Welcome to UnitedHealthcare.

We're here to help make your health care experience easier. Use this checklist to help you take charge of your health—and get more out of your plan. Let's get started:

1 Sign up on myuhc.com®.

Log in and use this personalized website to access and manage your health plan details. You can sign up starting on your effective date. Go to **myuhc.com**, click **Register Now** and follow the step-by-step instructions. Activate your **myuhc.com** account to:

- Print a copy of your health plan ID card.
- Find and estimate costs for the network care you need
- See what's covered and get information about preventive care.
- View claim details and account balances.
- Sign up for paperless delivery of your required plan communications

2 Get on-the-go access.

When you're out and about, the **Health4Me® app** puts your health plan at your fingertips. Download it to easily access your ID card, find nearby care, check prescription medication costs and more.

3 Know your network.

With almost every plan, you'll typically pay less if you choose doctors, clinics and hospitals in your network. Check who's in the network by using the provider directory on **myuhc.com** or the **Health4Me app.**

4 Save the Care24® phone number.

Call or chat with a nurse about an illness, injury and more. Save the number **1-888-887-4114** to your phone, post it on your fridge or anywhere that's convenient for you.

5 Make your first appointment.

Many preventive screenings and immunizations are covered at no additional cost to you, so it's a good idea to call your primary care provider (PCP) and get your first checkup on the calendar.

6 See a doctor from anywhere.

A Virtual Visit lets you see and talk to a doctor from your mobile device[1] or computer without an appointment. Register or download the app at **uhc.com/VirtualVisits.**

[1] Data rates may apply.

Virtual Visits are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times or in all locations.

The Care24 program integrates elements of traditional employee assistance and work life programs with health information lines for a comprehensive set of resources. It is not a substitute for a doctor's or professional's care. Due to the potential for a conflict of interest, legal consultation will not be provided on issues that may involve legal action against UnitedHealthcare or its affiliates, or any entity through which the caller is receiving these services directly or indirectly (e.g., employer or health plan). This program and its components may not be available in all states or for all group sizes and are subject to change. Coverage exclusions and limitations may apply.

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Northeast Indiana School Insurance Consortium
2019-2020 Plan Options

	Plan A	Plan B	Plan C	Plan D
	In-Network[2]	In-Network[2]	In-Network[2]	In-Network[2]
Deductible – Individual Family	$500 $1,000	$1,000 $2,000	$3,500 $7,000	$6,500 $13,000
Reimbursement Percentage[1]	90%	80%	100%	100%
Out-of-Pocket Maximum– Individual Family	$1,250 $2,500	$2,250 $4,500	$3,500 $7,000	$6,500 $13,000
Human Organ Tissue Transplant	100%	100%	100%	100%
Hospital Expenses	90%	80%	100%	100%
Emergency Room	$100 copay	$100 copay	100%	100%
Urgent Care Center	$50 copay	$50 copay	100%	100%
Physician Office Visits	$20 copay	$30 copay	100%	100%
Routine Care	$0 copay	$0 copay	100%(no ded)	100%(no ded)
Ambulance	100%	100%	100%	100%
Prescription Drugs Pharmacy-Retail	$30 brand $15 generic	$40 brand $20 generic	100% (Subject to Medical Deductible)	100% (Subject to Medical Deductible)
Mail Order	$60 brand $30 generic	$80 brand $40 generic		
RX Out of Pocket Max Individual Family	$4,600 $9,200	$4,600 $9,200	Included in Maximum Out of Pocket above	Included in Maximum Out of Pocket above
Single	$998	$900	$810	$649
Family	$2,491	$2,245	$2,018	$1,621

[1] *Reimbursement percentages are subject to the deductible unless otherwise indicated*

[2] *Out of network information can be found in the Summary of Benefits and Coverage (SBC) or the Summary Plan Description; generally the out of network deductible and maximum out- of- pocket are 2 times the in- network. The benefit descriptions outlined here are intended to be a brief outline of coverage and are not a legal contract. All Plan provisions, benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.*

2019-2020 NEW HEALTH INSURANCE RATES

SINGLE

		2019-2020	2018-2019
PLAN A	SINGLE YEARLY:	$11,976.00	$11,976.00
	EMPLOYEE SHARE:	$5,476.00	$5,476.00
	PER PAY (24PAYS)	**$228.17**	$228.17
PLAN B	SINGLE YEARLY:	$10,800.00	$10,800.00
	EMPLOYEE SHARE:	$4,143.00	$4,143.00
	PER PAY (24PAYS)	**$179.17**	**$179.17**
PLAN C	SINGLE YEARLY:	$9,720.00	$9,720.00
	EMPLOYEE SHARE:	$3,220.00	$3,220.00
	PER PAY (24PAYS)	**$134.17**	**$134.17**
PLAN D	SINGLE YEARLY:	$7,788.00	$7,788.00
	EMPLOYEE SHARE:	$1,288.00	$1,288.00
	PER PAY (24PAYS)	**$53.67**	**$53.67**

