Pennsylvania
Insurance Department

September 25, 2024

Via Email and U.S. Mail

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RE: Request for Modification of the Approving Determination and Order, dated April 29, 2013 (Order No. ID RC-13-06), as amended (the "2013 Order")

Dear Ms. Duronio, Mr. Kavanaugh and Mr. Sheridan:

On October 16, 2023, Highmark Health filed with the Pennsylvania Department of Insurance (the "Department") a Request for Modification (the "Request for Modification")[1] pursuant to Condition 27 of the 2013 Order to terminate[2] all of the conditions in the 2013 Order (the "Conditions").

The Department reviewed the Request for Modification, information provided by or on behalf of Highmark Health, information provided by the Department's consultants, comments from the public, and testimony at the Public Informational Hearing on May 1, 2024. Based on that review, pursuant to Condition 27, the Commissioner hereby amends the Conditions so that, as amended, the Conditions read as set forth in Appendix A, effective on the date of this letter. The revisions to the Conditions are being made in reliance upon Highmark Health's assurances that the information provided by or on behalf of Highmark Health in connection with the Request for Modification is true, accurate and complete.

[1]The Request for Modification was filed by Highmark Health for itself, Highmark Inc., "and any other impacted affiliates of Highmark Health."
[2] In the Request for Modification, Highmark Health requests the that the conditions be "lifted," which the Department assumes is intended to mean that it requests these conditions be terminated prospectively.

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Background

Highmark filed the Request for Modification pursuant to Condition 27, which gives to the Commissioner the authority, in the Commissioner's sole discretion, to modify one or more of the Conditions, as provided in Condition 27.[3]

Eight of the original Conditions in the 2013 Order have expired, been deleted or suspended or require no further filing.[4] The currently effective Conditions of the 2013 Order may be grouped as follows: (1) "Competitive Conditions" which protect and enhance competition (Conditions 1-2, 3, 5-6, 7-9); (2) "Financial Conditions" which regulate policyholder fund transfers and provide financial transparency by requiring financial reporting by the domestic insurers and Highmark's affiliated health care providers (Conditions 11-14 and 18); (3) Public interest and policyholder protection conditions (Conditions 20[5], 21 and 23); and (4) the remaining Conditions (which start at Condition 24) are miscellaneous provisions, including provisions imposing the cost of review and enforcement.

The Department's Review of the Request for Modification

Upon receipt of the Request for Modification, the Department requested its consultant, Compass Lexecon, to undertake a detailed review of the relief sought by Highmark Health and to supplement its earlier reports, particularly with regard to the Competitive Conditions. In addition, as the Department's review of the Request for Modification progressed, the Department asked Compass Lexecon to submit additional material and testify at the May 1, 2024 public informational hearing.[6] Periodic reviews conducted by Compass Lexecon at the request of the Department indicated continued concerns about potential anticompetitive effects in the context of changing market conditions. Specifically, Compass Lexecon concluded, among other things, that "[b]ut-for the constraints imposed by the Competitive Conditions, there is a reasonable likelihood of anticompetitive harm to competition and healthcare consumers in the [western Pennsylvania area]."[7]

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[3] Condition 27 provides: "[u]pon written request by a Highmark Health Entity setting forth: (a) the specific Condition(s) for which such Highmark Health Entity seeks relief; (b) the reason for which such relief is necessary and (c) an undertaking by such Highmark Health Entity to provide all such further information as the Department shall require to evaluate the request, the Department may evaluate and, after evaluation of the request, the Commissioner, in the Commissioner's sole discretion, may grant relief, in whole or in part, from one or more of the Conditions as the Commissioner may. . .deem appropriate."
[4] These conditions are: Conditions 4 (expired), 10 (suspended), 15,16 and 17 (expired), 19 (expired), 22 (transition plan filed, no further filing required) and 37 (expired).
[5] The Department's consultant, Compass Lexecon, considered Condition 20 to be a competitive condition in its review of the Conditions affecting competition.
[6] Copies of reports submitted to the Department by Compass Lexecon may be accessed on the Department's website. All of the material submitted by Compass Lexecon to the Department in connection with its review of the Request for Modification that is contained on the Department's website is collectively referred to as the "Compass Lexecon Reports."
[7] July 31, 2024 Assessment at page 25.

