

**CALIFORNIA HEALTH BENEFIT EXCHANGE SHOP PROGRAM
MODEL SUPPLEMENT RIDER
TO
GROUP SUBSCRIBER AGREEMENT**

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 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 participant.

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

NET PREMIUM shall mean the monthly amount paid to 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 care service plan or an insurance carrier, offering health maintenance organization (HMO) or preferred provider (PPO) products and participating in the SHOP. 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 PLAN to provide designated health care services to PLAN's Members.

PREMIUM shall mean the monthly amount charged to and payable by Subscribing Groups or COBRA subscribers for health care coverage from 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 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 in 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 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 PROGRAM

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

B. 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. However, if the employer pays one hundred percent (100%) of the employees' QHP premiums or the employer only employs one to three eligible employees, then all eligible employees must enroll in a QHP through the SHOP. For purposes of participation, eligible employees do not include an employee who is enrolled in coverage through another employer, an employee's union, Medicaid, or Medicare at the time GROUP initially contracts with HEALTH PLAN.

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 of the California Family Code. In order 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 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. 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 60 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.

2. 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 60 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. 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. The effective date of coverage is the date of the birth, placement for adoption or foster care, assumption of a parent-child relationship, or legal guardianship.

If application is not received by the 60th 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.

3. 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 60th 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.

4. Loss of Coverage – Qualified Employee and Dependents

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 one of the events listed below. 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.

- a. termination of employment
- b. termination of an employer sponsored plan
- c. reduction in hours that results in a loss of eligibility
- d. loss of coverage through Medicare or Medi-Cal or other government sponsored health care program
- e. exhaustion of COBRA or Cal-COBRA coverage.

5. Other Special Enrollment Events

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 60 days of the event. Coverage will become effective on the first day of the month following the loss of coverage.

- a. 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.
- b. 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.
- c. The Qualified Employee, spouse or registered domestic partner or eligible dependent child gains access to a new QHP as the result of a permanent move.
- d. 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;
- e. A spouse or registered domestic partner or eligible child dependent is released from incarceration.
- f. The Qualified Employee, spouse or registered domestic partner or eligible dependent child was receiving services from a contracting provider under another 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;

C. 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, less any time the employee or dependent was covered under prior creditable coverage.

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 minus the participation fee due to the SHOP. HEALTH PLAN agrees to accept the Net Premium due HEALTH PLAN and forwarded to HEALTH PLAN by and received by 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. On or about the fifteenth of the month prior to the coverage

month, an invoice is sent by the SHOP to GROUP, which payment must be received or postmarked by the last day of the invoicing month.

2. Notice of Consequences for Nonpayment of Premiums

SHOP on behalf of HEALTH PLAN will send a "Notice of Consequences 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 Cancellation for Nonpayment of Premiums and 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 and the effective date of cancellation if payment is not received by the end of the grace period.

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

The Notice will provide instructions for making the premium payment necessary in order to maintain coverage in force, and will repeat when such cancellation will be effective and will also state how and when GROUP may appeal the cancellation. If the Premium payment is not received by cancellation effective date, the Agreement will be terminated for non-payment effective 30 days from the date the Notice was sent. In such a case, a "Notice Confirming Cancellation of Coverage" will be mailed to GROUP by SHOP on behalf of HEALTH PLAN on the first business day of the month following the effective date of the cancellation. PLAN, or SHOP on behalf of HEALTH PLAN, will mail an individual Notice Confirming Cancellation of Coverage to each of its affected Members and also explaining their options for purchasing individual coverage.

All of the cancellation 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 Cancellation for Nonpayment of Premium and Grace Period will continue the Agreement, as modified by this Supplement, with no interruption in coverage. If payment of some or all delinquent Premiums is received by SHOP after the due date in the Notice, the Agreement will not be reinstated and a new application for coverage will be required.

4. 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.

5. 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. A new contract will be issued only upon demonstration that GROUP meets all eligibility requirements, including payment of any and all outstanding earned Premium payments still owing and due.

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 by providing at least thirty (30) days notice to the SHOP.

B. Termination by Enrollee

An Enrollee may terminate his or her coverage with a 14 day notice to the SHOP. An Enrollee's coverage will terminate 14 days after the date of the notice of termination, on a later date requested by the Enrollee, or an earlier date requested by the Enrollee and agreed to by HEALTH PLAN.

