**SERVICE FEE AGREEMENT**

**[Insert Legal Name of Broker or Consultant]** (“Service Provider”) and **[Insert Name of Employer Member and WMC Association Health Plan]** (“Clients”) (collectively, the “Parties”) enter into this agreement on **[Insert Date]**.

In consideration of good and valuable consideration, receipt and sufficiency of which is hereby acknowledged, the Parties agree to the following:

1. Service Provider shall provide the services described in the attached Schedule A to this Agreement (the “Services”).
2. Clients shall pay Service Provider a fee for such Services as is set forth in Schedule B to this Agreement (the “Fee”).
3. Service Provider agrees to maintain any and all licenses required by any applicable state, local and/or federal regulatory agencies, and meet any and all legal requirements necessary to perform the Services and to receive the Fee.
4. Both Clients and Service Provider understand and agree that entering into this Service Fee Agreement and the payment of the Fee is not a condition of the purchase or retention of any health insurance coverage, and that the Fee is not now, and shall never be, included as a component of any medical premium associated with a policy of health insurance which may have been or be in the future purchased by Clients, even if such Fee is administered by the insurance company issuing such policy and/or included on the same invoice with the medical premium for such insurance.
5. Both Clients and Service Provider understand and agree that this Agreement shall continue in full force and effect until the earlier of: (a) the date the Service Provider is no longer legally authorized to perform the Services described herein (e.g. no longer maintains appropriate license); or (b) thirty (30) days from the date either Party provides the other Party with written notice of termination.
6. Any provision of this Agreement may be amended or waived if such amendment is in writing and signed by each of the Parties.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Member Client Signature Date

 \_\_\_\_2/20/2020\_\_\_\_

Association Health Plan Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Service Provider Signature Date

**EMPLOYER MEMBER LEVEL BILLING AND COLLECTION AGREEMENT**

**(Exhibit D)**

This Billing and Collection Agreement (“Agreement”) by and among United HealthCare Services, Inc., and its subsidiaries and affiliates (collectively “UHS”), the designated service provider(s) [NAME OF THE PROVIDER] (individually and collectively, “Service Provider”) indicated on the attached Exhibit 1 to this Agreement (“Exhibit 1”), the designated association health plan WMC (“Policyholder”) and the designated employer Member [NAME of EMPLOYER MEMBER] (“Employer Member”), sets forth the terms and conditions under which UHS will assist in the billing and collection of Service Fees from the Employer Member, and the processing and remittance of the Service Fees to Service Provider. This Agreement is effective as of [EFFECTIVE DATE] (the “Effective Date”).

**RECITALS**

Employer Member has purchased certain medical insurance products (“Medical Benefit Plan(s)”) via a Policyholder, from a company controlled by or under common control with UHS including, without limitation, UnitedHealthcare Insurance Company (each, an “Affiliate”).

Policyholder, Employer Member and Service Provider represent that they have entered into one or more valid agreements under which Service Provider agrees to provide services to assist Employer Member with its benefit plan (individually and collectively, “Service Agreement”) in return for agreed upon compensation to be paid by Employer Member (“Service Fee”).

Policyholder, Employer Member and Service Provider acknowledge that UHS is not a party to the Service Agreement.

Policyholder, Employer Member and Service Provider have requested that UHS bill Employer Member for the monthly Service Fee on the Service Provider's behalf, and incorporate the Service Fee bill into the Medical Benefit Plan(s) bill for the Employer Member’s administrative ease.

Policyholder, Employer Member, Service Provider, and UHS acknowledge and agree that the Service Fee is not part of the premium charged for any Medical Benefit Plan offered by an Affiliate and is not a required contingency of obtaining the coverage purchased by the Employer Member via the Policyholder.

UHS agrees to provide the billing services described herein in reliance upon and subject to the aforementioned recitals and terms and conditions set forth below.

