SANTA BARBARA REGIONAL HEALTH AUTHORITY

GROUP MEMBER AGREEMENT

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SANTA BARBARA REGIONAL HEALTH AUTHORITY GROUP MEMBER AGREEMENT

THIS AGREEMENT (the "Agreement") is made and entered into effective January 1, 2005 (the "Effective Date") by and between Santa Barbara Regional Health Authority, ("Health Plan" or "Plan"), and the In-Home Supportive Services Public Authority of Santa Barbara County ("Public Authority" or "Group").

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

WHEREAS, Group wishes to participate in said program;

NOW THEREFORE, Group engages Health 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 January 1, 2005 ("Effective Date"), through December 31, 2005, with the anniversary date being January 1, 2006. Thereafter, this Agreement will automatically renew from year to year, unless terminated as provided herein.

2. The periodic prepayment fees ("Prepayment Fees") for Health Plan membership are specified in the Rate Schedule Attachment (1) to this Agreement. Subject to changes in rates or other terms as provided in Section 3 (Fees and Charges), the rates shall remain in effect for the Initial Term of this Agreement, and may be changed thereafter on the anniversary date as provided herein.

3. This Agreement is made in reliance upon the information provided by Group in its application; upon the statements of each Member in his or her application for coverage and upon Group's existing eligibility requirements and composition of Members.

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

5. No representative of Health Plan is authorized to waive or change any provision of this Agreement except in a writing signed by a duly authorized Health Plan officer.

6. The following specifications apply to this Agreement. In the event of a conflict between these specifications and the following text of the Agreement, these specifications prevail.

A. "Full-time Employee" means an employee who meets the following requirements:

1. has worked two (2) consecutive months in which he or she works a minimum of seventy (70) hours per month;

2. works or resides in the Service Area;

3. has not been previously terminated by the Plan for fraud or deception or failing to provide complete information; and

4. has submitted the required enrollment information to the Group.

B. Group Waiting Period: **None]**

C. The minimum employee participation in Health Plan is: **Not applicable**

D. The following designated non-employees are eligible to enroll: **N/A**

E. The following retired beneficiaries are eligible to enroll: **N/A**

Other Group specific provisions.

1. Dependents are not eligible for benefits under this Agreement.

2. Health Plan will administer COBRA benefits on behalf of Group, but Group will be responsible to administer or contract with another person or entity to administer COBRA. Premiums for any Members whose benefits are COBRA benefits will be paid to Health Plan together with premiums of other, non-COBRA Members.

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

ARBITRATION NOTICE: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this Agreement were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this Agreement, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. See Section 8 of this Agreement for further information about arbitration. This Agreement also precludes the award of punitive damages. See Section 9.

The undersigned representative of Group understands that Group and any Subscribers who enroll under this Health Plan are giving up their right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of neutral binding arbitration. This means that Group, Subscribers and other interested parties will not be able to try their case in court.

In Home Supportive Services Public Authority	
of Santa Barbara County	Santa Barbara Regional Health Authority
By:_____	By:_____
Name	Name
Title	Title
Date	Date
Address	Address
City, State and Zip Code	City, State and Zip Code

SECTION 1– ELIGIBILITY

1.1 MEMBER ELIGIBILITY

An In-Home Supportive Services (IHSS) worker is eligible to enroll for coverage after working two (2) consecutive months in which he or she works a minimum of seventy (70) hours per month. In addition, the IHSS worker must:

(A) reside in the Service Area on a full-time basis; or

(B) work in the Service Area; and

(C) not have been previously terminated by the Plan for fraud or deception or failing to complete required information; and

(D) have submitted the required enrollment information to the Public Authority; and

(E) have met the Public Authority's eligibility requirements.

OTHER RULES OF ELIGIBILITY

To be eligible to enroll and to continue enrollment as a Subscriber, the person must reside or work in the Health Plan Service Area and must not be on active duty with the Armed Forces.

No person is eligible to enroll or re-enroll if such person's coverage under this Agreement or under any other agreement with Health Plan has been terminated for:

(A) Knowingly failing to furnish material information;

(B) Knowingly furnishing incorrect or incomplete material information;

(C) Fraud or deception;

(D) Nonpayment by such person; or

(E) Disruptive or abusive behavior toward Participating Providers, their employees or Health Plan employees.

No person who is otherwise eligible will be refused enrollment because of his or her health status, requirements for health services, blindness, or the existence of a pre-existing physical or mental disorder at the time of his or her enrollment.

A Member's entitlement to Medi-Cal benefits under Chapter 7 (commencing with §1400) or Chapter 8 (commencing with § 14200) of Part 3 of Division 9 of the California Welfare and Institutions Code will not preclude the Member from enrollment.

1.2 FAMILY MEMBER ELIGIBILITY

Family Members are not eligible for benefits under this Agreement.

1.3 GROUP'S ELIGIBILITY RULES; OBLIGATIONS

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

Group agrees to accept the responsibility for furnishing current eligibility information and Health Plan may rely upon the latest information received as correct without further verification. Health Plan will not credit Group for any Prepayment Fees paid for an ineligible person if the request for such credit is made after the first of the month for which the premium was paid.

Member eligibility will be for one-year terms, which will automatically be renewed unless the Member is terminated. New hires will be eligible from the effective date of coverage determined by Group, through the end of the calendar year at which time their eligibility will automatically be renewed unless the Member is terminated. Unless they elect coverage under COBRA, terminated Members will lose their coverage as of the termination date.

1.4 ENROLLMENT

(A) To initially qualify for health coverage, IHSS workers must meet the eligibility requirements set forth in § 1.1, and complete the enrollment form.

(B) Eligibility for health care coverage will continue as long as the Member continues to receive authorization to work and does work at least seventy (70) hours per month.

1.5 COMMENCEMENT OF COVERAGE

The effective date of coverage for a Member who is an IHSS worker of the Public Authority will be the first day of the month following the month in which the Member's application is processed and found to meet the Public Authority's eligibility requirements stated in § 1.1 and Prepayment Fees are received by the Health Plan.

SECTION 2 –CHOICE OF PHYSICIANS AND PROVIDERS

2.1 REQUIRED USE OF PARTICIPATING PROVIDERS

The benefits described in this Agreement are Covered Services only if, and to the extent, they are Medically Necessary and meet the following requirements:

(A) They are provided by, or prescribed or referred in advance by, the Member's designated Primary Care Physician unless they are Self Referral Services; and

(B) They are obtained, unless they are Self Referral Services, from a Participating Provider located within the Service Area.

The only exceptions to the requirement to use Participating Providers are:

(1) In an Emergency or for out of Service Area Urgent Care Services; or

(2) Where the requested service is Medically Necessary and Prior Authorization is granted.

Certain services or supplies within the Service Area also require Prior Authorization. Members must identify themselves to the Participating Provider as a Health Plan Member before receiving any service or supply.

2.2 SELECTION OF A PRIMARY CARE PHYSICIAN

At enrollment, Members will receive a Provider Directory that lists all of the hospitals and physicians that make up the Plan's network of providers. The Directory contains the names, addresses and telephone numbers of Primary Care Physicians to help Members select providers that are convenient to them. The Directory also contains additional information that Members will find useful in selecting a Primary Care

physician. Health Plan requires each Member to designate a Primary Care Physician located within the Service Area where the Member lives or works. If a Member does not designate a Primary Care Physician, Health Plan will assign the Member to a Primary Care Physician. Physicians are then notified of the selection. A Primary Care Physician is one who is identified by Health Plan as such and who is willing to assume responsibilities regarding continuity of care, recordkeeping and referrals to specialist physicians.

Once the Primary Care Physician is designated, the Member must contact his/her Primary Care Physician before seeking medical or Hospital services unless an Emergency exists or the service is a Self Referral Service. In an Emergency, the Member may obtain the nearest available medical care. If a health care matter is beyond the normal practice of the Primary Care Physician, he or she may refer the patient to a Participating specialist Physician. The Primary Care Physician will manage referrals and ongoing care supplied by other providers and institutions.

In most cases, a Referral Authorization Form (RAF) must be issued by the Primary Care Physician when a referral is made. Services obtained from or prescribed by Participating specialist Physicians or other Participating Providers without the RAF from the Primary Care Physician will not be covered by Health Plan except as listed below.

Covered Services not requiring a referral include, but are not limited to:

(A) Medically Necessary Emergency or Urgent Care Services;

(B) On-call physicians who are providing care in the Primary Care Physician's place;

(C) OB-GYN services obtained from a Participating OB/GYN Physician, family practitioner, nurse practitioner or nurse midwife.;

(D) Services from a specialist in which the Member has a standing referral based on a treatment plan developed by the Member's Primary Care Physician, the specialist and the Member;

(E) Family Planning Services from a Participating Provider;

(F) Abortion services from a participating provider;

(G) AIDS/HIV testing;

(H) Sexually transmitted disease testing and treatment

(I) Nutrition Education (first visit) under the diabetes management benefit and for those receiving treatment for phenylketonuria

Health Plan does not cover services provided by non-Participating Physicians unless a RAF has been issued, (except for Emergency Services and other services listed above in 2.2 (A) – (I)), or if required Prior Authorization has been obtained. If a Member self-refers for health care services, other than for the Self Referral services listed above, without obtaining a referral from the Primary Care Physician or Prior Authorization from Health Plan, the services will not be covered.

2.3 CHANGING PRIMARY CARE PHYSICIANS

If a Member wishes to change his/her Primary Care Physician, the Member must first contact Health Plan's Member Services Department and follow the instructions provided. When notified before the 15th of the month, Health Plan will facilitate a change of Primary Care Physician consistent with continuity of care, effective as of the first day of the calendar month following the Member's request. The physician may decide to refuse the relationship at any time when allowed by medical ethics and contract, and may require the Member to change his/her Primary Care Physician designation for good cause

Once the Member is assigned to a new Primary Care Physician, the Member may receive Covered Services only from the Participating Providers, or non-Participating Providers when Medically Necessary, as referred by the new Primary Care Physician and subject to Prior Authorization when necessary. Failure to comply with any of the provisions regarding selection and changing of Primary Care Physicians will result in the Member being responsible for the charges.

2.4 PROVIDER NETWORK CHANGES OR TERMINATIONS

Health Plan's network of Participating Providers is made up of both group/clinic physicians and independently practicing physicians, allied health providers and hospitals, and may change by the decision of the provider or Health Plan. Whenever there is a contract termination of a physician, a Member who at that time is receiving a course of treatment from the terminated physician will be given the opportunity to select a new physician. Health Plan will assist the Member in transitioning to the new provider so that treatment may continue without interruption.

If a physician's contract is terminated by Health Plan, the Member will be notified in writing as soon as possible, but no later than thirty (30) days prior to the termination. However, if the physician's contract is terminated immediately due to endangering the health and safety of patients, committing criminal or fraudulent acts, or engaging in grossly unprofessional conduct, then Health Plan will provide written notice to the Member immediately upon notification of such termination but no later than thirty (30) days prior to the effective date of the specialist termination. If Health Plan terminates a Primary Care Physician responsible for directing a Member's referral to specialty physicians, Health Plan will provide instructions on selecting a new PCP. Further, Health Plan will remain financially responsible for any care obtained by Members through self-referrals for a period of sixty (60) days following the termination of the Member's PCP if notice under this section was not properly provided to the Member.

If Health Plan terminates a physician contract for any reason other than reasons relating to medical discipline, fraud or criminal activity, Members who are receiving treatment from the terminated physician for an acute condition, a serious chronic condition, a high-risk pregnancy, or pregnancy in the second or third trimester, may request to continue treatment with the terminated physician for up to ninety (90) days, or longer if necessary for a safe transfer to another provider, subject to the following: (i) the terminated provider must comply with the contract terms and conditions in effect at the time of the terminations; and (ii) the terminated provider must agree to accept an amount and method of payment similar to those provided by Health Plan to other contracted providers as payment in full, subject to any applicable Copayments. This provision does not apply if the physician voluntarily terminates his contract with Health Plan. For assistance in requesting this continuity of care provision, Members should call a Health Plan Member Service Representative at (877) 814-1861**.**

2.5 REIMBURSEMENT PROVISIONS

A Member should not make payments to any provider for the Covered Services under this Agreement except for applicable Copayments and for Emergency care when obtained outside the Service Area. Participating Providers are prohibited by contract from billing Members for Covered Services (other than Copayments). If a Participating Provider requests payment from the Member, other than Copayments, the Member should ask that he/she bill Health Plan directly. If for some reason the Member does pay a Participating Provider, the Member will be reimbursed by Health Plan for amounts paid for Covered Services (other than Copayments), not to exceed amounts which Participating Provider is under contract to accept as payment for services. Claims for reimbursement should be submitted to Health Plan at the address below.

If a Member pays a non-Participating Provider for Covered Services (e.g., Emergency services outside the Service Area), the Member must furnish evidence satisfactory to Health Plan that payment to such person or institution has been made for Covered Services. Health Plan will reimburse Member for such charges less applicable Copayments and less any payments made by Health Plan prior to receipt of Member's evidence of payment.

Requests for reimbursement for out-of-area Emergency or Urgent Care Services, along with proof of payment, should be mailed to: Santa Barbara Regional Health Authority, 110 Castilian Drive, Goleta, CA 93117-3028. Attn: Adjudication.

If a Member obtains prescription drugs from a non-participating pharmacy due to an emergency, the Member should contact the Member Services Department to obtain a "prescription drug claim form". The completed claim should be sent to the above address: Attn: Member Services.

The Member or Member's representative must notify Health Plan Member Services Department within forty-eight (48) hours, or as soon as reasonably possible, of any Covered Services rendered for which reimbursement will be claimed. Written proof of charges incurred must be submitted to the Health Plan within one hundred and eighty (180) days after the service is incurred, or as soon as reasonably possible.

All such charges will be paid within forty-five (45) working days of Health Plan's receipt of the satisfactory evidence described above, provided that all required information has been supplied and that Health Plan does not contest the claim. If Health Plan contests the claim, Health Plan will notify the Member within thirty (30) calendar days. Information required of Member may include but is not limited to reports, statements, releases, consents and assignments. Proof of payment is required.

SECTION 3 – FEES AND CHARGES

3.1 PREPAYMENT FEES

Public Authority will pay on or prior to the Effective Date the applicable Period Prepayment Fees/Premium for each Member entitled to receive benefits as of the date as reflected in the eligibility report. Thereafter, the Periodic Prepayment Fees/Premium shall be remitted to the Health Plan's offices on or before the twenty fifth (25th) day of each month ("due date") during the term of the Agreement. Such Prepayment Fee shall be payment for coverage for the succeeding calendar month. The Periodic Prepayment Fee set forth in Attachment 1, Rate Schedule, of this Agreement shall remain in effect for the term of this Agreement unless modified in writing by the parties hereto. Any contributions required of Members shall be arranged with Members solely by Public Authority. Retroactive deletions or additions are not allowed under this Agreement.

If the required Prepayment Fees are not paid in full on the due date, then Group will be in default and Health Plan may deem the failure of Group to pay the Prepayment Fees as action by Group to cancel the Agreement in accordance with Section 5 (Term, Cancellation and Related Provisions), subject to the reinstatement provisions as set forth in that section. Further, Health Plan will notify Group, on or after the twenty-fifth (25^{th}) day of the month, that it has failed to make the required prepayment and will immediately notify the Member(s) of such failure.

3.2 MEMBER COPAYMENTS

Members will be required to make certain Copayments for the Covered Services as indicated in Attachment 2 (Evidence of Coverage and Disclosure Form ((EOC)), which Member receives. Copayments must be paid at the time the Covered Services are rendered. Members will be required to pay Copayments as specified in the EOC. The total aggregate amount of Copayments per contract year for services shall also be specified in EOC and may vary by Plan type. Copayments for the following services shall not be included in the Annual Copayment Maximum amounts: Prescription Drugs, Durable Medical Equipment, and any Coinsurance charges that Member is required to pay. Within one hundred and eighty (180) days after the end of any contract year, a Member may apply to Health Plan for a refund of the excess of Copayments paid over the contract year.

Members who schedule appointments but fail to keep said appointments and who do not notify the Provider's office at least twenty-four (24) hours in advance to cancel said appointment may be charged by the Provider up to the Copayment amount. Copayments are set forth in the EOC, which is attached as Attachment 2 to this Agreement.

3.3 CHANGES IN FEES AND CHARGES

Health Plan will have the right to change the Prepayment Fees or Copayments as of any date to the extent or nature of the risk under this Agreement is changed by reason of any provision of law or change in any governmental program (including Medicare) or regulation. Health Plan will give Group written notice by certified mail thirty (30) days before such change in Prepayment Fees or Copayments takes effect.

Notwithstanding the foregoing, if a state or other taxing authority imposes upon Health Plan a tax or license fee which is levied upon or measured by Prepayment Fees or by Health Plan's gross receipts or any portion of either, then Group and Health Plan will meet and discuss additional fees to be paid by Group to offset said tax or license fee. Payment of any Prepayment Fees as changed in accordance with this section constitutes acceptance of continued coverage at the changed Prepayment Fees.

SECTION 4-– RECORDS

4.1 MAINTENANCE OF RECORDS

Health Plan will keep a record of Members. Group will forward the information periodically required by Health Plan in connection with the administration of this Agreement. Health Plan's liability for the fulfillment of any obligation dependent on information to be furnished by Group or Member will not arise prior to receipt of that information in the form requested by Health Plan. Nor will Health Plan be liable for any obligation due to information incorrectly supplied by Group or Member. All records of Group relating to coverage will be open for inspection by Health Plan at any reasonable time.

4.2 SUBMISSION OF CORRECT INFORMATION BY MEMBER

Members or applicants for membership must complete and submit to Health Plan such applications, medical review questionnaires, or other forms or statements as Health Plan may reasonably request. Members warrant that all information contained in such applications, questionnaires, forms or statements submitted to Health 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 5 (Term, Cancellation and Related Provisions).

4.3 AUTHORIZATION OF DISCLOSURE

Health Plan is entitled to receive from any provider of services to Member, information reasonably necessary in connection with the administration of this Agreement. By acceptance of coverage under this Agreement, and as allowed pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), each Member authorizes every provider of medical services to Member to disclose all facts pertaining to such care and treatment, and physical condition of Member, to Health Plan upon request, to render reports pertaining to the same, and permit copying of records by Health Plan.

4.4 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, or otherwise excepted under law, may not be disclosed without the consent of Member. Additionally, information concerning a Member's outpatient psychotherapy treatment will not be released to another unless the person requesting the information submits a signed, written request to the Member and to the provider as required by law. Members are entitled to a copy of the Health Plan's confidentiality policy upon request. Health Plan and Group shall make any and all efforts and take any and all actions necessary to comply with statutory and regulatory requirements of HIPAA ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements, but not later than the time permitted by the applicable HIPAA requirement after date of finalization.

SECTION 5 – TERM, CANCELLATION AND RELATED PROVISIONS

5.1 TERM

This Agreement will continue in effect for the term indicated in the Declarations; provided however, that Health Plan reserves the right to change the Prepayment Fees set forth in the Rate Schedule, Attachment 1, and the benefits and coverages herein, on each anniversary date of this Agreement. If Employer meets the applicable eligibility requirements as set forth in Section 1 (Eligibility), then this Agreement will renew automatically from year to year on the anniversary date unless terminated pursuant to this section, and subject to any changes in Prepayment Fees, other charges, benefits and coverages pursuant to Section 3 (Fees and Charges) and the paragraph entitled "Change in Agreement" under Section 10 (General Provisions).

5.2 EFFECT OF CANCELLATION

Upon cancellation or expiration of the term, this Agreement and/or a Member's coverage and rights under this Agreement (referred to as "coverage") are terminated subject to any applicable provisions for reinstatement, conversion to individual membership, temporary continuation of benefits, continuation coverage or extension of benefits. This Agreement and/or a Member's coverage may be canceled for the reasons identified below. When canceled, 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.

5.3 CANCELLATION OF INDIVIDUAL MEMBERS

5.3.1 Loss of Eligibility

If a Member ceases to meet the eligibility requirements of Section 1 (Eligibility), then (subject to any applicable provisions for continuation or conversion of benefits) the Member's coverage terminates at midnight on the last day of the month in which loss of eligibility occurs. Group and Members agree to notify Health Plan Member Services Department, either electronically or by letter, immediately if a Member ceases to meet the eligibility requirements. Health Plan will provide written notice to the Member at least fifteen (15) days prior to the termination.

5.3.2 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 Health Plan immediately that the Member has elected coverage elsewhere.

Member may voluntarily disenroll from Health Plan at any time for any reason by notifying the Public Authority of the intent to cancel membership. The Member's coverage terminates at midnight on the last day of the month during which the Member notified the Public Authority of the Member's intent to disenroll.

5.3.3 Cancellation of Member for Good Cause

(A) **Failure to Furnish or Furnishing Incorrect or Incomplete Information**. If a Member knowingly fails to furnish material information required in connection with this Agreement, or furnishes materially incorrect or misleading enrollment or required updated information, then Health Plan may cancel coverage of the Member effective fifteen (15) days after receipt by the Member of written notice of cancellation from the Health Plan, unless the Member furnishes Health Plan with the required information within such fifteen (15) day period.

(B) **Fraud or Deception**. If a Member engages in fraud or deception in the use of the services or facilities of Health Plan or permits such fraud or deception by another, including but not limited to the unauthorized use of an Health Plan identification card or making a material misrepresentation on an Health Plan enrollment document, then Health Plan may cancel the coverage of the Member(s) involved effective the date Health Plan mails notice of cancellation to such Member(s). However, if such fraud or deception is material to Health Plan's underwriting risk, then such cancellation will be retroactive to the date the fraud or deception was made. Fraud or misrepresentation concerning eligibility will be deemed to have occurred if, at any time, the employer Group or the enrollee knowingly enrolls, disenrolls or denies enrollment of any person on the basis of eligibility requirements which are not consistent with or are in violation of the eligibility requirements specified in this Agreement.

(C) **Disruptive or Abusive Behavior**. If a Member acts in a materially threatening, disruptive, abusive, or illegal manner toward a Participating Provider or their employees or a Health Plan employee, to the extent that normal operations of the Provider or the Health Plan are adversely impacted, Health Plan may cancel coverage for that Member.

(D) **Medicare Enrollment**. If a non-TEFRA Member (see Section 11.6.1 – Medicare Eligible Members) fails to enroll for Medicare coverage when eligible to purchase Medicare, Health Plan may cancel coverage of that Member.

5.4 CANCELLATION OF ENTIRE AGREEMENT

5.4.1 Nonpayment

If Group fails to pay when due any monthly Prepayment Fees on behalf of each Member, then Health Plan may cancel this Agreement. Health Plan shall mail to Group a prospective notice of cancellation, after the due date for the payment of Prepayment Fees/Premium payments to Health Plan. Health Plan shall also send a prospective notice of cancellation of the Health Plan contract to each Member. Upon such default, all rights to benefits terminate for all Members, subject to compliance with notice requirements, including those who are hospitalized or undergoing treatment for an ongoing condition unless Member may be covered under Section 6.4, Extension of Benefits (due to Total Disability) no less than fifteen (15) days after notification, but in no case later than midnight of the last calendar day of the following month. For example, if Health Plan sends notification of cancellation to the Group and each Member on April 28, benefits for Members will cease at midnight on May 31.

5.4.2 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, Health Plan will give Group written notice of termination, which termination will be effective retroactive to the date such information was provided or omitted.

5.4.3 Cancellation by Group

This Agreement may be terminated by Group by giving ninety (90) days prior written notice to Health 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. Health Plan has no obligation to notify Members in the event of such termination by Group.

5.4.4 Cancellation by Health Plan for Good Cause

If Group is not a "small employer" (as that term is defined in California law), Health Plan may decline to renew or may terminate this Agreement for cause, to the extent permitted by law, and if

any of the following events occur: (i) any change in Group's eligibility requirements, employer contribution or other material information stated in Group's application, without Health Plan's prior written approval and (ii) termination of Health Plan, a particular product type, or withdrawal from the market as permitted by law.

In the event of such termination, Health Plan will give written notice to Group by mail (postage pre-paid) or hand delivery at least one hundred and eighty (180) days in advance of the effective date of such termination. Group will promptly mail to each Member a legible, true copy of the notice of termination.

5.5 NOTICE OF CANCELLATION

5.5.1 Notice Where Individual Member is Canceled

In the event that Health Plan cancels or refuses to renew an individual Member's enrollment under this Agreement, Health Plan will mail notice thereof to the Member at the Member's address of record with Health Plan or hand deliver such notice to the Member.

5.5.2 Notice Where Agreement with Group is Canceled

When Health Plan mails or hand delivers a notice of cancellation to Group (by address or delivery to the person signing this Agreement on behalf of Group or such person's successor) Health Plan will also promptly mail a legible, true copy of such notice to each Member under this Agreement at the Member's current address. Health Plan shall instruct Group to promptly mail to each subscriber a legible, true copy of any confirming notice of cancellation of the Agreement between the Health Plan and the Group. Said notice of cancellation shall also include information, in clear and easily understandable language, regarding the conversion rights of Members covered under said Agreement upon termination of the Agreement. Group must promptly provide to Health Plan proof of the mailing and the date thereof.

5.6 CESSATION OF COVERAGE

Health 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 6 (Individual Continuation of Group Benefits and Individual Conversion), where applicable. Where termination is for fraud or for any of the reasons set forth in Paragraph 5.3.3 (Cancellation of Members for Good Cause), Members are not entitled to individual continuation of group benefits or individual conversion set forth in Section 6.

5.7 LIMITATIONS ON INDIVIDUAL CONVERSION

If Group terminates this Agreement for any reason, or if Health Plan terminates this Agreement because of nonpayment by Group of the Prepayment Fees or for fraud or deception by Group, coverage for all Members enrolled through Group terminates on the date this Agreement terminates. However, Members may convert to individual non-group coverage without regard to health status or requirements for health care services if the Group does not replace the Agreement for similar coverage within fifteen (15) days of the termination of this Group Agreement.

5.8 REINSTATEMENT IF THE AGREEMENT IS CANCELED FOR NON PAYMENT OF PREMIUMS.

5.8.1 Receipt by Health Plan of the proper monthly Prepayment Fees after termination of Group for non-payment of Prepayment Fees 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 Prepayment Fees, unless: (i) in the notice of termination, Health Plan notifies Group that if payment is not received within fifteen (15) days of the notice of cancellation, a new application is required and the conditions on which a new contract will be issued or the original contract reinstated; (ii) such payment is received more than fifteen (15) days after issuance of the notice of termination, and Health Plan refunds such payment within twenty (20) business days; or (iii) such payment is received more than fifteen (15) days after issuance of the notice of termination, and Health Plan issues to Group within twenty (20) business days of receipt of such payment, a new contract accompanied by written notice stating clearly those aspects in which the new contract differs from the canceled contract in benefits, coverage or otherwise.

5.8.2 Members have no individual rights to renewal or reinstatement of this Agreement if the Agreement is terminated by Health Plan or Group, or by operation of law.

5.9 REFUNDS IN THE EVENT OF CANCELLATION

In the event of cancellation by either Health Plan or Group, Health Plan will return to Group, within thirty (30) days of the effective cancellation date, the pro rata portion of the monthly Prepayment Fees paid to Health 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 cancellation, if any, less any amounts due Health Plan or Participating Providers, and neither Health Plan nor Participating 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 Health Plan or knowingly permitting such fraud or deception by another.

5.10 MEMBER'S RIGHT TO REVIEW OF CERTAIN CANCELLATIONS

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

SECTION 6 – INDIVIDUAL CONTINUATION OF GROUP BENEFITS AND INDIVIDUAL CONVERSION

6.1 CONTINUED GROUP COVERAGE (COBRA and Cal-COBRA)

Group is obligated under both federal and state law with regard to the continuation of health coverage for Members under certain circumstances where coverage would otherwise terminate ("continuation coverage"). The federal law is the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). COBRA applies to employers with twenty (20) or more eligible employees. The California state law is the California Continuation Benefits Replacement Act ("Cal-COBRA"). Cal-COBRA applies to employers with fewer than twenty (20) eligible employees. Many of the provisions of COBRA and Cal-COBRA are the same, however some differences do exist. The provisions of COBRA and Cal-COBRA are summarized below.

6.1.1 Group Obligations Under COBRA

Under federal law, an employer with twenty (20) or more employees on a typical business day during the prior calendar year must provide Members with the opportunity to elect COBRA 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: (i) provide Members with notice of the opportunity to

elect continuation coverage; and (ii) administer the continuation coverage. The obligation to provide notice includes both general notification to Members of their right to elect continuation coverage and specific notification of the right to continuation coverage within a specific time period after the occurrence of the event which triggers the continuation coverage option.

Group hereby acknowledges its legal obligations and agrees to abide by applicable legal requirements with respect to COBRA continuation coverage. Group also agrees to forward to Health Plan in a timely manner copies of any and all notices provided to Members regarding COBRA continuation coverage.

6.1.2 Group Obligations Under Cal-COBRA

Under California law, a health care service plan that contracts with employers who employ two (2) through nineteen (19) eligible employees on a typical business day during the prior calendar year is required to provide Members with the opportunity to elect Cal-COBRA continuation coverage in certain circumstances where coverage would otherwise terminate. Health Plan will administer or contract for the administration of continuation coverage under Cal-COBRA. Nonetheless, Group must provide certain notices to Health Plan and to Members as described below.

Group must notify Health Plan in writing of any employee who has a qualifying event defined in Section 6.1.3 within thirty (30) days of the qualifying event. Such notice must be separate from other communications from Group and must specifically reference Cal-COBRA. Notations of additions and/or deletions on monthly invoices will not constitute sufficient notice. Group must further provide written notice to Health Plan within thirty (30) days of the date Group becomes subject to § 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. § 1161 et seq.

Group must also notify qualified beneficiaries of the ability to continue coverage prior to terminating a group agreement (such as this Agreement) under which a qualified beneficiary is receiving continuation coverage. This notification shall be provided either thirty (30) days prior to the agreement termination or when all other enrolled employees are notified, whichever is greater. Group must notify any successor plan in writing of the qualified beneficiaries currently receiving continuation coverage to enable the successor plan, contracting employer, or administrator to provide such qualified beneficiaries with the premium information, enrollment forms, and disclosures necessary to allow the qualified beneficiaries to continue coverage under other available group plans.

If Group fails to meet these obligations, Health Plan will not provide continuation coverage to qualified beneficiaries under Cal-COBRA. Group hereby acknowledges its obligations and agrees to comply with all applicable legal requirements with respect to Cal-COBRA continuation coverage. Group also agrees to forward to Health Plan in a timely manner copies of any notice provided to Members regarding Cal-COBRA continuation coverage.

6.1.3 Eligibility for Continuation of Coverage

The following persons are entitled to elect continuation coverage in the following situations ("qualifying events"): Members whose coverage under this Agreement ends because of termination of Member'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.

6.1.4 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 thirty-six (36) months thereafter except if coverage for the Member ends because of the termination or reduction in hours of Member's employment. In that instance, continuation coverage will terminate no later than

eighteen (18) months thereafter; provided, however, that if the Member notifies the plan administrator within sixty (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 sixty (60) days of continuation coverage, coverage will terminate no later than twenty-nine (29) months thereafter.

Members who reach the maximum federal COBRA coverage may have rights to additional coverage under Cal-COBRA, not to exceed a total of 36 months of continuation coverage.

6.1.5 Exceptions to Maximum Time Periods of Coverage

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

(1) On the date Group ceases to provide any group health plan to any employee of an employer. For purposes of this Section 6, the term "employer" is that term as defined under the applicable statutes;

(2) On the date Member becomes covered under another health plan which does not contain any exclusion or limitation with respect to any pre-existing condition of the Member;

(3) On the date Member becomes entitled to Medicare benefits;

(4) On the date Member fails to make timely payment of any premium required under this Agreement; or

(5) In the case of the eleven (11) month extended coverage provided due to a disability, on the first (1st) day of the month which starts at least thirty (30) days after a final determination, under the Social Security Act, that Member is no longer disabled.

6.1.6 Type of Coverage

Coverage provided under the continuation of coverage option must be identical to the coverage Group provides to similarly situated persons who have not lost group coverage under this Agreement. Continued coverage cannot be conditioned on evidence of insurability.

6.1.7 Prepayment Fees

(A) **Under COBRA**

Group may require the Member to pay for COBRA continuation coverage, so long as the amount does not exceed one hundred and two percent (102%) of the applicable premium and in the case of a Member who is entitled to the eleven (11) month extended coverage period as a result of a disability, does not exceed one hundred and fifty percent (150%) of the applicable premium for the coverage during that extended period of coverage. Applicable premium for any twelve (12) month period of continuation coverage is defined as a reasonable estimate of the cost of providing coverage during the period for similarly situated persons who did not lose group coverage under this Agreement.

Group shall remit to Health Plan all premiums for Members who continue group coverage in monthly installments with Group's regular monthly payment. If Group requires a Member's COBRA continuation coverage to pay all or any part of the premiums for such coverage, Group shall be solely responsible for collecting those premiums. Group agrees that COBRA continuation coverage shall be provided only for persons eligible for such coverage under applicable law and regulations and for whom applicable premiums have been received by Health Plan.

For COBRA premium payments, Health Plan will provide Group a grace period of thirty (30) days prior to terminating coverage for failure to pay premium. However, Group shall immediately notify Health Plan if Group fails to receive the Member's premiums on the due date.

If a Member elects COBRA continuation coverage after the date of the event which entitles him or her to continuation coverage, Group must remit the first premium retroactive to the date coverage would otherwise have terminated within forty-five (45) days of the date of the election. No grace period applies to this first premium.

(B) **Under Cal-COBRA**

Health Plan may require the Member to pay for Cal-COBRA continuation coverage, so long as the amount does not exceed one hundred and ten percent (110%) of the applicable premium and in the case of a Member who is entitled to the eleven (11) month extended coverage period as a result of a disability, does not exceed one hundred and fifty percent (150%) of the applicable premium for the coverage during that extended period of coverage.

Members who continue group coverage under Cal-COBRA must remit all premiums directly to Health Plan, or its designated administrator. Member's first premium payment under Cal-COBRA must include the entire amount due retroactive from the date of the qualifying event and be received by Health Plan on or before the due date. No grace period applies to Member's first premium payment. With regard to subsequent Cal-COBRA premium payments, however, Health Plan will provide Members a grace period of fifteen (15) days prior to terminating coverage for failure to pay premiums.

6.1.8 Notice of Qualifying Event

(A) **Under COBRA**

The COBRA 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 thirty (30) days of the occurrence of any qualifying event. In turn, the plan administrator is obligated to notify Member of the opportunity to elect COBRA continuation coverage within fourteen (14) days after receiving notice of the qualifying event.

(B) **Under Cal-COBRA**

In the event of eligibility for Cal-COBRA continuation coverage due to termination of Member's employment (except when based on gross misconduct) or reduction of Member's work hours, Group must notify Health Plan of such qualifying event and to which Member(s) such event applies within thirty-one (31) days after the date of such event. If Group fails to provide such notice within the thirty-one (31) day period allowed, Health Plan will not provide Cal-COBRA continuation coverage to such Member(s).

In the event of eligibility for Cal-COBRA continuation coverage due to qualifying events, except those due to termination of Member's employment or reduction of Member's work hours, Member has the responsibility to notify Health Plan of such qualifying event within sixty (60) days of the event. If Member fails to provide such notice within the sixty (60) day period allowed, Health Plan will not provide Cal-COBRA continuation coverage to such Members.

6.1.9 Replacement Coverage

When the Health Plan replaces another carrier, any eligible person enrolled under such prior carrier's continued coverage COBRA providers shall be eligible to continue benefits with the Health Plan only for the remaining continuation period under COBRA.

6.1.10 Nonliability of Health Plan

Health Plan will cooperate with Group to assist Group in meeting its obligations regarding continued Group coverage, provided that, except as otherwise set forth in the following subsection, Health Plan assumes no responsibility for Group's compliance with Group's obligations under federal laws or regulations concerning continuation of group coverage. Group hereby indemnifies and holds Health 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 of group coverage.

6.1.11 Coordination of Benefits

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

6.1.12 Conversion Option

Subject to the terms of the provisions regarding individual conversion, individual non-group conversion coverage will be available to persons whose group continuation coverage terminates at the end of the applicable continuation period solely due to the expiration of the coverage period provided by law.

6.1.13 Regulations

In the event federal or state laws or regulations are enacted or issued governing continuation of group coverage and the application of such laws or regulations would modify this section regarding benefits under COBRA, such laws or regulations will supersede any contrary provision herein.

6.2 CONTINUED GROUP COVERAGE AFTER TERMINATION OF COBRA

If a Member elects to extend group health benefits under COBRA, the Member may be entitled to an extension of those group health benefits after COBRA benefits terminate. Group must notify the Member, if he or she is eligible for extended benefits upon termination of coverage under COBRA. The Member will be eligible for this extension if the Member: (i) worked for Group for at least five (5) years prior to the date employment terminated; (ii) is at least sixty (60) years old on the date employment terminated; and (iii) is entitled to and elected benefits under COBRA for himself or herself.

Under this extension of benefits, the Member will receive the same benefits as under COBRA, but the Member will be required to pay Prepayment Fees to Health Plan. Continued coverage under this paragraph will end automatically on the earlier of the date: (i) the Member reaches age 65; (ii) the Member is covered under any group health plan not maintained by Group, regardless of whether that coverage is less valuable; (iii) the Member becomes eligible for Medicare; or (iv) on which Group terminates this Agreement with Health Plan.

6.3 CONVERSION TO INDIVIDUAL NON-GROUP MEMBERSHIP

In the event a Member ceases to be covered under this Agreement solely as a result of leaving the Group through which he or she had enrolled in Health Plan, then such person may convert his/her membership to

individual non-group membership for him or herself without regard to health status or requirements for health care services. However, conversion is not available if:

(A) This Agreement terminated or the Member's Group terminated participation in this Agreement for any reason and this Group contract is replaced by similar coverage under another group contract within fifteen (15) days of the date of termination of the Group coverage or the Member's participation;

(B) The Member fails to pay amounts due to Health Plan;

(C) The Member is terminated by Health Plan for cause;

(D) The Member is eligible for benefits under Medicare or any other Federal or State law;

(E) The Member is eligible for health benefits under any form of group coverage, or is covered for health benefits under an individual policy or contract; or

(F) The Member has not been continuously covered during the three (3) month period immediately preceding the date of termination of group coverage.

Notwithstanding any other provision to the contrary, no Member is eligible to convert to individual non-group coverage where the Member's group coverage was terminated for cause.

Member will convert to non-group membership by submitting a written application and the first premium payment no later than sixty-three (63) days after termination from the Group, after which Health Plan will issue a conversion contract effective on the day following the termination of coverage under the Group Agreement.

It is the sole responsibility of Group to notify Members of the availability, terms and conditions of the non-group conversion coverage within fifteen (15) days of the termination of group continuation coverage.

6.4 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 Total Disability as determined by Health Plan, then such Member will be covered, subject to all limitations and restrictions of this Agreement, including payment of Copayments and the monthly Prepayment Fees, for Covered Services directly relating to the condition causing Total Disability. This extension of benefits terminates upon the earlier of: (i) the end of the twelfth (12^{th}) month after termination of this Agreement; (ii) the date the Member is no longer Totally Disabled as determined by Health Plan; or (iii) the date 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.

Determinations regarding the existence of a Total Disability will be made by a Participating Provider and approved by Health Plan Medical Director. A medical examination performed by a physician specified by Health Plan may be required to determine the existence of a Total Disability.

If Health Plan terminates this Agreement for cause as specified in Paragraph 5.4.4 (Cancellation by Health 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 fees 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 the earlier of: (i) the expiration of such benefits; or (ii) determination by Health Plan that hospitalization is no longer Medically Necessary.

If prior to termination there has been no default in the payment of the monthly Prepayment Fees or those made on the Member's behalf, and the Member is receiving inpatient obstetrical care at the date of termination, Health Plan will continue coverage of the obstetrical care for the mother until discharge from the hospital.

6.5 CONTINUATION COVERAGE

As a result of a being enrolled in the Health Plan, a Member has guaranteed access to continued coverage under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In order to qualify for such continued coverage, the Member must elect and exhaust COBRA or Cal-COBRA benefits.

SECTION 7– MEMBER SATISFACTION AND GRIEVANCE PROCESSES

7.1 MEMBER SATISFACTION

If a Member has a concern about the services received from a Participating Provider, the Member is encouraged to speak with the provider as soon as possible. If the Member does not feel comfortable discussing the issue with the provider, the Member may contact the Health Plan at (805) 685-9525, or outside of Santa Barbara, toll-free at (877) 814-1861. No discriminatory action will be taken against any Member for filing a grievance. The following disclosure is required to be placed in all Agreements, in the EOC, in complaint forms, etc. Use of "you" or "your/yours" refers to a Member.

The California Department of Managed Health Care ("department") is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your Plan by calling **1-877-814-1861or** our **TDD line 1-805-685-4131** for the hearing and speech impaired and use the plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

7.2 GRIEVANCE PROCESSES

Members may report a grievance in person, mail, e-mail, fax, by telephone or through the Plan's website at http://www.sbrha.org. Additionally, grievance forms are available at Health Plan provider offices. Ordinarily, Health Plan will provide written acknowledgment of the Member's grievance within five (5) business days of receipt of the grievance. A written statement of the resolution of the grievance will be sent to the Member within thirty (30) business days of the Plan's receipt of the grievance.

A grievance will be treated as "urgent" if it involves an imminent and serious threat to the health of the patient, including but not limited to severe pain, potential loss of life, limb, or major bodily function. In the case of an urgent grievance, Health Plan will provide the Member with a written statement on the disposition or pending status of the "urgent" grievance within three (3) business days of receipt.

7.2.1 Member Dissatisfaction

If the Member is dissatisfied with the Health Plan's decision, the Member may appeal by calling the Health Plan's Grievance Coordinator at (805) 685-9525, or outside Santa Barbara, toll-free at (877) 814-1861**.**

7.2.2 Independent Medical Reviews

Members are entitled to an Independent Medical Review (IMR) of disputed health care services or to examine Health Plan's coverage decisions regarding certain experimental or investigational therapies as required by law. A "disputed health care service" is any health care service eligible for coverage and payment under this Agreement that has been denied, modified, or delayed by the Health Plan or one of its Participating Providers, in whole or in part because the service is not Medically Necessary.

The IMR process, administered by DMHC, is in addition to any other procedures or remedies that may be available. There is no application or processing fee for IMR. Members have the right to provide information in support of their request for IMR. Health Plan will provide Members with an IMR application form with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause the Member to forfeit any statutory right to pursue legal action against the plan regarding the disputed health care service.

Additional information regarding the IMR process may be obtained by calling Health Plan at (805) 685-9525, or outside of Santa Barbara, toll-free at (877) 814-1861, or by writing to Santa Barbara Regional Health Authority, 110 Castilian Drive, Goleta, CA 93117-3028.

7.2.3 Time Limit for Commencing Arbitration

If the Member is dissatisfied with the final resolution upon completion of the grievance process and wishes to pursue the matter further, he or she may file a request for binding arbitration. Except as provided in Section 8.1 hereof, requests for arbitration must be made within the statutory time limits prescribed for litigation pursuant to the California Code of Civil Procedure.

SECTION 8 – MEDIATION AND ARBITRATION

8.1 VOLUNTARY MEDIATION

A Member may request non-binding voluntary mediation with the Health Plan prior to submitting a grievance to DMHC or initiating binding arbitration. If the Health Plan agrees to mediation, the expenses for mediation shall be borne equally by both sides. Mediation is administered privately, and not by the DMHC. The time limit for initiating binding arbitration is extended for the duration of the mediation process. The use of mediation services does not preclude Member from the right to submit a grievance to DMHC upon completion of the mediation.

8.2 BINDING ARBITRATION

It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this Agreement were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this Agreement, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Binding arbitration is the final process for resolving any disputes between Interested Parties arising from or related to Health Plan membership, whether stated in tort, contract or otherwise. This includes (but is not limited to) disputes involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered). "Interested Parties" means Members, the heirs-at-law or personal representative(s) of a Member, an employer group, a Participating Provider and Health Plan, including any agents or employees of an Interested Party. The agreement to elect binding arbitration shall be enforced even if an Interested Party is also involved in another action or proceeding with a third party arising out of

the same matter. Interested Parties may be giving up their constitutional right to the extent permissible by law to have their dispute decided in a court of law before a jury, if they accept binding arbitration.

Unless otherwise agreed by the parties to the arbitration, the arbitration shall occur within the Health Plan Service Area in accordance with the applicable rules of the American Arbitration Association (AAA) or such other neutral dispute resolution service as mutually agreed by the parties. If the AAA declines the case and the parties do not agree on an alternative service, either party may petition the court for appointment of a neutral arbitrator under California Code of Civil Procedure § 1281.6.

The parties will equally share the arbitrator's fee, if any, as well as any administrative fee, unless otherwise assessed by the arbitrator. In cases of extreme hardship to a Member, the arbitrator or dispute resolution organization may allocate all or a portion of the Member's share of the arbitrator's fees and expenses to Health Plan.

The arbitrator will establish the procedures which will govern the arbitration, including procedures concerning discovery. The arbitrator will be bound by applicable state and federal law and regulations; and will issue a written opinion setting forth findings of fact, conclusions of law and the basis of the decision. The parties will be bound by the decision of the arbitrator as a final determination of the matter in dispute, subject only to such grounds as are available to challenge an arbitration decision under California law. This arbitration provision is subject to enforcement and interpretation under the Federal Arbitration Act.

SECTION 9 – LIMITATIONS ON REMEDIES

9.1 MEDICAL INJURY COMPENSATION REFORM ACT

In any proceeding involving allegations of professional negligence, the damage limits provided by the California Medical Injury Compensation Reform Act shall apply. The ability to obtain an order for periodic payments under California Code of Civil Procedure § 667.7 shall be available in the same manner as if the dispute or controversy had been tried by a court or jury.

9.2 WAIVER OF PUNITIVE DAMAGES

In the event of any claim or controversy between Interested Parties, all Interested Parties expressly waive their right to recover punitive damages against other Interested Parties.

9.3 MEDICAL MALPRACTICE CLAIMS

Any claim alleging wrongful acts or omissions of Participating Providers shall not include Health Plan and shall include only the Participating Providers subject to the allegation.

SECTION 10 – GENERAL PROVISIONS

10.1 CHANGE IN COVERED SERVICES

Health Plan will not decrease Covered Services except as permitted by law and upon at least thirty (30) days prior written notice by postage-paid mail to Group.

10.2 NOTICE OF PARTICIPATING PROVIDER'S INABILITY TO PERFORM

Health Plan will provide affected Members with written notice within a reasonable time of any termination or breach of contract by, or the inability to perform of, any Participating Provider who is rendering services to said Member.

10.3 ADMINISTRATION OF AGREEMENT

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

10.4 NECESSARY DOCUMENTS

Any Member who fails to submit any documents requested under this Agreement related to services received must pay the charges for such services received.

10.5 I.D. CARDS

Cards issued by Health Plan to Members are for identification only. Possession of a Health Plan identification card confers no right to services or other benefits under this Agreement. To be entitled to such services or benefits, the holder of the card must, in fact, be a Member on whose behalf all applicable charges under this Agreement have actually been paid. If any Member permits the use of his or her Health Plan identification card by any other person, such card may be retained by Health Plan, and all rights of such Member pursuant to this Agreement shall be immediately terminable by Health Plan upon written notice. Any person receiving services or other benefits to which he or she is not then entitled pursuant to the provisions of this Agreement must pay applicable charges.

10.6 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.

10.7 WORKERS' 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 Health Plan under Section 11.5 (Third Party Responsibility).

10.8 NO MEMBER LIABILITY FOR HEALTH PLAN'S FAILURE TO PAY PARTICIPATING PROVIDERS

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

10.9 MEMBER LIABILITY TO NON-PARTICIPATING PROVIDERS

In the event Health Plan fails to pay a non-Participating Provider, Member may be liable to such non-Participating Provider for the cost of such provider's services, unless Prior Authorization has been obtained from Health Plan or the services were for Emergency services.

10.10 HEALTH PLAN LIABILITY FOR CHARGES

Upon termination of a Participating Provider contract, Health Plan will be liable for Covered Services (other than for Copayments) rendered by such Participating Provider for a Member under the care of such Participating Provider at the time of such termination until the Covered Services are completed, unless Health Plan makes reasonable and medically appropriate provisions for the assumption of such Covered Services by another provider.

10.11 NONDISCRIMINATION

Health Plan may not refuse to enter into any contract, cancel or decline to renew or reinstate any contract, nor may Health Plan modify the terms of a contract because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, genetic characteristics, handicapped status, or age (except

as provided in Section 1, Eligibility) of any contracting party, or person reasonably expected to benefit from such contract.

10.12 RELATIONSHIPS AMONG THE PARTIES

The relationship between Health Plan and Participating Providers is that of independent contractors. Participating Providers are not employees or agents of Health Plan. Neither Health Plan nor any of its employees are, or will be deemed to be employees, agents or representatives of Participating Providers.

Participating Providers maintain the provider-patient relationship with Members and are solely responsible to Members for all of their services. In no event will Health Plan be liable for the negligence, wrongful acts, or omissions by a Participating Provider's delivery of services regardless of whether they are covered under this Agreement, nor will Health Plan be liable for services or facilities which for any reason beyond its control are unavailable to Member. Neither Group nor any Member is the agent or representative of Health Plan.

10.13 BINDING EFFECT UPON MEMBERS

By executing this Agreement, Group agrees to make Health Plan benefits available to persons who are eligible and duly enrolled under Section 1 (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.

10.14 CHANGE IN AGREEMENT

Health Plan may add, amend, modify, or delete provisions in this Agreement as permitted by law by giving Group thirty (30) days written notice. Otherwise this Agreement may not be changed, amended, or modified except in writing executed by Group and Health Plan. Group's concurrence in such amendments is established by continuation of coverage hereunder after the effective date of the amendment. This Agreement may be amended, modified or terminated in accordance with its terms, without the consent of the Members.

10.15 NONWAIVER

No delay or failure by Health Plan to exercise any right under this Agreement will be deemed a waiver of such right in the future. The provision by Health 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.

10.16 ASSIGNMENT

Neither party shall have the right to assign this Agreement unless such assignment is required by law or the prior written consent of the other party is first obtained. Any purported assignment in violation hereof shall be void and unenforceable. Health Plan may, however, assign its rights and obligations under this Agreement to another licensed health care service plan or nonprofit hospital service plan affiliated with or acting as a successor to Health Plan.

10.17 NOTICES

Unless otherwise specified in this Agreement, Group agrees to disseminate to its Members the EOC and any changes to the EOC, plan summaries or other notices regarding material matters in the next regular communication to such Members, but in no event later than thirty (30) days after receipt thereof from Health Plan. Where Group is obligated to initiate notice, Group shall do so in accordance with the specific contractual terms and time frames contained in this Agreement and in accordance with applicable state and federal law pertaining to the notice.

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

To Health Plan:	Santa Barbara Regional Health Authority 110 Castilian Drive Goleta, CA 93117-3028
To Member:	Member's last address known to Health Plan
To Group:	Group's last address known to Health Plan

10.18 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.

10.19 GOVERNING LAW

Health Plan is subject to the requirements of the Knox-Keene Act and its regulations (Chapter 2.2 of Division 2 of the California Health & Safety Code and applicable regulations developed by the Director of DMHC as set forth in Chapter 1 of Title 28 of the California Code of Regulations). Any provisions required by either of the above will bind Health Plan whether or not specifically set forth in this Agreement.

10.20 ENTIRE AGREEMENT

This Agreement, addenda and membership applications constitute the entire agreement between the parties as of the Effective Date, 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 Health Plan unless expressly set forth in this Agreement.

SECTION 11 – LIMITATIONS ON BENEFITS

11.1 CIRCUMSTANCES BEYOND HEALTH PLAN'S CONTROL

If, due to circumstances not reasonably within the control of Health 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 Health 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. Under such conditions, Members should seek services from the nearest hospital or call the "9-1-1" emergency response system. In the case of labor disputes, the obligation of Health Plan will be to arrange and pay for an alternate method of receiving care.

11.2 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, CHAMPUS, or any other health plan or insurance policy. All sums paid or payable for Covered Services provided pursuant to this Agreement will be payable to and are deemed assigned to Health Plan. By executing an enrollment application, Member agrees for himself/herself to submit to Health Plan the necessary claim forms, consents, releases, assignments and other documents reasonably requested by Health Plan, including enrollment under Parts A and B of the Medicare Program, in order to assist Health Plan in recovering the reasonable value of Covered Services provided to a Member who receives benefits covered under Medicare, CHAMPUS, Workers' Compensation or any other health plan or insurance policy. Any Member who fails to submit such documents reasonably requested must pay charges for Covered Services received, as determined by Health Plan, and will be subject to termination. When a Member has available benefits with another health plan or insurance policy, Health 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 Member's obligation to make all required Copayments. The non-duplication provisions of this paragraph apply to the full extent permitted by law.

11.3 REIMBURSEMENT RESPONSIBILITY OF HEALTH PLAN

In the event Health Plan for any reason beyond its control, is unable to provide Covered Services, then Health 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 DMHC.

11.4 REFUSAL OF TREATMENT

Members may, for personal reasons, refuse to accept procedures or treatment recommended by Participating Providers. Participating Providers may regard such refusal to accept their recommendations as incompatible with the continuance of the physician-patient relationship and as obstructing the provision of proper medical care. If a Member refuses to accept such a recommended treatment or procedure and the Participating Provider believes that no professionally acceptable alternative exists, Member will be so advised and Member may seek a second opinion from another Participating Provider.

11.5 THIRD PARTY RESPONSIBILITY

In cases of injuries caused by any act or omission of a third party (including, without limitation, motor vehicle accidents and Workers' Compensation cases) and complications incident thereto, Health Plan will furnish Covered Services. However, in the event of any recovery from a third party on account of such injuries, Member will reimburse Health Plan for the reasonable costs actually paid to perfect the claim for reimbursement, as set forth below. By executing an enrollment application, each Member grants Health Plan a lien on any such recovery and agrees to protect the interests of Health Plan when there is a possibility that a third party may be liable for a Member's injuries.

(A) Member's reimbursement to Health Plan or the medical provider under this lien will not exceed the reasonable costs actually paid by Health Plan to perfect the lien. Determining the lien amount, depends on how the Participating Provider was paid and will be determined as permitted by law as follows: (1)For health care services not provided on a capitated basis, the amount actually paid by the licensee, medical group, or independent practice association pursuant to that contract or policy to any treating medical provider; (2) For health care services provided on a capitated basis, the amount equal to 80 percent of the usual and customary charge for the same services by medical providers that provide health care services on a noncapitated basis in the geographic region in which the services were rendered.

(B) Each Member will give prompt notification to Health Plan of the name and location of the third party, if known, the name and address of Member's lawyer if using one, and a description of how the injuries were caused.

(C) Each Member will: (i) complete any paperwork that Health Plan or the medical providers may reasonably require to assist in enforcing the lien; (ii) promptly respond to inquiries about the status of the third party case and any settlement discussions; (iii) notify the Health Plan immediately upon his/her or his/her lawyer receiving any money from the third parties or their insurance companies; and (iv) hold any money that he/she or his/her lawyer receives from the third parties or their insurance companies in trust, and reimburse Health Plan for the amount of the lien as soon as he/she is paid by the third party.

(D) If a Member obtains a final judgment that includes a special finding by a judge, jury or arbitrator that Member was partially at fault, the reimbursement due Health Plan under this section will be reduced by the same percentage of comparative fault by which the Member's recovery was reduced. The reimbursement due Health Plan under this section will also be reduced by a pro rata share of the Member's reasonable attorneys' fees and costs, in accord with the common fund doctrine. Further, the reimbursement due to Health Plan under this section will not exceed one-

third (1/3) of Member's recovery if Member engaged an attorney, or one-half (1/2) of Member's recovery if Member did not engage an attorney. (The provisions of this subparagraph (D) do not apply to reimbursement sought through a Workers' Compensation claim.)

(E) The obligation to reimburse Health 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.

(F) Hospitals and other parties providing medical services to Members may have additional lien rights of their own, which are not created through any agreement with Health Plan, and are separate from the lien rights described in this section.

11.6 COORDINATION OF BENEFITS (COB)

11.6.1 Medicare Eligible Members

For this Group, because there is no coverage for any dependents, the provisions of this subsection 11.6.1 shall most likely cover COB situations for Group Members. However, the provisions of Section 11.6.2 are set forth herein to describe all COB situations.

If Group employs twenty or more employees for each working day in each of twenty (20) or more calendar 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 Members who are employees actively at work (including reemployed retirees or annuitants) and who are age 65 or older will be subject to the same benefits, prepayment fees, and other conditions as other Members and Health Plan will provide primary coverage with respect to such active employees.

11.6.2 General COB Law and Regulation

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 Health Plan Members, and Health 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 thirty (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 Health Plan Members, and Health 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 Health Plan Members who do not have End Stage Renal Disease, provided that following the 30-month period or such other period as may be required by law, Health Plan will provide secondary coverage with respect to such Members who are Medicare eligible.

Except as otherwise provided above, Members who are or who become Medicare eligible shall enroll in Medicare (Parts A and B) as a condition of continued eligibility for Health Plan benefits. Health Plan will provide with respect to such Members only secondary coverage with Medicare deemed to be primary.

(A) Benefits Subject to This Provision

All the benefits provided under this Plan contract are subject to this Section 11.6.

(B) Definitions for Purposes of This Section:

(1) "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) Group, 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.

The term "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 Plans into consideration in determining its benefits and that portion which does not.

(2) "This Plan" means that portion of this Agreement which provides the benefits that are subject to this Section 11.6.

(3) "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 Plans covering the person for whom the claim is made. When a 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.

(4) "Claim Determination Period" means a calendar year.

(C) Effect on Benefits

(1) This Section (C) will apply in determining the benefits as to a person covered under This 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 Plan in the absence of this COB provision; and

(b) The benefits that would be payable under all other 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 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 Plans, except as provided in subparagraph (3) of this Section (C) will not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefor.

(3) If

(a) Another Plan which is involved in subparagraph (2) of this S(C) and which contains a provision coordinating its benefits with those of This Plan would, according to its rules, determine its benefits after the benefits of This Plan have been determined, and

(b) The rules set forth in subparagraph (4) of this Section (C) would require This Plan to determine its benefits before such other Plan, then, the benefits of such other Plan will be ignored for the purposes of determining the benefits under This 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 Plan which covers the person on whose expenses claim is based other than as a family member, will be determined before the benefits of a Plan which covers such person is covered as a family member, 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 Plan covering the person as a family member; and

2. Primary to the Plan covering the person as other than a family member (a retired employee);

then the benefits of the Plan covering the person as a family member are determined before those of the Plan covering that person as other than a family member.

(b) Except for cases of a person for whom claim is made as a child whose parents are separated or divorced, the benefits of a Plan which covers the person on whose expenses claim is based as a family member of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, will be determined before the benefits of a Plan which covers such person as a family member of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either Plan does not have the provisions of this subparagraph which results either in each Plan determining its benefits before the other or in each Plan determining its benefits after the other, the provisions of this subparagraph will not apply, and the rule set forth in the Plan which does not have the provisions of this subparagraph will determine the order of the benefits.

(c) Except as provided in subparagraph (4)(e) of this Section (C), in the case of a person for whom claim is made as a child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a family member of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody.

(d) Except as provided in subparagraph (4)(e) of this Section (C), in the case of a person for whom claim is made as a dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a dependent of the parent without custody.

(e) In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding subparagraphs (4)(c) and (4)(d), the benefit of a Plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other Plan which covers the child as a dependent child.

(f) Except as provided in subparagraph (4)(g) of this Section (C), the benefits of a Plan covering the person for whose expenses claim is based as a laid off or retired employee, or family member of such person, will be determined after the benefits of any other Plan covering such person as an employee, other than a laid off or retired employee or family member of such person.

(g) If either Plan does not have a provision regarding laid off or retired employees, which results in each Plan determining its benefits after the other, then the rule under subparagraph (4)(f) of this Section (C) will not apply.

(h) If a person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the following will be the order of benefit determination:

1. First, the benefits of a Plan covering the person as an employee, member, or Member, or as that person's family member;

2. Second, the benefits under continuation coverage. If the other Plan does not have the rules described above, and if, as a result, the Plans do not agree on the order of benefits, the rule under this subparagraph (4)(h) of Section (C) is ignored.

(i) When subparagraphs (4)(a) through (4)(h) of this Section (C) do not establish an order of benefit determination, the benefits of a 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 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 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 Plan.

(D) Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision of This Plan or any provision of similar purpose of any other Plan, This Plan may release to or obtain from any insurance company or other organization or person any information, with respect to any person, which This Plan deems to be necessary for such purposes. Any person claiming benefits under This Plan will furnish such information as may be necessary to implement this provision.

(E) Facility of Payment

Whenever payments which should have been made under This Plan in accordance with this COB provision have been made under any other Plans, This 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 Plan and, to the extent of such payments, This Plan will be fully discharged from liability under This Plan.

(F) Right of Recovery

Whenever payments have been made by This 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 Plan will have the right to recover such payments, to the extent of such excess, from one or more of the following, as This 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.

SECTION 12 – DEFINITIONS

12.1 **"Approved Drug Usage"** means: (i) use for the labeled indications (FDA-approved indications); or (ii) use by a Physician for treatment of a life-threatening condition; and (iii) use for which the drug has been recognized by the AMA Drug Evaluations, The American Hospital Formulary, the United States Pharmacopoeia, or at least two articles from major peer reviewed medical journals that present data supporting the proposed use as safe and effective unless clear and convincing contradictory evidence appears in a similar journal.

12.2 **"Charges"** means the Participating Providers' contracted rates or the actual charges payable for Covered Services, whichever is less. Actual charges payable to non-Participating Providers shall not exceed usual, customary and reasonable charges. "Usual" charges means the fees usually charged for given services by providers to their private patients (their usual fees). "Customary" charges mean the fees that are within the range of usual charges charged by providers of similar training and experience for the same services within the same geographic area as determined by Health Plan. "Reasonable" charges mean the charges that are usual and customary or are justifiable in consideration of any Medically Necessary special circumstances.

12.3 **"Copayment"** means the amount which a Member is required to pay for certain Benefits, as set forth in Attachment 2 of this Agreement, and as disclosed in the EOC.

12.4 **"Coinsurance"** means a Member's share of the medical benefit cost for certain covered benefits.

12.5 **"Covered Services"** means those Medically Necessary health care services and supplies that a Member is entitled to receive as determined by Health Plan and subject to all of the terms, conditions, exclusions and limitations of this Agreement.

12.6 **"Custodial" or "Domiciliary Care"** means care that can be provided by a lay person, that does not require the continuing attention of trained medical or paramedical personnel, and that has no significant relation to treatment of a medical condition. Such services include, but are not limited to, help in walking and getting out of bed, assistance in bathing, dressing, eating, using the toilet, preparation of special diets and supervision of medication which can usually be self-administered.

12.7 **"Dental Services"** means any services or X-ray exams involving one or more teeth, the tissue or structure around them, the alveolar process or the gums. Such services are considered dental even if a condition requiring any of these services involves a part of the body other than the mouth, such as treatment of Temporomandibular Joint Disorders (TMJD) or malocclusion involving joints or muscles by such methods as crowning, wiring or repositioning teeth. Medically Necessary surgical procedures for a condition directly affecting the upper or lower jawbone, or associated bone joints, is not considered a Dental Service.

12.8 **"Diabetes Equipment and Supplies"** means the following items for the treatment of insulin-using diabetes or non-insulin-using diabetes and gestational diabetes as Medically Necessary: (i) blood glucose monitors; (ii) blood glucose testing strips; (iii) blood glucose monitors designed to assist the visually impaired; (iv) insulin pumps and related necessary supplies; (v) ketone urine testing strips; (vi) lancets and lancet puncture devices; (vii) pen delivery systems for the administration of insulin; (viii) podiatric devices to

prevent or treat diabetes related complications; (ix) insulin syringes; and (x) visual aids, excluding eyewear to assist the visually impaired with proper dosing of insulin.

12.9 "Educational Services" means services or supplies whose primary purpose is to provide any of the following: training in the activities of daily living; instruction in scholastic skills such as reading or writing; preparation for an occupation; or treatment for learning disabilities.

12.10 "Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(A) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; or

(B) serious impairment to bodily functions; or

(C) serious dysfunction of any bodily organ or part.

Emergency services include (but are not limited to) the evaluation to determine if a psychiatric emergency medical condition exists and treatment necessary to relieve or eliminate the psychiatric emergency medical condition.

12.12 "Experimental or Investigational Treatment" means services, tests, treatments, supplies, devices or drugs that are not generally accepted by informed medical professionals in the United States, at the time the services, tests, treatments, supplies, devices or drugs are rendered, as safe and effective in treating or diagnosing the condition for which their use is proposed, unless approved by:

(A) The Diagnostic and Therapeutic Technology Assessment Project of the American Medical Association;

(B) The Office of Health Technology Assessment of the U.S. Congress;

(C) The National Institute of Health;

(D) The Federal Food and Drug Administration; or

(E) The specialty board and the academy it represents as recognized by the American Board of Medical Specialties (ABMS).

Approved Drug Usage will not be excluded as Experimental or Investigational.

12.13 "FDA-Approved Drug" means drugs, medications and biologicals approved by the Food and Drug Administration and listed in the United States Pharmacopoeia, the AMA Drug Evaluations and/or the American Hospital Formulary.

12.14 "Hospice Care" means care and services provided in a home or facility by a licensed or certified hospice provider that are: (i) designed to provide palliative and supportive care to individuals who have received a diagnosis of terminal illness (i.e. a medical prognosis that life expectancy is one year or less if the disease follows its natural course); (ii) directed and coordinated by medical professionals; and (iii) authorized by Health Plan.

12.15 "Hospital" means either of the following:

(A) a licensed and accredited health facility that is primarily engaged in providing, for compensation from patients, medical, diagnostic surgical facilities and/or rehabilitation services for the care and treatment

of sick and injured Members on an Inpatient basis, and which provides such facilities under the supervision of a staff of physicians and 24 hour a day nursing service by registered nurses. A facility that is principally a rest home, nursing home or home for the aged is not included; **or**

(B) a psychiatric hospital licensed as a health facility accredited by the Joint Commission on Accreditation of Health Care Organizations; **or**

(C) a licensed health facility operated primarily for the treatment of alcoholism and/or substance abuse accredited by the Joint Commission on Accreditation of Health Care Organizations; **or**

(D) a "psychiatric health facility" as defined in § 1250.2 of the Health and Safety Code.

12.16 "Inpatient Hospital Services" means those Covered Services which are provided by a Hospital, excluding long term non-acute care, to an individual who has been admitted to a Hospital as a registered bed patient and is receiving services under the direction of a Physician.

12.19 "Medical or Scientific Literature" means medical and scientific evidence from:

(A) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements;

(B) Medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS data base Health Services Technology Assessment Research (HSTAR);

(C) Medical journals recognized by the Secretary of Health and Human Services, under § 1861(t)(2) of the Social Security Act;

(D) The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;

(E) Findings**,** studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, for the purpose of evaluating the medical value of health services; or

(F) Peer-reviewed abstracts accepted for presentation at major medical association meeting.

12.20 "Medically Necessary" means that the service is:

(A) Rendered for the treatment or diagnosis of an injury or illness; and

(B) Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence, professionally recognized standards and Health Plan medical criteria; and

(C) Not furnished primarily for the convenience of the Member, the attending physician, or other provider of service, and not required solely for custodial, comfort, or maintenance reasons; and

(D) Furnished in the most economically efficient manner that may be provided safely and effectively to the Member, and at a frequency that is accepted by the medical community as medically appropriate.

The fact that a physician may have ordered or prescribed a service does not mean that it is Medically Necessary or a Covered Service under this Agreement.

Whether there is "sufficient scientific evidence" shall be determined by Health Plan based on, but not limited to, Medical or Scientific Literature.

12.21 **"Member"** means a Member who is entitled to receive covered services. For purposes of this Agreement, since there is no dependent coverage available, "subscriber" and "Member" may be used interchangeably. Additionally, when a husband and wife are both employees of the group both are entitled to claim the combined maximum contractual benefits to which an employee is entitled, not to exceed in the aggregate 100% of the charge for the covered expense or Covered Service.

12.22 **"Orthotic Device"** means a rigid or semi-rigid device used as a support or brace affixed to the body externally to support or correct an acutely injured or diseased body part and that is Medically Necessary to the medical recovery of the Member.

12.23 **"Out of Area Coverage"** means coverage while a Member is anywhere outside the Service Area, and shall also include coverage for Urgent Care Services to prevent serious deterioration of a Member's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the Member returns to the Service Area.

12.24 **"Outpatient Hospital Services"** means those Covered Services which are provided by a hospital to Members who are not inpatients at the time such services are rendered.

12.25 **"Participating Hospital"** means a duly licensed Hospital which, at the time care is provided to a Member, has a contract in effect with Health Plan to provide services to Members. The Covered Services which some Participating Hospitals may provide to Members are limited by Health 14.22

12.26 **"Participating Physician"** means a Physician who, at the time care is provided to a Member, has a contract in effect with Health Plan to provide services to Members.

12.27 **"Participating Provider"** means a Participating Physician, Participating Hospital, or other licensed health professional or licensed health facility, including subacute facilities, located within the Service Area who, or which, at the time care is provided to a Member, has a contract in effect with Health Plan to provide Covered Services to Members. Information about Participating Providers may be obtained by telephoning Health Plan at (805) 685-9525 or, outside of Santa Barbara, (800) 421-2560.

12.28 **"Person"** means any person, individual, firm, association, organization, partnership, business trust, foundation, labor organization, corporation, limited liability company, public agency, or political subdivision of the State.

12.29 **"Prepayment Fees"** means the amount required to be paid by Group on behalf of Members in order for Members to be entitled to receive Covered Services.

12.30 **"Primary Care Physician" or "PCP"** means a general practitioner, board certified or eligible family practitioner, internist, obstetrician/gynecologist, or pediatrician who has contracted with the Plan as a primary care physician to provide primary care to Members and to refer, authorize, supervise and coordinate the provision of all benefits to Members in accordance with Group Health Service Agreement.

12.31 **"Prior Authorization"** means the requirement that a Member's attending physician request approval of coverage from Health Plan prior to the Member obtaining certain Covered Services. Requests for Prior Authorization will be denied if not Medically Necessary. Requests for Prior Authorization of coverage for services by non-Participating Providers will also be denied if Health Plan determines that comparable or more appropriate services are available through Participating Providers. The fact that a Participating Provider may order or refer a Member for a service does not constitute Prior Authorization. Prior Authorization must come directly from Health Plan.

12.32 **"Prosthetic Device"** means a standard artificial device affixed externally to the body to replace a missing body part.

12.33 "Referral Authorization Form" or "RAF" means the required referral authorization form, or number, evidencing a referral by a PCP, the PCP's designee, or the Medical Director or his/her non-physician designee, to render services. Selected services that do not require RAFs (including but not limited to Emergency services and most Self Referral Services) are set forth in the Operations Manual that is made available to Participating Providers**.**

12.34 "Self Referral Services" means the services in addition to Emergency or Urgent Care Services that Members are allowed to access, through a Participating Provider, without authorization. Self-Referral Services include, but are not limited to the following: Family Planning and abortion services; OB/GYN services; AIDS/HIV testing; Sexually transmitted disease testing and treatment; services from a specialist when a standing RAF has been issued by the PCP, Nutrition Education services (first visit) under the diabetes management benefit or for those receiving treatment for phenylketonuria.

12.35 "Service Area" means Santa Barbara County, California.

12.36 "Skilled Nursing Facility" means a facility that is licensed to operate in accordance with the state and local laws pertaining to institutions identified as such and that is listed by the American Hospital Association and accredited by the Joint Commission on Accreditation of Hospitals and Related Facilities, or that is recognized as a Skilled Nursing Facility by the Secretary of Health and Human Services of the United States pursuant to the Medicare Act.

12.37 "Subscriber" means the person whose employment or other status, except for family dependency, is the basis for eligibility, who meets all applicable eligibility requirements of Section 1 (Eligibility) and who has enrolled in accordance with that Section 1. For purposes of this Agreement, since there is no dependent coverage available, "Subscriber" and "Member" may be used interchangeably.

12.38 "Surcharge" means an additional fee which is charged to a Member for a Covered Service but which is not provided for in this Agreement nor in the EOC. A Surcharge by any contracted provider constitutes a breach of contract.

12.39 "Totally Disabled" or "Total Disability" means that an individual, by reason of injury, illness, birth defect, or other physical condition, which has lasted or can be expected to last for a continuous period of not less than twelve (12) months, is unable to engage in substantially all of those normal activities conducted prior to the occurrence of the disability, including but not limited to, the duties of employment in any gainful employment for which such person is reasonably fitted by training, education, experience or school attendance, including the performance of housework. A Member who is able to work, attend school, or perform household activities on a part-time basis is not Totally Disabled. Determinations regarding the existence of the Total Disability shall be made only on the basis of medical examination by a Participating Physician of the person claiming such disability and concurrence by the Plan based on professionally recognized standards, including but not limited to, Social Security Administration criteria for total disability.

12.40 "Urgent Care Services" means services provided in response to the member's need for a prompt diagnostic workup and/or treatment of a medical or mental disorder that could become an emergency if not diagnosed and/or treated in a timely manner and delay is likely to result in prolonged temporary impairment, unwarranted prolongation of treatment increasing the likelihood of more complex or hazardous treatment, development of chronic illness, or inordinate physical or psychological suffering of the member.

12.41 "Vocational Rehabilitation" means evaluation, counseling and placement services designed or intended primarily to assist an injured or disabled individual find appropriate employment.

ATTACHMENT 1

RATE SCHEDULE

The following monthly rate is effective January 1, 2005 and will continue through December 31, 2007:

$335 per member per month.

ATTACHMENT B

EVIDENCE OF COVERAGE AND DISCLOSURE FORM (EOC)

The EOC will be provided to Group when the updated and printed version is available.