

GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT

THIS AGREEMENT (the “Agreement”) is made and entered into effective July 1, 2024 (the “Effective Date of Coverage”) by and between the County of Santa Clara, doing business as Valley Health Plan (“Plan”) and Santa Clara County In-Home Supportive Services Public Authority (“Group”).

RECITALS

WHEREAS, Plan is a prepaid health care service plan, which arranges for the provision of health care services for Members, subject to the licensing requirements and operational regulatory standards of the Knox-Keene Health Care Service Plan Act of 1975, as amended;

WHEREAS, Group wishes to participate in said program;

NOW THEREFORE, Group engages Plan to arrange for the provision of Medically Necessary Covered Services to Members in accordance with the following Declarations and all terms and conditions hereinafter provided.

DECLARATIONS

1. The initial term of this Agreement is July 1, 2024 through June 30, 2025. Thereafter, this Agreement will automatically renew from year to year for up to four additional years, unless terminated as provided herein.

2. As of the effective date, this Agreement supersedes and replaces any previous Group Service Agreement between the parties.

3. The Premiums for Plan membership are specified in the Rate Schedule to this Agreement. Subject to changes in rates or other terms as provided in Section 4 (Fees and Charges), the rates shall remain in effect for the Initial Term of this Agreement. Thereafter, the rate schedule is subject to change on the anniversary date as provided herein.

4. This Agreement is made in reliance upon the information provided by Group in its application; upon the statements of each Subscriber in their application for Coverage and upon Group’s existing eligibility requirements and composition of Members.

5. This Agreement is not effective until executed in writing by the duly authorized officer of Plan named below. No other employee or agent is authorized to bind Coverage.

6. No representative of Plan is authorized to waive or change any provision of this Agreement except in a writing signed by a duly authorized Plan officer. Notwithstanding that, a change can be made in accordance with Section 8.11 “Change in Agreement” of this Agreement.

IN WITNESS WHEREOF, Plan and Group have caused this Agreement to be executed by duly authorized representatives as of the Effective Date of Coverage.

GROUP

Santa Clara County In-Home Supportive Services
Public Authority
3100 De La Cruz Blvd, Ste 310
San Jose, CA 95054

By:

Susan Ellenberg
Chairperson, Governing Board of
Santa Clara County In-Home Supportive
Services Public Authority
Date: _____

Signed and certified that a copy of this
document has been delivered by electronic
or other means to the Chairperson, Governing
Board of Santa Clara County In-Home Supportive
Services Public Authority

ATTEST:

Curtis Boone
Acting Clerk of the Governing Board of Santa
Clara County In-Home Supportive
Services Public Authority
Date: _____

Approved as to Form and Legality:

DocuSigned by:
Lauren Lystrup
Lauren Lystrup
Deputy County Counsel
Date: 4/9/2024

PLAN

County of Santa Clara dba
VALLEY HEALTH PLAN

DocuSigned by:
Laura Rosas
Laura Rosas, 44F7464C291447...
Chief Executive Officer, VHP
Date: 4/9/2024

Approved By:

DocuSigned by:
James R. Williams
James R. Williams, 2492E000791F439...
County Executive
Date: 4/9/2024

Approved as to Form and Legality:

DocuSigned by:
Jennifer Sprinkles
Jennifer Sprinkles, 2492E000791F439...
Lead Deputy County Counsel
Date: 4/9/2024

EXHIBITS INCORPORATED INTO THIS AGREEMENT:

Exhibit A Premium Rate Schedule
Exhibit B Copayment Schedule

SECTION 1 – DEFINITIONS

- 1.1 “Agreement”** means this Group Medical and Hospital Service Agreement, including but not limited to the Evidence of Coverage which may be updated from time to time in compliance with regulatory requirements, any and all applications and information submitted by the Group and Members in applying for Coverage, all attachments and addenda and any amendments that may be added in the future.
- This Agreement contains the exact terms and conditions of Coverage. It incorporates all of the contracts, promises, and agreements exchanged by the Group and the Plan. It replaces any and all prior or concurrent negotiations, agreements, or communications, whether written or oral, between both parties with respect to the contents of the Agreement.
- 1.2 “Benefit Plan”** means the Covered Services contained in this Agreement. Any date referenced in this Benefit Plan begins at 12:01 a.m., Pacific Standard Time.
- 1.3 “Cal-COBRA (California Continuation Benefits Replacement Act)”** means the California legislation that requires health plans to offer continued access to group health care coverage provided to Eligible Employee, of employers with 2 to 19 eligible employees who are not currently offered continuation coverage under COBRA and whose coverage would end due to termination, layoff, or other change in employment status. Cal-COBRA also means Subscribers have the opportunity of group continuation coverage when coverage would otherwise cease due to the termination of COBRA. Maximum benefit period is up to 36 months.
- 1.4 “Calendar Year”** means a 12-month period that begins on January 1 and ends 12 consecutive months later on December 31.
- 1.5 “Classic Network Plan”** means VHP’s \$0 Copayment Plan.
- 1.6 “COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)”** means the federal legislation that requires most employers with group health plans to offer employees the opportunity to continue temporarily their group health care coverage under the employer’s plan if their coverage otherwise would cease due to termination, layoff, or other change in employment status.
- 1.7 “Continuation Coverage”** means extended Coverage under this Benefit Plan for Subscribers enrolled in this Benefit Plan upon the occurrence of certain events and subject to the terms set forth in Section 7 of this Agreement.
- 1.8 “Copayment”** means a fee charged to a Member, which is approved by the Department of Managed Health Care of the state of California, provided for in this Agreement and disclosed in the Evidence of Coverage. Within 180 days after the end of any Calendar Year, a Subscriber may apply to Plan for a refund of the excess of Copayments paid over the Calendar Year in excess of the Copayment Maximum.

- 1.9 “Copayment Maximum”** is the maximum amount a Member is required to pay for Covered Services during a Calendar Year. Copayments paid for eyeglasses, Dental Services, or any other supplementary benefit(s) that may be covered under this Benefit Plan are not counted against the Copayment Maximum.
- 1.10 “Coverage”** means the right to receive Covered Services under this Agreement.
- 1.11 “Coverage Decision”** means the approval or denial of Covered Services by Plan or Plan Providers. A Coverage Decision does not include a Disputed Covered Service(s).
- 1.12 “Covered Service(s) or Benefit(s)”** means those Medically Necessary health care services and supplies which a Member is entitled to receive, and which are described in the Evidence of Coverage (EOC).
- 1.13 “Department of Managed Health Care” or “Department”** is the state regulatory agency responsible for the regulation or oversight of health care plans in California.
- 1.14 “Disenrollment”** means a Member’s voluntary withdrawal from the Benefit Plan.
- 1.15 “Effective Date of Coverage”** means the date that Coverage under the Benefit Plan begins. The precise Effective Date of Coverage may be obtained from your Benefits Administrator (Public Authority).
- 1.16 “Eligible Employee”** means an individual provider or eligible individual provider employee who is paid for working at least 35 hours or more for the two most recent months as reported through Case Management Information and Payrolling System (CMIPS) from the State Controller’s office, or as agreed in writing by Plan's administrator and Group Director.
- 1.17 “Evidence of Coverage”** means the Combined Evidence of Coverage and Disclosure Form(s) and any document(s) issued to Members setting forth the Covered Services to which Members are entitled and any limitations on, or exclusions from such Covered Services.\
- 1.18 “Grace Period”** means the 30-days after payment of premiums are due and have not been paid.
- 1.19 “Group”** has the meaning ascribed to that term in the preamble of this Agreement.
- 1.20 “HIPAA”** means the Health Insurance Portability and Accountability Act of 1996.
- 1.21 “Initial Eligibility Period”** means the period during which Eligible Employees may initially enroll in Plan, and is further defined as follows:
- (A) For Group’s employees who are or will be Eligible Employees on the initial Effective Date of Coverage under this Agreement, the Initial Eligibility Period is the 31-day period prior to the Effective Date of Coverage.

