# ANTHEM BLUE CROSS HMO

## GROUP BENEFIT AGREEMENT

(the *agreement*)

for

## SAN JOAQUIN VALLEY INSURANCE AUTHORITY

(the *group*)

**AGREEMENT EFFECTIVE DATE: December 10, 2012**

BLUE CROSS OF CALIFORNIA, doing business under the trade name ANTHEM BLUE CROSS ("Anthem") agrees to provide the benefits of this *agreement* for enrolled *members* of the *group*. These benefits are subject to all of the terms and conditions of this *agreement*.

To the extent not preempted by federal law or regulation, this *agreement* will be governed, interpreted and enforced to remain in compliance with the laws of the state of California, along with applicable federal statutes and regulations. Nothing contained in this *agreement* will be construed as Anthem doing business in any state or jurisdiction in which it is not duly authorized.

This *agreement* has been approved by the officers of Anthem to become effective at 12:01 A.M. Pacific Standard Time on the Agreement Effective Date shown above. Payment of the first monthly subscription charges indicates the *group's* acceptance of this *agreement*. It continues from month to month as long as the required subscription charges are paid, unless it is terminated as described in GENERAL PROVISIONS: CANCELLATION.

The change in Agreement Effective Date from the preceding *agreement* indicates a change in terms and provisions and is thus a modification and continuation of the *agreement* between Anthem and the Group to provide group benefits.

President

Secretary

# TABLE OF CONTENTS



The *italicized* terms appearing in these administrative pages are defined in the Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form.

# GENERAL PROVISIONS

## AGREEMENT COMPONENTS

The entire *agreement* consists of:

1. these administrative pages, including any endorsements;
2. all Combined Evidence of Coverage and Disclosure Forms, including any amendments, which are made a part of this *agreement*;
3. the application of the *group*; and
4. the individual applications, if any, of eligible persons.

This *agreement* does not include the charter or by-laws of Anthem.

## LIABILITY FOR STATEMENTS

No statement made by the *group*, unless it appears on the written application or is fraudulent, will be used in any contest of the coverage under this *agreement*. Statements made by the *group* shall not be deemed warranties. After the coverage under this *agreement* has been in force for 24 months, no statement will be used in any contest of the coverage under this *agreement*.

## ENROLLMENT REQUIREMENTS

All of the persons eligible to be employees, who are not enrolled under another group-sponsored plan, must be enrolled as employees under this *agreement*. If the number of employees enrolled falls below either: (1) **75%** of the persons eligible to enroll as employees; or (2) **40** employees, Anthem may cancel or decline to renew this *agreement*. Anthem may also cancel or decline to renew this *agreement* if the *group* has less than **51** eligible employees.

## AGREEMENT CHANGES

No agent of Anthem may change this *agreement* or waive any of its contents. Anthem and the *group* may change any of the provisions of this *agreement* at any time by mutual consent. Anthem may also change this *agreement* as provided in 2 below.

No change in this *agreement* is valid unless the change is made in one of the following ways:

1. In the case of a written request by the *group* for a change, by an endorsement signed by the officers of Anthem; and (b) accepted by the *group* as evidenced by its payment of the subscription charges on and after the effective date of such change.

2. In the case of a change required by Anthem, by an endorsement that is: (a) signed by the officers of Anthem; and (b) accepted by the *group* as evidenced by its payment of the subscription charges on and after the effective date of such change. Anthem will give the *group* written notice of its intent to make such a change at least 60 days in advance of its effective date.

# GENERAL PROVISIONS

## CONTRACT LANGUAGE

In the event the *group* maintains a grandfathered health plan(s), as that term is used in the Patient Protection and Affordable Care Act ("PPACA"), the *group* shall not make any changes to such plan(s), including, but not limited to, changes with respect to employer contribution levels, without providing Anthem with advance written notice of the intent to change such plan(s). Making changes to grandfathered plans without notice to Anthem may result in the plan(s) losing grandfathered status and significant penalties and/or fines to the *group* and Anthem. In the event the *group* implements changes to its plan(s) and does not provide advance notice to Anthem, the *group* agrees to hold harmless Anthem from any penalties, fines or other costs assessed against Anthem and to reimburse Anthem from any such penalties, fines or other costs.

