Promise Health Plan
300 E McBee Avenue,
Suite 501
Greenville, SC 29601

Employer Group Application

SECTION A. GENERAL INFORMATION

1. Legal Name of Employer			
2. Company Name (DBA)		Tax ID	
3. Street Address	City	State	Zip
4. Mailing Address	City	State	Zip
5. Phone Number	Fax Number		
Email Address	Company Website		
6. Business Type ☐Sole Proprietorship ☐Partnership ☐Corporation ☐LLC ☐Other:			
Other business type:			
7. Nature of Business		In Business Since	
SIC Industry State			
8. Company Owner(s)	Email Address		
Title	Phone Number		
9.Company Contact(s)	Email Address		
Title	Phone Number		
10. Is Company subject to ERISA? ☐ Yes ☐ No	Renewal Date		

SECTION B. BENEFITS SELECTION

Plan Type ☐ Level Funded ☐ Traditional Self-Funded			
Plan Period ☐ Contract Year Month:	☐ Calendar Year		
Secondary Network ☒			
Pharmacy Benefit Manager CVS			
Is the plan currently grandfathered? ☐ Yes ☐ No			
Coverage Tier Selection ☐ Employee	☐ Employee +1	☐ Employee +Spouse	
☐ Employee +Child(ren)	☐ Family		
Does Carryover Deductible apply? ☐ Yes ☐ No			
Do you want to allow for coverage of domestic partners? ☐ Yes ☐ No			
Are you offering coverage for retirees? ☐ Under age 65	☐ Over age 65		

Any person who, with intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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SECTION B. BENEFITS SELECTION (CONTINUED)

Open Enrollment Period Begin Date: End Date:

What method will be utilized to maintain eligibility? ☐ Portal ☐ EDI Feed*

*EDI File implementation takes 60-180 days with client established vendor.

Complete the following fields if EDI is the chosen method.

EDI Vendor Name:

EDI Contact Name:

EDI Contact Email:

EDI Contact Phone Number:

If Luminare Health is not the COBRA administrator, please complete the following fields:

COBRA Vendor Name:

COBRA Contact Name:

COBRA Contact Email:

COBRA Contact Phone Number:

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SECTION B. BENEFITS SELECTION, COVERAGE OPTIONS

Benefit	What is covered?	Cost Share	Limitations/Exclusions	Recommendation
Acupuncture ☐ Cover ☐ Do not cover	Acupuncture, 1 or more needles with or without electrical stimulation.	Specialist physician cost share applies.	Limited to 24 visits per benefit period.	Most plans do not cover this service.
Hearing Aids ☐ Cover ☐ Do not cover	One hearing aid per ear, every 3 years, up to $2,000 per hearing aid.	Durable Medical Equipment benefit applies.	Limited to one hearing aid per ear, every 3 years, up to $2,000 per hearing aid.	Most plans do not cover this service.
Infertility Treatment ☐ Cover ☐ Do not cover	Charges for treatment of infertility may include artificial insemination, invitro fertilization, fertility drugs when used for treatment of infertility, embryo implantation, or gamete intrafallopian transfer (GIFT).	Cost share dependent upon place of service.	Limited to $10,000 per member per lifetime. Charges for surrogacy will not be covered, unless the surrogate mother is a covered person, in which case expenses would be eligible under the Woman's Preventive Services and/or Pregnancy benefits.	Most plans do not cover this service.

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SECTION C. ENROLLMENT INFORMATION

1. Requested Effective Date:

2. Employer's Contribution will be:

_____ of the single employee premium, and

_____ of the dependent coverage premium.

3. What is the New Hire Wait Period?

Salaried Employees: _____ day(s) of employment.

Hourly Employees: _____ day(s) of employment.

4. Employer groups must select whether continuation or COBRA benefits will be available to employees who lose eligibility under the group policy. Please select one of the following options:

☐ COBRA ☐ 12 Months of continuation (this option only for groups not eligible for COBRA)

5. Has this Employer ever been covered by Promise Health Plan before? ☐ Yes ☐ No

If yes, dates of coverage:

6. Total number of active full and part-time employees as defined in Section E:

7. Total number of eligible employees as defined in Section E:

8. Total number of eligible employees waiving group health insurance:

9. Total number of eligible employees applying for group health insurance:

10. Are any of the employees or dependents applying for group health insurance totally disabled? ☐ Yes ☐ No

If yes, please explain: _____

Name: _____ Age: _____ Date of Disability: _____

Name: _____ Age: _____ Date of Disability: _____

If you need additional space, please use the supplemental dependent page provided at the end of this form.

11. Are all eligible employees covered by Worker's Compensation? ☐ Yes ■ No

12. Who is your company's current health insurance carrier?

Carrier phone number: Years with this carrier:

☐ No Current Carrier

13. Under the Medicare Secondary Payer rules, which one applies for your group?

☐ Medicare is primary (less than 20 full time and part time employees)

☐ Promise Health Plan is primary (20 or more full time and part time employees) Promise Health Plan is primary coverage for groups with 20 or more total employees on each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

Promise Health Plan

SECTION D. EMPLOYER AGENT BROKER DESIGNATION (IF APPLICABLE)

The Employer authorizes the following agent(s)/broker(s) or agency(s) to be the Employer's Agent of Record:

Primary Agent/Broker

Name:	National Producer Number:
Name of Agency:	Email Address:

Secondary Agent/Broker

Name:	National Producer Number:
Name of Agency:	Email Address:

General Agent

Name:	National Producer Number:
Name of Agency:	Email Address:

To be completed by Primary Agent or Broker

Primary Agent PEPM	**Secondary Agent PEPM**

I as the Agent of record represent that all information contained above is complete and wholly true to the best of my knowledge, and that I know nothing unfavorable about the firm or any individual proposed for insurance except as noted on their Enrollment Application. I have complied with all all applicable eligibility and enrollment rules and have explained in detail the coverages. Any exceptions are detailed here or are referenced to on an additional sheet.

☐ Copy of Agent or Broker W-9 included

SIGNATURE OF PRIMARY AGENT/BROKER	DATE SIGNED (mmddyyyy)

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HIPAA and Privacy Authorization Form

Group Name _____ Group Number _____

INTRODUCTION

The Health Insurance Portability and Accountability Act (HIPAA), requires express permission before we may discuss/release your protected health information (PHI) to the employer's representative, insurance agent or any other delegated entity. This authorization is needed to document the group's intent and to identify the person(s) who have your permission to contact us on behalf of the group for claims status, benefit information, and/or other matters pertaining to the Plan.

TERMS

The individuals designated below are authorized to access reports, enrollment data, claims information of enrolled individuals and/or have access to the web portal on behalf of the Employer Group to conduct administrative activities as set forth in the HIPAA Privacy Provisions and applicable state data security laws. The Group/Employer Group and designated individuals are responsible to train personnel, take the appropriate and reasonable safeguards to protect the confidentiality, integrity, and availability of PHI of individuals, report to the Employer and Promise Health Plan any use or disclosure of an individual's PHI made in violation of or inconsistent with HIPAA or any applicable state data security laws. The Group/Employer Group and designated individuals will report to Promise Health Plan in a timely manner of any changes to previously submitted listing of employees and/or Business Associates allowing them with access to PHI data.

AUTHORIZATIONS FOR EMPLOYEES

Name	Job Title	Last 4 digits of SSN	Signature	Reports Including Claims	Eligibility	E-mail Address

AUTHORIZATIONS FOR BUSINESS ASSOCIATES

Name	Job Title*	Last 4 digits of SSN	Signature	Reports Including Claims and Eligibility		E-mail Address
				With PHI	Without PHI	

*Please indicate the organization this individual represents, e.g., your Broker/Agent. Please note Promise Health Plan requires any designated Business Associate to sign the Subcontractor Business Associate Agreement included in this packet.

Completed form should be returned to [EMAIL ADDRESS] or your Promise Health Plan representative.

Promise® Health Plan

SECTION E. ELIGIBILITY REQUIREMENTS FOR GROUPS COVERING 1099 EMPLOYEES (IF APPLICABLE)

For groups extending coverage to Contract (1099) Employees, the following guidelines will apply:

1. The Company must enroll (and maintain) at least 25 W-2 taxed employees.
2. No more than 50% of the group's eligible employees may be 1099 employees.
3. Eligible 1099 employees must be employed by the Company full time and year round.
4. Eligible 1099 employees are subject to the same waiting period (s) as all other eligible W-2 employees.
5. All present and future 1099 employees are subject to the same eligibility requirements as W-2 employees.
6. The Company must contribute the same amount for health insurance coverage for the 1099 employees at it contributes for all other eligible W-2 employees.

Please list below all individuals who meet the above qualifications and then sign below.

If you have more than six (6) 1099 employees please attach an additional sheet of paper and continue to fill out the information requested for all eligible 1099 employees.

Name	Social Security Number	Date of Hire	Hours per Week

COMPANY NAME (PLEASE PRINT)

AUTHORIZED SIGNATURE

DATE SIGNED (mmddyyyy)

Promise® Health Plan

SECTION E. EMPLOYEE ELIGIBILITY

An eligible employee is one of the following persons who is determined to be eligible for coverage under this contract by the Employer, subject to acceptance by the plan:

1. A Full-time employee (at least 17 years of age) of the Employer who works at least 30 hours per week as of the effective date and who works 50 weeks or more per year.
2. An employee who enters into full-time employment after the policy's effective date and who completes the required probationary (waiting) period for eligibility.
3. An employee who is employed and at the Employer's usual place of business. Full-time sales personnel with a primary source of income from the Employer are eligible.
4. An employee who receives a regular paycheck wherein the Employer deducts social security and/or state and federal income taxes.
5. Partners and owners are eligible only if they are bona fide employees of the organization whose main job is to conduct business for the Employer and they meet all other employee eligibility requirements.

SECTION F. EMPLOYER ELIGIBILITY

The Employer certifies that the information on this form is correct to the best of his/her knowledge. The employer further agrees to submit to the following requirements with the application and as may be necessary in the future:

1. The Employer is a corporation, partnership or proprietorship.
2. That the Employer is financially stable and has a minimum of two (2) participating employees.
3. That a payroll deduction system for employee contribution, if any, is in place.
4. That the Employer understands Promise Health Plan requires a minimum contribution with groups of 25 or more total employees.
5. That no other group health policy shall be in force.
6. That the employer will permit any eligible employee (as defined in Section E) to enroll.
7. That the Employer's organization was not formed for the sole purpose of obtaining insurance coverage.
8. That the Employer will assist the plan in obtaining a signed statement from the employee or dependents indicating coverage by any other insurance company for coordination of benefits purposes only.
9. That the Employer will permit an audit by Promise Health Plan to verify compliance with all policies, procedures and eligibility requirements as defined by the Plan.

SECTION G. FOR CLIENTS ENROLLING IN PROMISE HEALTH PLAN HSA PLAN:

The employer acknowledges that Promise Health Plan HSA is an integrated product providing individual subscribers with the option to select Promise Health Plan's partner [HealthEquity] to administer a Health Savings Account (HSA) for them. As the sponsor of this benefit plan the employer will do the following:

1. Enable employees who establish an HSA with [HealthEquity] to make contributions to this account via payroll deduction.
2. Direct employer HSA contributions, if any are to be made, to employee accounts at [HealthEquity].

