Cigna Health and Life Insurance Company Small Group

Group Agreement

This Policy is underwritten by Cigna Health and Life Insurance Company.

Cigna Health and Life Insurance Company
1-860-226-6000
900 Cottage Grove Road
Bloomfield, CT, 06002

GROUP INSURANCE POLICY

This group insurance policy (the “Policy”), is entered into by and between Cigna Health and Life Insurance Company (the “Insurance Company”) Insurance Company and «GROUPNAME» (“Group”).

A. APPLICATION

The attached application (the “Application”) is part of this Policy. It serves as the signature page of this Policy. The terms of the Application will control any conflict between the terms of the Application and this Policy.

B. CERTIFICATE

The attached Certificate is part of this Policy.

C. DEFINITIONS

Defined terms are capitalized in this Policy:

1. **Agreement** means the contract between the Insurance Company and the Group.

2. **Aggregate Premium** means the Premium required for all Members. Aggregate Premiums are shown on all Premium Statements.

3. **Application** means the Employer enrollment form. It serves as the signature page of this Policy.

4. **Certificate** means the document that contains the eligibility and termination conditions, as well as the benefits, limitations, and exclusions that apply to the Member’s coverage under the Policy.

5. **Coverage** means the Medically Necessary covered services paid for, arranged, or authorized for the Member by the Insurance Company under the terms and conditions of the Certificate.

6. **Eligible Employee** means any individual who performs services for an employing unit, and who is subject to the direction, rule or control of the employing unit as to both the method of performing or executing the services and the result to be effected or accomplished. Whether an individual is an employee under this definition shall be determined by the preponderance of the evidence.

7. **Employer** means the sponsor of this group insurance plan or any subsidiary or affiliate described in this Policy. An employer must employ at least one common-law employee. A business owner and his or her spouse are not considered common-law employees for this purpose if the entity is considered to be wholly owned by one individual or one individual and his or her spouse.

8. **Employer Enrollment Form** means the Group's application for Coverage.

9. **Group** means the legal entity identified as the "Group" on the face page of the Policy. The Group is the employer and policyholder.

10. **Group Health Plan** means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002(1)]) to the extent that the plan provides medical care (as defined in paragraph (2)) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

11. **Insurance Company** means Cigna Health and Life Insurance Company or designated third parties acting on behalf of Cigna Health and Life Insurance Company.

12. **Member** means the subscriber or a covered dependent who has satisfied the eligibility conditions, applied for coverage, and for whom required Premiums have been paid.

13. **Policy** means the document, including the Certificate, together with any riders, amendments and endorsements, which describe the agreement between the Insurance Company and the Group. The "Agreement" also means the Policy.

14. **Policyholder**: Means the legal entity identified as the Policyholder on the face page of the Policy who establishes, sponsors and endorses an employee benefit plan for insurance coverage.

15. **Premium** means the amount paid by the Group to the Insurance Company for Coverage.

16. **Small Employer** means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. A State may elect to define small employer by substituting “100 employees” for “50 employees.” In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

17. **Subscriber** means the eligible individual who elects and signs for the insurance coverage.

18. **Total Estimated Premium Amount** means an estimate of that amount of money necessary to fund the required Premiums to cover the total number of Members whom the Group estimates will enroll for Insurance Company Coverage under the Policy. Payment of the Total Estimated Premium Amount and execution of the Application is acceptance of this Policy. The Coverage will not begin until the Insurance Company receives the Total Estimated Premium Amount.

19. **Cigna Digital Resources**. The Insurance Company may provide written or electronic communications to Employees from time to time to inform Employees of the availability of Insurance Company websites (e.g., myCigna.com®), applications, or other electronic resources (“Cigna Digital Resources”) for the purposes of facilitating Employees’ access to their health plan information and providing instructions and assistance to allow Employees’ use of Cigna Digital Resources.

D. COVERED SERVICES

The Insurance Company provides Coverage to Eligible Employees. The Coverage is subject to the terms and conditions of this Policy and the Application. The Group grants the Insurance Company full discretionary authority to make Coverage decisions. These decisions are pursuant to this Agreement and include: (1) eligibility; and (2) benefit determinations. These decisions will be subject to the review standards applicable to ERISA plans, even if the Group’s group health Insurance Company is not otherwise subject to ERISA.

E. ENROLLMENT AND TERMINATION OF COVERAGE

1. Enrollment

The Certificate will describe the eligibility requirements for Eligible Employees (also referred to as Subscribers) and their Dependents. The Insurance Company relies on the Group to provide accurate information regarding hours worked or scheduled to work exclusively for the Group.

