MASTER GROUP AGREEMENT

BETWEEN

EXCELLUS HEALTH PLAN, INC., DOING BUSINESS AS EXCELLUS BLUECROSS BLUESHIELD

(the "Plan")

AND

_____

("Group")

This is the record of a Master Group Agreement (the "Agreement") made effective **_____, 20__,** between the Plan, with offices located at 165 Court Street, Rochester, New York 14647 and Group, with offices located at **_____**. The Plan is a nonprofit independent licensee of the BlueCross BlueShield Association.

1. Purpose. This Agreement sets forth the terms and conditions on which the Plan will issue to Group certain health benefits certificates and/or riders for the benefit of Group's employees and/or members, and/or (if applicable) employees or members of Group's member firms or participants (collectively, as applicable, "Group Members").

2. Term of Agreement; Renewal. This Agreement and the coverage to be provided pursuant to it will be effective on the date set forth above, provided that the Group meets all underwriting criteria, and the first premium has been paid to the Plan by the effective date. The Agreement and coverage will continue for the period specified in the attached Premium Rate Schedule (the "Initial Term"), unless earlier terminated as provided below. The Agreement will automatically be renewed for successive one year renewal terms (each a "Renewal Term") on each subsequent anniversary of the effective date, unless earlier terminated as provided below.

3. Benefits.

   a. Certificate. The Plan will provide group health care benefits (the "Benefits") to Group Members and their eligible dependents in the classification(s) specified in the association, trust fund, or employer agreement between the Plan and Group. The Benefits that the Plan will provide under this Agreement, including limitations and exclusions, are described in the Group Certificate(s) and Riders(s), if any (collectively, the "Certificate") that are identified on the attached Premium Rate Schedule and made a part of this Agreement. If any provision of this Agreement conflicts with any provision of the Certificate, this Agreement controls.

   b. Certificate Deductibles. In the event that the Certificate provides for an individual annual deductible, neither Group nor (if applicable) Group's member firms or participants may directly or indirectly (including pursuant to a health reimbursement arrangement established under Section 105 of the Internal Revenue Code) reimburse persons covered under the Certificate for deductible amounts paid by such persons, or

pay deductible amounts on such persons' behalf, unless the Plan is notified, and the rates reflect the cost-sharing reimbursement. Notwithstanding the preceding sentence, Group or (if applicable) Group's member firms or participants may make contributions to a cafeteria plan established under Section 125 of the Internal Revenue Code to be used for payment of deductible amounts and other expenses eligible for reimbursement under the cafeteria plan, provided that Group's contributions are conditioned upon contributions also being made by the covered persons.

c. Changes in Certificate. The Plan will not make any unilateral change to the Benefits without giving Group written notice at least 44 days prior to the anniversary of the effective date as of which the change is to be effective, unless the Plan is required by applicable law to implement such change on shorter notice. Upon receipt of notice of a change in the Benefits, Group will be deemed to have accepted the change in the Benefits, unless Group provides written notice to the Plan, as set forth in the "Termination" section of this Agreement and in the Certificate, of its intention to terminate this Agreement.

4. Premiums. Group will pay premiums to the Plan to secure the Benefits for Group Members and their enrolled dependents.

a. Initial Premium Rates; Changes in Premium Rates. The initial premium rates are set out in the attached Premium Rate Schedule. Changes in premium rates will be made as set forth on the attached Schedule of Changes in Premium Rates.

b. Payment of Premiums. All premium payments are due in advance. Group must pay the first premium payment for the Benefits prior to the effective date of coverage. All subsequent premium payments must be paid on or before the due date; except that the Plan will allow Group a 30-day grace period after the due date for payment. Notwithstanding the preceding sentence, the grace period shall not apply if an authorization for payment (e.g., check or ACH authorization) has been returned or refused by Group's bank due to insufficient funds in the account on which the payment was drawn with respect to a billing period occurring (in whole or in part) during the 12 months preceding the failure to make timely payment. At the option of the Plan, the Plan may charge, and Group will pay, a late charge of up to 18% per year for late payment of any premiums paid after the end of the grace period. The Plan will provide written notice to Group of any applicable late payment charges that are due and owing to the Plan. If requested, the Plan will provide to Group a written explanation of its method of calculation of the applicable late charges assessed.

c. Effect of Nonpayment.

i. If Group fails to pay the first premium payment due for the Benefits prior to the effective date, no coverage will be provided.

ii. If Group fails to pay any subsequent premium payment by the end of the grace period, the Plan may terminate the Agreement as set forth in the provision of the

