UnitedHealthcare of Arizona, Inc.

Group Policy

For

University of Arizona Alternative Health Care Program

Enrolling Group Number: 730610

Policy Effective Date: January 1, 2027

Group Policy

UnitedHealthcare of Arizona, Inc.

1 East Washington Street, Ste. 1700

Phoenix, Arizona 85004

This Policy is entered into by UnitedHealthcare of Arizona, Inc. and the "Group," as described in Exhibit 1.

When used in this document, the words "we," "us," and "our" refer to UnitedHealthcare of Arizona, Inc.

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 of Arizona, Inc.



Heather Kane, President and CEO

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.

If a refund of an overpayment is due from a person or organization other than the Covered Person, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part: (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Policy; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which we make payments.

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, through our electronic systems, or by telephone when information provided is sufficient as determined by us within 60 days of the effective date of enrollments, terminations, or other changes. The Group must notify us in writing, through our electronic systems, or by telephone when information provided and documented is sufficient as determined by us each month of any change in the Coverage Classification for any Subscriber.

If premium taxes 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 on the anniversary date of the Group's Policy after we provide 60 days prior written notice to the Group.

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 Group agrees to remit to us the Policy Charge due which is based on our enrollment records as provided by the Group at the time the invoice for the Policy Charge is issued. 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. If the Policy Charge remains unpaid, the Policy will end as described below under *5.1 When Does the Policy End?*

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 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. The Group's coverage under this Policy will continue in force during the grace period, provided the past due Policy Charge is paid prior to the end of the grace period subject to termination as provided in Article 5. 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?

The eligibility rules are the requirements the Group must use to determine who is eligible for coverage under the Policy. The eligibility rules must be applied consistently and can be found in this Policy, Group *Application*, and within 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 annual Open Enrollment Period or the special enrollment period. The term special

enrollment period has the same meaning as described in the provision titled *Special Enrollment Period Required by Federal Law* in *Section 3: When Coverage Begins* of the attached *Certificate of Coverage*.

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. At our option, retroactive to the last paid date of coverage if the grace period expires and the Policy Charge remains unpaid on the due date.

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 60 days prior written notice to the Group, that this Policy will end due to the Group's violation of the participation and contribution rules as shown in Exhibit 1.

D. On the date we specify, after at least 60 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. If this occurs, we will offer the Group the option to purchase any other health benefit plan that we currently offer.

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 attempted, in good faith, to resolve the dispute amongst themselves. In the event the dispute is not resolved within 30 days after one party has received written notice of the dispute from the other party, and either party wishes to pursue the dispute further, the dispute may be submitted to arbitration as noted below.

The parties acknowledge that because this Policy affects interstate commerce, the *Federal Arbitration Act* applies. If the Group wishes to seek further review of the dispute, it must submit the dispute to binding arbitration according to the rules of the *American Arbitration Association*. Binding arbitration is subject to Arizona Rules of Civil Procedure or otherwise agreed to by the parties. This is the only right the Group has for further consideration of any dispute that arises out of or is related to this Policy.

Arbitration will take place in Maricopa County, Arizona.

The matter must be submitted to binding arbitration within one year of the date notice of the dispute was received. The arbitrators will have no power to award any punitive or exemplary damages or to vary or ignore the provisions of this Policy, and will be bound by controlling law.

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

At least 60 days before the anniversary date of the Group's coverage under the Policy, we will provide written notice to the Group of any changes to its coverage under the Policy that would be effective on the anniversary date, including Amendments or alterations to the Policy. 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.

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.

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

We will provide at least sixty (60) days advance written notice regarding Policy administration to the Group's authorized representative and the Subscriber.

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 and billing and collection of Premium.

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 of Arizona, Inc. and University of Arizona Alternative Health Care Program, the Group.
2. **Effective Date.** The effective date of this Policy is 12:01 a.m. on January 1, 2027 in the time zone of the Group's location.
3. **Place of Issuance.** We are issuing this Policy in Arizona and reserve the right to review place of issuance determinations. The Policy is subject to the laws of the state of Arizona and ERISA, unless the Group is not a private plan sponsor subject to ERISA. To the extent that state law applies, Arizona law governs this Policy.
4. **Premiums.** We have the right to change the *Schedule of Premium Rates* shown in Exhibit 2, after a 60-day prior written notice at any time.
5. **Computation of Policy Charge.** A full month's Premium will be charged for any Covered Person who is covered under this Policy for any portion of a 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.** 50% 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 Group must maintain a minimum contribution requirement of 50% of the Premium for each Eligible Person.
9. **Notice.** Any notice sent to us under this Policy must be sent to:

   UnitedHealthcare of Arizona, Inc.

   1 East Washington Street

   Ste. 1700

   Phoenix, Arizona 85004

   Any notice sent to the Group under this Policy must be sent to:

   University of Arizona Alternative Health Care Program

   888 N. Euclid Ave, Suite 217

   Tucson, Arizona 85721
10. 730610: Group Number

Exhibit 2 Class 1

1. **Class Description.**

   All Employees enrolled in UnitedHealthcare Choice Plan ESEJ.

2. **Eligibility.** The eligibility rules are applied by the Group. The eligibility rules are the requirements the Group must use to determine who is eligible for coverage under the Policy. In addition to the requirements below, the eligibility rules can be found in this Policy, Group *Application,* and within the *Certificate of Coverage*:

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

      None.

