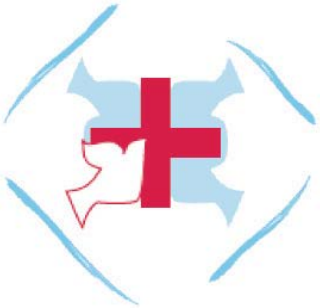

Friends Mutual Health Group

Mutual Care • Integrity • Community

Cooperative Agreement

As Amended May 30, 2014

This document, duly amended according the provisions herein, supersedes any previous agreements.

Friends Mutual Health Group

Employee Health Benefit Plan Cooperative Agreement

May 30, 2014

This Employee Health Benefit Plan Cooperative Agreement (the "Cooperative Agreement" or the "Agreement") is entered into among the organizations participating in the Friends Mutual Health Group Plan (hereinafter called the "Plan") and Friends Mutual Health Group, a Pennsylvania nonprofit corporation ("FMHG" or the "Corporation").

I. **Purpose**

A. The organizations participating in the Plan (the "Member Organizations") Member Organizations commit to cooperate with each other in administering and providing a health benefit programs for the employees and eligible dependents of Member Organizations.

B. This Cooperative Agreement establishes the obligations and duties of Member Organizations for the purpose of establishing a corporation that will provide employee health benefits through the Plan. Certain capitalized terms are defined in the Definition of Terms at the end of this Agreement.

C. A primary shared value of each of the Member Organizations is the concept of Mutual Aid, or bearing each other's burdens. As such, Member Organizations will collaborate for our mutual benefit through our mutual dependence; together sharing the risk of health insurance losses (and gains). This means that each Member Organization must view this agreement as a long-term commitment, rather than simply the purchase of insurance as a customer. Each Member Organization will initially commit for a period of three years.

D. The method of business practice of FMHG will follow the Quaker practice of discerning the Sense of the Meeting. Guided by the Spirit, those responsible for conducting the business of FMHG will gather themselves in unity in the presence of the Light. This will entail clear concise, accurate and timely communication to Member Organizations to allow effective participation in business matters, maintaining the long focus, and remaining open to continuing revelation through worship.

II. Eligibility

A. Participation in FMHG is only open to Friends organizations in the United States. To be eligible, an organization should be a recognized yearly meeting, quarterly meeting, monthly meeting or church of the Religious Society of Friends in the U.S.A.; a Quaker organization in the U.S.A.; a Recognized Regional or National Friends Association; or a member of a Recognized Regional or National Friends Association. No organization shall be eligible to participate if its participation would prevent the Plan from qualifying as a Church Plan as designated by the Internal Revenue Service.

B. The Board of the Corporation (the "Board") shall determine, on the basis of an application of an organization that requests to participate in the Plan, whether to permit such participation. All decisions by the Board will be final.

III Duties Of The Board

The Board shall have all powers and duties with respect to the Plan, and shall:

A. Assure the successful functioning of the Plan, financially and otherwise, through the establishment of appropriate committees to focus on specific aspects of the Plan. These committees may include Outreach, Claims Review, Finance, Nominating, Underwriting and Executive.

B. Approve overall Plan design of member Plans. Amend the Plan or Plans as deemed appropriate from time to time.

C. Maintain confidentiality of all Protected Health Information discussed in the context of managing the Plan and governing the Corporation.

D. Oversee development and maintenance of Plan documents.

E. Authorize and implement the amendment or termination of the Plan.

F. Hear and decide all eligibility questions, enrollment questions and decisions rendered by the Third Party Administrator with respect to procedural matters concerning the Plan.

G. Inform the Excess-loss Carrier of all changes in the Plan design or eligibility requirements.

H. Attend to financial and operational affairs of the Plan. In so doing the Board shall, among other items:

1. Through a Third Party Administrator or other consultant, negotiate and contract with third parties to provide any and all services deemed necessary and appropriate to carry out the terms of the Plan and monitor their performance.
2. Establish an Investment Policy to guide the investment of Plan financial assets with due consideration of risk and the need for accessible cash flow to pay expenses of the Plan.
3. Negotiate and enter into an appropriate arrangement with an Exclusive Agent to act on behalf of the Plan in carrying out the Plan's duties under the terms and provisions of the arrangement with the Third Party Administrator.
4. Oversee and approve arrangements for the management of the Plan.
5. Determine funding levels for the overall Plan and make decisions about Entrance Fees, risks and Premiums.
6. Identify amounts to be returned to Members on an annual basis from the Subvention Account in the form of an annual payment to the Member at the end of a fiscal year of the Plan until such time as all Subvention amounts are returned to each current member.
7. Once all Subvention amounts are returned, calculate any further Return of Excess Premiums to Members and determine the timing and amount of Return of Excess Premiums to each Member.
8. Maintain loss funds and excess-loss insurance from which to pay benefits.
9. Compute and collect a special assessment from each Member Organization in the event there is an overall projected deficit in funds in the self-insurance fund to pay benefits.
10. Pay benefits from the self-insurance fund on behalf of each Member Organization according to the terms of the applicable Summary Plan Description.
11. Comply with all appropriate state and federal regulations.
12. Engage auditors to perform annual financial audits of the operations of the Plan in accordance with generally accepted auditing standards in the United States of America.

13. Contract with other consultants from time to time as the need may arise as determined by the Board.
14. Review the Cooperative Agreement periodically and ensure that it is being observed in all particulars and that its components continue to be relevant to the Plan.
15. Review and approve or disapprove applications from organizations that wish to participate in the Plan. Decisions regarding applications from organizations that wish to participate in the Plan will be made by Sense of the Meeting, with a Quorum of the Board present required for approval, after consideration of recommendations from service providers.
16. Review and approve or disapprove any recommendation to expel a Member Organization from the Plan. Decisions regarding expulsion of a Member Organization from the Plan will be made by Sense of the Meeting, with a Quorum of the Board present required for expulsion. (See Section VI, B, 3).
17. Maintain adequate records for proof of loss as required by the Excess-loss Carrier. Provide information to the Excess-loss Carrier for claims reaching the level specified by the Excess-loss Carrier. See to the receipting and proper credit of all reimbursement provided by the Excess-loss Carrier.
18. Develop and maintain policies and procedures necessary to operate the Plan.
19. Solicit input from all Member Organizations before making significant changes to the Plan. The decisions of the Board will be final. The Board will communicate policy changes and other significant decisions of the Board to Member Organizations in a timely fashion.

In carrying out such powers and duties, the Board may delegate such specific powers and duties to committees, staff or others as it deems appropriate, subject to the limitations of Section V.A below. The Board will recruit new members for the Board and any committees from among the Member Organizations each year as provided by the Bylaws.

IV. Obligations Of Member Organizations

Each-Member Organization shall:

A. Meet minimum eligibility, participation and funding requirements, as follows:
   1. The minimum eligibility requirement for Part Time Staff to participate in the Plan must be at least 20 paid hours per week. Subject to the immediately preceding sentence and the other provisions of this Agreement, each Member Organization shall determine the eligibility requirements for its employees.
   2. Of those eligible employees not enrolled in other employer-sponsored or government health plans, 75 percent must participate in the Plan.
   3. For eligible Full Time Staff participating in the Plan, Member Organizations must:
      a. Pay at least 80% of the cost of single coverage OR
      b. Pay at least 50% of the cost of coverage for all Premium Types, determined by dividing the Member Organization's share of the premiums by the total premiums for that Member Organization (Member Organization's share of premiums/total premiums for Member Organization) OR
      c. Such higher amount as is required to comply with the Affordable Care Act.
   4. For Part Time Staff that are eligible to receive coverage under the Plan, Member Organizations – OR 40% for all other tiers OR such higher amount as is required by the Affordable Care Act.

5. Agreements made by collective bargaining units may not be superseded by the terms of Section IV (A)(1-4).

6. At the discretion of a Member Organization, a special class of employee may be created that would permit the participation of an employee who does not have a defined work period, but works a schedule that would otherwise qualify the employee for participation as either Full Time or Part Time Staff.

7. Each Member Organization shall renew its participation annually by demonstrating compliance with requirements IV (A)1-6. The Board may impose additional assessments or expel a Member Organization that fails to meet these requirements of this Section.

B. Pay Premiums, Entrance Fees and other costs and assessments imposed by the Board by the due date.

1. The Board may change the Premiums, Entrance Fees and other costs and assessments from time to time based on the needs of the Plan.

2. Each Member Organization shall pay its share of the aggregated costs required to operate and manage the Plan and the Corporation. These costs include direct medical expenses, prescription drug costs, vision plan expenses, dental plan expenses, plan administration fees, health plan provider fees, stop loss insurance, marketing expenses, audit expenses, legal expenses and other expenses and overhead as approved by the Board.

3. The Board shall factor all Plan costs into its consideration of the premium rates so that Premiums will be sufficient to cover the expected costs of the Plan and the Corporation.

4. The Board may change the method of determining the-Member Organizations' Premium Payments from time to time.

5. Each-Member Organizations that executes this Agreement shall pay an initial Entrance Fee as determined by the board.

6. Each Member Organization shall confirm the number of employees participating in the Plan at the time of initial enrollment.