SECTION H. NON-PAYMENT OF PREMIUMS AND FUTURE COVERAGE

Your premiums must be paid in full on time in order for your coverage to remain in effect. In accordance with the plan's grace period provisions, your coverage will be cancelled for non-payment of premiums. If you later decide to apply for enrollment in another Promise Health Plan, before the new coverage will start, we will require that you pay all past due premium owed to us for coverage you were enrolled in during the twelve-month period prior to the effective date of the new coverage. This will apply to annual open enrollment periods and special enrollment periods. You will also have to pay any applicable initial binder payments for your new coverage.

SECTION I. EMPLOYER CERTIFICATION

I represent that all information noted on this Employer Group Application and all Employee Applications / Health Questionnaires is true and accurate to the best of my knowledge. I hereby confirm that all employer and employee eligibility guidelines have been met and will continue through the contract. I understand that non-payment of premiums may result in a termination of coverage for all parties. I also understand that the proposed insurance coverage shall not become effective until approved by the plan.

PLEASE PRINT NAME	TITLE
AUTHORIZED SIGNATURE	DATE SIGNED (mmddyyyy)

Promise® Health Plan

Supplemental Form for Dependents (page 2, item 10)

Page 2, Item 10, continued: Are any of the employees or dependents applying for group health insurance totally disabled? If so, list them below

Name:		Age:		Date of Disability:	
Name:		Age:		Date of Disability:	
Name:		Age:		Date of Disability:	
Name:		Age:		Date of Disability:	
Name:		Age:		Date of Disability:	
Name:		Age:		Date of Disability:	
Name:		Age:		Date of Disability:	
Name:		Age:		Date of Disability:	
Name:		Age:		Date of Disability:	
Name:		Age:		Date of Disability:	
Name:		Age:		Date of Disability:	

Promise Health Plan

SUBCONTRACTOR BUSINESS ASSOCIATE AGREEMENT

THIS SUBCONTRACTOR BUSINESS ASSOCIATE AGREEMENT (this "Agreement"), by and between **Promise Risk Management Services, LLC** (the "Company") and on behalf of itself and its subsidiaries (the "Subcontractor Business Associate"), is effective as of

RECITALS

WHEREAS, the Company is a Business Associate to a health plan (the "Plan"), which is a covered entity, as such term is defined in the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and the Regulations (as defined below) promulgated thereunder; and

WHEREAS, due to the services (the "Services") performed by the Subcontractor Business Associate with respect to the Plan, Protected Health Information and Electronic Protected Health Information (collectively, "PHI") subject to those regulations set forth at 45 C.F.R. Parts 160-164 ("Privacy Regulations") and those regulations setting out the Standards for Security for Electronic Protected Health Information at 45 C.F.R. Part 160 and Subparts A and C of Part 164 ("Security Regulations"), promulgated by the United States Department of Health and Human Services ("HHS") under HIPAA (all regulations promulgated under HIPAA, as amended, the "Regulations"), may be transmitted, created, received, and/or maintained; and

WHEREAS, to the extent required by the Regulations, the Subcontractor Business Associate and the Company desire to comply with the "Subcontractor Business Associate" requirements of the Regulations and to memorialize their agreements with respect to such compliance.

AGREEMENT

NOW, THEREFORE, for an in consideration of the mutual covenants and conditions set forth herein, and other good and valuable consideration, the receipt and adequacy of which hereby are acknowledged, the Subcontractor Business Associate and the Company agree as follows:

1. Definitions. Unless otherwise defined herein, capitalized terms shall have the same meanings as set forth in the Regulations.

2. Restrictions on Use and Disclosure of PHI. The Subcontractor Business Associate may use PHI only to perform the permitted and required Uses and Disclosures as provided by this Agreement or as Required By Law. The Subcontractor Business Associate shall make reasonable efforts to limit PHI that is subject to this Agreement to the minimum amount that is necessary to accomplish the intended purpose of a required or permitted Use or Disclosure under this Agreement. To the extent practicable, Subcontractor Business Associate agrees that each use, disclose, or request of PHI shall be limited to PHI in a limited data set, as that term is defined at 45 C.F.R. § 164.514(e)(2).