(B) For future employees of Group who were not Eligible Employees on the Effective Date of Coverage, the Initial Eligibility Period is the applicable Group Waiting Period.

- 1.22** “**Member**” is any Subscriber who is enrolled in the Benefit Plan in accordance with the applicable eligibility requirements.
- 1.23** “**Network**” is a health care delivery service system within the Service Area, made up of Plan Physicians (such as Primary Care Providers and Plan Specialists), Plan Facilities, and Plan Hospitals.
- 1.24** “**Open Enrollment Period**” means a period of no less than 30 calendar days or as defined by the Group and agreed upon by the Plan, and that occurs at least once annually. The Open Enrollment Period is a time, during which all Eligible Employees are given the opportunity to enroll in the Plan.
- 1.25** “**PHI**” means Protected Health Information.
- 1.26** “**Plan**” or “**VHP**” means the Santa Clara County, doing business as Valley Health Plan, licensed under the Knox-Keene Health Care Service Plan Act of 1975, as amended.
- 1.27** “**Premiums**” means the prepayment fees paid by or on behalf of Members in order to be entitled to receive Covered Services.
- 1.28** “**Service Area**” means Santa Clara County and the geographic area, established by Plan and approved by the Department of Managed Health Care, where Plan provides health care services to Members.
- 1.29** “**Subscriber**” means the person whose employment or other status, is the basis for eligibility, who meets all applicable eligibility requirements of Section 2 (Eligibility) and who has enrolled in accordance with that section.

SECTION 2 – ELIGIBILITY

2.1 SUBSCRIBER ELIGIBILITY

A. “Eligible Individual Provider Employee also known as Eligible Employee means an employee who is an individual provider who is paid for working at least 35 hours or more for the two most recent months as reported through Case Management Information and Payrolling System (CMIPS) from the State Controller’s office, or as agreed in writing by Plan's administrator and Group Director.

B. Group Waiting Period:

i. Present Eligible Employees become eligible to enroll on the Effective Date of Coverage.

ii. Future Eligible Employees become eligible to enroll on the first day of the month following verification of paid hours and following completion of a waiting period of continuous service. Paid hours must be a minimum of 35

hours.

- C. Provider Network Plan Designs include a Classic Network Plan and a Preferred Network Plan approved by the DMHC. Group determines eligibility into the Provider Network Plan Designs based on Group Waiting Periods.

- i. Individuals enrolled in the Classic Network Plan shall be eligible to move between Classic Network Plan Providers at any time.

Upon termination of eligibility, such Eligible Employees, if re-enrolled shall only have access to the Preferred Network Plan.

- ii. All newly Eligible Employees will be enrolled in the Preferred Network Plan.

- D. Eligible Employee dependents, survivors, retirees and their survivors are not eligible for Coverage.

- E. Note: While the term “employee” is used in this Agreement, neither the County of Santa Clara nor the Plan is the common law employer of any individual who is eligible for coverage under the Plan and, therefore, neither is responsible for complying with any statutory or regulatory requirement applicable to employers with respect group health plan coverage they sponsor. The term “employee” is used for convenience only.

- F. To be eligible to enroll in Plan as a Subscriber, an individual must be an Eligible Employee of the Group and meet the requirements below:

- G. Prior to enrollment, the individual who is the Eligible Employee must (i) continuously reside or work within the Service Area, (ii) be entitled to Group employee benefits, the premiums for which are paid by or through Group, (iii) meet the applicable Group Waiting Period or any applicable statutorily authorized requirements, and (iv) the individual must be actively engaged prior to enrollment in the conduct of the business of the Group, with a normal work month of at least 35 hours, at the Group’s designated place(s) of business.

2.2 DEPENDENT ELIGIBILITY

Dependent spouse/domestic partner or Children of Subscriber/spouse/domestic partner are not eligible for enrollment.

2.3 OTHER RULES OF ELIGIBILITY

No person is eligible to enroll or re-enroll if such person’s Coverage under this Agreement, or under any other large group agreement with Plan has been terminated for:

- (A) Nonpayment by such person; or
- (B) Fraud or other intentional misrepresentation of material fact by such person.

No person who is otherwise eligible will be refused enrollment because of their pre-existing conditions.

2.4 GROUP'S ELIGIBILITY RULES; OBLIGATIONS

Group's eligibility requirements for Coverage in effect on the Effective Date of Coverage are material to the execution of this Agreement by Plan. No change in Group's eligibility or participation requirements shall affect the requirements for eligibility or enrollment under this Agreement unless such changes are agreed to in writing by Plan.

Group agrees to accept the responsibility for furnishing current electronic eligibility information and Plan may rely upon the latest information received as correct without further verification. Eligibility data to include: first name, last name, address, city, zip, phone number, date of birth, effective date, gender, language spoken and written, race, and ethnicity. Unless otherwise agreed to in writing by Plan and Group, Plan will not refund to Group any Premiums paid for an ineligible person if the request for such refund is made later than 60 days after the receipt of payment by Plan for said ineligible person.

Plan reserves the right to verify eligibility data maintained by Group and to review all employee records maintained by Group as they relate to establishment and maintenance of eligibility for Plan membership.

2.5 MEDICARE ELIGIBLE MEMBERS

If Group employs 20 or more employees for each working day in each of 20 or more weeks in the current Calendar Year or the preceding Calendar Year, and thus is obligated to comply with the Tax Equity and Fiscal Responsibility Act (TEFRA) laws and regulations, as amended, then Subscribers who are:

- (A) Employees actively at work and who are age 65 or older, and/or
- (B) Who elects Coverage under this Agreement, will be subject to the same benefits, prepayment fees, and other conditions as other Members.

Plan will provide primary Coverage with respect to such active employees.

Except as otherwise provided in the next paragraph, if Group normally employs at least 100 employees on a typical business day during the previous Calendar Year, then Members under age 65 who are entitled to Medicare based on disability shall be subject to the same benefits, prepayment fees, and other conditions as other Plan Members, and Plan will provide primary Coverage with respect to such disabled Members.

Irrespective of the number of employees of Group, Members who are under age 65 and who are entitled to Medicare solely on the basis of End Stage Renal Disease shall, for a period of 30 months from inception of Medicare eligibility, or such other period as may be required by law, be subject to the same benefits, prepayment fees and other conditions as other Plan Members, and Plan will provide primary Coverage to such Members for such time period. Notwithstanding any other limitation contained herein, Members who have End Stage Renal Disease (whether or not entitled to Medicare) will also be subject to the same benefits and the same prepayment fees as other Plan Members who do not have End Stage Renal Disease, provided that following the 18-month period or such other period as may be required by law, Plan will provide secondary Coverage with respect to such Members who are Medicare eligible.

2.6 REPLACEMENT COVERAGE

Whereas this Agreement provides replacement Coverage within 60 days after the discontinuance of a prior group HMO contract or insurance policy, then all persons who were validly covered under the previous contract or policy at the date of discontinuance and who otherwise meet the eligibility requirements of this Agreement are eligible to enroll, subject to the limitations of this paragraph and the paragraphs below.

Members who are initially eligible and enrolled under the paragraph above, qualify for full benefits under this Agreement upon meeting all eligibility requirements and complying with the enrollment requirements set forth below in the paragraphs entitled Enrollment. Full Coverage will commence as described in paragraphs entitled Commencement of Coverage as if the Member became newly eligible and enrolled after the Effective Date of Coverage.

