blue of california

[Date published]

GROUP NAME: **[Legal Name]**

GROUP NUMBER: **[Group Number]**

Thank you for selecting Blue Shield of California to provide healthcare coverage for your business. The enclosed Group Contract is an important document explaining our agreement. In order to complete the enrollment process, it is necessary for you to sign and return the original application page to us as soon as possible.

After you sign the first application page, please return it by fax to (209) 367-6433 or by email at Small.Group@blueshieldca.com. The accompanying Contract is for you to keep with your records.

We appreciate the trust you have placed in us and look forward to serving you and your employees.
Thank you for continuing your Blue Shield of California coverage.

The enclosed Contract replaces any that have previously been issued. In order to complete the enrollment process, it is necessary for you to sign and return the original application page to us as soon as possible.

Please sign the first application page and return it by fax to (209) 367-6433 or by email at Small.Group@blueshieldca.com. The accompanying Contract is for your records.

We appreciate your trust and look forward to a continuing relationship.

Contract Processing
Lodi Product Services
P.O. Box 3008
Lodi, CA 95241

APPLICATION IS HEREBY MADE TO

Blue Shield of California

(California Physicians' Service)

FOR A GROUP HEALTH SERVICE CONTRACT

BY: **[Legal Name]**
[Address 1]
[Address 2]
[City], [State] [Zip]

This Contract, number **[Group Number]**, shall be effective **[Effective Date]**. It has been read and approved, and the terms and conditions are accepted by the Contractholder.

The Contractholder, on behalf of itself and its Subscribers, hereby expressly acknowledges its understanding that this agreement constitutes a Contract solely between the Contractholder and Blue Shield of California (hereafter referred to as "the Plan"), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("Association"), an Association of independent Blue Cross and Blue Shield plans, permitting the Plan to use the Blue Shield Service Mark in the State of California, and that the Plan is not contracting as the agent of the Association. The Contractholder further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than the Plan and that neither the Association nor any person, entity, or organization affiliated with the Association, shall be held accountable or liable to the Contractholder or its Subscribers for any of the Plan's obligations to the Contractholder created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of the Plan, other than those obligations created under other provisions of this agreement.

The Contractholder shall sign, date, and return this original application page to Blue Shield of California by fax to (209) 367-6433. The Contract shall be retained by the Contractholder. Payment of Premiums and acceptance of Blue Shield's performance hereunder by the Contractholder shall be deemed to constitute the Contractholder's acceptance of the terms hereof, whether or not this agreement is signed by the Contractholder.

The Contractholder is responsible for communicating any changes to Benefits as set forth in *Part IX., Contractholder Responsibility for Distribution and Notification Requirements*. Please see this section for important timelines for distribution of information.

It is agreed that this application supersedes any previous application for this Contract.

Dated at _____ (City, State)

this _____ day of _____ 20 ____

_____

(Legal Name of Contractholder)

By _____

Title _____

PLEASE SIGN, DATE AND FAX THE ORIGINAL APPLICATION PAGE
TO BLUE SHIELD OF CALIFORNIA AT: (209) 367-6433
or mail to Blue Shield of California,
P.O. Box 629014, El Dorado Hills, CA 95762.

Inquiries concerning any problems that may develop in the administration of this Contract should be directed to Blue Shield of California at the address provided on page GC-1.

blue of california

COVERED CALIFORNIA SMALL BUSINESS

blue of california

601 12th Street
Oakland, CA 94607
(510) 607-2000

GROUP HEALTH SERVICE CONTRACT

Blue Shield PPO Savings + Child Dental

between

[Legal Name]
("Contractholder")

and

California Physicians' Service
dba Blue Shield of California
a not-for-profit corporation

In consideration of the applications and the timely payment of Premiums, Blue Shield agrees to provide Benefits of this Contract to covered Employees and their covered Dependents.

This Contract shall be effective as of **[Effective Date]**, for a term of 12 months, subject to the provisions entitled, "Changes: Entire Contract".

Jason Bleau
Vice President and General Manager
Small Business and Core Accounts

Group Number: **[Group Number]**

Original Effective Date: **[Original Effective Date]**

MONTHLY DUES/PREMIUMS SCHEDULE

Refer to PART V. of this Contract for additional information pertaining to the payment of Dues/Premiums.

The Employer will pay to Covered California for Small Business (CCSB) the following monthly Premiums:

[Legal Name] [Group Number]
Dues - Subscriber / Member Rates
Region [Region]

Age Category	Premiums	Age Category	Premiums	Age Category	Premiums	Age Category	Premiums
0-14	[0-14]	27-27	[27]	40-40	[40]	53-53	[53]
15-15	[15]	28-28	[28]	41-41	[41]	54-54	[54]
16-16	[16]	29-29	[29]	42-42	[42]	55-55	[55]
17-17	[17]	30-30	[30]	43-43	[43]	56-56	[56]
18-18	[18]	31-31	[31]	44-44	[44]	57-57	[57]
19-19	[19]	32-32	[32]	45-45	[45]	58-58	[58]
20-20	[20]	33-33	[33]	46-46	[46]	59-59	[59]
21-21	[21]	34-34	[34]	47-47	[47]	60-60	[60]
22-22	[22]	35-35	[35]	48-48	[48]	61-61	[61]
23-23	[23]	36-36	[36]	49-49	[49]	62-62	[62]
24-24	[24]	37-37	[37]	50-50	[50]	63-63	[63]
25-25	[25]	38-38	[38]	51-51	[51]	64-plus	[64-120]
26-26	[26]	39-39	[39]	52-52	[52]		

HEALTH DUES/PREMIUMS

An Employee's Premiums will automatically increase the first day of the plan year following the plan year in which an age change that moves the Employee into the next higher age category occurs. Dependent age changes will similarly affect the portion of the premium attributed to them, if any. The Premiums set forth above do not include coverage for dental (other than pediatric dental benefits), vision (other than pediatric vision benefits), or life insurance when applicable.

The Employer must be located in, and the Employee and all Dependents must live, reside, or work in, the Service Area to be eligible for this health plan.

IMPORTANT

No person has the right to receive the Benefits of this Contract for services or supplies furnished following termination of coverage, except as specifically provided in the *Group Continuation of Group Coverage, Extension of Benefits, and Continuity of Care* sections of the Evidence of Coverage. Other than noted exceptions, Benefits of this Contract are available only for services and supplies as included in the applicable sections of the Evidence of Coverage, furnished during the term the Contract is in effect and while the individual claiming Benefits is actually covered by this Contract. Benefits may be modified during the term of this Contract under the applicable section in *Part V. Premiums, Part VIII. General Provisions, D. Changes: Entire Contract*, or upon renewal. If Benefits are modified, the revised Benefits (including any reduction in Benefits or the elimination of Benefits) apply for services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the Benefits of this Contract.

FULL PPO FOR HSA PLAN

Important Information Regarding HSAs

The Full PPO for HSA Plan is designed as a "high deductible health plan" that may allow Small Employers, if they are eligible, to take advantage of the income tax benefits available when they establish an HSA for their employees. The money put into the HSA is used to pay for qualified medical expenses subject to the deductibles under this Plan.

NOTICE: Blue Shield does not provide tax advice. If Small Employers intend to purchase this Plan to use with an HSA for tax purposes, they should consult with their tax advisor about whether they are eligible and whether their HSA meets all legal requirements. **The HSA is a governmental pilot program that is continued year to year at the discretion of Congress.**

Blue Shield has designed this Plan to meet government requirements for a high deductible health plan to be used in conjunction with establishing eligibility for HSA tax benefits. Although Blue Shield believes that this Plan meets these requirements, the Internal Revenue Service has not ruled on whether the Plan is qualified as a high deductible health plan.

Should a Small Employer purchase this Plan in order to obtain the income tax benefits associated with an HSA and the Internal Revenue Service were to rule that this Plan does not qualify as a high deductible health plan, the Employer and employees may not be eligible for the income tax benefits associated with an HSA. In this instance, they may have adverse income tax consequences with respect to their HSA for all years in which they were not eligible.

However, if there were such a ruling, or if government requirements for a high deductible health plan change, Blue Shield intends to amend the PPO HSA Plan prospectively, if necessary, to meet the requirements of a qualified plan. A change in the Plan's Premiums may also be required as a result of a change in the Plan.

Subscribers of this Plan may be eligible to establish a tax deductible Health Savings Account (HSA) plan in accordance with the provisions of the Internal Revenue Code, Section 223.

This is a Participating Provider Plan. Its Benefits, particularly the payment for Services received from Non-Participating Providers, differ from other Blue Shield plans. Benefits for Services provided by Non-Participating Providers may be substantially reduced, and certain Services are not covered.

