Employer Group Medical and Hospital Service Agreement Cover Sheet

GROUP INFORMATION

Group Name:

Group #:

Address:

Telephone: ( ) -

Fax No.: ( ) -

Contact Person:

Title:

Email Address:

Definition of Eligibility: **Full time employee. Please see Evidence of Coverage and Disclosure Form.**

Probationary Period for New Employees:

Open Enrollment Period: to

Effective Date for coverage:

COVERAGE

The Group has selected **Plan** for all eligible Members.

MONTHLY PAYMENTS

Base Rate Structure – see attached rate sheets

Optional Rider – see attached rider sheets

[insert rate sheet]

[insert optional rider sheet]

Employer Group
Medical and Hospital Group Subscriber Agreement

This Medical and Hospital Group Subscriber Agreement (this "**Agreement**") is entered into between Chinese Community Health Plan ("**CCHP**"), a California corporation, and the employer, association, or other entity specified as "Group" on the Cover Sheet ("**Group**").

WHEREAS, CCHP is a health care service plan licensed under the California Knox-Keene Health Care Service Plan Act of 1975 which arranges for the provision of medical, hospital, and preventive medical services to persons enrolled as Members through contracts with associations of licensed physicians, hospitals, and other health care providers.

WHEREAS, Group is an employer, union, trust, organization, or association which desires to provide such health care for its eligible Subscribers and Dependents.

WHEREAS, CCHP desires to contract with Group to arrange for the provision of such health care services to Subscribers and Dependents of Group, and Group desires to contract with CCHP to arrange for the provision of such services to its Subscribers and Dependents.

NOW THEREFORE, in consideration of the application of Group for the benefits provided under this Agreement, and in consideration of the periodic payment of Health Plan Premiums on behalf of Members in advance as they become due, CCHP agrees to arrange for or provide medical, surgical, hospital, and related health care benefits subject to all terms and conditions of this Agreement.

1. Definitions. Following are a list of definitions used in this Agreement. Terms not defined herein shall have the meanings as set forth in the Health Plan Documents.

1.1 Agreement is this Medical and Hospital Group Subscriber Agreement and the Health Plan document, which are incorporated herein by this reference.

1.2 Cover Sheet is the Medical and Hospital Group Subscriber Agreement Cover Sheet which is attached to and an integral part of this Agreement.

1.3 Enrollment is the execution of a CCHP Enrollment Form, by the Subscriber on behalf of the Subscriber and his or her Dependents, and acceptance thereof by CCHP, conditioned upon the execution of this Agreement and the timely payment of applicable Health Plan Premiums by Group.

1.4 Group is the single employer, labor union, trust, organization, or association identified on the Cover Sheet.

1.5 Health Plan is the health plan described in this CCHP Medical and Hospital Group Subscriber Agreement and the Health Plan Documents, subject to modification pursuant to the terms of this Agreement.

1.6 **Health Plan Documents** include without limitation this Agreement, the Cover Sheet, the rate sheet, the optional rider sheet, the Combined Evidence of Coverage and Disclosure Form, all attachments, addendum, amendments thereto, and other materials containing information regarding the benefits, services, and terms of the Health Plan.

1.7 **Health Plan Premiums** are amounts established by CCHP to be paid to CCHP by Group on behalf of Members in consideration of the benefits provided under this Health Plan; such amounts are set forth in the Cover Sheet of this Agreement.

1.8 **Member** is the Subscriber or any Dependent who is eligible, enrolled, and covered by CCHP.

1.9 **Open Enrollment Period** is the annual period of not less than thirty (30) days agreed upon by CCHP and Group, during which all eligible and prospective Subscribers and their eligible Dependents may enroll in the Health Plan. The Open Enrollment Period is specified on the Cover Page.

1.10 **Subscriber** is the individual enrolled in the Health Plan for whom the appropriate Health Plan Premium has been received by CCHP, and whose employment or other status, except for family dependency, is the basis for enrollment eligibility.