2.7 COMMENCEMENT OF COVERAGE

After fulfilling all conditions of enrollment as stated above, and provided that the Premiums have been paid and all other conditions of this Agreement, have been met, Coverage will commence as follows:

- (A) For a Subscriber who is enrolled on the original Effective Date of Coverage, Coverage will commence as of the Effective Date of Coverage;
- (B) For a Subscriber who is enrolled after the Effective Date of Coverage, Coverage is effective as of the first day of the month following the month in which the Subscriber satisfies the Group's eligibility criteria;
- (C) For any Subscriber who applies for enrollment or re-enrollment during the Group's Open Enrollment Period, Coverage is effective as of the first day of the month following Open Enrollment. However, no enrollment shall be effective unless the Member's completed application is received by Plan within 31 days after such Coverage was to become effective.

SECTION 3 - ENROLLMENT

Each person eligible to become a Subscriber, who submits to Group, and Group receives, a complete membership application for themselves on forms provided or approved (prior to use by Group) by Plan no later than 31 days after they first becomes eligible (see Section 1 definition "Initial Eligibility Period"), and who has fulfilled the requirements of this Section 3, shall have fulfilled the conditions of enrollment.

If an application for membership as a Subscriber is not received by Group within 31 days after a person first becomes eligible to become a Subscriber, Group will refuse such membership until the Group's next Open Enrollment Period.

Applicants for membership must complete and submit to Group such applications or other forms or statements as Group may reasonably request. Subscribers represent that all information with respect to Subscriber information contained in such applications, questionnaires, forms or statements submitted to Group incident to enrollment under this Agreement or the administration hereof shall be true, correct and complete and all rights to benefits hereunder are subject to the condition that all information shall be true, correct and complete.

At the time of enrollment, all Members must designate a Primary Care Provider, who will be responsible for the coordination of Member's health care. If an enrollment form is received without selection of a Primary Care Provider, Plan will assign a Primary Care Provider, but the Member may request a change to another Primary Care Provider. If a Member wishes to change Primary Care Providers, the Member must first contact Plan and follow the instructions which are provided.

SECTION 4 – FEES AND CHARGES

4.1 PREPAYMENT FEES

Group will pay Premiums in the amounts and on the dates set forth in the Premium Rate Schedule attached hereto as Exhibit A and incorporated herein by this reference, as amended from time to time as provided herein. Any contribution to the Premium by Subscriber will be arranged solely by and between Group and Subscriber.

Only Members for whom payment is received by Plan are entitled to Covered Services under this Agreement for the period for which such payment is received.

Unless otherwise stated on the Premium Rate Schedule, Premiums will be paid by Group to Plan at its offices on the last day of each calendar month, as payment for Coverage in the succeeding calendar month. If a Member is no longer eligible to receive Coverage under this Agreement and the Group has paid Premiums for this Member after the Member was eligible, the Group will receive credit for any such Premiums paid for the Member's Coverage, provided Group has notified Plan in writing within 60 days after the Member is no longer eligible and Plan has not provided or arranged any Medical or Hospital Services for the Member within these 60 days.

If payment of Premiums is not received by Plan from Group by the last day of the month prior to the effective benefit month, Plan will issue a 30-Day Grace Period Notice to Group. Group must issue a 30-Day Grace Period notice to its members. If payment of Premiums is not made within the 30-Day Grace Period, Plan will terminate coverage and Group will send a Notice of Cancellation to its Subscribers within five (5) calendar days of the cancellation.

If Group defaults in the payment of Premiums and any undisputed amount remains due, Group will pay to Plan a late payment penalty in an amount equal to one and one-half percent of the Premiums past due. Such late payment penalty is due and payable with the Premiums then owing to Plan.

4.2 OTHER CHARGES

Members will be required to make certain Copayments, as described in Exhibit B, Copayment Schedule, for Covered Services which must be paid at the time the Covered Services are rendered. Plan will send periodic notices to Member informing them of the total amount of copayments incurred. Within 180 days after the end of any Calendar Year, a Member may apply to Plan for a refund of the excess of Copayments paid over the Calendar Year in excess of the Copayment Maximum.

4.3 CHANGES IN FEES AND CHARGES

Plan reserves the right to change the Premiums or Copayments for any reason, on any renewal date of this Agreement, provided that written notice of such change must be emailed, mailed, or hand delivered

to Group and Member(s) at least 60 days in advance of the renewal date on which such change is to take effect.

Plan will have the right to change the Premiums or Copayments as agreed to by Group as of any date during the Agreement period. Plan or Group will give written notice 30 days before such change in Premiums or Copayments take effect.

Payment of any Premiums as changed in accordance with this section constitutes acceptance of continued Coverage at the changed Premiums.

4.4 PREMIUMS AND HEALTH CARE BENEFITS RATIO

Beginning January 1, 2011, regulations require that VHP spends on average at least 85% of premiums on health care benefits, this requirement is known as a "medical loss ratio" or "minimum loss ratio" (MLR). MLR is the ratio of administrative costs, including taxes and fees, versus medical costs.

Premiums are adjusted on an annual basis and are outlined in the Agreement.

SECTION 5 – RECORDS

5.1 MAINTENANCE OF RECORDS

Plan will keep a record of Members. Group will forward the information periodically required by Plan in connection with the administration of this Agreement. Plan's liability for the fulfillment of any obligation that is dependent on information to be furnished by Group or Member shall not arise prior to receipt of that information in the form requested by Plan. Nor will Plan be liable for any obligation resulting from information incorrectly supplied by Group or Member. All records of Group, which have a bearing on Coverage, will be open for inspection by Plan at any reasonable time. Plan adheres to HIPAA and protects PHI as required by law.

5.2 SUBMISSION OF CORRECT INFORMATION BY MEMBER

Members or applicants for membership will be required to complete and submit to Plan such applications, medical review questionnaires, or other forms or statements as Plan may reasonably request. Members will be required to declare that all information contained in such applications, questionnaires, forms or statements submitted to Plan incident to enrollment under this Agreement or the administration hereof will be true, correct, and complete. Any breach of this warranty may give rise to termination of Coverage as provided in Section 6 (Term, Cancellation and Related Provisions).

5.3 CONFIDENTIALITY

Information from medical records of Members and information received from physicians, surgeons, or hospitals pursuant to the doctor-patient relationship will be kept confidential; and, except for use incident to bona fide medical research or education, or reasonably necessary in connection with the administration of this Agreement, the aforementioned information will not be disclosed without the written consent of Member or as required by law. Plan adheres to HIPAA and protects PHI as required by law.

SECTION 6 – TERM, CANCELLATION AND RELATED PROVISIONS

6.1 TERM

This Agreement will continue in effect for the term indicated in the Declarations; provided however, that Plan reserves the right to change the Premiums set forth in the Premium Rate Schedule and the benefits and coverages herein, on each anniversary date of this Agreement. This Agreement will renew automatically from year to year on the anniversary date unless a new agreement is negotiated between the Plan and Group, or terminated pursuant to this section, and subject to any changes in Premiums, other charges, benefits and coverages pursuant to Section 4 (Fees and Charges), and the paragraph entitled “Change in Agreement” under Section 8 (General Provisions).

6.2 EFFECT OF CANCELLATION

Upon termination of this Agreement and/or an individual Member’s Coverage under this Agreement, all rights of Group’s Members or such individual Member to receive Covered Services hereunder are terminated subject to any applicable provisions for reinstatement, temporary continuation of benefits, Continuation Coverage or extension of benefits. Cancellation of this Agreement cancels Coverage for all Subscribers of Group.

This Agreement and/or an individual Member’s Coverage may be cancelled for the reasons identified below. When cancelled, all Coverage and rights hereunder will terminate at the time indicated below. Any benefits or services received after the effective cancellation date will be directly chargeable to the Member.

6.3 CANCELLATION OF INDIVIDUAL MEMBERS

6.3.1 Loss of Eligibility

If a Member ceases to meet the eligibility requirements of Section 2 (Eligibility), then (subject to any applicable provisions for continuation of benefits and payment of Plan premiums) the Member’s Coverage terminates at midnight on the last day of the month in which Group verifies the Member has failed to meet the eligibility requirements for two consecutive months. Group and Members agree to notify Plan immediately if a Member ceases to meet the eligibility requirements. As of October 1, 2014, if a Member in the Classic Plan loses eligibility for Coverage, they do not qualify to re-enroll in the Classic Plan and are only eligible to enroll in the Preferred Plan in the future.

6.3.2 Disenrollment by Member

If a Member elects coverage under an alternative health benefits plan offered by or through Group as an option in lieu of Coverage under this Agreement, then Coverage for such Member terminates automatically at the time and date the alternate coverage becomes effective. In such event, Group agrees to notify Plan immediately that the Member has elected coverage elsewhere.

Member may voluntarily disenroll from Plan at any time for any reason by notifying Group of the intent to cancel membership. The Member’s Coverage terminates at

midnight on the last day of the month in which the final premium was received by the Plan.

6.3.3 Cancellation of Members for Cause

(A) **Nonpayment.** If a Member fails to pay or fails to make satisfactory arrangements to pay any Premium due Group, then Coverage may be cancelled following a notice of cancellation. Notice of a 30-day Grace Period may be mailed or hand delivered by the Group. If the Member fails to pay the Premium due within the 30-day Grace Period, the Group must send a Notice of End of Coverage to the Member within 5 calendar days after the Member's coverage has ended.

(B) **Fraud or Deception.**

Plan may terminate Member with 30 days' notice if:

Member commits Fraud in connection with membership, Plan, or a Plan Provider. Some examples of Fraud include:

- Intentional failure to furnish material information required in connection with the enrollment under the Agreement, such as knowingly misrepresenting material eligibility or enrollment information, or intentionally giving incorrect or incomplete material enrollment information in any document, or if Member fails to intentionally notify Plan of material changes.
- Engage in an intentional misrepresentation of material fact in the use of the services or facilities of Plan, Plan Providers, or Non-Plan Providers.
- Unauthorized use of a Plan ID Card by permitting a non-Member to use a Member's Plan ID Card to obtain Benefits.

Member may use the Grievance procedure to contest an involuntary Disenrollment or Termination for cause. Refer to Member Grievance Section of the *Evidence of Coverage*.

6.4 CANCELLATION OF ENTIRE AGREEMENT

6.4.1 Nonpayment

If the Group fails to pay when due any undisputed Monthly Premium on behalf of each Member, then Plan will send "Notice of Start of Grace Period" to Group. This notice will begin a 30-day grace period. The Group is also required to send the "Notice of Start of Grace Period" to its members.

The Agreement will be terminated on the day after the 30-day grace period ends if payment from the Group was not received on or before the last day of the Grace Period. If the Agreement is terminated, Group is required to send the Subscriber a "Notice of End of Coverage" within 5 calendar days after the Coverage ended. If the Member is undergoing treatment for a medical condition, services provided beyond the date of Termination will be the financial responsibility of the Member unless they are covered by continuation Coverage through VHP.

6.4.2 Fraud

If Group knowingly furnishes materially incorrect, incomplete or misleading enrollment or other requested information regarding Group, its business, or any Member; or if Group knowingly permits fraud or deception by any of its Members, Plan may give Group written notice of termination. Group will promptly mail to each Subscriber a legible, true copy of the notice of termination and will promptly provide Plan proof of such mailing and the date thereof. Termination will be effective 30 days after the notice is mailed to the Subscriber.

6.4.3 Cancellation by Group

This Agreement may be terminated by Group by giving 60 days prior written notice to Plan. In such event, all rights to benefits hereunder cease as of the effective date of termination of this Agreement regardless of whether a condition or course of treatment commenced while Coverage was in effect. Plan has no obligation to notify Subscribers in the event of such termination by Group. Group will promptly notice each Subscriber of Group's termination of Plan Agreement. Such notice will be to all Members on COBRA or Cal-COBRA and notification will be provided as required by Section 1366.25 of the Health and Safety Code.

6.4.4 Cancellation by Plan for Cause

Plan may decline to renew or may terminate this Agreement for material noncompliance with or breach of this Agreement (collectively, "Breach"), which Breach is not cured by Group within 60 days after notice to the Group of the nature of the Breach. If such Breach cannot be cured within such 60-day period, then the commencement of such cure within such 60-day period and its diligent prosecution to completion will automatically rescind the notice of termination. In the event of nonrenewal or termination, Group will promptly mail to each Subscriber a legible, true copy of the notice of termination and will promptly provide Plan proof of such mailing and the date thereof.

Plan may decline to renew or may terminate this Agreement if Plan ceases to provide or to arrange for the provision of health care services for new health benefit plans in this state. In the event of such termination, Plan will give written notice to Group by mail (postage prepaid) or hand delivery at least 180 days in advance of the effective date of such termination.

6.5 NOTICE OF CANCELLATION

6.5.1 Notice When Individual Member's Coverage is Cancelled

If Group cancels or refuses to renew an individual Member's enrollment under this Agreement, Group will mail notice thereof to the Subscriber at the Subscriber's address of record or hand deliver such notice to the Subscriber.

6.5.2 Notice Where Agreement with Group is Cancelled

If Plan cancels or refuses to renew this Agreement, the following provisions will apply

regarding notice to all Subscribers of Group:

- (A) Group's Obligation to Give Notice. If Plan mails or hand delivers a notice of cancellation to Group (by mail addressed to or by hand delivery to the person signing this Agreement on behalf of Group or such person's successor) with instructions that Group give notice to all Subscribers under this Agreement, then Group will promptly mail a legible, true copy of such notice to each Subscriber under this Agreement at the Subscriber's current address. Group will promptly provide proof of such mailing and the date thereof to Plan.
- (B) Plan's Obligation to Give Notice. If Plan does not mail or deliver a notice of cancellation to the Group with instructions that Group give notice to Group's Subscribers, Plan will mail a notice of cancellation to each Subscriber under this Agreement at each Subscriber's address of record with Plan.

6.6 CESSATION OF COVERAGE

Plan does not cover any services or supplies provided after the effective date of termination of this Agreement or of a Member. Coverage ceases regardless of whether a condition or course of treatment commenced while Coverage was in effect. The only exceptions are the provisions set forth in Section 7 (Individual Continuation of Group Benefit), where applicable. Where termination is for fraud or for any of the reasons set forth in Paragraph 6.3.3 (Cancellation of Members for Cause), Members are not entitled to individual continuation of group benefits set forth in Section 7.

6.7 REINSTATEMENT

Receipt by Plan of the proper Monthly Premium after termination of Group for non-payment of Premiums not under good faith dispute will reinstate Group as though there never was a termination, if such payment is received on or before the due date for the succeeding Monthly Premium, unless:

- (A) In the notice of termination, Plan notifies Group that if payment is not received within 30 days, a new application is required and the reasonable conditions on which a new contract will be issued or the original contract reinstated;
- (B) Such payment is received more than 30 days after issuance of the notice of termination, and Plan refunds such payment within 20 business days; or
- (C) Such payment is received more than 30 days after issuance of the notice of termination, and Plan issues to Group within 20 business days or receipt of such payment, a new contract accompanied by written notice clearly stating those aspects in which the new contract differs from the canceled contract in benefits, coverage or otherwise.

6.8 REFUNDS IN THE EVENT OF CANCELLATION

In the event of cancellation by either Plan or Group, Plan will return to Group, within 30 days of the effective cancellation date, the pro rata portion of the Premiums paid to Plan which correspond to any unexpired period for which payment had been received together with amounts due Members on claims for reimbursement of charges (for Covered Services) incurred prior to the effective date of termination, if any, less any amounts due Plan or Plan Providers, and neither Plan nor Plan Providers has any further liability or responsibility under this Agreement. However, no such refund will be made where

cancellation is in the case of fraud or deception in the use of services or facilities of Plan or knowingly permitting such fraud or deception by another.

6.9 MEMBER'S RIGHT TO REVIEW OF CERTAIN CANCELLATIONS

A Member who alleges that Member's Coverage, subscription or enrollment has been cancelled or not renewed because of the Member's health status or requirements for health care services, may request a review by the California Department of Managed Health Care.

SECTION 7 – INDIVIDUAL CONTINUATION OF GROUP BENEFIT

7.1 CONTINUED GROUP COVERAGE UNDER COBRA/CAL-COBRA

Under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), an employer who maintains a group health plan and employs 20 or more employees on a typical business day during the prior Calendar Year is required to provide Members with the opportunity to elect to continue their Coverage in certain circumstances where Coverage would otherwise terminate. Similarly, under the California Continuation Benefits Replacement Act ("Cal-COBRA"), an employer who maintains a group health plan, employs two to 19 employees on at least 50% of its working days in the prior Calendar Year (or previous calendar quarter, if the employer was not in business during any part of the preceding year), and is not subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement or Income Security Act is required to offer Continuation Coverage in certain circumstances where Coverage would otherwise terminate. Such employers and their group health plan's administrators (in certain cases, the employer may be the plan administrator) have the obligation to: (1) provide Members with notice of the opportunity to elect Continuation Coverage; and (2) administer the Continuation Coverage.

The obligation to provide notice includes general notification to Members of their right to elect Continuation Coverage. In addition, each Member must be provided notification of the right to Continuation Coverage within a specific time period after the occurrence of the event, which triggers the Continuation Coverage option. In the event that Group terminates the Agreement, Group must notice Members either 30 days prior to the termination of Agreement, or when all enrolled employees are notified, whichever is later. Group must ensure that the notice is distributed to its Continuation Coverage Members and that these Members are eligible to enroll in continuation coverage in any successor health plan that Group enrolls in.

Group hereby acknowledges its legal obligations and agrees to abide by applicable legal requirements with respect to Continuation Coverage. Group also agrees to forward to Plan in a timely manner copies of any notice regarding Continuation Coverage provided to Members. Group further acknowledges that in the event a Subscriber is terminated by Group because of gross misconduct, the Group will notify Plan immediately or within ten days of termination of employment; such Subscriber would not be eligible for Continuation Coverage.

7.1.1 Eligibility for Continuation of Coverage

The following persons are entitled to elect Continuation Coverage:

- (A) Subscribers whose Coverage under this Agreement ends because of termination of Subscriber's employment (unless employment is terminated because of gross

misconduct), or whose Coverage terminates because of a reduction in hours of employment, have the right to elect Continuation Coverage for themselves;

- (B) Certain retired Subscribers whose employer files for bankruptcy under Chapter 11 may be eligible for Continuation Coverage. (Special rules apply in this instance and employees should consult their employer or plan administrator.)

The occurrence of an event that causes any Member to be entitled to elect Continuation Coverage is referred to herein as a “qualifying event”.

7.1.2 Maximum Time Periods of Coverage

Continuation Coverage begins on the date of the event that would otherwise trigger the loss of Coverage under this Agreement and terminates no later than 36 months thereafter, except if Coverage for the Subscriber ends because of the termination or reduction in hours of Subscriber’s employment. In that instance, Continuation Coverage will terminate no later than 18 months thereafter; provided, however, that:

- (A) If the Subscriber notifies the plan administrator within 60 days after the date of a determination, under Titles II or XVI of the Social Security Act, that he or she was disabled at any time within the first 60 days of Continuation Coverage, Coverage will terminate no later than 29 months thereafter.
- (B) If during the 18-month period or, where applicable, 29-month period from the date of the termination or reduction in hours of Subscriber’s employment, or the event described in subsection 7.1.1 (B) above occurs, Coverage under this Agreement will terminate no later than 36 months from the date of the termination of employment or reduction in hours.
- (C) If the Subscriber notifies the employer or plan administrator within 60 days after the date of a determination, under Section 1366.29 of the Health and Safety Code, that he or she has exhausted continuation coverage under COBRA, Coverage will terminate no later than 18 months from the COBRA termination. Continuation Coverage under this subsection 7.1.2 (C) will terminate no later than 36 months from the date of the qualifying event.

7.1.3 Exceptions to Maximum Time Periods of Coverage

Notwithstanding the maximum time periods set forth above, Continuation Coverage will end upon the occurrence of any one of the following events:

- (A) On the date Group ceases to provide any group health plan to any employee. For purposes of this Section 7 the term “employer” is that term as defined under COBRA and applicable regulations; provided, however, that if Group employs two to 19 employees, then the term “employer” shall have the meaning ascribed to it under Cal-COBRA and applicable regulations;
- (B) On the date Member becomes covered under another health plan which does not contain any exclusion or limitation with respect to any preexisting condition of the Member;

- (C) On the date Member is enrolled for Medicare benefits; or
- (D) In the case of the 11-month extended Coverage provided due to a disability, on the first (1st) day of the month which starts at least 30 days after a final determination, under the Social Security Act, that Member is no longer disabled.

7.1.4 Type of Coverage

Coverage provided under the Continuation Coverage option will be identical to the Coverage Group provides to similarly situated persons who have not lost group Coverage under this Agreement. Continuation Coverage will not be conditioned on evidence of insurability.

7.1.5 Premiums

Group may require the Member to pay for Continuation Coverage as long as the amount does not exceed 102% of the applicable premium, except that:

- (A) In the case of a Member who is entitled to the 11-month extended Continuation Coverage period as a result of a disability, such Member may be required to pay up to 150% of the applicable premium for the Coverage during that extended period of Coverage.
- (B) In the case of a Member who is entitled to up to the 18-month extended Continuation Coverage period as a result of exhausting continuation coverage under COBRA Coverage, such Member may be required to pay up to 110% of the applicable premium for the Coverage during that extended period of Coverage.

“Applicable premium” for any 12-month period of Continuation Coverage under (A) and (B) above means the Premium paid by the Group to Plan for such Coverage during the period for similarly situated persons who did not lose Group Coverage under this Agreement.

Group will remit to Plan the Premiums for Members who elect Continuation Coverage with Group’s regular monthly payment. If Group requires a Subscriber electing Continuation Coverage to pay all or any part of the Premiums for such Continuation Coverage, Group will be solely responsible for collecting those Premiums. Group agrees that Continuation Coverage will be provided only for persons eligible for such Continuation Coverage under applicable law and regulations and for whom applicable Premiums have been received by Plan.

Plan will provide Group a grace period of 30 days prior to terminating Coverage for failure to pay premium. However, Group will immediately notify Plan if the Group fails to receive the Member’s Premiums on the due date. If a Member elects Continuation Coverage after the date of the event which entitles them to Continuation Coverage, Group must remit the first premium retroactive to the date Coverage would otherwise have terminated within 45 days of the date of the election. No grace period applies to

this first premium.

Eligible persons will be terminated from Coverage upon a qualifying event but will be enrolled retroactively to the qualifying event upon timely election of Continuation Coverage under COBRA [or Cal-COBRA]. If an eligible person requires services before election, the eligible person must either (1) elect and pay for the Coverage or (2) pay Reasonable Charges (i.e., reasonable and customary charges) for the services subject to reimbursement by Plan within 30 days of such person's timely election of Continuation Coverage under COBRA [or Cal-COBRA].

7.1.6 Notice of Qualifying Event

In the event of eligibility for Continuation Coverage due to divorce, legal separation, or the exhaustion of continuation coverage under COBRA, the Member has the responsibility to notify the administrator of Group's health benefit plan of such qualifying event within 60 days after the date of such event. If the Member fails to give that notice within the 60-day period, he or she will not be entitled to Continuation Coverage. The plan administrator is designated in the document establishing Group's health benefits plan. In the absence of such designation, the administrator is the employer. Group must notify the plan administrator (if Group and plan administrator are not the same) within 30 days of the occurrence of any other qualifying event. In turn, the plan administrator is obligated to notify Subscriber of the opportunity to elect Continuation Coverage within 14 days after receiving notice of the qualifying event.

7.1.7 Nonliability of Plan

Plan will cooperate with Group to assist Group in meeting its obligations regarding Continuation Coverage, provided that, except as otherwise set forth in the following subsection, Plan assumes no responsibility for Group's compliance with Group's obligations under federal laws or regulations concerning Continuation Coverage. Group hereby indemnifies and holds Plan harmless from any and all claims, liability and expenses arising out of Group's failure to comply with its obligations under federal laws or regulations regarding Continuation Coverage.

7.1.8 Coordination of Covered Services

If a Member who has elected Continuation Coverage under this Agreement subsequently becomes covered under another group health care plan or policy which has an exclusion for preexisting conditions, the Continuation Coverage under this Agreement will be secondary to coverage under such other plan or policy; except that the Continuation Coverage under this Agreement will be primary with respect to the preexisting conditions which are excluded under such other group plan or policy.

7.1.9 Regulations

If federal or state laws or regulations are enacted or issued governing Continuation Coverage and the application of such laws or regulations would modify this section regarding benefits under COBRA [or Cal-COBRA], such laws or regulations will supersede any contrary provision provided herein.

7.2 CONTINUED GROUP COVERAGE AFTER TERMINATION OF COBRA

If a Subscriber elects to extend group health benefits under COBRA [or Cal-COBRA], the Subscriber may be entitled to an extension of those group health benefits after COBRA [or Cal-COBRA] benefits terminate. Group must notify the Subscriber if they are eligible for extended benefits upon termination of Continuation Coverage under COBRA [or Cal-COBRA].

COBRA enrollees who reach the 18-month or 29-month maximum available under COBRA may elect to continue coverage under Cal-COBRA for a maximum period of 36 months from the date the Member's continuation coverage began under COBRA. If elected, the Cal-COBRA coverage will begin after the COBRA coverage ends. Group or Group COBRA administrator will notify Member of eligibility to continue coverage under Cal-COBRA. Member has 60 days from that notification to contact VHP to continue Group Coverage under Cal-COBRA.

Note: COBRA enrollees must exhaust the entire COBRA coverage to which they are entitled before the Member can become eligible to continue coverage under Cal- COBRA.

In no event will continuation of Group Coverage under COBRA, Cal-COBRA, or a combination of both be extended for more than three years from the date such Coverage began.

7.3 EXTENSION OF BENEFITS

Except as expressly provided in this section, all rights to services and other benefits hereunder terminate as of the effective date of termination of this Agreement.

If, when this Agreement is terminated as to the entire Group, a Member is receiving treatment for a condition for which benefits are available under this Agreement and which condition has caused such Member to be Totally Disabled as determined by Plan, then such Member will be covered, subject to all limitations and restrictions of this Agreement, including payment of Copayments and the Monthly Premium, for Covered Services directly relating to the condition causing the Member to be Totally Disabled. This extension of benefits terminates upon the earlier of (1) the end of the twelfth month after termination of this Agreement, or (2) the date the Member is no longer Totally Disabled as determined by Plan, or (3) the date the Member's coverage becomes effective under any replacement contract or policy without limitation as to the disabling condition. A person is Totally Disabled if he or she satisfies the definition of Totally Disabled in this Agreement.

If Plan terminates this Agreement for cause as specified in Paragraph 6.4.4 (Cancellation by Plan for Cause), any Member who is a registered bed patient in a hospital at the effective date of termination will, subject to payment of the periodic prepayment fee and applicable Copayments, receive all benefits otherwise available hereunder to institutionalized patients for the condition under treatment during the remainder of the particular episode of institutionalization, until either (1) the expiration of such benefits or (2) determination by Plan that hospitalization is no longer Medically Necessary, whichever occurs first.

If prior to termination there has been no default in the payment of the Monthly Premium or those made on the Member's behalf, and the Subscriber are receiving inpatient obstetrical care at the date of termination, Plan will continue Coverage of the obstetrical care for the parent until discharge from the hospital.

SECTION 8 – GENERAL PROVISIONS

8.1 CHANGE IN COVERED SERVICES

Plan will not decrease Covered Services during the term of this Agreement except as agreed to in writing between Group and Plan; however, Plan may decrease Covered Services with at least 90 days written notice prior to the effective renewal date of the Agreement. Such written notice will be made by postage-paid mail to the Group or will be hand delivered to the Group.

8.2 SERVICES NON-TRANSFERABLE

No person other than a Member is entitled to receive Covered Services under this Agreement. Such right to Covered Services is not transferable.

8.3 WORKER'S COMPENSATION INSURANCE

This Agreement is not in lieu of and does not affect any requirement of coverage by Workers' Compensation insurance. All benefits paid or payable by Workers' Compensation for Covered Services are payable to Plan under the paragraph entitled "Third Party Responsibility" in Section 9 (Limitations).

8.4 RULES AND CRITERIA

Plan may adopt reasonable policies, procedures, rules, criteria and interpretations to promote orderly and efficient administration of this Agreement.

8.5 NO MEMBER LIABILITY FOR PLAN'S FAILURE TO PAY PLAN PROVIDERS

As required by law, every contract between Plan and a Plan Provider specifies that if Plan fails to pay such Plan Provider, the Member will not be liable to the Plan Provider for any sums owed by Plan.

8.6 MEMBER LIABILITY TO NON-PLAN PROVIDERS

The Member may be liable to such Non-Plan Provider for the cost of such Non-Plan Provider's services, unless Prior Authorization has been obtained from Plan or the services were Emergency Services.

8.7 PLAN LIABILITY FOR CHARGES

Upon termination of a Plan Provider contract, Plan will be liable for Covered Services (other than for Copayments) rendered by such Plan Provider for a Member under the care of such Plan Provider at the time of such termination until the Covered Services are completed, unless (i) Plan makes reasonable and medically appropriate provision for the assumption of such Covered Services by another Plan Provider or (ii) Plan arranges for the continuation of Covered Services by the terminated provider at the time of termination and at the request of a Member who is undergoing a course of treatment for one of the following conditions:

1. For an Acute Condition shall be provided for the duration of the Acute Condition.

2. For a Serious Chronic Condition shall be provided for a period necessary to complete the course of treatment and to arrange for a safe transfer to a Plan Provider. Completion of Covered Services shall not exceed 12 months.
3. For a Pregnancy shall be provided for the duration of the Pregnancy.
4. For a Maternal Mental Health Condition that impacts a person during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, completion of Maternal Mental Health Covered Services shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.
5. For a Terminal Illness Covered Services shall be provided for the duration of the Terminal Illness. Terminal Illness for continuity of care purposes is defined as an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of Covered Services shall be provided for the duration of a Terminal Illness, which may exceed 12 months from the Plan Provider contract termination date or 12 months from the Effective Date of Coverage for a new Member.
6. For the care of a newborn child between birth and age 36 months, completion of Covered Services shall not exceed 12 months.
7. For the performance of a surgery or other procedure that is Authorized by VHP as part of a documented course of treatment and has been recommended and documented by the current provider at the time of enrollment or Plan Provider termination. Completion of such surgical Covered Services must occur within 180 days.

8.8 NONDISCRIMINATION

Plan shall not refuse to enter into any contract, cancel or decline to renew or reinstate any contract, nor shall Plan modify the terms of a contract because of race, color, national origin, ancestry, religion, disability, sex, gender, gender identity, gender expression, marital status, sexual orientation, genetic characteristics, age (except as provided in Section 2, Eligibility), of any other classification prohibited by state or federal laws.

8.9 RELATIONSHIPS AMONG THE PARTIES

The relationship between Plan and Plan Providers is that of independent contractors. Plan Providers are not employees or agents of Plan nor is Plan nor any employee of Plan an employee or agent of Plan Providers. No Member is an agent or representative of Plan, its agents or employees, or Plan Providers, or any person or organization with which Plan made or will make arrangements for the performance of services under this Agreement.

Plan Providers maintain the provider-patient relationship with Members and are solely responsible to Members for all of their services. In no event will Plan be liable for the negligence, wrongful acts, or omissions by a Plan Provider in the course of delivery of services (regardless of whether such services are Covered Services), nor will Plan be liable for services or facilities which are unavailable to the Member for any reason beyond Plan's control. Neither Group nor any Member is the agent or representative of Plan and neither will be liable for any acts or omissions of Plan, its agents or employees, any Plan Provider, Medical Group or any other person or organization with which Plan has made or hereafter makes arrangements for the performance of services under this Agreement.

8.10 BINDING EFFECT UPON MEMBERS

By this Agreement, Group makes Plan Coverage available to persons who are eligible and duly enrolled under Section 2 (Eligibility). By enrollment or accepting services or benefits under this Agreement, Members legally capable of contracting and legal representatives of all Members incapable of contracting agree to all terms, conditions, and provisions hereof and thereby agree to be bound by this Agreement.

8.11 CHANGE IN AGREEMENT

The Plan may, at any time, add, amend, modify, or delete provisions in this Agreement by giving the Group 60 days written notice. Otherwise, this Agreement may not be changed, amended, or modified except in writing executed by the Group and Plan. This Agreement may be amended, modified or terminated in accordance with its terms, without the consent of the Members.

Notwithstanding the above, changes in premium rates or changes in coverage can only become effective (i) on the renewal effective date of the Agreement if the Plan gives the Group at least 60 days written notice prior to the renewal effective date or (ii) at any time in writing if executed by the Group and Plan.

Group understands that if there are changes required by the law Plan may request to modify this Agreement to maintain compliance with Applicable Requirements.

8.12 NONWAIVER

No delay or failure by Plan to exercise any right under this Agreement will be deemed a waiver of such right in the future. The provision by Plan of extra contractual benefits to a Member will not create any rights to extra contractual benefits, either to the same Member in the future or as to any other Member.

8.13 ASSIGNMENT

This Agreement is not assignable by Group without the prior written consent of Plan. The rights, benefits and any payments under this Agreement are not assignable by Members without the written consent of Plan.

8.14 NOTICES

Unless otherwise specified in this Agreement, the Group agrees to disseminate to its Members any disclosure forms, plan summaries or other notices regarding material matters in the next regular communication to such Members, but in no event later than 30 days after receipt thereof from Plan.

Notice will be sent by United States mail, first class, postage prepaid, addressed to:

To Plan: Valley Health Plan
2480 N. First Street, Suite 160
San Jose, California 95131
Attn: Chief Executive Officer

To Member: Member's last address known to Plan.

To Group: Group's last address known to Plan.

Director of Public Authority Services
Public Authority Services
by Sourcewise
3100 De La Cruz Blvd, Suite 310
Santa Clara, CA 95054

8.15 PARAGRAPH HEADINGS

The paragraph headings and captions of this Agreement are for ease of reference and will not limit, amplify or otherwise affect the meaning of any provision of this Agreement.

8.16 GOVERNING LAW

Plan is subject to the requirements of Chapter 2.2 of Division 2 of the California Health & Safety Code and applicable regulations developed by the Director of the Department of Managed Health Care as set forth in Title 28 of the California Code of Regulations. Any provisions required by either of the above will bind the parties to this Agreement whether or not provided in this Agreement.

8.17 ENTIRE AGREEMENT

This Agreement, addenda and membership applications constitute the entire agreement between the parties as of the Effective Date of Coverage and supersedes all other agreements between the parties. No representation by any broker, agent, or marketing representative or any other person will be binding upon Plan unless expressly set forth in this Agreement.

8.18 CONTRACT EXECUTION

Unless otherwise prohibited by law or County policy, the parties agree that an electronic copy of a signed contract, or an electronically signed contract, has the same force and legal effect as a contract executed with an original ink signature. The term “electronic copy of a signed contract” refers to a transmission by facsimile, electronic mail, or other electronic means of a copy of an original signed contract in a portable document format. The term “electronically signed contract” means a contract that is executed by applying an electronic signature using technology approved by the County.”

SECTION 9 – LIMITATIONS

9.1 CIRCUMSTANCES BEYOND PLAN’S CONTROL

If, due to circumstances not reasonably within the control of Plan, such as complete or partial destruction of facilities, major disaster, epidemic, war, riot, civil insurrection, or similar causes, the rendition of Covered Services is delayed or rendered impractical, then neither Plan nor any Plan Provider will have any liability or obligation on account of such delay or failure to provide or arrange for services, except that Plan will make a good faith effort to provide or arrange for such Covered Services under this Agreement within the limitations of such policies and personnel as are then available. In the case of labor disputes, the obligation of Plan will be to arrange and pay for an alternate method of receiving care.

9.2 NON-DUPLICATION OF BENEFITS

The benefits under this Agreement are not designed to duplicate any benefits for Members who are entitled to receive benefits under Workers' Compensation, employer liability laws, Medicare, or CHAMPUS. All sums paid or payable for Covered Services provided pursuant to this Agreement will be payable to and are deemed assigned to Plan. By executing an enrollment application, Subscriber agrees for themselves to submit to Plan the necessary claim forms, consents, releases, assignments and other documents reasonably requested by Plan, including enrollment under Parts A and B of the Medicare Program, in order to assist Plan in recovering the Reasonable Charges (i.e. reasonable value of services) provided to a Member who receives benefits covered under Medicare, CHAMPUS, the Workers' Compensation Law or any other health plan or insurance policy. Any Member who fails to submit such documents reasonably requested must pay charges for services received, as determined by Plan, and will be subject to termination. When a Member has available benefits with another health plan or insurance policy, Plan as a secondary payor will pay only the remaining allowable charges whether or not a claim is made to the primary payor. The fact that a Member has duplicate coverage in no way reduces the Member's obligation to make all required Copayments. The non-duplication provisions of this paragraph apply to the full extent permitted by law.

9.3 REIMBURSEMENT RESPONSIBILITY OF PLAN

If Plan for any reason beyond its control, is unable to provide Covered Services, then Plan will be liable for reimbursement of the expenses necessarily incurred by any Member in procuring the services through non-participating providers to the extent required by the California Department of Managed Health Care.

