RESOLUTION NO. 2017-061

A RESOLUTION OF THE CITY COUNCIL OF ROHNERT PARK AUTHORIZING AND APPROVING (1) SUTTER HEALTH PLAN LARGE GROUP HEALTH CARE SERVICES CONTRACT, AND (2) ACN GROUP OF CALIFORNIA, INC DBA AS OPTUMHEALTH PHYSICAL HEALTH OF CALIFORNIA. GROUP ENROLLMENT AGREEMENT

WHEREAS, the City of Rohnert Park offers health insurance to its active employees and pre-Medicare retirees through Kaiser Permanente and the Redwood Municipal Insurance Fund and;

WHEREAS, the City of Rohnert Park desires to offer its active employees and pre-Medicare retirees the opportunity to participate in additional health insurance plans with comparable benefits and competitive rates and;

WHEREAS, Sutter Health Plans ("Sutter") and ACN Group of California, Inc. dba as OptumHealth Physical Health of California ("ACN") offer health plans with comparable benefits and competitive rates.

NOW, THEREFORE, BE IT RESOLVED that the City Council of the City of Rohnert Park hereby approves (1) Sutter Health Plan Large Group Health Care Services Contract which is attached hereto as Exhibit A and is incorporated herein by this reference; (2) ACN Group of California, Inc. dba as OptumHealth Physical Health of California which is attached hereto as Exhibit B and is incorporated herein by this by this reference.

BE IT FURTHER RESOLVED that the City Manager is authorized and directed to execute the Sutter Health Plan Large Group Health Care Services Contract and ACN Group of California, Inc. dba as OptumHealth Physical Health of California Group Enrollment Agreement and any other necessary documents on behalf of the City of Rohnert Park. The City Manager is further authorized to make any needed revisions to the contract to clarify its terms or to comply with law.

DULY AND REGULARLY ADOPTED by the City Council of the City of Rohnert Park this 9th day of May 2017.

CITY OF ROHNERT PARK

Jake Mackenzie, Mayor

ATTEST:

Caitlin Saldanha, Deputy City Clerk

Attachments: Exhibit A and Exhibit B

AHANOTU: Aye BELFORTE: Aye CALLINAN: Aye STAFFORD: Aye MACKENZIE: Aye

AYES: (5) NOES: (0) ABSENT: (0) ABSTAIN: (0)

Exhibit A

LARGE GROUP HEALTH CARE SERVICES CONTRACT EXECUTION SHEET
(This Contract Execution Sheet is an integral part of the Agreement between Group and Sutter Health Plan)

GROUP NAME: CITY OF ROHNERT PARK	**NUMBER OF ELIGIBLE EMPLOYEES: 221**
GROUP PHYSICAL ADDRESS: **130 AVRAM AVENUE** **ROHNERT PARK, CA 94928**	**EMPLOYEE ELIGIBILITY** **Minimum Hours Worked per Week: 20** **DEPENDENT ELIGIBILITY:** **Age Limits: Up to Age 26**
COVERAGE EFFECTIVE DATE: 07/01/2017	**MONTHLY PREMIUM RATES:**
INCLUDED EMPLOYERS:	**(if more than one benefit plan, attach rate sheet) See attached** **Single:** **EE + Spouse:** **EE + Child(ren):** **Family:**
	GROUP CONTRIBUTION AMOUNT: $500/$1,000/$1,400

GROUP'S AGREEMENT TO BE BOUND: The Agreement shall be effective on the Coverage Effective Date, as set forth above, if the initial premium has been paid and the Agreement is duly executed below. The Agreement continues as long as the required premiums are paid, unless it is terminated as set forth in Article 7.

MANDATORY ARBITRATION. Group, Member (including any heirs or assigns) and SHP agree and understand that any and all disputes by and between them, including claims of medical malpractice (that is as to whether any medical services rendered under the Health Plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, shall be determined by submission to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Each party, including any heirs or assigns, to this Agreement is giving up its constitutional right to have any such dispute decided in a court of law before a jury, and instead is accepting the use of binding arbitration.

IN WITNESS WHEREOF, the parties hereto, being first duly authorized, have set their hands on the dates set forth below.

Group:	**Sutter Health Plan:**
PRINTED NAME: _____	PRINTED NAME: Rob Carnaroli
By: _____	By: _____
Title: _____	Title: Vice President of Sales
Date: _____	Date: _____

This Large Group Health Care Services Contract ("Agreement") is made by and between Sutter Health Plan ("SHP"), a California not-for-profit health care service plan and the employer, association or other entity specified as "GROUP" on the Contract Execution Sheet ("hereinafter referred to as "Group") for the provision of health services.

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RECITALS

A. SHP is a health care service plan that arranges for the provision of medical, hospital and preventive medical services to persons enrolled as Members through contracts with licensed physicians, hospitals and other health care providers. Group is an employer, union, trust, organization, or association which desires to make such health care available to its Eligible Employees and their Eligible Dependents.

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

Article 1

DEFINITIONS

The terms used in this Agreement have the meanings set forth in this Article 1, and the meanings set forth in the Combined Evidence of Coverage and Disclosure Form, attached hereto as Attachment 2, and made a part of this Agreement.

1.1 Agreement The Agreement includes this Group Health Care Services Contract, the Contract Execution Sheet, the Group Application, the Rate Sheet, [any Optional Benefit Riders]and any amendments thereto.

1.2 Associated Companies. Associated Companies are employers that are the Group's subsidiaries or affiliates listed as "Included Employers" on the Contract Execution Sheet.

1.3 Combined Evidence of Coverage and Disclosure Form. Combined Evidence of Coverage and Disclosure Form is the document issued to prospective and enrolled Subscribers disclosing and setting forth the benefits and terms and conditions of coverage to which Members of the Health Plan are entitled, attached as Attachment 2, and includes any Combined Evidence of Coverage and Disclosure Forms for Optional Benefit Riders attached as Attachment 3, if Group has elected to purchase such additional optional coverage.

1.4 Copayments. Copayments are fees payable to a health care provider by the Member for provision of Covered Services, which are in addition to the Health Plan Premiums paid by the Group. Such fees may be a specific dollar amount or a percentage of total fees as specified herein, depending on the type of services provided.

1.5 Contract Execution Sheet. Contract Execution Sheet is the Group Health Care Services Contract Execution Sheet, which is attached to and is an integral part of this Agreement

1.6 Dependent is any spouse, registered domestic partner or a married or unmarried child (including a step-child or adopted child or newborn) of a Subscriber who is enrolled hereunder, who meets all the eligibility requirements set forth in the SHP Combined Evidence of Coverage and Disclosure Form attached to this Agreement, and for whom applicable Health Plan Premiums are received by SHP. Dependent also includes a non-registered domestic partner if the option to include non-registered domestic partners is selected by the Group on the Group Application and documentation set forth on the Group Application is provided in a timely manner.

1.7. Eligible Dependent. Eligible Dependent is any spouse, registered domestic partner or a married or unmarried child (including a step-child or adopted child or newborn) of an Eligible Employee, who works or resides within the service area and who is eligible for Enrollment as a Dependent in the Health Plan.

1.8 Eligible Employee. Eligible Employee is a Group employee (as defined under State and Federal law) who meets any applicable waiting period and additional criteria specified by the Group for eligibility in the Health Plan. Consultants, temporary labor, suppliers or contractors are not Eligible Employees.

1.9. Enrollment. Enrollment is the execution of an SHP Enrollment form, or a non-standard Enrollment form approved by SHP, by the Group, and by the Subscriber on behalf of the Subscriber and his or her Dependents, and acceptance thereof by SHP, conditioned upon the execution of this Agreement by SHP, and either the execution of this Agreement by Group or the timely payment of applicable Health Plan Premiums by Group. SHP may, in its sole discretion and subject to specific protocols, accept Enrollment through an electronic submission from Group.

1.10. Group. Group is the single employer labor union, trust, organization, or association identified on the Contract Execution Sheet. If a Group has delegated any of its duties under this Agreement or the laws and regulations pertaining to this Agreement, the term "Group" shall include the Group's designee.

1.11. Group Contribution. Group Contribution is the amount of the Health Plan Premium applicable to each Subscriber which is paid solely by the Group or Included Employer(s) and which is not paid by the Subscriber either through payroll deduction or otherwise.

1.12. INTENTIONALLY LEFT BLANK.

1.13. Health Plan. Health Plan is the benefit program described in this SHP Group Service Agreement, Contract Execution Sheet and attachments, including the Combined Evidence of Coverage and Disclosure Form, subject to modification pursuant to the terms of this Agreement.

1.14 Health Plan Premiums. Health Plan Premiums are amounts set forth on the Rate Sheet to be paid to SHP on behalf of Members in consideration of the benefits provided under this Health Plan, as such amounts are from time-to-time amended in accordance with the terms of this Agreement.

1.15 Initial Enrollment Period. Initial Enrollment Period means the thirty-one day period commencing the first day an employee of the Group or a Dependent becomes an Eligible Employee or Eligible Dependent, respectively.

1.16 Included Employers. Included Employers under the Agreement are the Group and its Associated Companies, if any. An Employee of more than one Included Employer will be considered an Employee of only one of those employers for the purpose of the Group Health Care Coverage. On any date when an employer ceases to be an Included Employer, the Agreement will be considered to end for Employees of that employer. This applies to all of those Employees except those who, on the next day, are still within the covered classes of the Agreement as Employees of another Included Employer.

1.17 Notifications. Group must notify SHP, in writing, when an employer listed as an Associated Company is no longer one of its subsidiaries or affiliates.

1.18 Open Enrollment Period. Open Enrollment Period is a once a year period, as mutually agreed by the Group and SHP, during which Eligible Employees and their Eligible Dependents who have not previously enrolled in this Health Plan may do so. Unless otherwise mutually agreed by SHP and Group, the Open Enrollment Period will be the 30 day period immediately preceding the renewal date of this Agreement.

1.19 Rate Sheet. Rate Sheet is the attachment to this Agreement entitled Attachment 1 and setting forth the Health Plan Premiums to be paid by Group to SHP in consideration of coverage under the Health Plan. By this reference, the Rate Sheet is incorporated in this Agreement as though set forth fully herein.

1.20 INTENTIONALLY LEFT BLANK.

1.21 Subscriber. Subscriber is the Eligible Employee enrolled in the Health Plan for whom the appropriate Health Plan Premium has been received by SHP, and whose employment or other status, except for family dependency, is the basis for enrollment eligibility.

Article 2

ELIGIBILITY AND ENROLLMENT OF INDIVIDUALS, SUBSCRIBERS AND DEPENDENTS

Individuals are eligible for enrollment hereunder only upon meeting and continuing to meet the requirements set forth in this Article 2.

2.1 Enrollment Procedure

2.1.1 Enrollment Form. Group must submit a properly completed Enrollment form, on a form provided by SHP, or a non-standard form approved by SHP, signed by Employee and Group, for each Eligible Employee and any Eligible Dependents to be enrolled in the Health Plan. SHP may, in its discretion and subject to specific protocols, accept Enrollment through an electronic submission from Group.

2.1.2 Time of Enrollment. Except for applications from those Eligible Employees or Eligible Dependents who meet the requirements for late Enrollment as set out in the Combined Evidence of Coverage and Disclosure Form, all applications for Enrollment shall be submitted within the Eligible Employee's or Eligible Dependent's Initial Enrollment Period, or during Open Enrollment Periods. All applications for Enrollment which are not received by SHP within the respective Eligible Employee's or Eligible Dependent's Initial Enrollment Period, or within thirty one (31) days from the end of the Open Enrollment Period shall be subject to rejection by SHP. Eligible Employees and their Eligible Dependents may reapply at the next Open Enrollment Period in the event an application was not received by SHP within such thirty one (31) day period. Group shall provide notice to Eligible Employees of the applicable Initial Enrollment Period and Open Enrollment Periods.

2.1.3 Declination of Coverage (Waiver). Group shall provide a written notice and acknowledgement on a form prepared by SHP, or substantially similar to the form prepared by SHP, to Eligible Employees during their Initial Enrollment Period. The written notice and acknowledgement shall provide notice of the

availability of coverage under the Health Plan and indicate that an Eligible Employee's failure to elect coverage, on his or her behalf or on behalf of any Eligible Dependents, permits SHP to exclude coverage for a period up to twelve (12) months until the Group's next Open Enrollment Period. Group shall require any Eligible Employee declining coverage under the Health Plan, on behalf of himself or herself or any Eligible Dependent, to certify on the written notice and certification prepared by SHP the reason for declining Enrollment in the Health Plan, and that he or she has reviewed the notice and acknowledgement and understands the consequences of declining coverage under the Health Plan. Group agrees to retain all completed notices and certifications and to provide such notices and certifications to SHP as set forth in Section 3.2.3 of this Agreement.

2.1.4 Extension of Eligibility. SHP and the Group may together agree to the extension of eligibility to persons other than those provided for in the Evidence of Coverage. Any such extension of eligibility shall be in writing.

2.2 Commencement of Coverage. Coverage under this Health Plan shall be effective in accordance with the terms of the Contract Execution Sheet and this Agreement. SHP's acceptance of each Member's Enrollment is contingent upon receipt of the applicable Health Plan Premium payment. Applicants will be considered enrolled only after SHP has accepted the enrollment form. SHP acceptance will be based upon timely receipt from the Group of the enrollment form and the applicable Subscription Rate and satisfaction of all of the requirements of this Agreement.

2.3 SHP's Liability in the Event of Conversion From a Prior Carrier. With respect to employees or dependents who were totally disabled on the date of discontinuation of the prior contract or policy, and entitled to an extension of benefits pursuant to Section 1399.62 of the California Health & Safety Code or Section 10128.2 of the California Insurance Code under the prior contract or policy, SHP shall not be financially responsible for any payment of benefits or provision of services directly related to any condition which caused the total disability. In such a situation, the prior carrier shall continue to be financially responsible for all benefits or services directly related to any condition that caused or resulted from the total disability until such extension of benefits is no longer required under California or federal law.

Article 3

GROUP OBLIGATIONS

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

3.2 Notices to SHP.

3.2.1 Enrollment Forms. Group shall forward to SHP all completed or amended Enrollment forms for each Member within thirty-one (31) days of the Member's initial eligibility. Group acknowledges that any Enrollment applications not forwarded to SHP within such thirty-one (31) day period may be rejected by SHP. Group further agrees to transmit to SHP any Enrollment application amendments.

3.2.2 Notice of Termination. Group shall forward all notices of termination to SHP within thirty-one (31) days after Member loses eligibility or elects to terminate membership under this Agreement. Group agrees to pay any applicable Member Health Plan Premiums through the last day of the month in which notice of termination is received by SHP.

3.2.3 Notice of Declination of Coverage. Group shall provide to SHP, within five (5) days of the request, a written statement that the written notice and acknowledgement set forth in Section 2.1.3 was provided to an Eligible Employee by Group and was executed by the Eligible Employee. Group shall attach to the written statement prepared by Group a copy of the written notice and acknowledgement executed by the Eligible Employee.

Group's failure to provide the written notice and acknowledgement to an Eligible Employee and failure to obtain the Eligible Employee's signature on the form shall constitute a material breach of this Agreement. Group shall be responsible for all damages incurred by SHP as a result of a breach, including the full actual cost to SHP of providing Covered Services to the Eligible Employee and/or his or her Eligible Dependents for the period beginning the date the Eligible Employee and/or his or her Eligible Dependents obtained eligibility under the Health Plan and ending the date the Eligible Employee and/or his or her Eligible Dependents would have obtained eligibility were it not for Group's failure to provide the written notice and acknowledgement to the Eligible Employee. The parties agree that this represents a fair and

reasonable estimate of the costs that SHP will incur by reason of Group's failure to obtain the signature of an Eligible Employee on the written notice and acknowledgement.

3.3 Notices to Member.

3.3.1 Notice of Termination. If Group terminates this Agreement pursuant to Section 7 below, Group shall promptly notify all Members enrolled through Group of the termination of their coverage in this Health Plan. Group shall provide such notice by delivering to each Subscriber a true, legible copy of the notice of termination sent from SHP to Group at the Subscriber's then current address. Upon SHP's request, Group shall promptly provide SHP with a copy of the notice of termination delivered to each Subscriber, along with evidence of the date the notice was provided.

3.3.2 Notice of Change in Premiums or Benefits. If, pursuant to Sections 3.6.1 and 3.6.2 below, SHP increases Health Plan Premiums, or if SHP increases Copayments or Deductibles, or reduces Covered Services provided under this Agreement, Group shall promptly notify all Members enrolled through Group of the increase or reduction. In addition, Group shall promptly notify Members enrolled through Group of any other changes in the tern-is or conditions of this Agreement affecting the Members' benefits or obligations under the Health Plan. Group shall provide such notice by delivering to each Subscriber a true, legible copy of the notice of the increase in Health Plan Premiums, Copayments, or Deductibles, or reduction in Covered Services sent from SHP to Group at the Subscriber's then current address. Upon request by SHP, Group shall promptly provide SHP with a copy of the notice of Health Plan Premium or Copayment increase or reduction in Covered Services delivered by Group to each Subscriber, along with evidence of the date the notice was provided.

3.3.3 SHP Non-Liability. SHP shall have no responsibility to Members in the event Group fails to provide the notices required by this Section 3.3.

3.4 Indemnification. Group agrees to indemnify, defend and hold SHP and its respective employees, officers, directors, representatives, agents, successors and assigns harmless from any and all damages, claims, judgments, losses, costs and expenses, including attorneys' fees, and to accept all legal and financial responsibility for any liability arising out of a failure by Group or Group's employees, officers, directors, or subcontractors to perform Group's obligations as set forth in this Section 3, or to comply with state and federal laws applicable to their performance of these obligations.

3.5 Payment of Premiums. Group shall pay premiums to SHP for the duration of the Agreement, in accordance with the Premium Rate as noted on the Contract Execution Sheet. Except as provided below in Section 3.6, the rates shall remain in effect throughout the duration of the Agreement.

3.5.1 Due Date. Health Plan Premiums are due in full on a monthly basis by check or electronic transfer and must be paid directly to SHP on or before the last business day of the month prior to the month for which the Health Plan Premium applies. Failure to provide payment on or before the due date may result in termination of Group, as set forth in Section 7.2.1 below.

3.5.2 Delinquent Payment. SHP reserves the right to assess an administrative fee in the amount of five percent (5%) of the monthly group premium for each delinquent premium payment. This fee will be assessed solely at SHP's discretion. In the event that payments not made in a timely manner are received by SHP after termination of Group, the deposit or application of such funds does not constitute acceptance, and such funds shall be refunded by SHP within twenty (20) business days of receipt if SHP, in its sole discretion, does not reinstate Group. Group understands that untimely payment of premium may result in SHP sending notices of termination of Health Plan coverage to Members enrolled through Group.

3.6 Modification of Rates and Benefits.

3.6.1 Modification of Health Plan Premium Rates. The Health Plan Premium rates set forth on the Rate Sheet may be modified by SHP in its sole discretion upon sixty (60) days prior written notice mailed postage prepaid to Group. Any such modification shall take effect commencing the first full month following the expiration of the sixty (60)-day notice period.

Notwithstanding the above, if the State of California or any other taxing authority imposes upon SHP a tax or license fee which is levied upon or measured by the monthly amount of Health Plan Premiums or by SHP's gross receipts or any portions of either, then upon sixty (60) days written notice to Group, Group shall remit to SHP, with the appropriate payment, a pro rata amount sufficient to cover all such taxes and license fees, rounded to the nearest cent.

3.6.2 Modification of Benefits or Terms. The Covered Services set forth in the Combined Evidence of Coverage and Disclosure Form, the Covered Services Summary, and any supplemental attachments to this Agreement, as well as other terms of this Agreement, may be modified by SHP in its sole discretion upon sixty (60) days written notice mailed postage prepaid to Group. Any such modification shall take effect commencing the first full month following the expiration of the sixty (60)-day notice period.

3.7 Effect of Payment; Health Plan Premium for Newborn Members. Except as otherwise provided in this Agreement, only Members for whom Health Plan Premiums are received by SHP are entitled to Covered Services as described in this Agreement, and then only for the period for which such payment is received.

Group agrees to pay Health Plan Premium to SHP for coverage for newborn Members commencing 30 days after birth on the following basis: if the thirtieth day after the birth of the child falls before the fifteenth calendar day of the month, Group will pay the full month's Health Plan Premium for coverage during that month without proration; if the thirtieth day after the birth the child falls on or after the fifteenth calendar day of the month, no Health Plan Premium will be payable for that month.

3.8 Additions and Terminations. SHP will bill only full month Premium Rates for additions and terminations of Members during any month as follows:

a. Additions effective on or before the 15th day of the monthly billing cycle will be billed for a full month's Premium Rate; additions effective after the first 15 days of the monthly billing cycle will result in no Premium Rate billed for that month.

b. Terminations effective on or before the 15th day of the monthly billing cycle will result in no Premium Rate billed for that month; terminations effective after the 15th day of the monthly billing cycle will result in a full month's Premium Rate being billed.

c. Group must notify SHP in writing within 10 days of the receipt of a completed Enrollment Form and within 10 days of receipt of all termination and change forms. This requirement is in addition to the requirement in Section 3.2 to submit copies of enrollment forms and change forms.

3.9 Retroactive Adjustments. At the discretion of SHP, retroactive adjustments may be made for any additions and terminations of Members and changes in coverage class not reflected in Group records at the time the Premium Rates were calculated. However, no retroactive credit will be given for any period which is more than two months prior to the date on which SHP received notice of termination of the Member or change in coverage class. Additionally, no retroactive adjustment will be made if claims for Covered Services have been made for dates of service subsequent to the requested termination date. Furthermore, by requesting a retroactive termination date, Group is confirming that there have been no premiums taken from the member after the requested retroactive termination date.

3.10 Group Eligibility. During the term of this Agreement, the Group will promptly notify SHP of any significant changes in the Group's composition, eligibility requirements, or employees' costs associated with coverage. Any such change that is deemed adverse by SHP (unless agreed to in writing by SHP prior to such change) shall give SHP the option, in its discretion, of adjusting rates or modifying benefit design or limiting enrollment, subject to the notice requirements of Section 3.6. Any loss of Group eligibility shall give SHP the option, in its discretion, of terminating this Agreement, subject to the notice requirements of Section 7.2. If termination of this Agreement is a result of Group's loss of eligibility, SHP may, in its sole discretion, offer the Group replacement coverage under any other health benefits product as may be offered by SHP from time to time.

3.11 Minimum Enrollment. The Group must maintain a minimum enrollment agreed upon by SHP. Any such agreement shall be in writing, and shall constitute a part of this Agreement. SHP may terminate this Agreement by giving the Group 31 days' prior written notice in the event enrollment falls below this minimum.

3.12 Health Care Plan Administrator. Group has established and as sponsor maintains pursuant to other written documents, a health benefits program for the benefit of its eligible employees and their eligible dependents, which is an "employee welfare benefit plan" within the meaning of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). SHP is not the "administrator", "plan sponsor" or a named or unnamed "fiduciary" for purposes of ERISA, provided that for purposes of determining whether to pay all or any portion of a claim, SHP shall have the exclusive discretionary and final authority to make such determination, and such determination shall be binding unless it is shown that such determination was arbitrary and capricious.

It is the responsibility of the Group to inform its eligible employees and their eligible dependents of their ERISA mandated rights and to comply with any ERISA mandated responsibilities, obligations and duties. In no event shall SHP have any responsibility to provide any person with any notice under the Internal Revenue Code of 1986,

as amended, or ERISA, that is required to be provided by the Group or the plan administrator of any plan sponsored by the Group.

3.13 Notice of Individual Conversion Rights. Within fifteen (15) days after a Member's coverage terminates, Group shall notify the Subscriber on behalf of the Subscriber and his or her Dependents or, if no Subscriber is available, any terminated Dependent, of the availability, terms, and individual conversion rights as set forth in the Combined Evidence of Coverage and Disclosure Form, for Members with COBRA coverage, for Members with Cal-COBRA coverage, and for Members who have neither COBRA nor Cal-COBRA coverage but are entitled to individual conversion rights.

Article 4

BENEFITS AND CONDITIONS FOR COVERAGE

4.1 Benefits. The attached Combined Evidence of Coverage and Disclosure Form(s), Benefit Summary Matrix or Matrices, and additional related attachments included at the end of this Agreement are integral parts of this Agreement, and include a complete description of the Benefits and Conditions of Coverage of this Health Plan.

4.2 Material Provided to Employees. For each Member, SHP shall provide individual identification cards, a Combined Evidence of Coverage and Disclosure Form, including a Benefit Plan Summary, information on riders selected by the Group, and information on how to search for providers (including a printed directory if requested).

4.3 Payment to Providers. SHP will assure that every Provider or facility that treats Members will seek reimbursement from SHP and not from a Member or the Group, except with respect to Co-Payment/Co-Insurance and other costs and expenses that are required to be paid by Member directly to Provider pursuant to the Evidence of Coverage.

4.4 Records. The Parties agree that it is necessary for SHP to obtain and review certain information about Members in order to meet its obligations under this Agreement. SHP is under no obligation to tell, nor obtain the consent of, a Member to obtain such information. Group agrees to provide any necessary information to SHP needed to pay the claim. Group will keep a record of all Members, including key facts about their coverage under the Agreement. Group agrees to notify SHP immediately upon any change in any Member's eligibility, including termination of the employee's employment. If Group fails to notify SHP of such a change in eligibility, Group shall be responsible for any benefits provided to any Member on or after the date such Member fails to satisfy the eligibility requirements to be a Member. SHP agrees to retain in confidence any medical information it possesses concerning a Member, but may release such information to its authorized agents and Participating Providers as necessary to process the claim.

4.5 Member Appeals and Grievances. The Combined Evidence of Coverage and Disclosure Form includes a complete description of the SHP appeals and grievance procedures and dispute resolution processes for Members.

Article 5

RELATIONSHIPS BETWEEN PARTIES; HIPAA CERTIFICATES

5.1 Relationship of Parties. Group is not the agent or representative of SHP and shall not be liable for any acts or omissions of SHP, its agents, employees or providers, or any other person or organization with which SHP has made, or hereafter shall make, arrangements for the performance of services under this Health Plan. Member is not the agent or representative of SHP and shall not be liable for any acts or omissions of SHP, its agents or employees.

5.2 Compliance with the Health Insurance Portability and Accountability Act of 1996. SHP agrees to furnish written certification of prior creditable coverage ("Certificates") to all eligible Members, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). SHP and Group acknowledge that SHP's agreement to issue Certificates to all eligible Members relieves Group of its obligation under HIPAA to furnish Certificates. Further, Group acknowledges that SHP must rely completely on eligibility information and data (including, but not limited to, Member's name and current address) furnished by Group in issuing Certificates to Members. Group agrees to notify SHP of all terminations within 30 days of the termination, and to provide SHP with eligibility information and data within 30 days of its receipt or change. Group agrees to indemnify, defend and hold SHP harmless and accept all legal, financial and regulatory responsibility for any liability arising out of SHP's furnishing Certificates to eligible members under HIPAA.

5.3 Subcontractors. If Group subcontracts with any person or entity to perform any of Group's obligations involving transmission between SHP and the subcontractor of Individually Identifiable Health Information (IIHI), Protected Health Information (PHI), Personally Identifiable Information (PII) or other information or data protected under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), Group shall identify in Attachment 4 all subcontractors so authorized and shall assure that all such subcontractors are contractually obligated to comply with all state and federal laws regarding the protection of Member confidentiality and privacy, including but not limited to the California Confidentiality of Medical Information Act and HIPAA.

Attachment 4 is incorporated herein by this reference, and may be updated by Group without need to amend this Agreement provided that Group gives SHP not less than sixty (60) days advance written notice.

Article 6

TERM OF AGREEMENT; RENEWAL PROVISIONS

6.1 Term; Automatic Renewal. The term of this Agreement shall be one year, commencing on the Group Coverage Effective Date set out in the Contract Execution Sheet, unless otherwise indicated on the Contract Execution Sheet or unless this Agreement is terminated as provided herein. This Agreement shall automatically renew for a one year term on each anniversary of the date of commencement of this Agreement or as indicated on the Contract Execution Sheet, unless terminated as provided herein. Renewal of this Agreement shall be subject to modification of rates and benefits pursuant to Section 3.6. Termination and renewal are subject to Article 7 of this Agreement.

Article 7

TERMINATION

7.1 Termination by Group. Group may terminate this Agreement by giving a minimum of sixty (60) days written notice of termination to SHP. Group termination must always be effective on the first day of the month. Group shall continue to be liable for Health Plan Premiums for all Members enrolled in this Health Plan through Group until the date of termination.

7.2 Termination by SHP.

7.2.1 For Nonpayment of Health Plan Premiums. SHP may terminate this Agreement if Group fails to pay Health Plan Premiums when due. Nonpayment of Health Plan Premiums includes payments returned due to non-sufficient funds (NSF) and post-dated checks. If Health Plan Premiums are not paid when due, then following the last day of the period for which Health Plan Premiums were paid, SHP shall provide notice of termination stating that all unpaid Health Plan Premiums must be received by SHP within thirty (30) days of the notice date, and that if payment is not received within the thirty (30) day period, no further notice shall be given, and this Agreement will be cancelled and coverage for all Members will be terminated upon expiration of the thirty (30) day notice period. Group understands that it will retain the obligation to pay the Health Plan Premiums applicable to the extension of coverage provided by SHP during the 30 days notice period, and acknowledges SHP's right to recover those amounts from Group after cancellation of the Agreement.

7.2.1.1 Reinstatement. Receipt by SHP of all Health Plan Premiums then due and owing after termination of this Agreement for nonpayment shall reinstate this Agreement as though it had never been cancelled, if such payment then due and owing is received on or before the due date of the succeeding Health Plan Premium payment due date. However, SHP may avoid such reinstatement by one or more of the following methods:

(a) Specifying in the notice of termination, that if payment is not received within thirty (30) days of issuance of such notice, a new application will be required and the conditions under which a new contract will be issued or the original agreement reinstated; or

(b) If such payment is received more than thirty (30) days after issuance of the notice of termination, SHP refunds such payment within twenty (20) business days; or

(c) If such payment is received more than thirty (30) days after issuance of the notice of termination, SHP 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 terminated contract in benefits, coverage's and other aspects.

7.2.2 For Providing Misleading or Fraudulent Information. SHP may terminate this Agreement immediately upon sending written notice to Group if Group commits fraud or intentionally misrepresents a material fact in the Group Coverage Application. Group agrees that it shall be deemed to have committed fraud or intentional misrepresentation of a material fact if Group has knowledge that a Member has committed fraud or intentionally misrepresented a material fact in the membership Enrollment Form and Group fails to inform SHP and take good faith action to redress the Member's fraud or intentional misrepresentation.

7.2.3 For Ceasing to Meet Group Eligibility Criteria. SHP may terminate Group upon thirty (30) days written notice to Group if:

(a) Group fails to maintain Group Contribution requirements; or

(b) Group fails to meet Group enrollment requirements.

(c) Termination pursuant to this Section 7.2.3 shall be effective at the end of the period for which all required premiums have been paid.

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

7.4 Effect of Termination of Agreement. Upon termination, whether by failure to pay premiums or upon written notice, all rights to benefits shall terminate at the end of the period for which all required premiums have been paid and upon the expiration of the applicable notice period. Group agrees to be responsible for notifying its employees that the Agreement has terminated. Upon termination, Group and Members shall be obligated, jointly and severally, to pay to SHP all billed charges for all health services and benefits received by a Member or a Member's dependent after the Agreement is terminated. Upon default in making payments, SHP shall notify Group and Members of the effective date of termination, and individual conversion coverage will not be available. No termination shall relieve the Group from any obligation incurred prior to the date of termination of this Agreement.

It is the responsibility of the Group to notify the Members of the termination of the Agreement in compliance with all applicable laws and as provided in Section 3.3.1. However, SHP reserves the right to notify Members of termination of the Agreement for any reason, including non-payment of premium. The Group shall provide written notice to Members of their rights upon termination of coverage

7.5 Termination of Member's Coverage. Coverage under this Agreement will terminate at 11:59 Pacific Standard Time on the last day in which a Member ceases to meet the eligibility requirements set forth in Article 11 of the Evidence of Coverage. Group and Members shall be obligated, jointly and severally, to pay to SHP all billed charges for all health services and benefits received by a Member or a Member's dependent after the eligibility ceases, and SHP may withhold from or offset any other amounts owed to Member to recover such amount.

Article 8

MISCELLANEOUS PROVISIONS

8.1 Governing Law. This Agreement is subject to the laws of the State of California and the United States of America, including the Knox-Keene Health Care Service Plan Act of 1974, as amended, (codified at Chapter 2.2 of Division 2 of the California Health and Safety Code), and the regulations promulgated thereunder by the California Department of Managed Health Care (codified at Chapter 1 of Division 1 of Title 28 of the California Code of Regulations); and, the Employee Retirement Income Security Act of 1974, as amended, (codified at Chapter 18 of Title 29 of the United States Code and the regulations promulgated thereunder by the United States Department of Labor (codified at Chapter XXV of Title 29 of the Code of Federal Regulations). Any provisions required to be in this Agreement by any of the above laws and regulations shall bind SHP, Group and Member whether or not expressly provided in this Agreement.

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

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

8.4 Validity. The unenforceability or invalidity of any part of this Agreement shall not affect the enforceability and validity of the balance of this Agreement.

8.5 Confidentiality. SHP agrees to maintain and preserve the confidentiality of any and all medical records of Member in accordance with all applicable State and federal laws. However, Group, by entering into this Agreement and offering coverage to its employees or association members, as applicable, agrees on behalf of its employees and/or members to the release of information and access to any and all of Member's medical records for purposes of utilization review, quality review, processing of any claim, financial audit, coordination of benefits, or for any other purpose reasonably related to the provision of benefits under this Agreement to SHP, its agents and employees, Member's participating medical group, and appropriate governmental agencies. SHP shall not release any information to Group which would directly or indirectly indicate to the Group that a Member is receiving or has received Covered Services, unless authorized to do so by the Member.

8.6 Amendments. This Agreement may be modified by SHP as set forth in Section 3.7, above, or it may be amended upon the mutual written consent of the parties.

8.7 Attachments. The Contract Execution Sheet and attachments to this Agreement, and all terms and conditions set forth therein, as they are from time-to-time amended are incorporated by reference herein and made an integral part of this Agreement.

8.8 Use of Gender. The use of masculine gender in this Agreement includes the feminine gender and the singular includes the plural.

8.9 Waiver of Default. The waiver by SHP of any one or more defaults by Group or Member shall not be construed as a waiver of any other or future defaults under the same or different terms, conditions or covenants contained in this Agreement.

8.10 Notices. Any notice required or permitted under this Agreement shall be in writing and either delivered personally or by regular, registered, or certified mail, U.S. Postal Service Express Mail, or overnight courier, postage prepaid, or by facsimile transmission at the addresses set forth below:

If to Group :	**If to Sutter Health Plan:**
CITY OF ROHNERT PARK **130 AVRAM AVENUE** **ROHNERT PARK, CA 94928**	**Sutter Health Plan** **2880 Gateway Oaks Drive, Suite 150** **Sacramento, California 95833**

Any notice sent by registered or certified mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. If sent by regular mail, the notice shall be deemed given forty-eight (48) hours after the notice is addressed and mailed with postage prepaid. Notices delivered by U.S. Postal Service Express mail or overnight courier that guarantees next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the United State Postal Service or courier. If any notice is transmitted by facsimile transmission or similar means, the notice shall be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail.

8.11 Acceptance of Agreement. Group may accept this Agreement either by execution of the Agreement or by making its initial payment to SHP of Health Plan Premiums on or before the due date specified on the Contract Execution Sheet. Member accepts the terms, conditions and provisions of this Agreement upon completion and execution of the Enrollment Form. Acceptance by any of these methods shall render all terms and provisions of this Agreement binding on SHP, Group and Members.

8.12 Entire Agreement. This Agreement, including all exhibits, attachments, and amendments, contains the entire understanding of Group and SHP with respect to the subject matter hereof and it incorporates all of the covenants, conditions, promises, and agreements exchanged by the parties hereto with respect to such matter. This Agreement supersedes any and all prior or contemporaneous negotiations, agreements, representations, or communications, whether written or oral, between Group and SHP with respect to the subject matter of this Agreement.

8.13 Contracting Provider Termination.

8.13.1 Except as provided in 8.13.2, SHP will provide written notice to Group within a reasonable time if it receives notice that any contracting provider terminates or breaches its contract with SHP, or is unable to perform such contract, if the termination, breach, or inability to perform may materially and adversely affect Group.

8.13.2 At least 60 days prior to the termination date of a contract between SHP and a provider group or a general acute care hospital, SHP shall send written notice of the termination by United States mail to Group and to Members who are assigned to the terminated provider group or hospital.

8.14 Headings. The headings of the various sections of this Agreement are inserted merely for the purpose of convenience and do not expressly, or by implication, limit or define or extend the specific terms of the section so designated.

8.15 No Third Party Beneficiaries. Except as otherwise expressly indicated in this Agreement, this Agreement shall not create any rights in any third parties who have not entered into this Agreement, nor shall this Agreement entitle any such third party to enforce any rights or obligations that may be possessed by such third party.

8.16 Disputes Between SHP and Group. All disputes between Group and SHP shall be resolved by binding arbitration before JAMS, a nonjudicial arbitration and mediation service. If the amount at issue is less than $200,000, then the arbitrator will have no jurisdiction to award more than $200,000. The JAMS Comprehensive Arbitration Rules and Procedures ("Rules") in effect at the time a demand for arbitration is made will be applied to the arbitration. Either party may initiate arbitration by serving on the other party an arbitration notice setting forth a brief statement of the dispute with a sufficiently detailed statement of the facts and the relief requested to apprise the other party and the arbitrator of the nature of the dispute and relief requested. The parties will seek to mutually agree on the appointment of an arbitrator; however, if an agreement cannot be reached within 30 days following the date demanding arbitration, the parties will use the arbitrator appointment procedures in the Rules. Arbitration hearings will be held at the neutral administrator's offices in Sacramento, California or at another location agreed upon in writing by the parties. Civil discovery may be taken in such arbitration as provided by California law and civil procedure. The arbitrator(s) selected will have the power to control the timing, scope and manner of the taking of discovery and will have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California. This includes, but is not limited to, the imposition of sanctions. The arbitrator(s) will have the power to grant all remedies provided by California law. The arbitrator(s) will prepare in writing an award that includes the legal and factual reasons for the decision. The parties will divide equally the fees and expenses of the arbitrator(s) and the neutral administrator. The arbitrator(s) will not have the power to commit errors of law or legal reasoning, and the award may be vacated or corrected pursuant to California law.

8.17 Inability to Arrange Services. In the event that due to circumstances not within the reasonable control of SHP, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of SHP's Participating Providers or entities with whom SHP has arranged for services under this Agreement, or similar causes, the rendition of medical or hospital benefits or other services provided under this Agreement is delayed or rendered impractical (a "Force Majeure Event"), SHP shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid premiums held by SHP on the date such event occurs. Upon the occurrence of a Force Majeure Event, SHP shall notify Group and describe in reasonable detail the manner in which such Party's performance of this Agreement has been impaired and the expected length of such impairment. SHP shall use best efforts to resume performance whenever and to whatever extent possible without delay and as medically appropriate refer Members to emergency care.

8.18 Group's Agreement To be Bound: The Agreement shall be effective on the Coverage Effective Date, as set forth above, if the initial premium has been paid and the Agreement is duly executed below. The Agreement continues as long as the required premiums are paid, unless it is terminated as set forth in Article 7.

8.19 MANDATORY ARBITRATION. Group, Member (including any heirs or assigns) and SHP agree and understand that any and all disputes by and between them, including claims of medical malpractice (that is as to whether any medical services rendered under the Health Plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, shall be determined by submission to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Each party, including any heirs or assigns, to this Agreement is giving up its constitutional right to have any such dispute decided in a court of law before a jury, and instead is accepting the use of binding arbitration.

IN WITNESS WHEREOF, the parties hereto, being first duly authorized, have set their hands on the dates set forth below.

Group	**Sutter Health Plan**
Printed Name: _____	Printed Name: Rob Carnaroli
By: _____	By: _____
Title: _____	Title: Vice President of Sales
Date: _____	Date: _____

ATTACHMENT 1

RATE SHEET

Sutter Health Plus
Your Health Plan

LARGE GROUP PROSPECT: SOLD SIGN-OFF SHEET

Group Name: City of Rohnert Park - ACTIVES

Zip Code: 94928 (Sonoma)

Effective Dates: 7/1/2017 - 6/30/2018
Agency: Real Care Insurance Marketing
Broker: Pat O'Brien
Commission: 5.00%

MAJOR MEDICAL PLAN SELECTION (12 payments per year)

Major Medical - Final Plan and Tier Rate Information

Plan	Product	Plan Code	EE Only	EE + 1	EE + 2 or More	Sold (X)
LG HSP $20 - $500 - 10%	HMO	ML20	$466.02	$976.65	$1,394.84	
LG Standard $25 - $0	HMO	ML31	$493.79	$1,034.83	$1,477.94	
LG HDHP $20-$1,500 (HSA Compatible) Embedded	HMO	HD01	$398.45	$835.03	$1,192.59	

Sutter Health Plus
Your Health Plan

LARGE GROUP PROSPECT: SOLD SIGN-OFF SHEET

Group Name: City of Rohnert Park - EARLY RETIREES

Zip Code: 94928 (Sonoma)

Effective Dates: 7/1/2017 - 6/30/2018
Agency: Real Care Insurance Marketing
Broker: Pat O'Brien
Commission: 5.00%

MAJOR MEDICAL PLAN SELECTION (12 payments per year)

Major Medical - Final Plan and Tier Rate Information

Plan	Product	Plan Code	EE Only	EE + 1	EE + 2 or More	Sold (X)
LG HSP $20 - $500 - 10%	HMO	ML20	$701.97	$1,472.23	$2,102.72	
LG Standard $25 - $0	HMO	ML31	$743.79	$1,559.94	$2,228.00	
LG HDHP $20-$1,500 (HSA Compatible) Embedded	HMO	HD01	$600.18	$1,258.75	$1,797.83	

FINANCIAL TERMS AND CONDITIONS

The quoted rates are valid for a twelve-month contract period, and become effective 7/1/2017. The proposed rates and benefits assume the participation and contribution requirements provided at the time of the quote apply. Should any of the assumptions change, Sutter Health Plus (SHP) reserves the right to re-rate. The below conditions are intended to be informative and not all-inclusive. Other policies and guidelines may apply.