"Termination" section pertaining to default in the payment of premiums. In the event that the Plan terminates the Agreement for nonpayment of premiums:

- the Plan will notify Group of its intention to terminate the Agreement for nonpayment of premiums, as set forth in the Agreement;
- the Plan will include, with its notice of termination, a written notice to Group regarding Group's obligations under Section 217 of the New York Labor Law, as required by Section 4235 of the New York Insurance Law; and
- Group will be responsible for the payment of all premiums and applicable late payment charges owed to the Plan as of the date of termination, which will be the first day following the end of the period for which premiums were paid.

d. Cure of Default by Group. If, prior to the end of the grace period, Group pays all of the premiums and applicable late payment charges due and owing to the Plan, this Agreement will not be terminated by the Plan for nonpayment of premiums.;

5. Delivery of Notices and Materials. When notices or other materials (e.g., applications, identification cards, certificates, riders) are to be provided by the Plan to Group Members, the Plan may deliver them to Group, and Group will, in a timely manner, distribute them to the Group Members.

6. Termination.

a. By Group. This Agreement may be terminated by Group upon the provision of 30 days advance written notice to the Plan.

b. By the Plan. At the option of the Plan, this Agreement may be terminated by the Plan:

i. as of the date to which the premium has been paid, if the Plan does not receive premium payment from Group as of the end of the applicable grace period (if any);

ii. 30 days from the date on which the Plan provides notice to Group, if Group commits fraud or makes an intentional misrepresentation of material fact under the terms of this Agreement;

iii. 30 days from the date on which the Plan provides notice to Group, if Group no longer qualifies as a group. The Plan has certain administrative rules that describe the Plan's requirements for groups. The Plan's rules are consistent with New York State law and regulations governing the types of coverage issued by the Plan;

iv. 30 days from the date on which the Plan provides written notice to Group, if Group fails to comply with a material plan provision relating to employer contribution or group participation rules, as permitted under Section 4235 of the Insurance Law;

v. six months from the date on which the Plan provides notice to Group, if the Plan withdraws from the applicable market through which Group obtained coverage under this Agreement;

vi. upon notice to Group, if there cease to be any Group Members who live, reside or work in the Plan's Service Area; or

vii. for any reason approved by the Superintendent of Insurance and authorized by the Health Insurance Portability and Accountability Act of 1996, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act.

c. By the Superintendent. This Agreement will automatically terminate if the Superintendent of Insurance of the State of New York informs the Plan that it may not participate in this Agreement.

d. Termination of Specific Certificates and Riders. The Plan may terminate specific group certificates and riders forming part of the Certificate 90 days from the date on which the Plan provides notice to Group, if the Plan terminates the entire class of contract to which such certificates and riders belong.

7. Relationship of Parties. The parties to this Agreement are independent contractors and are not to be construed as having any other relationship, either with respect to this transaction or any other transaction between the parties. No party will have, or hold itself out as having, the power or authority to bind or create liability for the other by its intentional or negligent act or omission.

8. Notices. All notices and other communications given under this Agreement must be in writing and delivered personally, by established overnight courier or by first class mail, postage prepaid, to the addresses set forth at the beginning or to such other address as one party may provide to the other in writing. Notices and communications will be deemed received at the time of personal delivery (except that, if personal delivery occurs on a day other than a business day, the next business day will be deemed the date of receipt), one business day after shipping via overnight courier, and three business days after mailing.

9. Jurisdiction; Venue. Jurisdiction of any litigation with respect to this Agreement will be in New York, with venue in a court of competent jurisdiction in Monroe County.

10. Governing Law. This Agreement will be governed by, and construed in accordance with, the laws of the State of New York.

11. Required Disclosure. The Plan is required to notify Group of the following:

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and will also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

12. Entire Agreement. This Agreement, including attached schedules (as they may be replaced or added from time to time), together with the association, trust fund, or employer agreement entered into between the parties as of the date of this Agreement, constitute the entire agreement among the parties and supersedes any prior understandings or agreements with respect to the subject matter. No changes, additions or modifications to the terms of this Agreement will be made or binding, unless in writing and signed by both parties.