2. **Eligibility and Enrollment**. Please refer to the Health Plan Documents for a complete description. Members or applicants for membership shall complete and submit to CCHP such applications and/or other forms or statements that CCHP may reasonably request.

3. **Group Obligations, Health Plan Premiums, and Copayments**.

3.1 **Non-Discrimination**. Group shall offer CCHP an opportunity to market the Health Plan to its employees and shall offer its employees an opportunity to enroll in the Health Plan under no less favorable terms or conditions than Group offers enrollment in other health care service plans or employee health benefit plans.

3.2 **Notices to CCHP**.

3.2.1 **Enrollment Material**. Group shall forward all completed or amended Enrollment forms for each Member for receipt by CCHP within sixty (60) days of the Member's initial eligibility. Group acknowledges that any Enrollment applications not received by CCHP within such sixty (60) day period may be rejected by CCHP.

3.2.2 **Termination of Member**. Group shall forward all notices of termination to CCHP within thirty (30) days after Member loses eligibility or elects to terminate membership under this Agreement. Group agrees to pay any applicable Member Health Plan Premiums through the last day of the month in which notice of termination is received by CCHP.

3.2.3 **Qualifying Events; Notification**. In accordance with California Health and Safety Code §1366.25, Group shall notify CCHP in writing within thirty (30) days of any of the following events:

(1) The death of a Subscriber;

(2) The termination of employment or reduction in hours of a Subscriber's employment, except for termination for gross misconduct;

(3) The divorce or legal separation of the Subscriber from the Subscriber's spouse;

(4) The loss of dependent status by a dependent enrolled in the group benefit plan; or

(5) With respect to a covered dependent only, the Subscriber's entitlement to benefits under Title XVIII of the United States Social Security Act (Medicare).

3.2.4 Group shall notify CCHP, in writing, within thirty (30) days of the date if Group becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Sec. 1161 et seq.

3.3 Notices to Member.

3.3.1 Health Plan Documents. Group shall make Health Plan Documents available to all Members and all persons eligible for the Health Plan. The Group shall inform Subscribers: (i) of the monthly payment applicable to their coverage; (ii) of conditions of eligibility regarding Subscribers and Dependents; and (iii) when coverage becomes effective and terminates.

3.3.2 Notices. Group shall disseminate notices to Subscribers by the next regular communication to them, but in no event later than thirty (30) days after receipt therefore, of all matters of which Group receives notice from CCHP to which a reasonable person would attach importance in determining the action to be taken upon the matter.

3.3.3 Termination of Contract. If Group or CCHP terminates this Agreement pursuant to Section 8 (Termination), Group shall promptly notify all Members enrolled through Group of the termination of coverage in the Health Plan. Group shall provide such notice by delivering to each Subscriber a true, legible copy of the notice of termination sent from CCHP to Group at the Subscriber's then current address and promptly provided proof of such mailing and the date thereof to CCHP. In the event that CCHP terminates this Agreement for non-payment of Health Plan Premiums, Subscriber will receive notice of termination from CCHP.

3.3.4 Increase or Reductions. If CCHP increases Copayments or Coinsurance, or reduces covered services provided under the Health Plan, Group shall promptly notify all Subscribers of the increase or reduction. In addition, Group shall promptly notify Subscribers of any other changes in the terms or conditions of this Agreement affecting the Subscriber benefits or obligations under the Health Plan. Group shall provide such notice by delivering to each Subscriber a true, legible copy of the notice of the Copayments or Coinsurance increase or reduction in covered services sent from CCHP to Group at the Subscriber's then current address and promptly provided proof of such mailing and the date thereof to CCHP.

3.3.5 Continue Coverage. In accordance with Cal Health and Safety §1366.27, Group shall notify qualified beneficiaries currently receiving continuation coverage, whose continuation coverage will terminate under one group benefit plan prior to the end of the period the qualified beneficiary would have remained covered, of the qualified beneficiary's ability to continue coverage under a new group benefit plan for the balance of the period the qualified beneficiary would have remained covered under the prior group benefit plan. This notice shall be provided either thirty (30) days prior to the termination or when all enrolled employees are notified, whichever is later.