7. The Board retains the right to change from time to time the payment basis for Entrance Fee payable by any Member Organization that executes this Agreement after December 31, 2006 (a "New Member Organization").

8. A Member Organization will pay a Supplemental Entrance Fee Amount if the number of its employees covered under the Plan increases by 20% or more over the number of participating employees confirmed at the time its initial Subvention Amount or Entrance Fee was determined. The Supplemental Entrance Fee will be based on the payment basis for Entrance Fees for New Participating Employer Organizations in effect at the time the payment is assessed.

9. Each Member Organization shall pay its Premiums,-Entrance Fees, and other costs and assessments to the Exclusive Agent of the Plan by the due date. If such Premiums, Entrance Fees, and other costs and assessments are not paid when due, and remain unpaid more than 15 days after receipt of written notice of failure to pay (but not less than 30 days after the date due), the Board may terminate coverage as of the due date and issue a written notice of termination of coverage to the Member Organization. In such case, the Board may also initiate proceedings to expel the Member Organization from the Plan.

10. Each Member Organization shall collect the employee contribution to the Premium, and forward those amounts to the Exclusive Agent of the Plan.

11. Each Member Organization shall pay any costs of transferring funds to the Exclusive Agent for the Plan, including wire transfer or other means for which a separate fee is required.

C. Notify the Third Party Administrator of the Plan of changes in enrollment 15 days prior to the date a Plan Participant becomes eligible for coverage or within 15 days after a Plan Participant loses eligibility for coverage under the Plan.

D. If a Member Organization fails to notify the Third Party Administrator of a change in enrollment of a Plan Participant within such 15 day period, the Member Organization shall be responsible to pay any benefits paid on behalf of the Plan Participant.

E. Participate actively in the oversight of the Plan, as requested, through Board membership, sub-committees, ad hoc committees, special meetings, etc.

1. Attend in person, or by phone or web conference, the annual meeting of the Member Organizations and Board.
2. Serve on the Board, or a subcommittee in regular rotation if asked, starting no later than three years after joining the Plan.
3. Respond to Board communications when requested, in a timely fashion, in the same format that communications are issued.

F. Member Organizations must notify the Third Party Administrator of their election to participate in the optional Dental and Vision Plans.

V. Delegation Of Duties

A. Member Organizations agree that the Board may delegate all or part of the administrative responsibilities of the Plan to a third party or parties, including a Third Party Administrator, Exclusive Agent, etc., as detailed in the annual Summary Plan Description, provided that no third party may take action with respect to:

1. Hearing appeals by a Plan Participant to determine if the Third Party Administrator has followed due process and Plan requirements for coverage.
2. The admission and/or expulsion of Member Organizations.
3. Changes and/or amendments to the Cooperative Agreement.
4. Nomination and/or approval of members of the Board.
5. Approval of policies and procedures.
6. Selecting a Third Party Administrator and/or Exclusive Agent.

VI. Termination

A. After it has completed its initial three-year commitment, a Member Organization may withdraw from participation in the Plan upon delivery of written notice four months prior to the commencement of the subsequent Plan year (e.g. September 1 for January 1 Plan year.)

B. The Board may expel a Member Organization from the Plan for reasons it deems appropriate, including but not limited to:

1. Failure to pay premiums on the dates they are due.
2. Failure to meet the eligibility requirements.
3. Failure to comply with Sections IV(A)(1-6) or IV(B)(1-11), Obligations of the Member Organizations.

No Member Organization shall be expelled without such decision being made by the Board pursuant to a Sense of the Meeting at a meeting of the Board at which a Quorum is present, of which the Member Organization being considered for expulsion has had at least 30 days prior written notice and at which the Member Organization has had an opportunity to be heard. No formal hearing procedure need be followed.

C. A Member Organization that has been expelled may seek reinstatement from the Board by submitting a formal letter requesting such action and clearly addressing any issues that were the basis of the original decision for expulsion.

D. A Member Organization which withdraws or is expelled forfeits any future Surplus returns. Withdrawal or expulsion does not affect a Member's rights to any remaining Subvention amounts contributed by the departing Member.

VII. Subvention Account Returns/ Return of Excess Premiums

A. The FMHG Board has established a Subvention Account return policy effective January 1, 2014. After review of the financial statement for December 31, 2013, the FMHG Board will determine an amount from the Subvention Account to be returned to the Members. The amount shall be returned over a period of time no less than 2 years and no more than 3 years. The FMHG Board will determine the amounts available to the Members each year. The amounts to be returned in total to each Member will equal the Subvention amounts paid by each Member. The FMHG Board will review the Subvention amount to be returned each year until all Subvention amounts have been assigned for return to the Members.

B. If a Member withdraws or is expelled before the entire Subvention amount contributed by the Member is returned, the Board shall return the unpaid amounts as follows. If a Member withdraws or is expelled more than five years after its initial payment, FMHG will repay 25% of its remaining proportionate share, without interest, on the first anniversary of the termination and 75% of the amount due on the second anniversary of the termination. If a member withdraws or is expelled before the five year date, FMHG will repay its remaining proportionate share less 20% for each year or partial year between the date of termination and the five year date. FMHG will pay without interest 25% of the amount due on the sixth anniversary of the initial payment and 75% on the seventh anniversary of the initial payment.

C. Once all available Subvention amounts have been allocated for return, future Returns of Excess Premiums may be available for Members after review of the FMHG's financial statement as of December 31st of every third year. The FMHG Board, will decide upon a total amount to be allocated as Return of Excess Premiums. This amount is based on amount of Excess Premiums over claims and costs in the period since the last distribution of Excess Premiums and the FMHG's overall surplus position.

D. FMHG will allocate 50% of the Return of Excess Premiums amount declared based on a member's loss experience (that is, its contribution to surplus) since the last distribution and 50% based on the total of a member's premium contributions to the FMHG since the last distribution.

E. As respects the 50% allocated based on a member's loss experience, those members who have not contributed to surplus (had an overall loss) due to unfavorable loss experience do not receive any of this portion of the overall amount allocated to the Return of Excess Premiums. Loss experience will be valued as of March 31st of each year for this calculation.

F. In order to be eligible for Return of Excess Premiums, a Member must have at least one full year of loss experience going into the overall calculation. Former Members are not eligible and may not take with them any amounts that they may have accrued in the Return of Excess Premiums when

they depart the FMHG. Also, current Members who have notified FMHG of their intent to withdraw as a Member will not receive Return of Excess Premiums. Amounts forfeited by former and departing Members shall be added to surplus for the remaining Members.

G. A Return of Excess Premiums account is maintained for each Member Organization. Additions are made for the Member Organization's portion of each overall allocation. Deductions are made for distributions from the Return of Excess Premiums. The amount of unused Return of Excess Premiums will be shown in FMHG's balance sheet as a liability.

H. The entirety of a Member's Return of Excess Premiums account is not fully available in the year it is allocated, but is paid out over 2-3 years. Amounts available for return each year are determined by the FMHG Board.

VIII. Miscellaneous

A. *Dispute Resolution*: FHMG and the Member Organizations agree to engage in good faith negotiations to resolve any disputes. In the event that a dispute cannot be resolved through negotiation, then such dispute shall be submitted to arbitration in the county in which the defendant has its principal place of business in accordance with the arbitration rules of the American Arbitration Association and the award rendered by the arbitrators shall be binding between the parties. Any fees or expenses incurred due to arbitration shall be shared equally among the parties to the dispute.

B. *Waiver*. Each-Member Organization hereby releases, waives, covenants not to sue and discharges FMHG, its officers, Directors, volunteers and employees from any and all liability for any and all damages, and any claims or demands for damages arising, directly or indirectly, in connection with the services provided hereunder except for willful misconduct and gross negligence.

C. *Amendments*: This Cooperative Agreement may be, and shall be deemed, amended upon approval by the Board of FHMG and by the Member Organizations determined by the Sense of the Meeting at a duly called meeting of the members of FHMG, provided that notice of such meeting of members setting forth the substance of the changes proposed shall be provided in writing at least 30 days prior to the meeting. For purposes of determining a quorum at such meeting of members, a proxy in favor of the proposed amendment(s) shall be deemed participation in the meeting.

D. *Assignment*: This Agreement shall bind and inure to the benefit of the parties hereto and their respective heirs, successors and assigns. This Agreement may be assigned by any party, provided, however, that such assignment shall not relieve any party of its obligations as provided herein.

E. *Law and Severability*: This Agreement, its validity, construction, and effect shall be governed by the laws of the Commonwealth of Pennsylvania, without regard to conflicts of laws principles. In the event that any part of this Agreement is declared to be void or unenforceable by arbitrators or a court having jurisdiction, the remainder of this Agreement shall continue in full force and effect with such void or unenforceable part thereof deleted there from.

IX. Agreement

This Agreement represents the entire contract among the Member Organizations and FMHG and supersedes, with respect to its subject, any prior oral or written agreements. This agreement is effective as of the date indicated below.

IN WITNESS WHEREOF, FMHG and each Member Organization has caused this Cooperative Agreement to be executed in counterpart by its duly authorized and empowered officer or representative as of the effective date set forth above.

Employer Organization: _____

Authorized Signature: _____

Name: _____

Title and Date: _____

DEFINITION OF TERMS
Next Page

Definition of Terms:

Annual Meeting of the Board: the Regular Meeting of the Board at which new Directors are appointed, Premium amounts are established, and any other business of the Board is conducted as determined by the Board.

Directors: those individuals who have the legal authority to conduct the business of FMHG and who are appointed to their roles by a process defined in the FMHG Bylaws.

Entrance Fee: An amount of contribution to be paid by new Members to add to FMHG surplus to support the additional underwriting risk assumed by FMHG for the new Member**.**

Exclusive Agent: the organization under contract with FMHG to pay claims and to provide access to health care networks of primary care physicians, specialists, hospitals and any other health care services described in the Summary Plan Description for the health, dental and vision plans.

Excess-loss Carrier: the insurance company under agreement with FMHG to provide the excess-loss coverage for Plan participants once the incurred losses for an individual exceed the amount specified in the Plan up to the aggregate coverage level provided for in the agreement.

Full Time Staff: any employee who works a schedule of not less than 32 hours per week based on a 40 hour work week.

Investment Policy: the document that defines how reserves and excess cash balances are to be invested to ensure that funds are readily available to pay claims and other expenses of the Plan, to provide income, to define risk tolerance, to reflect socially responsible investing and other criteria as may be determined by the Board.

Mutual Aid: the community we create within the context of this collaboration sets the stage for the mutual dependence we will have on one another. The aim of the program is to create community among the organizations participating and to provide mutual aid to each other as well as to moderate costs though these shared goals.

New Member Organization: any organization that applies to join the Plan after December 31, 2006

Part Time Staff: any employee who works a schedule of less than 32 hours per week based on a 40 hour work week.

Member Organization: an organization that joins the Plan and that meets the eligibility requirements for participation.

Participation Fee: the fee assessed to any New Member Organization.

Plan: the self-funded health insurance plan or plans that are governed by the Cooperative Agreement that is adopted by all Member Organizations

Plan Participant: an employee or eligible dependent that is enrolled in the Plan.

Premium Payments or Premiums: the amounts paid by each Member Organization to fund the cost of the Plan or Plans.

Premium Types: the levels of health insurance coverage offered under the Plan or Plans. This may include single, employee/spouse, employee/partner, employee/child, employee/children or family coverage.

Definition of Terms, Cont'd

Protected Health Information: protected health information (PHI) under HIPAA includes any *individually identifiable* health information. *Identifiable* refers not only to data that is explicitly linked to a particular individual (that's *identified* information); it also includes health information with data items that reasonably could be expected to allow individual identification.

Quorum of the Board: a quorum of FMHG's Board as set forth in its Bylaws. At the effective date of this Agreement, a quorum was 70% of the Directors in office.

Recognized Regional or National Friends Association: an organization which is a recognized regional or national Friends organization, such as Friends Services for the Aging, Friends Council on Education, Friends Association of Higher Education, etc.

Regular Meeting of the Board: a meeting of the Board that is held on a predetermined date and which is published in the Board meeting calendar.

Return of Excess Premiums: An amount of excess surplus designated by the FMHG Board to be returned over a two or three year period to the Members. The amount and timing of the payment will be determined every three years by the FMHG Board.

Sense of the Meeting: a Quaker process of decision making by which the Board seeks spiritual unity in the decisions to matters that are put before it. Sense of the Meeting requires listening rather than contending, weighing rather than reacting. The Clerk discerns the Sense of the Meeting.

Subvention Account: a separate account consisting of the Subvention Amounts and any Supplemental Subvention Amounts paid by Participating Employer Organizations, reduced by Plan expenses, any general redemption, redemptions on the Termination of any Participating Member Organization and the reduction in Proportionate Share for any Member Organization terminating before the Five Year Date

Supplemental Entrance Fee Amount: an additional Entrance Fee Amount required of a Member Organization due to an increase of 20% or more in the number of employees from that organization enrolled in the Plan.

Surplus: An account made up of accumulated surplus of premiums over expenses over the life of FMHG which is maintained to provide adequate funds to cover adverse claims experience and provide for the stability of FMHG.

Third Party Administrator: an organization under contract with FMHG to provide administrative services to the Board and/or to Member Organizations, including but not limited to information about claims experience, enrollment management, changes to enrollment, education information, etc.