13. Prescription Drug Rebates. If the Benefits include coverage for prescription drugs, the following additional terms apply.

    a. Purpose.

        i. The Plan conducts various utilization management activities designed to ensure appropriate prescription drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, Group and Group Members benefit by obtaining appropriate prescription drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the premiums for coverage.

        ii. From time to time, the Plan enters into agreements with pharmacy benefit managers, manufacturers of prescription drugs, prescription drug distributors or other entities (collectively, "Vendor"), which result in the Plan receiving rebates for prescription drugs.

        iii. Rebates are based upon utilization of prescription drugs across all of the Plan's business and not solely on a covered person's or group's utilization of prescription drugs. Any rebates received by the Plan may or may not be applied, in whole or in part, to reduce premiums or administrative expenses. Rebates may be retained by the Plan at its discretion, in whole or in part, in order to fund such activities as negotiating and administering rebate arrangements, retail pharmacy audits, new utilization management activities, community benefit activities, and increasing reserves for the protection of covered persons.

        iv. The Plan wishes to set forth how Group will obtain the benefit of the prescription drug rebates.

b. Eligible Prescription Drug Claims. Only prescription drug claims that are fully-processed through the Plan's on-line, electronic system are eligible for a rebate. This means that the claim must be both submitted and remitted by and to the pharmacy provider. No paper claims, member-submitted claims, or claims paid directly to members are eligible for a rebate.

c. Rebate Return Schedule.

   i. On a regular basis and when new agreements are entered into, the Plan will review its rebate return schedule, which will include the amount of the rebate for each eligible prescription drug claim, depending upon whether the prescription drug benefit is managed or otherwise. The Plan will also determine what prescription drug coverage will be considered a managed care product.

   ii. The rebate return schedule will be available to Group upon request.

d. Re-negotiation or Cancellation of Rebate Returns. Rebate returns are subject to re-negotiation or cancellation in the event of occurrences beyond the Plan's reasonable control, including government action or regulation, or the failure or inability of Vendor to provide contracted rebates.

e. Calculation of Renewal Rates. During the calculation of the premium rates for the next Renewal Term, the estimated amount of the prescription drug rebates for the base period will be used to offset the estimated incurred charges for benefits for the base period. Rebates will not change or reduce the amount of any copayments, coinsurance or deductibles applicable under Group's prescription drug coverage.

14. Right to Audit. The Plan will have the right to conduct random audits of Group, to verify that Group is in compliance with the underwriting rules of the Plan, any rules imposed upon the Plan by external agencies/entities with authority over the Plan, and/or applicable law and regulation. Group will be required to provide the Plan with any and all documentation needed to facilitate the audit.

15. Out-of-Area Services. The Plan has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever Group Members and their enrolled dependents (collectively, "Members") access healthcare services outside of the Plan's Service Area, the claims for those services may be processed through one of these Inter-Plan Programs and presented to the Plan for payment according to the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Members under this Agreement are described generally below.

Typically, Members, when accessing care outside the Plan's Service Area, will obtain care from healthcare providers that have a contractual agreement (i.e., are "Participating Providers" or "In-Network Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from Non-Participating (or Out-of-Network) Providers. The Plan's payment practices in both instances are described below.

The Plan covers only limited healthcare services received by HMO Members outside the Plan's Service Area. As used in this Amendment, then, any reference to covered healthcare services received within the geographic area serviced by a Host Plan and processed through the BlueCard® Program as described below means, with respect to HMO Members, services to treat an Emergency Condition that are obtained outside the Plan's Service Area. Any other services obtained by HMO Members outside the Plan's Service Area will not be covered, even when processed through any Inter-Plan Programs arrangements.

a. **BlueCard® Program.** Under the BlueCard® Program, when Members access covered healthcare services within the geographic area served by a Host Blue, the Plan will remain responsible to Group for fulfilling the Plan's contractual obligations. However, in accordance with the applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its Participating/In-Network Providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, the Plan's action will be consistent with the spirit of this description.

   i. **Liability Calculation Method per Claim**. The calculation of the Member liability on claims for covered healthcare services processed through the BlueCard Program, if not a flat dollar Copayment, will be based on the lower of: the provider's billed covered charges for covered services; or the negotiated price made available to the Plan by the Host Blue.