FAMILY

	2019-2020	2018-2019
FAMILY YEARLY:	$29,892.00	$29,892.00
EMPLOYEE SHARE:	$16,892.16	$16,892.16
PER PAY (24PAYS)	**$703.83**	**$703.83**
FAMILY YEARLY:	$26,940.00	$26,940.00
EMPLOYEE SHARE:	$13,940.00	$13,940.00
PER PAY (24PAYS)	**$580.83**	**$580.83**
FAMILY YEARLY:	$24,216.00	$24,216.00
EMPLOYEE SHARE:	$11,216.00	$11,216.00
PER PAY (24PAYS)	**$467.33**	**$467.33**
FAMILY YEARLY:	$19,452.00	$19,452.00
EMPLOYEE SHARE:	$6,452.00	$6,452.00
PER PAY (24PAYS)	**$268.83**	**$268.83**

EMPLOYER SHARE : SINGLE **$6,500.00**

EMPLOYER SHARE: FAMILY **$13,000.00**

2019-2020 NEW HEALTH INSURANCE RATES/EXCEL

8/29/2019

Enrollment Application/Change/Cancellation Request

UnitedHealthcare

Indiana

☐ Enroll ☐ Cancel ☐ Change

☐ Address Change ☐ Name Change Date of Change___ ___ ___

To Be Completed By Employer

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm the employee completed the appropriate information, 2) complete the information in this section and 3) provide your signature and today's date. If the employee is waiving coverage, do not submit the application but retain it for your records.

Company Name | Group # | Department #

Plan Variation
Medical ______ Vision ______
Dental ______ Life ______

Reporting Code
Medical ______ Vision ______
Dental ______ Life ______

Benefit Level/Class Code, if applicable
Life/AD&D ______ Suppl. Life ______
Spouse Life ______ Suppl. AD&D ______

☐ **New Enrollment/Additions: (Check one)**
Date of Hire Requested Date of Coverage ___ ___ ___
☐ New Hire ☐ Status Change (PT to FT)
☐ Return from Leave/Layoff
☐ Birth ☐ Marriage ☐ Adoption
☐ Court ordered dependent
☐ Other (describe) ______________________
☐ COBRA/State Continuation start date _______ stop date________
☐ **Annual Open Enrollment** Requested Effective Date of Enrollment ___ ___ ___

☐ **Cancellations:** Last Date of Employment ___ ___ ___
Requested Effective Date of Cancellation ___ ___ ___
☐ Cancel all coverage
☐ Cancel all listed below – Section B
Reason: (check one)
☐ Death ☐ Employee Terminated ☐ Divorce
☐ Moved out of service area
☐ Dependent reached dependent max age
☐ Other (describe)______________________

Employee Type ☐ Union ☐ Non-union | ☐ Salaried ☐ Hourly | ☐ Active ☐ COBRA/State Cont. ☐ Retire Date __________ | #Hours worked per week _________

Signature ______________________________ Date ____________

Employer Position ________________________ Phone Number______________

A. Employee Information

Last Name | First Name | MI | Social Security Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Address | Apt # | City | State | Zip Code | Home/Cell Phone

Date of Birth / / | Sex ☐ M ☐ F | Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed | Work Phone

Email Address

Language Preference, if not English

Race – Check all that apply (Optional)[2]
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American
☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White
☐ Other–Please specify ______________________

Primary Physician[1]
Physician First & Last Name ______________________
ID # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___ ___

Primary Dentist[1]
Dentist First & Last Name ______________________
ID# ______________________

[1]IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

[2]Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company
Dental coverage provided by UnitedHealthcare Insurance Company
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

B. Family Information

List All Enrolling/Changing/Cancelling (Attach sheet if necessary)

