isolved Benefit Services Service Agreement

Section 1: Employer Information

Employer Legal Name– Please print ("Employer")		
Federal Employer Identification Number (FEIN)	isolved Customer Account Number (Please include on check when sending in payment)	
Number of Benefits Eligible Employees	Number of Benefits Enrolled Employees	Number of Reporting Locations
Address	City/State/Zip	
Phone number	Fax number	Nature of business
Primary Contact ☐ All Svcs ☐ COBRA only ☐ FSA only ☐ PHI Contact	Telephone	E-mail address
Secondary Contact ☐ Reports ☐ All Svcs ☐ COBRA ☐ FSA ☐ PHI Contact	Telephone	E-mail address
Implementation Contact *(if other than primary contact)*	Telephone	E-mail address
Agency Contact	Telephone	E-mail address

Third Party Reporting Authorization (if applicable)

We hereby authorize the following designee to submit certain reporting forms on our behalf, which we acknowledge are our responsibility to provide. We are aware that if this reporting arrangement changes, we must notify isolved directly. If we assign this reporting function to any other source, we will make isolved aware of such a change.

Agency name:			
Agency contact		Phone	
Address		Fax	
E-mail address		Other	
We authorize the above designee for:	Online access: ☐ Yes ☐ No	Contact on COBRA notice: ☐ Yes ☐ No	PHI Contact: ☐ Yes ☐ No

Section 2: Terms and Conditions and Service Agreements

Employer is purchasing the service(s) listed below in Section 3 and, in doing so, each party acknowledges and agrees that isolved's General Terms and Conditions available at [www.isolvedbenefitservices.com/legal] (as may be amended from time to time) (the "Terms and Conditions") and the COBRA Service Agreement and General Notice Blanket Mailing and Open Enrollment Mailing Service Agreement available at [www.isolvedbenefitservices.com/legal] (as may be amended from time to time) (the "Additional Service Agreements") are each incorporated herein by reference and Employer shall have all rights and obligations of the "Employer" thereunder.

isolved Benefit Services use only		Agreement valid for 30 days from	
Internal agent #	HAS00000	Account #	
		Service effective date	

Section 3: Fees and Consideration

Current number of Insured Employees

	Service	Per Unit or Minimum	Setup Fee	Annual Fee	Total
✓	COBRA Administration	*		*	*
✓	COBRA Premium Collection			Included	
☐	COBRA Open Enrollment (requires Premium Collection)	*$12.00 per packet mailed, or $60.00 minimum			
☐	COBRA Eligibility Management				
☐	State Continuation Coverage Administration (for CA ☐ NY ☐ TX ☐ CT ☐ MN ☐ CO ☐ UT ☐ VA ☐ PA ☐ DE ☐ &MD ☐ only) (requires Premium Collection)				
☐					*

COBRA fees are based upon one reporting location. Separate tracking for additional locations will require an additional annual fee per location.

Check box if applicable.

☐ Employer is a customer on the iSolved HCM Platform for payroll and benefits enrollment and would like full integration of COBRA and iSolved.

Fringe Benefit Account Based Plans

	Service	Per Unit or Minimum	Setup Fee	Annual Fee	Total
☐	Health Flexible Spending Account Administration (IRC Sections 105 and 125)				
☐	Dependent Care Flexible Spending Account Administration (IRC Sections 129 and 125)				
☐	Limited Health Flexible Spending Account Administration (IRC Sections 105 and 125)				
☐	Health Reimbursement Arrangement Administration (IRC Section 105)				
☐	Transit Account Administration (IRC Section 132)				
☐	Parking Account Administration (IRC Section 132)				
☐	Health Savings Account Administration (IRC Section 223)				
☐	Tuition Reimbursement Account Administration (IRC Section 127)				
☐	Life Style Flexible Spending Account Administration (IRC Sections)				
☐					
☐	Electronic Payment Card Services - included for all Fringe Benefit Plans (including Health Savings Accounts) except certain HRAs. An additional $.15 pppm charged for each Transit Plan participant.				

If purchasing any of the services listed above, please indicate:

Current number of FSA participants	Current number of Transit participants
Current number of HRA participants	Current number of Parking participants
Current number of HSA participants	Number of Banking Accounts
Plan year start date	Plan year end date

Check box if applicable.