      Host Blues may use various methods to determine a negotiated price, depending upon the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to the Plan by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:

      - an actual price. An actual price is a negotiated payment without any other increases or decreases; or

      - an estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and nonclaim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

      - an average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such

transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to the Plan is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

A small number of states require a Host Blue either: to use a basis for determining Member liability for covered healthcare services that does not reflect the entire savings realized, or expected to be realized, on a particular claim; or to add a surcharge. Should the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the Plan would then calculate Member liability in accordance with applicable law.

ii. **Return of Overpayments.** Under the BlueCard Program, recoveries from a Host Blue or its Participating/In-Network Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

Negotiated (non-BlueCard Program) National Account Arrangements.

b. **Calculation of Member Liability for Services of Non-Participating/Out-of-Network Providers outside the Plan's Service Area.** The Allowable Expense definition in the Member's Contract or Certificate, as amended from time-to-time, describes how the Plan's payment (the "Allowable Expense") for covered services of Non-Participating/Out-of-Network Providers outside the Plan's Service Area is calculated. For HMO Members, based upon that Allowable Expense definition, the HMO Member's liability for covered services is limited to the Copayment, if any, required by the Member's Contract or Certificate. For other (non-HMO) Members, the Allowable Expense may be based upon the amount provided to the Plan by the Host Blue or the payment the Plan would make to Non-Participating/Out-of-Network Providers inside the Plan's Service Area. Regardless of how the Allowable Expense is calculated, the Member will be liable for the amount, if any, by which the provider's actual charge exceeds the Allowable Expense, which amount is in addition

to any other cost sharing (Deductible, Copayment or Coinsurance) required by the Member's Contract or Certificate.

16. The Plan Is Independent. Excellus Health Plan, Inc., doing business as Excellus BlueCross BlueShield, is an independent corporation organized under the Insurance Law of New York State. Excellus BlueCross BlueShield also operates under licenses with the BlueCross BlueShield Association, an Association of independent Blue Cross and Blue Shield Plans, which licenses Excellus BlueCross BlueShield to use the Blue Cross and Blue Shield service marks in a portion of New York State. Excellus BlueCross BlueShield does not act as an agent of the BlueCross BlueShield Association. Excellus BlueCross BlueShield is solely responsible for the obligations created under this Agreement.

The parties' assent to the terms of this Agreement as of the date set forth at the beginning is established by their signatures below.

Dated: _____

Excellus Health Plan, Inc., d/b/a
Excellus BlueCross BlueShield

By: _____

Title: _____

Dated: _____

Group Name: _____

By: _____

Title: _____

SCHEDULE OF ATTACHMENTS TO AGREEMENT
AND OTHER REQUIRED DOCUMENTATION

I. Attached to Agreement by Plan

1. Premium Rate Schedule & Contract Summary;
2. Schedule of Changes in Premium Rates;
3. Medicare Part D Addendum, if applicable;
4. Agreement

II. Provided by Group

1. Completed group information form or enrollment questionnaire

2. Completed Addendum authorizing Broker and/or Administrator, if applicable.

PREMIUM RATE SCHEDULE

If the conditions in the Agreement are met, the Agreement has an effective date of _____, 20__ for the Initial Term expiring _____, 20__. The renewal date is _____, 20__.

Rates

For the Benefits described in the Agreement, including the Certificate (identified below), the Plan will charge and Group will pay the following premium rates:

Refer to the attached Premium Rate Schedule & Contract Summary

The above rates are effective for the Initial Term of the Agreement. Rates for any Renewal Term will be provided to Group in a rate renewal notice.

Certificate

The Certificate consists of the following subscriber contracts, certificates, riders, and/or endorsements (form numbers and/or descriptions, including variables):

Refer to the attached Premium Rate Schedule & Contract Summary

SCHEDULE OF CHANGES IN PREMIUM RATES
Community-Rated, Rolling Rate

1. Changes in Premium Rates.

   a. Changes upon Renewal. The premium rates for each Renewal Term of the Agreement will be provided to Group in a renewal rate notice, which will specify the effective date of the new rates.

   b. Changes Due to Change in Benefits. If, during the term of the Agreement, the Plan makes a unilateral change in the Benefits as permitted by the Agreement, the Plan may change the premium rates to adjust for that change in the Benefits.

   c. Changes if Plan Ceases to Offer Guaranteed Rolling Rates. Subject to paragraph b. above, the rates set forth in the attached Premium Rate Schedule are guaranteed for the Initial Term, and the rates set forth in each renewal rate notice are guaranteed for the Renewal Term for which they are quoted. Notwithstanding the preceding sentence, these rates may be modified by the Plan at any time, using the notice procedure set forth in paragraph 2 below, in the event that the Plan ceases to offer one year guaranteed "rolling rates" for the benefits evidenced by this Agreement.

2. Notice of Changes in Premium Rates. The Plan will not make any changes to the premium rates without giving Group at least 30 days' prior written notice. Upon receipt of notice of a change in the premium rates, Group will be deemed to have accepted the new rates, unless Group provides timely written notice to the Plan of its intention to terminate this Agreement or modify the Benefits.

