University of Richmond - Vision

Group Enrollment Agreement

Take Control of Your Health

Your Health Care Plan

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HealthKeepers, Inc.
Group Enrollment Agreement

HealthKeepers, Inc. ("HealthKeepers") and the Group (as defined in the Group Application, a copy of which is attached hereto) hereby agree that, in consideration of the payment of premiums by Group, HealthKeepers shall contract and/or arrange for covered services in accordance with the terms and provisions of this Agreement and the Evidence of Coverage, a copy of which are attached hereto and made a part hereof, and shall make these services available to eligible Subscribers of the Group and their family Dependents who elect to enroll hereunder with HealthKeepers. Such persons, once enrolled, are referred to as "Members".

I. Eligibility
Eligible Subscribers of the Group are defined as one of the following persons who is determined by the Group to be eligible for coverage under the Group’s contract for coverage:

- an active employee of the Group who works the number of hours to be considered full-time as defined by the Employer and approved by HealthKeepers as of the effective date.
- any other class of persons represented by the Group, provided that prior written approval of that class’ eligibility is obtained from HealthKeepers.

Dependents shall be those persons who satisfy the Dependent eligibility provisions of the Evidence of Coverage. Such eligibility requirements cannot be altered for the duration of this Agreement without the consent of HealthKeepers. If a Member or Subscriber becomes ineligible as a member of the Group, then the Group must advise HealthKeepers prior to such Member’s ineligibility or the Group will continue to be responsible for the premium billed to the Group for any such Members until notice is received by HealthKeepers of any such Member’s ineligibility.

II. Enrollment and Effective Date of Coverage
The Group hereby agrees to offer HealthKeepers membership to all eligible Subscribers of the Group. It is understood that eligible Subscribers of the Group shall be free to choose either HealthKeepers membership or such other coverage as may be available through the Group only during the initial and subsequent yearly open enrollment periods. Every eligible Subscriber of the Group shall be given a fair opportunity to elect one of such options over the other and shall not be penalized by the Group because of such a choice.

The Group agrees that, in addition to the open enrollment period under this Agreement, each new employee will be given the opportunity to elect HealthKeepers membership in accordance with the Group’s policies and procedures for new employee enrollment eligibility. Subject to the Group’s payment of applicable monthly premiums, the receipt of an application by HealthKeepers for each prospective Subscriber and eligible Dependents of the Subscriber, and the provisions of this Agreement, coverage under this Agreement shall become effective on the following dates:

1. For Subscribers, coverage shall be effective upon receipt of the application and premium.
2. For a Dependent who satisfies all eligibility requirements on the effective date of the Subscriber's coverage, coverage shall commence as of the Subscriber's effective date. For all other Dependents, coverage shall be effective as set forth in the Evidence of Coverage.

3. Individuals seeking to enroll in HealthKeepers who were not previously eligible for HealthKeepers coverage hereunder may do so only if application is received by HealthKeepers within 31 days after they become eligible for coverage hereunder. The attached Evidence of Coverage defines those persons who are eligible to enroll in HealthKeepers at times other than the employer's open enrollment period.

III. Payments
The premium due date is the last business day of the month preceding the month of coverage. The Group agrees to remit on or before the premium due date, the applicable total monthly premium for each eligible Subscriber enrolled hereunder who elects HealthKeepers membership for himself/herself and his or her family Dependents.

New Members may be added during the term of this Agreement in accordance with the Group's policies and procedures for new employee enrollment eligibility and subject to the requirements stated in the Evidence of Coverage and any HealthKeepers administrative policies.

If premium payment is not made in full by the Group on or prior to the premium due date, a 31-day grace period shall be granted to the Group for payment. The grace period shall begin on the premium due date and continue for 31 days. During the grace period, coverage shall remain in effect. If payment is not made by the Group within the grace period, HealthKeepers may cancel coverage after the 31-day grace period or 15 days after HealthKeepers has provided the Group with a written or printed notice of termination, including a specific date, whichever is later. The Group will be liable to HealthKeepers for any premium owed for the time the coverage is in force during a grace period.

IV. Cooperation
The Group agrees to cooperate with HealthKeepers by advising Subscribers of HealthKeepers policy and service information and by allowing enrollment representatives fair and reasonable access to potential Subscribers for the purpose of enrollment. The Group shall make the appropriate payroll deductions, if applicable, for Subscribers who elect HealthKeepers membership and shall deliver to Subscribers the Evidence of Coverage, notices and identification cards when requested by HealthKeepers. The Group also agrees to cooperate with HealthKeepers in obtaining information about enrolled Members which is relevant to claims of eligibility, reimbursement, coordination of benefits and proper administration of this Agreement. The Group will also give at least 60 days notice to HealthKeepers of its intent to offer any other coverage in addition to the coverage provided under this Agreement.
V. Group Contribution

A. Health Coverage
The Group shall offer HealthKeepers to all Subscribers of the Group on terms no less favorable with respect to the total group contribution than those applicable to such other health benefits coverage as may be available through the Group. Except as hereinafter provided, the group contributions set forth in the premium schedule on the Group Application, and in any subsequent premium revisions, shall not be changed during the term of this Agreement unless such change is agreed to in writing by HealthKeepers. If, however, the Group's contribution to such other coverage as may be available through the Group is increased during the term of this Agreement, the Group agrees to increase its contribution for HealthKeepers coverage, effective the first premium due date following such increase.