Additionally, at each renewal after September 23, 2010, the *group* shall affirm in writing, upon reasonable request of Anthem, that it has not made changes to its plan(s) that would cause the plan(s) to lose it/their grandfathered status.

## INTERPRETATION OF PROVIDER CONTRACTS

Subject to applicable California state or federal law and regulation, Anthem shall have final authority to interpret its contracts with providers, and the *group* agrees that (a) it is not a party to Anthem's contracts with providers and (b) it will accept Anthem's interpretation of said provider contracts. Furthermore, Anthem shall have full authority and discretion to resolve any questions or disputes with providers that participate in any of Anthem's provider networks, except as applicable law provides for judicial or regulatory review of such disputes, and the *group* will accept said resolution of such matters as final.

## CLERICAL ERRORS

1. Clerical errors made by the *group* do not deprive any *member* of his or her coverage under this *agreement*, provided that the enrollment form or membership change form is: (a) completed according to the WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE section of the Evidence of Coverage Form; and (b) received by Anthem within 90 days of the eligibility date of a *member's* coverage. Enrollment forms which are received by Anthem more than 90 days after the *member's* eligibility date will be processed in accordance with the WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE section of the Evidence of Coverage Form.

2. Clerical errors made by the *group* will not continue any *member's* coverage which would not otherwise be effective.

3. Any subscription charge adjustment due to the correction of a clerical error will be made on the next Subscription Charge Due Date after the facts are made known to Anthem. Adjustments for retroactive changes are made in accordance with the "Accuracy of Information" provision of the section entitled SUBSCRIPTION CHARGE PROVISIONS.

## AGREEMENT EFFECTIVE DATE

The Agreement Effective Date is the date the *agreement* between Anthem and the *group* becomes effective. This date and any other date in this *agreement* begins at 12:01 a.m. Pacific Standard Time.

## AGREEMENT ANNIVERSARY DATE

The first Agreement Anniversary Date is the date one year following the Agreement Effective Date. Later Agreement Anniversary Dates are one year periods which start and end on succeeding Agreement Anniversary Dates.

# GENERAL PROVISIONS

## AGREEMENT RENEWAL

This *agreement* is considered to renew on each Agreement Anniversary Date. On this date, and on any Subscription Charge Due Date, upon 60-days written notice to the Policyholder, we may change the terms of the *agreement*, the terms of the *plan,* and the subscription charges.

## MAILING ADDRESSES

Any notice required of Anthem in this *agreement* will be mailed to the address of the *group* as shown on Anthem records. Any notice required of the *group* in this *agreement* must be mailed to Anthem Blue Cross at P.O. Box 4089, Woodland Hills, California 91365.

## ENROLLMENT APPLICATIONS

The *group* agrees to forward promptly all enrollment applications to Anthem. If this *agreement* replaces a prior Anthem *agreement* issued to the same *group*, applications are not required for any *members* enrolled immediately before termination of the prior *agreement*.

## CONFIDENTIALITY

The *group* agrees that it will, at all times under this *agreement*, require that each employee sign the disclosure authorization included on the enrollment form. From time to time, the *group* may receive from Anthem information marked “Confidential Information.” The *group* agrees that it shall hold all such information strictly confidential, and further agrees to indemnify and hold Anthem, its affiliates, officers, directors and employees harmless from any and all liability, claims, costs and expenses arising out of or in connection with the unauthorized disclosure of confidential information by the *group*, its employees, agents, officers or directors.

## DECLINATION FORMS

Each eligible *member* is required to enroll under a *group*-sponsored health plan. If any *member* does not enroll for such coverage, or is terminating coverage (disenrolling), the *group* agrees to obtain a written notice, signed by that *member* (or that *member's* guardian in the case of a minor), that the *member* declines coverage or is terminating coverage under all *group*-sponsored health plans.