**TERMS AND CONDITIONS**

**Section 1: Rights and Responsibilities.**

1. **Responsibility of UHS:**
2. UHS agrees to bill Employer Member for the Service Fee identified in Attachment 1 on a monthly basis and incorporate this billing with the premium bill for the Medical Benefit Plan(s) purchased by the Employer Member via the Policyholder during the Term.
3. UHS agrees to forward or transmit any collected Service Fee to the appropriate Service Provider (as outlined in Exhibit 1) within sixty (60) days of receipt of the Service Fee from Employer Member.

**B. Responsibilities of Employer Member:**

1. Employer Member agrees to pay the Service Fee at the same time as payment is made for the premium for the Medical Benefit Plan(s) included on the same invoice.
2. Employer Member agrees to notify UHS immediately of the termination of any one or more Service Agreements.
3. Employer Member shall take all steps necessary to recover from Service Provider any overpayment of the Service Fee which is due to Employer Member’s error.
4. Employer Member agrees that it is responsible for any tax reporting related to the payment of the Service Fee to the Service Provider.

**C. Responsibilities of Service Provider:**

1. Service Provider agrees to notify UHS immediately of any change in the contractual relationship between it and the Employer Member and/or the Policyholder that would impact the Service Fee payment.
2. Service Provider agrees to return to UHS any Service Fee overpayments that occur as a result of a processing error by UHS within thirty (30) days of UHS’s request for such repayment.
3. Service Provider agrees that UHS is not responsible for any tax reporting related to the payment of the Service Fee to the Service Provider.
4. Service Provider acknowledges and agrees that it is solely responsible for determining what licenses (state, local or otherwise) are required for it to perform the services described herein and/or in the Service Agreement, and for obtaining such licenses and maintaining them in good standing throughout the Term.

**Section 2: Payments and Adjustments.**

1. All parties agree to promptly notify the others upon becoming aware of an incorrect payment amount, and to promptly remit any amounts overpaid.
2. If the amount the Employer Member pays to UHS for both Service Fee and premium related to the Medical Benefit Plan(s) purchased by Employer Member via the Policyholder is less than the amount billed by UHS, the amount forwarded to the Service Provider will vary in direct proportion to the difference in the amount paid compared to the amount billed. This variation will apply regardless of the basis used for calculating the Service Fee, including a percent of premium, a set amount per enrolled employee, per month, or a set dollar amount per month.
3. UHS may recover overpayments from Service Provider by offsetting the overpayment against any other compensation due to Service Provider by UHS.
4. Service Fees will be subject to garnishments and any other legal attachments as required by a legal court order or similar action.
5. If the Service Fee Rate is determined by the number of enrolled employees according to a Service Fee Schedule, the Service Fee Rate for that Employer Member, will be based on the number of enrolled employees at the time that United enrollees the Employer Member in the AHP, and will not change.
6. The Service Fee Rate or Service Fee Schedule may be modified by the Policyholder on a prospective basis only. UHS must be informed of the change in writing, including the date that the change will be implemented (which must be at least thirty (30) days from the date of such notice to UHS). UHS will notify Employer Member and Service Provider in writing that it will implement the change on the date requested; provided, however, that UHS has the right to designate a date subsequent to the date requested if, in its reasonable judgment, UHS believes that such a delay is necessary.

**Section 3: Amendments.**

1. UHS may amend the terms and conditions of this Agreement, except for terms and conditions related to the amount of the Service Fee, at any time by notifying the Policyholder, Employer Member and Service Provider of the change in writing at least thirty (30) days prior to the effective date of the change.
2. Only the Policyholder may request a change to the amount of the Service Fee subject to the requirements contained in Section 2(E) above. The Employer Member and the Service Provider agree to be bound by any change made to the Service Fee by the Policyholder.
3. All other amendments to the provisions of this Agreement, not addressed by 3(A) or 3(B) above, must be set forth in writing and signed by an authorized representative of each party to this Agreement.

**Section 4: Term and Termination.**

This Agreement is effective on the Effective Date and shall continue until terminated as set forth in this Section 4 (the “Term”).

