

UnitedHealthcare Insurance Company

Group Policy

For

Atchison USD 409

Enrolling Group Number: 744597

Policy Effective Date: July 1, 2020

Group Policy

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

877-294-1429

This Policy is entered into by UnitedHealthcare Insurance Company and the "Group," as described in Exhibit 1.

When used in this document, the words "we," "us," and "our" refer to UnitedHealthcare Insurance Company.

Upon our receipt of the signed Group *Application* and payment of the first Policy Charge, this Policy is executed. The Group's *Application* is made a part of this Policy.

We agree to provide Benefits for Covered Health Care Services stated in this Policy, including the attached *Certificate(s) of Coverage* and *Schedule(s) of Benefits*, subject to the terms, conditions, exclusions, and limitations of this Policy. This Policy replaces and overrules any previous agreements relating to Benefits for Covered Health Care Services between the Group and us. The terms and conditions of this Policy will in turn be overruled by those of any future agreements relating to Benefits for Covered Health Care Services between the Group and us.

We are not an employer or plan administrator for any purpose with respect to the administration or provision of benefits under the Group's benefit plan. We are not responsible for fulfilling any duties or obligations of an employer or plan administrator with respect to the Group's benefit plan.

This Policy is effective on the date shown in Exhibit 1 and continues in force by the timely payment of the required Policy Charges when due, subject to the end of this Policy as provided in Article 5.

When this Policy ends, as described in Article 5, this Policy and all Benefits under this Policy will end at 12:00 midnight on the date the Policy ends.

This Policy is issued as described in Exhibit 1.

Issued By:

UnitedHealthcare Insurance Company



William J Golden, President

Article 1: Glossary of Defined Terms

The terms used in this Policy have the same meanings as those defined in *Section 9: Defined Terms* in the attached *Certificate(s) of Coverage*. In addition, the following terms apply:

Coverage Classification - one of the categories of coverage described in Exhibit 2 for rating purposes (for example: Subscriber only, Subscriber and spouse, Subscriber and children, Subscriber and family).

Material Misrepresentation - any oral or written communication or conduct, or combination of communication and conduct, that is untrue and is intended to create a misleading impression in the mind of another person. A misrepresentation is material if a reasonable person would attach importance to it in making a decision or determining a course of action, including but not limited to, the issuance of a policy or coverage under a policy, calculation of rates, or payment of a claim.

Article 2: Benefits

Subscribers and their Enrolled Dependents are entitled to Benefits for Covered Health Care Services subject to the terms, conditions, limitations and exclusions stated in the *Certificate(s) of Coverage* and *Schedule(s) of Benefits* attached to this Policy. Each *Certificate of Coverage* and *Schedule of Benefits*, including any Riders and Amendments, describes the Covered Health Care Services, required Co-payments, and the terms, conditions, limitations and exclusions related to coverage.

Article 3: Premium Rates and Policy Charge

3.1 Premiums

Monthly Premiums payable by or on behalf of Covered Persons are shown in the *Schedule of Premium Rates* in Exhibit 2 of this Policy or in any attached *Notice of Change*.

We have the right to change the *Schedule of Premium Rates* as described in Exhibit 1 of this Policy. We also have the right to change the *Schedule of Premium Rates* at any time if the *Schedule of Premium Rates* was based upon a Material Misrepresentation relating to health status that resulted in the Premium rates being lower than they would have been if the Material Misrepresentation had not been made. We have the right to change the *Schedule of Premium Rates* for this reason retroactive to the effective date of the *Schedule of Premium Rates* that was based on the Material Misrepresentation.

3.2 How Is the Policy Charge Calculated?

The Policy Charge will be calculated based on the number of Subscribers in each Coverage Classification that we show in our records at the time of calculation. The Policy Charge will be calculated using the Premium rates in effect at that time. Exhibit 1 describes the way in which the Policy Charge is calculated.

The Group is solely responsible for enrollment and Coverage Classification changes (including the end of a Covered Person's coverage) and for the timely payment of the Policy Charges.

3.3 When Is the Policy Charge Adjusted?

We may make retroactive adjustments for any additions or terminations of Subscribers or changes in Coverage Classification that are not reflected in our records at the time we calculate the Policy Charge. We will not grant retroactive credit for any change happening more than 60 days prior to the date we received notification of the change from the Group. We also will not grant retroactive credit for any calendar month in which a Subscriber has received Benefits.