☐ Employer is a customer on the isolved HCM Platform for payroll and benefits enrollment and would like full integration of Fringe Benefit and isolved.

Please Note:*Discount applied.

Section 4: Additional Service Fees and Consideration

Not including applicable fees noted above in Section 3, additional service fees may apply for services outlined below:

Additional COBRA Service Fees (if applicable):

1. Premium Remittance Check Fee - $10 per check. Direct deposit remittance provided at no additional cost.
2. General Notice Blanket Mailing for existing covered individuals - $3.25 per notice, $50 minimum. General notices for new insurance enrollees included in applicable fees from Section 3 of this Agreement.
3. Custom reports or extraneous development - $190 per hour. Such requests are subject to approval by isolved.
4. Open Enrollment mailing service prior to service effective date: Setup fee $200 (plus $12 per packet mailed).

Additional Fringe Benefit Administration Service Fees (if applicable):

1. FSA enrollment kits - $.95 each for paper (free online)
2. FSA enrollment meetings – Negotiable fee plus travel expenses; webinars available at no charge
3. FSA paper enrollments - $2.50 per enrollment, $25 minimum.
4. Additional Debit Cards - Participants receive two cards initially at no charge. Additional/replacement debit cards are $5 per set of two cards, deducted from participant account.
5. Plan changes after plan initialized - $150 per hour, minimum one hour.
6. Custom reports or extraneous development - $190 per hour. Employer shall submit such requests and are subject to approval by isolved.
7. Positive Pay Tool - $500 annually
8. ACH Transfer failure - $75 each
9. Additional non-discrimination tests not otherwise included - $1,000

Additional Health Savings Account Administration Service Fees (if applicable):

1. Paper Enrollment - $10 each

Standard Hourly Rate for Correcting Inaccurate Data (any service) = $150 per hour

IN WITNESS WHEREOF, Employer and isolved have caused this Agreement to be executed in their names by their undersigned officer, the same being duly authorized to do so. Please sign, date and return this Service Agreement via email to salesagreement@isolvedhcm.com.

Employer Authorized Signature	Date
isolved Authorized Signature	Date

COBRA

Employer Legal Name:

Notices – The information provided below will be used to generate the COBRA notices for your company.

1. Provide the name of your group health plan:

If you do not provide it, we will list it as "(Legal Name) Group Health Plan"

2. Are there locations or insured employees who reside in California? ** ☐ Yes ☐ No ***If no, move to question 3*

If not answered or both are answered, isolved Benefit Services will include

a. Is the group health plan fully insured or self insured? ☐ Fully insured ☐ Self-insured

b. Is the group health plan written in the state of California? ☐ Yes ☐ No

c. Are 51% or more of your employees and the principal place of business located in California? ☐ Yes ☐ No

3. Does your company sponsor any group health plan insurance or HMO contract(s) written in the state of Illinois? ☐ Yes ☐ No

4. Does your company sponsor any group health plans written in any of the following states?

☐ Arizona	☐ Delaware	☐ New York	☐ Utah
☐ Colorado	☐ Maryland	☐ Pennsylvania	☐ Virginia
☐ Connecticut	☐ Minnesota	☐ Texas	☐ Washington D.C.

5. Who is your Plan Administrator?

If you do not provide it, we will use the employer as the Plan Administrator

COBRA Activity

1. How will you be reporting New Enrollees/General Notices and Qualifying Events? (please select one of the following)

☐ File Feed (EDT/EDI) – please note, file feed builds can take up to 8-12 weeks

☐ Direct Entry via COBRA Online Portal ☐ isolved integration

2. Is there anyone on your group health plan currently receiving coverage under COBRA? ☐ Yes ☐ No

3. Is there anyone who has recently been mailed a COBRA event notice and is still within their 60-day COBRA election period? ☐ Yes ☐ No