4. Payments.

4.1 Rates (Prepayment Fees). The Health Plan Premium rates are set forth in the Cover Sheet and supplemental Health Plan Premium notices.

4.2 Due Date. Group shall pay the Health Plan Premiums on a monthly basis by cash or check, and the payment must be paid on or before the first day of the month for which the premium applies. Failure to provide payment on or before the due date may result in termination of Group. CCHP reserves the right to assess an administrative fee of five (5%) percent of the monthly premium prorated on a thirty (30) day month for each day it is delinquent thereafter. This fee will be assessed solely at CCHP's discretion. In the event that deposit of payments not made in a timely manner are received by CCHP after termination of Group, the depositing or applying of such funds does not constitute acceptance, and such funds shall be refunded by CCHP within twenty (20) business days of receipt if CCHP, in its sole discretion, does not reinstate Group.

4.3 Effect of Payment. Except as otherwise provided in this Agreement, only Members for whom Health Plan Premiums are received by CCHP are entitled to health care benefits as described in this Agreement, and then only for the period for which such payment is received. Group agrees to pay premium to CCHP for the first month of coverage for newborn or adopted children who become eligible as provided in the Health Plan Document.

4.4 Copayments and Co-Insurance. Members are responsible to pay the Copayments and Co-Insurance, and any other costs or charges as described in the Health Plan Documents.

4.5 Modification of Health Plan Premium Rates, Copayment, and Coinsurance. The Health Plan Premium rates set forth on the Cover Sheet, Copayment, and Coinsurance may be modified by CCHP upon thirty (30) days prior written notice mailed postage prepaid to Group. Any such modification shall take effect commencing the first full month following the expiration of the thirty (30) day notice period. Health Plan Premium Rates, Copayments and Coinsurance may not be modified more than once in a twelve (12) month period. Notwithstanding the above, if the State of California or any other taxing authority imposes upon CCHP a tax or license fee which is levied upon or measured by the monthly amount of Health Plan Premiums or by CCHP's gross receipts or any portions of either, then upon thirty (30) days written notice to Group, Group shall remit to CCHP, with the appropriate payment, a pro rata amount sufficient to cover all such taxes and license fees, rounded to the nearest cent.

5. Benefits and Conditions for Coverage.

CCHP shall provide the Health Plan Documents as required by California Health and Safety Code §1363 and Title 28 California

Code of Regulations §1300.63.2. The Health Plan Documents are an integral part of this Agreement and include a complete description of the benefits and conditions of coverage of the Health Plan.

5.1 Modification of Benefits or Terms. This Agreement and the Health Plan benefits set forth in the Health Plan Documents may be modified by CCHP upon thirty (30) days written notice mailed postage prepaid to Group. Any such modification shall take effect commencing the first full month following the expiration of the thirty (30) day notice period.

6. [Reserved]

7. Term. The term of this Agreement shall be one (1) year, commencing on the Group Coverage Effective Date set out in the Cover Sheet, unless otherwise indicated on the Cover Sheet or unless this Agreement is terminated as provided herein. This Agreement shall automatically renew for a one (1) year term on each anniversary of the date of commencement of this Agreement or as indicated on the Cover Sheet, unless terminated as provided herein. Renewal of this Agreement shall be subject to modification of rates and benefits.

8. Termination.

8.1 Termination by Group. Group may terminate this Agreement with or without cause by giving a minimum of thirty (30) days written notice of termination to CCHP. Group termination must be effective on the first day of the month. Group shall continue to be liable for Health Plan Premiums for all Members enrolled in this Health Plan through Group until the date of termination.