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.C 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.

D. Open Enrollment

HEALTH PLAN, through SHOP, will provide a period of at least fourteen (14) days for the annual employer election period and thirty (30) days for employee annual open enrollment period prior to the anniversary date of the Agreement, and any changes requested must be received fourteen (14) days prior to such date, 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.

E. 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.



**Kaiser Foundation Health Plan, Inc.
Northern and Southern California Regions**

A nonprofit corporation

Group Agreement for COVERED CALIFORNIA FOR SMALL BUSINESS

Group ID: 399999

Group ID: 799999

Contract Year 2016

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Introduction

This Group Agreement (*Agreement*), including the California Health Benefit Exchanges Small Business Health Options (SHOP) Program Supplement Rider (Supplement) and the *Evidence of Coverage (EOC)* document(s) listed below, the group application that Group submitted to Health Plan, and any amendments to any of them, all of which are incorporated into this *Agreement* by reference, constitute the contract between Kaiser Foundation Health Plan, Inc., (Health Plan) and Group. In this *Agreement*, some capitalized terms have special meaning; please see the "Definitions" section in the *EOC* document(s) for definitions of terms that are used in *EOC* document(s) and this *Agreement*. Pursuant to this *Agreement*, Health Plan will provide covered Services to Members in accord with the following *EOC* document(s):

<u>Product name</u>	<u>Contract option name</u>	<u>EOC #</u>
Kaiser Permanente for Small Business	Platinum 90 HMO 0/20 w/o Child Dental	13
Kaiser Permanente for Small Business	Gold 80 HMO 0/35 w/o Child Dental	14
Kaiser Permanente Deductible HMO Plan	Silver 70 HMO 1500/45 w/o Child Dental	15
Kaiser Permanente HSA-Qualified Deductible HMO Plan	Bronze 60 HSA 4500/40% w/o Child Dental	17
Kaiser Permanente Deductible HMO Plan	Bronze 60 HMO 6000/70 w/o Child Dental	18
Kaiser Permanente Deductible HMO Plan	Gold 80 HMO 500/30 w/o Child Dental	77
Kaiser Permanente Deductible HMO Plan	Silver 70 HMO 1000/50 w/o Child Dental	78
Kaiser Permanente for Small Business	Platinum HMO 0/15 w/o Child Dental	101

Term of Agreement and Renewal

Term of Agreement

Unless terminated as set forth in the "Termination of *Agreement*" section, this *Agreement* is effective from January 1, 2016, through December 31, 2016.

Renewal

This *Agreement* does not automatically renew. If Group complies with all of the terms of this *Agreement*, Health Plan will offer to renew the *Agreement*, upon 60 days prior written notice to Group, by doing one of the following:

- Providing Group with a new *Group Agreement* to become effective immediately after termination of this *Agreement*
- Extending the term of this *Agreement* and making other changes pursuant to "Amendments Effective in 2016 (Anniversary Date)" in the "Amendment of *Agreement*" section
- Sending Group a renewal notice, which will include a summary of changes to this *Agreement* that will become effective immediately after termination of this *Agreement*. The new *Group Agreement* will incorporate the changes summarized in the renewal notice. Health Plan will send Group the new *Group Agreement* after Group confirms it wants to make additional changes or 60 days after Group's Anniversary Date, if Group does not confirm

If Group does not want to renew the *Agreement*, Group must give Health Plan written notice as described under "Termination on Notice" or "Termination due to Nonacceptance of Amendments" in the "Termination of *Agreement*" section. Coverage of dental services benefits under the Delta Dental Contract attached to this *Agreement* will automatically renew upon the renewal of this *Agreement*.

Amendment of Agreement

Amendments Effective in 2016 (Anniversary Date)

Upon 60 days prior written notice to Group, Health Plan may extend the term of this *Agreement* and make other changes by amending this *Agreement* effective 2016 (the Anniversary Date).

Amendments Related to Government Approval

If Health Plan notified Group that Health Plan had not received all necessary governmental approvals related to this *Agreement*, Health Plan may amend this *Agreement* by giving written notice to Group after receiving all necessary governmental approvals. Any such government-approved provisions go into effect on 2016 (unless the government requires a later effective date).