This notice shall clearly indicate that the *member* is aware that if he or she does not enroll for coverage under the *plan* within 31 days from the *member's* eligibility date or disenrolls as described, the *member* may not be eligible to reapply for coverage until the *group’s* next open enrollment period.

The *group* shall maintain files for all such notices of declination of coverage, and shall, upon request, provide copies promptly to Anthem.

The *group* will indemnify, defend and save Anthem, and its affiliates, harmless from any claims, demands, loss, cost or expense, including attorney's fees, arising from or related to the *group’s* failure to fully and faithfully perform under this provision entitled "Declination Forms". If Anthem is required to provide coverage because of the *group’s* failure to fully and faithfully perform under this provision, in addition to any other claim Anthem may have against the *group* for such failure, the *group* will pay all subscription charges due for such coverage.

## GROUP RECORDS

The *group* is responsible for keeping records relating to this *agreement*. Anthem has the right to inspect and audit those records. In the event of the termination of this *agreement*, Anthem maintains the right to inspect those records pertinent to the period of time this *agreement* was in effect.

## COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORMS

The Combined Evidence of Coverage and Disclosure Forms describe the benefits to which the employee and enrolled family members are entitled, and other important terms of their coverage. For the employee, and their covered family members, Anthem has posted on its website, www.anthem.com/ca, the Combined Evidence of Coverage and Disclosure Forms that apply to the *group's* plan of benefits which the *members* can access using their own identification number shown on their ID card. Anthem will instruct the *group* on how to access the Combined Evidence of Coverage and Disclosure Forms and the *group* agrees to notify the employees of the location of the electronic Combined Evidence of Coverage and Disclosure Forms and how to access them, and subsequently, if changes are made in the plan of benefits, of the location of the amendments showing the changes. Further, Anthem Blue Cross agrees to furnish, and the *group* agrees to distribute promptly, upon request by the employee, an appropriate Combined Evidence of Coverage and Disclosure Form to each employee who requests one.

## SUMMARY OF BENEFITS AND COVERAGE

In advance of the next renewal year, within the time period designated by Anthem, the *group* shall provide Anthem with all necessary benefit information to enable Anthem to provide the *group* the Summary of Benefits and Coverage (SBC) as required by Paragraph three of this provision.

As may be required by law, Anthem shall (1) provide the *group* with an SBC and (2) provide the *group* an updated SBC in the context of a Notice of Material Modification (NMM). The *group* shall be solely responsible for disseminating an electronic copy (via the internet or otherwise) or a paper copy of the SBC to *members* (including pre-enrollees) in a manner compliant with (a) the Employee Retirement Income Security Act (ERISA), if applicable; (b) all the requirements of Section 2715 of the Public Health Service Act (PHSA) as added by Section 1001 of the Patient Protection and Affordable Care Act (PPACA) ; (c) any applicable regulations implementing PHSA Section 2715 codified in the Code of Federal Regulations; and (d) any sub-regulatory guidance regarding PHSA Section 2715. Notwithstanding the above, the *group* agrees that Anthem may, upon advance notice to the *group*, deliver the SBC to *members* via paper, electronic means, or internet access, as permitted by law. The *group* agrees that it will provide the NMM (including the updated SBC) to its *members* in accordance with the requirements set forth in the statutes and regulations referenced in this paragraph. The *group* will notify Anthem immediately if it fails to deliver the SBC to members.

The *group* shall defend, indemnify and hold harmless Anthem from all costs, including but not limited to all losses, claims, judgments, fines, assessments and fees (including attorneys' fees and other litigation costs), incurred by Anthem as a result of the *group's* failure (through no fault of Anthem) to (1) timely provide Anthem with all renewal information as required by this endorsement, and (2) distribute the SBCs to the group health plan *members* as required by PHSA Section 2715, 29 CFR Part 2590.715-2715, et seq. or 45 CFR Part 147.200, et seq.