Conclusions

In evaluating the Request for Modification, the Department considers the effect of the Request for Modification on the underlying purposes of the 2013 Order, namely "to preserve and promote competition in insurance in the Commonwealth of Pennsylvania, to protect the public interest, and to protect the financial stability of the Highmark Insurance Companies."[8]

In essence, Highmark Health's argument in support of the request for Modification can be summarized as: (i) in 2013 there may have been a need for the Conditions; (ii) Highmark Health, Highmark Inc. and Allegheny Health Network, formerly West Penn Allegheny Health System ("AHN"), have been operating - assuming in a compliant manner - with the Conditions; (iii) Highmark Inc. and AHN, have been performing well and competition in the relevant markets has increased; (iv) continuing these conditions on Highmark and AHN without also imposing the same competitive and consumer choice conditions on its rivals does not ensure a level playing field in competing for insureds or patients; and (v) therefore it is time to remove the Conditions.

Condition 27 expressly requires Highmark Health to show that "relief is necessary." Highmark Health advanced general arguments and assertions, devoid of any specific factual substantiation, in support of its arguments. Importantly, Highmark Health did not produce any factual support or fact-based analysis about what would happen to competition if the Commissioner agreed to terminate the Competitive Conditions. At the May 1, 2024 Public Informational Hearing, Highmark Health was invited to advise whether it would continue to comply with the restrictions imposed by the Conditions going forward if the Conditions were terminated and declined to so commit.

The record reflects concerns that there would be risks to competition if the Conditions would be terminated. Additionally, the economic analysis provided by Compass Lexecon in its July 31, 2024 assessment concluded that, contrary to Highmark Health's unsupported assertions, "[b]ut-for the constraints imposed by the Competitive Conditions, there is a reasonable likelihood of anticompetitive harm to competition and healthcare consumers in the [western Pennsylvania area]."[9]

Competitive Conditions: First, Highmark Health's position assumes/concludes that the purpose of the 2013 Order has been achieved and that "lifting" the 2013 Order will not impose any further competitive concerns, a conclusion that is contrary to Compass Lexecon's overall findings. Highmark Health's argument implicitly assumes, without providing any data or economic analysis, that removing the Conditions would have no negative effects on competition. Such a position is not consistent with the record, and particularly with Compass Lexecon's conclusions, as stated in its July 31, 2024 assessment and elsewhere.

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[8] 2103 Order, at p. 3
[9] July 31, 2024 Assessment at page 25.

Moreover, Highmark was invited on multiple occasions to provide specific examples of actual harm that continuing the Conditions, and particularly the Competitive Conditions, would have on Highmark's ability to compete in the western Pennsylvania area. Representatives of Highmark Health and its economic consultant made multiple submissions that are part of the record. They appeared and testified at the public hearing. However, despite its arguments and submissions, neither Highmark Health nor its economic consultant have ever demonstrated that Highmark Inc. or AHN would be harmed in any specific respect as a result of having to continue to comply with the Competitive Conditions.[10] Based on its review of the entire record, the Department does not consider it appropriate to modify the Conditions beyond the changes made in the revised Conditions document attached hereto as Exhibit A.

Financial Conditions: With respect to the 2013 Order's Financial Conditions, Highmark Health argues in support for the Request for Modification that Highmark Inc. continues to be a very strong, fiscally sound health insurance company. While its current financial position is relevant, the Financial Conditions also are concerned with the potential impact of future obligations. Highmark Inc. continues to provide at least $200 million per year in financial support to AHN and its operations and is expected to continue to provide significant support in the future. It is the Department's understanding that AHN would, at the least, have significant financial difficulty if Highmark Inc. did not provide it with significant annual subsidies.

