Plan Services Agreement Effective Date:_____

New Application ☐ Renewal ☐ Changes/Additional Services ☐ BOR

MGU/SL Carrier: _____

Section 1: Group Information

Legal Name of Company:		
Trading as:		
Physical Address:		
City:	State:	ZIP:
Mailing Address (if different than above):		
City:	State:	ZIP:
Billing Address (if different than above):		
City:	State:	ZIP:
Do you have multiple divisions? ☐YES ☐NO If yes, please list full address in special notes section		

Type of Business: ☐ Corporation ☐Partnership ☐ C-Corp ☐ S-Corp ☐ Sole Proprietorship ☐ LLC ☐Other _____	SIC Code:	Tax ID:

Section 2: Contacts

Company Executive:	Phone:	Email:

Authorized: ☐ **Monthly Invoice Alert** ☐**Access Employer Account Information** ☐ ***Employee Online Transactions**

HR/Administrative Contact:	Phone:	Email:

Authorized: ☐ **Monthly Invoice Alert** ☐**Access Employer Account Information** ☐ ***Employee Online Transactions**

Additional Contact:	Phone:	Email:

Authorized: ☐ **Monthly Invoice Alert** ☐**Access Employer Account Information** ☐ ***Employee Online Transactions**

***If you select Employee Online Transactions, please complete the Client Portal Agreement**

Section 3: Invoicing

The Client shall pay GBS monthly, as billed, out of its General Assets, as indicated in the annual Employer Stop Loss Application (or Employer Stop Loss Supplemental Application) and any additional Schedule attached thereto. Payments are to be sent to the address indicated on the invoice.

All payments are due on the last day of the month prior to the month for which coverage and service are to be effective. Any contributions for funding, stop-loss premium, or administration fees received after the last day of the month for which coverage and services are to be effective will be considered late and GBS reserves the right to hold all claims payment and authorizations for care until such payments are received. If the payment is received past the last day of the coverage month, the group will be subject to cancellation.

If coverage is cancelled due to non-payment and the group wishes to reinstate their coverage, they will be subject to a $500 reinstatement fee.

☐ Online Bill Delivery (Fee Waived) *Or* ☐ Paper Billing ($15 monthly fee)

☐ Mail in One Check *Or* ☐ Electronic Payment (see GBS E-Payment Sheet)

Section 4: Benefits Eligibility

# Full-Time Employees	# Part-Time Employees	# Employees Waiving	# Employees Enrolling

Waiting Period for NEW employees: ☐ Same waiting period for all coverages ☐ WAIVE Waiting period for employees in their probationary period

MEDICAL Waiting Period (may not exceed 90 days): ☐ First of the month following 30 days ☐ First of the month following 60 days	
DENTAL Waiting Period: First of the month following _____ days VISION Waiting Period: First of the month following _____ days LIFE/AD&D Waiting Period: First of the month following _____ days	STD Waiting Period: First of the month following _____ days LTD Waiting Period: First of the month following _____ days

Do you offer coverage to:

Domestic Partners – Same Sex ☐YES ☐NO Domestic Partners – Opposite Sex ☐YES ☐ NO

Section 5: Carrier History

Current Medical Carrier: *If this plan is replacing current group coverage, please provide the most recent copy of your invoice	Policy Renewal Date:
Is your current medical coverage: ☐Fully-Insured ☐Self-Funded ☐ N/A	Prior Insurance Carrier or Third Party Administrator (TPA):

Section 6: Workers Compensation, COBRA & Payroll

Workers Compensation Carrier:	Policy #:
Are any persons to be covered NOT also covered by worker's compensation? If YES, please attach a list of the names and reasons for each	☐YES ☐NO
Are you subject to COBRA? See https://www.dol.gov/general/topic/health-plans/cobra for more information	☐YES ☐NO
Current Payroll Vendor:	

Section 7: ID Cards

Each employee (primary insured) will receive 2 ID Cards at implementation with his/her name written on both cards. If additional cards are needed for dependents that do not live with the primary insured, please specify in the special notes below.
Do you wish to have employee ID Cards sent to: ☐Group Address ☐ Employee Homes

Section 8: Special Notes

Section 9: Medical and Prescription Plan Selection

☐ Plan Year Deductible	☐ Calendar Year Deductible		
HealthyAdvantage Medical Plan Options: Choose up to 3 options or HealthySolutions alone			
☐ PPO 250/100	☐ PPO 500/80	☐ PPO 1000/70	☐ PPO 1500/50
☐ PPO 2000/100	☐ PPO 2500/80	☐ PPO 3000/50	☐ PPO 3000/80
☐ PPO 3500/80	☐ PPO 4000/80	☐ PPO 5000/100	☐ PPO 7000/100
☐ QHDHP 1500/100	☐ QHDHP 2700/100	☐ QHDHP 2700/80	☐ QHDHP 3500/100
☐ QHDHP 4000/70	☐ QHDHP 5000/100	☐ HealthySolutions PPO 3000/100	
☐ MEC	☐ MEC + Value (Grandfathered Plans Only)		
Prescription Options:	☐ Rx 0: $0 Deductible (for PPO Options)	☐ Rx Integrated: Integrated Deductible (for QHDHP Options)	