AGREEMENT, continued

2. Restrictions on Use and Disclosure of PHI, continued. The Subcontractor Business Associate shall not Use or Disclose PHI received from the Company or any participant in a Participating Health Plan in any manner that would constitute a violation of the Regulations if the Company made the same Use or Disclosure, except that the Subcontractor Business Associate may Use or Disclose such PHI for the Subcontractor Business Associate's proper management and administration and legal responsibilities.

The Subcontractor Business Associate may Disclose PHI for the purposes described in this Section 2 only in the following circumstances: such Disclosure is Required By Law; or the Subcontractor Business Associate obtains reasonable assurances from the person to whom the PHI is Disclosed that it will be held confidentially and Used or further Disclosed only as Required By Law or for the purpose for which it was Disclosed to the person, and the person agrees to notify the Subcontractor Business Associate of any instances of which it is aware in which the confidentiality of the PHI has been breached.

3. Agents and Subcontractors Bound by Agreement. If any agent or subcontractor of the Subcontractor Business Associate (other than the Subcontractor Business Associate's Workforce) will have access to PHI that is received from, or created or received by the Subcontractor Business Associate on behalf of the Company, then the Subcontractor Business Associate will enter into an agreement with such agent or subcontractor whereby the agent or subcontractor agrees to be bound by the terms of this Agreement with respect to PHI.

4. Safeguards for Protection of PHI; Report of Unauthorized Use or Disclosure. The Subcontractor Business Associate agrees that it will implement and use appropriate safeguards to prevent any Use or Disclosure of PHI in violation of this Agreement. The Subcontractor Business Associate agrees that it will report to the Company and the applicable Participating Health Plan any Use or Disclosure of PHI, of which the Subcontractor Business Associate becomes aware, that is in violation of this Agreement, including breaches of unsecured PHI as required at 45 C.F.R. § 164.410 and any security incident of which it becomes aware. The Subcontractor Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to the Subcontractor Business Associate of a Use or Disclosure of PHI by the Subcontractor Business Associate in violation of this Agreement. Subcontractor Business Associate will not maintain any PHI outside the fifty states of the United States of America and the District of Columbia, except upon the prior written notice to Company.

AGREEMENT, continued

5. Cooperation by the Subcontractor Business Associate. The Subcontractor Business Associate agrees to cooperate with the Company and/or the applicable Participating Health Plan in providing an accounting of Disclosures of PHI received under this Agreement as requested by an individual to whom it relates, except to the extent the Regulations provide otherwise. In the event that Subcontractor Business Associate uses or maintains an electronic health record, Subcontractor Business Associate agrees that such accounting shall include disclosures made to carry out treatment, payment, and health care operations through the use of such electronic health record. Upon receiving a request for an accounting of disclosures directly from an individual who has received an accounting of disclosures from Company, which provided a list of all Subcontractor Business Associates acting on behalf of the Plan, including Subcontractor Business Associate, Subcontractor Business Associate agrees to provide an accounting of its disclosures of PHI to such individual as required by the Privacy Regulations. In response to such a request from an individual, Subcontractor Business Associate may elect to provide either (i) an accounting of disclosures that includes disclosures of subcontractors and/or agents acting on behalf of Subcontractor Business Associate or (ii) an accounting of disclosures that are made by the Subcontractor Business Associate as well as a list of all subcontractors and/or agents acting on behalf of Subcontractor Business Associate, including contact information such as mailing address, phone, and email address. The Subcontractor Business Associate shall respond to requests from the Company for the information described in this Section 5 and make available such information to the Company within a reasonable period of time to enable the Company to timely respond to any request.

The Company agrees that the Subcontractor Business Associate will not maintain any Designated Record Sets on its behalf and that the Subcontractor Business Associate assumes no responsibility to respond to individuals' requests for access or amendments as provided in Sections 164.524 and 164.526 of the Regulations.