## CANCELLATION

Anthem may terminate, cancel or decline to renew this *agreement* in the event of any of the following:

1. The *group's* failure to pay subscription charges as described below;

2. The *group's* failure to meet the conditions set forth in the section ENROLLMENT REQUIREMENTS as described below;

3. The *group's* fraud or intentional misrepresentation of material fact under the terms of this *agreement*, or the *group's* knowing permission of such fraud or intentional misrepresentation by another, including without limitation, any *member*;

4. The occurrence of any other event permitting termination, cancellation or nonrenewal described below; or

5. Anthem may terminate, cancel or decline to renew this *agreement* when required to effectuate the purposes of the Knox-Keene Health Care Service Plan Act, with the consent of the California Director of the Department of Managed Health Care. Additionally, Anthem may incorporate into this *agreement* any of the bases for termination, cancellation or nonrenewal described in items a or b below upon 60 days prior written notice to the *group*, in the event of:

    a. An amendment to the Knox-Keene Act, or a change in the applicable interpretations thereof, which expands the basis upon which a health plan may terminate, cancel or decline to renew group benefit agreements; or

    b. The approval by the California Director of the Department of Managed Health Care of good causes for termination, cancellation or nonrenewal of a group benefit agreement of Anthem other than as set forth in this *agreement*.

**Delinquent subscription charges.** If the *group* fails to pay subscription charges as they become due, Anthem may terminate this *agreement* as of the last day of the Grace Period described below. Nevertheless, Anthem will terminate this *agreement* only upon first giving the *group* a written Notice of Cancellation at least 30 days prior to that cancellation (or any longer period of time required for advance notice by applicable federal law, rule, or regulation).

The Notice of Cancellation shall state that this *agreement* shall not be terminated if the *group* makes appropriate payment in full within 30 days after Anthem issues the Notice of Cancellation (or any longer period of time required by applicable federal law, rule, or regulation). The Notice of Cancellation shall also inform the *group* that, if this *agreement* is terminated for nonpayment and the *group* wishes to apply for reinstatement, the *group* shall be required to submit a new application for coverage, and that Anthem either may decline to permit reinstatement in Anthem's sole discretion or may permit reinstatement upon terms and conditions as Anthem shall determine appropriate in its sole discretion.

**Failure to meet enrollment requirements**. In the event that the *group* fails to meet the conditions set forth in the section ENROLLMENT REQUIREMENTS, Anthem may terminate this *agreement* on any Subscription Charge Due Date by giving the *group* a written Notice of Cancellation, stating the reason for the cancellation, at least 30 days prior to the date of cancellation.

**No employee notification.** Anthem shall not in any event be required to issue to *members* any notice of termination, cancellation or nonrenewal of this *agreement*. The *group* shall promptly mail or deliver a legible, true copy of the termination, cancellation or nonrenewal notice it received from Anthem to each *member,* not later than seven days prior to the date coverage will end, and shall promptly provide Anthem with proof of that mailing or delivery has been made and the date thereof.

**COBRA ADMINISTRATION**

In no event will Anthem be the plan administrator with regard to the Consolidated Omnibus Budget Reconciliation Act (COBRA). The term "plan administrator" refers either to the *group* or to a person or entity other than Anthem, engaged by the *group* to perform or assist in performing administrative tasks in connection with the *group's* health *plan*. In providing notices and otherwise performing under the Continuation of Coverage provisions outlined in the *agreement*, the *group* is not acting as the agent of Anthem. Rather the *group* is fulfilling statutory obligations imposed on it by Federal Law and, where applicable, acting as the agent of the *member*.