Check appropriate box	Relationship[2]	Last Name	First Name	MI	Sex	Date of Birth
☐ Enroll ☐ Cancel ☐ Change	Spouse /Domestic Partner				☐ M ☐ F	____ /____ /____
		Social Security Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___		Primary Physician[1] Name: ID#		
Race – Check all that apply (Optional)[3]	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify ______			Primary Care Dentist[1] Name: ID#		
☐ Enroll ☐ Cancel ☐ Change	Dependent				☐ M ☐ F	____ /____ /____
		Social Security Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___		Primary Physician[1] Name: ID#		
Race – Check all that apply (Optional)[3]	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify ______			Primary Care Dentist[1] Name: ID#		
☐ Enroll ☐ Cancel ☐ Change	Dependent				☐ M ☐ F	____ /____ /____
		Social Security Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___		Primary Physician[1] Name: ID#		
Race – Check all that apply (Optional)[3]	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify ______			Primary Care Dentist[1] Name: ID#		
☐ Enroll ☐ Cancel ☐ Change	Dependent				☐ M ☐ F	____ /____ /____
		Social Security Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___		Primary Physician[1] Name: ID#		
Race – Check all that apply (Optional)[3]	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify ______			Primary Care Dentist[1] Name: ID#		

[1]IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

[2]For some cases, such as Qualified Medical Child Support, additional documentation may be required. Please see employer representative for more information.

[3]Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

C. Product Selection

Please check the box for each coverage in which you or your dependents are enrolling.
If your employer offers a choice of plans, indicate which plan you are selecting. Indicate the dollar amount selected for the Life and Accidental Death & Dismemberment (AD&D), Supplemental Life, Short-Term Disability (STD), and Long-Term Disability (LTD) plans. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	Basic Life/AD&D	Supp Life/AD&D	Voluntary AD&D
Employee	☐ ______	______	☐	☐ $______	$______	☐ $______
Spouse/Domestic Partner	☐		☐	☐ $______	☐ $______	☐ $______
Dependent	☐		☐	☐ $______	☐ $______	☐ $______

Person	STD	LTD	STD Buy Up	LTD Buy Up	Salary $ ______ Required only if Life, STD, or LTD based on salary
Employee					

Life Insurance Beneficiary Full Name and Address (if applying for Life Insurance with UnitedHealthcare)		Relationship
Primary		
Secondary		

D. Other Medical Coverage Information

This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? ☐ YES (continue completing this section) ☐ NO (skip the rest of this section)

Name of other carrier ______________________________

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date	End Date	Name and date of birth of policyholder for other coverage
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)

S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.

F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

☐ Enrolled in Part A: Effective Date ____________ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)

☐ Enrolled in Part B: Effective Date ____________ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)

☐ Enrolled in Part D: Effective Date ____________ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)

Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

Medicare – Spouse/Dependent Name: ______________________________

☐ Enrolled in Part A: Effective Date ____________ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)

☐ Enrolled in Part B: Effective Date ____________ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)

☐ Enrolled in Part D: Effective Date ____________ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)

Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

E. Waiver of Coverage

I decline coverage for:

☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

Declining coverage due to existence of other coverage:

☐ Spouse's Employer's Plan ☐ Individual Plan
☐ Covered by Medicare ☐ Medicaid
☐ COBRA from Prior Employer ☐ VA Eligibility
☐ Tri-Care
☐ I (we) have no other coverage at this time
☐ Other ______________________

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period. I acknowledge that I have received the "Important Information" statement which is included with this form.

Employee Initials	Date

F. Signature

Your enrollment in the plan is expressly conditioned upon your acceptance of all terms and conditions contained in this enrollment application. If you do not agree to the following terms and conditions, you may not complete your enrollment.

TERMS AND CONDITIONS

As a condition of my and/or my dependents' participation in the plan, and in consideration for the privileges that come from participation in the plan, I hereby agree for myself and/or for my dependents as follows:

I recognize and understand that the plan contracts with physicians and other providers that make up the plan network. I recognize that all physicians and other providers that participate in the plan network are subject to credentialing under applicable State regulations and pursuant to the plan's network credentialing process. I understand that such credentialing includes a review of provider education, training and licensure. However, by participating in the plan I hereby acknowledge and accept that the plan is not a provider of medical services, and I am aware that obtaining or not obtaining medical care involves significant risks such as serious injury and even death. I acknowledge that the credentialing of physicians and other providers does not in any way reduce this risk. I agree to assume all risks and responsibility for, and hold the plan harmless from, any and all claims for damages, including personal injury or death, medical expenses, disability, lost wages, and loss of earning capacity which may be incurred or associated with medical treatment obtained through a participating physician or other provider. I recognize that all physicians and other providers that participate in the plan network are independent contractors and not the plan's employees or agents and are solely responsible for any malpractice, adverse outcomes, or any other claims arising from medical treatment rendered to me and my dependents. I HEREBY AGREE THAT THE PLAN IS NOT RESPONSIBLE NOR LIABLE FOR ANY ADVICE, COURSE OF TREATMENT, DIAGNOSIS OR ANY OTHER INFORMATION, SERVICES OR PRODUCTS THAT I OR MY DEPENDENTS OBTAIN THROUGH A PARTICIPATING NETWORK PHYSICIAN OR OTHER PROVIDER.