8.2 Termination by CCHP.

8.2.1 For Nonpayment of Health Plan Premiums. CCHP may terminate this Agreement in the event Group or its designee fails to remit Health Plan Premiums in full by the due date to CCHP. CCHP will duly notify Group and provide at least a thirty (30) day grace period in accordance with Cal Health and Safety Code §1365. Nonpayment of Health Plan Premiums includes without limitation payments returned due to non-sufficient funds (NSF) and post-dated checks.

8.2.2 Reinstatement Following Termination for Non-Payment of Premium. Receipt by CCHP of all Health Plan Premium payments then due and owing on or before the succeeding Health Plan Premium payment due date will reinstate this Agreement as though it had never been terminated. Notwithstanding anything to the contrary, CCHP may, in its discretion, elect not to reinstate this Agreement in any of the following circumstances:

(1) the notice of termination states that, if Health Plan Premium payment is not received within fifteen (15) days of issuance of the notice of termination, a new application is required and identifies conditions under which a new agreement will be issued or this Agreement reinstated;

(2) if payment of Health Plan Premiums is received by CCHP more than fifteen (15) days after the issuance of notice of termination, and CCHP refunds such payment within twenty (20) business days of receipt; or

(3) if payment of Health Plan Premiums is received more than fifteen (15) days after issuance of the notice of termination, and CCHP issues to Group, within twenty (20) business days of receipt of such Health Plan Premiums, a new Agreement accompanied by written notice stating clearly those respects in which the new Agreement differs from this Agreement in benefits, coverage or otherwise. In the event CCHP receives untimely payments after Group has been terminated, the deposit or application of such funds by CCHP does not constitute acceptance of such funds or reinstate group, and such funds may be refunded by CCHP at its sole discretion.

8.2.3 [Reserved]

8.2.4 **For Providing Misleading or Fraudulent Information**. CCHP may terminate this Agreement thirty (30) days after CCHP sends written notice to Group if CCHP demonstrates fraud or an intentional misrepresentation of material fact under the terms of the Agreement by the Group.

8.2.5 [Reserved]

8.2.6 **For Loss of Group's Location within Service Area**. CCHP may terminate Group if Group no longer maintains a physical work location within the Service Area. CCHP shall provide Group with thirty (30) days written notice prior to such termination. Group must notify CCHP of changes of the Group's location provided on the Group application within (30) thirty days of such change.

8.3 **Return of Prepayment Premium Fees Following Termination**. In the event of termination by either CCHP (except in the case of fraud or deception in the use of CCHP services or facilities, or knowingly permitting such fraud or deception by another) or Group, CCHP will, within thirty (30) days, return to Group the pro-rata portion of money paid to CCHP which corresponds to any unexpired period for which payment has been received, together with amounts due on claims, if any, less any amounts due to CCHP.

8.4 **Continued Benefits for Disabled Members**.

8.4.1 In the event a Member becomes totally disabled while enrolled under Health Plan and continues to be totally disabled at the date of discontinuance of the Health Plan, such Member is entitled to a reasonable extension of benefits in accordance with Cal Health and Safety §1399.62 or Cal Insurance Code §10128.2. Please refer to the Health Plan Documents for a complete description. This extension of benefits may be terminated at such time as the Member is no longer totally disabled or at such time as a succeeding carrier may elect to provide replacement coverage to that member without limitation as to the disabling condition. The services provided during any extension of benefits may be subject to all limitations or restrictions contained in this Agreement.

8.4.2 Notwithstanding the foregoing, with respect to Members who were totally disabled on the date of discontinuation of the prior contract or policy, and entitled to an extension of benefits pursuant to Cal. Health and Safety §1399.62 or Cal Insurance Code §10128.2 under the prior contract or policy, CCHP shall not be financially responsible for any payment of benefits or provision of services directly related to any condition which caused the

total disability. In such a situation, the prior carrier shall continue to be financially responsible for all benefits or services directly related to any condition which caused the total disability until such extension of benefits is no longer required under California or federal law.