## CALCOBRA NOTIFICATION REQUIREMENTS

Prior to termination of the *agreement*, the *group* shall notify both (a) those *members* who are receiving coverage under CalCOBRA and (b) qualified beneficiaries who have been notified of their ability to continue coverage through CalCOBRA, who have not yet elected such coverage and who may still elect coverage within the specified 60-day election period of their ability to continue coverage under a new group benefit plan for the remainder of the continuation period. This notification must be made at least 30 days prior to the termination of the *agreement* or at the time all *members* are notified, whichever is later. The *group* shall notify the successor plan, if any, in writing of those *members* who are receiving coverage under CalCOBRA and of those qualified beneficiaries who may still elect coverage through CalCOBRA.

## NOTIFICATION OF CONVERSION AND HIPAA COVERAGE

The *group* agrees to notify promptly, upon termination of coverage, any eligible person of conversion coverage availability and procedures for application. The *group* acknowledges its legal obligation under Health and Safety Code Section 1373.6, Labor Code Section 2800.2, and ERISA to provide this notification.

The *group* agrees to notify promptly any federally eligible defined person of the availability of health coverage through Article 4.6 of the Health and Safety Code and Section 2741 of the Public Health Service Act, and to provide such persons with the necessary information to make timely application for such coverage. The *group* acknowledges its legal obligations under ERISA to provide this notification.

The *group* agrees to indemnify and save Anthem harmless from any claim, demand, loss, damage, or expense (including reasonable attorney fees) arising from or in connection with any failure to properly provide the notifications described above.

## BLUE CROSS AND BLUE SHIELD ASSOCIATION DISCLOSURE

This *agreement* constitutes a contract solely between the *group* and Anthem, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the “Association”) permitting Anthem to use the Blue Cross Service Mark in the State of California, and that Anthem is not contracting as the agent of the Association. The *group*, on behalf of itself and its employees, acknowledges and agrees that it has not entered into this *agreement* based upon representations by any person other than Anthem and that no person, entity, or organization other than Anthem shall be held accountable or liable to the *group* for any of its obligations to the *group* created under this *agreement*. This provision shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under the other provisions of this *agreement*.

## INTER-PLAN PROGRAM DISCLOSURE

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever *members* access healthcare services outside the geographic area Anthem and/or the designated Anthem affiliate serve, the claim for those services may be processed through one of these Inter-Plan Programs and presented to Anthem for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to *members* under this *agreement* are described generally below.

Typically, *members*, when accessing care outside the geographic area Anthem serves, obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, *members* may obtain care from Non-Network Providers. Anthem’s payment practices in both instances are described below.

Anthem covers only limited healthcare services received outside of the service area Anthem and/or the designated Anthem affiliate serve. As used in this section, "out-of-area covered healthcare services" refers to emergency care and urgent care obtained outside the geographic area Anthem and/or the designated Anthem affiliate serve. Except for emergency care and urgent care, services must be provided or authorized by the *member's primary care doctor* or *medical group*.

**BlueCard® Program**

Under the BlueCard® Program, when *members* access out of area covered healthcare services within the geographic area served by a Host Blue, Anthem will remain responsible to group for fulfilling Anthem's contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating healthcare providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

**Liability Calculation Method Per Claim:** The calculation of the *member* copay, if not a flat dollar copay, for out-of-area covered healthcare services processed through the BlueCard Program will be based on the lower of the participating healthcare provider's billed covered charges or the negotiated price made available to Anthem by the Host Blue.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to Anthem by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:

(i) an actual price. An actual price is a negotiated payment without any other increases or decreases, or

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

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

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the *member* is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to Anthem is a final price irrespective of any future adjustments based on the use of estimated or average pricing. A small number of states require a Host Blue either (i) to use a basis for determining *member* liability for out-of-area covered healthcare services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, Anthem would then calculate *member* liability in accordance with applicable law.

**Return of Overpayments***:* Under the BlueCard Program, recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

## NON-NETWORK PROVIDERS OUTSIDE ANTHEM'S SERVICE AREA

**Member Copay Calculation***:* When out-of-area covered healthcare services are provided outside of Anthem's service area by Non-Network Providers, the copay, if not a flat dollar copay, a *member* pays for such services will generally be based on either the Host Blue's Non-Network Providers local payment or the pricing arrangements required by applicable state law.