Amendment Due to Tax or Other Charges

If a government agency or other taxing authority imposes or increases a tax or other charge (other than a tax on or measured by net income) upon Health Plan or Plan Providers (or any of their activities), then upon 60 days prior written notice, Health Plan may increase Group's Premiums to include Group's share of the new or increased tax or charge. Group's share will be determined by dividing the number of Members enrolled through Group by the total number of members enrolled in Health Plan's Northern California Region.

Other Amendments

Health Plan may amend this *Agreement* at any time by giving written notice to Group, in order to address any law or regulatory requirement, which may include an increase in Premiums to reflect an increase in costs to Health Plan or Plan Providers (Health Plan will give Group 60 days prior written notice of any increase in Premiums or reduction in benefits), or ensure that the deductible amount in any High Deductible Health Plan *EOC* continues to meet the U.S. Department of Treasury's minimum deductible amount required in High Deductible Health Plans.

Acceptance of Amendments

All amendments are deemed accepted by Group unless Group gives Health Plan written notice of nonacceptance within 15 days after the date of Health Plan's amendment notice, in which case this *Agreement* will terminate pursuant to "Termination due to Nonacceptance of Amendments" in the "Termination of *Agreement*" section.

Termination of Agreement

This *Agreement* will terminate under any of the conditions listed below. All rights to benefits under this *Agreement* end on the termination date, except as expressly provided in the "Termination of Membership" or "Continuation of Membership" sections of an *Evidence of Coverage*. The termination date is the first day when this *Agreement* is no longer in effect (for example, if the termination date is January 1, 2017, the last minute this *Agreement* was in effect was at 11:59 p.m. on December 31, 2016).

If Health Plan terminates this *Agreement*, Health Plan will give Group written notice. In the case of "Termination for Nonpayment", "Termination for Fraud or Intentionally Furnishing Incorrect or Incomplete Information", and "Termination for Discontinuance of a Product or all Products within a Market," Health Plan will provide both advance notice of the termination in addition to a final notice of termination. Within five business days of receipt of an advance or final notice of termination, Group will mail to each Subscriber a legible copy of the notice and will give Health Plan proof of that mailing and of the date thereof.

Coverage of dental services benefits under the Delta Dental Contract attached to this *Agreement* will automatically terminate upon the termination of this *Agreement*.

Termination on Notice

Group may terminate this *Agreement* effective in 2016 (the Anniversary Date) by giving at least 15 days prior written notice to Health Plan and remitting all amounts payable relating to this *Agreement*, including Premiums, for the period prior to the termination date.

Termination Due to Nonacceptance of Amendments

All amendments are deemed accepted by Group unless Group gives Health Plan written notice of nonacceptance within 15 days after the date of Health Plan's amendment notice and remits all amounts payable related to this *Agreement*, including Premiums, for the period prior to the amendment effective date. This *Agreement* will terminate the day before the effective date of the amendment.

Termination for Nonpayment

Premium payments are due as described in the "Premiums" section. If Health Plan does not receive full Premium payment on or before the due date, we will send a notice of nonpayment to Group as described under "Notices" in the "Miscellaneous Provisions" section. This notice will include the following information:

- A statement that we have not received full Premium payment and that we will terminate this *Agreement* for nonpayment if we do not receive the required Premiums by the specified date
- The amount of Premiums that are due

If we terminate this *Agreement* because we did not receive the required Premiums when due, the *Agreement* will terminate on the date specified in the notice of nonpayment, which will be at least 30 days after the date of the notice. The *Agreement* will remain in effect during this grace period, but upon termination Group will be responsible for paying all past due Premiums, including the Premiums for this grace period.

We will mail a termination notice to Group as described under "Notices" in the "Miscellaneous Provisions" section if we do not receive full Premium payment within 30 days after the date of the notice of nonreceipt of payment.

Termination for Fraud or Intentionally Furnishing Incorrect or Incomplete Information

Health Plan may terminate this *Agreement* upon 15 days prior written notice to Group, if Group commits fraud or intentionally furnishes incorrect or incomplete material information to Health Plan.

Termination for Violation of Contribution or Participation Requirements

Health Plan may terminate this *Agreement* upon 15 days prior written notice to Group, if Group fails to comply with Health Plan's participation or contribution requirements (including those discussed in the "Contribution and Participation Requirements" section).

Termination for Discontinuance of a Product or all Products within a Market

Grandfathered products

Health Plan may terminate a particular product or all products offered in a small or large group market as permitted or required by law. If Health Plan discontinues offering a particular grandfathered product in a market, Health Plan may terminate this *Agreement* with respect to that product upon 90 days prior written notice to Group. Health Plan will offer

Group another product that it makes available to groups in the small or large group market, as applicable. If Health Plan discontinues offering all products to groups in a small or large group market, as applicable, Health Plan may terminate this *Agreement* upon 180 days prior written notice to Group and Health Plan will not offer any other product to Group. A "product" is a combination of benefits and services that is defined by a distinct *Evidence of Coverage*.

All other products

Health Plan may terminate a particular product or all products offered in the group market as permitted or required by law. If Health Plan discontinues offering a particular product (other than a grandfathered product) in the group market, Health Plan may terminate this *Agreement* with respect to that product upon 90 days prior written notice to Group. Health Plan will offer Group another product that it makes available the group market. If Health Plan discontinues offering all products in the group market, Health Plan may terminate this *Agreement* upon 180 days prior written notice to Group and Health Plan will not offer any other product to Group. A "product" is a combination of benefits and services that is defined by a distinct *Evidence of Coverage*.

Contribution and Participation Requirements

No change in Group's contribution or participation requirements listed below is effective for purposes of this *Agreement* unless Health Plan consents in writing. As a condition to consenting to Group's revised contribution and participation requirements, Health Plan may require Group to agree to amend the Premiums, benefits, or other provisions of this *Agreement*.

Group must:

- Contribute to all health care coverage available through Group on a basis that does not financially discriminate against Health Plan or against people who choose to enroll in Health Plan
- For each Family, Group's contribution must be no less than 50 percent of the Premiums required for the lowest-priced Kaiser Permanente medical plan offered by your group
- Ensure that:
 - ◆ all employees enrolled in Health Plan must meet the definition of "eligible employee" in Section 1357.500 or 1357.600
 - ◆ all employees enrolled in Health Plan are covered by workers' compensation or the employer's liability benefits, unless not required by law to be covered
 - ◆ at least 70 percent of eligible employees are covered by a group health care plan
 - ◆ at least one active employee is enrolled under this *Agreement*
 - ◆ all Subscribers live or work inside the Service Area applicable to their coverage when they enroll
- Hold an annual open enrollment period during which all eligible people may enroll in Health Plan or in any other health care plan available through Group. Also, Group must not hold open enrollment for 2017 until Group receives its 2017 group agreement Premium and coverage information from Health Plan. If Group holds the open enrollment without receiving 2017 group agreement Premium and coverage information, Health Plan may change Premiums and coverage (including benefits and Cost Sharing) when it offers to renew Group's *Agreement* as described under "Renewal" in the "Term of *Agreement* and Renewal" section
- Meet all applicable legal and contractual requirements, such as:
 - ◆ meet and continue to meet the definition of "small employer" or "guaranteed association" in Section 1357.500 or 1357.600 of the California Health and Safety Code
 - ◆ for Groups enrolled as guaranteed associations, meet and continue to meet all legal requirements applicable to guaranteed associations
 - ◆ elect any coverage that Group is required by law to provide
 - ◆ distribute disclosures about coverage as described under "Member Information" in the "Miscellaneous Provisions" section
 - ◆ adhere to all requirements set forth in the applicable *Evidence of Coverage*