The Financial Conditions are designed, among other things, to "limit the amount of policyholder funds that may be transferred to any Domestic lnsurer's new parent entity or other Affiliates of the parent" and to "enhance the level of transparency and accountability with respect to [Highmark Inc.'s] stated goal of deriving tangible policyholder benefits."[11] In July 2017, the Department substantially revised certain of the Financial Conditions which reduced significantly (i) the circumstances under which Highmark Inc. must seek Department approval of specific transactions and (ii) certain reporting obligations contained in the Financial Conditions. Considering that Highmark Inc. continues to anticipate providing substantial annual financial support to AHN, the Department does not consider it appropriate to modify the Financial Conditions beyond the changes made in the revised Conditions document attached hereto as Exhibit A.

Other Conditions: The Department has agreed to amend the other Conditions as set forth in Exhibit A.

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[10] The cost of compliance is not relevant to assessing competition, unless it can be shown that the diversion of funds to compliance diminishes an entity's ability to compete. Highmark Health did not offer any information that would lead to such a conclusion.
[11] 2013 Order at page 6.

Effective on the date of this letter, the Conditions, related preambles and definitions are revised to provide as set forth in the attached Exhibit A. Other than the revisions to the Conditions, the provisions of the 2013 Order are unchanged and remain in full force and effect. This letter does not amend, alter or affect the 2013 Order prior to the date of this letter.

Sincerely,

Michael Humphreys
Insurance Commissioner

Exhibit A
Conditions Contained In The
Approving Determination and Order
Order No. ID-RC-13-06
(Conditions As Modified Through
The Department's Letter Dated September 25, 2024)

The following are the Conditions contained in the Commissioner's Approving Determination and Order, Order No. ID-RC-13-06, issued on April 29, 2013, as amended through the Department's letter dated September 25, 2024. The Approving Determination and Order specifically provides that all of these Conditions must be complied with in order for the approval contained in the Approving Determination of Order to be valid.

Competitive Conditions

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

Prohibition On Exclusive Contracting

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

2. No Highmark Health Entity shall, directly or indirectly, prohibit or limit the authority of any other Highmark Health Entity that is a Health Care Provider from entering into any contract or arrangement with any Health Care Insurer. Exclusive contracts with specialized providers, such as anesthesiologists or emergency room physicians, may be entered into by a Highmark Health Entity that is a Health Care Insurer with at least thirty (30) days' prior written notice to the Department, so long as the Department does not advise the requesting Health Care Insurer that the Department either disapproves the request for approval or requests any further information or explanation regarding the request for approval within such thirty (30) day period.

Provider/Insurer Payment Contract Length Limitation

3. Except as provided in this Condition, no Domestic Insurer shall enter into any contract or arrangement with any Health Care Provider, and no Highmark Health Entity that is a Health Care Provider shall enter into any contract or arrangement with any Health Care Insurer (other than a Domestic Insurer), the term of which is in excess of five (5) years (including the initial term together with all renewal terms) without the prior Approval of the Department. Notwithstanding the foregoing, a contract or arrangement between a Domestic Insurer and a Health Care Provider, or a Highmark Health Entity that is a Health Care Provider and a Health Care Insurer (other than a Domestic Insurer) may have a length (including the initial term together with all renewal terms) in excess of five (5) years without obtaining the prior Approval of the Department if for the subsequent years:

   A. the contract or arrangement contains a reasonable market-based compensation adjustment provision; or

   B. the contract or arrangement contains another type of compensation adjustment provision that has received prior written approval of the Department.

Prohibition On Most Favored Nation Contracts Or Arrangements

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

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

Firewall Policy

6. Highmark Health shall maintain, monitor the operation of, and enforce strict compliance with a Firewall Policy for Highmark Health, AHN, and each Highmark Health Entity that is a Health Care Provider or a Health Care Insurer (and for such other Highmark Health Entities as the Department may require) in a form and substance acceptable to the Department including, without limitation, the elements set forth in Appendix 2 (Firewall Policy), which is attached hereto and is incorporated herein by reference. Different Firewall Policies may be submitted for separate Highmark Health Entities or types of Highmark Health Entities, provided that each such separate policy shall substantially include all of the elements set forth in Appendix 2 (Firewall Policy) and be accompanied by an explanation that describes the need for a separate policy. Once Approved by the Department, each Firewall Policy ("Approved Firewall Policy") shall be made publicly available in accordance with the requirements of the Department. After Approval of the Department of the Approved Firewall Policy, Highmark Health shall cause each applicable Highmark Health Entity to maintain in full force the applicable Approved Firewall Policy. No Highmark Health Entity may make any material amendment, waive enforcement of or terminate any material provision of its Approved Firewall Policy without the Approval of the Department. Each Highmark Health Entity required to have and to maintain an Approved Firewall Policy shall give prompt notice to the Department of any other amendment, waiver or termination of its Approved Firewall Policy.

7. The requirements of Former Condition 8 have been deleted.

8. Highmark Health, AHN, and each Highmark Health Entity that is a Health Care Provider or a Health Care Insurer shall provide the Department with such information regarding its Approved Firewall Policy and its implementation and enforcement as the Department shall from time to time request. Approved Firewall Policy implementation and enforcement shall be subject to review and/or examination by the Department, or consultants retained by the Department at the expense of the Highmark Health Entity, to the extent that the Department believes that such review and/or examination is in the public interest.

Financial Conditions

Preamble: The following Financial Conditions are intended to: (i) limit the amount of policyholder funds that may be transferred to Highmark Health or other Affiliates of Highmark Health; (ii) establish an enhanced standard of review and assessment that is required to be undertaken prior to any Domestic Insurer entering into additional material financial commitments; (iii) continue ongoing reporting and monitoring requirements related to a Domestic Insurer's investments into the AHN Entities; and (iv) enhance the level of transparency and accountability with respect to Highmark's stated goal of deriving tangible policyholder benefits, in the form of relative premium and cost of care savings, related to financial commitments made in connection with the Transaction.

Financial Commitment Limitations

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

   A. **Due Diligence Standard**. For all Financial Commitments: (i) the Highmark Health Entity making or agreeing to make any Financial Commitment shall conduct a Commercially Reasonable Process to evaluate and assess the benefits and risks to policyholders, subscribers or other stakeholders, as applicable, and whether the Financial Commitment furthers and is consistent with the Highmark Health Entity's nonprofit mission, if the Highmark Health Entity is exempt from Federal taxation pursuant to Section 501(c)(3) of the Internal Revenue Code; and (ii) the terms of any Financial Commitment shall satisfy the provisions of 40 P.S. § 991.1405, as if the Financial Commitment transaction were made or agreed to be made between or among members of the holding company system. Each Highmark Health Entity making or agreeing to make any Financial Commitment shall reasonably document the Commercially Reasonable Process undertaken pursuant to this Condition 9.A., shall provide to the Department upon any filing with the Department pursuant to this Condition 9, or whenever requested by the Department, a summary of the documentation supporting the performance of such Commercially Reasonable Process and shall provide such further information as requested by Department. Documentation evidencing such Commercially Reasonable Process shall be retained by the Highmark Health Entity for five (5) years after making the Financial Commitment to which the Commercially Reasonable Process relates.