**EXCEPTIONS***:* In some exception cases, Anthem may pay claims from Non-Network Providers outside of Anthem's service area based on the provider's billed charge, such as in situations where a *member* did not have reasonable access to a Network Provider, as determined by Anthem, in Anthem's sole and absolute discretion, or by applicable state law. In other exception cases, we may pay such a claim based on the payment we would make if Anthem were paying a Non-Network Provider inside of Anthem's service area, as described elsewhere in this *policy*, where the Host Blue's corresponding payment would be more than Anthem's in-service area Non-Network Provider payment, or in our sole and absolute discretion, we may negotiate a payment with such a provider on an exception basis.

## MISCELLANEOUS PROVISIONS

Anthem shall not decrease, in any manner, the benefits and coverages provided hereunder, except after at least 60 days prior written notice to the *group*.

Anthem shall provide written notice to the *group* within a reasonable period of time of any participating provider's termination, or breach of, or inability to perform under, any provider contract, if Anthem determines that the *group* or *members* may be materially and adversely affected thereby.

Upon the termination of the contract or other agreement with any participating provider, Anthem shall be liable to pay the cost of covered services (other than applicable Co-Payment) rendered by that provider to a *member* who retains eligibility under this *agreement* or by operation of law, and who is under the care of that provider at the time of such termination, and that provider shall continue to provide such services to the *member* in accordance with the terms of this *agreement*, until the services being rendered are completed, unless reasonable and medically appropriate provision is made for the assumption of such services by another provider.

Anthem is subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975, as amended, as set forth at Chapter 2.2 of Division 2 of Chapter 3 of Title 28 of the California Code of Regulations, and any provision required to be stated herein by either of the above shall bind Anthem whether or not provided in this *agreement*. This *agreement* shall be construed and enforced in accordance with the laws of the state of California.

## ASSIGNMENT

This *agreement* may not be assigned by the *group* without prior written consent of an officer of Anthem. Any purported assignment without such written consent shall be void as to Anthem.

# SUBSCRIPTION CHARGE PROVISIONS

## PAYMENT DATES

The term "subscription charges" refers to the payment due from the Group to Anthem which maintains the *agreement* in force. For this *agreement*, subscription charges are calculated under a minimum premium funding arrangement. The amount, method and timing of the subscription charge payment from the Group to Anthem is detailed in the Funding Provisions document which accompanies this *agreement*. The initial payment of subscription charges is due on or before the Agreement Effective Date.

## GRACE PERIOD

For every Subscription Charge Due Date except the first, there is a 31-day grace period in which to pay subscription charges. This *agreement* remains in force during the grace period. The *group* is liable for payment of subscription charges covering any period of time that this *agreement* remains in force. If the *group* fails to pay us the subscription charges due during the grace period, Anthem will not end coverage for covered employees or family members until the end of the grace period. The employees will not be required by Anthem to pay the subscription charges for the *group* nor will members be required to pay more than their copay for any services received during the grace period.

If subscription charges due are not paid by the end of the grace period, this *agreement* will be canceled as described above.

## SUBSCRIPTION CHARGE INCREASE

Anthem may not increase subscription charges without first providing written notification to the *group* at least 60 days prior to the date the increase is to take effect.

## ACCURACY OF INFORMATION

**Responsibilities of the Group**. The *group* is responsible for supplying up-to-date eligibility information. Anthem may rely upon the latest information received as correct without verification; however, Anthem maintains the right to verify any eligibility information provided by the *group*.

**Retroactive Credits.** In order for the *group* to receive full credit for a correction or change in eligibility information, any such change or correction must be received by Anthem within 90 days of the date a *member* ceases to be eligible under the plan. In any event, the maximum retroactive credit for subscription charges paid for an ineligible *member*, whether or not benefits are actually provided for that *member*, shall not exceed 60 days. In addition, benefits provided for an ineligible *member* because of inaccurate information supplied by the *group* are charged against the *group's* experience.