9.4 THIRD PARTY RESPONSIBILITY

In cases of injuries caused by any act or omission of a third party (including, without limitation, motor vehicle accidents and injuries and illnesses covered by Workers' Compensation) and complications incident thereto, Plan will furnish Covered Services. However, if any recovery from a third party is received on account of such injuries, Member will reimburse Plan for the value of the services and benefits, as set forth below. By executing an enrollment application, each Member grants Plan a lien on any such recovery and agrees to protect the interests of Plan when there is a possibility that a third party may be liable for a Member's injuries. Each Member specifically agrees as follows:

- (A) Each Member will give prompt notification to Plan of the name and location of the third party, if known, and of the circumstances which caused the injuries;
- (B) Each Member will execute and deliver to Plan or its nominee any and all lien authorizations, assignments or other documents requested by Plan which may be necessary or appropriate to protect the legal rights of Plan or its nominee fully and completely; and
- (C) Immediately upon receiving a monetary recovery based on a judgment, award or negotiated settlement on account of such injury, each Member will reimburse Plan for the value of all such services and benefits provided or arranged by Plan at the "Plan Provider's rates". All Covered Services provided through Plan Hospitals or Plan Physicians will be deemed provided to Members in the form of services rather than cash payments. "Plan Provider rates" means the rates charged for the services and benefits

for medical, surgical, hospital and related health care services as provided or arranged by Plan. Any such monetary recovery by or on behalf of Member or Member's attorney or other representative will be held in trust for the benefit of Plan and will not be used or disbursed for any other purpose without Plan's express prior written consent.

- (D) The reimbursement required by this section will not exceed the total amount of recovery obtained by Member. The obligation to reimburse Plan for the value of services and benefits provided or arranged by Plan applies to the full amount of the recovery even though the judgment, award or settlement is less than the total amount of the Member's alleged damages, or does not specify a monetary amount for medical expenses, or specifies that all or part of the recovery is for damages other than medical expenses.

9.5 COORDINATION OF BENEFITS

- (A) Covered Services Subject to This Provision

All of the benefits provided under this Plan contract are subject to this provision.

- (B) Definitions for Purposes of This Section

- (1) "Health Plan" means any plan providing benefits or services for or by reason of medical or dental care or treatment which benefits or services are provided by:
 - (a) Employer, blanket, or franchise insurance coverage;
 - (b) Service plan contracts, group practice, individual practice, and other prepayment coverage;
 - (c) Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans; and
 - (d) Any coverage under governmental programs, and any coverage required or provided by any statute.
- (2) The term "Health Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any policy, contract or other arrangement which reserves the right to take the benefits or services of other Health Plans into consideration in determining its benefits and that portion which does not.
- (3) "This Health Plan" means that portion of this Agreement which provides the benefits that are subject to this provision.
- (4) "Allowable Expense" means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Health Plans covering the person for whom the claim is made. When a Health Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an

Allowable Expense and a benefit paid.

(5) “Claim Determination Period” means a Calendar Year.

(C) Effect on Covered Services

- (1) This Section (C) will apply in determining the benefits as to a person covered under This Health Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such person for such period, the sum of:
 - (a) The value of the benefits that would be provided by This Health Plan in the absence of this Coordination of Benefits (COB) provision; and
 - (b) The benefits that would be payable under all other Health Plans in the absence therein of provisions of similar purpose to this provision, would exceed such Allowable Expenses.
- (2) As to any Claim Determination Period to which this COB provision is applicable, the benefits that would be provided under This Health Plan in the absence of this COB provision for the Allowable Expenses incurred as to such person during such Claim Determination Period will be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other Health Plans, except as provided in subparagraph (3) of this Section (C) will not exceed the total of such Allowable Expenses. Covered Services payable under another Health Plan include the benefits that would have been payable had claim been duly made therefore.
- (3) If
 - (a) Another Health Plan which is involved in subparagraph (2) of this Section (C) and which contains a provision coordinating its benefits with those of This Health Plan would, according to its rules, determine its benefits after the benefits of This Health Plan have been determined, and
 - (b) The rules set forth in subparagraph (4) of this Section (C) would require This Health Plan to determine its benefits before such other Health Plan,

then, the benefits of such other Health Plan will be ignored for the purposes of determining the benefits under This Health Plan.
- (4) For the purposes of subparagraph (3) of this Section (C), the rules establishing the order of benefit determination are:
 - (a) The benefits of a Health Plan which covers the person on whose expenses claim is based will be determined before the benefits of a Health Plan which covers such person is covered as an eligible dependent, except that if the person is also a Medicare beneficiary and as a result of the rules established by Title XVIII of the Social Security Act

and implementing regulations, Medicare is:

1. Secondary to the Health Plan covering the person as an eligible dependent; and
 2. Primary to the Health Plan covering the person as other than an eligible dependent (a retired employee);
- (b) Then the benefits of the Health Plan covering the person as an eligible dependent are determined before those of the Health Plan covering that person as other than an eligible dependent. Except as provided in subparagraph (4)(c) of this Section (C), the benefits of a Health Plan covering the person for whose expenses claim is based as a laid off or retired employee will be determined after the benefits of any other Health Plan covering such person as an employee, other than a laid off or retired employee.
- (c) If either Health Plan does not have a provision regarding laid off or retired employees, which results in each Health Plan determining its benefits after the other, then the rule under subparagraph (4)(b) of this Section (C) will not apply.
- (d) If a person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Health Plan, the following will be the order of benefit determination:
1. First, the benefits of a Health Plan covering the person as an employee, member, or subscriber;
 2. Second, the benefits under Continuation Coverage. If the other Health Plan does not have the rules described above, and if, as a result, the Health Plans do not agree on the order of benefits, the rule under this subparagraph (4)(d) of Section (C) is ignored.
- (e) When subparagraphs (4)(a) through (4)(d) of this Section (C) do not establish an order of benefit determination, the benefits of a Health Plan which has covered the person on whose expenses claim is based for the longer period of time will be determined before the benefits of a Health Plan which has covered such person the shorter period of time.
- (5) When this COB provision operates to reduce the total amount of benefits otherwise payable as to a person covered under This Health Plan during any Claim Determination Period, each benefit that would be payable in the absence of this COB provision will be reduced proportionately, and such reduced amount will be charged against any applicable benefit limit of This Health Plan.

(D) Facility of Payment

Whenever payments which should have been made under This Health Plan in accordance with this COB provision have been made under any other Health Plans, This Health Plan will have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it will determine to be warranted in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under This Health Plan and, to the extent of such payments, This Health Plan will be fully discharged from liability under This Health Plan.

(E) Right of Recovery

Whenever payments have been made by This Health Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this COB provision, This Health Plan will have the right to recover such payments, to the extent of such excess, from one or more of the following, as This Health Plan will determine: any persons to or for or with respect to whom such payments were made, any insurers, service plans or any other organizations.

EXHIBIT A

IN-HOME SUPPORTIVE SERVICES PUBLIC AUTHORITY

VALLEY HEALTH PLAN

PREMIUM RATE SCHEDULE

EFFECTIVE 07/01/2024 – 06/30/2025

Rates for Active Subscriber – Monthly

	Classic Network	Preferred Network
Subscriber	\$1,217.02	\$ 929.79

Rates for COBRA* – Monthly

	Classic Network	Preferred Network
Subscriber	\$1,241.36	\$948.39

Rates for Cal-COBRA – Monthly**

	Classic Network	Preferred Network
Subscriber	\$1,277.87	\$976.28

*COBRA rates include a 2% administration fee. The administration fee is paid directly to the COBRA administrator. The administrator shall pay Plan the monthly Premium rate.

**Cal-COBRA rates include a 5% administration fee. Plan is the Cal-COBRA administrator. Subscriber shall pay Plan the monthly Premium and the 5% administration fee.

EXHIBIT B

COPAYMENT SCHEDULE

Group Plan

- \$0 or no Copayments prescription drugs,
- \$0 Copayments office visit(s),
- \$0 Copayments for Preventive Health Services, such as Immunizations and injections, and for Pregnancy/Maternity Care services
- Except for:
- \$10.00 Copayment for Chiropractic or Acupuncture Care,
- Weight Management support for Commercial members. VHP continues to pay a 50 percent subsidy for all members.

COPAYMENT / COINSURANCE MAXIMUM SCHEDULE

Group Plan:

- No maximum lifetime benefit (overall limit). The only maximum benefit limits are those specifically mentioned.
- No deductibles
- Individual: \$1,000 per Calendar Year.