3. Affected Products. The foregoing provisions apply to all contracts, certificates, riders, and/or endorsements forming part of the Certificate.

ADDENDUM

Group has appointed _____ to act as agent/broker of record in connection with the Certificate (as defined in the Agreement). _____ must elect one form of payment only with respect to its services:

☐ Commission from the Plan under agent/broker agreement; or

☐ Compensation from Group for remitting agent services

Group has also appointed _____ to act as the "Administrator" with respect to this Agreement. Administrator has offices located at _____ _____. Administrator assumes joint and several liability for compliance with Group's obligations under this Agreement.

Dated: _____ GROUP:_____

By: _____

Title: _____

Dated: _____ ADMINISTRATOR: _____

By: _____

Title: _____

AGREEMENT

Between

Excellus Health Plan, Inc., Doing Business As
Excellus BlueCross BlueShield

(The "Plan")
And

_____

("Employer")

This is the record of an Agreement (the "Agreement") made effective **_____,** 20__**,** between the Plan, with offices located at 165 Court Street, Rochester, New York 14647 and Employer, with offices located at **_____**.
The Plan is a nonprofit independent licensee of the BlueCross BlueShield Association.

1. **Purpose.** This Agreement establishes certain mutual obligations in connection with the Plan's issuance of one or more group and/or group remittance contracts to or through Employer for purposes of providing coverage to Employer's employees and their eligible dependents. All the terms and conditions of the group and/or group remittance contracts to which this Agreement attach also apply to this Agreement, except where they are specifically changed by this Agreement.

2. **Representations and Warranties of Employer.** Employer represents and warrants to the Plan at the time of execution of this Agreement and throughout the term of this Agreement as follows:

a. If an organization, Employer is duly organized, validly existing and in good standing under the laws of the jurisdiction of its organization.

b. Employer's documents required to be delivered to the Plan pursuant to paragraph 6 of this Agreement are accurate and complete;

c. If Employer does not have 20 or more individuals in current employment status for each working day in each of 20 or more calendar weeks in the current and preceding calendar years, the group health plan maintained by Employer has taken the steps required to elect to have Medicare as primary payer for Medicare-eligible employees/members and their covered dependents;

d. Employer has not denied and will not deny either individual participation or the Plan's coverage, directly or indirectly, based upon age, sex, health status, or occupation of any employee or any covered dependent;

e. All employees of Employer, or all of any class or classes thereof determined by conditions pertaining to their employment or a combination of such conditions and conditions pertaining to family status, are eligible for coverage through Employer; and

f. The premiums for the coverage are paid by Employer, either from Employer's funds, or from amounts contributed by Employer's employees, or jointly from amounts contributed by Employer and the employees. If no amounts are contributed by the employees, then all employees (or all of any class or classes thereof determined by conditions pertaining to their employment or a combination of such conditions and conditions pertaining to family status) are covered at all times. If all or part of the premium is derived from amounts contributed by the employees, then at least the percentage of employees required by the Plan's minimum participation rules, which shall be at least 50% (or, if less, 50 of the employees) are covered at all times.

3. **Breach of Representations and Warranties.** Employer will defend with competent counsel, indemnify, and hold harmless the Plan and its directors, officers, employees, agents, successors, and assigns from and against any and all claims, demands, actions, suits and proceedings (whether civil, criminal or administrative), and all liability, loss, expense (including reasonable attorneys' fees), costs or damages, that result, directly or indirectly, from a breach of Employer's representations and warranties under this Agreement. Without limitation, Employer will reimburse the Plan for any expense or loss resulting from inaccurate eligibility information that is provided to the Plan by Employer.

4. **Coverage and Termination of Individuals**.

a. Employer will be responsible for notifying the Plan when its employees and their eligible dependents are to become covered or are no longer to be covered by a Plan contract or certificate, in accordance with the requirements of the contract or certificate. The Plan will not be responsible for providing or terminating benefits, unless it receives notification from Employer within 30 days of the occurrence of the event causing a person's eligibility or ineligibility for coverage. Employer will obtain completed applications from its employees and shall submit the applications in hard copy format, or an accurate reproduction of the information contained in the applications in a mutually agreeable electronic format, on a timely basis sufficient to permit the Plan to provide coverage within the time frames specified in the Plan's contracts and certificates. In the event that Employer submits electronic enrollment information pursuant to the preceding sentence, (i) each such submission shall constitute a representation by Employer that it has received a signed application from the employee, and that the information submitted to the Plan accurately reflects the information set forth in the application; (ii) Employer shall maintain each underlying application form in a secure location for a period of six years after coverage has terminated for all persons listed on the application; and (iii) Employer shall make the underlying application forms available to the Plan upon reasonable advance notice at any time during the period referenced in clause (ii).