4. OBRA of 1989 amended COBRA to allow an employer to choose an optional extension of COBRA time frames. This provision allows employers to calculate the COBRA coverage from the loss of coverage date instead of the qualifying event date. Normally, COBRA coverage is calculated from the event date, often causing COBRA coverage to begin while still covered as an active plan participant or for the COBRA coverage to end in the middle of a month. With your carrier's approval, COBRA coverage can be calculated from the loss of coverage date. COBRA coverage would then expire at the end of the final month of COBRA. **NOTE: Always check with your carrier prior to using this rule and obtain their approval in writing.**
Choose either OBRA of 1989 Rule for coverage period end or Month End Expires Rule for coverage period end:

☐ OBRA of 1989 Rule (COBRA ends 18/29/36 months from loss of coverage);

☐ Month End Expires (COBRA ends last day of 18/29/36 months of COBRA coverage);

☐ Neither (COBRA ends 18/29/36 months from event date). If none selected, this option will be applied.

COBRA Activity Continued

5. isolved Benefit Services delays the aging of participant records for nonpayment by a variable time period called the mail transit period. This period allows payments which are postmarked within the grace period to reach us before coverage is terminated. This mail transit period is typically between seven and ten calendar days. For shortened mail transit periods, if a valid payment postmarked within the grace period is received after a Removal due to nonpayment has been sent to you, a Reinstatement will be sent requesting that you reinstate the COBRA coverage. Shortened mail transit periods may result in an increase in Reinstatements.

*Do you wish to shorten the mail transit period for any of your plans? ☐ Yes – Number of Days ☐ No

** If unanswered, isolved Benefit Services will use the standard eight (8) days

(Please note: isolved Benefit Services highly recommends that at least three (3) mail transit days be allowed. If you wish to shorten the mail transit period for any of your plans, a Mail Transit Period Change Form will be provided for your signature.)

Additional Information

The General Notice of COBRA Rights is a required COBRA notice. Notification to participants already covered on the

plan is done by a blanket mailing as part of the implementation of the account.

isolved Benefit Services Blanket Mailing Service: A Memorandum of Agreement will be needed for this service and will be provided by the Account Manager setting up your account. This would be at an additional charge of $3. 25 per notice with a $50 minimum.

Do you wish to use our blanket mailing services ☐ Yes ☐ No

isolved Benefit Services offers three options for reporting COBRA elections, terminations and plan changes to carriers. Please choose one option.

- ☐ isolved Benefit Services sending the report to the employer or third-party contact: The employer or third party will be responsible for communicating reinstatement/removal and plan changes to the carrier. If a reporting option is not selected, the account will be setup with this option.
- ☐ isolved Benefit Services faxes or emails report to the carrier: An authorization form will be required for this option. Carrier direct reporting will be implemented upon receipt of the signed form. Employer will receive copies of the report and should audit the reports and carrier records on a regular basis to confirm all changes were made.
- ☐ COBRA Eligibility Management Service: isolved Benefit Services will communicate COBRA elections, terminations and plan changes directly to the carriers utilizing the carrier's web portals. Additional fees may apply for this service. The employer will receive reports for auditing purposes, but isolved Benefit Services will handle the work. Please note: If you choose this option, you must complete the attached Application for isolved Benefit Services COBRA Eligibility Management and return it along with the COBRA Setup Forms.

For COBRA Eligibility Management Service (CEMS) we expect to receive access to all carriers within 45 days from our initial contact. After 45 days, if the project is not showing progress, the isolved Benefit Services Team will close the project. Closed projects will not receive follow up reminders from the isolved Benefit Services Team. We will begin billing upon receipt of the first carrier's credentials.

Coverage Information – Indicate the types of health plans offered by your company:

☐ Medical	☐ Dental	☐ Vision	☐ Wellness Program
☐ Health FSA	☐ Health Reimbursement Arrangement (HRA)	☐ Employee Assistance Plan (EAP)	☐ Other

Please complete the coverage information form to include each of these plans.

Coverage and Plan Information

Instructions

Please complete a separate chart for each plan or plan package that is COBRA eligible. Note, the following plan charts need only be completed if you are going to be receiving our Premium Collection service along with your COBRA Administration service.

Special Note Regarding Health Reimbursement Arrangement (HRA) Premiums:

HRA plans are subject to COBRA and require a COBRA premium. You must offer COBRA even if the HRA has a spend-down provision that allows participants to spend down their unused account balance after termination of employment.

Per COBRA law, the COBRA premium is 102 percent of the total cost of coverage to the plan. Because an HRA is a self-funded group health plan, there are special rules for calculating the total cost of coverage to the plan. These rules are in 26 USC §4980B(f)(4), a copy of which is available from isolved Benefit Services. In summary, two options are available:

- **Reasonable Actuarial Estimate:** A reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries that is determined on an actuarial basis.
- **Past Cost:** The cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period, adjusted for inflation. This option is not available for new HRAs or HRAs experiencing a significant design change in the current plan year.

Because an HRA has less than a 100 percent utilization rate each year, it is not permissible to simply use the annual contribution as the basis for calculating the HRA COBRA premium. Determining the applicable HRA COBRA premium may require assistance from an accountant, reinsurance carrier or other professional service. Your broker may be able to assist as well. Isolved Benefit Services clients can access an HRA Premium Calculation Tool located on our website behind your Client Login. Just enter your username and password and look for **HRA COBRA Premium Calculation Tool.**

Account Name:

Please complete a separate chart for each plan or plan package that is COBRA eligible. Note, the following plan charts need only be completed if you are going to be receiving our Premium Collection service along with your COBRA Administration service.

isolved Benefit Services will calculate the 2% administration fee and send you a confirmation. Do not include the 2% fees in your rates below.

Current Plan Year Start Date:		End Date:	
Carrier Name: (ex, BCBS, Kaiser)			
Plan Name: (ex, Medical, Dental)			
Group No.:			
Plan Options:			
Single/EE Only	$	EE+Spouse or EE+1	$
EE+Child(ren)	$	Family	$
	$		
Rate Tables:	☐ Yes ☐ No		
Only complete below if Eligibility Management has been selected.			
Carrier Contact Name:			
Contact Email:			

Current Plan Year Start Date:		End Date:	
Carrier Name: (ex, BCBS, Kaiser)			
Plan Name: (ex, Medical, Dental)			
Group No.:			
Plan Options:			
Single/EE Only	$	EE+Spouse or EE+1	$
EE+Child(ren)	$	Family	$
	$		
Rate Tables:	☐ Yes ☐ No		
Only complete below if Eligibility Management has been selected.			
Carrier Contact Name:			
Contact Email:			

Important: After your account is established, you will receive a Plans and Rates report listing premiums. Please review the report carefully to ensure accuracy of rates.

Completed by (please print): Date:

Account Name:

Please complete a separate chart for each plan or plan package that is COBRA eligible. Note, the following plan charts need only be completed if you are going to be receiving our Premium Collection service along with your COBRA Administration service.

isolved Benefit Services will calculate the 2% administration fee and send you a confirmation. Do not include the 2% fees in your rates below.

Current Plan Year Start Date:		End Date:	
Carrier Name: (ex, BCBS, Kaiser)			
Plan Name: (ex, Medical, Dental)			
Group No.:			
Plan Options:			
Single/EE Only	$	EE+Spouse or EE+1	$
EE+Child(ren)	$	Family	$
	$		
Rate Tables:	☐ Yes ☐ No		
Only complete below if Eligibility Management has been selected.			
Carrier Contact Name:			
Contact Email:			

Current Plan Year Start Date:		End Date:	
Carrier Name: (ex, BCBS, Kaiser)			
Plan Name: (ex, Medical, Dental)			
Group No.:			
Plan Options:			
Single/EE Only	$	EE+Spouse or EE+1	$
EE+Child(ren)	$	Family	$
	$		
Rate Tables:	☐ Yes ☐ No		
Only complete below if Eligibility Management has been selected.			
Carrier Contact Name:			
Contact Email:			

Important: After your account is established, you will receive a Plans and Rates report listing premiums. Please review the report carefully to ensure accuracy of rates.

Completed by (please print): Date:

Account Name:

Please complete a separate chart for each plan or plan package that is COBRA eligible. Note, the following plan charts need only be completed if you are going to be receiving our Premium Collection service along with your COBRA Administration service.

isolved Benefit Services will calculate the 2% administration fee and send you a confirmation. Do not include the 2% fees in your rates below.