Section 9a. Medical Payroll Deductions

Enter the plan name and the employee payroll deduction below for each pay period per plan and family status

Number of Pay Periods per Year:

Medical Plan 1:		Medical Plan 2:		Medical Plan 3:	
Employee	$	Employee	$	Employee	$
Employee/Spouse	$	Employee/Spouse	$	Employee/Spouse	$
Employee/Child(ren)	$	Employee/Child(ren)	$	Employee/Child(ren)	$
Family	$	Family	$	Family	$

Section 10: Ancillary Plan Selection

10a. DENTAL

Self-Funded Dental PPO Options

☐ PPO 25/1500 ☐ Orthodontia ☐ No Orthodontia	☐ PPO 25/2000 ☐ Orthodontia ☐ No Orthodontia	☐ PPO 50/1000 ☐ Orthodontia ☐ No Orthodontia

Dental coverage is not covered by stop-loss or included in aggregate claims funds. Internal plan limits on dental help to keep employer exposure at appropriate levels. Dental claims, a small administration, and PPO fee are funded by the employer. Must have 50+ enrolled to offer Self-Funded dental on a stand-alone basis.

MetLife Dental PPO Options

☐ Opt 1: $50 Deductible/$1000 Max W/Ortho/80% Out of Network	☐ Opt 2: $50 Deductible/$1000 Max No Ortho
☐ Opt 3: $50 Deductible/$1000 Max W/Ortho	☐ Opt 4: $50 Deductible/$1500 Max No Ortho
☐ Opt 5: $50 Deductible/$1500 Max W/Ortho	

10b. DENTAL PAYROLL DEDUCTIONS ☐ Employer Paid ☐ Voluntary

Dental Plan Name:

Employee:	$	Employee/Child(ren)	$
Employee/Spouse	$	Family	$

10c. VISION

METLIFE VISION PLAN OPTIONS (Exams/Lenses/Frames/Contact Lenses Frequency)

☐ $10 Exam 12/12/24/12 $130 Frame	☐ $10 Exam 12/12/12/12 $130 Frame	☐ $10 Exam 12/12/24/12 $150 Frame

10d. VISION PAYROLL DEDUCTIONS ☐ Employer Paid ☐ Voluntary

Vision Plan Name:

Employee:	$	Employee/Child(ren)	$
Employee/Spouse	$	Family	$

10e. METLIFE GROUP TERM LIFE (100% Employer Paid)

☐ $25,000 Flat Amount	☐ $50,000 Flat Amount	☐ 1 X Salary - $100,000 MAX

10f. METLIFE EMPLOYEE SUPPLEMENTAL GROUP TERM LIFE

☐ $100,000 MAX GI	☐ $50,000 MAX GI

10g. METLIFE DEPENDENT SUPPLEMENTAL GROUP TERM LIFE (50% of Employee)

☐ $50,000 MAX SPOUSE	☐ $25,000 MAX SPOUSE	☐ $10,000 CHILD

10h. METLIFE SHORT TERM DISABILITY (100% Employer Paid)	
☐ $1,000 Max Weekly Benefit/14 Day Waiting Period	☐ $1,000 Max Weekly Benefit/ 7 Day Waiting Period

10i. METLIFE LONG TERM DISABILITY (100% Employer Paid)	
☐ $5,000 Monthly Max Benefit/RBD/SSNRA Benefit Period	☐ $5,000 Monthly Max Benefit/Lesser of RBD/5 Years Benefit Period
☐ $6,000 Monthly Max Benefit/RBD/SSNRA Benefit Period	

10j. METLIFE VOLUNTARY SHORT TERM DISABILITY	☐ Employer Contribution	☐ Employee Paid
☐ $1,000 Max Weekly Benefit/14 Day Waiting Period	☐ $1,000 Max Weekly Benefit/ 7 Day Waiting Period	

10k. METLIFE VOLUNTARY LONG TERM DISABILITY	☐ Employer Contribution	☐ Employee Paid
☐ $5,000 Monthly Max Benefit/RBD/SSNRA Benefit Period	☐ $5,000 Monthly Max Benefit/Lesser of RBD/5 Years Benefit Period	

If a different Ancillary carrier is utilized, please indicate the carrier, benefit and payroll deduction below:

DENTAL PAYROLL DEDUCTIONS	☐ Employer Paid	☐ Voluntary	
Dental Plan Name:			
Employee:	$	Employee/Child(ren)	$
Employee/Spouse	$	Family	$