If the Group offers Insurance Company one or more other group health benefit plans for like benefits, to eligible Persons and their eligible Dependents, the Group must permit them to enroll in this Policy. The Group: (1) will make equitable contributions to this Policy and any other plans; and (2) will not promote any other Insurance Company over this Policy. The Group will not directly or indirectly encourage, discourage or otherwise attempt to influence eligible Persons or Dependents to enroll in the Coverage under this Policy based upon: (1) health status; or (2) anticipated utilization of Covered Services.

a. The Group shall allow and eligible Persons can enroll for Coverage for themselves and their eligible Dependents during: (1) the initial enrollment period; (2) an annual Open Enrollment Period; or (3) upon a Qualifying Event. The Parties may agree to an additional Open Enrollment Period.
b. The eligible Persons must complete and submit an Enrollment Form to the group administrator for transmittal to the Insurance Company.
c. When the Group provides enrollment data and that data does not match the Insurance Company's data, the Insurance Company's data will be used to determine the premium. The Insurance Company will work with the Group to resolve the discrepancy. If no agreement can be reached, the Insurance Company's records will control. Until the dispute is resolved, the Group must pay the premium indicated, based on the Insurance Company's records.
d. The Group's enrollment data shall not contain ineligible Persons and/or Dependents.

2. Enrollment Program Data

The Group must follow the Insurance Company's guidelines for the transmittal of Member enrollment or termination data, which shall be facilitated through the use of Microsoft Excel spreadsheets in an ".xls" file format, or such other format as may be determined by Insurance Company in its sole discretion.

a. Insurance Company's Duties and Responsibilities:
    i. The Insurance Company will work with the Group to facilitate secure transmittal of Member enrollment and eligibility data.
    ii. The Insurance Company will assist the Group in correcting errors, as identified through the editing process administered by the Insurance Company. The Insurance Company may need to contact the Group to resolve such issues.
    iii. Member enrollment and eligibility data will be uploaded into the Insurance Company's system within 10 calendar days of its receipt by the Insurance Company.
    iv. .Exception errors will be worked by the Insurance Company within 10 calendar days of upload of file transmission.
b. Group's Duties and Responsibilities:
    i. The Group will specify which persons have authority to transmit Member spreadsheet enrollment and eligibility data to the Insurance Company on behalf of the Group.
    ii. The Group must transmit Member spreadsheet enrollment and eligibility data through Insurance Company- approved medium. The parties shall agree on the medium the Group will use before the program starts.
    iii. The Group will submit its ETD data in one of the following formats:
        a) The Insurance's Company's standard Microsoft Excel "xls" spreadsheet format (supplied to the Group), or such other format as may be required by the Insurance Company in its sole discretion.
        b) Custom format, subject to prior approval by the Insurance Company.
    iv. The Group is responsible for assuring all Member spreadsheet enrollment and eligibility data is accurate/valid.
    v. The Group shall indemnify the Insurance Company to the extent permitted by applicable law in the state of AZ, including the AZ Governmental Tort Liability Act for damages or injuries to the Insurance Company caused by the Insurance Company's reliance on Member spreadsheet enrollment and eligibility data from the Group.

3. Notification of Termination of Coverage

The Group will notify the Insurance Company of the termination of a Member's Coverage not more than 15 days after the Member is no longer eligible for Coverage.

F. DISTRIBUTION OF MATERIALS

Group shall handle and distribute enrollment materials in a timely manner and promptly provide to Insurance Company the information necessary to administer this Policy. Group's failure to provide information in a timely manner may substantially delay and/or jeopardize the enrollment of eligible Members.

1. Group shall distribute notices to Members that Group and/or Insurance Company are legally required to provide (e.g., summary of benefits and coverage documents) in a timely manner and in accordance with all applicable laws. Group shall indemnify Insurance Company and hold Insurance Company harmless from any damages, loss, action, claim or suit (including court costs and attorney's fees) arising from or related to its failure to provide such notices.

2. If Insurance Company provides its enrollment and/or change forms ("Forms") and/or any summary Insurance Company descriptions, benefit summaries, summary of benefits and coverage, and/or comparison sheets ("Documents") in an electronic medium, and Group delivers Documents electronically to Members or includes Documents on the Group's internal intranet or by similar means or for similar purposes, Group agrees that:
   a) electronic access shall be limited to the Group's enrolling employees and covered employees and be restricted to a "read- only" or similar basis;
   b) they will replace any hard-copy Forms that have been modified by Insurance Company;
   c) the hard-copy documents on file with Insurance Company including the Policy (which includes the Application and the Certificate) shall control in the event of any discrepancy; and
   d) the Group remains solely responsible for the content of the documents and all other legal requirements pertaining to them (e.g., distribution).