This Plan is intended to qualify as a "high deductible health plan" within the meaning of Section 223 of the Internal Revenue Code of 1986, as amended. In order to qualify, the calendar year deductible and out-of-pocket maximum amounts may increase annually. In the event that any court, agency, or administrative body with jurisdiction over the matter makes a final determination that this Plan does not qualify, Blue Shield will make efforts to amend this Plan prospectively, if necessary, to meet the requirements of a qualified plan. If Blue Shield determines that the amendment necessitates a change in the Plan provisions, Blue Shield will provide written notice of the change, and the change shall become effective on the first (1st) day of the month following the expiration of 30 days from the date the notice was sent.

To learn more about Health Savings Accounts, eligibility and the law's current provisions, the Subscriber can consult with a financial advisor.

(GPHSA)

TABLE OF CONTENTS

PART I. INTRODUCTION

What is a Health Savings Account (HSA)?

An HSA is a tax-advantaged personal savings or investment account intended for payment of medical expenses, including Plan deductibles and Copayments, as well as some medical expenses not covered by the health Plan. Contributions to a qualified HSA are deductible from gross income for tax purposes and can be used tax-free to pay for qualified medical expenses. HSA funds may also be saved on a tax-deferred basis for the future.

How a Health Savings Account Works

An HSA is very similar to the flexible spending accounts currently offered by some employers. If the employer qualifies for and establishes an HSA, the money deposited will be tax-deductible and can be used tax-free for many medical expenses. So, instead of using taxed income for medical care as the individual satisfies their deductible, they may use 100% of every dollar invested (plus interest). And, as with an Individual Retirement Account, any amounts the individuals do not use (or withdraw with penalty) can grow. The individual's principal and returns may be rolled over from year to year to provide tax-deferred savings for future medical or other uses.

Blue Shield of California ("Blue Shield") will provide or arrange for the provision of services to eligible Subscribers and Dependents of the Contractholder in accordance with the terms, conditions, limitations, and exclusions of this Group Health Service Contract ("Contract"), and any Supplements to this Contract.

The EOC is included and made part of this Contract

Contractholder is obtaining the benefits of this Contract through Covered California for Small Business ("CCSB"), operated by the California Health Benefit Exchange, dba Covered California ("Covered California"). Blue Shield and Contractholder agree to abide by the rules and requirements established for the purpose of purchasing coverage through CCSB, and that the obligations under this Contract, and any Supplements to this Contract, are to be performed in a manner consistent with such rules and requirements.

PART II. DEFINITIONS

In addition to the provisions contained in the "*Definitions*" section of the Evidence of Coverage, the following provisions apply to this Contract:

Employee - an individual engaged in the conduct of the business of the Employer and whose duties in such employment are performed at the Employer's regular places of business. This individual is a permanent employee and works a normal workweek of an average of 30 hours per week over the course of a month. At the option of the Employer and elected prior to issuance of the Contract, an Employee may also include a permanent employee who works at least [PT Hours] hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. An individual who works on a part-time, temporary, or substitute basis is not included in this definition (e.g., short-term employment).

Employee - an individual engaged in the conduct of the business of the Employer and whose duties in such employment are performed at the Employer's regular places of business. This individual is a permanent employee and works a normal workweek of an average of 30 hours per week over the course of a month. At the option of the Employer and elected prior to issuance of the Contract, an Employee may also include a permanent employee who works at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. An individual who works on a part-time, temporary, or substitute basis is not included in this definition (e.g., short-term employment).

Qualified Health Plan (QHP) has the same meaning as that term is defined in the Patient Protection and Affordable Care Act Section 1301 (42 USC §18021). If a standalone dental plan is offered through CCSB, another health plan offered through CCSB shall not fail to be treated as a QHP solely because the health plan does not offer coverage of benefits offered through the standalone dental plan under 42 USC §18022(b)(1)(J).

PART III. ELIGIBILITY

A. Employee Eligibility, Waiting Periods and Open Enrollment

In addition to the provisions contained in the *Eligibility and Enrollment* section of the Evidence of Coverage, the following provisions apply to this Contract:

CCSB shall be solely responsible for enrollment and eligibility determinations for eligible Employees and their Dependents, and Blue Shield shall rely upon the accuracy of current eligibility and enrollment information furnished by CCSB.

B. Associated Employers

Employees of the following listed Employers associated with the Employer as subsidiaries or affiliates are eligible for Benefits in accord with this Contract. For the purposes of this Contract only, service with any associated Employers shall be considered service with the Employer. The Employer may act for and on behalf of any associated Employers in all matters pertaining to this Contract, and every act done by, agreement made with, or notice given to the Employer shall bind all associated Employers.

(list of associated Employers)

None

PART III. ELIGIBILITY

C. Termination of Benefits

Blue Shield's right to terminate or cancel Benefits under this Contract, including for nonpayment of Premiums by the Employer, shall be in accordance with the Supplement to this Contract, as well as any termination rules established by CCSB per applicable laws, rules and regulations.

In addition to the provisions contained in the *Termination of Benefits* section of the Evidence of Coverage, the following provisions apply to this Contract:

1. The Benefits of a Subscriber shall cease on the first day of the month following the month in which the Subscriber retires, is pensioned, leaves voluntarily, or is dismissed from the employ of the Contractholder or otherwise ceases to be a Member of a class eligible for coverage, unless a different date on which the Subscriber no longer meets the requirements for eligibility has been agreed to between Blue Shield and the Contractholder or is established by CCSB, except that:

    a. if the Subscriber ceases active work because of a disability due to illness or bodily injury, or because of an approved leave of absence or temporary layoff, payment of Premiums for that Subscriber shall continue coverage in force in accordance with the Employer's policy regarding such coverage; or,

    b. if the Employer is subject to the California Family Rights Act of 1991 and/or the Federal Family & Medical Leave Act of 1993, and the approved leave of absence is for family leave pursuant to such Acts, payment of Premiums for that Subscriber shall keep coverage in force for the duration(s) prescribed by the Acts. The Employer is solely responsible for notifying Employees of the availability and duration of family leaves.

2. With respect to a newborn child or a child placed for adoption, coverage will cease on the 31st day at 11:59 p.m. Pacific Time following the Dependent's effective date of coverage, except that coverage shall not cease if a written or electronic application for the addition of the Dependent is submitted to and received by Blue Shield within 60 days following the date of birth or placement for adoption.

D. Employer Eligibility/Participation Requirements and Contribution Requirements

The Employer will be eligible for this Contract if the Employer is determined to be an eligible Employer by CCSB as detailed in the Supplement to this Contract. The Employer shall comply with minimum participation and contribution rates as established by CCSB upon issuance of the Contract and at renewal.

PART IV. GROUP RENEWAL PROVISIONS

A. Advance Notification of Blue Shield's Intent to Renew the Group Health Service Contract

The Employer shall be notified by Blue Shield or CCSB of its intent to renew this Group Health Service Contract at least 60 days prior to the proposed effective date of the renewal. However, this renewal advance notification is distinct from, and does not alter the notification periods specified in *Part V. Dues, Paragraph D., or in Part VIII. General Provisions, Paragraph D. Changes: Entire Contract*.

B. Renewal of the Group Health Service Contract

Blue Shield will renew this Contract at the option of the Contractholder except in the following instances:

1. Contractholder violates a material contract provision relating to group contributions or group participation requirements as specified under *Part III. D*;
2. Contractholder fails to pay the required Premiums as specified under *Part V. Premiums*;
3. Contractholder commits fraud or other intentional misrepresentation of material fact;
4. Contractholder relocates outside of California;
5. Blue Shield ceases to offer a plan type purchased by the Contractholder;
6. Blue Shield ceases to offer health benefit plans in the state (withdrawal of all products).
7. Contractholder is an association and association membership ceases.
8. Employer is no longer eligible to purchase this coverage through CCSB.

PART V. PREMIUMS

A. Premiums

The monthly Premiums for the Subscriber and any Dependents are shown on the Monthly Premiums Schedule page.

B. When And Where Payable

CCSB shall be responsible for the collection, aggregation and administration of Premiums as described in the Supplement to this Contract.

1. The first month's Premiums must be paid to CCSB by the effective date of this Contract and subsequent Premiums shall be prepaid in full by the same date of each succeeding month. No Member will be covered under this Contract until the first month's Premiums payment has been received by Blue Shield.

2. Premiums for Employees and/or Dependents who become eligible on a date other than the bill date are waived for the month during which eligibility for covered Benefits is attained. Premiums for Employees and/or Dependents whose eligibility for covered Benefits terminates on a date other than the bill date are due in full for the month during which eligibility is terminated.