8.5 **Termination of Specific Members**. A Member may be terminated in accordance with Cal Health and Safety Code §1365(a). Please refer to the Health Plan Documents for a complete description. A Member who alleges that an enrollment or subscription has been or will be improperly canceled, rescinded, or not renewed may request a review by the director of the California Health and Human Services Agency, a Department of Managed Health Care pursuant to Cal Health and Safety Code Section 1365(b).

9. Dispute Resolution; Arbitration

9.1 **Arbitration**. Subject to the terms of this Agreement, any controversy, dispute or claim of whatever nature and irrespective of the facts or circumstances or the legal theories advanced shall be resolved by binding arbitration in San Francisco at the request of either party. Arbitration shall be administered by Judicial Arbitration and Mediation Services ("JAMS") in accordance with the JAMS Comprehensive Arbitration Rules and Procedures. The Federal Arbitration Act, 9 U.S.C. Sections 1-16, shall also apply. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, California state law governing agreements to arbitrate shall apply. The arbitrator's findings shall be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings. The arbitrator shall prepare in writing and provide to the parties an award including factual findings and the legal reasons on which the award is based.

9.2 Claimant shall initiate arbitration by serving a written demand for arbitration to the respondent in accordance with JAMS procedures for submittal of arbitration. The demand for arbitration shall include: the basis of the claim against the respondent; the amount of damages the claimant seek in the arbitration; the names, addresses, and telephone numbers of the claimant and their attorney, if any; and the names of all respondents. Claimant shall include all claims against respondent that are based on the same incident, transaction, or related circumstances in the demand for arbitration.

9.3 All other respondents, including individuals, must be served as required by California Code of Civil Procedure.

9.4 If the total amount of damages claimed is two hundred thousand ($200,000) dollars or less, a single neutral arbitrator shall be selected, unless the parties agree in writing, after a case or dispute has arisen and the request for arbitration has been submitted, to use a tripartite arbitration panel. The arbitrator shall not have authority to award monetary damages that are greater than two hundred thousand $200,000. If the total amount of damages claimed is more than two hundred thousand ($200,000) dollars, the dispute shall be heard and determined by one neutral arbitrator and two party arbitrators, one appointed by claimant(s) and one appointed by respondent(s). If all parties agree, arbitration may be heard by a single neutral arbitrator.

9.5 **Costs and Fees**. If a party brings an action or proceeding arising out of or relating to this Agreement, the non-prevailing party shall pay to the prevailing party reasonable attorneys' fees and costs incurred in such action, including without limitation, the reasonable

direct costs of counsel. The prevailing party shall be the party who is entitled to recover its costs of suit (as determined by the court of competent jurisdiction or the arbitrator), whether or not the action or proceeding proceeds to final judgment or award.

9.6 **Waiver**. Each party knowingly acknowledges and agrees that the foregoing constitutes a waiver of their constitutional right to a jury trial.

9.7 **Confidentiality**. The arbitration and any information obtained in connection with this Agreement or through discovery is confidential and neither the parties nor the arbitrator shall disclose such information to third parties without the written consent of the parties, except that the parties may disclose such information as necessary to seek confirmation of the arbitration award, to enforce any judgment entered on account of the award or as otherwise is required by law; however, the parties may make such disclosure as is necessary to their respective auditors, accountants, attorneys and insurers.

9.8 A claim shall be waived and forever barred if: (1) on the date the demand for arbitration is served, the claim, if asserted in a civil action, would be barred as to the respondent served by the applicable statute of limitations; (2) claimant fails to pursue with reasonable diligence, the arbitration claim in accord with JAMS rules and procedures; or (3) the arbitration hearing is not commenced within five (5) years after the earlier of (a) the date the demand for arbitration was served, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the arbitrator may proceed to determine the controversy in the party's absence.

9.9 The California Medical Injury Compensation Reform Act of 1975, including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for noneconomic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any claims for professional negligence or any other claims as permitted or required by law.

10. General Terms.

10.1 **Acceptance of Agreement.** Group accepts this Agreement by execution of this Agreement. Member accepts the terms, conditions and provisions of this Agreement upon completion and execution of the Enrollment form. Acceptance by any of these methods shall render all terms and provisions of this Agreement binding on CCHP, Group, and Members.