Current Plan Year Start Date:		End Date:	
Carrier Name: (ex, BCBS, Kaiser)			
Plan Name: (ex, Medical, Dental)			
Group No.:			
Plan Options:			
Single/EE Only	$	EE+Spouse or EE+1	$
EE+Child(ren)	$	Family	$
	$		
Rate Tables:	☐ Yes ☐ No		
Only complete below if Eligibility Management has been selected.			
Carrier Contact Name:			
Contact Email:			

Current Plan Year Start Date:		End Date:	
Carrier Name: (ex, BCBS, Kaiser)			
Plan Name: (ex, Medical, Dental)			
Group No.:			
Plan Options:			
Single/EE Only	$	EE+Spouse or EE+1	$
EE+Child(ren)	$	Family	$
	$		
Rate Tables:	☐ Yes ☐ No		
Only complete below if Eligibility Management has been selected.			
Carrier Contact Name:			
Contact Email:			

Important: After your account is established, you will receive a Plans and Rates report listing premiums. Please review the report carefully to ensure accuracy of rates.

Completed by (please print): Date:

isolved Benefit Services

Set Up Forms

Attached are the isolved Benefit Services Setup Forms. These forms will be reviewed during your initial service implementation call.

Please complete and return these forms along with the signed isolved Benefit Services Agreement, or be ready to review them during your initial call.

Please return together:

- isolved Benefit Services Agreement
- Business Associate Agreement
- Banking Forms

All are required before the implementation of your new isolved Benefit Services may begin.

Banking Authorization

COBRA Administration

If you want isolved Benefit Services to process premium remittances and carry out other related activities, please complete the following information. Providing this information allows for quicker reimbursements.

- On a monthly basis, isolved Benefit Services will generate and deliver Premium Remittance Reports through our secure website (i.e., the Download Center). These reports will be available to the client on the first business day of each month and will identify the remittance amount that will be sent by direct deposit.
- isolved Benefit Services will send direct deposits of premiums within five business days of the delivery of the Premium Remittance Report. isolved Benefit Services will also generate and deliver any Voucher Premium Invoice Reports through the Download Center on the first business day of each month.
- isolved Benefit Services may deduct fees from your remittance (saving you time and cost of generating a check back to us) in the event that funds are required from the company for payment of remittance related activity, including but not limited to, Voucher Premium Invoice Adjustment, Refund Adjustment or NSF Adjustment. In the case where fees are deducted from your remittance, please refer to additional report documentation(s) at the time of the deduction.

Company name (Employer):

isolved Benefit Services Company #:

☐ Opt Out: I request Premium Remittances via a paper check. I am aware of a $10 fee, per check, as a handling charge will be deducted for each remittance that is sent via a paper check.

Depository Name: Branch:

City: State: Zip:

Transit/ABA Number (Must be 9 digits):

Account Number:

This Banking Authorization is hereby incorporated into the service agreement between the parties, and this Banking Authorization supersedes the terms and conditions of the service agreement to the extent that it contradicts any provisions related to premium collection services.

This authority is to remain in full force and effect until isolved Benefit Services has received written notification from the above name d company of its termination in such time and in such manner as to afford isolved Benefit Services and depository a reasonable opportunity to act on it. By your signature below, you agree that isolved Benefit Services is not responsible for any unauthorized access to an account that is beyond its reasonable control.

Signed: Date:

Printed Name Title Phone

This form must be returned by the 20th of the month to enable direct deposit for the following month.