b. Within 30 days of receipt of each invoice from the Plan, Employer will review and reconcile the invoice and provide the Plan with written notice of any errors in the invoice.

c. When coverage changes occur, Employer is solely responsible for administering continuation coverage under the federal law and regulations commonly known as "COBRA," including the provision of all notices required under COBRA, if applicable. In addition, Employer will notify each employee and spouse, if any, enrolled for coverage of the continuation coverage right available under New York State law, as described in the contract(s) and/or certificate(s).

5. Enrollment Process and Requirements.

a. During the term of this Agreement, Employer must meet or exceed the Plan's minimum participation levels, as established from time to time by the Plan.

b. Without the Plan's prior written approval, Employer's open enrollment periods will be limited to one per year.

c. During each open enrollment period, Employer will permit the Plan's personnel to have access to its eligible employees, to recruit eligible persons to enroll for benefits. Persons who become eligible for coverage as set out in the contract(s) and/or certificate(s) other than during Employer's open enrollment periods will be offered the opportunity to enroll for benefits at the time they meet the eligibility requirements set out in the contract(s) and/or certificate(s).

6. Additional Duties of Employer. In addition to Employer's duties that may be described elsewhere in this Agreement:

a. Employer will verify to the Plan, upon request, the employment status of any covered individuals.

b. Employer will deliver to the Plan information regarding its covered individuals who are covered by or eligible for Medicare, indicating whether Medicare is the primary or secondary payer.

c. Prior to the effective date of coverage, Employer will deliver to the Plan the following documentation:

i. a completed group information form or enrollment questionnaire; or other information requested by the Plan for purposes of validating Employer for group coverage.

ii. a copy of Employer’s most recent NYS-45-ATT form with notations indicating eligible and ineligible employees; and

iii. if applicable, a copy of the documentation authorizing the Administrator to act on behalf of Employer.

7. **Termination.** This Agreement will automatically terminate upon the termination of all master group and/or group remittance agreements between Employer and the Plan.

8. **Relationship of Parties.** The parties to this Agreement are independent contractors and are not to be construed as having any other relationship, either with respect to this transaction or any other transaction between the parties. No party will have, or hold itself out as having, the power or authority to bind or create liability for the others by its intentional or negligent act or omission.

9. **Jurisdiction; Venue.** Jurisdiction of any litigation with respect to this Agreement will be in New York, with venue in a court of competent jurisdiction in Monroe County.

10. **Governing Law.** This Agreement will be governed by, and construed in accordance with, the laws of the State of New York.

11. **Entire Agreement.** This Agreement, together with the group agreement and/or group remittance agreement entered into between the parties as of the date of this Agreement and any other agreements contemplated thereby, constitutes the entire agreement among the parties and supersedes any prior understandings or agreements with respect to the subject matter. No changes, additions or modifications to the terms of this Agreement will be made or binding, unless in writing and signed by all parties to the Agreement.

12. **Notices.** All notices and other communications given under this Agreement must be in writing and delivered personally, by established overnight courier or by first class mail, postage prepaid, to the addresses set forth at the beginning or to such other address as one party may provide to the other in writing. Notices and communications will be deemed received at the time of personal delivery (except that, if personal delivery occurs on a day other than a business day, the next business day will be deemed the date of receipt), one business day after shipping via overnight courier, and three business days after mailing.

13. **The Plan Is Independent.** Excellus Health Plan, Inc., doing business as Excellus BlueCross BlueShield, is an independent corporation organized under the Insurance Law of New York State. Excellus BlueCross BlueShield also operates under licenses with the BlueCross BlueShield Association, an Association of independent Blue Cross and Blue Shield Plans, which licenses Excellus BlueCross BlueShield to use the Blue Cross and Blue Shield service marks in a portion of New York State. Excellus BlueCross BlueShield does not act as an agent of the BlueCross BlueShield Association. Excellus BlueCross BlueShield is solely responsible for the obligations created under this Agreement.

The parties' assent to the terms of this Agreement as of the date set forth at the beginning is established by their signatures below.

Dated:_____

Excellus Health Plan, Inc. d/b/a
Excellus BlueCross BlueShield

By: _____

Title: _____

Dated: adfadsf

Employer: _____

By: _____

Title: _____