10.2 **Contracted Provider**. In accordance with 28 CCR 1300.67.4(a)(10), if one of CCHP's contract health care providers terminates its contract with CCHP, CCHP will be liable for covered services rendered by such provider (other than for Copayments and Coinsurance) to a Member who retains eligibility under the Health Plan or by operation of law under the care of such provider at the time of such termination until the services being rendered to the Member by such provider are completed, unless CCHP makes reasonable and medically appropriate provision for the assumption of such services by a contracting provider.

10.3 **Indemnification**. Each party shall indemnify and hold the other party and its directors, officers, trustees, employees, representatives and assigns harmless from and against

any and all claims, causes of action, liabilities, losses, damages, penalties, assessments, judgments, awards or costs, including reasonable attorneys' fees and costs, arising out of, resulting from, or relating to: (i) the indemnifying party's breach of this Agreement; (ii) the indemnifying party's breach of any applicable State, Federal, or local law, rules or regulations; (iii) the negligent acts or omissions of the indemnifying party or any employees or agent of the indemnifying party in the performance of his/her obligations under this Agreement; and (iv) the indemnifying party's acts of harassment or illegal discrimination.

10.4 Cumulative Rights. Any specific right or remedy in this Agreement will not be exclusive but will be cumulative of all other rights and remedies.

10.5 Entire Agreement. This Agreement contains the entire agreement of the parties and supersedes all prior agreements, representations or understandings, whether written or oral, between the parties relating to the subject matter hereof.

10.6 Captions. Captions in this Agreement are descriptive only and do not affect the intent or interpretation of the Agreement.

10.7 Survival. All provisions that logically ought to survive termination of this Agreement shall survive.

10.8 Severability. If any provision of this Agreement shall be held invalid, illegal or unenforceable by any court of competent jurisdiction, the remaining provisions shall not in any way be affected or impaired thereby.

10.9 Waiver. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach or violation.

10.10 Force Majeure. Either party shall be excused for failures and delays in performance of its respective obligations under this Agreement due to any cause beyond the control and without the fault of such party, including without limitation, any act of God, war, riot or insurrection, law or regulation, strike, flood, fire, explosion or inability due to any of the aforementioned causes to obtain labor, materials or facilities. Nevertheless, each party shall use its best efforts to avoid or remove such causes and to continue performance whenever such causes are removed, and shall notify the other party of the problem.

10.11 Agreement Binding on Members. By this Agreement, the Group makes Health Plan coverage available to persons who are eligible. However, this Agreement is subject to amendment, modification, or termination in accord with any provision hereof or by mutual agreement between CCHP and Group without the consent or concurrence of Members. By electing Health Plan coverage pursuant to this Agreement, or accepting benefits hereunder, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

10.12 Identification Cards. Cards issued by CCHP to Members are for identification only. Possession of a CCHP identification card confers no rights to services or other benefits under this Agreement. To be entitled to such services or benefits, the holder of the card must, in fact, be a Member on whose behalf all applicable charges under this Agreement have been

paid. Any person receiving services or benefits to which he or she is not entitled pursuant to the provisions of this Agreement is chargeable for such services at non-Member rates.

10.13 Right to Examine Records. CCHP, upon reasonable notice, may examine during business hours at Group's regular place of business, the Group's pertinent records with respect to eligibility and monthly payments under this Agreement.

10.14 Governing Law. CCHP is subject to the requirements of Chapter 2.2 of Division 2 of the California Health and Safety Code and of Subchapter 5.5. of Chapter 3 of Title 10 of the California Administrative Code, and any provision required to be in this Agreement by either of the above shall bind the Plan whether or not set forth herein. This Agreement and the rights and obligations of the parties hereunder shall be construed, interpreted, and enforced in accordance with, and governed by, the laws of the State of California and the United States of America, including, without limitation, the Knox-Keene Health Care Service Plan Act of 1975, as amended, and the regulations adopted thereunder by the California Department of Managed Health Care, the Federal Health Maintenance Organization Act of 1973, as amended, and the regulations adopted thereunder by the United States Department of Health and Human Services.

10.15 CCHP Names, Logos and Service Marks. CCHP reserves the right to control all use of its name, product names, symbols, logos, trademarks, and service marks currently existing or later established. Group shall not use CCHP's name, product names, symbols, logos, trademarks, or service marks without obtaining the prior written approval of CCHP.

10.16 Assignment. This Agreement and the rights, interests and benefits hereunder shall not be assigned, transferred, pledged, or hypothecated in any way by either party and shall not be subject to execution, attachment or similar process, nor shall the duties imposed herein be subcontracted or delegated without the approval of the other party. Notwithstanding the above, if CCHP are assigns, sells or otherwise transfers substantially all of its assets and business to another corporation, firm or person, with or without recourse, this Agreement will continue in full force and effect as if such corporation, firm or person were a party to this Agreement, provided such corporation, firm or person continues to provide prepaid health services.

10.17 Confidentiality. CCHP agrees to maintain and preserve the confidentiality of any and all medical records of Member in accordance with all applicable state and federal laws. However, Member authorizes the release of information and access to any and all of Member's medical records for purposes of utilization review, quality review, processing of any claim, financial audit, coordination of benefits, or for any other purpose reasonably related to the provision of benefits under this Agreement to CCHP, its agents and employees, Member's participating medical group, and appropriate governmental agencies. CCHP shall not release any information to Group which would directly or indirectly indicate to the Group that a Member is receiving or has received covered services, unless authorized to do so by the Member.

10.18 Amendments. This Agreement may be modified by CCHP as set forth in this Agreement. This Agreement may by modified upon thirty (30) days notice to Group in order to comply with any state or federal law.

10.19 Administration of Agreement. CCHP may adopt reasonable policies, procedures, rules, and interpretations to promote orderly and efficient administration of this Agreement.

10.20 Independent Contractor Relationship. The relationship between CCHP and Group is an independent contractor relationship. Neither party or its employees or agents are employees or agents of the other party. This Agreement shall not be construed to create a relationship of agency, representation, joint venture, ownership, control or employment between the parties other than that of independent parties contracting solely for the purpose of effectuating this Agreement. Nothing contained in this Agreement shall cause either party to be liable or responsible for any debt, liability or obligation of the other party or any third party unless such liability or responsibility is expressly assumed by the party sought to be charged therewith.

10.21 Incorporation. The Health Plan Documents, exhibits, and attachments are an integral part of this Agreement and are incorporated in full herein by this reference.

10.22 Notices. All notice required or permitted by this Agreement shall be by personal delivery or by U.S. mail, postage pre-paid, certified or registered mail, return receipt requested, addressed to the party at its address set forth with its signature. Either party may change such address upon written notice to the other party. Notice shall be deemed delivered as of the date of personal delivery, or three (3) days after mailing. Any notice under this Agreement may be given by United States mail, postage prepaid, addressed as follows:

If to CCHP: Chinese Community Health Plan
445 Grant Avenue, Suite 700
San Francisco, CA 94108

If to a Subscriber: to the latest address provided for the Subscriber on enrollment or changes of address forms actually delivery to CCHP.

If to the Group: to the address indicated on the Cover Sheet.

10.23 State of California Review of Member Complaints. Cal Health and Safety §1368.02 requires that the following statement appear in this Agreement. The word "you" refers to Members:

> "The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan's telephone number) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a

health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online."

IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Agreement as of the latest date stated below.

Group		**CCHP** Chinese Community Health Plan	
Signature:	_____	Signature:	_____
NAME:	_____	NAME:	Brenda Yee, RN, MSN
TITLE:	_____	TITLE:	Chief Executive Officer
DATE:	_____	DATE:	_____

Agent Name: _____

Agent Code: _____

Agent Company: _____

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.