3. All Premiums are payable by the Employer to Blue Shield of California. The payment of any Premiums shall not maintain the Benefits under this Contract in force beyond the date immediately preceding the next transmittal date except as otherwise provided in *Part V. F.*

C. The terms of this Contract or the Premiums payable therefor may be changed from time to time as set forth in *Part VIII., D. Changes: Entire Contract*.

D. The Employer shall remit to CCSB the amount specified in *Part V. A. ("the Premiums")*. If a Federal, State or any other taxing or licensing authority imposes upon Blue Shield any tax or fee on account of any of the Employer's health benefit plans that is not included in the Premiums, whether such tax or fee is based on Premiums, gross receipts, enrollment or any other basis, Blue Shield may amend the Contract to increase the Premiums by an amount sufficient to cover any such tax or fee rounded to the nearest cent. This amendment shall be effective as of the date stated in the notice, which shall not be earlier than the date of the imposition of such tax or fee, by mailing a postage prepaid notice of the amendment to the Employer at its address of record with Blue Shield at least 60 days before the effective date of the amendment. In the case of Federal excise taxes, Blue Shield may also amend the Premiums to include any increased Federal income taxes to Blue Shield associated with such Federal excise taxes.

E. If benefit amounts are changed due to a change in the terms of this Contract or if a tax or fee is levied under *Part V. D.*, the Premiums charge therefore may be made, or the Premiums credit therefore may be given, as of the effective date of such change.

F. A grace period of 30 days to pay all delinquent Premiums and avoid cancellation will be granted for the payment of Premiums accruing other than those due on the effective date of this Contract, during which period this Contract shall continue in force, but the Employer shall be liable to CCSB for the payment of all Premiums accruing during the period the Contract continues in force during the grace period. Blue Shield will send a Notice of Start of Grace Period to the Employer after the last date of paid coverage. The 30-day grace period begins on the day the Notice of Start of Grace Period is dated. Cancellation for non-payment of Premiums shall be in accordance with *PART VII.B.*

PART VI. INTER-PLAN ARRANGEMENTS (BLUECARD® PROGRAM AND OTHERS)

Out-of-Area Services

Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as Inter-Plan Arrangements. Whenever a Member accesses Covered Services outside of California, the claim for those services may be processed through one of these Inter-Plan Arrangements and presented to Blue Shield for payment in accordance with the Blue Cross Blue Shield Association rules and procedures then in effect. The Inter-Plan Arrangements available to Members under this agreement are described generally below.

When Members access Covered Services outside of California, within the BlueCard Service Area, they may obtain care from participating health care providers that have a contractual agreement with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (Host Blue). In some instances, Members may obtain care from health care providers in the Host Blue geographic area that do not have a contractual agreement with the Host Blue (non-participating providers). Blue Shield's payment practices in both instances are described below.

BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this arrangement, when Members access Covered Services within the geographic area served by a Host Blue, Blue Shield will remain responsible for fulfilling our contractual obligations. However, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating health care providers.

The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method Per Claim

Calculation of Member liability on claims for Covered Services processed through the BlueCard Program, if not a flat dollar copayment, will be based on the lower of the participating provider's billed charges for Covered Services or the negotiated price made available to Blue Shield by the Host Blue. The negotiated price may represent one of the following:

(i) an actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases, or

(ii) an estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced, or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

(iii) an average price. An average price is a percentage of billed charges for Covered Services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its health care providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual price, estimated price, or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., a prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the BlueCard Program requires that the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by Blue Shield in determining the Employer's Premiums.

PART VI. INTER-PLAN ARRANGEMENTS (BLUECARD® PROGRAM AND OTHERS)

Inter-Plan Arrangements: Federal/State Taxes/Surcharges/Fees

In some instances, federal or state laws or regulations may impose a surcharge, tax, or other fee that applies to insured accounts. If applicable, Blue Shield will include any such surcharge, tax, or other fee in determining Employer's Premiums.

Non-Participating Providers Outside of California

When Covered Services, other than Emergency Services, are received from non-participating providers outside of California, but within the BlueCard Service Area, the amount(s) a Member pays for such services will generally be based on the Host Blue's non-participating provider local payment, the Allowable Amount Blue Shield pays a Non-Participating provider in California if the Host Blue has no non-participating provider allowance, or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the non-participating provider bills and the payment Blue Shield will make for the Covered Services as set forth in this paragraph.

Claims for covered Emergency Services are paid based on the Allowable Amount as defined in the EOC.

Blue Shield Global Core

If Members are outside the BlueCard Service Area, they may be able to take advantage of Blue Shield Global Core when accessing Out-of-Area Covered Health Care Services. Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard Service Area. Although Blue Shield Global Core assists Members with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a Host Blue plan. As such, when Members receive care from providers outside the BlueCard Service Area, Members will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services. Details for Blue Shield Global Core claim submission are provided in the *Inter-Plan Arrangements* section of the EOC.

PART VII. CANCELLATION/REINSTATEMENT/GRACE PERIOD

A. Cancellation Without Cause

The Employer may cancel this Contract at any time by written notice delivered or mailed to Blue Shield and CCSB, effective on receipt or on such later date as specified in the notice.

B. Cancellation for Non-Payment of Dues/Premiums

Blue Shield or CCSB may cancel this Contract for non-payment of Premiums. If Premiums are not received when due, coverage will end the day following the 30-day grace period, as described in Part V.F. hereof. The Employer will be liable for all Premiums accrued while this Contract continues in force including those accrued during the 30-day grace period. In such case, Blue Shield will send a Notice of End of Coverage to the Employer and enrolled Employees no later than five calendar days after the date coverage ends. A new application for coverage will be required by the Employer and a new Contract will be issued only upon demonstration that the Employer meets all underwriting requirements at the time of application.

C. Cancellation/Rescission for Fraud, Intentional Misrepresentations of Material Fact

Blue Shield may cancel or rescind this Contract within 24 months following issuance for fraud or intentional misrepresentation of material fact by the Employer; or with respect to coverage of Employees or Dependents, for fraud or intentional misrepresentation of material fact by the Employee, Dependent, or their representative. Fraud or intentional misrepresentations of material fact on an application may, at the discretion of Blue Shield, result in the cancellation or rescission of this Contract. A rescission voids the Contract retroactively as if it was never effective. Blue Shield will send the Notice of Cancellation, Rescission or Nonrenewal to the Employer prior to any rescission. The Employer must provide enrolled Employees with a copy of the Notice of Cancellation, Rescission or Nonrenewal.

D. Grace Period

The Employer shall be entitled to a grace period of 30 days for payment of Premiums, as described in *PART V.F.* hereof. If during a Premiums grace period written notice is given by the Employer to Blue Shield and CCSB that the Contract or (subject to the consent of Blue Shield) any part of the Contract is to be discontinued before the expiration date of the grace period, the Contract or such part shall be discontinued as of the date specified by the Employer or the date of receipt of such written notice by Blue Shield, whichever is the later date. The Employer shall be liable to Blue Shield for the full month's payment of Premiums if discontinuance of coverage occurs on or after the 15th of the month. If discontinuance of coverage occurs prior to the 15th of the month then Premium payment will be waived and refunded to the Employer.

E. Payment or Refund of Dues/Premiums Upon Cancellation

In the event of cancellation, the Employer shall promptly pay any earned Premiums which have not previously been paid. CCSB shall within 30 days of cancellation (1) return to the Employer the amount of prepaid Premiums, if any, that Blue Shield determines have not been earned as of the effective date of cancellation, and (2) provide Benefits of the Plan for services incurred during the time coverage was in effect up to and including the effective date of cancellation.

F. Termination of Benefits

No Benefits shall be provided for services rendered after the effective date of cancellation, except as specifically provided in the *Group Continuation of Coverage and Extension of Benefits* sections of the Evidence of Coverage.

In the event this Contract is cancelled for any reason, including but not limited to for non-payment of Premiums, no further Benefits will be provided after cancellation unless the Member is a registered Inpatient or is undergoing treatment for an ongoing condition and obtains an extension of Benefits in accordance with the *Extension of Benefits* section of the Evidence of Coverage.

G. Employer to Provide Subscribers with Notice of Cancellation, Rescission or Nonrenewal

If this Contract is rescinded, or cancelled by either party, the Employer shall notify the Subscribers. If rescinded or cancelled by Blue Shield, the Employer shall promptly send a copy of Blue Shield's Notice of Cancellation, Rescission or Nonrenewal to each Subscriber and provide Blue Shield proof of such mailing and the date thereof.