B. Dental Coverage
Except as hereinafter provided, the group contributions set forth above in the premium schedule on the Group Application, and in any subsequent premium revisions, shall not be changed during the term of this Agreement unless such change is agreed to in writing by HealthKeepers.

VI. Administration
The Group agrees to furnish HealthKeepers on a monthly basis, on HealthKeeper’s approved forms, such information as may reasonably be required by HealthKeepers for the administration of HealthKeeper’s program. In addition, HealthKeepers may at reasonable times examine the Group’s records with respect to eligibility and premium payments hereunder.

VII. Termination of Member's Coverage
HealthKeepers will provide continuous coverage for Members of the Group until the Group provides prior written notice of termination of a Member's coverage. The Group agrees to pay premiums for all of its Member(s) for the period that HealthKeepers provides coverage to such Member(s). No Member will be terminated without prior written notice from the Group. Special provisions are outlined in the Evidence of Coverage for Members who may be terminated for cause by HealthKeepers. If the coverage of a Member is terminated for cause, premium payments received on behalf of the terminated Member applicable to periods after the effective date of termination, shall be credited to the Group within 30 days, and neither HealthKeepers nor any HealthKeepers provider shall have any liability under this Agreement to such terminated Member.

VIII. Entire Agreement
This Group Enrollment Agreement, the attached Evidence of Coverage and any amendments thereto shall constitute the entire agreement between the parties. No portion of the charter, by-laws, or other document of HealthKeepers shall constitute part of this Agreement unless it is set forth in full in the contract. To the extent there is an express conflict between the Group Enrollment Agreement and the Evidence of Coverage, the Group Enrollment Agreement shall control.
IX. Amendments
All changes to this Agreement must be by amendment. HealthKeepers may amend any of the terms of this Agreement upon 30 days notice to the Group, or at any time when required by applicable law or regulation. However, the benefit levels or Covered Services specified in this Agreement may not be reduced under this Paragraph except on any renewal date of the Agreement. Any such amendment shall be in writing and must be approved and executed by the President of HealthKeepers. Continued payment of the premium by the Group subsequent to such 30-day notice shall constitute acceptance of such amendment. No agent of HealthKeepers has the authority to change this Agreement, waive any of its provisions or restrictions, or extend the time for making a payment.

X. Health Status
HealthKeepers will not expel or refuse to re-enroll any Member because of such person’s state of health or his requirements for covered services. In addition, HealthKeepers will not refuse to enroll individual eligible members of the Group on the basis of the health status or the needs of those individuals for covered services.

XI. Term and Termination
This Agreement will become effective on the date shown on the Group Application at 12:01 a.m. Eastern Time, subject to payment of premiums as provided herein, and will remain in force and effect until the Anniversary Month and Year shown on the Group Application and for each 12-month period thereafter subject to the right of the Group to terminate this Agreement upon at least 31 days prior written notice.

This Agreement may be terminated, at HealthKeeper’s option, when:

a. the Group does not pay the appropriate premium when due, subject to the grace period;
b. the Group fails to perform any duties required by this Agreement;
c. the Group commits fraud or misrepresentation with respect to this Agreement or with respect to a Member’s coverage under this Agreement;
d. the Group fails to comply with underwriting guidelines of HealthKeepers with respect to employer contribution and participation requirements;
e. there is no longer a Member who lives, resides or works in HealthKeeper’s service area;
f. HealthKeepers decides, in accordance with state law, to discontinue offering the particular type of group coverage specified in this Agreement, provided that in such instance HealthKeepers gives at least 90 days written notice of its intent to the Group and the Members enrolled under the Agreement; or
g. HealthKeepers decides, in accordance with state law, to discontinue offering all group coverage in this state, provided that in such instance HealthKeepers gives at least 180 days written notice of its intent to the Virginia State Corporation Commission, the Group, and the Members enrolled under the Agreement.

If the Group is an association offering coverage under this Agreement to its membership, HealthKeepers may terminate coverage for any subgroup in the association upon the occurrence of any event listed in subparagraph a. through e. above if the failure is attributable to that subgroup. Also, in the event HealthKeepers terminates the Agreement under subparagraph f. or g. above, the notice requirements of those paragraphs also apply to each association subgroup.

The Group represents that all information contained in applications, questionnaires, forms or statements submitted to HealthKeepers is true, correct, and complete, and if the Group furnished incorrect or
incomplete information which constitutes a material misrepresentation, then the Group's coverage may be terminated immediately upon written notice. If so terminated, HealthKeepers shall not be responsible to pay for those services provided to Members of the Group that are related to such incorrect or incomplete information.

XII. Claims Experience
Upon request by the Group, HealthKeepers will provide the group a complete record of the claims paid under this Agreement. This record shall include all claims incurred for the shorter of:

1. the period of time since the Agreement was issued or issued for delivery; or
2. the period of time since the Agreement was last renewed, reissued or extended, if already issued.

This record will be made available promptly to the Group upon request made not less than thirty (30) days prior to the date upon which the premiums or contractual terms of the Agreement may be amended.

XIII. Independent Corporation
By accepting this Agreement, the Group agrees to the following:

1. This Agreement constitutes a contract solely between the Group and HealthKeepers.
2. HealthKeepers is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association").
3. HealthKeepers is permitted to use the Blue Cross and Blue Shield service marks in a portion of the Commonwealth of Virginia.
4. HealthKeepers is not contracting as the agent of the Association.
5. The Group acknowledges that it has not entered into this Agreement based upon representations by any person other than HealthKeepers or its agents and representatives and that no person, entity, or organization other than HealthKeepers shall be held accountable or liable for any of HealthKeepers's obligations created under this Agreement.
6. This paragraph shall not create any additional obligations whatsoever on the part of HealthKeepers other than those obligations created under other provisions of this Agreement.

XIV. Notice
Any notice under this Agreement may be given by United States Mail, first class, postage prepaid, addressed as described below. Notices shall be considered given to the Group when placed in the mail by HealthKeepers to the last known address for the Group as shown in HealthKeeper's records. Notices from the Group will be considered given to HealthKeepers when actually received by HealthKeepers.

If to Group:  
Address shown on the Group Application

If to HealthKeepers:  
HealthKeepers, Inc.  
Post Office Box 26623  
Richmond, Virginia 23261
XV. Out-of-Area Services
The provisions of the BlueCard Program do not apply to routine vision care benefits.

HealthKeepers has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever subscribers access healthcare services outside the geographic area HealthKeepers serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to us for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to subscribers under this agreement are described generally below.

Typically, subscribers, when accessing care outside the geographic area HealthKeepers serves, obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, subscribers may obtain care from non-participating healthcare providers. Our payment practices in both instances are described below.

We cover only limited healthcare services received outside of our service area. As used in this section, “Out-of-Area Covered Healthcare Services” include, emergency care and urgent care obtained outside the geographic area HealthKeepers serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements. These “other services” must be provided or authorized by member’s primary care physician (“PCP”).

BlueCard® Program
Under the BlueCard® Program, when members access covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, in accordance with 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 healthcare 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, our action will be consistent with the spirit of this description.

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 healthcare provider's billed covered charges or the negotiated price made available to us by the Host Blue.

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

(i) an actual price. An actual price is a negotiated payment without any other increases or decreases, or
(ii) 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 non-claim 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

(iii) 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 HealthKeepers 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 (i) 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 (ii) 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, we would then calculate member liability in accordance with applicable law.

Return of Overpayments
Under the BlueCard Program, recoveries from a Host Blue or its participating healthcare 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.

Non-Participating Healthcare Providers Outside HealthKeeper’s Service Area
Subscriber Liability Calculation
When Out-of-Area Covered Healthcare Services are received from non-participating healthcare providers, the amount(s) a subscriber pays for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the subscriber may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment HealthKeepers will make for the covered services as set forth in this paragraph.

Exceptions
In some exception cases, HealthKeepers may pay claims from non-participating healthcare providers for Out-of-Area Covered Healthcare Services based on the provider's billed charge, such as in situations where a subscriber did not have reasonable access to a participating provider, as determined by HealthKeepers in
our sole and absolute discretion or by applicable state law. In other exception cases, we may pay such a claim based on the payment we would make if HealthKeepers were paying a non-participating provider for the same covered healthcare services inside of our service area, as described elsewhere in this agreement where the Host Blue’s corresponding payment would be more than our in-service area non-participating provider payment, or in our sole and absolute discretion, we may negotiate a payment with such a provider on an exception basis. In any of these exception situations, the subscriber may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment HealthKeepers will make for the covered services as set forth in this paragraph.

XVI. Coordination of Benefits (COB)
All benefits provided under this agreement are subject to this provision. However, benefits will not be increased by this COB provision.

This provision applies if the total payment under this agreement absent this provision and under any other contract is greater than the value of covered services.