VISION PAYROLL DEDUCTIONS	☐ Employer Paid	☐ Voluntary	
Dental Plan Name:			
Employee:	$	Employee/Child(ren)	$
Employee/Spouse	$	Family	$

☐ GROUP TERM LIFE (100% Employer Paid)	
Carrier Name:	Plan Name:

☐ EMPLOYEE SUPPLEMENTAL GROUP TERM LIFE	
Carrier Name:	Plan Name:

☐ DEPENDENT SUPPLEMENTAL GROUP TERM LIFE (50% of Employee)	
Carrier Name:	Plan Name:

☐ SHORT TERM DISABILITY (100% Employer Paid)	
Carrier Name:	Plan Name:

☐ LONG TERM DISABILITY (100% Employer Paid)	
Carrier Name:	Plan Name:

☐ VOLUNTARY SHORT TERM DISABILITY	☐ Employer Contribution	☐ Employee Paid
Carrier Name:	Plan Name:	

☐ VOLUNTARY LONG TERM DISABILITY	☐ Employer Contribution	☐ Employee Paid
Carrier Name:	Plan Name:	

Section 11: Confidential Information

The PLAN is established and operating under the federal mandate of the Employee Retirement Income Security Act (ERISA) of 1974, as amended. The Plan provides benefits to the plan participants. Group Benefit Services, Inc. (GBS) has been contracted by the Plan Sponsor to perform certain administrative services for the PLAN, including but not limited to the processing of benefit claims.

The Plan Sponsor and GBS have agreed to the following:

PLAN ADMINISTRATOR
Group Benefit Services, Inc.

1. Agrees to provide the following services:
    a. Administer the Plan in accordance with its terms and establish its policies, interpretations, practices and procedures.
    b. Update employee enrollment information.
    c. Print and distribute to the Plan Sponsor ID cards for new or existing Plan Participants.
    d. Perform or contract for the performance of managed care services.
    e. Adjudication services including coordination of benefits.
    f. Investigate third party liability matters and, at GBS's discretion, pursue recovery through subrogation/reimbursement or litigation as necessary.
    g. Issue standard reports periodically or when reasonably requested.
    h. Update the Summary Plan Description as necessary to conform with applicable laws and regulations.
2. Is responsible for:
    a. Processing of Plan benefit claims according to the terms and provisions of the SPD, using its established claim adjudication procedures.
3. Shall maintain:
    a. A fidelity bond for its employees who may collect, handle or disburse Plan Funds, as required by ERISA.
4. Shall provide access to:
    a. A network of designated preferred providers, some or all of which shall provide health services under the Plan to the Plan Participants. GBS makes no representations or promises regarding continued availability of any particular provider or network nor does GBS make any warranties or representations as to compensation arrangements between these networks and designated providers. GBS may in its sole discretion make deletions from or additions to the list of designated provider networks.
5. Is authorized to:
    a. Do all things necessary or convenient to carry out the terms and purposes of the Plan and this Plan Service Agreement.
6. Shall:
    a. Have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan.
    b. Make determinations regarding eligibility for benefits, decide disputes relative to a Plan Participants rights, and decide questions of Plan interpretations and those of fact relating to the Plan.
    c. Have authority to remedy ambiguities, inconsistencies or omissions.
    d. Delegate to any person or entity such powers, duties and responsibilities it deems appropriate.
7. Shall Administer COBRA by:
    a. Furnishing required notices once GBS is notified by the Employer of a possible Qualifying Event.
    b. Assist the Employer with qualification of certain events.
    c. Assist the Employer with determinations of COBRA liabilities.
    d. Provide any further COBRA compliance support as appropriate.
8. Shall furnish to the Employer:
    a. SPDs for distribution to Plan Participants.
    b. Summaries of Material Modification including Plan changes or material reductions in benefits, if applicable.
    c. Notifications of Termination of Coverage.
    d. Notifications of inadequate funding to Plan Participants.
9. When HealthySolutions is selected:
    a. Establish access to the HealthySolutions web portal for wellness program facilitation, coaching & tracking.
    b. Engage & manage wellness vendors for plan fulfillment as above.
    c. Process wellness incentive payments as required.
    d. Debit Claims account as appropriate for biometric screening and incentive benefit payments.

PLAN SPONSOR

1. Agrees that upon acceptance of this agreement by GBS, the employee benefit plans proposed by GBS and selected by the Plan Sponsor (Employer) under the Plan Selections sections of this agreement shall be adopted by the Employer and will be the basis for the administration of the Employer's employee benefit plan for the 12 month period beginning on the implementation or renewal date of this contract.
2. Shall promptly provide GBS necessary information including, but not limited to:
    a. Completed enrollment forms.
    b. Changes in participation.
    c. Other information and/or documents requested by GBS and needed for normal Plan Administration as set forth by this Agreement.
3. Shall assist in and cooperate with:
    a. All applicable state and federal laws and regulations affecting the Plan and Plan Sponsor.