- ◆ obtain Health Plan's prior written approval of any Group eligibility requirements that are not stated in the applicable *Evidence of Coverage*
- ◆ use Member enrollment application forms that are provided or approved by Health Plan
- ◆ for any coverage identified in an *EOC* as a "grandfathered health plan" under the Patient Protection and Affordable Care Act, immediately inform Health Plan if this coverage does not meet (or no longer meets) the requirements for grandfathered status
- Offer enrollment in Health Plan to all eligible people on conditions no less favorable than those for any other health care plan available through Group
- Offer enrollment in accord with eligibility requirements in state law (for example, domestic partners must be eligible if married spouses are eligible and disabled dependents must be eligible if dependent children are eligible)
- Meet the Health Plan offering requirement to not fund or directly reimburse Members for any Deductibles, Coinsurance, or Copayments, including employer reimbursements of employee Cost Sharing through employee flexible spending accounts (FSAs) or limited purpose FSAs, except for the following:
 - ◆ Group must fund a health reimbursement account (HRA) in accord with federal tax law if the employee is enrolled in a Deductible HMO with HRA Plan
 - ◆ Group may fund a health savings account (HSA) in accord with federal tax law if the employee is enrolled in a HSA-Qualified Deductible HMO Plan
- Upon request, provide Health Plan with documentation that proves each Subscriber is an eligible employee, proprietor, or partner. Also, Group must provide, upon request, documentation that demonstrates to Health Plan's satisfaction that Group is complying with all contribution and participation requirements

Miscellaneous Provisions

Assignment

Health Plan may assign this *Agreement*. Group may not assign this *Agreement* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without Health Plan's prior written consent. This *Agreement* shall be binding on the successors and permitted assignees of Health Plan and Group.

Attorney Fees and Costs

If Health Plan or Group institutes legal action against the other to collect any sums owed under this *Agreement*, the party that substantially prevails will be reimbursed for its reasonable litigation expenses, including attorneys' fees, by the other party.

Confidential Information about Health Plan or its Affiliates

For the purposes of this "Confidential Information about Health Plan or its Affiliates" section, "Confidential Information" means any oral, written, or electronic information concerning Health Plan or its affiliates, if the information either is marked "confidential" or is by its nature proprietary or non-public, except that it does not include any of the following:

- Information that is or becomes available to the public other than as a result of disclosure by Group or its employees, advisors, or representatives
- Information that was available to Group or within its knowledge before Health Plan disclosed it to Group
- Information that becomes available to Group from a source other than Health Plan, but only if that source is not bound by a confidentiality agreement with Health Plan

If Group receives any Confidential Information, it will use that information only to evaluate Health Plan and actual or proposed group agreements with Health Plan. Group will ensure that the information is not disclosed to anyone other than a

limited number of Group's employees and advisors, and only to the extent necessary in connection with the evaluation of Health Plan and actual or proposed group agreements with Health Plan. Group will inform any such employees and advisors that the information is confidential and that they must treat it confidentially.

Upon Health Plan's request Group will promptly return to Health Plan all Confidential Information, and will destroy any other copies and any notes or other Group documents about the information.

If Group is requested or required (by oral questions, interrogatories, request for information or documents, subpoena, civil investigative demand, or similar process) to disclose any Confidential Information, Group will give Health Plan prompt notice of the request or requirement, and Group will cooperate with Health Plan in seeking to legally avoid the disclosure. If, in the absence of a protective order, Group is legally compelled, in the opinion of its counsel, to disclose any of the information, Health Plan either will seek and obtain appropriate protective orders against the disclosure or will be deemed to waive Group's compliance with the provisions of this "Confidential Information about Health Plan or its Affiliates" section to the extent necessary to satisfy the request or requirement.

Group understands (and will inform any employees and advisors who receive Confidential Information) that United States securities laws prohibit anyone who has material non-public information about a company from buying or selling that company's securities in reliance upon that information or from communicating the information to any other person or entity under circumstances in which it is reasonably foreseeable that the person or entity is likely to buy or sell that company's securities in reliance upon the information. Group agrees that it and its affiliates, associates, employees, agents, and advisors will not rely on any Confidential Information in directly or indirectly buying or selling any Health Plan securities.

Monetary damages would not be a sufficient remedy for any breach or threatened breach of this "Confidential Information about Health Plan or its Affiliates" section. Health Plan will be entitled to equitable relief by way of injunction or specific performance if Group or any of its officers, directors, employees, attorneys, accountants, agents, advisors, or representatives breach, or threaten to breach, any of the provisions of this "Confidential Information about Health Plan or its Affiliates" section.

Group's obligations under this "Confidential Information about Health Plan or its Affiliates" section will continue indefinitely and will survive the termination or expiration of this *Agreement*.

Contract Providers

Health Plan will give Group written notice within a reasonable time of any termination or breach of contract by, or inability to perform of, any health care provider that contracts with Health Plan if Group may be materially and adversely affected thereby.

Delegation of Claims Review

Group delegates to Health Plan the discretion to determine whether a Member is entitled to benefits under this *Agreement*. In making these determinations, Health Plan has discretionary authority to review claims in accord with the procedures contained in this *Agreement* and to construe this *Agreement* to determine whether the Member is entitled to benefits. If coverage under an *EOC* is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), Health Plan is a "named claims fiduciary" to review claims under that *EOC*.

Enrollment Application Requirements

Group must use enrollment application forms that are provided by Health Plan. If Group wants to use a different form or system for enrolling Members, Group must obtain Health Plan's approval of the form or system. Other forms and systems include a "universal" enrollment application form, interactive voice recording (IVR) enrollment system, or intranet online enrollment system. All forms and systems must meet Health Plan requirements for enrolling Members, including disclosure of binding arbitration in accord with Section 1363.1 of the California Health and Safety Code and other applicable law. Group must retain documentation of each Member's acceptance of the use of binding arbitration, and upon request, must be

able to produce documentation relating to a specific Member to Health Plan at any time. In the event that the contract between Health Plan and Group terminates or Group is unable to comply with this document retention requirement, Group must transfer possession of all such documentation to Health Plan in a mutually agreeable manner. Group's Health Plan account manager can provide Group with Health Plan's current requirements for enrollment application forms and systems.

Governing Law

Except as preempted by federal law, this *Agreement* will be governed in accord with California law and any provision that is required to be in this *Agreement* by state or federal law, shall bind Group and Health Plan whether or not set forth in this *Agreement*.

Member Information

Group will inform Members and prospective Members of eligibility requirements for Subscribers and Dependents and when coverage becomes effective and terminates.

When Health Plan notifies Group about changes to this *Agreement* or provides Group other information that affects Members, Group will disseminate the information to Members by the next regular communication to them, but in no event later than 30 days after Group receives the information.

For each Health Plan coverage included in this *Agreement*, Health Plan will provide Group with the following disclosures for Group to distribute in accord with applicable laws:

- A Disclosure Form for each non-Medicare coverage. Group will provide *Disclosure Forms* to Subscribers and potential Subscribers when the coverage is offered
- A *Summary of Benefits and Coverage (SBC)* for each non-Medicare coverage other than retiree plans with fewer than two current employees. Group will provide electronic or paper *SBCs* to Members and potential Members to the extent required by law, except that Health Plan will provide *SBCs* to Members who make a request to Health Plan
- An *EOC* for each non-Medicare coverage. Group will provide *EOCs* to Subscribers, except that Health Plan will provide *EOCs* to Members and potential Members who make a request to Health Plan

No Waiver

Health Plan's failure to enforce any provision of this *Agreement* will not constitute a waiver of that or any other provision, or impair Health Plan's right thereafter to require Group's strict performance of any provision.

Notices

Notices must be sent to the addresses listed below. Health Plan or Group may change its addresses for notices by giving written notice to the other. All notices are deemed given when delivered in person or deposited in a U.S. Postal Service receptacle for the collection of U.S. mail.

Notices from Health Plan to Group will be sent to:

[Name and Address of Group]

Notices from Group to Health Plan must be sent to:

If Group's mailing information changes or if Group wants to terminate its *Agreement* as described in the "Termination of *Agreement*" section, Group must send its notice to:

Covered California P.O. Box 7010
Newport Beach, CA 92658

Other Group coverages that cover essential health benefits

For each non-grandfathered non-Medicare Health Plan coverage, except for any retiree-only coverage, Group must do all of the following if Group provides Health Plan Members with other medical or dental coverage (for example, separate pharmacy coverage) that covers any Essential Health Benefits:

- Notify Health Plan of the out-of-pocket maximum (OOPM) that applies to the Essential Health Benefits in each of the other medical or dental coverages.
- Ensure that the sum of the OOPM in Health Plan's coverage plus the OOPMs that apply to Essential Health Benefits in all of the other medical and dental coverages does not exceed the annual limitation on cost sharing described in 45 CFR 156.130.