HIPAA Business Associate Agreement

1. **PREAMBLE AND DEFINITIONS.**
   - 1.1. Pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended (**"HIPAA"**), (**"Covered Entity"**) and isolved, Inc. , or any of its corporate affiliates (**"Business Associate"**), a Michigan corporation, enter into this Business Associate Agreement (**"BAA"**) as of (the **"Effective Date"**) that addresses the HIPAA requirements with respect to "Business Associates," as defined under the privacy, security, breach notification, and enforcement rules at 45 C.F.R. Part 160 and Part 164 (**"HIPAA Rules"**) to the extent applicable to the services provided by Business Associate to Covered Entity. A reference in this BAA to a section in the HIPAA Rules means the section as in effect or as amended.
   - 1.2. This BAA is intended to describe the steps that Business Associate will take to implement appropriate safeguards for the Protected Health Information (**"PHI"**) (as defined under the HIPAA Rules) to the extent that Business Associate may receive, create, maintain, use, or disclose PHI in connection with the functions, activities, and services that Business Associate performs for Covered Entity. The functions, activities, and services that Business Associate performs for Covered Entity are defined in the administrative services agreement (the **"Underlying Agreement"**).
   - 1.3. Pursuant to changes required under the Health Information Technology for Economic and Clinical Health Act of 2009 (the **"HITECH Act"**) and under the American Recovery and Reinvestment Act of 2009 (**"ARRA"**), this BAA also reflects federal breach notification requirements imposed on Business Associate when "Unsecured PHI" (as defined under the HIPAA Rules) is acquired by an unauthorized party, and the expanded privacy and security provisions imposed on business associates.
   - 1.4. Unless the context clearly indicates otherwise, the following terms in this BAA shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, disclosure, Electronic Media, Electronic Protected Health Information (ePHI), Health Care Operations, individual, Minimum Necessary, Notice of Privacy Practices, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured PHI, and use.
   - 1.5. A reference in this BAA to the Privacy Rule means the Privacy Rule, in conformity with the regulations at 45 C.F.R. Parts 160-164 (the **"Privacy Rule"**) as interpreted under applicable regulations and guidance of general application published by HHS, including all amendments thereto for which compliance is required, as amended by the HITECH Act, ARRA, and the HIPAA Rules.
2. **GENERAL OBLIGATIONS OF BUSINESS ASSOCIATE.**
   - 2.1. Business Associate agrees not to use or disclose PHI, other than as permitted or required by this BAA or as Required by Law, or if such use or disclosure does not otherwise cause a Breach of Unsecured PHI
   - 2.2. Business Associate agrees to use appropriate safeguards, and to comply with Subpart C of 45 C.F.R. Part 164 with respect to ePHI, to prevent use or disclosure of PHI other than as provided for by the BAA.
   - 2.3. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate as a result of a use or disclosure of PHI by Business Associate in violation of this BAA's requirements or that would otherwise cause a Breach of Unsecured PHI. The Business Associate agrees to report to Covered Entity any Breach of Unsecured PHI not provided for by the BAA of which it becomes aware within 30 calendar days of "discovery" within the meaning of the HITECH Act. Such notice shall include the identification of each individual whose Unsecured PHI has been, or is reasonably believed by Business Associate to have been, accessed, acquired, or disclosed in connection with such Breach. In addition, Business Associate shall provide any additional information reasonably requested by Covered Entity for purposes of investigating the Breach and any other available information that Covered Entity is required to include to the individual under 45 C.F.R. § 164.404(c) at the time of notification or promptly thereafter as information becomes available. Business Associate's notification of a Breach of Unsecured PHI under this Section shall comply in all respects with each applicable provision of Section 13400 of Subtitle D (Privacy) of ARRA, the HIPAA Rules and related guidance issued by the Secretary or the delegate of the Secretary from time to time.
   - 2.4. Business Associate agrees, in accordance with 45 C.F.R. §§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, to require that any Subcontractors that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the restrictions, conditions, and requirements materially the same or more protective of PHI as those that apply to the Business Associate with respect to such information.
   - 2.5. Business Associate agrees to make available PHI in a Designated Record Set to Covered Entity to enable it to satisfy Covered Entity's obligations under 45 C.F.R. § 164.524.
     - (i) Business Associate agrees to, at the direction of Covered Entity, comply with an individual's request to restrict the disclosure of their personal PHI in amanner consistent with 45 C.F.R. § 164.522, except where such use, disclosure, or request is required or permitted under applicable law.
     - (ii) Business Associate agrees that when requesting, using, or disclosing PHI in accordance with 45 C.F.R. § 164.502(b)(1)

that such request, use, or disclosureshall be to the minimum extent necessary, including the use of a "limited data set" as defined in 45 C.F.R. § 164.514(e)(2), to accomplish the intended purpose of such request, use, or disclosure, as interpreted under related guidance issued by the Secretary from time to time.

2.6. Business Associate agrees to incorporate any amendments to PHI in a Designated Record Set as implemented by the Covered Entity pursuant to 45 C.F.R. § 164.526,or take other measures as necessary to facilitate Covered Entity's compliance with its obligations under 45 C.F.R. § 164.526.