(continued on next page)

F. Signature (Continued)

I recognize and understand that the plan does not recommend, endorse or make any representation about the appropriateness or suitability of any specific tests, products, procedures, treatments, services, or opinions. I recognize that the plan, plan documents, and any health and wellness information provided by the plan, are not intended or implied to be a substitute for professional medical advice, diagnosis or treatment. I agree to confirm any medical information obtained from or through the plan with other sources, and will review all information regarding any medical condition or treatment with my physician. I HEREBY AGREE TO NEVER DISREGARD PROFESSIONAL MEDICAL ADVICE OR DELAY SEEKING MEDICAL TREATMENT BECAUSE OF SOMETHING I HAVE READ OR ACCESSED THROUGH THE PLAN.

I confirm that the information I have provided on this form is complete and accurate.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I acknowledge that I have received the "Important Information" statement which is included at the end of this form.

Date	Employee Signature for all applying and waiving	Spouse Signature (if applying for coverage)

IMPORTANT INFORMATION

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if, after enrollment, your Certificate of Coverage or other materials do not answer your questions. Further information is available at **www.myuhc.com** or at the toll-free Customer Care number located on the back of your identification card or on other plan materials.

1. We do not provide health care services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
   - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
   - We do not decide what care you need or will receive. You and your provider make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We may use individually identifiable information about you to identify for you (and you alone) procedures, products, and services that you may find valuable.
4. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
5. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your provider's treatment or plan.
6. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to your provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for coverage.

I (we) request the indicated group coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings.

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the health history, condition, or treatment of any persons named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for health coverage and eligibility for benefits under an existing policy.

I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date below. I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I understand that the Certificate of Coverage and other documents, notices, and communications regarding my health benefit plan may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments.

Northeast Indiana School Insurance Trust
MSD Steuben County

Open Enrollment Selection Form

(for the period October 1, 2019 to September 30, 2020)

- **Check the appropriate box below to indicate your choice of health coverage.**

	Plan A	Plan B	Plan C	Plan D
	Network / Non	***Network / Non***	***Network / Non***	***Network / Non***
Deductible Individual Family	 $500 / $1,000 $1,000 / $2,000	 $1,000 / $2,000 $2,000 / $4,000	 $3,500 / $7,000 $7,000 / $14,000	 $6,500 / $13,000 $13,000 / $26,000
Reimbursement	90% / 70%	80% / 50%	100% / 50%	100% / 50%
Out of Pocket Max Individual Family	 $1,250 / $2,500 $2,500 / $5,000	 $2,250 / $4,500 $4,500 / $9,000	 $3,500 / $13,000 $7,000 / $26,000	 $6,500 / $13,000 $13,000 / $26,000
Office Visit	$20 copay / 70%	$30 copay / 50%	100% / 50%	100 % / 50%
Rx Copay Retail Mail Order	 $30 brand $15 generic $60 brand $30 generic	 $40 brand $20 generic $80 brand $40 generic	100% / 50% (Subj to Med Ded)	100 % / 50% (Subj to Med Ded)
Rx out of Pocket Max	Individual $4,600 Family $9,200	Individual $4,600 Family $9,200	Subject to Medical Deductible and Coinsurance	Subject to Medical Deductible and Coinsurance

This represents simply a summary of the benefit plans. Please see your United Healthcare Certificate for complete detail. Coinsurance Reimbursement percentages are subject to the deductible unless otherwise indicated.

- I choose to enroll in: Plan A ☐ Plan B ☐ Plan C ☐ Plan D ☐

OR

Waiver of Coverage: ☐ I certify that I have been given an opportunity to apply for the Plan Sponsor's group health coverage and after careful consideration, have decided not to take advantage of this offer.

(Please check one)

Name: ______________________ Social Security Number: ______________________

School: MSD Steuben County ______________________ Date: ______________________

Signature: ______________________

Employees and their eligible dependents that do not enroll in the group health plan when first eligible OR during the annual Open Enrollment Period will not be permitted to enroll until the next Open Enrollment Period OR unless a qualifying event (as defined by federal HIPAA guidelines) occurs. Enrollment forms must be completed within 30 days of the HIPAA event. For additional information regarding HIPAA special enrollment events, contact your HR Department.

The benefit descriptions outlined in this presentation are intended to be a brief outline of coverage and are not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail