizabeth.parish@cms.hhs.gov; Angela.Belgrove@hhs.gov; Marcus.S.Sacks@usdoj.gov; Matthew.Lynch@cms.hhs.gov; Leslie.Stafford@hhs.gov; Sharon.Williams@usdoj.gov
Subject: RE: Meritus Mutual and Meritus Health Plans - Notice Regarding Proof of Claim

Attached is a copy of the Order Re Petition No. 26 Scheduling Hearing Regarding Requested Claim Determination and Setoff Related to Claims of the United States. The hearing is scheduled for March 8, 2019.

A copy is also being sent via overnight delivery.

From: Glover, Joel A.
Sent: Thursday, December 13, 2018 11:48 AM
To: Elizabeth.parish@cms.hhs.gov; Angela.Belgrove@hhs.gov; Marcus.S.Sacks@usdoj.gov; Matthew.Lynch@cms.hhs.gov; Leslie.Stafford@hhs.gov; Sharon.Williams@usdoj.gov
Subject: Meritus Mutual and Meritus Health Plans - Notice Regarding Proof of Claim

This firm is legal counsel to the Receiver of Compass Cooperative Health Plan, Inc., dba Meritus Health Partners, in Receivership (MHP) and Compass Cooperative Mutual Health Network, Inc. dba Meritus Mutual Health Partners, in Receivership (Meritus Mutual).

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- Petition No. 26
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  Proposed Order Scheduling Hearing Regarding Requested Claim Determination and Setoff Related to Claims of the United States (PDF file)

If you have any questions or would like to discuss, please feel free to contact me.

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Elizabeth E. Parish (Elizabeth.parish@cms.hhs.gov)
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Sharon C. Williams, Esq. (Sharon.Williams@usdoj.gov)

Sent via overnight delivery to:

Elizabeth E. Parish
Acting Director, Payment Policy & Financial Management Group
U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services
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Washington, DC 20005

The United States
Sharon C. Williams, Esq.
1100 L St., N.W., Room 10016
Washington, DC 20005

Chris DeRose, Clerk of Court
*** Electronically Filed ***
12/20/2018 8:00 AM

SUPERIOR COURT OF ARIZONA
MARICOPA COUNTY

CV 2016-011872 12/18/2018

HONORABLE DANIEL G. MARTIN

CLERK OF THE COURT
J. Eaton
Deputy

STATE OF ARIZONA, et al.

LYNETTE EVANS

v.

COMPASS COOPERATIVE MUTUAL HEALTH NETWORK INC, et al.

ANDREW ABRAHAM
JOEL GLOVER
ROBERT F KETHCART
D BURR UDALL
SAMUEL DAVID CHILDERS
JUDGE DANIEL MARTIN

MINUTE ENTRY

Pending before the Court is counsel for the Receiver's Petition No. 26 Request for Hearing, Claim Determination and Setoff Related to Claims of the United States. Good cause appearing,

IT IS ORDERED granting the request.

IT IS FURTHER ORDERED setting the Hearing on **March 8, 2019, at 10:30 a.m.** (time allotted: 30 minutes) all in accordance with the formal written Amended Order RE: Petition No. 26 signed by the Court on December 18, 2018, and filed (entered) by the Clerk on December 18, 2018.

Please note: The Court has signed a paper copy of the order which was originally provided electronically. After the order has been scanned and docketed by the Clerk of Court, copies of this order may be available through ECR online at clerkofcourt.maricopa.gov or through www.AZTurboCourt.gov and from the Public Access Terminals at the Clerk of Court's offices located throughout Maricopa County.

FAEGRE BAKER DANIELS LLP
1700 Lincoln Street, Suite 3200
Denver, Colorado 80203

Joel A. Glover (State Bar No. 034018)
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Direct Fax: 303.607.3600
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Attorneys for Receiver

SUPERIOR COURT OF ARIZONA

COUNTY OF MARICOPA

STATE OF ARIZONA, *ex rel.* KEITH SCHRAAD, Interim Director of Insurance, Plaintiff, vs. COMPASS COOPERATIVE MUTUAL HEALTH NETWORK, INC., dba MERITUS MUTUAL HEALTH PARTNERS, an Arizona corporation; and COMPASS COOPERATIVE HEALTH PLAN, INC., dba MERITUS HEALTH PARTNERS, an Arizona corporation, Defendants.	No. CV2016-011872 **AMENDED ORDER RE PETITION NO. 26** **SCHEDULING HEARING REGARDING REQUESTED CLAIM DETERMINATION AND SETOFF RELATED TO CLAIMS OF THE UNITED STATES** (Assigned to The Honorable Daniel Martin)

Keith Schraad, Interim Director of the Arizona Department of Insurance, as Receiver of Compass Cooperative Mutual Health Network, Inc. doing business as Meritus Mutual Health Partners ("Meritus Mutual") and Compass Cooperative Health Plan, Inc., dba Meritus Health Partners ("MHP"), having filed Petition No. 26 – Request for Hearing, Claim Determination and Setoff Related to Claims of the United States and good cause appearing therfor

. . .

IT IS ORDERED:

Hearing.

The Receiver has requested a hearing to be scheduled regarding Petition No. 26 at least seventy-five (75) days after the filing date of Petition 26.

Accordingly, a hearing in this matter regarding the Receiver's Petition No. 26 requesting a Hearing, Claim Determination and Setoff Related to Claims of the United States is scheduled for the following date and time:

Date: March 8, 2019

Time: 10:30 a.m.

Responses and/or Objections.

Any response and/or objection to the relief requested in the Receiver's Petition No. 26 must be filed with the Court and served on the Master Service List at least fifteen (15) days before the scheduled hearing.

Receiver's Reply.

The Receiver may file a reply to the response and/or objection filed, if any, within ten (10) days after such response and/or objection is filed and served.

ENTERED this 18th day of December, 2018.

The Honorable Daniel Martin
Maricopa County Superior Court Judge

Exhibit 10

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SUPERIOR COURT OF ARIZONA

COUNTY OF MARICOPA

STATE OF ARIZONA, *ex rel.* KEITH SCHRAAD, Interim Director of Insurance, Plaintiff, vs. COMPASS COOPERATIVE MUTUAL HEALTH NETWORK, INC., dba MERITUS MUTUAL HEALTH PARTNERS, an Arizona corporation; and COMPASS COOPERATIVE HEALTH PLAN, INC., dba MERITUS HEALTH PARTNERS, an Arizona corporation, Defendants.	No. CV2016-011872 **ORDER RE PETITION NO. 26** **GRANTING CLAIM DETERMINATION AND SETOFF RELATED TO CLAIMS OF THE UNITED STATES** (Assigned to The Honorable Daniel Martin)

Keith Schraad, Interim Director of the Arizona Department of Insurance, as Receiver of Compass Cooperative Mutual Health Network, Inc. doing business as Meritus Mutual Health Partners ("Meritus Mutual") and Compass Cooperative Health Plan, Inc., dba Meritus Health Partners ("MHP"), having filed Petition No. 26 – Request for Hearing, Claim Determination and Setoff Related to Claims of the United States and after a hearing duly noticed held on March 8, 2019, being fully advised in the premises and good cause appearing therefor, the Court enters the following FINDINGS OF FACT AND CONCLUSIONS OF LAW AND ORDERS:

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDERS:

1. On August 10, 2016, this Court entered the Order for Receivership and Injunction with respect to Compass Cooperative Mutual Health Network, Inc. dba Meritus Mutual Health Partners ("Meritus Mutual") and Compass Cooperative Health Plan, Inc. dba Meritus Health Partners ("MHP"), declaring Meritus Mutual and MHP insolvent and placing each under an order of liquidation.

2. On March 8, 2017, the Order Approving Liquidation Plan was entered which, among other things, approved and established a proof of claim procedure and a claims bar deadline.

3. The United States submitted three proofs of claim in accordance with the Order Approving Liquidation Plan, including claims by the Department of Health and Human Services, Centers for Medicare & Medicaid Services ("CMS") against MHP in the combined total amount of $50,650,123.02 (the "CMS-MHP Claims"); claims by CMS against Meritus Mutual in the combined total amount of $94,581,998.78 (the "CMS-Meritus Mutual Claims"), and claims by the United States Department of Justice against Meritus Mutual and MHP in an undetermined amount (the "DOJ Claims").

a. With respect to the CMS-MHP Claims, the asserted claim amounts were attributable to the Affordable Care Act ("ACA") Risk-Sharing Programs as follows:

CSR:	$ 3,899,178.47
PPACA Reinsurance:	$ 510,975.30
Risk Adjustment:	$ 46,195,827.78
PPACA Fee:	$ 44,141.47
Total:	$ 50,650,123.02

b. With respect to the CMS-Meritus Mutual Claims, the asserted claim amounts were attributable to loan and note claims and to ACA Risk-Sharing Programs as follows:

Loan/Note Claims:		
Start-Up Loan:	$ 20,890,333.00	
Solvency Note:	$ 72,935,928.25	
Total:	$ 93,826,261.25	
ACA Related Claims:		
CSR:	$	115,649.36
PPACA Reinsurance:	$	46,091.54
Risk Adjustment:	$	594,168.87
Exchange User-Fee:	$	7.76
Total:	$	755,917.53

c. With respect to the DOJ Claims, no amount was specified and instead there was a general assertion of rights as a creditor against MHP and Meritus Mutual.

4. This Court is vested with exclusive original jurisdiction of insurer receiverships and is authorized to make all necessary and proper orders to carry out the purposes of A.R.S. § 20-601, *et seq.* (the "Arizona Receivership Act"). A.R.S. § 20-612(A). Among other things, one of the purposes of the Arizona Receivership Act is to provide an exclusive forum to hear and determine claims against MHP and Meritus Mutual. *See* A.R.S. § 20-628. In response to the claim procedures ordered by this Court, CMS and DOJ have filed proofs of claim against MHP and Meritus Mutual in these receivership proceedings asserting claims for amounts due under the ACA. As a result, this Court has jurisdiction with respect to the determination and adjudication of those claims under the Arizona Receivership Act.

5. While claims have been asserted against MHP and Meritus Mutual under the ACA Risk Programs, MHP and Meritus Mutual also have specific claims against CMS under the ACA Risk-Sharing Programs.

a. The following amounts are owed by CMS to MHP:

Risk Corridor Claims:	$ 55,513,299.00
Reinsurance:	$ 7,171,320.00
Total:	$ 62,684,619.00

b. The following amounts are owed by CMS to Meritus Mutual:

Risk Corridor Claims:	$ 12,938,057.00
Reinsurance:	$ 3,283,275.00
Total:	$ 16,221,332.00

6. Dated November 16, 2017, the Receiver's Counsel sent separate letters providing notice of the amounts due and of the setoff and claim determination with respect to the CMS-MHP Claims, the CMS-Meritus Claims, and the DOJ Claims. The letter requested that CMS and/or DOJ notify the Receiver of any response and/or objection to the determination. CMS and DOJ made no objection to the notice of setoff and claim determination.