3. Insurance Company shall create the Summary of Benefits and Coverage ("SBC") and provide to Group or its legal representative for Group, for distribution to Members within required timeframes. Group shall distribute SBC to Members in manner, method and timeframes required under applicable law. The information in the SBC and other Forms provided by Insurance Company is based only on those services provided by Insurance e Company. Group's distribution of the Forms, SBC, or other materials indicates that Group has reviewed and approved the content of such materials. In no circumstance will Members be charged for access to, or creation of the SBC.

G. PREMIUMS

1. Amount

The initial Premium Amounts payable for Coverage under this Policy are set out in the Application. To begin Coverage, the Group must pay the Total Estimated Premium Amount to the Insurance Company. The Total Estimated Premium Amount is an estimate of that amount of money necessary to fund the required Premiums to cover the total number of Members whom the Group estimates will enroll for Insurance Company Coverage under the Policy. Payment of the Total Estimated Premium Amount and execution of the Application is acceptance of this Policy. The Coverage will not begin until the Insurance Company receives the Total Estimated Premium Amount.
The Aggregate Premium is the Premium required for all Members. Aggregate Premiums are shown on all Premium Statements.

The Insurance Company may change the Premium amounts upon 60 days written notice to the Group at renewal based on various factors, including: (1) the Group's claim experience; and (2) the demographics of the Members Covered by the Insurance Company, including their age, geographic area, family composition, tobacco use, or number of Members. The Insurance Company may also change the Premiums on a quarterly basis, based on scheduled trend increases or additional rate changes allowed by the state regulatory authority. In the event of termination or addition of a subsidiary, operation or class of Subscribers Covered by the Insurance Company, the Insurance Company may change the Premium amounts as noted above

The Group may reject any revised Premium by terminating this Policy as of the date that the revised Premiums would become effective. To do so, the Group must provide written notice of termination not less than 30 days prior to the date that revised Premium would first become payable pursuant to this Policy.

2. **Premium Statement**
   The Insurance Company will prepare and submit a monthly Premium statement ("Statement") to the Group, listing: (1) Subscribers shown on its records; (2) type of Coverage selected by each Subscriber (e.g., individual, family, etc.); and (3) the Aggregate Premium payable to the Insurance Company for providing Coverage for all Members for the next billing period. The Insurance Company will prepare this statement not less than 15 days prior to the end of each billing period this Policy remains in effect.
   The Group must pay the Aggregate Premium for anyone Covered or added during the billing period.

3. **Subscribers Listed on Premium Statement and Terminations**
   a. A Subscriber and his or her Covered Dependents will not have Coverage if the Subscriber is not listed on the Premium statement. Any such Subscriber and his or her Covered Dependents may still have coverage if:
      i. The Insurance Company receives the Enrollment Form from the Group within 30-60 days after:
         1. the date the Enrollment Form was executed; or
         2. the end of the Open Enrollment Period during which the Member is eligible to enroll in Coverage
      ii. And if:
         1. the Group promptly submits the Enrollment Form to the Insurance Company; and
         2. the Group pays the applicable Premium to the Insurance Company from the date that error occurred upon discovery of that error and a request for such payment from the Insurance Company.

   b. The Group may terminate a Member's Coverage by submitting a termination request to the Insurance Company. The Group will not request retroactive termination of a Member's coverage for any time period during which the applicable premium was paid.

      The Insurance Company will retroactively terminate a Member's Coverage to the extent allowed by law, if:
      i. the Group notifies the Insurance Company of a Member's termination from Coverage within 90 days after the Member's termination. The Insurance Company will refund any remitted Premium.

ii. the Group does not notify the Insurance Company of a Member's termination from Coverage within 90 days after the date of Member's termination. The Insurance Company will only retroactively terminate the Member's Coverage for 90 days from the date of notice to the Insurance Company. The Insurance Company will not refund more than 3 months of Premium payments to the Group if it fails to notify the Insurance Company of the termination of the Member's Coverage in a timely manner.

c. If after notification, the Insurance Company fails to terminate that Member's Coverage; then, upon the Group's discovery of the Insurance Company's failure to delete the Member, the Insurance Company will:
   i. terminate the Member's Coverage retroactively; and
   ii. credit the Group for Premiums paid during such time period when Coverage was retroactively terminated.