PART VIII. GENERAL PROVISIONS

In addition to the provisions contained in the EOC, the following provisions apply to this Contract:

B. Use of Masculine Pronoun

Whenever a masculine pronoun is used in this Contract, it shall include the feminine gender unless the context clearly indicates otherwise.

C. Workers' Compensation

This Contract is not in lieu of, and shall not affect, any requirements for coverage by Workers' Compensation Insurance.

D. Changes: Entire Contract

This Contract, including appendices, attachments, or other documents incorporated by reference constitutes the entire agreement between the parties, and any statement made by the Employer or by any Subscriber shall, in the absence of fraud, be deemed a representation and not a warranty.

The terms of this Contract, the Premiums payable therefor, and the benefits of this Plan, including but not limited to Covered Services, Deductible, Copayment and annual Out-of-Pocket Maximum amounts, may be changed from time to time. Blue Shield will provide at least 60 days' written notice of any such change, and these changes shall not become effective until at least 60 days after written notice of such change is delivered or mailed to the Employer's last address as shown on the records of Blue Shield or CCSB. Benefits for services furnished on or after the effective date of any Benefit modification shall be provided based on the modification. No change in this Contract shall be valid unless approved by an executive officer of Blue Shield and a written endorsement is issued. No other representative has authority to change this Contract or to waive any of its provisions.

Notice of changes in Benefits, and any documents that may be delivered to the Employer or the Employer's representative for the purpose of informing Members of the details of their coverage under this Contract, will be distributed by the Employer or his representative as set forth in *Part IX., Contractholder Responsibility for Distribution and Notification Requirements*.

E. Statutory Requirements

This Contract is subject to the requirements of the Knox-Keene Health Care Service Plan Act, Chapter 2.2 of Division 2 of the California Health and Safety Code and Title 28 of the California Code of Regulations. Any provision required to be in this Contract by reason of the Act or Regulations shall bind Blue Shield whether or not such provision is actually included in this Contract. In addition, this Contract is subject to applicable state and federal statutes and regulations, which may include the Employee Retirement Income Security Act, Health Insurance Portability and Accountability Act ("HIPAA"), the Patient Protection and Affordable Care Act ("PPACA"), and applicable Centers for Medicare and Medicaid Services ("CMS") requirements. Any provision required to be in this Contract by reason of such state and federal statutes shall bind the Group and Blue Shield whether or not such provision is actually included in this Contract.

F. Legal Process

Legal process or service upon Blue Shield must be served upon a corporate officer of Blue Shield.

G. Time of Commencement or Termination

Wherever this Contract provides for a date of commencement or termination of any part or all of this Contract, commencement or termination shall be effective as of 12:01 a.m. Pacific Time of the commencement date and as of 11:59 p.m. Pacific Time of the termination date.

H. Records and Information to be Furnished

The Employer shall furnish Blue Shield with such information as Blue Shield may require to enable it to administer this Plan, to determine the Premiums and to enable it to perform this Contract. CMS specifically requires Blue Shield to obtain

the following information: Social Security numbers for Subscribers and dependents over forty-five (45) years of age, Subscriber employment status, Employer identification number and Employer size. Failure to provide any such information required by this Section may result in immediate Cancellation of this Contract.

I. Inquiries and Complaints

Inquiries concerning any problems that may develop in the administration of this Contract should be directed to Blue Shield at the address or telephone number indicated on page *GC-1* of this Contract. (See also the *Customer Service* section of the EOC.)

J. Confidentiality

The Contractholder shall comply with all applicable state and federal laws regarding the privacy and confidentiality of the personal and health information of Subscribers and Dependents. The Contractholder shall not require the Blue Shield to release the personal and health information of individual Subscribers or Dependents without written authorization from the Subscriber, unless permitted by law. No information may be disclosed by either party in violation of Cal. Civ. Code §§ 56, et seq. At the request of the Contractholder, Blue Shield may provide aggregate, encrypted, or encoded data regarding Subscribers and Dependents to the Contractholder, unless such data would explicitly or implicitly identify specific Subscribers or Dependents. To the extent the Contractholder receives, maintains, or transmits personal or health information of Subscribers or Dependents electronically, the Contractholder shall comply with all state and federal laws relating to the protection of such information including, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) provisions on security and confidentiality.

K. ERISA Plan Administrator

If the Contractholder's Plan is governed by ERISA (29 USC Sections 1001, et seq.), it is understood that Blue Shield is not the plan administrator for the purposes of ERISA. The plan administrator is the Contractholder.

L. Continuity of Care

Blue Shield will administer continuity of care benefits as described in the Evidence of Coverage during the term of the Contract. Blue Shield will continue to administer continuity of care benefits for a maximum of 90 days following the date of receipt of notice of the termination of this Contract, as required under 42 USCS § 300gg-113.

M. Prescription Drug and Health Care Spending Report

1. The Contractholder is responsible for any reporting requirements for services not provided by Blue Shield. Blue Shield will annually report on prescription Drug spending, and health care spending, enrollment and Premiums for services provided by Blue Shield, consistent with the requirements of 45 C.F.R. § 149.710 -149.740.
2. Blue Shield will annually report on Premium contributions consistent with these requirements provided that Contractholder provides Blue Shield with consent and complete information on a timely basis to report this information on the Contractholder's behalf. If Contractholder fails to timely provide consent and complete information, Contractholder will be solely responsible for reporting Premium contribution information.

PART IX. CONTRACTHOLDER RESPONSIBILITY FOR DISTRIBUTION AND NOTIFICATION REQUIREMENTS

The Contractholder has various distribution of notices and Member materials and other notification requirements under this Contract. Some of the major Contractholder distribution and notification requirements are summarized below; however, this is a summary only and is not to be construed as an all-inclusive list.

A. Obtaining Declinations or Waivers of Coverage

All eligible Employees will be offered health benefits coverage during the initial and subsequent enrollment periods. If an Employee elects to decline or waive coverage, the Employer is responsible for obtaining the Employee's signed acknowledgment of receipt of an explicit written notice in bold type specifying that failure to elect coverage during the Open Enrollment Period permits Blue Shield to impose an exclusion from coverage for a period of 12 months or at the Employer's next Open Enrollment Period, whichever is earlier, if the Employee later decides to elect coverage.

B. Distribution of Summary of Benefits and Coverage (SBC)

A summary of benefits and coverage (SBC) will be issued by Blue Shield for all eligible Employees and Dependents. The Employer is solely responsible for the timely distribution of a complete SBC for each benefit plan offered. The Employer will distribute the SBCs free of charge to Members and prospective Members as required by applicable federal law and regulations.

The Employer shall distribute the SBCs in a manner which complies with applicable federal law and regulations. If the Employer does not distribute paper SBCs, then the Employer will ensure that any alternative or electronic distribution method used complies with applicable federal requirements.

If a material modification is made to the Employer's group health plan that impacts the SBC, other than at the time of renewal, then notice of the material change, as provided by Blue Shield, will be distributed by the Employer to the Subscriber and any Dependents no later than sixty (60) days prior to the date on which the modification will become effective. The notice shall be distributed in a manner that complies with applicable federal requirements.

In the event that the Employer fails to distribute SBCs to Members or prospective Members as required herein, Blue Shield will, after notice to the Employer, distribute SBCs as necessary to comply with applicable federal statutes and regulations. In such case, the Employer agrees to reimburse Blue Shield for the reasonable costs incurred by Blue Shield to generate and distribute the SBCs.

C. Distribution of Member ID Cards and EOC Booklets

1. Member ID Cards

Member identification cards will be issued by Blue Shield for all Subscribers and will either be sent to the Contractholder for distribution to the Subscribers, or sent directly to the Subscribers, depending on the Contractholder's instructions.

2. Evidence of Coverage Booklets

An Evidence of Coverage (EOC) which summarizes the Benefits of this Contract and how to obtain Covered Services will be issued by Blue Shield for all Subscribers. Blue Shield will send the EOC to the Contractholder, and, the Contractholder is responsible for distributing the EOC to Subscribers whether in printed, hardcopy or electronic form.

EOCs will be provided to the Contractholder in electronic form (such as by Compact Disk (CD) or posted on Blue Shield's employer website) or in paper hard copy form. If Contractholder receives the EOC in electronic form, Contractholder is not authorized to modify or alter in any way the text or the formatting of the electronic EOC file. Blue Shield assumes no responsibility for any changes in text or formatting that may occur in the EOC after it is provided to Contractholder. If Contractholder receives the EOC in hard copy form, Contractholder will notify Subscribers that printed hard copies of the EOC are available and will promptly distribute to Subscribers.

PART IX. CONTRACTHOLDER RESPONSIBILITY FOR DISTRIBUTION AND NOTIFICATION REQUIREMENTS

Contractholder may ensure electronic distribution of the EOC to Subscribers by one of the following methods: (1) by posting the EOC in a read-only format on an intranet site which is accessed by Employees of Contractholder; (2) by emailing the EOC directly to Subscribers; or (3) by providing Subscribers with Blue Shield's instructions for accessing the EOC from the Blue Shield website.

If Contractholder posts the electronic EOC on its intranet site, it shall do so in such a way so as to permit Employees of Contractholder to download and print a complete and accurate copy of the EOC. Contractholder will notify Employees enrolled with Blue Shield that the EOC for their plan is available to review, download and print from Contractholder's intranet site, and will provide Subscribers with reasonable and appropriate instructions by which to access and print the document from its intranet site.

Contractholder will provide a hard copy of the EOC to an Employee upon request. If Blue Shield receives an inquiry from an Employee of the Contractholder regarding obtaining a copy of the EOC, Blue Shield will refer that individual to Contractholder's human resources benefits staff with instructions that a copy of the EOC is available from Contractholder on request.

In the event Blue Shield reasonably concludes that Contractholder is either using the electronic EOC in a matter not permitted by this Agreement or is not providing Subscribers with access to the EOC in accordance herewith, then Blue Shield will print copies of the EOC, and Contractholder will cooperate with Blue Shield to ensure that printed copies of the EOC are timely provided to all Employees of Contractholder enrolled with Blue Shield. Contractholder agrees to reimburse Blue Shield for the reasonable cost of printing and delivering the EOC documents.

D. Notice of Start of Grace Period or Notice of Cancellation, Rescission or Nonrenewal

Upon receipt of a Notice of Start of Grace Period or a Notice of Cancellation, Rescission or Nonrenewal from the Plan, the Employer shall promptly send any such Notice to each subscriber in a manner which complies with applicable law.

E. Notice of Cancellation, Rescission or Nonrenewal to Subscribers

If this Contract is rescinded, or cancelled by either party, the Employer shall notify the Subscribers. If rescinded or cancelled by Blue Shield, the Employer shall promptly send a copy of Blue Shield's Notice of Cancellation, Rescission or Nonrenewal to each Subscriber and provide Blue Shield proof of such mailing and the date thereof.

F. Notification of COBRA and Cal-COBRA Coverage Option and Other COBRA/Cal-COBRA Notices

The following provisions are applicable only when the Contractholder is subject to Title X. of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended or the California Continuation Benefits Replacement Act (Cal-COBRA). See the Continuation of Group Coverage and Extension of Benefits sections of the Evidence of Coverage for additional information.

1. COBRA

Blue Shield is not the plan administrator or plan sponsor, as those terms are defined by ERISA, for any purpose, including but not limited to COBRA, and has no responsibility for the Contractholder's COBRA administration obligations

To the extent required by COBRA, and upon timely receipt of Premiums and proper enrollment forms, Blue Shield will continue the group coverage to qualified beneficiaries after the period that their coverage would normally terminate under the Contract.

Blue Shield will not be responsible for determining whether a Subscriber or Dependent is eligible to receive continuation coverage; such determination is based on the requirements of COBRA and the procedures established by the Contractholder or its COBRA administrator.

PART IX. CONTRACTHOLDER RESPONSIBILITY FOR DISTRIBUTION AND NOTIFICATION REQUIREMENTS

If the Contractholder or any Subscriber or Dependent fails to meet its obligations under the Contract and COBRA, Blue Shield shall not be liable for any claims of the Subscriber or Dependent after his/her termination of coverage, except as expressly provided in other applicable provisions of the Contract.

The Contractholder is solely responsible for all aspects of the administration of COBRA and any amendments with respect to the group health coverage provided by this Contract. The obligations of the Contractholder, in the event that federal continuation of coverage requirements of COBRA apply to the Contractholder, include the following:

a. Contractholder or its COBRA administrator will complete and timely provide all notices and enrollment forms to all eligible Subscribers and Dependents (including the initial notice of COBRA rights) required under COBRA.

b. Contractholder or its COBRA administrator will establish procedures to verify eligibility for COBRA coverage and receive COBRA election forms from Qualified Beneficiaries.

c. The Contractholder will notify its COBRA administrator (or the Plan administrator if the Contractholder does not have a COBRA administrator) of the Subscriber's death, termination, or reduction of hours of employment, or of the Subscriber's Medicare entitlement, or the Employer's (Contractholder's) filing for reorganization under Title XI, United States Code.

d. Contractholder or its COBRA administrator will establish a determination date upon which applicable COBRA rates may be annually changed and determine the applicable premium amount for qualified COBRA beneficiaries in accordance with its Contract with Blue Shield, adding the 2% administrative fee permitted by COBRA.

e. Contractholder or its COBRA administrator will bill and collect premiums from COBRA Qualified Beneficiaries, and provide timely notification of nonpayment of COBRA continuation coverage premiums, per the terms of the Contract and COBRA.

f. Contractholder or its COBRA administrator will remit premiums to Blue Shield on behalf of the COBRA qualified beneficiary until Blue Shield receives notice from the Contractholder that such beneficiary is no longer entitled to COBRA coverage.

g. Contractholder or its COBRA administrator will provide notification of continuation of coverage rights to the extent required by COBRA or any other federal or state laws as applicable, on termination of COBRA coverage. The Contractholder or its COBRA administrator is responsible for notifying COBRA enrollees of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end.

h. Contractholder or its COBRA administrator will inform eligible Subscribers and Dependents of changes in the COBRA law as they occur, including an explanation of the impact of these changes upon COBRA coverage.

i. The Contractholder agrees to assume responsibility for any and all COBRA violations resulting from the failure of the Contractholder or its COBRA administrator to perform its COBRA administration responsibilities.

2. Cal-COBRA

Contractholders subject to the California Continuation Benefits Replacement Act (Cal-COBRA) are responsible for notifying Blue Shield in writing within 30 days when the Contractholder becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.

Contractholders subject to the California Continuation Benefits Replacement Act (Cal-COBRA) are responsible for notifying Blue Shield in writing of the Subscriber’s termination or reduction in hours of employment within 30 days of the Qualifying Event.

EVIDENCE OF COVERAGE

An EOC booklet and any applicable Supplements will be issued by Blue Shield for all Subscribers covered under this Group Health Service Contract. The following pages contain the exact provisions of this EOC and any applicable Supplements and are included as part of this Contract.

CALIFORNIA HEALTH BENEFIT EXCHANGE SHOP PROGRAM
SUPPLEMENT RIDER
TO
GROUP HEALTH SERVICE CONTRACT

This California Health Benefit Exchange Small Business Health Options (SHOP) Program Supplement Rider (the "Supplement") supplements that certain Group Subscriber Agreement (the "Agreement") between Health Plan or Insurance Issuer (HEALTH PLAN) and [Legal Name] (GROUP). This Supplement is an integral part of the Agreement, and is intended by the Parties hereto to be interpreted to be consistent therewith; any inconsistencies or conflicts in terms with the Agreement are to be resolved in favor of the terms in this Supplement.

WHEREAS, GROUP is eligible to participate in the Small Business Health Options Program Exchange and desires to offer its Employees a range of choice of health care plans from which to receive their health care; and

WHEREAS, HEALTH PLAN is a participant in the SHOP Program, as defined below; and

WHEREAS, at least one Employee of GROUP has selected HEALTH PLAN, through HEALTH PLAN's participation in the SHOP Program, as the health care service plan or insurance issuer from which to receive his or her health care;

THEREFORE, HEALTH PLAN and GROUP have entered into the Agreement, as supplemented by this Supplement.

I. DEFINITIONS

SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP) is that program operated by the California Health Benefit Exchange, also known as Covered California through which a small employer can provide its employees and their dependents with access to one or more products offered by HEALTH PLAN.

ELIGIBLE EMPLOYEE is an employee as defined in Section 1357.500(c) of California Health and Safety Code and in Section 10753(f) of California Insurance Code.

ENROLLEE shall mean an individual and his or her eligible dependents, as defined by HEALTH PLAN, who lives or works in an approved Service Area, who meets the eligibility requirements of GROUP and HEALTH PLAN, who has made application to HEALTH PLAN through the SHOP Program, and for whom premiums have been paid by GROUP or individually as a COBRA or Cal-COBRA participant.

MEMBER shall mean an individual who is covered for health care services by HEALTH PLAN, but who may or may not have obtained coverage through the SHOP.

NET PREMIUM shall mean the monthly amount paid to HEALTH PLAN by GROUP through SHOP for health care coverage of GROUP's Enrollees, which shall consist of the Premium minus authorized expenses of SHOP deducted pursuant to this Supplement.

PARTICIPATING PLAN shall mean a HEALTH PLAN, offering health maintenance organization (HMO) or preferred provider (PPO) products and participating in the SHOP. HEALTH PLAN is a Participating Plan.

PARTICIPATING PROVIDER shall mean a health care provider, individual or institution, who or which is employed by or under contract with HEALTH PLAN to provide designated health care services to HEALTH PLAN's Members.

PREMIUM shall mean the monthly amount charged to and payable by Subscribing Groups or COBRA or Cal-COBRA subscribers for health care coverage from HEALTH PLAN (including commissions, administrative expenses, billing fees, taxes or license fees, if any), and the payment of which entitles Enrollees to the health care coverage offered under the terms of the Agreement.

QUALIFIED HEALTH PLAN (QHP) has the same meaning as that term is defined in Patient Protection and Affordable Care Act Section 1301 (42 USC § 18021).

SERVICE AREA shall mean that geographic area in which HEALTH PLAN is licensed to offer and provide
QHPs to Small Group Employers.

SMALL GROUP EMPLOYER shall mean a "small employer" as defined in Section 1357.500(k) of California Health and Safety Code and Section 10753(q) of California Insurance Code.

SMALL GROUP MARKET shall mean the aggregation of Small Group Employers in the state of California.

SUBSCRIBING GROUP or SUBSCRIBING EMPLOYER shall mean an organization or firm, which applied for health care coverage by a PARTICIPATING PLAN through the *SHOP*, was screened for compliance with SHOP's eligibility criteria, and was accepted by SHOP for participation. The Subscribing Group contracts directly with HEALTH PLAN to arrange for the provision of health care services for its Employees or Members and/or their spouses or domestic partners and/or their dependents. GROUP upon execution of the Agreement, as modified by this Supplement, is a Subscribing Group.

II. THE SHOP

The SHOP is a mechanism in which HEALTH PLAN and other health care service plans and insurance issuers simultaneously offer Qualified Health Plans (QHP) to Small Group Employers.

A. Contribution and Participation Requirements

HEALTH PLAN and GROUP understand and agree to the following contribution and participation requirements for the provision of services pursuant to the Agreement.

1. For medical coverage, GROUP must contribute a minimum of the equivalent of fifty percent (50%) of the Premium cost of the Employee-only rate in the reference plan selected by the Employer.

2. For medical coverage, GROUP must have a minimum of seventy percent (70%) of Eligible Employees enroll in a QHP through the SHOP. If the GROUP pays 100 percent of its Qualified Employees' QHP premiums, then all Eligible Employees must enroll in health coverage through the SHOP. For purposes of participation, eligible employees are not included in the calculation for minimum participation requirements if they are enrolled in coverage through another employer, an employee's union, Medicaid, Medicare, any other federal or state health coverage programs, or any health coverage meeting the definition of minimum essential coverage pursuant to Health and Safety Code Section 1345.5.

3. If GROUP does not meet such minimum contribution and minimum participation requirements, GROUP may only enroll with HEALTH PLAN through SHOP from November 15th through December 15th of each year.

III. ELIGIBILITY AND ENROLLMENT

A. Eligibility and Enrollment for Open Enrollment

SHOP is responsible for determining eligibility for all GROUPs and applicant Employees of GROUP and their dependents. Except for special enrollments addressed below, coverage effective dates will be determined pursuant to 10 CCR Section 6536.

Employee Eligibility

A Qualified Employee is an employee who has been offered coverage by his or her employer and who is an Eligible Employee.

Dependent Eligibility

1. A dependent claiming eligibility hereunder as a spouse must be legally married to a Qualified Employee.
2. A dependent claiming eligibility hereunder as a domestic partner must be a registered domestic partner, as defined in section 297 and 299.2 of the California Family Code. For an Employee's unregistered domestic partner to be eligible for coverage, the Employer must make an offer of coverage to the Employee's unregistered domestic partner and the eligibility of unregistered domestic partners must be documented in Employer's Employee Benefit Plan documents. It is the Employer's responsibility to ensure that unregistered domestic partnerships are eligible under the terms and conditions of the Employer's plan.
3. A dependent child claiming eligibility hereunder must be born to, a step-child or legal ward of, adopted by or placed in the foster care of the Eligible Employee or the Eligible Employee's spouse or domestic partner, a minor child ordered by a court to be covered by an employee's Plan, or a child for whom the employee has assumed a parent-child relationship and under the age of 26 unless disabled.
4. A dependent child who exceeds the age limit for dependent children and is disabled, who is incapable of self-support because of a physical or mental disability which existed continuously from a date prior to attainment of age, until termination of such incapacity shall be considered eligible. A disabled child who is age 26 or over will be enrolled at the time of initial enrollment of the employee provided that satisfactory evidence of such disability is provided to the PLAN, if requested by the PLAN, within 60 days of the initial enrollment. The PLAN shall provide this information to SHOP within 60 days.
5. For a child that is enrolled, SHOP will provide a 90-day notice that a dependent is about to reach the age limit for dependent children and will lose coverage unless provided with written certification from a competent health care professional, within 60 days of receiving this 90-day notice, that the dependent meets the above conditions of being disabled.

Documentation of eligibility and existence of the relationship of any dependent to the Qualified Employee may be requested at the time of enrollment and before a child attains the limiting age, but not more frequently than annually after the two-year period following a child's attainment of the limiting age.

B. Eligibility and Enrollment for Special Enrollment

1. Newly Eligible Employee

   An employee who becomes a qualified employee outside of the initial employee open enrollment period, the annual employee open enrollment period, or a special enrollment period shall have a 30-day period to enroll in a QHP beginning from the first day the employee becomes a qualified employee.

2. New Dependents – Spouse or Registered Domestic Partnership

   An eligible spouse or registered domestic partner may be added to coverage at the time of initial enrollment of the Employee, at each open enrollment period of GROUP or due to one of the following special enrollment qualifying events if the application for coverage, along with any supporting documentation is received by SHOP within 30 calendar days of the event. Coverage will become effective on the first day of the month following the receipt of the application for coverage.

   When an employee is newly married or has a newly registered domestic partnership, he or she must submit a stamped copy of the Marriage Certificate or the date the Declaration of Domestic Partnership is filed with the California Secretary of State if requested by SHOP.

   When an employee gains a child dependent, the employee may enroll a spouse or registered domestic partner to the Plan during the same special enrollment period as the newly gained child dependent.

3. New Dependents - Birth/Adoption/Legal Guardianship/Assumption of a Parent-Child Relationship

   An individual who becomes a new dependent by virtue of birth, placement for adoption or foster care, assumption of a parent-child relationship, or legal guardianship is eligible for coverage under the Agreement, as modified by this Supplement, at other than the Employer's initial or annual open enrollment, and the appropriate request form should be received by SHOP within 30 days after such birth, placement for adoption, placement in foster care or effective date of a guardianship order, with coverage to be effective upon the date of the birth, placement for adoption, foster care placement, assumption of parent-child relationship, or legal guardianship assignment unless the Employee requests the coverage to be effective on the first day of the month following the date of the birth, placement for adoption, foster care placement, assumption of parent-child relationship, or legal guardianship assignment. The first 31 days of coverage for such new or adopted child is automatic, regardless of whether the child is enrolled or not after this 31-day period.

   If application is not received by the 30th day after the birth, adoption, placement, assignment, or assumption of parent-child relationship, the HEALTH PLAN providing coverage for the covered parent will only provide coverage for the first 31 days from the event under that parent's policy. After that time, the dependent child will no longer have coverage.

4. New Dependents – Unregistered Domestic Partnership

   If an employer offers coverage to unregistered domestic partners, the SHOP must receive an application for coverage of an unregistered domestic partner by the 30th day after the establishment of the unregistered domestic partnership. Coverage will be effective on the first of the month following the receipt of the application for coverage of the unregistered domestic partner by SHOP.

   Employers must agree to notify SHOP immediately upon termination of the unregistered domestic partnership.