   B. **Transactions to or with Highmark Health Entities**. Without the Approval of the Department, no Domestic Insurer shall, directly or indirectly, make or agree to make any Financial Commitment to or with any Highmark Health Entity if in any calendar year either (i) the amount thereof, together with all other Financial Commitments made or agreed to be made directly or indirectly by all of the Domestic Insurers to or with any Highmark Health Entity in such calendar year, equals or exceeds ten percent (10%) of Highmark's surplus as regards to policyholders as shown on its last annual statement on file with the Department; or (ii) the RBC Rating of Highmark is, or as a result of the Financial Commitment is likely to be, 525% or below. The calculation of the RBC Rating of Highmark for the purposes of this Condition 9.B shall be made as provided in Condition 9.E. The calculation of the amount of the Financial Commitment shall be made as provided in Condition 9.F.

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

to be, 525% or below. The calculation of the RBC Rating of Highmark for the purposes of this Condition 9.C shall be made as provided in Condition 9.E. The calculation of the amount of the Financial Commitment shall be made as provided in Condition 9.F.

D. **Calculation of Financial Commitment Limitations.** If a Financial Commitment is made by a Domestic Insurer to a Highmark Health Entity and such Highmark Health Entity further makes a Financial Commitment to a Person other than a Highmark Health Entity, the Financial Commitment made by the Domestic Insurer to the Highmark Health Entity and by the Highmark Health Entity to the Person other than a Highmark Health Entity shall not be aggregated, but for the purposes of this Condition 9, such Financial Commitment made to the Highmark Health Entity shall be subject to the requirements of Condition 9.B.

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

1) The calculation of the RBC Rating of Highmark to determine if the RBC Rating of Highmark is, or as a result of a Financial Commitment is likely to be, 525% or below shall be based upon the last annual statement of Highmark on file with the Department, adjusted for the impact of the proposed Financial Commitment and the most recently available information.

2) Simultaneously with the submission to the Department of any request to approve any Financial Commitment pursuant to this Condition 9, Highmark shall provide to the Department, in addition to all other information required or requested by the Department: (i) a calculation of the effect or impact of the proposed Financial Commitment on the RBC Rating of Highmark (determined as provided in Condition 9.E.(1)); (ii) a "downside" or "stress" analysis of such effect on the RBC Rating of Highmark; and (iii) a calculation of the effect or impact of the proposed Financial Commitment on the RBC Rating of Highmark based upon the last annual statement of Highmark on file with the Department prior to the applicable Financial Commitment.

F. **Financial Commitment Calculation**.

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

2) Former Condition 11(G)(2) is deleted because the action required in the Condition has been completed.

3) Notwithstanding any other provision of this Approving Determination and Order, with respect to any Financial Commitment relating to any guaranty or surety arrangement, the amount of the Financial Commitment for a calendar year with respect to that guaranty or surety arrangement shall be equal to the

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

G. Application to Certain Transactions.

1) Condition 9.B. shall not apply to Highmark's forgiveness of any indebtedness owed to it as of July 31, 2017 by Highmark Health and/or AHN and/or subsidiaries of Highmark Health or any alternative repayment method of such indebtedness acceptable to the Department in form and substance. This indebtedness, as of July 31, 2017, is estimated to be approximately $500,000,000 owed by AHN to Highmark and the $200,000,000 owed by Highmark Health to Highmark (collectively the "$700,000,000 Debt").

2) No later than thirty (30) days after the RBC Rating of Highmark exceeds 650% as calculated by Highmark on a quarterly basis, Highmark shall forgive for statutory accounting purposes (or finalize an alternative repayment method acceptable to the Department in form and substance with respect to) the $700,000,000 Debt. Any time after November 30, 2019, the Department may require Highmark to forgive for statutory accounting purposes (or finalize an alternative repayment method satisfactory to the Department with respect to) the $700,000,000 Debt.

3) Condition 9.B. shall not apply to: (i) the extension of Highmark's existing guarantee of the WPAHS term loan dated May 22, 2014 by and between WPAHS and certain lenders; and/or (ii) a successor guarantee by Highmark of such loan, if such extension or successor guaranty is acceptable to the Department in form and substance.

4) Condition 9.B. shall not apply to a Financial Commitment that is: (i) otherwise in compliance with applicable Pennsylvania law, including but not limited to the Insurance Holding Company Act, which act shall at all times apply to Financial Commitments of Highmark and each direct or indirect subsidiary of Highmark and (ii) either (A) from Highmark to a direct or indirect subsidiary of Highmark; or (B) from a direct or indirect subsidiary of Highmark to Highmark or another direct or indirect subsidiary of Highmark; provided that any Financial Commitment made by a direct or indirect subsidiary of Highmark to any Person other than to Highmark or any other direct or indirect subsidiary of Highmark shall be treated for the purpose of this Condition 9 as if it were a Financial Commitment of Highmark on the

date of such Financial Commitment by such direct or indirect subsidiary of Highmark.

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

I. **No Limitation on Other Obligations**. Nothing contained in this Approving Determination and Order shall limit or affect the obligations of each Highmark Health Entity to comply with applicable law, including without limitation the Insurance Holding Company Act. No Approval of the Department shall be required under this Condition 9 if Department approval for the Financial Commitment has been obtained under 40 P.S. § 991.1405.

Disclosure Of Financial Commitments And Financial And Operational Information

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

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

12. Former Condition 14 is deleted. The Commissioner reserves the right to require AHN or any AHN Affiliate to provide the Department with such financial and operational information related to AHN or any AHN Affiliate as the Commissioner shall from time to time request.

Public Interest/Policyholder Protection Conditions

Consumer Choice Initiatives

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

13. From and after April 29, 2013, no Domestic Insurer shall enter into a contract or arrangement with a Health Care Provider that prohibits and/or limits the ability of any Domestic Insurer to implement Consumer Choice Initiatives, without the prior Approval of the Department. From and after April 29, 2013, no Highmark Health Entity that is a Health Care Provider shall enter into a contract or arrangement with a Health Care Insurer that prohibits and/or limits the ability of the Highmark Health Entity to implement Consumer Choice Initiatives, without the prior Approval of the Department. This Condition does not prohibit a Domestic Insurer or a Highmark Health Entity that is a Health Care Provider from entering into a contract that provides volume discounts, provided that such volume discounts are not conditioned upon or related to commitments not to implement Consumer Choice Initiatives.

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

Department deems confidential. The obligations of the Highmark Health Entities to the Department for all such costs and expenses shall be joint and several obligations.

Modification Of Approving Determination and Order

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

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

Settlement Of Litigation

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

Modification Of Affiliation Agreement

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

Required Record Retention

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

Enforcement

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

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

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

Appendix 1 (Definitions)

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

"1996 Department Order" shall mean the Department's Decision and Order dated November 27, 1996 (Docket No. MS96-04-98).

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

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

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

"AHN Affiliate" means all Affiliates of AHN.

"AHN Entities" or "AHN Entity" means, individually and/or collectively, AHN and all AHN Affiliates, including but not limited to WPAHS and WPAHS Affiliates.

"Allegheny Health Network" or "AHN" means Allegheny Health Network, a Pennsylvania nonprofit corporation(formerly known as "UPE Provider Sub), its successors and assigns.

"Approval of the Department" or "Approved by the Department" means, except as otherwise provided in this definition: either (1) the Department expressly grants its written approval to a written request by the applicable requesting party for Department approval; or (2) within thirty (30) days after the receipt by the Department of the written request for approval, the Department does not advise the requesting party that the Department either disapproves the request for approval or requests any further information or explanation regarding the request for approval. With respect to Condition 3 (Provider/Insurer Payment Contract Length Limitation), Condition 6 (Firewall Policy) and Condition 13 (Consumer Choice Initiatives), "Approval of the Department" means when the Department expressly grants its written approval to a written request by the applicable requesting party for Department approval.

"Approved Firewall Policy" shall have the meaning set forth in Condition 6 (Firewall Policy).