The following definition applies to this provision:
Other Contract means any arrangement providing health care benefits or services through:

- group or blanket insurance coverage;
- group Blue Cross Blue Shield, health maintenance organization, and other prepayment coverage;
- coverage under labor management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; and
- coverage under any tax supported or government program to the extent permitted by law.

If there is more than one other contract, this provision will apply separately to each. If an other contract has a coordination of benefits provision that applies to only part of its services, the terms of this paragraph will be applied separately to that part and to any other part.

When benefits are provided in the form of services, the reasonable cash value of each service shall be deemed the benefit.

HealthKeepers will not determine the existence of any other contract, or the amount of benefits payable under any other contract except this agreement. The payment of benefits under this agreement shall be affected by the benefits payable under other contracts only when HealthKeepers is given information about other contracts.

If the rules of this agreement and the other contract both provide that this agreement is primary, then this agreement is primary. When HealthKeepers determines that this agreement is secondary under the rules described below, benefits will be coordinated so that our payment plus the other contract’s payment will not exceed HealthKeeper’s maximum allowed amount for covered services.

Rules for determining primary/secondary status are as follows:

If coverage under a contract is taken out in the name of a covered person, then that contract will be primary for that covered person. However, if the person is also entitled to Medicare, and as a result of federal law Medicare is:

- secondary to the contract covering the person as a dependent; and
• primary to the contract covering the person as other than a dependent (e.g., a retired employee);

then the benefits of the contract covering the person as a dependent are determined before those of the contract covering the person as other than a dependent.

For children who are covered under both parents’ contracts, the following will apply:
• The contract of the parent whose birthday occurs earlier in the calendar year will be primary.

When parents are separated or divorced, the following special rules will apply:

• If the parent with custody has not remarried, that parent’s contract will be primary.
• If the parent with custody has remarried, that parent’s contract will be primary and the stepparent’s contract will be secondary. The benefits of the contract of the parent without custody will be determined last.

The rules listed above may be changed by a court decree:
• A court decree that orders one of the parents to be responsible for health care expenses will cause that parent’s contract to be primary, but only if the entity providing the benefits in this case is notified of the court decree before applying benefits.
• If the court decree does not state that one of the parents is responsible for health care expenses and both parents have joint custody, the contract of the parent whose birthday occurs earlier in the calendar year will be primary.

If the other contract includes the gender rule, then that rule will be used instead of the rules listed above. The gender rule states that the father’s contract will be primary for the children.

If there are situations not covered above, then the contract that has been in effect the longest period of time (without interruption) will be primary. There is an exception to this rule. The contract that covers a working employee (or his dependent) will be primary. The contract of a laid-off employee, a retired employee, or a person on continuation of coverage options under federal or state law will be secondary.

If another contract has different rules from those listed above other than the gender rule, that contract will be primary.

If payments should have been made under this agreement under the rules of this provision, but they have been made under any other contract, HealthKeepers may pay an entity (provider, other carrier, etc.) that has paid any amounts it determines will meet the intent of this provision. These amounts shall be deemed to be benefits paid under this agreement. Upon this payment, HealthKeepers will no longer be liable under this agreement.

**XVII. Grandfathered Health Plans**

By accepting this agreement, the group agrees to the following: In the event the group maintains a grandfathered health plan(s), as that term is used in the Patient Protection and Affordable Care Act (“PPACA”), the group shall not make any changes to such plan(s), including, but not limited to, changes with respect to employer contribution levels, without providing HealthKeepers with advance written notice of the intent to change such plan(s). Making changes to grandfathered plans without notice to HealthKeepers may result in the plan(s) losing grandfathered status and significant penalties and/or fines to the group and HealthKeepers. In the event the group implements changes to its plan(s) and does not
provide advance notice to HealthKeepers, the group agrees to hold harmless HealthKeepers from any penalties, fines or other costs assessed against HealthKeepers and to reimburse HealthKeepers for any such penalties, fines or other costs.

Additionally, at each renewal after September 23, 2010, the group shall affirm in writing, upon reasonable request of HealthKeepers, that it has not made changes to its plan(s) that would cause the plan(s) to lose it/their grandfathered status.

XVIII. Right of Recovery
HealthKeepers shall have the right to recover any overpayment of benefits from persons or organizations that HealthKeepers has determined to have realized benefits from the overpayment:

- any persons to or for whom such payments were made;
- any insurance company;
- a facility or provider; or
- any other organization.

The subscriber will be required to cooperate with us to secure HealthKeeper's right to recover the excess payments made on your behalf, or on behalf of covered persons enrolled under your family coverage.

Under certain circumstances, if HealthKeepers pays the healthcare provider amounts that are the responsibility of the member under this agreement, we may collect such amounts from the member.

C. Burke King
HealthKeepers, Inc.
President