4. Is responsible for:
    a. Notifying GBS of COBRA Qualifying Events within 30 days of such Qualifying Event. GBS may rely on the notification without further qualification or certification as to the event being a Qualifying Event for COBRA purposes.
5. Is responsible for:
    a. Expenses under the Plan except for those assumed by GBS in this agreement.
6. Recognizes that:
    a. GBS is not an insurer underwriting the liability of the Plan Sponsor. Each year GBS offers, and the Plan Sponsor selects the insurer and determines the coverage, deductibles, co-payments, provider options including the retention and limits of coverage on behalf of the Sponsor.
7. Shall, upon receipt from GBS, furnish Plan Participants with:
    a. SPDs.
    b. Summaries of Material Modification including Plan changes or material reductions in benefits, if applicable.
    c. Other required notifications as furnished by and instructed from GBS.
8. Is responsible for:
    a. All filings under the IRS, DOL (including Form 5500), and any other state, federal or local filings, reports or returns as required.
9. When HealthySolutions is selected:
    a. Agrees that no additional benefit reimbursements will be made via employer contributions to health reimbursement arrangements, flexible spending accounts or otherwise. Breach of this provision shall subject the Plan to re-rating.
    b. Provide a scheduled meeting with employees to communicate plan methodology, plan provisions, and operations.

FUNDING AND COMPENSATION

The Plan Sponsor shall:

1. Provide:
    a. Funds for benefit payments by the first of each month as required by its funding agreement. GBS is under no obligation to pay any benefits when the Plan Sponsor has not provided adequate funds as required by the funding arrangement. As indicated by ERISA, the Plan Sponsor is financially responsible for all eligible claims incurred while the Plan is in effect. If funds are not provided as agreed in the funding arrangement and pursuant to this agreement, GBS will deny all unfunded claims in process and may be required to notify all Plan Participants of inadequate funds.
2. Compensate:
    a. GBS for fixed costs set forth in the monthly billing statement, which includes fees for services rendered and premium for the Plan Sponsor's excess loss insurance policy, by the first of each month.
3. Agree that:
    a. Monies provided for payment of claims may be used to pay for services rendered by GBS and for excess loss insurance; administrative costs will be paid first, and any monies owed to the excess loss carrier will be paid second.
    b. GBS shall retain any interest earned on sponsor funding and any rebates received from prescription drug programs.
4. Agree to:
    a. Investigate and correct any allegation of error in compensation paid, when notified and/or requested by GBS.
5. Be responsible:
    a. For any tax, fee, or claims against the Plan, Plan Sponsor, or GBS as assessed by federal, state or local governments during the operation of the Plan or following termination of the Plan. Any tax, fee, or claims against the Plan shall be the responsibility of the Plan Sponsor and charged against the Plan as such.
6. When HealthySolutions is selected:
    a. Agrees that a portion of their fixed costs will be utilized to provide wellness services.
    b. Agrees that a fee shall be deducted from the claims fund during the first month to provide payment for biometric screening and related health care services.

OTHER PROVISIONS

1. The following will be provided by GBS on a "fee-for-service" basis when applicable:
    a. Special (non-standard) reports as requested.
    b. Investigation of extraordinary claims.
    c. When HealthySolutions is selected, additional optional services as elected by the employer from time to time.
2. Plan Expense:
    a. GBS will not be required to reimburse the Plan or Plan Sponsor for any incorrect payments when such payments were made in good-faith or made in reliance upon information reasonably believed to be true, correct, and accurate.
    b. The Plan sponsor maintains all rights to seek recovery from or commence an action against any party receiving payments to which it was not entitled
    c. In the event of mid-year (early) termination, unused claims funds, if any, will be retained by the Plan Administrator to pay for on-going expenses.
3. Hold Harmless:
    a. The Plan Sponsor will hold harmless from any and all losses, costs, fines, penalties, judgments, or damages of any kind including attorney's fees in connection with GBS performing its responsibilities under this agreement.
    b. GBS will hold the Plan Sponsor harmless from all losses and damages incurred as a result of bad faith or intentional wrongful acts committed by GBS, or its employees while performing its responsibilities under this agreement.
4. Severability:

a. It is the intent of GBS, and the Plan Sponsor that the provisions of this Agreement be and are severable. If any provision of this Agreement is invalid by law, it will not affect any other provision of the Agreement.

5. New York and Massachusetts Surcharge:
    a. Any plan with a member who receives care in a NY facility (the surcharge is for facilities only) is subject to the surcharge regardless of whether the member lives or works in NY.