Reporting Membership Changes and Retroactivity

Group must report membership changes (including sending appropriate membership forms) within the time limit for retroactive changes and in accord with any applicable "rescission" provisions of the Patient Protection and Affordable Care Act and regulations. The time limit for retroactive membership changes, except retroactive membership additions, is the calendar month when Health Plan's California Service Center receives Group's notification of the change. For example, if Group wants June 1 to be the first day that the Member is not covered, Health Plan's California Service Center must receive Group's notification no later than the end of June.

The time limit for retroactive membership additions is the calendar month when Health Plan's California Service Center receives Group's notification of the change plus the previous two months. For example, if Group wants June 1 to be the first day that the member is to be covered, Health Plan's California Service Center must receive Group's notification no later than the end of August.

Group must send membership changes to the following address:

Covered California P.O. Box 7010
Newport Beach, CA 92658

Representation Regarding Waiting Periods

By entering into this Agreement, Group hereby represents that Group does not impose a waiting period exceeding 90 days on employees who meet Group's eligibility requirements. For purposes of this requirement, a "waiting period" is the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective in accord with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.

In addition, Group represents that eligibility data provided by the Group to Health Plan will include coverage effective dates for Group's employees that correctly account for eligibility in compliance with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations. For example, if the hire date of an otherwise-eligible employee is January 19, the waiting period begins on January 19 and the effective date of coverage cannot be any later than April 19. Note: Because the effective date of your Group's coverage is always on the first day of the month, in this example the effective date cannot be any later than April 1.

Right to Examine Records

Upon reasonable notice, Health Plan may examine Group's records with respect to contribution and participation requirements, eligibility, and payments under this *Agreement*.

Social Security and Tax Identification Numbers

Within 60 days after Health Plan sends Group a written request, Group will send Health Plan a list of all Members covered under this Agreement, along with the following:

- The Social Security number of the Member
- The tax identification number of the employer of the Subscriber in the Member's Family
- Any other information that Health Plan is required by law to collect

Premiums

Only Members for whom Health Plan (or its designee) has received the appropriate Premium payment listed below are entitled to coverage under this *Agreement*, and then only for the period for which Health Plan (or its designee) has received appropriate payment. Group is responsible for paying Premiums, except that Members who have Cal-COBRA coverage under an EOC that is included in this Agreement are responsible for paying Premiums for Cal-COBRA coverage.

Please refer to your agreement with Covered California for Small Business for information about Premiums.

Agreement Signature Page

Acceptance of Agreement

Group acknowledges acceptance of this *Agreement* by signing the Signature Page and returning it to Health Plan. If Group does not return it to Health Plan, Group will be deemed as having accepted this *Agreement* if Group pays Health Plan any amount toward Premiums.

Group may **not** change this *Agreement* by adding or deleting words, and any such addition or deletion is void. Health Plan might not respond to any changes or comments submitted on or with this Signature Page. Group may not construe Health Plan's lack of response to any submitted changes or comments to imply acceptance. If Group wishes to change anything in this *Agreement*, Group must contact its Health Plan account manager. Health Plan will issue a new *Agreement* or amendment if Health Plan and Group agree on any changes.

Binding Arbitration

As more fully set forth in the arbitration provision in the applicable *Evidence of Coverage*, disputes between Members, their heirs, relatives, or associated parties (on the one hand) and Health Plan, Kaiser Permanente health care providers, or other associated parties (on the other hand) for alleged violation of any duty arising out of or related to this *Agreement*, including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this *Agreement*, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. Members enrolled under this *Agreement* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the applicable *Evidence of Coverage* except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeals procedure as applicable to Kaiser Permanente Senior Advantage Members
- Claims that cannot be subject to binding arbitration under governing law

Signatures

COVERED CALIFORNIA for SMALL BUSINESS

Kaiser Foundation Health Plan, Inc.
Northern California Region



Authorized Group officer signature

Wade J. Overgaard
Authorized officer
Senior Vice President, California Health Plan Operations

Please print your name and title

Effective 2016

Date signed

Please keep this copy with your *Agreement*. An extra copy of the Signature Page is enclosed for mailing to Health Plan's California Service Center at P.O. Box 23448, San Diego, CA 92193-3448.