Subcontractor Business Associate agrees that the requirements of the Privacy Regulations shall be applicable to Subcontractor Business Associate in the performance of its obligations pursuant to the Agreement.

Subcontractor Business Associate agrees that it shall not directly or indirectly receive remuneration in exchange for any PHI, unless a valid authorization, as that term is defined at 45 C.F.R. § 164.508, is obtained or the purpose of the exchange meets one of the exceptions set forth in 45 C.F.R. 164.502(a)(5)(ii).

6. Documenting Disclosures. In order to cooperate with the Company in accordance with Section 5 above, the Subcontractor Business Associate agrees to document all Disclosures of PHI and information related to such Disclosures as would be required for the Company to respond to an individual's request for an accounting of Disclosures of PHI under Section 164.528 of the Regulations. Such documentation shall include: (a) the date of the Disclosure; (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a brief description of the PHI Disclosed; and (d) a brief statement of the purpose of the Disclosure (which would reasonably inform an individual of the basis for the Disclosure).

AGREEMENT, continued

7. HHS. The Subcontractor Business Associate agrees to make its internal practices, books and records relating to the Use and Disclosure of PHI received from or created or received by the Subcontractor Business Associate on behalf of the Company available to the Secretary of HHS for purposes of determining the Company's compliance with the Regulations. Notwithstanding this Section 7, no attorney-client privilege or other privilege shall be deemed waived by the Company or the Subcontractor Business Associate.

8.Termination. Company and Subcontractor Business Associate shall each have the right to immediately terminate this agreement upon the violation by the other of a material term of this Agreement or of the Regulations, including violations relating specifically to the permitted and required Uses and Disclosures of PHI by the Company or Subcontractor Business Associate; provided, however, that the breaching party shall be provided the opportunity to cure the breach to the satisfaction of the other within a reasonable period of time. If the breaching-party does not cure the default, the non-breaching party shall be entitled to terminate this Agreement or if it is not feasible to terminate this Agreement, report the problem to the Secretary of HHS.

Upon termination of this Agreement, the Subcontractor Business Associate and the Company agree to determine whether the return or destruction of PHI received from, or created or received by, the Subcontractor Business Associate under this Agreement is feasible. If such return or destruction is mutually determined to be feasible, the Subcontractor Business Associate shall promptly return or destroy all such PHI received from or created or received by the Subcontractor Business Associate under this Agreement. If such return or destruction is mutually determined to not be feasible, the protections of this Agreement shall continue to apply to such PHI after termination (including the Subcontractor Business Associate's obligations in Section 5), and further Uses and Disclosures of such PHI shall be restricted to only those purposes that make the return or destruction of the information infeasible. If mutual agreement is not made as to the feasibility of any return or destruction of PHI, the parties agree to use mediation to resolve this issue.

9. Term of Agreement. The term of this Agreement shall be such period of time as the Subcontractor Business Associate is performing the Services. In the event that such Services are terminated, this Agreement also shall terminate, except that the provisions of Sections 8 and 15 shall survive any termination of this Agreement.

Promise Health Plan

AGREEMENT, continued

10. Notice. All written communications, demands, and notices between the parties hereto must be posted by first class mail, postage paid or express mail to the following addresses:

To the Subcontractor Business Associate:

To the Subcontractor Business Associate:

Promise Risk Management Services, LLC

Attn: VP, Promise Health Plan

300 E. McBee Ave., Ste. 500

Greenville, SC 29601

11. Entire Agreement. This Agreement supersedes all previous contracts and constitutes the entire agreement of whatever kind or nature existing between the parties with respect to the subject matter hereof, and no party shall be entitled to benefits other than those specified herein. As between the parties, no oral statement or prior written material not specifically incorporated herein shall be of any force and effect; and the parties specifically acknowledge that in entering into and executing this Agreement, the parties rely solely upon the representations and agreements contained in this Agreement and no others. This Agreement may be amended only by an instrument in writing executed by the parties hereto and may be supplemented only by documents delivered in accordance with the express terms hereof.

12. Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but which together shall constitute one and the same instrument.

13. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein or therein confer, upon any person other than the Company and the Subcontractor Business Associate and their respective successors or assigns in interest, any rights, remedies, obligations, or liabilities whatsoever.

14. Modification For Change in Law. Upon the occurrence of changes or amendments to the Regulations or other law that affect the legality of or any provision in this Agreement, the Company and the Subcontractor Business Associate agree to modify this Agreement to comport with such changes or amendments. Any such modification of this Agreement shall be in writing and signed by the Company and the Subcontractor Business Associate.

AGREEMENT, continued

15. Indemnification. Subcontractor Business Associate shall indemnify, defend, and hold harmless the Company, the Plan, and Covered Entity's affiliates (the "Indemnified Parties"), from and against any and all losses, expense, damage, or injury (including, without limitation, all costs and reasonable attorney's fees) that the Indemnified Parties may sustain as a result of, or arising out of: (a) a breach of this Agreement by Subcontractor Business Associate or its agents or Subcontractors, including but not limited to, any unauthorized use of PHI; (b) Subcontractor Business Associate's failure to notify any and all parties required to receive notification of any Breach of unsecured PHI; or (c) any negligence or wrongful acts or omissions by Subcontractor Business Associate or its agents or Subcontractors, including, without limitation, failure to perform Subcontractor Business Associate's obligations under this Agreement, the Privacy Regulations or the Security Regulations. Notwithstanding the forgoing, nothing in this Agreement shall limit any rights that any of the Indemnified Parties may have under applicable law for any acts or omissions of Subcontractor Business Associate or its agents or its Subcontractors.

16. Security. The Subcontractor Business Associate shall:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Company as required by the Regulations;

(b) Ensure that any agent, including any subcontractor, to whom the Subcontractor Business Associate provides such Electronic Protected Health Information agrees in writing to implement reasonable and appropriate safeguards to protect it;

(c) Report to the Company any security incident of which the Business Associate becomes aware; provided that the parties acknowledge that probes and reconnaissance scans are commonplace in electronic information systems and the parties therefore acknowledge and agree that, to the extent such probes and reconnaissance scans constitute security incidents under the Security Rule, this Section 16(c) constitutes notice to the Company of the ongoing existence and occurrence of such security incidents for which no additional notice shall be required. Probes and reconnaissance scans include, without limitation, pings and other broadcast attacks on the Business Associate's firewall, port scans, and unsuccessful log-on attempts, as long as such probes and reconnaissance scans do not result in unauthorized Use or Disclosure of PHI;

(d) Make its policies and procedures and documentation required by the Regulations relating to such administrative, physical, and technical safeguards, available to the Secretary of HHS for purposes of determining the Company's compliance with the Regulations;

(e) Acknowledge its obligation to comply with the Security Regulations in using and disclosing Electronic Protected Health Information, including but not limited to 45 C.F.R. §§ 164.308 (Administrative safeguards), 164.310 (Physical safeguards), 164.312 (Technical safeguards), and 164.316 (Policies and procedures and documentation requirements) of the Security Regulations.

(f) Notify the Company without unreasonable delay in writing of the occurrence of a breach, as that term is defined at 45 C.F.R. § 164.402, of which Subcontractor Business Associate becomes aware. Subcontractor Business Associate shall also promptly provide Company such other information required to be provided to individuals under 45 C.F.R. § 164.404(c) as it becomes available after such breach.

17. Governing Law. Except to the extent preempted by federal law, this Agreement shall be governed by and construed under the laws of the State of South Carolina without regard to the principles of conflicts of laws of said state.

IN WITNESS WHEREOF, the parties herein have caused this Subcontractor Business Associate Agreement to be executed by their duly authorized representatives as of the date first written above.

COMPANY	SUBCONTRACTOR BUSINESS ASSOCIATE
_____	_____
By: _____	By: _____
Its: _____	Its: _____