       The plan will be charged the tax whether or not they pay the GME amount (i.e., the PEPM based on members who reside in NY). The difference is the amount of the surcharge applied to the claim. For those plans that do not "elect", the surcharge rate is 33.63% (i.e., there is an additional 24% that is applied for plans that do not "elect to pay the GME").
    b. Massachusetts surcharge: there is no "election" but the plan will pay the surcharge for any member who receives care at a Massachusetts facility.

TERMINATION

This agreement may be terminated by the Plan Sponsor or GBS. To terminate this agreement, a written notice must be delivered to the other party not less than 30 days before the Effective Date of the termination. If such notice is not provided, the Plan Sponsor shall be liable for a late notification fee. GBS, subject however, to the following, shall have the right to cancel this agreement only at renewal.

1. GBS shall have the right to terminate this agreement with five days prior written notice if:
    a. The Plan Sponsor does not perform its obligations of Plan benefit payments; in no case shall this relieve a Plan Sponsor of its obligation to reimburse GBS for the payment of Plan benefits.
    b. The Plan Sponsor amends the Plan without prior written acknowledgement from GBS.
    c. The Plan Sponsor fails to pay any fees or charges due and payable under this Agreement, GBS shall have the right, and may be required, to notify Plan Participants of the termination of this Agreement for such non-payment.
2. GBS may terminate this Agreement immediately without Notice to the Plan Sponsor as of the date:
    a. The Plan Sponsor becomes insolvent, bankrupt, or subject to liquidation, receivership, or conservatorship.
    b. The excess of loss insurance carrier terminates its policy.
3. If GBS has terminated this Agreement for non-payment of fixed costs, the Plan Sponsor may apply for reinstatement according to GBS terms and at GBS's discretions and option.
4. Termination of this Agreement shall not affect the validity, provisions or terms of the Plan, the Plan shall continue to be effective until it is cancelled pursuant to its terms as indicated in the SPD.

In the event of early termination, the Plan Sponsor shall forfeit any unused claims funds remaining in their account. ***The aggregate excess loss policy benefits will cease as of the date of termination and any unpaid claims will be the responsibility of the Plan Sponsor.***

CLAIMS FUNDING AGREEMENT

Under the terms of my Plan Service Agreement with GBS, I have agreed to provide funds for benefits payments monthly or more frequently, as required and agree GBS is under no obligation to pay my benefits if I have not provided adequate funds pursuant to the funding arrangement. I understand that in accordance with ERISA and this agreement, I am financially responsible for all eligible claims incurred while my Plan is in effect.

FUNDING ARRANGEMENTS

PRE-FUNDING

I will remit my Maximum Monthly Medical Claims Liability, along with my monthly costs by the first of each month to GBS. My funding contribution will be held in a non-interest bearing account. GBS will process and pay claims according to their standard procedures. Upon notification that additional funding is required, as is typical for optional benefits or enrollment changes, I will remit the amount due which is to be received by GBS within five (5) days of notification.

DENTAL PRE-FUNDING

I will remit my Initial Dental Claims funding amount before inception of coverage. I will remit additional claims funding as needed and requested by GBS. I will remit my monthly costs for administration as billed by the first of each month to GBS. My funding contribution will be held in a non-interest bearing account. GBS will process and pay claims according to their standard procedures. Upon notification that additional funding is required, I will remit the amount due which is to be received by GBS within five (5) days of notification. In the event of a deficit in dental claims funding, dental benefits will be held until funding is received by GBS.

IMPORTANT NOTE

If you fail to remit funds as required after notifications by GBS, administration of your Plan will be terminated. The Employee Retirement Income Security Act (ERISA) of 1974, as amended places a Fiduciary Burden on the employer -as Plan Sponsor, to ensure the Plan is adequately funded. GBS may notify all Plan Participants if your claims account is determined to be in jeopardy, which would be a result of non-payment.

HIPAA BUSINESS ASSOCIATE AGREEMENT

WHEREAS, the PARTIES to this CONTRACT wish to enter into or have entered into an arrangement whereby BUSINESS ASSOCIATE provides certain services to COVERED ENTITY; and

WHEREAS, the PARTIES to this CONTRACT, in order to provide and receive such services, must share PROTECTED HEALTH INFORMATION, on a continuing basis; and

WHEREAS, such PROTECTED HEALTH INFORMATION shared between Parties, is afforded special protections related but not limited to use and disclosure; and

WHEREAS, such special protections are set forth, mandated, regulated, and enforced under and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA);

THEREFORE, as necessary to comply with HIPAA, BUSINESS ASSOCIATE and COVERED ENTITY agree that PROTECTED HEALTH INFORMATION (written, oral, or electronic) created, printed, received, stored, maintained, used, disclosed or otherwise shared by and between PARTIES is subject to the HIPAA BUSINESS ASSOCIATE AGREEMENT section of this Plan Service Agreement as follows:

1) Definitions. Unless otherwise defined, all terms contained in this CONTRACT shall have the same meanings as those similar terms set forth and defined by HIPAA. In the event of inconsistencies in definitions and terms, when permitted and not specifically excluded by HIPAA, this agreement shall be controlling.

    a. BREACH: "Breach" shall mean the acquisition, access, use or disclosure of protected health information which compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information in accordance with HITECH Act Subtitle D.
    b. BREACH NOTIFICATION RULE: "Breach Notification Rule" shall mean the Standards and Implementation Specifications for Notification of Breaches of Unsecured Protected Health Information under 45 CFR Parts 160 and 164, subparts A and D.
    c. BUSINESS ASSOCIATE: "Business Associate" shall mean Plan Administrator (GBS).
    d. CFR: "CFR" shall mean Code of Federal Regulations.
    e. CONTRACT: The HIPAA Business Associate Agreement section of this document.
    f. COVERED ENTITY: "Covered Entity" shall mean Plan Sponsor (Employer).
    g. DESIGNATED RECORD SET: "Designated Record Set" shall have the same meaning as the term 'designated record set" in 45 CFR § 164.501.
    h. DHHS: Secretary of the Department of Health and Human Services ("DHHS") or duly authorized representative thereof.
    i. ELECTRONIC HEALTH RECORD: "Electronic Health Record" shall mean an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff.
    j. ELECTRONIC PROTECTED HEALTH INFORMATION: "Electronic Protected Health Information" means Protected Health Information that is transmitted by Electronic Media (as defined in the Security and Privacy Rule) or maintained in Electronic Media.
    k. ENFORCEMENT RULE: "Enforcement Rule" shall mean the Enforcement Provisions set forth in 45 CFR Part 160.
    l. GENETIC INFORMATION: "Genetic Information" shall mean the Enforcement Provisions set forth in 45 CFR Part 160.
    m. HEALTH CARE OPERATIONS: "Health Care Operations" shall have the meaning given to such term under the Privacy Rule in accordance with 45 CFR § 164.501.
    n. HHS: "HHA" shall mean the Department of Health and Human Services.
    o. HIPAA RULES: "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.
    p. HITECH: The Health Information Technology for Economic and Clinical Health Act as contained within ARRA (American Recovery & Reinvestment Act). "HITECH" shall mean additional regulations providing strict penalties for violators of HIPAA's privacy and security provisions.
    q. INDIVIDUAL: "Individual" shall have the same meaning as the term individual in 45 CFR 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502 (g).
    r. INFORMATION/PROTECTED HEALTH INFORMATION: "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
    s. PARTIES: BUSINESS ASSOCIATE and COVERED ENTITY.
    t. PERSONAL HEALTH RECORD
    u. PRIVACY RULE: "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information as set forth in the Code of Federal Regulations; § 45 CFR 160, 164, subparts A and E.
    v. SECURITY RULE: "Security Rule" shall mean the requirements regarding security for the protection of electronic protected health information at 45 CFR Parts 160, 162 and 164.

2) Term. The term of this CONTRACT shall be from the date this Agreement is approved and signed by the Plan Administrator, the "EFFECTIVE DATE" until the date either party submits notice to the other of its intent to terminate this CONTRACT, at which time all of the INFORAMATION shall be returned to COVERED ENTITY, destroyed by BUSINESS ASSOCIATE, or maintained in an extended manner pursuant to and set forth by HIPAA.

3) Limits on Use and Disclosure of Information. BUSINESS ASSOCIATE agrees that it is prohibited from use and disclosure of INFORMATION for any purpose other than those expressly permitted by this CONTRACT. Limits on Use and Disclosure by BUSINESS ASSOCIATE are pursuant to the PRIVACY REGULATIONS in the same regard as required for the COVERED ENTITY. BUSINESS ASSOCIATE further agrees that it does not assume or acquire title or rights to the INFORMATION as a result of this CONTRACT, including but not limited to information that has been "de-identified" in accordance with the PRIVACY REGULATIONS.

4) Stated Purpose for Use or Disclose of Information. The PARTIES agree that BUSINESS ASSOCIATE may use and disclose INFORMATION for the following stated purposes:
   a. To carry out responsibilities and provide administrative services set forth in any agreements between of the PARTIES.
   b. To facilitate, provide, and carry out treatment, payment, or healthcare operations permitted by the PRIVACY REGULATIONS.

5) Use of Information for Management, Administration, and Legal Responsibilities. BUSINESS ASSOCIATE is permitted to use INFORMATION as permitted by the PRIVACY REGULATIONS for management and administration of BUSINESS ASSOCIATE or to carry out legal responsibilities of BUSINESS ASSOCIATE.