1. Policyholder and Employer Member may terminate the Agreement at any time, for any reason (or no reason), by providing written notice of such termination; provided, however, that if the termination does not specify an effective date at least thirty (30) days in the future, Policyholder and Employer Member acknowledge and agree that such termination will be effective up to thirty (30) days following UHS’s receipt of such notice. Unless otherwise specifically so stated, notice that the Policyholder and/or Employer Member has elected to work with a different Service Provider shall be considered to be effective notice of the termination of this Agreement.
2. UHS and Service Provider may terminate this Agreement at any time, for any reason (or no reason), by providing written notice of such termination at least sixty (60) or more days before the effective date of the termination.
3. UHS may terminate this Agreement immediately, upon written notice to Policyholder, Employer Member and Service Provider, if UHS is made aware that responsibilities and duties called for herein are no longer legally permissible.
4. This Agreement will terminate automatically and without any further action being required on the part of any party as of the effective date of the cancelation or termination of the last of the Medical Benefit Plan(s) purchased by Employer Member via Policyholder from an Affiliate then in existence.
5. In addition, this Agreement will terminate automatically and without any further action being required on the part of any party as of the effective date of a subsequently executed Billing and Collection Agreement by and between UHS, Policyholder, Employer Member and any Service Provider (whether the same Service Provider named in Exhibit 1 or not).
6. Notwithstanding the foregoing, the provisions of this Agreement which, by their nature, are intended to survive beyond the termination of this Agreement shall survive such termination, including, but not limited to, Sections 1(B), 1(C), 2(A), 2(C), 2(D), and 5.

**Section 5: Additional Policyholder, Employer Member and Service Provider Acknowledgments and Approvals.**

1. Policyholder and Employer Member understands that UHS may compensate Service Provider for the sale, service and retention of Medical Benefit Plan(s) and that the Medical Benefit Plan(s) purchased by Employer Member via Policyholder may, if eligible, be taken into account in the calculation of any bonus or override program offered by UHS to Service Provider, unless Policyholder and Employer Member specifically designates, in the format provided by UHS, that the Medical Benefit Plan(s) purchased by Policyholder and Employer Member not be taken into account for such purposes. Potential eligibility for such bonus and/or override programs is determined by UHS based on a number of factors including, but not limited to, potentially applicable state-specific regulatory requirements (provided, however, that UHC makes no representations regarding the potential applicability of any particular state legal or regulatory requirement). Policyholder and Employer Member understand and acknowledges that further information regarding UHS’s compensation of Service Provider, including the actual amounts paid to Service Provider in any given measurement period, is available upon request.
2. By executing this Agreement below, Policyholder and Employer Member represent that either the payment of a bonus and/or override by UHS, as described in 5(A) above, does not create a conflict of interest or, to the extent of any apparent conflict, it is understood and hereby waived by Policyholder and Employer Member to the maximum extent permitted by applicable law.
3. Policyholder, Employer Member and Service Provider acknowledge and agree that the Service Fee may be deposited by UHS in an account with other funds collected by UHS in the normal course of business.  All available funds may be invested in short-term instruments shortly after deposit into this account (typically once per day) which can earn interest income at market rates.  By way of example only, the applicable second quarter, 2013 market interest rates were 0.23% in April, 0.22% in May, and 0.20% in June, which is fairly standard for market rates.  With relation to utilization for such short-term investments, Service Fees are generally treated like all other funds collected by UHS in the normal course of business so long as in UHS’s possession.  Service Fees are in UHS’s possession for a period of approximately thirty (30) to sixty (60) days under normal circumstances prior to being forwarded to the Service Provider as discussed elsewhere in this Agreement.  The payer of any interest received by UHS on Service Fees as the result of such short-term investment activity will be the sponsor of the relevant investment vehicle.  UHS retains interest earned on the Service Fees while in its possession as consideration for UHS’s services under this Agreement.
4. Service Provider acknowledges that UHS has no obligations to Service Provider to collect amounts owed to it by the Policyholder or the Employer Member other than those expressly set forth in this Agreement.
5. This Agreement represents the entire understanding and agreement between the parties with respect to the subject matter addressed herein and entirely and completely supersedes, voids and replaces all agreements, negotiations, understandings and representations (whether written or oral) in existence between the parties as of the Effective Date and relating to the same subject matter.
6. This Agreement may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same Agreement. A signature by facsimile transmission or other electronic means which allows the identity of the signer to be reasonably confirmed shall be as good and binding as an original signature.