The Group must notify us in writing within 60 days of the effective date of enrollments, terminations, or other changes. The Group must notify us in writing each month of any change in the Coverage Classification for any Subscriber.

If premium taxes, guarantee or uninsured fund assessments, or other governmental charges relating to or calculated in regard to Premium are either imposed or increased, those charges will be added to the Premium at that time. In addition, any change in law or regulation that affects our cost of operation may result in an increase in Premium in an amount we determine.

3.4 How Is the Policy Charge Paid?

The Policy Charge is payable to us in advance by the Group as described under "Payment of the Policy Charge" in Exhibit 1. The first Policy Charge is due and payable on or before the effective date of this Policy. Future Policy Charges are due and payable no later than the first day of each payment period shown in item 6 of Exhibit 1, while this Policy is in force.

All payments shall be made in United States currency, in immediately available funds, and shall be sent to us at the address on the invoice, or at another address that we may designate in writing. The Group agrees not to send us payments marked "paid in full", "without recourse", or similar language. In the event that the Group sends such a payment, we may accept it without losing any of our rights under this Policy and the Group will remain obligated to pay any and all amounts owed to us.

Late payment charges are assessed for any Policy Charge not received within 10 calendar days following the due date. There will be a service charge added to the Group's account for any check returned for non-sufficient funds. The names of all Covered Persons must be attached when payment is made.

The Group will reimburse any attorney's fees and costs related to collecting past due Policy Charges.

3.5 Does a Grace Period Apply?

A grace period of 31 days will be granted for the payment of any Policy Charge not paid when due. During the grace period, this Policy will continue in force. The grace period will not extend beyond the date this Policy ends.

The Group is responsible for payment of the Policy Charge during the grace period. If we receive written notice from the Group to end this Policy during the grace period, we will adjust the Policy Charge so that it applies only to the number of days this Policy was in force during the grace period.

This Policy ends as described in Article 5.1 if the grace period expires and the past due Policy Charge remains unpaid.

Article 4: Eligibility and Enrollment

4.1 What Are the Eligibility Rules?

Eligibility rules for each class are stated in Exhibit 2 and in the Group *Application*. The eligibility rules stated in Exhibit 2 are in addition to those shown in *Section 3: When Coverage Begins* of the *Certificate of Coverage*.

4.2 Initial Enrollment Period

Eligible Persons and their Dependents may enroll for coverage under this Policy during the Initial Enrollment Period. The Initial Enrollment Period is set by the Group and will be a period of no less than 31 days from the date of the Eligible Person's initial eligibility.

4.3 Open Enrollment Period

An Open Enrollment Period will be provided for each class, as shown in Exhibit 2. During an Open Enrollment Period, Eligible Persons may enroll for coverage under this Policy.

4.4 Effective Date of Coverage

The effective date of coverage for enrolled Eligible Persons and their Dependents is stated in Exhibit 2.

Article 5: End of Policy

5.1 When Does the Policy End?

This Policy and all Benefits for Covered Health Care Services will automatically end on the earliest of the dates shown below:

- A. On the last day of the grace period if the Policy Charge remains unpaid. The Group remains responsible for payment of the Policy Charge for the period of time this Policy remained in force during the grace period.
- B. On the date specified by the Group, after at least 31 days prior written notice to us that this Policy will end.
- C. On the date we specify, after at least 31 days prior written notice to the Group, that this Policy will end due to the Group's violation of the participation rule as shown in Exhibit 1.
- D. On the date we specify, after at least 31 days prior written notice to the Group, that this Policy will end because the Group performed an act, practice or omission that constituted fraud or made an intentional misrepresentation of a fact that was material to the execution of this Policy or to the provision of coverage under this Policy. In this case, we have the right to rescind this Policy back to either:
 - The effective date of this Policy.
 - The date of the act, practice or omission, if later.
- E. On the date we specify, after at least 90 days prior written notice to the Group, that this Policy will end because we will no longer issue this particular type of group health benefit plan within the applicable market.
- F. On the date we specify, after at least 180 days prior written notice to the applicable state authority and to the Group, that this Policy will end because we will no longer issue any employer health benefit plan within the applicable market.