4. Determining Premium

On approximately the fifteenth day of each month, the Insurance Company will determine the number of Members Covered under the Policy, and this will be the basis for the Premium charged by the Insurance Company for the following billing period. The Group will submit monthly a listing of Members for the Insurance Company to reconcile Members covered under the Group's Coverage. The following describes how the Insurance Company will bill for adding and terminating Members:

a. Additions

   If a Subscriber or Dependent becomes eligible under the Group's Coverage during the billing period, the Subscriber or Dependent is added on the first day of the next billing period following the date he or she becomes eligible for Coverage. Subscribers are not added during the billing period, unless they become eligible for Coverage due to a Qualifying Event.

b. Subscriber Terminations

   If a Subscriber's or Dependent's Coverage terminates during a billing period, and the Premium would be affected by this change, the Premium charged for that Subscriber's Coverage for the last billing period does not reduce.

c. Qualifying Event
If a Member has been added or terminated as a result of a Qualifying Event, the addition or termination will be handled according to the statutory requirement for the Qualifying Event. Premiums will be determined in accordance with the provision outlined in Section E.4.a and E.4.b above.

5. Payment of Premium

The Aggregate Premium is due in full at the Insurance Company's office on or before the first day of each billing period.
After payment of the Total Estimated Premium Amount, subsequent payments have a grace period of 31 days following the Premium due date (the "Grace Period").
The Aggregate Premium may be paid to the Insurance Company during that Grace Period without causing termination of the Policy. If the Aggregate Premium is paid after the Grace Period, the Insurance Company's acceptance or depositing of such funds shall not be construed to mean or equate to a guarantee of or acquiescence to reinstate the Policy, continue Coverage, or waive termination of of the Policy by the Insurance Company.
If the Group pays the premium electronically, the Group will transfer the amount specified in the statement into an account or the Insurance Company's designated account so that such funds will be available through the ACH (Automated Clearing House) by the first day of each billing period.
There will be a charge for any checks for payment of premiums that are returned to the Insurance Company for insufficient funds, closed accounts, or any other reason.

6. Failure to Pay Premiums

If the Aggregate Premium is not paid by the end of the Grace Period, the Insurance Company, in its sole discretion, may: (1) notify the Group of such non-payment and termination date of the Policy and all Coverage thereunder and terminate the Policy Coverage back to the last Premium due date; or (2) work with the Group to arrange payment of the Aggregate Premium, for a period of up to 90 days. If the Group fails to pay the Premium when required, the Insurance Company will be entitled to recover Insurance Company Expenses. Insurance Company Expenses include: (1) the total outstanding Aggregate Premium; (2) the finance charge set forth below; and (3) a fee for any checks for payment of Premiums that are returned to Insurance Company for insufficient funds, closed accounts, or any other reason; and (4) any expenses reasonably incurred in recovering the amount owed to the Insurance Company including attorney's fees.

If the Insurance Company terminates the Policy back to the last Premium due date, the Insurance Company may recoup benefit payments from Members and/or Providers.

The Group is still obligated to reimburse the Insurance Company for any claims or charges which the Insurance Company has to pay, as required by: (1) state or federal law; (2) pharmacy benefit management agreement; or (3) provider agreement, plus a reasonable administrative fee.

7. Termination for Non-Payment of Premium

If the payment received does not pay the Aggregate Premium, plus any other due charges in full, the Insurance Company has the discretionary authority to terminate the Policy, or place an administrative hold on the payment of Policy benefits. A payment of less than the full amount due will be deemed non-payment. If the Group has access to pharmacy benefits through the Insurance Company's pharmacy benefit manager, and its Members incur claims after the termination date of Coverage, the Group must reimburse the Insurance Company for the cost of these services.

8. Reinstatement

If this Policy is terminated and the Group requests reinstatement, the Group must remit: (1) the total outstanding Aggregate Premium; (2) the applicable finance charge or fee; and (3) the Aggregate Premium for the current billing period. The Group must do so within fifteen (15) calendar days following the termination date. The Policy may be reinstated by the Insurance Company as though it had remained continuously in effect. The Insurance Company reserves the right to decline to reinstate this Policy, however, upon refunding the Aggregate Premium for the current billing period to the Group.

9. Finance Charge

The Insurance Company may impose a finance charge of five percent (5%) per month. This applies to the amount of any Aggregate Premiums not remitted to the Insurance Company on or before the first day of any billing period after the expiration of the Grace Period. This applies through the duration of this Policy.