**Signatures:** Through the signature of their respective authorized representatives, the parties hereby agree to the terms and conditions of this Agreement.

|  |  |  |
| --- | --- | --- |
| **For POLICYHOLDER:** |  | **For EMPLOYER MEMBER:** |
|  |  |  |
| Signature – Authorized Representative of Policyholder |  | Signature – Authorized Representative of Employer Member |
| Dale Heiking |  |  |
| Printed Name |  | Printed Name |
| Account Executive |  |  |
| Title |  | Title |
| 2/20/2020 |  |  |
| Date |  | Date |

|  |  |  |
| --- | --- | --- |
| **For SERVICE PROVIDER:** |  | **For UHS:** |
|  |  |  |
| Signature – Authorized Representative of Service Provider |  | Signature – Authorized Representative of UHS |
|  |  |  |
| Printed Name |  | Printed Name |
|  |  |  |
| SSN/TIN |  | Title |
|  |  |  |
| Date |  | Date |

**employer Member LEVEL Billing and Collection Agreement**

**Atttachment 1**

**This Section To Be Completed By Employer Member**

**Name:** [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

**Service Agreement Effective Date:** [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

**Designated Service Provider**

**(Person or firm that will receive Service Fee):**

[\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

**Service Provider Representative Responsible for Employer   
Member’s Account:**

[\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

**Service Provider Address:**

[\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

**PLEASE NOTE THAT THE INFORMATION CONTAINED IN THE BOX ABOVE MAY BE CHANGED PERIODICALLY BY UHS AS DIRECTED. ANY OTHER ALTERATIONS TO THE TOP HALF OF THIS FORM MUST BE INITIALED BY THE EMPLOYER MEMBER TO DOCUMENT CONSENT TO THE CHANGE.**

Please check only one of the following Service Fee payment methods and indicate the **TOTAL** rate to be paid.

[\_] **Percentage of Required Contribution** [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_] %

(Please be advised that, unlike commissions, the Service Fee is not a component of premium.)

X **Per Employee Per Month (PEPM)** $ 25 .00

[\_] Check here if the Designated Service Provider and Service Provider Representative named above are to be designated as the Agent of Record and Writing Agent, respectively, of all of the Employer Member’s non-medical lines of coverage. Checking this box will replace the existing Agent of Record and Writing Agent for those lines of coverage. If more than one Service Provider is designated above, please indicate with specificity which, if any, non-medical lines of coverage should have changes to the currently designated Agent of Record: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature (Authorized Representative of Employer Member): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name (Printed)** [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_] **Title** [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_] **Phone** [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

**For Internal Use Only (To be Completed By United HealthCare Services, Inc.)**

UNET / BASICs Platform: \*Please use “All” or list policies / state(s) covered by this specific agreement.

Payee / Producer ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WA CRID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Base / Situs State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Member #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agreement State\*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Oxford / Pulse Platform:

Payee Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WA Code:\_:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Base / Situs State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FACETs Platform (RV/NHP):

Payee CRID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Base / Situs State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Arrangement ID\*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agreement State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

West Coast / Nice Platform: (Requests for multiple payees and the amount to be paid to each should be listed out and attached)

Payee ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Payee Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Writing Agent ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Writing Agent Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

All Group #s Covered by Agreement\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Please circle the group# that the service fee will be billed to.

**ADDENDUM**

**MANAGEMENT FEE**

The Association establishes the Management Fee to be paid by all Employer Members as the following:

Please check only one of the following Management Fee payment methods:

X **Percentage of Required Contribution** 2.5 %

[\_] **Per Employee Per Month (PEPM)** $ [\_\_\_\_\_\_\_\_\_\_\_\_\_] .00