5. Loss of Coverage – Qualified Employee and Dependents

A. A Qualified Employee or an eligible spouse or registered domestic partner and/or eligible child dependent may be added to coverage at a time other than at initial enrollment of the Qualified Employee or at each open enrollment period of GROUP if they experience a loss of Minimum Essential Coverage due to one of the events listed below. Receipt of the application for coverage and any supporting documents must be within 30 days of the event. Coverage will become effective on the first day of the month following the loss of coverage.

    a. Loss of eligibility for health insurance coverage due to:
        1. legal separation;
        2. divorce;
        3. cessation of dependent status;
        4. termination of employment; or
        5. reduction in the number of hours of employment.
    b. Termination of qualified employer contributions toward the employee's or dependent's health insurance coverage.
    c. Exhaustion of COBRA or Cal-COBRA coverage.

B. A Qualified Employee and/or an eligible spouse or registered domestic partner and/or eligible child dependent may be added to coverage at a time other than at initial enrollment of the Qualified Employee or at each open enrollment period of GROUP if they experience a loss of Minimum Essential Coverage due to the loss of coverage through Medicare or Medi-Cal or other government sponsored health care program. Receipt of the application for coverage and any supporting documents must be within **60 days** of the event. Coverage will become effective on the first day of the month following the loss of coverage.

6. Other Special Enrollment Events

A. A Qualified Employee and/or an eligible spouse or registered domestic partner and/or eligible child dependent may be added to coverage at a time other than at initial enrollment of the Qualified Employee or at each open enrollment period of GROUP if they experience one of the events listed below. Receipt of the application for coverage and any supporting documents must be within 30 days of the event. Coverage will become effective on the first day of the month following the loss of coverage.

    a. The enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the enrollee, or his or her dependent, dies.
    b. The Qualified Employee, spouse or registered domestic partner or eligible dependent child's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS or its instrumentalities as evaluated and determined by the Exchange.
    c. The Qualified Employee, spouse or registered domestic partner or eligible dependent child adequately demonstrates to the Exchange that the QHP in which he or she is enrolled, substantially violated a material provision of its contract in relation to the qualified employee.
    d. A Qualified Employee or enrollee, or his or her dependent , gains access to new QHPs as a result of a permanent move and either
    (A) Had MEC as described in 26 CFR Section 1.5000A-1(b) (December 26, 2013), hereby incorporated by reference, for one or more days during the 60 days preceding the permanent move; or

(B) Was living outside of the United States or in a United States territory at the time of the permanent move.

e. Was released from incarceration, or is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code;

f. An Indian, as defined by Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603(c)), may enroll in a QHP or change from one QHP to another one time per month;

g. A Qualified Employee or dependent is receiving services from a contracting provider under a health benefit plan, as defined in Section 1399.845(f) of the Health and Safety Code or Section 10965(f) of the Insurance Code, for one of the conditions described in Section 1373.96(c) of the Health and Safety Code and that provider is no longer participating in the health benefit plan;

h. A Qualified Employee or dependent loses pregnancy-related coverage described under Section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)) and Section 14005.18 of the Welfare and Institutions Code. The date of the loss of coverage is the last day the consumer would have pregnancy-related coverage;

i. A Qualified Employee or dependent demonstrates to the Exchange, with respect to health plans offered through the Exchange, or to the applicable regulator, with respect to health benefit plans offered outside the Exchange, that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the employee or dependent because he or she was misinformed that he or she was covered under MEC;

j. A Qualified Employee, or his or her dependent, demonstrates to the Exchange, in accordance with guidelines issued by HHS and as determined by the Exchange on a case-by-case basis, that the individual meets other exceptional circumstances. Such circumstances include, but are not limited to, the following circumstances:
(A) If a child who has been determined ineligible for Medi-Cal and CHIP, and for whom a party other than the party who expects to claim him or her as a tax dependent is required by court order to provide health insurance coverage for the child, the child shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP.

k. A Qualified Employee or his or her dependent loses eligibility for pediatric dental coverage subsequent to turning nineteen (19) years of age and wishes to continue dental coverage under a standalone dental plan offered by a QDP in the SHOP;

l. A Qualified Employee, or his or her dependent, is a victim of domestic abuse or spousal abandonment, is enrolled in MEC, and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment. A dependent of a victim of domestic or spousal abandonment who is on the same application as the victim may enroll in coverage at the same time as the victim;

m. Applies for coverage on the Exchange during the annual enrollment period, is deemed eligible for Medi-Cal or CHIP, and is deemed ineligible for Medi-Cal or CHIP after open enrollment has ended or more than 60 days after the qualifying event;

n. Applies for coverage with Medi-Cal or CHIP during the annual enrollment period and is deemed ineligible for Medi-Cal or CHIP after open enrollment has ended.

B. A Qualified Employee and/or an eligible spouse or registered domestic partner and/or eligible child dependent may be added to coverage at a time other than at initial enrollment of the Qualified Employee or at each open enrollment period of GROUP if

they become eligible for assistance, with respect to health insurance coverage under a SHOP, under a Medi-Cal plan (including any waiver or demonstration project conducted under or in relation to such a plan). Receipt of the application for coverage and any supporting documents must be within 60 days of the event. Coverage will become effective on the first day of the month following the loss of coverage.

7. Process of Enrollment

GROUP's application to contract with HEALTH PLAN for coverage of one or more of its Employees will be reviewed by the SHOP for completeness and eligibility. HEALTH PLAN's receipt of transmitted application data of GROUP from the SHOP will constitute the filing of that application with HEALTH PLAN. The SHOP will notify GROUP and its employees of its acceptance and the effective date of coverage for its employees.

The GROUP shall specify the waiting period for coverage in the Employer's Employee Benefit Plan documents, which shall be equally applicable to all Employees and dependents. The waiting period shall not exceed 90 days.

IV. COVERED SERVICES AND BENEFITS

The Evidence of Coverage describes the separate plan(s) of covered services and benefits, as well as excluded benefits, which HEALTH PLAN agrees to provide to GROUP's Enrollees, pursuant to GROUP's choice through SHOP. GROUP understands that one Employee and his or her designated dependents may select one of these plans, and other GROUP Employees and their respective designated dependents may select the same or another of the described benefit plans, but an Employee and his or her designated dependents must all select the same benefit plan, although they may select different medical groups and primary care physicians. The SHOP plans offered pursuant to the terms of the Agreement and this Supplement are the only benefits which are covered benefits offered by HEALTH PLAN to GROUP through SHOP. HEALTH PLAN itself shall make all benefit and coverage determinations. All such determinations shall be subject to HEALTH PLAN's grievance procedures.

A. Cal-COBRA and COBRA

HEALTH PLAN agrees to provide coverage for GROUP's Cal-COBRA and COBRA-eligible Enrollees at the applicable group rate.

B. Enrollee Materials

HEALTH PLAN shall issue or mail to a new Enrollee an identification card and its Evidence of Coverage booklet provided, however, that only one Evidence of Coverage booklet shall be issued to each Enrollee and his or her dependents, unless the Enrollee or his or her dependent requests an additional Evidence of Coverage booklet be sent. HEALTH PLAN shall be responsible for distributing, or making available for distribution, its federally required Summary of Benefits and Coverage ("SBC"). HEALTH PLAN agrees to provide copies of its Evidence of Coverage, Supplement and SBC to any person requesting such materials, within seven (7) business days of PLAN's receipt of such request. SHOP will post on its website a copy of HEALTH PLAN's current SBC and Evidence of Coverage. HEALTH PLAN agrees to provide to Enrollees and their dependents a copy of its Summary Brochure.

V. FISCAL PROVISIONS

HEALTH PLAN agrees to arrange for the provision of health care services for GROUP's Enrollees, as described in the Evidence of Coverage, in exchange for the Net Premiums received from GROUP less the monies owed to SHOP. HEALTH PLAN agrees to accept the Net Premium due HEALTH PLAN and forwarded to HEALTH PLAN from the SHOP, and any applicable Enrollee co-

payments, as full and complete payment for services provided under the Agreement and this Supplement thereto.

A. Premium Collection

1. Premium Payment. GROUP's Premiums for its Enrollees in HEALTH PLAN will be billed to GROUP by the SHOP in a unified billing mechanism which will include itemized Premiums due from GROUP for other SHOP Participating Plans selected by GROUP's Employees.
    a. A Qualified Employer's first premium payment shall be paid in full, and must be delivered to the SHOP or postmarked by the due date indicated on the invoice, for effectuation to occur on the date requested on the employer's application.
    b. For on-going premiums, on or about the fifteenth of the month prior to the coverage month, an invoice is sent by the SHOP to GROUP, for which payment must be delivered to the SHOP or postmarked by the last day of the invoicing month. On-going monthly premium payments must be made for the total balance due, by the due date on the invoice to avoid delinquency.

2. Notice of Consequences for Nonpayment of Premiums
SHOP on behalf of HEALTH PLAN will send a "Notice of Consequence for Nonpayment of Premiums" concurrently with the invoice to GROUP informing GROUP that the group contract may be cancelled or not renewed if the premium amount due is not received by SHOP.