   B. Notwithstanding the 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. Minimum required hours per week as outlined in the Group *Application* or as agreed to by the Group and us, and as required by applicable law.

   D. Other:

      None

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 January 1, 2027.

   For an Eligible Person who becomes eligible after the effective date of this Policy, the effective date of coverage is as determined by the Group, Benefits are effective the first day of the pay period following enrollment. 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 January 1, 2027 is shown below:

Coverage Classification	**Monthly Premium**
Subscriber only	$885.17
Subscriber and spouse	$1,858.87
Subscriber plus one child	$1,770.33
Subscriber plus family	$2,793.10

Exhibit 3 - Advocate4Me[SM]

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 - Performance Funding

The following Performance Funding provision, How Is the Policy Charge Paid?, addresses calculation of the Policy Charge. When Performance Funding applies, Article 3.4 of the Policy does not apply.

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 and as described below for Performance Funding. The Group agrees to remit to us the Policy Charge due which is based on our enrollment records as provided by the Group at the time the invoice for the Policy Charge is issued. The first Policy Charge is due and payable on or before the effective date of the Policy. Future Policy Charges are due and payable no later than the first day of each payment period specified in item 6 of Exhibit 1, while the Policy is in force. If the Policy Charge remains unpaid, the Policy will end as described under *5.1 When Does the Policy End?* of the Policy.

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

The following defined terms apply for Performance Funding:

Adjusted Policy Charge - the greater of: (a) the Policy Charge Due for the Policy year and (b) four times the Policy Charge Due for the last three calendar months of the Policy year.

Agreement Period - 12 consecutive months beginning with the effective date.

Experience Refund - the amount determined by us to be due to the Group for readjustment of the rate of Premium for the Policy based on the expense experience under the Policy, and according to the calculations shown under the *Experience Refund Calculations* provision below, in the form of a Policy Charge credit.

Experience Refund Report - the document that we will prepare and deliver to the Group containing details on Policy Charge Due, Policy Charge Paid, Total Expenses and any refund due.

Policy Charge Due - the sum of Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy due from the Group as calculated by us according to our records.

Policy Charge Paid - the sum of Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy due from and paid by the Group for a Policy year as calculated by us according to our records.

Total Expenses - the sum of all expenses incurred by us on behalf of Covered Persons during the Policy year, as calculated by us. Total Expenses will be calculated by adding the following amounts:

- *Retention* - a charge of 25.00% of the Policy Charge Due for a Policy year in consideration of: (i) the administrative services provided pursuant to the Policy; (ii) any premium tax or other governmental charge; and (iii) the risk for the Experience Refund assumed by us.
- *Incurred Allowed Amounts* - Allowed Amounts incurred during a Policy year, which will be determined as (1) plus (2) minus (3) as follows:

  (1) Allowed Amounts paid during a Policy year, irrespective of the date they are incurred.

  (2) 11.0% of the Adjusted Policy Charge for a Policy year.

(3) 9% of the Adjusted Policy Charge for the prior Policy year (but $0 if the Policy year is the initial Policy year).

The following provisions apply for Performance Funding:

How Is Experience Refund Calculated?

The following formulas will be used to calculate any Experience Refund due:

- Policy Charge Paid minus Total Expenses equals the excess amount of Policy Charge Paid.
- Experience Refund equals the lesser of: (a) 50% multiplied by the excess amount of Policy Charge Paid.

The Experience Refund will be calculated by us in accordance with the following terms:

- In the event Total Expenses equal or exceed the Policy Charge Paid, no Experience Refund will be made.
- In the event the Policy Charge Paid exceeds Total Expenses, no Experience Refund will be made if the Policy has been terminated by either us or the Group prior to the end of a Policy year or by the Group at the time the Experience Refund Report is delivered.
- In the event the Policy Charge Paid exceeds Total Expenses, an Experience Refund will be made in the form of a Policy Charge credit. The Policy Charge credit will be applied to one or more of the Policy Charge statements which become due after the date the Experience Refund Report is delivered.

Does the Group Offer Multiple Policies?

When the Group has coverage under other Policies for which we, or our related entities, make payments, this Performance Funding provision will apply to the multiple Policies. It will be applied as a single calculation, combining all features of Performance Funding, as described in this Exhibit, across those multiple Policies.

What Is an Experience Refund Report?

We will prepare and deliver to the Group an Experience Refund Report containing details on Policy Charge Due, Policy Charge Paid, Total Expenses and any refund due. Such report will be delivered within 120 days following the last day of the Policy year. The Experience Refund Report will contain details regarding the method used by us to make any refund due.

When Does Performance Funding End?

Performance Funding may end in any of the following ways:

- If the Policy ends, Performance Funding will automatically end at the same time; provided however, that the Group will be entitled to any outstanding Experience Refund if the Group is then subsequently contracted with us for an administrative services only (self-funded) arrangement for medical benefits similar to those provided under the Policy.
- Performance Funding may end upon any mutually agreed upon date.

What Is the Relationship of Experience Refund to Receipt of Benefits?

The amount of any Experience Refund made in accordance with the terms of Performance Funding will bear no relationship to the frequency or extent of Benefits furnished to any specific Covered Person, but will be based only on the Allowed Amounts for Benefits paid for all Covered Persons under the Policy during the Policy year.