“Commercially Reasonable Process” means such due diligence and evaluative process that would be customarily performed by parties to an arm’s length transaction in the geographic area in which the Financial Commitment is to be made in order to assess the merits and risks of a Financial Commitment and the financial, operational and policy effects to the involved Highmark Health Entity. This includes but is not limited to obtaining, where commercially appropriate and reasonable or to the extent required by law, of a third party fairness opinion or fair market value analysis of such Financial Commitment or other financial analysis and/or stakeholder cost-benefit assessment as may be customarily or reasonably expected to be performed in connection with such a transaction.

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

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

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

“Department” means the Insurance Department of the Commonwealth of Pennsylvania.

“Domestic Insurers” means the following Pennsylvania domestic insurers to which the Form A applies: Highmark Inc.; Highmark Casualty Insurance Company, a Pennsylvania stock insurance company; Highmark Senior Resources Inc., a Pennsylvania stock insurance company; HM Casualty Insurance Company, a Pennsylvania stock insurance company; HM Health Insurance Company, d/b/a Highmark Health Insurance Company, a Pennsylvania stock insurance company; HM Life Insurance Company, a Pennsylvania stock insurance company; Keystone Health Plan West, Inc., a Pennsylvania business corporation and licensed health maintenance organization; United Concordia Companies, Inc., a Pennsylvania stock insurance company; United Concordia Dental Plans of Pennsylvania, Inc., a Pennsylvania business corporation and

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

"Donation" means any contribution, grant, donation, distributions under 40 P.S. § 991.1405 or other transfer or payment of funds, property or services (or a commitment to make a Donation), whether made directly or indirectly, in cash or in kind, by any Highmark Health Entity to any other Highmark Health Entity or to any other Person; provided, however, that "Donation" shall not include any transfer or payment made in exchange for the fair value of goods or services received by the transferring or paying Person. For the avoidance of doubt, the term "Donation" shall also include: (i) any dividends, howsoever denominated; and/or (ii) any distribution made to (A) AHN; (B) any direct or indirect subsidiary of AHN; and/or (C) any direct or indirect subsidiary of Highmark Health that is not a wholly-owned direct or indirect subsidiary of Highmark.

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

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

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

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

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

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

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

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

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

"Highmark Health" means Highmark Health, a Pennsylvania nonprofit corporation (formerly known as "UPE") and being the ultimate parent entity, its successors and assigns.

"Highmark Health Entity" or "Highmark Health Entities" means individually and/or collectively Highmark Health and Affiliates of Highmark Health, including, but not limited to,

AHN, Highmark, all Highmark Affiliates, WPAHS, and all WPAHS Affiliates, JRMC, and all of JRMC Affiliates, SVHS and all SVHS Affiliates, any entity Controlled by any of the foregoing, and their respective successors and assigns.

"Highmark Insurance Companies" shall mean, collectively, Highmark; First Priority Life Insurance Company, Inc.; Gateway Health Plan, Inc.; Highmark Casualty Insurance Company; Highmark Senior Resources Inc.; HM Casualty Insurance Company; HM Health Insurance Company, d/b/a Highmark Health Insurance Company; HM Life Insurance Company; HMO of Northeastern Pennsylvania, Inc., d/b/a First Priority Health; Inter-County Health Plan, Inc.; Inter-County Hospitalization Plan, Inc.; Keystone Health Plan West, Inc.; United Concordia Companies, Inc.; United Concordia Dental Plans of Pennsylvania, Inc.; and United Concordia Life and Health Insurance Company.

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

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

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

"JRMC Affiliates" means all Affiliates of JRMC.

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

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

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

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

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

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

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

"SVHS Affiliates" means all Affiliates of SVHS.

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

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

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

"WPAHS Affiliates" means all Affiliates of WPAHS.

Appendix 2 (Firewall Policy)

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

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

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

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

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

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

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

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

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

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

- Present and future reimbursement rates by payor;

- Payor-provider reimbursement contracts;

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

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

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

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

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