**Retroactive Subscription Charges.** Enrollment or membership change forms to add employees or family members must be completed in accordance with the WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE section of the Evidence of Coverage Form, and received by Anthem within 90 days of any such *member's* eligibility date. Retroactive subscription charges will then be billed to the *group* as of the *member's* effective date.

If such forms are received later than 90 days from the *member's* eligibility date, the *member's* effective date of coverage will be determined in accordance with the WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE section of the Evidence of Coverage Form. In no event will any retroactive effective date be more than 90 days prior to the date the enrollment or membership change forms are received by Anthem. Subscription charges will begin if, and when, that *member's* coverage becomes effective.

# SUBSCRIPTION CHARGE PROVISIONS

## TAX LIABILITY

If a state or any other taxing authority imposes a tax on Anthem which is based on subscription charges, the subscription charges stated in this *agreement* will be increased by an amount sufficient to cover that tax. Anthem will give the *group* at least 60-days advance written notice of the increase in subscription charges sufficient to coverage the tax prior to the date they tax goes in to affect. If it is not possible to give the *group* 60-days advance written notice of the increase in subscription charges due to the tax, Anthem will notify the *group* in writing as soon as possible and will increase the subscription charges on the date the tax goes into effect. Any subsequent change to the tax may result in a further increase in subscription charges upon appropriate written notice.

## REFUNDS OF UNEARNED SUBSCRIPTION CHARGES

If this *agreement* is terminated for any cause, any subscription charges received by Anthem for periods occurring after the effective date of that termination, less any amounts due to Anthem, will be refunded, and Anthem shall have no further liability or responsibility with regard to the *group* or any *member* under this *agreement*. If the termination is for any reason other than an employee's or a family member's fraud or deception in the use of services or facilities of Anthem (or knowingly permitting such fraud or deception by another), Anthem will make this refund within 30 days.

## MEDICAL LOSS RATIO REBATE

For any rebate due and payable as a consequence of the medical loss ratio ("MLR") requirements of the Patient Protection and Affordable Care Act ("PPACA") and/or applicable state law, all such rebates paid shall constitute a return of subscription charges. The *group* shall promptly provide Anthem with any information needed to calculate the applicable rebate amount. Anthem reserves the right to pay the rebate to either the *group* or the employee.

If Anthem pays the rebate to the *group*, the *group* shall promptly refund to each employee his/her proportional share of the rebate in accordance with the requirements of PPACA. Upon reasonable request, the *group* shall provide to Anthem documentation required by 45 CFR 158.242(b)(2) of the distribution of the rebate to employees. The *group* agrees to provide such documentation within the time frame designated by Anthem.

In the event of a claim related to the amount of the employee's rebate, the *group* shall cooperate with Anthem and provide Anthem with information required to investigate the claim. If Anthem is required to pay additional amounts to an employee due to the *group's* failure to either (1) provide accurate information to Anthem, or (2) make a refund of the appropriate rebate amount due to the employee, then the *group* agrees to reimburse Anthem for such additional amount paid by Anthem to the employee. This provision shall survive the termination of this *agreement*.

## COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORMS INCLUDED IN THIS AGREEMENT

Benefit provisions of this *agreement* appear in the Combined Evidence of Coverage and Disclosure Forms listed below. Copies of all Evidence of Coverage Forms and any applicable amendments issued to employees covered under this *agreement* are attached. These documents form an integral part of the entire *agreement*. In any interpretation of the *agreement,* all documents will be read together.

Employees are enrolled under the *plan* or *plans* indicated on their enrollment forms.

| PLAN DESCRIPTION | FORM NUMBER | EFFECTIVE DATE |
|---|---|---|
| Anthem Blue Cross HMO Plan (County of Fresno) | RT275341-1 1212 | December 10, 2012 |
| Anthem Blue Cross HMO Plan (County of Tulare) | RT275341-2 1212 | January 1, 2013 |