2.7. Business Associate agrees to maintain and make available the information required for Covered Entity to provide an accounting of disclosures to the individual as necessary to satisfy Covered Entity's obligations under 45 C.F.R. § 164.528.

2.8. Business Associate agrees to make its internal practices, books, and records, including policies and procedures regarding PHI, relating to the use and disclosure of PHI and Breach of any Unsecured PHI received from Covered Entity, or created or received by the Business Associate on behalf of Covered Entity, available to the Secretary for the purpose of the Secretary determining Covered Entity's compliance with the Privacy Rule (as defined in Section 7).

2.9. To the extent that Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 C.F.R. Part 164, Business Associate agrees to comply with the requirements of Subpart E that apply to the Covered Entity in the performance of such obligation(s).

2.10. Business Associate agrees to account for the following disclosures:

(i) Business Associate agrees to maintain and document disclosures of PHI and Breaches of Unsecured PHI and any information relating to the disclosure of PHI and Breach of Unsecured PHI in a manner as would be required for Covered Entity to respond to a request by an individual or the Secretary for an accounting of PHI disclosures and Breaches of Unsecured PHI.

(ii) Business Associate agrees to provide to Covered Entity information collected in accordance with this Section 2.11, to permit Covered Entity to respond to a request by an individual or the Secretary for an accounting of PHI disclosures and Breaches of Unsecured PHI.

(iii) Business Associate agrees to account for any disclosure of PHI used or maintained as an Electronic Health Record (as defined in Section 5) (**"EHR"**) in a manner consistent with 45 C.F.R. § 164.528 and related guidance issued by the Secretary from time to time.

3. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE.

3.1. General Uses and Disclosures. Business Associate agrees to receive, create, use, or disclose PHI only in a manner that is consistent with this BAA, the Privacy Rule, or Security Rule (as defined in Section 5) and only in connection with providing services to Covered Entity; provided that the use or disclosure would not violate the Privacy Rule, including 45 C.F.R. § 164.504(e), if the use or disclosure would be done by Covered Entity. For example, the use and disclosure of PHI will be permitted for "treatment, payment, and health care operations," in accordance with the Privacy Rule.

3.2. Business Associate may use or disclose PHI as Required by Law.

3.3. Business Associate agrees to make uses and disclosures and requests for PHI: Consistent with Covered Entity's Minimum Necessary policies and procedures.

3.4. Business Associate may not use or disclose PHI in a manner that would violate Subpart E of 45 C.F.R. Part 164 if done by the Covered Entity.

3.5. Business Associate may use PHI to provide data aggregation services as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).

3.6. Business Associate may use or disclose PHI to create de-identified data consistent with the applicable provisions of HIPAA and may use or disclose any such de- identified data for any purpose permitted by law

4. OBLIGATIONS OF COVERED ENTITY.

4.1. Covered Entity shall:

(i) Promptly provide Business Associate with the Notice of Privacy Practices that Covered Entity produces in accordance with the Privacy Rule, and any changes or limitations to such notice under 45 C.F.R. § 164.520, to the extent that such changes or limitations may affect Business Associate's use or disclosure of PHI.

(ii) Notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to or is required to comply with under 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI under this BAA. Covered Entity will make such notification prior to the disclosure of such PHI to Business Associate or, if Covered Entity agrees or becomes subject to such restriction after disclosing the PHI to Business Associate, then Covered Entity will make such notification not later than five (5) business days prior to the date such restriction will become effective.

(iii) Notify Business Associate of any changes in or revocation of permission by an individual to use or disclose PHI, if such change or revocation may affect Business Associate's permitted or required uses and disclosures of PHI under this BAA.

4.2. Covered Entity shall not disclose to Business Associate more than the minimum necessary PHI for Business Associate to perform its obligations under the Underlying Agreement.

4.3. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy and Security Rule if done by Covered Entity, except as provided under Section 3 of this BAA.

5. COMPLIANCE WITH SECURITY RULE.

5.1. Effective April 20, 2005, Business Associate shall comply with the HIPAA Security Rule, which shall mean the Standards for Security of Electronic Protected Health Information at 45 C.F.R. Part 160 and Subparts A and C of Part 164, as amended by ARRA and the HITECH Act. The term **"Electronic Health Record"** or **"EHR"** as used in this BAA shall mean an electronic record of health-related

information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff.

5.2. In accordance with the Security Rule, Business Associate agrees to:

(i) Implement the required administrative safeguards set forth at 45 C.F.R. § 164.308, the required physical safeguards set forth at 45 C.F.R. § 164.310, the required technical safeguards set forth at 45 C.F.R. § 164.312, and the required policies and procedures set forth at 45 C.F.R. § 164.316 to reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of Covered Entity as required by the Security Rule

(ii) Require that any agent, including a Subcontractor, to whom it provides such PHI agrees to implement reasonable and appropriate safeguards to protect the PHI; and

(iii) Report to the Covered Entity any Security Incident of which it becomes aware.

6. TERM AND TERMINATION.

6.1. This BAA shall be in effect as of the date signed by both Business Associate and Covered Entity, and shall terminate on the earlier of the date that:

(i) Report to the Covered Entity any Security Incident of which it becomes aware.

(ii) Either party terminates for cause as authorized under Section 6.2.

(iii) All of the PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity. If it is not feasible to return or destroy PHI, protections are extended in accordance with Section 6.3.

6.2. Upon either party's knowledge of material breach by the other party, the non- breaching party shall provide an opportunity for the breaching party to cure the breach or end the violation. If the breaching party does not cure the breach or end the violation within a reasonable timeframe not to exceed 30 days from the notification of the breach, or if a material term of the BAA has been breached and a cure is not possible, the non-breaching party may terminate this BAA and the Underlying Agreement, upon written notice to the other party.

6.3. Upon termination of this BAA for any reason, the parties agree that: Upon termination of this BAA for any reason, Business Associate, with respect to PHI received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity, shall:

(i) Retain only that PHI that is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities.

(ii) At Business Associate's option, return to Covered Entity or destroy the remaining PHI that the Business Associate still maintains in any form.

(iii) Continue to use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164 with respect to ePHI to prevent use or disclosure of the PHI, other than as provided for in this Section 7, for as long as Business Associate retains the PHI.

(iv) Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out at paragraphs (2) and (3) above which applied prior to termination.

(v) At Business Associate's option, return to Covered Entity or destroy the PHI retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.

6.4. The obligations of Business Associate under this Section 7 shall survive the termination of this BAA.

7. MISCELLANEOUS

7.1. The parties agree to take such action as is necessary to amend this BAA to comply with the requirements of the Privacy Rule, the Security Rule, HIPAA, ARRA, the HITECH Act, the HIPAA Rules, and any other applicable law.

7.2. The respective rights and obligations of Business Associate under Section 6 and such other provisions of this BAA that by their nature logically ought to survive the Termination of this BAA shall survive the termination of this BAA.

7.3. This BAA shall be interpreted in the following manner:

(i) Any ambiguity shall be resolved in favor of a meaning that permits the parties to comply with the HIPAA Rules.

(ii) Any inconsistency between the BAA's provisions and the HIPAA Rules, including all amendments, as interpreted by the HHS, a court, or another regulatory agency with authority over the Parties, shall be interpreted according to the interpretation of the HHS, the court, or the regulatory agency.

(iii) Any provision of this BAA that differs from those required by the HIPAA Rules, but is nonetheless permitted by the HIPAA Rules, shall be adhered to as stated in this BAA.

7.4. This BAA constitutes the entire agreement between the parties related to the subject matter of this BAA. This BAA supersedes all prior negotiations, discussions, representations, or proposals, whether oral or written. This BAA may not be modified unless done so in writing and signed by a duly authorized representative of both parties. If any provision of this BAA, or part thereof, is found to be invalid, the remaining provisions shall remain in effect.

7.5. This BAA will be binding on the successors and assigns of the Covered Entity and the Business Associate.

7.6. This BAA may be executed in two or more counterparts, each of which shall be deemed an original.

7.7. Except to the extent preempted by federal law, this BAA shall be governed by and construed in accordance with the same internal laws as that of the administrative services agreement.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the last date below.

isolved HCM, LLC	Company:
By:	**By:**
Name:	**Name:**
Title:	**Title:**
Date:	**Date:**