7. On December 11, 2018, the Receiver filed Petition No. 26, the Request for Hearing and Setoff Related to Claims of the United States ("Setoff Petition"). Among other things, the Setoff Petition seeks relief in response to the CMS-MHP Claims, the CMS-Meritus Mutual Claims, and the DOJ Claims.

a. The Setoff Petition seeks an Order establishing that the CMS claims against Meritus Mutual under the Start-Up Note and the Solvency Note, which combined total $93,826,261.26 (collectively, the "CMS Surplus Notes"), are classified as Class 10 priority level claims under A.R.S. § 20-629(A)(10). Under the relief requested in the Setoff Petition, determination of the Class 10 claim amount would be deferred unless and until it appears to the Receiver that a distribution may be made at the Class 10 level and, by their contractual terms, the CMS Surplus Notes would not be subject to setoff.

b. The Setoff Petition seeks an Order establishing a Setoff in accordance with A.R.S. § 20-638 as between the mutual debts or credits as between CMS and MHP as follows:

Risk Corridor Claims due from CMS to MHP:	$55,513,299.00
(MINUS) Total Due from MHP to CMS:	$50,650,123.00
(EQUALS) Net Risk Corridor Claims due from CMS to MHP:	$4,863,176.00

The total amount of the Risk Corridor Claims exceeds the amount due to CMS under the ACA Risk-Sharing Programs. As a result, there is no setoff applicable to reduce the amount of the Reinsurance Claims.

Reinsurance Claims due from CMS to MHP:	$ 7,171,320.00
(MINUS) Balance Due from MHP to CMS:	$ 0.00
(EQUALS) Net Reinsurance Claims due from CMS to MHP:	$ 7,171,320.00

c. The Setoff Petition seeks an Order establishing a Setoff in accordance with A.R.S. § 20-638 as between the mutual debts or credits as between CMS and Meritus Mutual as follows:

Risk Corridor Claims due from CMS to Meritus Mutual:	$12,938,057.00
(MINUS) Total Due from Meritus Mutual to CMS:	$ 755,917.00
(EQUALS) Net Risk Corridor Claims due from CMS to Meritus Mutual:	$12,182,140.00

The total amount of the Risk Corridor Claims exceeds the amount due to CMS under the ACA Risk-Sharing Programs. As a result, there is no setoff applicable to reduce the amount of the Reinsurance Claims.

Reinsurance Claims due from CMS to Meritus Mutual:	$ 3,283,275.00
(MINUS) Balance Due from Meritus Mutual to CMS:	$ 0.00
(EQUALS) Net Reinsurance Claims due from CMS to Meritus Mutual:	$ 3,283,275.00

8. In the Amended Order Re Petition No. 26 Scheduling Hearing Regarding Requested Claim Determination and Setoff Related to Claims of the United States, this Court scheduled the hearing for this matter on March 8, 2019 and established February 21, 2019, the date that is fifteen days before the hearing, as the date Order for filing a response or objection. Pursuant to A.R.S. § 20-628, notice of the Setoff Petition, the response deadline and the scheduled hearings was provided to designated representatives of CMS and DOJ on December 13, 2018, December 14, 2018 and December 21, 2018. No response or opposition to the requested relief has been filed.

ACCORDINGLY, IT IS FURTHER FOUND, DETERMINED AND ORDERED THAT:

9. The Receiver's Request for Claim Determination and Setoff Related to Claims of the United States is granted in all respects and the Receiver is authorized and directed to take such steps as are reasonable and appropriate under the circumstances to implement this Order. All claims of the United States related to the Affordable Care Act as asserted in the CMS-MHP Claims, the CMS-Meritus Mutual Claims and to the extent encompassed or otherwise addressed in the DOJ Claims are fully and finally resolved subject to and in accordance with this Order.

10. CMS's claims for payment from Meritus Mutual under the converted start-up note and the solvency note, referred to as the CMS Surplus Notes, are Class 10 priority level claims under A.R.S. § 20-629 and are not subject to setoff.

11. Any determination as to the amount of CMS's claims for payment from Meritus Mutual under the converted start-up note and the solvency note shall be deferred unless and until such time as the Receiver reasonably anticipates that there may be a distribution for Class 10 level claimants.

12. In accordance with A.R.S. § 20-638, the setoff of all claims as between MHP and CMS under the ACA Risk-Sharing Programs, including, but not limited to CSR, Reinsurance, Risk Adjustment, and Risk Corridor, is approved so that the net effect is that the remaining amount that CMS owes MHP under the ACA Risk-Sharing Programs (with all related mutual debts and credits setoff and otherwise deemed satisfied) is as follows:

Net Risk Corridor Claims due and owing from CMS to MHP: $ 4,863,176.00

Net Reinsurance Claims due and owing from CMS to MHP: $ 7,171,320.00

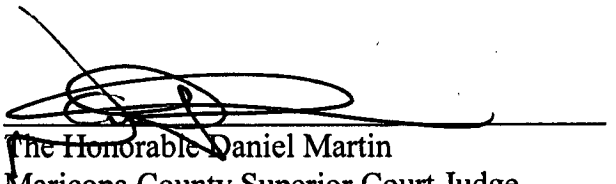
13. In accordance with A.R.S. § 20-638, the setoff of all claims as between Meritus Mutual and CMS under the ACA Risk-Sharing Programs, including, but not limited to CSR, Reinsurance, Risk Adjustment, and Risk Corridor, is approved so that the net effect is that the remaining amount that CMS owes Meritus Mutual under the ACA Risk-Sharing Programs (with all related mutual debts and credits setoff and otherwise deemed satisfied) is as follows:

Net Risk Corridor Claims due and owing from CMS to Meritus Mutual: $12,182,140.00

Net Reinsurance Claims due and owing from CMS to Meritus Mutual: $ 3,283,275.00

14. Pursuant to A.R.S. § 20-628(D), this Order shall be deemed to be an appealable order.

ENTERED this 8th day of March, 2019.