5.2 Payment When the Policy Ends

When the Policy ends, the Group is and will remain responsible to us for the payment of any and all Premiums which are unpaid at the time the Policy ends. This will include a pro rata portion of the Policy Charge for any period this Policy was in force during any grace period preceding the end of the Policy.

Article 6: General Provisions

6.1 What Is the Entire Policy?

This Policy, the *Certificate(s) of Coverage*, the *Schedule(s) of Benefits*, the *Group Application*, and any Amendments, *Notices of Change*, and Riders, make up the entire Policy.

6.2 Dispute Resolution

No legal proceeding or action may be brought until the parties have completed the complaint procedures specified in *Section 6: Questions, Complaints and Appeals* of the *Certificate of Coverage*.

6.3 Time Limit on Certain Defenses

No statement made by the Group, except a fraudulent statement, can be used to void this Policy after it has been in force for a period of two years.

6.4 Amendments and Alterations

Amendments and Riders to this Policy are effective upon the Group's next anniversary date, except as otherwise permitted by law. Other than changes to Exhibit 2 stated in a *Notice of Change* to Exhibit 2, no change will be made to this Policy unless made by an Amendment or a Rider which is signed by one of our authorized executive officers and consistent with applicable notice requirements. No agent has authority to change this Policy or to waive any of its provisions.

If an Amendment reduces or eliminates Benefits, the consent of the Enrolling Group is required.

6.5 Our Relationship with Providers and Groups

We have agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements with us to provide Covered Health Care Services to Covered Persons.

The relationship between a Network provider and any Covered Person is that of provider and patient. The Network provider is solely responsible for the services provided. The relationship between any Group and any Covered Person is that of employer and employee, Dependent, or any other category of Covered Person described in the Coverage Classifications shown in this Policy.

The Group is solely responsible for enrollment and Coverage Classification changes (including the end of a Covered Person's coverage) and for the timely payment of the Policy Charges.

6.6 Records

We may require information related to the Policy, from the Group. Upon request, the Group must provide us with the requested information and proofs which may include:

- All documents provided to the Group by an individual in connection with coverage.
- The Group's payroll.
- Any other records pertinent to the coverage under this Policy.

By accepting Benefits under this Policy, each Covered Person authorizes and directs any person or institution that has provided services to him or her, to provide us or our designees any and all information and records or copies of records relating to the health care services provided to the Covered Person. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form.

We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are needed to administer the terms of this Policy including records for appropriate medical and quality review or as required by law or regulation.

During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy for research and analytic purposes.

Please note: Neither the U.S. brokers that handled this insurance nor the insurers that have underwritten this insurance will disclose nonpublic personal information concerning the buyer to non-affiliates of the brokers or insurers except as permitted by law.

6.7 Administrative Services

The services needed to administer this Policy and the Benefits provided under it will be provided in accordance with our standard administrative procedures or those standard administrative procedures of our designee. If the Group requests that administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, the Group must pay for such services or reports at the then current charges for such services or reports.

We may offer to provide administrative services to the Group for certain wellness programs including, but not limited to, fitness programs, biometric screening programs and wellness coaching programs.

6.8 Employee Retirement Income Security Act (ERISA)

When this Policy is purchased by the Group to provide benefits under a health and welfare plan governed by the federal *Employee Retirement Income Security Act* 29 U.S.C., 1001 et seq., we will not be named as, and will not be, the plan administrator or the named fiduciary of the health and welfare plan, as those terms are used in ERISA.

6.9 Do We Require Examination of Covered Persons?

In the event of a question or dispute concerning Benefits for Covered Health Care Services, we may require that a Network Physician, of our choice examine the Covered Person at our expense.

6.10 What Happens When There Is a Clerical Error?

Clerical error will not deprive any individual of Benefits under this Policy or create a right to Benefits. Failure to report enrollments is not a clerical error. We will not provide retroactive coverage for Eligible Persons when the Group fails to report enrollments. Failure to report the end of coverage will not continue the coverage for a Covered Person beyond the date it is scheduled to end. Upon discovery of a clerical error, any needed adjustment in Premiums will be made. However, we will not grant any such adjustment in Premiums or coverage to the Group for more than 60 days of coverage prior to the date we received notification of the clerical error.

6.11 Is Workers' Compensation Affected?

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

6.12 Conformity with Law

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is deemed to be amended to follow the minimum requirements of those statutes and regulations.

6.13 Notice

When we provide written notice regarding Policy administration to the Group's authorized representative. Once delivered, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Group is responsible for giving notice to Covered Persons on a timely basis.

Any notice sent to us under this Policy and any notice sent to the Group must be addressed as described in Exhibit 1.

6.14 Continuation Coverage

We agree to provide Benefits under this Policy for those Covered Persons who are eligible to continue coverage under federal or state law, as described in *Section 4: When Coverage Ends* of the *Certificate of Coverage*.

We will not provide any administrative duties with respect to the Group's compliance with federal or state law. All duties of the plan sponsor or plan administrator remain the sole responsibility of the Group, including but not limited to notification of COBRA and/or state law continuation rights. We will provide billing information and all monthly premiums should be forwarded to us.

6.15 Subscriber's Individual Certificate

We will issue *Certificate(s) of Coverage, Schedule(s) of Benefits*, and any attachments to the Group for delivery to each Subscriber. The *Certificate(s) of Coverage, Schedule(s) of Benefits*, and any attachments will show the Benefits and other provisions of this Policy. In addition, the *Certificate(s) of Coverage and Schedule(s) of Benefits* may be available online at www.myuhc.com.

6.16 Summary of Benefits and Coverage

We will provide a *Summary of Benefits and Coverage ("SBC")*, as required by the *Affordable Care Act* and related regulations ("*ACA*"), to the Group for each benefit plan purchased. The Group is responsible for delivering the *SBC* to all Covered Persons and to other persons eligible for coverage in the manner and at the times required by the *ACA*.

6.17 System Access

The term "systems" as used in this provision means systems that we make available to the Group to facilitate the transfer of information in connection with this Policy.

System Access

We grant the Group the nonexclusive, nontransferable right to access and use the functionalities contained within the systems, under the terms of this Policy. The Group agrees that all rights, title and interest in the systems and all rights in patents, copyrights, trademarks and trade secrets encompassed in the systems will remain ours. To access the systems, the Group will obtain, and be responsible for maintaining, at no expense to us, the hardware, software and Internet browser requirements we provide to the Group, including any amendments to those requirements. The Group is responsible for obtaining internet access.

The Group will not:

- Access systems or use, copy, reproduce, modify, or excerpt any of the systems documentation provided by us in order to access or use systems, for purposes other than as expressly permitted under this Policy.
- Share, transfer or lease its right to access and use systems, to any other person or entity which is not a party to this Policy.

The Group may designate a third party access to the systems on its behalf, provided the third party agrees to these terms and conditions. The Group remains responsible for the third party's compliance with the entire *System Access* provision.

Security Procedures

The Group will use commercially reasonable physical and software-based measures and comply with our security procedures, as may be amended from time to time, to protect the system, its functionalities, and data accessed through systems from any unauthorized access or damage (including damage caused by computer viruses). The Group will notify us immediately if any breach of the security procedures, such as unauthorized use, is suspected.

End of System Access

We have the right to end the Group's system access:

- On the date the Group does not accept the hardware, software and browser requirements provided by us, including any amendments to the requirements.
- Immediately on the date we reasonably determine that the Group has breached, or allowed a breach of, any applicable provision of this Policy. Upon the date this Policy ends, the Group agrees to cease all use of systems, and we will deactivate the Group's identification numbers and passwords and access to the system.

Exhibit 1

1. **Parties.** The parties to this Policy are UnitedHealthcare Insurance Company and Atchison USD 409, the Group.
2. **Effective Date.** The effective date of this Policy is 12:01 a.m. on July 1, 2020 in the time zone of the Group's location.
3. **Place of Issuance.** We are issuing this Policy in Kansas. The Policy is subject to the laws of the state of Kansas and ERISA, unless the Group is not a private plan sponsor subject to ERISA. To the extent that state law applies, Kansas law governs this Policy.
4. **Premiums.** We have the right to change the *Schedule of Premium Rates* shown in each Exhibit 2, after a 31-day prior written notice at any time.
5. **Computation of Policy Charge.** A full calendar month's Premiums will be charged for Covered Persons whose effective date of coverage falls on or before the 15th of that calendar month. No Premiums will be charged for Covered Persons whose effective date of coverage falls after the 15th of that calendar month. A full calendar month's Premiums will be charged for Covered Persons whose coverage ends after the 15th of that calendar month. No Premiums will be charged for Covered Persons whose coverage ended on or before the 15th of that calendar month.
6. **Payment of the Policy Charge.** The Policy Charge is payable to us in advance by the Group on a monthly basis.
7. **Minimum Participation Requirement.** 75% of Eligible Persons excluding spousal waivers but no less than 50% of all Eligible Persons must be enrolled for coverage under this Policy.
8. **Minimum Contribution Requirement.** The Minimum Contribution Requirement does not apply.
9. **Notice.** Any notice sent to us under this Policy must be sent to:
UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, Connecticut 06103-0450

Any notice sent to the Group under this Policy must be sent to:
Atchison USD 409
626 Commercial St.
Atchison, Kansas 66002
10. 744597: Group Number

Exhibit 2 Class 1

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description.**

All Employees enrolled in UnitedHealthcare Choice Plus Plan 2T8.

2. **Eligibility.** The eligibility rules are established by the Group. The following eligibility rules are in addition to the eligibility rules shown in the *Group Application* and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

A. The waiting or probationary period for newly Eligible Persons is as follows:

None

B. Notwithstanding Group's eligibility rules for health plan participation, continued coverage under this Policy for a Covered Person on a leave of absence (LOA) will be available in accordance with the following, unless state, local or federal law requires a longer period of time:

- ◆ For a Covered Person on a non-medical LOA, coverage will be available for no longer than 13 consecutive weeks from the beginning of the LOA.
- ◆ For a Covered Person on a medical LOA, coverage will be available for no longer than 26 consecutive weeks from the beginning of the LOA.

C. Other:

Retired Employees under 65 years of age

3. **Open Enrollment Period.** An Open Enrollment Period of at least 60 days will be provided by the Group when Eligible Persons may enroll for coverage. The Open Enrollment Period will occur on an annual basis.

4. **Effective Date for Eligible Persons.** The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is July 1, 2020.

For an Eligible Person who becomes eligible after the effective date of this Policy, the effective date of coverage is the first day of the month following the date the Eligible Person joins the Group. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates.**

The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of July 1, 2020 is shown below:

Coverage Classification	Monthly Premium
Employee Only	\$511.64
Employee Plus Spouse	\$1,151.21
Employee plus Child(ren)	\$1,074.46
Employee Plus Family	\$1,637.27

Exhibit 2 Class 2

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description.**

All Employees enrolled in UnitedHealthcare Choice Plus (HSA) Plan AE3L.

2. **Eligibility.** The eligibility rules are established by the Group. The following eligibility rules are in addition to the eligibility rules shown in the Group *Application* and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

A. The waiting or probationary period for newly Eligible Persons is as follows:

None

B. Notwithstanding Group's eligibility rules for health plan participation, continued coverage under this Policy for a Covered Person on a leave of absence (LOA) will be available in accordance with the following, unless state, local or federal law requires a longer period of time:

- ◆ For a Covered Person on a non-medical LOA, coverage will be available for no longer than 13 consecutive weeks from the beginning of the LOA.
- ◆ For a Covered Person on a medical LOA, coverage will be available for no longer than 26 consecutive weeks from the beginning of the LOA.

C. Other:

Retired Employees under 65 years of age

3. **Open Enrollment Period.** An Open Enrollment Period of at least 60 days will be provided by the Group when Eligible Persons may enroll for coverage. The Open Enrollment Period will occur on an annual basis.

4. **Effective Date for Eligible Persons.** The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is July 1, 2020.

For an Eligible Person who becomes eligible after the effective date of this Policy, the effective date of coverage is the first day of the month following the date the Eligible Person joins the Group. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates.**

The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of July 1, 2020 is shown below:

Coverage Classification	Monthly Premium
Employee Only	\$433.64
Employee Plus Spouse	\$975.69
Employee plus Child(ren)	\$910.65
Employee Plus Family	\$1,387.66

Exhibit 2 Class 3

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description.**

All Employees enrolled in UnitedHealthcare Choice Plus Plan ABHQ.

2. **Eligibility.** The eligibility rules are established by the Group. The following eligibility rules are in addition to the eligibility rules shown in the Group *Application* and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

A. The waiting or probationary period for newly Eligible Persons is as follows:

None

B. Notwithstanding Group's eligibility rules for health plan participation, continued coverage under this Policy for a Covered Person on a leave of absence (LOA) will be available in accordance with the following, unless state, local or federal law requires a longer period of time:

- ◆ For a Covered Person on a non-medical LOA, coverage will be available for no longer than 13 consecutive weeks from the beginning of the LOA.
- ◆ For a Covered Person on a medical LOA, coverage will be available for no longer than 26 consecutive weeks from the beginning of the LOA.

C. Other:

Retired Employees under 65 years of age

3. **Open Enrollment Period.** An Open Enrollment Period of at least 60 days will be provided by the Group when Eligible Persons may enroll for coverage. The Open Enrollment Period will occur on an annual basis.

4. **Effective Date for Eligible Persons.** The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is July 1, 2020.

For an Eligible Person who becomes eligible after the effective date of this Policy, the effective date of coverage is the first day of the month following the date the Eligible Person joins the Group. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates.**

The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of July 1, 2020 is shown below:

Coverage Classification	Monthly Premium
Employee Only	\$479.81
Employee Plus Spouse	\$1,079.57
Employee plus Child(ren)	\$1,007.62
Employee Plus Family	\$1,535.39

Exhibit 3 - Advocate4MeSM

The Group agrees to take part in an advocate-based consumer experience program. This program provides Subscribers and Enrolled Dependents with an additional level of support services.

For the purpose of this Exhibit, "advocate" means representatives that are a part of the Advocate4Me program.

Advocate4Me provides the following enhanced levels of support:

- **Expert Advocate Support** - Provides a point of contact to answer questions. This contact will address and resolve issues, and engage in clinical programs.
- **Integrated Financial Support** - The ability for the advocate to address simple financial questions in advance and in connection with *Optum Bank*. This includes questions on balances, last transactions and enrollment.
- **Elevated Issue Resolution** - Provide enhanced issue resolution. This includes escalation to experts to address issues in reduced timeframes.
- **Consumer Preference Communication** - Offer communication across technologies. This includes email, fax and telephone.

Exhibit 4 - SimplyEngaged®

The Group agrees to put in place a wellness program that provides Subscribers and Enrolled Dependent spouses with rewards for completing certain wellness criteria, as we determine. If unable to meet a standard related to a health factor for a reward under this wellness program, the Subscriber or Enrolled Dependent spouse may qualify to earn the same reward by different means. The Subscriber or Enrolled Dependent spouse may call us at 1-855-215-0230 and we will work with the Subscriber or Enrolled Dependent spouse (and, if needed, with the Physician) to find another way for the same reward to be earned.

The Group also agrees to put in place the following program requirements:

- Provide the reward type and maximum. The Group will be responsible for funding all rewards.
- Provide an announcement letter sent to all the Group's employees from the Group's owner or a senior executive, promoting the reward program.
- Sponsor at least one health fair/wellness event within the first 120 days, or later as we determine, of the Policy year (with biometric screening), making reasonable effort to encourage attendance. The biometric screening event must be held the same day as the health/wellness event during standard hours for screening events, which are Monday through Friday, 5:00 a.m. to 7:00 p.m., EST. After we receive at least 60 days prior written notice that the event is taking place, we will cover the cost of one biometric screening, per fair /wellness event, per year. If less than 20 Subscribers and Enrolled Dependent spouses take part in such biometric screening, we may impose an additional fee on the Group.
- Provide information needed to help promotional activities.

The Group agrees it will meet two times per year with its broker and our representative. These meetings will be with the Group's owner or a senior executive of the Group. The first meeting must occur early in the Policy year to discuss the details of putting in place the requirements as described in this Exhibit. The second meeting must occur at least 120 days, or later as we determine, prior to the anniversary date of the Policy.

The Group accepts that rewards can only be earned once during a reward period. For example, if a health survey is completed on February 1, 2018, and the reward period began January 1, 2018, the Subscriber or Enrolled Dependent spouse will not become eligible to earn an additional reward for completion of a new health survey until January 1, 2019.

Exhibit 5 - Wellness Stipend Program

The Group is eligible for a wellness stipend of up to \$18,160 during the Policy year. The stipend is to be used to establish, implement and maintain a program to target increased awareness of health risks and support behavior change.

The Group and our representatives will define and plan wellness services and program strategies which may include but are not limited to the following:

- *Awareness and Education* means activities such as biometric screenings and health kiosks.
- *Behavioral Change* means health and wellness educational programs such as smoking cessation or *Weight Watchers*.
- *Environmental Change* means activities such as onsite exercise classes and/or equipment.
- Incentives which encourage or reward taking part in wellness programs.

The Group will maintain documentation of program costs and related expenses. The Group will provide the documentation to us upon request.

General Purposes and Limitations of the Kansas Life and Health Insurance Guaranty Association

K.S.A. 40-3001, et. seq.

Disclaimer

THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MAY NOT PROVIDE COVERAGE FOR ALL OR A PORTION OF THIS POLICY. IF COVERAGE IS PROVIDED, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS, AND IS DEPENDENT UPON CONTINUED RESIDENCE IN KANSAS. THEREFORE, YOU SHOULD NOT RELY UPON COVERAGE BY THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELECTING AN INSURANCE COMPANY OR IN SELECTING AN INSURANCE POLICY. INSURANCE COMPANIES AND THEIR AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELLING YOU ANY FORM OF AN INSURANCE POLICY, OR TO INDUCE YOU TO PURCHASE ANY FORM OF AN INSURANCE POLICY. EITHER THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE KANSAS INSURANCE DEPARTMENT WILL RESPOND TO ANY QUESTIONS YOU MAY HAVE REGARDING THIS DOCUMENT.

THE KANSAS LIFE AND HEALTH

INSURANCE GUARANTY ASSOCIATION

5867 SW 29TH STREET

TOPEKA, KS 66614-2464

THE KANSAS INSURANCE DEPARTMENT

420 SOUTHWEST 9TH STREET

TOPEKA, KS 66612-1678

This is a summary of the basic provisions of the Kansas Life and Health Insurance Guaranty Association Act. It is only a summary, and does not provide an in-depth analysis of the Act. Nothing in this summary modifies the rights of persons who are protected by the Act, or the rights or duties of the Association.

The purpose of the Kansas Life and Health Insurance Guaranty Association Act is to protect certain individuals who purchase life insurance, annuities or health insurance in Kansas. The Act provides for the establishment of a funding mechanism to pay benefits or provide insurance coverage to individuals when a life or health insurance company is unable to meet its obligations by reason of insolvency or financial impairment.

However, not all individuals with a right to recover under life or health insurance policies are protected by the Act. An individual is only provided protection when:

- the individual, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, is the beneficiary, assignee or payee of a covered policy or contract holder,
- the individual policy or contract holder is a resident of the state of Kansas,
- the individual is not a resident of the state of Kansas, but only with respect to an annuity contract which has been awarded pursuant to a judgment or settlement agreement in a medical malpractice liability action,

- the individual is not a resident of the state of Kansas, but only under all of the following conditions:
 - the impaired or insolvent insurer was a Kansas domestic insurer; and
 - the insurer never had a license to do business in the state in which the individual resides; and
 - the state in which the individual resides has an association similar to this state's, and
 - the individual is not eligible for coverage by the association of the state in which the individual resides.

Additionally, the Association may not provide coverage for the entire amount the individual expects to receive from the policy. The Association does not provide coverage for any portion of the policy where the individual has assumed the risk, for any policy of reinsurance, for interest rates that exceed a specified average rate, for employers' plans that are self funded, for parts that provide dividends or credits in connection with the administration of the policy, for policies sold by companies not authorized to do business in Kansas, or for any unallocated annuity contract. Also, the Association will not provide coverage where any guaranty protection is provided to the individual under the laws of the insolvent or impaired insurer's state of domicile.

The Act also limits the amount the Association is obligated to pay individuals on various policies. The Association does not pay more than the amount of the contractual obligation of the insurance company. Regardless of the number of policies or contracts, the Association is not obligated to pay amounts over \$300,000 in life insurance death benefits; \$100,000 in net cash surrender and net cash withdrawal values for life insurance; \$100,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values; \$100,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, unless the annuity contract is awarded pursuant to a judgment or settlement agreement in a medical malpractice liability action; or more than \$300,000 in the aggregate for the above coverages with respect to any one life.