3. Cancellation for Nonpayment of Premiums. If a billed Premium payment is not received on or before the last day of the month prior to the month of coverage, a "Notice of Start of Grace Period" will be sent via USPS to GROUP by SHOP on behalf of HEALTH PLAN on the first day of that month, identifying the date the 30 day grace period begins and ends, the effective date of cancellation if payment is not received by the end of the grace period, dollar amount past due, and the employer's right to appeal.

GROUP shall promptly send such Notice to each subscriber receiving coverage under the GROUP's policy.

The Notice will provide instructions on how to submit the past due premium payment to maintain coverage and will reiterate when such cancellation will be effective. The notice will also state how and when the GROUP may appeal the cancellation. If the Premium payment is not received by the cancellation effective date, the Agreement will be terminated for non-payment effective 30 days from the date the Notice of Start of Grace Period was sent. In such a case, a "Notice of End of Coverage" will be mailed to GROUP by SHOP on behalf of HEALTH PLAN within 3 days if an electronic notice is sent or 5 business days if a mailed hard copy is sent. HEALTH PLAN, or SHOP on behalf of HEALTH PLAN, will mail an individual Notice of End of Coverage to each of its affected Members, explaining their options for purchasing individual coverage.

All of the notices described above will include statements regarding the reason for the cancellation, the amount of premiums due, a statement of the 30-day grace period, the effective date of the cancellation, and the right of GROUP to seek review by the appropriate regulator, either the California Department of Managed Health Care or the California Department of Insurance (including the responsibility of GROUP to pay premiums during any such review and the right of GROUP to be reinstated back to the effective date of termination if it prevails in such review).

Receipt by SHOP of all Premium payments due and owing by the due date indicated in the Notice of Start of Grace Period will continue the Agreement, as modified by this Supplement, with no interruption in coverage. If full payment of all delinquent Premiums is not received by SHOP by the due date indicated in the Notice of Start of Grace Period, the Agreement will be terminated.

GROUP may request to be reinstated in the same coverage in which it was last enrolled within 30 days after the effective date of the termination. Past due premiums, if any, must be paid before the GROUP may be reinstated without a lapse in coverage.

GROUP may not reinstate coverage 31 or more days following the effective date of termination. GROUP may only reinstate terminated coverage once during the 12-month period beginning on the original effective date or the most recent renewal date, whichever is more recent.

4. Non-Sufficient Funds
If a qualified employer makes a premium payment that is returned unpaid for any reason, the SHOP shall apply a $25.00 insufficient funds fee. If a qualified employer makes a second premium payment that is returned unpaid for any reason within six months of the prior returned payment, the qualified employer shall submit premium payment and the insufficient funds fee for returned payment in the form of a cashier's check or money order. This requirement to make monthly premium payments in the form of a cashier's check or money order shall continue for a period of 12 months beginning with the first of the month following the last paid through date. If premium payment is not submitted in one of these two forms, the qualified employer group may be subject to termination for nonpayment of premium as described in 10 CCR § 6538 (c)(2). In no event shall the failure to pay the insufficient funds fee be a basis to terminate, non-renew or cancel coverage pursuant to Health and Safety Code Section 1365 or Insurance Code Section 10273.4, as applicable.

5. GROUP Liable for Premiums During Grace Period. During the grace period described in the preceding paragraphs, the Agreement, as modified by this Supplement, shall continue in force, and GROUP shall be liable for the payment of all Premiums accruing during the grace period.

6. Issuance of New Contract. Following cancellation for nonpayment of Premiums, the current Agreement will not be reinstated. Instead, GROUP must submit a new application for coverage.

7. Delinquent Accounts: Collections: In the event GROUP's account becomes delinquent, SHOP shall undertake collections per State Accounting Manual (SAM) Section 8776.6 (non-employee accounts receivable).

B. Premium Rates

HEALTH PLAN's premium rates are guaranteed for twelve (12) months from the initial enrollment date of the Supplement, which shall be the effective date of the Supplement, and from each subsequent anniversary renewal date thereof. Renewal increases will be based on HEALTH PLAN's "new business" rates in effect on the anniversary date of the Supplement effective date with GROUP.

VI. VOLUNTARY TERMINATION, RENEWAL AND OTHER CHANGES

A. Termination by GROUP

Group may terminate this Agreement at the end of each month. The last day of coverage shall be the end of the month in which the GROUP provided notice of termination, if the GROUP provides notice to the SHOP on or before the fifteenth of the month, or on a case-by-case basis an earlier date upon agreement between the HEALTH PLAN and the SHOP. If the GROUP does not provide notice to the SHOP on or before the fifteenth of the month, the last day of the month following the month in which the GROUP gave notice of termination, or on a case-by-case basis an earlier date upon agreement between the HEALTH PLAN and the SHOP.

B. Termination by Enrollee

An Enrollee may terminate his or her coverage at the end of each month by providing GROUP with written notice of such intent to terminate up to the last day of the month in which the termination is to be effective. An Enrollee's coverage will terminate on the last day of the month in which the written notice is received or on a later date requested by the Enrollee as long as that date is the last day of the month. GROUP to notify SHOP of enrollee's termination request upon receipt of that request.

The coverage of an Enrollee terminating employment with GROUP or losing eligibility for coverage shall extend through the last day of the month in which his or her employment terminated, or such eligibility was lost. GROUP must inform the SHOP within 30 days after the date of termination of coverage of an Enrollee and/or his or her dependents.

C. Annual Enrollment and Renewal

SHOP will send GROUP a renewal package 60 days in advance of the end of the GROUP's current plan year. The renewal package will consist of the QHPs available to the GROUP, changes to current QHPs, and the rates for the following plan year.

If GROUP wishes to renew its coverage through SHOP upon the anniversary date of the Agreement, GROUP must meet the minimum contribution and participation requirements in Section II. A above. If GROUP does not meet such minimum contribution and minimum participation requirements, GROUP may only enroll with HEALTH PLAN through SHOP from November 15th through December 15th of each year.

1. GROUP may only make changes to reference plan during the renewal period.
2. If employee does not enroll in a different QHP during his or her annual employee open enrollment period, the employee will remain in the QHP selected in the previous year unless the employee notifies employer to terminate his or her coverage from the QHP.
3. If the Qualified Employee's current QHP is not available, the employee shall be enrolled in a QHP offered by the same HEALTH PLAN at the same metal tier that is the most similar to the Qualified Employee's current QHP, as determined by the SHOP on a case-by-case basis.
    a. If the HEALTH PLAN of the QHP in which the Qualified Employee is currently enrolled is no longer available, or if another QHP is not available from the current insurance carrier in the same metal tier, the Qualified Employee may be enrolled in the lowest cost QHP offered by a different Health Plan in the same metal tier as the Qualified Employee's current QHP, as determined by the SHOP on a case-by-case basis.

D. Open Enrollment

HEALTH PLAN, through SHOP, will provide a period of at least twenty (20) days for the annual employer election period and at least twenty (20) days for employee annual open enrollment period prior to the anniversary date of the Agreement, with such requested changes to be effective on such anniversary date. During the employer election period, the employer may change its offering of dependent coverage, its contribution level to employee coverage, and level of coverage within which its employees and dependents can select a QHP.

1. Enrollees electing to make open enrollment changes shall provide the Change Form to their employer for submission to the SHOP prior to 1st of the renewal month.
2. Enrollees Open Enrollment changes submitted to SHOP during the first thirty (30) days of the new plan year are only permitted to make changes within the same Health Plan.
    a. Requests to the SHOP received on the first through the fifteenth day of the month after effective date shall become retroactively effective to the first day of the month, unless the employer requests an effective date of the first of the following month.
    b. Requests to the SHOP received on the sixteenth day of the month up to the thirtieth day of the month after effective date shall become effective on the first day of the following month.

E. Discontinued Group's Reference Plans

If GROUP's reference plan is no longer available, GROUP must select a new reference plan during the annual election period. If GROUP fails to select a reference plan a default alternative reference plan will be auto-selected for the GROUP in accordance with 10 CCR section 6526.

F. Miscellaneous

1. Enrollees may not change plan benefit levels within HEALTH PLAN, if GROUP has made such option available, other than during the open enrollment period.
2. An Eligible Employee of GROUP who, at the time GROUP initially enters into the Agreement, as modified by this Supplement, had declined coverage through the SHOP and who did not have coverage from another source at that time must wait to enroll until the next open enrollment period unless he or she experiences a special enrollment qualifying event in the interim.