The Honorable Daniel Martin
Maricopa County Superior Court Judge

Exhibit 11

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SUPERIOR COURT OF ARIZONA

COUNTY OF MARICOPA

STATE OF ARIZONA, *ex rel.* KEITH SCHRAAD, Interim Director of Insurance, Plaintiff, vs. COMPASS COOPERATIVE MUTUAL HEALTH NETWORK, INC., dba MERITUS MUTUAL HEALTH PARTNERS, an Arizona corporation; and COMPASS COOPERATIVE HEALTH PLAN, INC., dba MERITUS HEALTH PARTNERS, an Arizona corporation, Defendants.	No. CV2016-011872 **PETITION NO. 30** **RECEIVER'S PETITION TO ACCEPT LIQUIDATION BALANCE SHEET, ADMINISTRATIVE EXPENSES AND REPORT AS OF DECEMBER 31, 2018** (Assigned to The Honorable Daniel Martin)

Keith Schraad, Interim Director of Insurance, as Receiver (hereinafter "Receiver") of Compass Cooperative Mutual Health Network, Inc. doing business as Meritus Mutual Health Partners ("Meritus Mutual") and Compass Cooperative Health Plan, Inc. dba Meritus Health Partners ("MHP") (collectively referred to as the "Meritus Companies"), appointed pursuant to A.R.S. § 20-611, *et seq*., hereby petitions the Court for entry of the Order re Petition No. 30 Accepting Liquidation Balance Sheet, Administrative Expenses and Report as of December 31, 2018.

1. In an Order dated August 10, 2016, this Court placed Meritus Mutual and MHP into receivership under orders of liquidation.

2. Consistent with and subject to the Arizona Insurer Receivership Act, A.R.S. § 20-611 *et seq.* and Orders entered by this Court, the Receiver for MHP and Meritus Mutual continues to marshal and liquidate assets and to administer and adjudicate liabilities and claims. While the marshalling, liquidating, administration, adjudication and related analysis is continuing, at this time the Receiver is submitting this Liquidation Balance Sheet, Administrative Expenses and Report as of December 31, 2018.

3. The information in this petition is based on the attached Declaration of Special Deputy Receiver Regarding Liquidation Balance Sheet, Administrative Expenses and Report as of December 31, 2018, including the Liquidation Balance Sheet, Administrative Expenses and the accompanying Notes attached as Declaration Exhibit 1 (the "Declaration"). The Declaration and including in particular the accompanying Notes to the Liquidation Balance Sheet and Administrative Expenses are incorporated herein by reference.

4. Dated December 11, 2018, the Receiver filed Petition No. 26, Request for Hearing, Claim Determination and Setoff Related to Claims of the United States (the "Setoff Petition"). The hearing for the Setoff Petition is scheduled for March 8, 2019 at 10:30 a.m. The Liquidation Balance Sheet, Administrative Expenses and Report also address the Setoff Petition with additional columns headed "Offset" and "Proforma".

5. Estate Assets – Liquidation Basis. Cash and cash-equivalents for MHP total $3,589,959 and for Meritus Mutual total $619,250.

a. The other non-cash assets primarily are comprised of receivables, claims, causes of action and setoffs. Those assets are not readily liquidated or otherwise reduced to cash and their liquidation remains subject to a number of factors beyond the Receiver's control. While the Receiver reserves all rights to marshal and liquidate all assets of the estates, the Receiver included a figure as a "reserve" in order to allow the amounts to net out to zero for purposes of reporting the asset on a liquidation basis.

b. For example, negative balances and receivables related to providers total less than $450,000 for MHP and less than $300,000 for Meritus Mutual. The Receiver reserves

the right to seek collection of such amounts by offset or otherwise depending on the circumstances.

c. Additionally, claims against the United States government are addressed in the Setoff Petition. As identified in and subject to the Setoff Petition and related to claims under certain Affordable Care Act programs, MHP's claims against the United States total $62,684,619 and Meritus Mutual's claims against the United States total $16,221,332 (as reflected in "Due from CMS"). According to the relief requested in the Setoff Petition, the net claims that would be due to MHP from CMS total $12,034,498 and would be comprised of Risk Corridor claims totaling $4,863,178 and Reinsurance claims totaling $7,171,320. Likewise, the net claims that would be due to Meritus Mutual from CMS total $15,465,416 and would be comprised of Risk Corridor claims totaling $12,182,141 and Reinsurance claims totaling $3,283,275. The hearing for the Setoff Petition is scheduled for March 8, 2019 and any order by the Court could affect, modify or otherwise change these figures.

6. Liabilities – Statutory Priority System. Liabilities to be adjudicated for the receivership estates are organized according to the statutory priority system (A.R.S. § 20-629) based on claims made with the Receiver in accordance with the Liquidation Plan previously approved by the Court. Claims in each class must be paid in full before estate assets may be used to pay creditors at the next level. A.R.S. § 20-629(.A). Among other things, proofs of claim remain subject to an adjudication process which includes the opportunity for notice, objection and Court determination. The figures are subject to change and the Receiver may adopt a different recommendation from that provided herein depending on the circumstances. However, initial figures at this time include the following.

a. **Class 1** – Administrative expenses are incurred on an on-going basis subject to and in accordance with the Arizona Insurer Receivership Act and Orders entered by this Court. Payments to legal counsel, the Special Deputy Receiver and Regulatory Services Group continue to be reported on a quarterly basis in the Status Reports. Details

associated with the administrative expenses are set forth in the spreadsheets attached to the Declaration of Special Deputy Receiver. As of December 31, 2018, the combined amount of all administrative expenses incurred from the inception of the receiverships (since August of 2016) totals $3,227,918, which on average totals approximately $232,651 per month. However, the administrative expenses have been greatly reduced since the first five months of the receivership (from August to December of 2016). For example, the combined monthly administrative expenses were reduced from $288,958 in 2016 to $54,499 in 2018. Much of this can be attributed to reductions in combined monthly salary (reduced from $116,420 in 2016 to $17,997 in 2018), and in combined monthly rent (reduced from $11,480 in 2016 to $3,349 in 2018). The administrative expenses will continue in accordance with Arizona law depending on the circumstances and subject to the Arizona Insurer Receivership Act and Orders entered by this Court.

b. **Class 2** – Guaranty Association claims for Meritus Mutual currently total $3,340,743, which number may be revised as the Guaranty Association continues to incur expenses, pay claims and provide coverage in accordance with its enabling act, A.R.S. § 20-681 *et seq*. Because the Guaranty Association was not legally authorized to provide coverage for MHP as a health care services organization, there are no Guaranty Association claims applicable to MHP.

c. **Class 3** – Policyholder, member and provider claims for MHP that are out of network currently, also referred to as "non-contracted" provider claims, total $5,687,436. For Meritus Mutual, the Class 3 claims that are not covered by the Guaranty Association currently total $1,153.

d. **Class 4** – Claims of the United States Government that would constitute Class 4 claims as submitted under the proof of claim process by the United States total $50,650,121 as against MHP and $755,916 as against Meritus Mutual. Those claims are subject to the Setoff Petition and, as noted above and addressed in the Setoff Petition, those claims are less than the amounts that the United States owes MHP and Meritus

Mutual. As a result, if the relief sought in the Setoff Petition were granted, the net amount of Class 4 claims would be zero.

e. **Class 5** – There are no claims for compensation to employees.

f. **Class 6** – The amount of state taxes and fees that would be Class 6 claims total $730,505 for MHP and total $11,848 for Meritus Mutual.

g. **Class 7** – The amount of claims against MHP for providers required by law or agreement to hold enrollees harmless from liability for services (referred to as in-network or contract providers) currently totals $4,221,510. Because Meritus Mutual is not a health care services organization, there are no Class 7 claims applicable to Meritus Mutual.

h. **Class 8** – The amount of claims for other general creditors totals $52,225,015 for MHP and totals $14,808 for Meritus Mutual. Among other things, this figure includes intercompany payables as between MHP and Meritus Mutual totaling in excess of $51 million. The amount of intercompany payables may be subject to further consideration depending on the circumstances.

i. **Class 9** – At this time, the Receiver has not identified untimely proofs of claim but may do so in the future.

j. **Class 10** – The United States has submitted a claim against Meritus Mutual associated with surplus notes totaling $93,826,261. The claim, including its priority level, is subject to the pending Setoff Petition.

7. Magnitude of Insolvency – Comparing Assets to Liabilities on a Liquidation Basis. The magnitude of the insolvency for MHP and Meritus Mutual remains substantial when considered on a liquidation basis in accordance with the Arizona Insurer Receivership Act.

a. With respect to MHP, there are cash and/or cash equivalents of approximately $3,589,959 in addition to potential claims, causes of action and setoff. Without any offset, the amount of the capital (calculated as the amount by which the assets

exceed the liabilities) is (- $109,946,774). If the setoff were granted, the capital position for MHP would be improved to (- $59,296,653).

b. With respect to Meritus Mutual, there are cash and/or cash equivalents of approximately $619,250 in addition to potential claims, causes of action and setoff. Without any offset, the amount of the capital (calculated as the amount by which the assets exceed the liabilities) is (- $97,961,856). If the setoff were granted, the capital position for MHP would be improved to (- $96,586,690).

WHEREFORE, the Receiver requests that the Court enter the Order re Petition No. 30 Accepting Liquidation Balance Sheet, Administrative Expenses and Report as of December 31, 2018.

Dated this 19th day of February, 2019.

FAEGRE BAKER DANIELS LLP

By: /s/ Joel Glover (#034018)
Joel A. Glover

Attorneys for Receiver

COPY of the foregoing mailed this 19th day of February, 2019 to the attached Master Service List

/s/ Brenda McHenry
Brenda McHenry

SUPERIOR COURT OF ARIZONA

COUNTY OF MARICOPA

No. CV2016-011872 (Assigned to The Honorable Daniel Martin)

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SUPERIOR COURT OF ARIZONA

COUNTY OF MARICOPA

STATE OF ARIZONA, *ex rel.* KEITH SCHRAAD, Interim Director of Insurance, Plaintiff, vs. COMPASS COOPERATIVE MUTUAL HEALTH NETWORK, INC., dba MERITUS MUTUAL HEALTH PARTNERS, an Arizona corporation; and COMPASS COOPERATIVE HEALTH PLAN, INC., dba MERITUS HEALTH PARTNERS, an Arizona corporation, Defendants.	No. CV2016-011872 **PETITION NO. 30** **DECLARATION OF SPECIAL DEPUTY RECEIVER REGARDING LIQUIDATION BALANCE SHEET, ADMINISTRATIVE EXPENSES AND REPORT AS OF DECEMBER 31, 2018 WITH DECLARATION EXHIBIT 1.** (Assigned to The Honorable Daniel Martin)

By signing below, I, Darren Ellingson, state to the Court under penalty of law, that the information stated on these pages is true and correct to the best of my knowledge and belief.

1. I am over eighteen years of age, and I have personal knowledge of the facts herein. I acquired my personal knowledge in my capacity as Special Deputy Receiver of Meritus Mutual Health Partners, in liquidation ("Meritus Mutual") and of Meritus Health Partners, in liquidation ("MHP"). I have served as Special Deputy Receiver since the commencement of the Meritus Mutual and MHP receiverships and, in that capacity, I am familiar with and have personal knowledge of the books and records of Meritus Mutual and MHP. In acquiring my personal knowledge, I relied upon work performed by one or

more persons that worked under my direction with respect to the Meritus Mutual and MHP receiverships.

2. Attached hereto as Declaration Exhibit 1 is the Liquidation Balance Sheet and Administrative Expenses as of December 31, 2018 for Meritus Mutual and MHP along with and subject to the accompanying Notes which are incorporated herein by reference. Based on my knowledge and belief and the determinations I have made in my capacity as Special Deputy Receiver, the Liquidation Balance Sheet and Administrative Expenses report on and present the financial information for Meritus Mutual and MHP as of December 31, 2018 based on the books and records of Meritus Mutual and MHP calculated on a liquidation basis and subject to the accompanying Notes.

By signing below, I state to the Court, under penalty of law, that the information stated on these pages is true and correct to the best of my knowledge and belief.

Darren Ellingson

Date: 2/15/2019

Darren Ellingson, Special Deputy Receiver

EXHIBIT 1
TO DECLARATION OF SPECIAL DEPUTY RECEIVER

Liquidation Balance Sheet as of December 31, 2018
Meritus Mutual Health Partners (PPO) and Meritus Health Partners (HMO)
In Liquidation - No. CV2016-011872

	MMHP (PPO)			MHP (HMO)		
	12/31/2018	Offset	Proforma	12/31/2018	Offset	Proforma
Current Assets-Cash	$ 619,250		$ 619,250	$ 3,589,959	$ -	$ 3,589,959
Due From CMS						
Accrued Risk Corridor	$ 12,938,057	$ (755,916)	$ 12,182,141	$ 55,513,299	$(50,650,121)	$ 4,863,178
Accrued Federal Reinsurance	3,283,275	$ -	$ 3,283,275	$ 7,171,320		$ 7,171,320
Reserve	(16,221,332)	$ (755,916)	$ (15,465,416)	$ (62,684,619)	$(50,650,121)	$ (12,034,498)
Amount due after reserve	$ -		$ -	$ -		$ -
Solvency loan						
HMO solvency loan	$ 51,652,071		$ 51,652,071	$ -		$ -
Reserve	$ (51,652,071)		$ (51,652,071)	$ -		$ -
Net receivable	$ -		$ -	$ -		$ -
Other Assets						
Provider Receivables	$ 299,382			$ 446,305		
Reserve Provider	$ (299,382)			$ (446,305)		
Intercompany Receivable	$ -			$ 2,085		$ 2,085
Total assets	$ 619,250		$ 619,250	$ 3,592,044		$ 3,592,044
Liabilities						
Premium refunds	$ 7,895		$ 7,895	$ 24,231	.	$ 24,231
Class 1	$ 3,232		$ 3,232	$ -	$ -	$ -
Class 2	$ 3,340,743		$ 3,340,743	$ -	$ -	$ -
Class 3	$ 1,153		$ 1,153	$ 5,687,436	.	$ 5,687,436
Class4						
CSR claims on paid claims	$ 115,649	$ (115,649)	$ -	$ 3,899,178	$ (3,899,178)	$ -
Reinsurance fees	$ 46,092	$ (46,092)	$ -	$ 510,975	$ (510,975)	$ -
Risk Adjustment	$ 594,167	$ (594,167)	$ -	$ 46,195,827	$(46,195,827)	$ -
PPACA Risk Adjustment User Fee	$ 8	$ (8)	$ -	$ 44,141	$ (44,141)	$ -
Total Class 4	$ 755,916	$ (755,916)	$ -	$ 50,650,121	$(50,650,121)	$ -
Class 6	$ 11,848		$ 11,848	$ 730,505	.	$ 730,505
Class 7	$ -			$ 4,221,510	.	$ 4,221,510
Class8	$ 14,808		$ 14,808	$ 52,225,015	.	$ 52,225,015
Class 10	$ 93,826,261		$ 93,826,261	$ -		$ -
Total liabilities	$ 97,961,856		$ 97,205,940	$ 113,538,818		$ 62,888,697
Capital(Assets minus Liabilties)	(97,342,606)		$ (96,586,690)	$(109,946,774)		$ (59,296,653)

MERITUS MUTUAL HEALTH PARTNERS IN RECEIVERSHIP (MMHP/PPO)
Administration Expenses from Date of Liquidation (08/10/2016) through 12/31/2018

	PPO 2016 AUG-DEC	PPO 2017 JAN-DEC	PPO 2018 JAN-DEC	PPO TOTAL
ADMINISTRATIVE EXPENSES				
Salary Expense	58,210	25,355	21,596	105,161
Payroll Tax Expense	2,400	2,078	1,749	6,228
Payroll Benefits	1,922	7,131	2,110	11,163
Contract Labor	1,847	914	633	3,394
Bank charges	14,615	29,075	7,754	51,445
Employee Travel Expense	2,272	143	-	2,414
Insurance	14,451	1,777	2,280	18,509
IT Access, Software, Hardware Exp	5,757	9,262	1,709	16,728
Legal Expenses	70,049	-	-	70,049
Mileage	90	8	-	97
Miscellaneous Expenses	30	238	45	314
Office Cleaning	169	-	-	169
Outsourcing Services	-	514	18	532
Postage and Delivery	63	526	106	695
Printing Expense	185	-	-	185
Professional Services	7,517	9,149	4,715	21,381
Receivership Legal	48,976	94,903	105,441	249,319
Receivership Management	27,060	58,990	39,134	125,184
Rent	3,351	4,847	4,018	12,217
Security System	1,245	-	-	1,245
Supplies	111	(1,048)	96	(841)
Taxes & Fees	-	1,775	-	1,775
Telephone	703	820	731	2,253
TPA Services	15,498	26,264	-	41,762
Utilities	2,558	-	-	2,558
Total Administrative Expenses	279,079	272,721	192,136	743,936

MERITUS HEALTH PARTNERS IN RECEIVERSHIP (MHP/HMO)
Administration Expenses from Date of Liquidation (08/10/2016) through 12/31/2018

	HMO 2016 AUG-DEC	HMO 2017 JAN-DEC	HMO 2018 JAN-DEC	HMO TOTAL
ADMINISTRATIVE EXPENSES				
Salary Expense	523,888	203,416	194,367	921,671
Payroll Tax Expense	21,611	18,708	15,745	56,064
Payroll Benefits	17,745	62,278	18,129	98,151
Contract Labor	16,627	8,227	5,696	30,550
Bank charges	6,624	8,067	1,116	15,806
Employee Travel Expense	2,289	1,282	-	3,571
Insurance	52,080	13,926	20,520	86,527
IT Access, Software, Hardware Exp	40,771	83,359	15,382	139,513
Legal Expenses	118,762	-	-	118,762
Mileage	807	68	-	875
Miscellaneous Expenses	1,153	2,146	404	3,703
Office Cleaning	1,524	-	-	1,524
Outsourcing Services	-	721	166	887
Postage and Delivery	567	4,940	954	6,461
Printing Expense	1,664	-	-	1,664
Professional Services	67,025	13,170	4,265	84,460
Receivership Legal	45,755	98,540	105,536	249,831
Receivership Management	30,225	61,480	35,969	127,674
Rent	54,050	43,628	36,165	133,843
Security System	11,203	-	-	11,203
Supplies	1,085	576	860	2,521
Taxes & Fees	-	1,475	-	1,475
Telephone	6,323	7,379	6,579	20,281
TPA Services	140,309	223,028	-	363,337
Utilities	3,629	-	-	3,629
Total Administrative Expenses	**1,165,717**	**856,413**	**461,852**	**2,483,982**

Notes Accompanying
Liquidation Balance Sheet and Administrative Expenses as of December 31, 2018
Meritus Mutual Health Partners (PPO) and Meritus Health Partners (HMO)
In Liquidation – No CV2016-011872

1. Receivership Generally. The Liquidation Balance Sheet and Administrative Expenses Report is presented with respect to Meritus Health Partners, in Receivership ("MHP) and Meritus Mutual Health Partners, in Receivership ("Meritus Mutual") subject to and in accordance with the Arizona Insurance Receivership Act, A.R.S. § 20-611, *et seq.*, (the "Receivership Act") the Order for Appointment of Receiver and Injunction entered on August 10, 2016 with respect to MHP and Meritus Mutual (the "Receivership Order") in CV2016-011872 pending in the Superior Court of Arizona, County of Maricopa (the "Receivership Court") and subsequent orders entered by the Receivership Court. The statements rely upon pre-receivership company books and records as updated based on a statutory liquidation basis of accounting in accordance with the Receivership Act that differs from generally accepted accounting principles and that differs from statutory accounting principles that would otherwise be applicable to ongoing licensed insurance entities that are not in liquidation. Estimates and assumptions are utilized to report values and amounts. The Receiver for MHP and Meritus Mutual continues to marshal and to liquidate assets and to administer and adjudicate liabilities and claims subject to and in accordance with the Receivership Act. The Receiver makes no representations or warranties regarding the accuracy of the information or the opinions, estimates, assumptions or evaluations contained and/or reflected in this Liquidation Balance Sheet and Administrative Expenses Report.

2. Application to MHP and Meritus Mutual. The Receivership Order established one proceeding for MHP and Meritus Mutual for administrative efficiencies while recognizing that MHP and Meritus Mutual would each be liquidated separately subject to and in accordance with the Receivership Act. (Receivership Order, Par. 5, page 4; Par. 8, page 5.) Unless otherwise provided herein, these Notes are applicable to MHP and to Meritus Mutual.

3. Receivership Act. References to the Receivership Act are to the version of the Receivership Act in force at the time of the commencement of the Receivership proceedings. Subsequent amendments and/or modifications of the Receivership Act are not applicable unless retroactivity is expressly declared therein. A.R.S. § 1-244.

4. Offset and Proforma Columns Related to Setoff Petition. The column headed 12/31/2018 includes the figures for MHP and Meritus Mutual as of that date. The other two columns, headed Offset and Proforma, are included to facilitate review and consideration of Petition No. 26, Request for Hearing, Claim Determination and Setoff Related to Claims of the United States (the "Setoff Petition") in advance of the hearing for the Setoff Petition scheduled for March 8, 2019 at 10:30 a.m.

5. Receivables – CMS and Setoff Petition. All amounts identified as Assets under the heading "Due from CMS" and as Liabilities under Class 4 Claims involving Center for

Medicare and Medicaid Services ("CMS") are as yet undetermined and are subject to the Setoff Petition. Subject to very minor rounding limited to the dollar level, the figures are identical to the figures from the Setoff Petition and the Declaration of Ray Minehan, Exhibit 4, to the Petition No. 26 (the "Minehan Declaration"). Likewise, the impact of the Setoff Petition as reflected in the Offset and Proforma columns is based on figures from the Setoff Petition and the Minehan Declaration, in particular, paragraphs 6, 7, 8 and 9. With respect to the claims CMS asserted against MHP and Meritus Mutual, the Offset column applies the setoff which results in $0 being due to CMS at the Class 4 priority level. With respect to the Due from CMS figures, the Offset and Pro Forma columns reflect the net remaining claims that MHP and Meritus Mutual have against CMS with respect to the Risk Corridor and Reinsurance programs. The Reserve row is added in order to allow the amounts to net out at zero for purposes of reporting the potential claims against CMS on a liquidation basis. The Receiver reserves all rights related to the Risk Corridor and Reinsurance Claims including but not limited to seeking and recovering the maximum amount authorized by law under the circumstances. The Setoff Petition has been filed with the Receivership Court and is subject to hearing and may be contested and the relief requested may not be granted and/or may be modified. The Receiver reserves all rights to revise and modify these estimates and the Liquidation Balance Sheet based upon and subject to future orders of the Receivership Court.

6. Solvency Loan. The amount identified as the Solvency loan reflects a transaction between MHP and Meritus Mutual. The full amount of the loan is also reflected as a reserve in order to allow the amount to net out at zero for purposes of reporting it on a liquidation basis. The Receiver reserves all rights related to the Solvency Loan including but not limited to seeking and recovering the maximum amount authorized by law under the circumstances.

7. Provider Receivables. All amounts for Receivables related to providers are, as yet, undetermined. The amount identified as Provider Receivables is also reflected as a reserve in order to allow the amount to net out at zero for purposes of reporting it on a liquidation basis. The Receiver reserves all rights related to the Provider Receivables, including but not limited to seeking and recovering the maximum amount authorized by law under the circumstances.

8. Special Deposits. Special deposits have been released subject to and in accordance with prior orders of the Receivership Court. (See Order re Petition No. 6 for Release of Special Deposits.)

9. Class 1 Claims – Administrative Expenses. Administrative expenses are incurred on an on-going basis subject to and in accordance with the Receivership Act and Orders entered by this Court. Payments to legal counsel, the Special Deputy Receiver and Regulatory Services Group continue to be reported on a quarterly basis in the Status Reports. Details associated with the administrative expenses are set forth in the spreadsheets attached to the Declaration of Special Deputy Receiver. As of December 31, 2018, the combined amount of all administrative expenses incurred from the inception of the Receiverships

(since August of 2016) totals $3,227,918, which on average totals approximately $232,651 per month. However, the administrative expenses have been greatly reduced since the first five months of the receivership (from August to December of 2016). For example, the combined monthly administrative expenses were reduced from $288,958 in 2016 to $54,499 in 2018. Much of this can be attributed to reductions in combined monthly salary (reduced from $116,420 in 2016 to $17,997 in 2018), and in combined monthly rent (reduced from $11,480 in 2016 to $3,349 in 2018). The administrative expenses will continue in accordance with Arizona law depending on the circumstances and subject to the Receivership Act and Orders entered by this Court.

10. Statutory Proof of Claim Process. Amounts reported as "Net Liabilities" are generally based on the amount claimed on proofs of claims (POCs) filed with the Receiver subject to the Receivership Act and Orders of the Receivership Court. The estate liability, if any, has not been determined. The amounts owed and the priorities of the claims have not been determined. The Receiver has commenced the process of adjudicating POCs. The Receiver reserves all rights to adjust these amounts and priority levels based on the adjudication of claims process under the Receivership Act and Orders of this Court.

11. Class 8 Claims. The amount of claims for other general creditors totals $52,225,015 for MHP and totals $14,808 for Meritus Mutual. Among other things, this figure includes intercompany payables as between MHP and Meritus Mutual totaling in excess of $51 million. The amount of intercompany payables may be subject to further consideration depending on the circumstances.

12. Class 10 Claims – Surplus Notes. The amount and priority level for the surplus note claims are based on the figures included in the Setoff Petition. For administrative efficiency, the estimates included herein are provided in a manner consistent with the relief requested in the Setoff Petition. The Setoff Petition has been filed with the Receivership Court and is subject to hearing and may be contested and the relief requested may not be granted and/or may be modified. The Receiver reserves all rights to revise and modify these estimates based upon and subject to future orders of the Receivership Court.

13. Excess Premiums. MHP and Meritus Mutual are continuing to hold funds that appear to be payments made in excess of the amount of premiums that was due and owing ("Excess Premiums"). There currently appear to be payments from approximately 130 members with the total amount of Excess Premiums equal to approximately $32,215. The Excess Premiums are subject to Petition 28, Petition to Approve Limited Return of Excess Premiums, filed with the Court on January 28, 2019.

14. Claim Adjudication Process. The figures identified as liabilities are based on the amounts claimed on proofs of claims (POCs) filed with the Receiver subject to the Receivership Act and Orders of the Receivership Court. The estate liability, if any, has not been determined. Specifically, the amounts owed and the priorities of the claims have not been determined. The Receiver has commenced the process of adjudicating

POCs. The Receiver reserves all rights to adjust these amounts and priority levels based on the adjudication of claims process under the Receivership Act and Orders of this Court.

15. Receivership Liquidation Fund. Pursuant to A.R.S. § 20-648, the Receiver previously made payments to the Receivership Liquidation Fund in accordance with the Receivership Court's Order Regarding Petition No. 4, Regarding Receivership Liquidation Fund Per A.R.S. § 20-648. To the extent additional payments to the Receivership Liquidation Fund are anticipated, the Receiver reserves all rights to update and/or modify the Liquidation Balance Sheet as necessary or appropriate under the circumstances.