Health Net PPO
Group Insurance Policy

A20601 (CA 1/22) SHOP

HEALTH NET PPO GROUP INSURANCE POLICY
(the Policy)

ISSUED BY

HEALTH NET LIFE INSURANCE COMPANY
(HNL)

LOS ANGELES, CALIFORNIA

Health Net Life Insurance Company agrees to provide the benefits of the Policy, as herein limited and defined, for enrolled Covered Persons of the Employer. These benefits are subject to all the terms and conditions of this Policy.

Upon payment of premium charges in the amount and manner provided in this Policy. Health Net Life Insurance Company

HEREBY AGREES

to provide benefits as defined in the Policy to eligible employees and their eligible Dependents of:

Group Name:	**1/2022 Sample**
Group ID:	**XXXXXX**
Coverage Code:	**XXXX**
Plan Code:	**XXX**

(herein called the "Group")

according to the terms and conditions of this Policy. Payment of premiums by the Group in the amount and manner provided for in the Policy shall constitute the Group's acceptance of the terms and conditions of the Policy. This Health Net Life Insurance Company Policy, the "Application for Group Policy," including the conditions of enrollment, the underwriting criteria and the enrollment forms of the Group's eligible employees, inclusively shall constitute the entire agreement between the parties.

HEALTH NET LIFE INSURANCE COMPANY

Steven Sickle
Secretary

J. Brian Ternan
President

NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

  Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

  The basic coverage protections provided by the Association are as follows.

  - **Life Insurance, Annuities and Structured Settlement Annuities**

    For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

    - **Life Insurance**

      80% of death benefits but not to exceed $300,000

      80% of cash surrender or withdrawal values but not to exceed $100,000

    - **Annuities and Structured Settlement Annuities**

      80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

    The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

  - **Health Insurance**

    The maximum amount of protection provided by the Association to an individual, as of April 1, 2011, is $470,125. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O Box 16860
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927- 4357

www.insurance.ca.gov

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

Nondiscrimination Notice

Health Net Life Insurance Company (Health Net) complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at:

Group Plans through Health Net 1-800-522-0088 (TTY: 711)

If you believe that Health Net has failed to provide these services or discriminated in another way based on one of the characteristics listed above, you can file a grievance by calling Health Net's Customer Contact Center at the number above and telling them you need help filing a grievance. Health Net's Customer Contact Center is available to help you file a grievance. You can also file a grievance by mail, fax or email at:

Health Net Life Insurance Company Appeals & Grievances
PO Box 10348
Van Nuys, CA 91410-0348

Fax: 1-877-831-6019

Email: Member.Discrimination.Complaints@healthnet.com (Covered Persons) or Non-Member.Discrimination.Complaints@healthnet.com (Applicants)

You may submit a complaint by calling the California Department of Insurance at 1-800-927-4357 or online at https://www.insurance.ca.gov/01-consumers/101-help/index.cfm

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Term Of Policy

This Policy becomes effective on XXXX at 12:00 a.m. Pacific Time, and will remain in effect for a term of 12 consecutive months, subject to the payment of premiums as required in the "Premiums" section. This Policy may be terminated by the Group with a 30 day written notice to HNL. Covered California may terminate or not renew this Policy for good cause as set forth below with a 30 day written notice. For premiums with regards to age rated groups, please refer to the “Premiums” section below. If the terms of this Policy are altered by the consent of both parties, no resulting reduction in coverage will adversely affect a Covered Person who is confined to a Hospital at the time of such change.

Good cause for termination or not renewing of this Policy by HNL shall include:

- Failure of the Group to pay any premiums before the end of the grace period;
- Failure of the Group to meet minimum participation and the Group (Employer) contribution requirement at the time of renewal; and
- If Group is enrolled as a guaranteed association, failure of the Group to meet and continue to meet all legal requirements applicable to guaranteed associations.

Termination of this Policy for good cause for the reasons described above shall become effective upon 30 days' written notice to the Group.

Covered Persons who are totally disabled on the date coverage under this Policy ends may be eligible for continuation of coverage. See the "Extension of Benefits" portion of the "Eligibility, Enrollment and Termination" section in the *Certificate* portion of this Policy.

If HNL decides to discontinue offering a particular medical benefit plan in the group market in California, HNL will:

- Provide notice to the Commissioner of Insurance of California, each affected Group, and all affected Covered Persons of its intention to discontinue offering the particular medical benefit plan in California;
- Provide such notice at least 90 days prior to discontinuance of the particular Comprehensive Medical Benefit plan; and
- Offer to each affected group whose coverage is being discontinued, the option of replacing the discontinued plan with any other Group plan currently being offered by HNL in California, for which the Group is eligible.

The Group understands and agrees that the health insurance plan(s), applied for by the Group, and issued by HNL, under the Policy, is intended to be issued as a stand-alone plan(s) only, where applicable, unless the health insurance plan(s) has been specified by HNL as available for wrapping, self-funding or otherwise insuring of the Calendar Year Deductible. Such plan(s), except for the plans specified by HNL as available for wrapping, self-funding or otherwise insuring of the Calendar Year Deductible, may not be combined with any form of partial self-funding or otherwise insuring of the Calendar Year Deductible, whether in a wraparound, addition or companion capacity, including a partially self-funded Section 105 wraparound, at any time during which the Policy is in force. Failure to comply is a breach of the Policy and any Underwriting Assumptions used by HNL to determine premium rates, and will result in HNL canceling the health insurance plan coverage initially issued, and replacing it with the most similar plan from the plan suite available from HNL at the time of the breach, that allows for

wrapping or self-funding or otherwise insuring of the Calendar Year Deductible. The replacement health insurance plan will be issued at the applicable premium rates in effect at that time.

Premiums

The Group shall pay HNL monthly premiums in accordance with the terms set below.

The premiums in effect on the effective date of this Policy are those determined by HNL. The charges are set out in the notice issued to the Group with or prior to the delivery of this Policy. The charges will be shown on the monthly billing statements sent to the Group (subject to any subsequent corrections). Such charges shall be calculated by Policy from current records as to number of Covered Persons enrolled.

Retroactive payment adjustments will be made in subsequent billing statements for any additions or terminations of Covered Persons not currently reflected in HNL's records at the time of calculation of premiums. The effective date of the addition or termination will be in accordance with rules established by HNL for determining effective dates of retroactive adjustments, but in no event will the effective date be more than 30 days prior to the date of receipt of the written request by HNL.

In order for a credit of premiums to be applied for terminated Covered Persons, HNL must receive notification as soon as possible following the date of the Covered Person’s ineligibility, but in no event later than 30 days following such date. HNL will credit a maximum of 30 days of premium to the Group for ineligible Covered Persons.

Only Covered Persons for whom payment is received by HNL shall be eligible for services and benefits hereunder and only for the period covered by such payment. Upon such termination, prepaid premiums received on account of the terminated Covered Person or Covered Persons applicable to periods after the effective date of the termination will be credited back to the Group on the next following billing statement, and HNL shall not have any further liability or responsibility under this Policy to such terminated Covered Person. HNL will credit a maximum of 30 days of premium to the Group for terminated Covered Persons.

In the foregoing instances where a Covered Person is being retroactively terminated, the effective date of retroactive termination cannot be prior to any date on which services or supplies were provided to the Covered Person under this Policy. In such instances, the date of termination will be the first day of the calendar month following the month in which services or supplies were provided, and any applicable credit of premium will be calculated from that date.

If the Group seeks to retroactively add Covered Persons, enrollment forms must be received by HNL as soon as possible following the Covered Person’s eligibility date, but in no event later than 30 days following such date. HNL will charge the Group retroactive premium according to the Covered Person’s Effective Date, which will be in accordance with rules established by HNL for determining effective dates of retroactive adjustments, but in no event will the effective date be more than 30 days prior to when HNL receives the enrollment or membership change form.

The first premiums must be paid to HNL on or before the effective date of this Policy. After that, payment is due on the first of each month while the Policy is in effect. If payment is not received by the due date, HNL will send the Group a Notice of Start of Grace Period and will allow a grace period for payment as described in "Grace Period" under the "General Provisions" section below. If HNL does not receive payment of the delinquent premium from the Group within the grace period, the Policy will be canceled at the end of the grace period. HNL will mail the Group a notice of cancellation.

Except as described below, HNL will not change the premiums, applicable Copayments, Coinsurance or Deductibles for the length of this Policy, after (1) the Group has delivered notice of acceptance of the Policy, (2) the start of the Group's Open Enrollment Period or (3) premiums are paid by the Group in the amount and manner provided for in this Policy.

For groups that are age-rated, premiums are based on the age of the principal Covered Person at the time of enrollment or renewal.

If the principal Covered Person changes their address during the course of the year, which results in a change to the rating region, the new rate will be effective as follows:

- If received from the 1st to the 15th of the month the change will be effective the 1st of the current month; or
- If received from the 16th to the 31st of the month the change will be effective the 1st of the following month.

If a governmental authority (a) imposes a tax or fee that is computed on premiums or (b) requires a change in coverage or administrative practice that increases HNL's risk, HNL may amend this Policy and increase the premium sufficiently to cover the tax, fee, or risk. The effective date shall be the date set forth in a written notice from HNL to the Group. The effective date shall become effective only upon renewal and no earlier than 12 months from the group’s effective date.

If this Policy is terminated for any reason, the Group shall be liable for all premiums for any time this Policy is in force during a grace period and any notice period.

General Provisions

Form or Content of Policy

No agent or employee of HNL is authorized to change the form or content of this Policy. Any changes can be made only through an endorsement authorized and signed by an officer of HNL.

Entire Agreement

This Policy, the application of the Group, including the conditions of enrollment, underwriting criteria and the enrollment forms of the Group's eligible employees shall constitute the entire agreement between the parties, and all statements made by the Group or by any individual Covered Person shall, in the absence of fraud, be deemed representations and not warranties, and no such statement shall be used in defense to a claim under this Policy unless it is contained in a written application. After 24 months following the issuance of this Policy, HNL may not rescind the Policy for any reason, and shall not cancel the Policy, limit any of the provisions of the Policy, or raise premiums on the Policy due any omissions, misrepresentations or inaccuracies in the application form, whether willful or not.

Grace Period

A grace period will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force (subject to the right of the insurer to cancel in accordance with the cancellation provision hereof). A minimum 31-day grace period will end no sooner than the 31st day following the last day of coverage for which HNL has received payment.

The grace period will begin on the first day after the last day of paid coverage and will end on either:

a. The 31st day following the last day of paid coverage, if the Notice of Start of Grace Period has been sent by HNL no later than the first day after the last day of paid coverage; or

b. The 31st day following the day HNL sends the Notice of Start of Grace Period if the notice has been sent by HNL after the first day after the last day of paid coverage.

Continuation of Coverage for Covered Persons

Except as otherwise provided herein, HNL shall not have the right to cancel or terminate any individual certificate issued to any Covered Person while this Policy remains in force and effect, and while said Covered Person remains in the eligible class of employees of the Group, and his or her premiums are paid in accordance with the terms of this Policy.

Charter Not Part of Policy

None of the terms or provisions of the charter, constitution, or bylaws of HNL shall form a part of this Policy or be used in the defense of any suit hereunder, unless the same is set forth in full in this Policy.

Distribution of Notices

HNL will send required notices as specified in this Policy to the Group's address on record. The Policy will be posted electronically on HNL's secure Web site at www.healthnet.com. By registering and logging on to HNL's Web site, the Group can access, download and print the Policy, if it so chooses, or the Group can opt to receive the Policy by U.S. mail, in which case HNL will mail the Policy to the Group's address on record with HNL.

Enrollment Regulations

This Policy may be terminated by HNL if at any time the number of Covered Persons does not meet the enrollment regulations of HNL.

Regulation and Interpretation of Policy

This Policy is issued with and is governed by the State of California. The regulations and laws of California shall be applied to interpretations of this Policy.

Recordkeeping

The Group is responsible for keeping records relating to this Policy. HNL has the right to inspect and audit those records.

Nondiscrimination

HNL and the Group hereby agree that no person who is otherwise eligible for coverage under this Policy shall be refused enrollment nor shall his or her coverage be canceled solely because of race, color, national origin, ancestry, religion, sex, gender, gender identity, gender expression, marital status, sexual orientation, age, disability, health status, or physical or mental handicap.

Notice of Cancellation

If this Policy terminates for any reason, HNL will send the notice of cancellation to the Group. The Group shall promptly mail a copy of the notice to each Covered Person and provide HNL proof of such mailing, including the date thereof. However, if HNL decides to discontinue offering a particular

medical benefit plan in the group market in California, HNL will notify both the Group and the affected Covered Persons of its intention to discontinue offering the particular medical benefit plan.

Medical Loss Ratio (MLR) Rebates

In conjunction with the requirements of the federal Affordable Care Act, upon HNL's request, the Group shall provide the Group's average number of employees employed on business days during the previous Calendar Year, in order for HNL to accurately categorize the Group, for purposes of determining the appropriate MLR value that is applicable to the Group.

Misstatement of Age

If the age of the Covered Person has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

Modifications to Plan and Notice Obligations

If the plan is modified in accordance with the terms and provisions of this Group Policy, HNL will send notice of such modification to the holder of the Group Policy with at least 60 days written notice. HNL will not provide notice of such changes to Covered Persons of this plan unless it is required to do so by law. The Group may have obligations under state or federal law to provide notification of these changes to the Covered Persons under this plan.

Modifications to Preferred Provider Organization Network and Notice Obligations

HNL will send written notice to the holder of the Group Policy within a reasonable period of time, of any termination, permanent breach of contract or permanent inability to perform of any Preferred Provider, if that termination, breach or inability materially and adversely affects the holder of the Group Policy or Covered Persons of this plan. In such circumstances, the Group must provide the substance of such notice of the termination, breach or inability to perform, to the principal Covered Persons covered under this plan, not later than 30 days after the receipt of such notice from HNL.

Religious Employer

Only a religious employer that meets the definition below will be issued a Policy that does not provide coverage for contraceptives.

- The inculcation of religious values is the purpose of the entity.
- The entity primarily employs persons who share the religious tenets of the entity.
- The entity serves primarily persons who share the religious tenets of the entity.
- The entity is a nonprofit organization pursuant to Section 6033(a)(2)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

Worker’s Compensation Insurance

This Health Net PPO Policy is not a substitute for and does not affect any requirement for coverage by worker’s compensation insurance on behalf of Group.

Summary of Benefits and Coverage (SBC)

Regulations under the federal Patient Protection and Affordable Care Act (SBC Regulations) require that HNL (a group health insurance issuer) and Group (a group health plan) provide a Summary of Benefits and Coverage (SBC), notice of modification of the SBC, and, upon request, a uniform glossary to Participants and Beneficiaries who are enrolled in the group health plan (Covered Persons) as well as to Participants and Beneficiaries who are eligible for but not enrolled in the group health plan (Eligible Persons). These documents must be available without charge to individuals who enroll or re-enroll in group health coverage during an open enrollment period (including former employees with COBRA continuation coverage) or other than through an open enrollment period (including individuals who are newly eligible for coverage or Special Enrollees).

Group and HNL, in accordance with the responsibilities assigned to each party as set forth herein below, agree to undertake their respective assignments to satisfy all timing, form and content requirements that pertain to the distribution of SBCs and the uniform glossary to Covered and Eligible Persons. Both Group and HNL shall cooperate with each other in good faith and to the extent reasonably necessary to ensure that the parties fully comply with requirements of the SBC Regulations.

- **DEFINITIONS**

  This provision defines words that will help you understand this "Summary of Benefits and Coverage (SBC)" section. The terms used within this section have certain meanings that are specific to this section.

  1. "Beneficiary" means a person designated by a Participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.
  2. "Covered Persons" means Participants and Beneficiaries who are enrolled in the group health plan.
  3. "Eligible Persons" means Participants and Beneficiaries who are eligible for but not enrolled in the group health plan.
  4. "Group" is the business organization (usually an employer or trust) to which HNL has issued the agreement to provide the benefits to Covered Persons.
  5. "Participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.
  6. "Special Enrollee" means any Participant or Beneficiary who is eligible to enroll as described in the *Certificate* under "Exceptions to Late Enrollment Rule" in the "Eligibility, Enrollment and Termination" section.

- **PREPARATION OF SBCs:**

  HNL shall prepare and deliver to Group an SBC for each HNL health benefit plan which Group offers to Covered and Eligible Persons. HNL shall use reasonable commercial efforts to provide required SBCs to Group before Group’s open enrollment process for the next year is scheduled to commence. HNL shall prepare and deliver a modified SBC to Group whenever HNL determines that material modifications must be made to a previously delivered SBC.

- **DISTRIBUTION OF SBCs**:

  Group shall provide Covered and Eligible Persons with SBCs in the exact and unmodified form (including appearance and content) in which HNL provides the SBCs to Group pursuant to the provisions of this section and as described herein below.

- **TIMING**:

  Group shall provide an SBC to an Eligible or Covered Person:

  1. Upon application for enrollment:
     a. along with any written application materials, or, if the Group does not distribute written application materials for enrollment, then no later than the first date the Eligible or Covered Person is eligible to enroll in coverage for the Participant or any Beneficiaries; and by the first day of coverage, if HNL provides a modified SBC between the date an Eligible or Covered Person applied for coverage and the first day of coverage; or by the first day of coverage, if HNL provides a modified SBC between the date an Eligible or Covered Person applied for coverage and the first day of coverage; or
     b. within ninety (90) days following enrollment, if the Eligible or Covered Person is a Special Enrollee.
  2. Upon renewal or reissuance of this Agreement:
     a. no later than the date on which application materials (including, but not limited to, open enrollment materials) are distributed, if written application (or active election) is required for renewal; or
     b. if renewal is automatic, no later than 30 days prior to the first day of the new plan or policy year. If the Agreement is not issued or renewed before this 30 day period, Group shall provide the SBC as soon as practicable but not later than 7 business days after the Agreement is issued or HNL receives your Group's written confirmation of its intent to renew the Agreement, whichever is earlier.

        The Group is not required to provide an SBC to a Covered Person automatically upon renewal for benefit packages in which the Covered Person is not enrolled. However, if a Covered Person requests an SBC for a benefit package in which he or she is not enrolled, such SBC must be provided as soon as practicable, but in no event later than 7 business days following receipt of the request.
  3. At any time, upon request for an SBC or summary information about any HNL health benefit package for which an eligible or Covered Person is eligible. The SBC must be provided as soon as practicable, but within 7 business days following receipt of the request.

- **NUMBER:** A single SBC may be provided to a Participant and any Beneficiaries at the Participant's last known address, unless any Beneficiary is known to reside at a different address. In that case, a separate SBC must be provided to any Beneficiary at his or her last known address.

- **FORM AND MANNER:** Group shall provide the SBC to an Eligible or Covered Person in paper form or, alternatively, electronically (such as by email or an Internet posting) if the following conditions are met:

1. SBCs reproduced and distributed in paper form must be in the uniform format provided by HNL; they must be copied on four, double-sided pages in length and not include print smaller than 12-point font.
2. SBCs displayed electronically may be on a single webpage, so the viewer can scroll through the information required to be on the SBC without having to advance through pages. However, columns or rows may not be deleted when displaying a complete SBC.
3. For Covered Persons who are already covered under a benefit package provided under this Agreement, Group may provide the required SBCs electronically if the requirements of the U.S. Department of Labor's regulations at 29 C.F.R. § 2520.104b-1 are met. This regulation contains fiduciary disclosure requirements as well as an electronic distribution safe harbor.
4. For Eligible Persons, Group may provide SBCs electronically if (1) the format is readily accessible (such as in an html, MS Word, or pdf format) and can be electronically retained and printed, (2) paper copies are provided free of charge upon request, and (3) if the electronic form is an Internet posting, the Group timely advises Eligible Persons in paper form (such as a postcard) or by email that the SBCs are available on the Internet, provides the Internet address, and notifies the Eligible Persons that the documents are available in paper form upon request.

Model language for an e-card or postcard in connection with a website posting of an SBC follows:

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is available on the web at: www.healthnet.com. A paper copy is also available, free of charge, by calling **1-800-361-3366** (a toll-free number).

- **NOTICE OF MODIFICATION OF AN SBC DURING THE PLAN OR POLICY YEAR:**

  Upon receipt of timely notice from HNL of material changes to the contents of an SBC and an updated SBC which reflects such changes, and that occurs other than in connection with a renewal or reissuance of coverage under this Agreement, Group shall provide notice of the material changes to Covered Persons no later than 60 days prior to the date on which material changes will become effective. Group shall distribute such notice to Covered and Eligible Persons in the same number, form and manner (so as to comply with the SBC regulations) in which Group provided the original SBC which was subsequently updated.

- **UNIFORM GLOSSARY:**

  The SBC informs the reader that he or she can view a Glossary of bolded terms used in the SBC at www.cciio.cms.gov or can call HNL at the number on his or her ID card to request a copy. HNL

shall provide a written copy of the Glossary to a Covered or Eligible Person who requests a written copy within 7 business days after HNL receives the request.

- **PARTIES TO BEAR THEIR OWN COSTS:**

  HNL and Group shall each bear its own costs in connection with the execution of the respective party's responsibilities under this Agreement, as amended, including but not limited to the production, reproduction and distribution of SBCs and the Glossary.

- **ADVICE OF COUNSEL:**

  Group and HNL each acknowledge that they have consulted with and have had appropriate advice and legal counsel to determine their responsibilities under the SBC Regulations. Group and HNL have executed this Agreement, as amended, knowingly and voluntarily.

- **DELAYED DISTRIBUTION:**

  In the event that HNL determines that the Group failed to distribute the SBCs to Covered Persons or Eligible Persons as required herein, HNL will contact the Group and assure the immediate distribution of the SBCs to comply with applicable federal statutes and regulations. In such case, the Group agrees to reimburse HNL for any costs incurred by HNL to assure distribution of the SBCs.

Binding Arbitration

Sometimes disputes or disagreements may arise between HNL and the Group or Covered Persons regarding the construction, interpretation, performance or breach of this Policy, or regarding other matters relating to or arising out of this Policy. HNL uses binding bilateral arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved. However, the Group and Covered Persons are not required to participate in final, binding arbitration to resolve disputes concerning adverse benefit determinations and are entitled to pursue any remedies available under the law. In addition, disputes with HNL involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

As a condition to contracting with HNL, **THE GROUP AND COVERED PERSONS AGREE TO SUBMIT ALL DISPUTES RELATING TO OR ARISING OUT OF HNL MEMBERSHIP, TO INDIVIDUAL FINAL AND BINDING ARBITRATION, EXCEPT DISPUTES CONCERNING ADVERSE BENEFIT DETERMINATIONS AS DEFINED IN 45 CFR 147.136, AND YOU AGREE NOT TO PURSUE CLASS ARBITRATION. Likewise, HNL agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that Group, Covered Persons and HNL are bound to use binding bilateral arbitration as the final means of resolving disputes that may arise between them, and thereby the parties agree to forego any right they may have to a jury trial on such disputes**. However, no remedies that otherwise would be available to the parties in a court of law will be forfeited by virtue of this agreement to use and be bound by HNL's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

HNL's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that the total amount of damages claimed is $500,000 or less ($50,000 or less with respect to

disputes with HNL involving alleged professional liability or medical malpractice), the parties shall, within 30 days of submission of the demand for arbitration to HNL, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $500,000 or $50,000, whichever is applicable. In the event that total amount of damages is over $500,000 or $50,000, whichever is applicable, the parties shall, within 30 days of submission of the demand for arbitration to HNL, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

If the parties fail to reach an agreement during this time frame, then any party may apply to a Court of Competent Jurisdiction for appointment of the arbitrator(s) to hear and decide the matter. When a petition is made to the court to appoint a neutral arbitrator, the court shall nominate five persons from lists of persons supplied jointly by the parties to the arbitration or obtained from a governmental agency concerned with arbitration or private disinterested association concerned with arbitration. The parties to the agreement who seek arbitration and against whom arbitration is sought may within five days of receipt of notice of the nominees from the court jointly select the arbitrator whether or not the arbitrator is among the nominees. If the parties fail to select an arbitrator within the five-day period, the court shall appoint the arbitrator from the nominees.

Arbitration can be initiated by submitting a demand for arbitration to HNL at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

Health Net Life Insurance Company
Attention: Legal Department
PO Box 4504
Woodland Hills, CA 91365-4504

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this Policy, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law, and that award will be final and binding on all parties except to the extent that or federal law provides for judicial review of arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees. In cases of extreme hardship to a Covered Person, HNL may assume all or portion of a Covered Person's share of the fees and expenses of the arbitration. Upon written notice by the Covered Person requesting a hardship application, HNL will forward the request to an independent professional dispute resolution organization for a determination. Such request for hardship should be submitted to the Legal Department at the address provided above.

COBRA and California-COBRA Program (Cal-COBRA) Continuation Coverage

HNL recognizes that many Groups must comply with the continuation of group coverage requirements under federal and California laws and regulations which respectively are commonly referred to as "COBRA" and "Cal-COBRA." HNL acknowledges that Groups who are so affected cannot discharge their legal responsibilities without HNL's informed and willing participation in providing the required continuation coverage.

HNL is, therefore, committed to the following:

- Maintaining an awareness of the continuation coverage requirements of federal and state laws. This includes federal requirements under the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act, regulations which are issued by the Secretaries of these federal agencies and state law requirements under the California COBRA Program (Article 4.5 of the California Health and Safety Code and Article 1.7 of the California Insurance Code).
- Providing continuation coverage to plan Covered Persons upon the request of an Group when such requests are consistent with the Group‘s obligations under the law.
- Sharing knowledge regarding COBRA and Cal-COBRA with Groups as they experience problems, but HNL will not give legal advice on these matters.

Cal-Cobra Obligations

When the Group is a Small Employer (as defined in "Small Employer Cal-COBRA Continuation Coverage" under the "Eligibility, Enrollment and Termination" section in the *Certificate* portion of this Policy), the Group must notify HNL in writing within 30 days of an employee’s losing eligibility for coverage through this plan due to (1) termination of employment for reasons other than gross misconduct or (2) reduction in hours worked.

Additionally, any Group with enrolled Cal-COBRA qualified beneficiaries must do the following:

- Notify Current Cal-COBRA Qualified Beneficiaries of Group’s Intent to Terminate This Group Service Agreement: If the Group intends to terminate this Policy with HNL and replace it with coverage through another California HMO or disability (health) insurer, the Group must, at least 30 days prior to the termination, inform all existing Cal-COBRA qualified beneficiaries of this action. The Group must also inform qualified beneficiaries that they have the ability to choose to continue coverage through the new plan for the balance of the period that they could have continued coverage through the HNL plan. HNL will provide the employer the names and last known addresses of enrolled Cal-COBRA qualified beneficiaries.
- Notify the Successor Plan of the Qualified Beneficiaries Currently Receiving Cal-COBRA Coverage. The Group must notify the successor plan in writing of the qualified beneficiaries currently receiving continuation coverage so that the successor plan, or contracting employer or administrator may provide those qualified beneficiaries with the necessary information to allow the qualified beneficiary to continue coverage through the new plan.

Plan Benefits And Benefit Certificate

HNL will issue and deliver to each principal Covered Person a Health Net PPO *Certificate of Insurance*, electronically by posting it on HNL’s website at www.healthnet.com, if so designated by the Group and elected by the Covered Person (or hard copy by mail to the Covered Person’s address on record if so designated by the Group and elected by the Covered Person). The Health Net PPO *Certificate of Insurance* sets forth a statement of benefits to which the Covered Persons are entitled. HNL will also issue and deliver an identification card by mail to the Covered Person’s address on record.

The benefits of this plan and the language of the Health Net PPO *Certificate of Insurance* are specifically incorporated herein by reference.

Coverage for Domestic Partners

A principal Covered Person's Domestic Partner is eligible for coverage provided that the partnership meets the Group's domestic partnership eligibility requirements. The Group's eligibility requirements must be compliant with California law. The Domestic Partner and the dependent children of the Domestic Partner may enroll on the same basis as a principal Covered Person's spouse and his or her children in accordance with the terms and conditions of this Policy that apply generally to the spouse of a principal Covered Person under this Plan.

Domestic Partners and their enrolled dependent children are eligible for California COBRA coverage on the same basis as other enrollees based on the Group's eligibility rule. Determination of COBRA qualification for Domestic Partners and their children will be based on agreement between HNL and the Group.

In addition, in relation to a period of time when the Group's employees are subject to federal COBRA and a COBRA qualifying event occurs during this period, HNL agrees to provide federal COBRA-like coverage on the same basis to the domestic partner and his or her unmarried dependent children as other COBRA qualified enrollees. The same is true regarding additional coverage following federal COBRA coverage that is available according to state law for over age 60 employees and their spouses.

Further, in relation to a time period when the Group's employees are subject to Small Group Cal-COBRA Coverage, and when a qualifying event occurs during this period, HNL will provide coverage according to the section titled "Small Group Cal-COBRA Continuation Coverage" in the *Certificate* segment of this Policy.

Compliance with Medicare Part D Regulations in Administration of Group's Outpatient Prescription Drug Plan (PDP)

Where Group offers a qualified retiree prescription drug plan, Group and HNL agree to the requirements set forth in sections A and B below:

A. In accordance with section 1860D-22 ("Part D") of the Social Security Act (the "Act"), HNL agrees that Group may determine how much of a Covered Person's Part D monthly beneficiary premium it will subsidize, subject to the restrictions set forth below in (1) – (5).

   1. Group can subsidize different amounts for different classes of Covered Persons in the Agreement's PDP provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried versus hourly). Different classes cannot be based on eligibility for the Low Income Subsidy as defined in 1860D-14 of the Act.
   2. Group cannot vary the premium subsidy for individuals within a given class of Covered Persons.
   3. Group cannot charge a Covered Person for prescription drug coverage provided under the Agreement more than the sum of his or her monthly Medicare beneficiary premium attributable to basic prescription drug coverage and 100% of the monthly beneficiary premium attributable to his or her supplemental prescription drug coverage (if any).

4. For all Covered Persons eligible for the Low Income Subsidy, the low income premium subsidy amount will first be used to reduce the portion of the monthly beneficiary premium attributable to basic prescription drug coverage paid by the Covered Person, with any remaining portion of the premium subsidy amount then applied toward the portion of the monthly beneficiary premium attributable to basic prescription drug coverage paid by the Group.
5. If the low income premium subsidy amount for which a Covered Person is eligible is less than the portion of the monthly beneficiary premium paid by the Covered Person, then the Group shall communicate to the Covered Person the financial consequences for the Covered Person of enrolling in the Group's PDP as compared to enrolling in another Part D plan with a monthly beneficiary premium equal to or below the low income premium subsidy amount.

B. Group agrees to notify Covered Persons of the Group's intent to enroll them in HNL's PDP and to provide them with all of the information more fully described in the instructions set forth in Subchapter 30.1.6 (Group Enrollment for Employer/Union Sponsored PDPs) of the Center for Medicare and Medicaid Services' PDP Guidance for Eligibility, Enrollment and Disenrollment finalized August 29, 2005 and as summarized below.
   1. Notify all Covered Persons that the Group intends to enroll Covered Persons in a PDP the Group is offering; and
   2. Inform Covered Persons that they may affirmatively opt out of such enrollment; how to accomplish that; and any consequences to Group benefits opting out would bring; and
   3. Provide notice to Covered Persons not less than 30 calendar days prior to the effective date of the Covered Persons enrollment in the Group sponsored PDP; and
   4. Provide Covered Persons a summary of benefits offered under the Group sponsored PDP, an explanation of how to get more information about the PDP, and an explanation of how to contact Medicare for information on other Part D options that might be available to the Covered Person; and
   5. Provide required enrollment disclosure information contained within the Centers for Medicare & Medicaid Services (CMS) model enrollment form; and
   6. Provide all the information required for HNL to submit a complete enrollment request transaction to CMS; and
   7. Provide CMS with any information it has on other insurance coverage for the purpose of coordination of benefits.

CALIFORNIA HEALTH BENEFIT EXCHANGE SHOP PROGRAM MODEL SUPPLEMENT RIDER
TO
GROUP POLICY

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 Health Insurer (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.

This Supplement, the California Health Benefit Exchange SHOP Program Supplement Rider to *Certificate of Insurance*, the Policy, the application of the Group, including the conditions of enrollment, underwriting criteria and the enrollment forms of the Group's Eligible Employees, shall constitute the entire agreement between the parties. All statements made by the Group or by any individual Covered Person shall, in the absence of fraud, be deemed representations and not warranties, and no such statement shall be used in defense to a claim under this Policy unless it is contained in a written application. After 24 months following the issuance of this Policy, Health Net Life Insurance Company (HNL) may not rescind the Policy for any reason, and shall not cancel the Policy, limit any of the provisions of the Policy, or raise premiums on the Policy due any omissions, misrepresentations or inaccuracies in the application form, whether willful or not.

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 organization (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 EMPLOYEE means any employee or former employee of a qualified employer who has been offered health insurance coverage by such qualified employer through the SHOP for himself or herself and, if the qualified employer offers dependent coverage through the SHOP, for his or her dependents.

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).

REFERENCE PLAN means a QHP that is selected by an employer, which is used by the SHOP to determine the contribution amount the employer will be making towards its employees' premiums.

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 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 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, placed for adoption with, 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. A non-disabled child's dependent coverage will terminate on the first day of the month following the dependent's 26th birthday.

4. A dependent child age 26 or older who is incapable of self-support because of a physical or mental disability which existed continuously from a date prior to attainment of age 26 is eligible to initiate or continue dependent coverage until termination of such incapacity. A disabled child who is age 26 or over will be enrolled at the time of initial enrollment of the employee provided that written certification from a competent health care professional that the dependent meets the above conditions of being disabled is provided to the HEALTH PLAN, if requested by the HEALTH PLAN, within 60 days of receiving the request. The HEALTH PLAN shall provide this information to SHOP within 60 days of receipt by the HEALTH PLAN.
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. If SHOP fails to make the determination of whether the child is eligible to continue coverage before the child turns 26 years of age, coverage will continue pending the determination.

   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

   The SHOP must provide an employee who becomes a Qualified Employee outside of the initial or annual open enrollment period an enrollment period beginning from the first day of becoming a Qualified Employee. A newly Qualified Employee must have at least 30 days from the beginning of his or her enrollment period to select a QHP. The enrollment period must end no sooner than 15 days prior to the date that any applicable employee waiting period longer than 45 days would end if the employee made a plan selection on the first day of becoming eligible.

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, including a Qualified Employee who becomes a 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. 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. Coverage is 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 (MEC), which includes but is not limited to, loss of 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:

         i. legal separation;

         ii. divorce;

         iii. cessation of dependent status

         iv. termination of employment; or

         v. reduction in hours that results in a loss of eligibility

b. Termination of qualified employer contributions toward the employee's or dependent's health insurance coverage

c. exhaustion of COBRA and Cal-COBRA continuation coverage

Voluntary termination of coverage, or loss of coverage due to failure to pay premiums on a timely basis or committing fraud or intentional misrepresentation of material fact in connection with the coverage do not constitute loss of MEC that entitles one to a Special Enrollment Period.