6) Disclosure of Information for Management, Administration, and Legal Responsibilities. BUSINESS ASSOCIATE is permitted to disclose INFORMATION as permitted by the PRIVACY REGULATIONS for management and administration of BUSINESS ASSOCIATE provided that:
   a. The disclosure is required by law; or
   b. The BUSINESS ASSOCIATE obtains reasonable assurances from the person to whom the INFORMATION is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, the person will use appropriate safeguards to prevent use or disclosure of the INFORMATION, and the person immediately notifies the BUSINESS ASSOCIATE of any instances of which it is aware in which the confidentiality of the INFORMATION has been breached.

7) Data Aggregation Services. BUSINESS ASSOCIATE may use or disclose INFORMATION to provide data aggregation services in any manner permitted by the PRIVACY REGULATIONS.

8) Limits on Use and Further Disclosure. BUSINESS ASSOCIATE agrees that INFORMATION shall not be further used or disclosed other than as permitted by the PRIVACY REGULATIONS and this CONTRACT.

9) Appropriate Safeguards. BUSINESS ASSOCIATE and COVERED ENTITY are both responsible for establishing, implementing, and maintaining appropriate safeguards to prevent any use or disclosure of INFORMATION other than permitted by the PRIVACY REGULATIONS and this CONTRACT.

10) Reports on Improper Use or Disclosure. BUSINESS ASSOCIATE agrees to report to COVERED ENTITY, and any other required entity under HITECH if there is a BREACH of protected health information whether a mistake or intentional, any knowledge, discovery, or identification of use or disclosure of INFORMATION not permitted by the PRIVACY REGULATIONS, HITECH, and this CONTRACT.

11) Subcontractors. BUSINESS ASSOCIATE agrees to enter into agreements with subcontractors and/or affiliates in all cases where INFORMATION is provided or made available to that subcontractor and/or affiliate. Agreements will be consistent with the same terms and limitations provided in this CONTRACT regarding use and disclosure of INFORMATION

12) Availability of Information. BUSINESS ASSOCIATE agrees to make available and provide a right to access, amend, and request an accounting of use and disclosure of INFORMATION to the INDIVIDUAL to whom it belongs. BUSINESS ASSOCIATE further agrees to make its internal books and records available to the DHHS for purposes of determining the COVERED ENTITY's compliance with the PRIVACY REGULATIONS.

13) Termination. BUSINESS ASSOCIATE agrees that COVERED ENTITY has the right to terminate this CONTRACT and seek relief if COVERED ENTITY determines that BUSINESS ASSOCIATE has breached or violated a material term of this CONTRACT or the PRIVACY REGULATIONS. Any failure on the part of the BUSINESS ASSOCIATE, to comply with the terms of this CONTRACT or the PRIVACY REGULATIONS, may be Grounds for Breach, in cases where the BUSINESS ASSOCIATE knows of, or reasonably should have known of failure to comply and failed to immediately take reasonable steps to cure the failure. At time of termination, BUSINESS ASSOCIATE agrees to return or destroy INFORMATION created, received from or received on behalf of the COVERED ENTITY. BUSINESS ASSOCIATE also agrees that if INFORMATION is destroyed, it will certify the destruction of that INFORMATION. BUSINESS ASSOCIATE further agrees not to retain any copies of INFORMATION it destroys or returns, and in cases where the INFORMATION cannot reasonably be returned or destroyed, BUSINESS ASSOCIATE agrees to continue to maintain the INFORMATION in accordance with the PRIVACY REGULATIONS.

14) Mitigation Procedures. BUSINESS ASSOCIATE agrees to appropriately mitigate any and all violations and breaches of use and disclosure in accordance with the PRIVACY REGULATIONS and this CONTRACT.

15) Sanction Procedures. BUSINESS ASSOCIATE agrees to develop, establish, implement and enforce policies and procedures containing sanctions for any employee, subcontractor, affiliate, or agent who violates the PRIVACY REGULATIONS and this CONTRACT.

16) Additional Provisions. This CONTRACT shall be governed by the laws of the State of Maryland. It is the intent of the BUSINESS ASSOCIATE and COVERED ENTITY to comply with all terms and provisions of this CONTRACT and the PRIVACY REGULATIONS. However, BUSINESS

ASSOCIATE shall be excused from performance of this CONTRACT for any period to which it is prevented from performing the services because of an Act of God, war, terrorist act, civil uprising or disturbance, court order, or any other reason beyond the control of the BUSINESS ASSOCIATE. In the event that the CONTRACT or the terms thereof fail to address or comply with the most recent requirements or recent changes to the HIPAA PRIVACY REGULATIONS, then the PRIVACY REGULATIONS shall apply and have binding effect on both PARTIES. If after such time BUSINESS ASSOCIATE or COVERED ENTITY become aware that the CONTRACT fails to address or comply with the PRIVACY REGULATIONS, both PARTIES will, within a reasonable time, in good faith, address and remedy the failure(s) to ensure immediate compliance. If after such reasonable time, BUSINESS ASSOCIATE and/or COVEDED ENTITY fail to comply, then either party has the right to terminate this CONTRACT upon written notice to the other party. Both PARTIES further recognize that Group Benefit Services, Inc. enjoys title to "Business Associate" under the PRIVACY REGULATIONS and is recognized as "Covered Entity" only for purposes of this contact.