H. TERM

The initial term of this Policy is set forth in the Application. The Policy will automatically renew for an additional 12 month period unless terminated by the Group upon not less than 30 days advance written notice prior to the end of the Renewal Date. The Insurance Company shall give the Group not less than 60 days written notice of any: (1) change in the Premium for providing Coverage to Members; (2) material changes in the Covered Services; or (3) other material changes in the provisions of this Policy; that will become effective on a Renewal Date. Payment of the applicable Aggregate Premium on or after that date shall constitute acceptance of those changes by the Group, individually and on behalf of all Members.

I. TERMINATION POLICY

1. For Cause

a. If the Insurance Company does not receive payment of any Aggregate Premium, when due, the Insurance Company may terminate this Policy in accordance with section D of this Agreement.

b. The Insurance Company may terminate this Policy, upon not less than 30 days prior written notice, if the Group fails to comply with a material Insurance Company provision relating to the Group's contribution or group participation rules.

c. Upon written notice, the Insurance Company may terminate or rescind the Policy for fraud or intentional misrepresentation of a material fact concerning the coverage.

d. Upon written notice, the Insurance Company may terminate a Subscriber's or Member's Coverage under this Policy for fraud or intentional misrepresentation by the Group or the Member of a material fact concerning the Subscriber or Member. Termination of a Subscriber's Coverage automatically terminates Coverage for all of his or her Dependents.

2. For No Cause

The Group may terminate this Policy upon providing 30 days' notice in advance of the requested termination date.

3. **Effect upon Incurred Obligations**
   The termination of this Policy shall not relieve either party from any obligations incurred prior to the date of termination. The termination will not constitute an election of remedies by the terminating party. Any remedies available upon the termination of this Policy will be cumulative.

   If the Insurance Company terminates the Policy back to the last date through which the Group's Premium has been paid, the Insurance Company may recoup benefit payments from Members and/or Providers.

   The Group is still obligated to reimburse the Insurance Company for any claims or charges which the Insurance Company has to pay, as required by: (1) state or federal law; (2) pharmacy benefit management agreement; or (3) provider agreement, plus a reasonable administrative fee.
   If the Group has access to pharmacy benefits through the Insurance Company's pharmacy benefit manager, and its Members incur claims after the termination date of Coverage, the Group must reimburse the Insurance Company for the cost of these services.

4. **Post Termination Premium Balances**
   Within 120 days from the date the Insurance Company is notified of the Group's Coverage termination, the Insurance Company will conduct a final accounting. The final accounting will take into account all payments, funds transfers, etc., necessary to fulfill both parties' obligations under this Policy. If any outstanding payments, funds, transfers, etc. due to the Insurance Company or the Group total less than $25 when the Group's Coverage terminates: (1) the amount shall be forgiven; and (2) the parties agree that any financial obligation to the other party shall end.

5. **Post Termination Reports**
   Upon termination of this Policy, the Group must pay charges for the cost of producing any report in advance of receiving the requested report. Among other things, this applies to post- termination audits, requests from replacement insurers or administrators, and requests from the Group itself.

J. CONTINUATION OF COVERAGE AND CONVERSION

1. Continuation of Coverage

If a Member's Coverage terminates as the result of an event which permits that Member to elect to continue his or her Coverage in accordance with applicable Federal or State laws (a "Qualifying Event"), ("Continuation Coverage"), that Member will be entitled to remain Covered under this Policy. The Member must comply with the requirements of the laws and pay the applicable Premium for the Coverage. Federal and state laws determine how long the Group is required to continue to provide Coverage to that Member. The EOC describes the terms and conditions of such Continuation Coverage in greater detail.

NOTICE TO MEMBERS OF OPPORTUNITY TO ELECT CONTINUITY OF CARE ON POLICY TERMINATION. The Policyholder must provide written notice to members who are continuing care patients as defined in §2799A-3(b)(1) of the PHS Act, of the opportunity to elect continuity of care coverage when this Policy is terminated, either by the Policyholder or by the Insurance Company. The Policyholder will provide promptly to the Insurance Company proof of that mailing and the date thereof.

The Group will notify Members of their right to obtain Continuation Coverage following a Qualifying Event. The Group will collect and remit the Premium for the Coverage to the Insurance Company. If Members do not enroll and pay the Premium for Continuation Coverage, on or before the date their Continuation Coverage would become effective, the Insurance Company will terminate their Coverage. They may be reinstated if they subsequently enroll and pay the applicable Premiums within the enrollment period for Continuation Coverage specified by law. If the Group fails to notify a Member of his or her right to enroll for Continuation Coverage in accordance with applicable laws, the Insurance Company will not extend the enrollment period beyond that required by law had the Group informed the Member of that right in a timely manner. The Insurance Company may consent, in writing, to extend the enrollment period for Continuation Coverage for that Member.

2. Conversion Coverage

If Members are eligible to purchase individual conversion coverage from the Insurance Company upon the termination of his or her Coverage under this Agreement, the Insurance Company will offer those individuals the right to purchase the conversion coverage as outlined in the Certificate.

K. RELATIONSHIPS WITH OTHER PARTIES

1. Between Network Providers and the Insurance Company

The Insurance Company may enter into agreements with health care providers, insurers, and any other individuals or entities, as it deems necessary to fulfill its obligations under this Agreement. Such parties are independent contractors. Network Providers are independent contractors who are solely responsible for any services rendered to their Member patients. The Insurance Company makes no express or implied warranties or representations concerning the continued participation of any Network Provider. The Group acknowledges for itself and on behalf of Members that the Insurance Company has established various arrangements to encourage Network Providers to render Covered Services in an appropriate and cost effective manner. Such arrangements include provider penalties.

2. Between the Group and the Insurance Company

The relationship between the Insurance Company and the Group is a contractual relationship between independent contractors. Neither party is a partner, joint venturer, agent or employee of the other when performing its obligations pursuant to this Agreement.

Nothing in this Agreement shall be construed to make the Insurance Company a sponsor, administrator or fiduciary of the Group's Employee benefit under ERISA. The Insurance Company is not and shall not be deemed to be a fiduciary of the Group's plan, except as necessary to exercise the discretionary authority granted to it by the Group in making authorization, eligibility and coverage determinations and construe the terms of Members' Coverage pursuant to this Policy.

L. GROUP ADMINISTRATION ASSIGNMENT TO BROKER OR OTHER THIRD PARTY AND HOLD HARMLESS ARRANGEMENT

If the Group has assigned some or all of those functions, as indicated below, to a third party and if the Group has appointed such third party to act on its behalf for those functions, the Group understands and agrees that the third party is the contractor and/or agent of the Group and not the Insurance Company. This Group is responsible and shall hold the Insurance Company harmless as a result of any actions resulting from such delegation and appointment. The Group affirms that it has properly executed a Business Associate Agreement (as defined in 45 CFR Part 160) with such third party.

1. **Third Party to Provide Enrollment Information**
   If the Group has contracted with a third party to provide enrollment information to the Insurance Company on the Group's Members, the third party shall submit such enrollment information to the Insurance Company in either paper or electronic form. The third party must submit the enrollment information using the Insurance Company's approved forms or electronic guidelines. In the event the Group and the third party submit duplicate or conflicting information, the Insurance Company will rely on the latest information provided.

   If the third party submits such enrollment information to the Insurance Company in electronic format (including but not limited to on-line enrollment via the web or other electronic media), then the Insurance Company may provide a password for use by the third party in accessing the electronic system to provide enrollment information. If granted, this password is for the exclusive use of the third party and will expire, at the latest, when the Group's relationship with the third party expires. A separate and distinct password will be supplied to the Group. All access and activity to the electronic system will be monitored by the Insurance Company. Such access may be limited or confined to certain information according to the agreement between the Group and the third party. The Insurance Company reserves the right to block access to information contained in the electronic system.

   The Group authorizes the Insurance Company to accept such enrollment information. The Group shall be responsible for the validity and accuracy of the information provided to the Insurance Company and shall indemnify and hold the Insurance Company harmless from any and all liability, loss, damages, claims and expenses, including attorney's fees, as a result of the actions or inactions of the third party, including without limitation, any incorrect information provided.

2. **Third Party to Receive Premium Statement and/or Make Premium Remittance**
   If the Group has contracted with a third party to receive the Premium Statement and/or make premium remittances to the Insurance Company, the Group understands that this does not relieve the Group from remittance of the amount due by the due date. The Group will be held responsible for the premium remittance. The Group will be responsible for any late fees or finance charges imposed for late payment. Any payment delinquency notices or coverage termination notices for non- payment of premium will be sent to the third party for notice and delivery to Group Members.