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 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, misconduct or inaction of an officer, employee, or agent of the Exchange or HHS or its instrumentalities or a non-Exchange entity providing enrollment assistance or conducting enrollment activities 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, or to the applicable regulator, with respect to health plans offered outside the Exchange, that the health plan, in which he or she is enrolled, substantially violated a material provision of its contract in relation to the Qualified Employee or his or her dependents.

d. A Qualified Employee or enrollee, or his or her eligible dependent gains access to new QHPs as a result of a permanent move.

e. A Qualified Employee or dependent was released from incarceration.

f. A Qualified Employee or dependent 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.

g. A Qualified Employee who is an Indian, as defined by Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603(c)), and his or her dependent who is enrolled or is enrolling in a QHP through an Exchange on the same application as the Qualified Employee, may enroll in a QHP or change from one QHP to another one time per month.

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. Receipt of the application for coverage and any supporting documents must be within 60 days of the event;

i. A Qualified Employee or dependent demonstrates to the Exchange, with respect to health benefit 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:

    i. If a child who has been determined ineligible for Medi-Cal, 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 was receiving services from a contracting provider under another health plan for one of the conditions described below and the provider is no longer participating in that health plan:

    i. An acute condition. (An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.)

    ii. A serious chronic condition. (A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.)

    iii. A pregnancy. (A pregnancy is the three trimesters of pregnancy and the immediate postpartum period.)

    iv. A terminal illness. (A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less.)

    v. The care of a newborn child between birth and age 36 months.

vi. Performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered insured.

l. A Qualified Employee is a victim of domestic abuse or spousal abandonment, as defined by 26 Code of Federal Regulation 1.36B-2, including a dependent or unmarried victim within a household, are enrolled in minimum essential coverage and seek to enroll in coverage separate from the perpetrator of the abuse or abandonment. Dependents of the victim, who are on the same application as the victim, are also eligible to enroll at the same time as the victim.

m. A Qualified Employee or dependent applies for coverage on the Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the Exchange as potentially eligible for Medi-Cal, and is determined ineligible for Medi-Cal by the State Medi-Cal agency either after open enrollment has ended or more than 60 days after the qualifying event.

n. A Qualified Employee or dependent applies for coverage at the State Medi-Cal agency during the annual open enrollment period, and is determined ineligible for Medi-Cal after open enrollment has ended.

o. A Qualified Employee or his or her dependent adequately demonstrate to the Exchange that a material error related to plan benefits, service area or premium influenced your decision to purchase coverage through the Exchange.

p. 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 *Certificate of Insurance* 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 *Certificate of Insurance* booklet provided, however, that only one *Certificate of Insurance* booklet shall be issued to each Enrollee and his or her dependents, unless the Enrollee or his or her dependent requests an additional *Certificate of Insurance* 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 *Certificate of Insurance*, 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 *Certificate of Insurance*. 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 Certificate of Insurance, 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 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. There is a minimum 30-day grace period for payment of premium during which coverage remains in effect. The grace period may end no sooner than the thirtieth (30th) day following the last day of coverage for which SHOP has received payment. 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 or after the first day after the last day of coverage for which SHOP has received payment. The notice will identify the date the grace period begins and ends and the effective date of cancellation if payment is not received by the end of the grace period and include notice of the employer's right to request a review of the cancellation by the California Insurance Commissioner.

   GROUP shall promptly send such Notice to each principal Covered Person 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 request a review of the cancellation by the California Insurance Commissioner. 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 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 grace period, the effective date of the cancellation, and the right of GROUP to seek review by 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 full payment of all delinquent Premiums is not received by SHOP by the due date indicated in the Notice, the Agreement will be terminated. Any excess premium received after termination will be promptly returned unless a request for reinstatement is granted.

   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 coverage once during the 12-month period beginning on the original effective date or the most recent renewal date, whichever is more recent.

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. Terminated groups seeking to reapply for coverage 31 or more days following the effective date of termination shall be considered a new group with an effective date consistent with the provisions in the California Code of Regulations, Title 10, Section 6520(a)(13).
6. 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 non-payment 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.
7. Delinquent Accounts: Collections. In the event GROUP's account becomes delinquent, SHOP shall undertake collections as 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 any 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 coverage shall be 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 any 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 shall notify SHOP of an enrollee's termination request as soon as reasonably possible 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 the Qualified Employee does not enroll in a different QHP during his or her annual employee open enrollment period, the Qualified Employee will remain in the QHP selected in the previous year unless the Qualified Employee notifies employer to terminate his or her coverage from the QHP.
    a. If the Qualified Employee's current QHP is not available, the Qualified Employee shall be enrolled in a QHP offered by the same Health Plan that is the same metal tier and the most similar to the Qualified Employee's current QHP, as determined by the SHOP on a case-by-case basis.
    b. 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 HEALTH PLAN 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 ten (10) 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 by the last day of the annual open enrollment period.
2. Enrollees are permitted to change their QHP during the first 30 days of the new plan year, provided that the newly selected QHP is offered by 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 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. 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 or period in the interim.