☐ The COVERED ENTITY hereby understands that there will be times when GROUP BENEFIT SERVICES, INC. is requested to provide information to the COVERED ENTITY or to the PRODUCER in order to assist in making business decisions regarding plan designs associated with plan costs. Some of this information may be identifiable information regarding subscribers and dependents currently enrolled in the plan.

☐ The COVERED ENTITY agrees that GROUP BENEFIT SERVICES, INC. can provide such information to the PRODUCER directly if requested. However, if the COVERED ENTITY and/or PRODUCER fail to protect the sensitive information provided, then GROUP BENEFIT SERVICES, INC. will not be held liable for any complaint or claim filed by an individual based on breach of Protected Health Information (PHI).

☐ The COVERED ENTITY agrees that the PRODUCER has access to the COVERED ENTITY's claims and group information on the online system.

☐ If the box above and in front of this statement is not checked, GROUP BENEFIT SERVICES, INC. will not provide information other than the minimum necessary required under the PRIVACY REGULATIONS to the PRODUCER.

IN WITNESS WHEREOF, BUSINESS ASSOCIATE and COVERED ENTITY have agreed to the terms and conditions of the above written agreement having the effective date as of the same date that all parties agree to the entire Plan Service Agreement.

PLAN SPONSOR AGREEMENT

The producer has explained the details of the coverage(s) and I, the undersigned acknowledge reading the entire application, including the Claims Funding Agreement and Plan Services Agreement. The answers I have provided are true and complete. I understand that the terms and conditions herein bind the Applicant and GBS only when the Applicant receives written approval from GBS .

Dated On (Month, Day, Year): _____

Full Legal Business Name: _____

Signature: X _____

(Must be signed by a person authorized to purchase coverage for this firm.)

Print Name and Title: _____

A hard copy of the Summary Plan Description (SPD) is sent to the Employer enclosed in the Welcome Kit. It is the responsibility of an employer to provide a SPD Description to each employee. We make this SPD available to each employee on-line. However, you MUST communicate the availability of this site, and for employees not having web access, you must offer them on-line access and/or the option to receive a printed copy from you.

PRODUCER SIGNATURE

☐ I hereby represent that all of the information contained in the Employer Application is correct and I know of nothing unfavorable about this new firm or any individual proposed for benefits (except as noted on the Employer Applications) that has not already been disclosed.

☐ I have complied with the underwriting rules and regulations and have explained in detail the proposed benefits for the new member firm and its employees.

☐ I understand that I represent the interest of the Applicant for benefits and have advised my client not to terminate any existing benefits until receiving notice that the benefits being applied for by this application are accepted. I understand that I have no right to bind these benefits, to alter the terms of the employee benefit plan contract or application in any manner or to adjust any claim or benefits under the employee benefit plan contract.

☐ I understand that I am entitled to the below consulting fees as long as I am the appointed consultant of record for this client and as long as this client with this program.

GBS Paying:

☐ MGA only (MGA will pay Agency and/or Consultant)
☐ MGA, Agency & Consultant directly
☐ *MGA & Agency (MGA or Agency will pay Consultant)*

Indicate Entity being paid with corresponding Tax ID or Social Security Number

Producer (1) Name:		*Producer (2) Name:*	
Tax ID/Social Security #:		*Tax ID/Social Security #:*	
Street:		*Street:*	
City, State Zip:		*City, State Zip:*	
Telephone Number:		*Telephone Number:*	
Fax Number:		*Fax Number:*	
Email Address:		*Email Address:*	
Commission:	_____ *PEPM or* _____ %	*Commission:*	_____ *PEPM or* _____ %
Production Split:	_____ %	*Production Split:*	_____ %

I have notified the employer not to terminate present coverage until notified in writing by Group Benefit Services, Inc. of acceptance of this application.

Producer Signature 1	X _____	*Producer Signature 2*	X _____
Date:		*Date:*	
MGA:		*Agency:*	
MGA Tax ID #:		*Agency Tax ID:*	
MGA Address:		*Agency Address:*	
City, State ZIP		*City, State ZIP*	
MGA Commission:	_____ *PEPM or* _____ %	*Agency Commission:*	_____ *PEPM or* _____ %

GROUP BENEFIT SERVICES, INC.

Signature:	X _____	*Date:*	
Effective Date:		*Approved & Accepted by:*	
GBS Broker Rep:		*GBS Broker Select AM:*	
Comments:			