The Group authorizes the Insurance Company to send such Premium Statements to and receive and accept such premium remittances from the third party. The Group shall be responsible for the validity and accuracy of the information provided to the Insurance Company and shall indemnify and hold the Insurance Company harmless from any and all liability, loss, damages, claims and expenses, including attorney's fees, as a result of the actions or inactions of the third party, including without limitation, any incorrect information provided.

If the Group assigns other functions to the third party, this Agreement shall control the performance of those functions.

The Insurance Company is not a party to the agreement between the Group and the third party. The Insurance Company may refuse to accept information from the third party.

The Insurance Company shall make reasonable accommodation to assist the Group in the administration of its assigned duties and responsibilities.
With regard to Electronic Protected Health Information (as defined in 45 CFR Parts 160 and 162 ("Security Standards")), the Group shall:

a. implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Group creates, receives, maintains or transmits as required by the Security Standards;
b. ensure that any agent, including third party or any subcontractor to whom the Group provides such information agrees to implement reasonable and appropriate safeguards to protect it;
c. report to the Insurance Company any Security Incident (as defined in the Security Standards) involving the Group's data of which the Group becomes aware within seven (7) days of the Security Incident.

3. This section will take effect on the effective date of the Agreement and will end on the earlier of:
    a. The date the Group's Insurance Company terminates.
    b. The date the Group notifies the Insurance Company in writing 31 days of the termination of such agreement that is has terminated the relationship with the third party.
    c. The information provided is consistently unusable by the Insurance Company in the administration of the Group's Insurance Company.
    d. The information provided is not in the format required by the Insurance Company.
    e. The inability of the third party to perform obligation(s) of the agreement between it and the Group.
    f. Any password provided to the third party will be blocked when this arrangement terminates. Any notice required to be sent to either the Insurance Company or the Group may be sent to the address of that party as shown in this Agreement or it attachments.

M. DISPUTE RESOLUTION

The Group may agree that any dispute related to this Policy must be submitted to non-binding arbitration. Unless the parties otherwise agree, such arbitration shall be conducted in accordance with applicable rules of the American Arbitration Association ("AAA") and the AZ Uniform Arbitration Act.

The arbitrator shall be required to issue a reasoned opinion explaining the basis of the decision and the manner of calculating any award. The arbitrator may not award punitive or exemplary damages and must base the decision on the terms of this Agreement and applicable law. Once the parties agree to accept the arbitrator's decision, it may be entered and enforced in any state or federal court. Once it has been agreed to by the parties, that decision may only be vacated, modified or corrected for the reasons set forth in the AZ Uniform Arbitration Act, if the award contains material errors of law or is arbitrary and capricious.
Upon completion of arbitration, the parties may pursue other available legal remedies.

N. INSURANCE COMPANY'S RIGHT TO AUDIT

The Insurance Company has the right to randomly audit for compliance with participation and eligibility requirements. This audit will take place no more than twice a year.

The Insurance Company has the right to randomly audit if intentional misrepresentation of material fact or fraud is suspected.

The Group shall have the right to review the Insurance Company's audit for participation and eligibility requirements to verify that it has conducted the audit according to the Insurance Company's guidelines.

O. MISCELLANEOUS

1. Information Request from Insurance Company

Group shall promptly provide Insurance Company with any and all information requested by Insurance Company for the purposes of Insurance Company's compliance with any state or federal law or regulation, including, but not limited to Group's Premium Contribution Rate and amount.

GROUP MUST IMMEDIATELY NOTIFY INSURANCE COMPANY OF ANY AND ALL CHANGES IN GROUP'S PREMIUM CONTRIBUTION RATE AND CONFIRM THE CONTRIBUTION RATE AT RENEWAL.

2. Premium Rebates

If Insurance Company is required by law to provide a premium rebate to Group's Members and former Subscribers, Insurance Company, in its sole discretion, will as allowed by law:

a. Group will provide Insurance Company with any information that is necessary for Insurance Company to pay the rebates to Members in accordance with applicable law, including, but not limited to information relating to premium contribution amounts and contact information.
b. If Group fails to provide Insurance Company with premium contribution information that is necessary to calculate a rebate to Members on a pro rata basis based on the percentage of premium paid, Insurance Company will distribute 100% of the rebate for Group's coverage to Members, without regard to the pro-rata share of the premium contribution made by Group and Group waives any claim it has to a share of the rebate.

3. Entire Agreement

This Policy, including the Application, Certificate, any Riders, and any Amendments, Attachments or Exhibits, constitute the entire agreement between the parties. It supersedes all prior oral or written understanding or agreements between the parties.

4. Effective Date of This Policy

This Policy will be effective as of the date indicated after the Insurance Company accepts the Application and accepts the Total Estimated Premium Amount. The Group's execution of the Application and payment of the Total Estimated Premium Amount will be its acceptance of this Policy. The Application is the signature page of this Policy.

5. **Renewals**
   The parties may agree to extend the term of this Policy. The Group will indicate its acceptance of any change in terms of the Agreement by the payment of the next due Aggregate Premium.

6. **Amendments**
   This Policy may be amended, in writing, by an authorized representative of both parties. The Insurance Company may also amend the Policy, upon notice to the Group, as necessary to comply with: (1) applicable laws; (2) regulations; or (3) lawful orders of governmental agencies. Only an officer of the Insurance Company has the authority to: (1) modify this Policy; (2) waive any of its provisions; or (3) extend the time for taking any action required by this Policy.

7. **Claim Adjudication**
   The Insurance Company adjudicates claims in accordance with its internal administrative guidelines. Any rebates or refunds on Member's Covered Services are credited against the Group's experience for rating purposes.

8. **Clerical Errors**
   Clerical errors will not change the rights or obligations of either party under this Policy. They also will not grant additional benefits to Members. The parties shall cooperate, in good faith, to promptly correct such errors.

9. **Waiver**
   The terms or conditions of this Policy may only be waived by express written consent of the party from whom such a waiver is requested. Any waiver of a breach of any provision shall not constitute a waiver of any subsequent breach of the same or any other provision of this Policy.

10. **Assignability**
    No rights or duties under this Policy are assignable by the Group to any other party unless the Insurance Company consents to such assignment in writing.

11. **Notices**
    Any notice required or permitted under this Policy shall be in writing. Such notice will be deemed to have been given on the date when delivered to the other party's most recent address: (1) in person; or (2) by certified or overnight mail, return receipt requested. Notice from the Insurance Company to the Group will be deemed to be notice to all Members.

12. Third Parties

This Policy does not confer any rights or obligations on third parties except as specifically provided herein.

13. Construction

This Policy will be construed without regard to the party that drafted it. Any ambiguity will not be interpreted against either party but will, instead, be resolved in accordance with other applicable rules concerning the interpretation of contracts.

14. Governing Law and Severability

This Policy is executed and is to be performed in accordance with applicable federal and AZ laws. If any provision of this Policy is deemed to be invalid or illegal by a court or regulatory agency having jurisdiction over such matters, the surviving provisions of this Policy shall remain in effect unless the severance of that provision shall deprive a party of the material benefits of this Policy

15. Legal Action

No action at law or in equity shall be brought to recover on this Policy until 60 days after written proof of loss has been furnished as required by this Policy. No such action shall be brought beyond 3 years after the time written proof of loss is required to be furnished.

16. Confidentiality

The parties acknowledge that this Policy and information provided to the other party that is identified as confidential information, including, but not limited to, reimbursement information, group membership lists, marketing information and information obtained from and/or about the Insurance Company ("Confidential Information"); shall be treated as confidential, proprietary or trade secret information. A party may release Confidential Information to providers or its affiliates, or their respective directors, partners, officers, employees, advisors and other representatives ("Representatives") who: have a need to know such Confidential Information, for purposes of their participation in or oversight of matters within the scope of this Policy; and are under a duty or obligation of confidentiality at least as restrictive as those set forth in this Policy. Each party shall advise its Representatives of their obligation to maintain the confidentiality of such information. Each party is responsible if its Representative breaches this Section. Neither party shall otherwise release nor disclose such Confidential Information to third parties without the other party's prior written consent, except as required by law. This paragraph shall survive the termination of this Policy.

Notwithstanding anything herein to the contrary, the following shall not constitute Confidential Information for the purposes of this Policy:

a. Confidential Information that is or becomes generally available to the public other than as a result of a disclosure by a party or its Representatives;
b. Confidential Information that was available to the parties on a non-confidential basis prior to its disclosure by a party or its Representatives; or
c. Confidential Information that becomes available to the parties on a non- confidential basis from a third party, provided that third party is not known to be subject to any prohibition against transmitting that information.

17. Other Acceptable Forms of this Document and its Attachments

The following shall have the same legal effect as an original: facsimile copy, imaged copy, scanned copy, and/or an electronic version, including a digital or electronic signature.

18. Additional Programs

The Insurance Company may, from time to time, offer or arrange for various entities to offer discounts, benefits or other consideration to Employees for the purpose of promoting their general health and well-being. Contact the Insurance Company for details of these programs.