1) Employer contribution is at least 50% of the employee cost for the lowest cost plan offered. SHP reserves the right to re-rate if the contribution does not meet our minimum requirement.

2) At least 70% of eligible employees who have satisfied their waiting period must enroll in either Sutter Health Plus (SHP) or another group health plan offered by the employer, excluding those who provided proof of coverage in a spouse's plan.

3) The prospect represents employees that live or work within SHP's licensed service area based on information provided in the census. The geographic mix of the enrolled group does not change during the contract period in a way that would increase the per capita premium more than 10% versus the assumed when developing the final rates.

4) Demographic mix of the enrolled group changes in a way that would increase the per capita premium more than 10% versus the assumed when developing the final rates.

5) This quote is offered on a triple slice basis.

6) The proposed rates and plans will be extended to the employer group included in our current eligibility files. Our rates assume coverage will not be extended to any additional groups of employees without additional information and underwriting approval and that the total group enrolled or eligible employees will not increase or decrease by more than 10%. We have assumed that approximately 180 employees and early retirees are enrolled in medical coverage who have access to SHP service areas and 45 will be enrolled with SHP.

7) Changes in the plan of benefits offered or required due to legislative or regulatory action may result in a rate revision. Our quote assumes that our standard contract provisions will apply.

8) COBRA enrollees vary by more than 10% of the quoted enrollment .

9) All proposal provisions are subject to federal, state and local mandates. Future mandates will be incorporated into plans as of the date required by law, and may require rate adjustment.

10) The information presented in the chart is a summary only. The information does not include all of the detailed explanation of benefits, exclusions and limitations. Plan participants should refer to the Evidence of Coverage (EOC) document for coverage details. In the event the information in this summary differs from the EOC, the EOC will prevail.

ATTACHMENT 2

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

[ATTACH EOC/DF]

Sutter Health Plus
Your Health Plan

LARGE GROUP PROSPECT: SOLD SIGN-OFF SHEET

Group Name: City of Rohnert Park - EARLY RETIREES

Zip Code: 94928 (Sonoma)

Effective Dates: 7/1/2017 - 6/30/2018
Agency: Real Care Insurnace Marketing
Broker: Pat O'Brien
Commission: 5.00%

MAJOR MEDICAL PLAN SELECTION (12 payments per year)

Major Medical - Final Plan and Tier Rate Information						
Plan	**Product**	**Plan Code**	**EE Only**	**EE + 1**	**EE + 2 or More**	**Sold (X)**
LG HSP $20 - $500 - 10%	HMO	ML20	$701.97	$1,472.23	$2,102.72	
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LG HDHP $20-$1,500 (HSA Compatible) Embedded	HMO	HD01	$600.18	$1,258.75	$1,797.83	

EARLY RETIREES ANCILLARY BENEFIT PLAN SELECTION (12 payments per year)

Chiropractic and Acupuncture - Final Plan and Tier Rate Information						
Product ID	**Max Visits**	**Copayment**	**EE Only**	**EE + 1**	**EE + 2 or More**	**Sold (X)**
XA04	Unlimited	20	$3.64	$7.42	$10.73	

Employer Signature	
Employer Authorized Signature	

FINANCIAL TERMS AND CONDITIONS

The quoted rates are valid for a twelve-month contract period, and become effective 7/1/2017. The proposed rates and benefits assume the participation and contribution requirements provided at the time of the quote apply. Should any of the assumptions change, Sutter Health Plus (SHP) reserves the right to re-rate. The below conditions are intended to be informative and not all-inclusive. Other policies and guidelines may apply.

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3) The prospect represents employees that live or work within SHP's licensed service area based on information provided in the census. The geographic mix of the enrolled group does not change during the contract period in a way that would increase the per capita premium more than 10% versus the assumed when developing the final rates.

4) Demographic mix of the enrolled group changes in a way that would increase the per capita premium more than 10% versus the assumed when developing the final rates.

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6) The proposed rates and plans will be extended to the employer group included in our current eligibility files. Our rates assume coverage will not be extended to any additional groups of employees without additional information and underwriting approval and that the total group enrolled or eligible employees will not increase or decrease by more than 10%. We have assumed that approximately 180 employees and early retirees are enrolled in medical coverage who have access to SHP service areas and 45 will be enrolled with SHP.

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9) All proposal provisions are subject to federal, state and local mandates. Future mandates will be incorporated into plans as of the date required by law, and may require rate adjustment.

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Sutter Health Plus
Your Health Plan

LARGE GROUP PROSPECT: SOLD SIGN-OFF SHEET

Group Name: City of Rohnert Park - ACTIVES

Zip Code: 94928 (Sonoma)

Effective Dates: 7/1/2017 - 6/30/2018
Agency: Real Care Insurnace Marketing
Broker: Pat O'Brien
Commission: 5.00%

MAJOR MEDICAL PLAN SELECTION (12 payments per year)

Major Medical - Final Plan and Tier Rate Information

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ACTIVES ANCILLARY BENEFIT PLAN SELECTION (12 payments per year)

Chiropractic and Acupuncture - Final Plan and Tier Rate Information

Product ID	Max Visits	Copayment	EE Only	EE + 1	EE + 2 or More	Sold (X)
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Employer Signature	
Employer Authorized Signature	

FINANCIAL TERMS AND CONDITIONS

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Exhibit B

ACN GROUP OF CALIFORNIA, INC.
d/b/a OPTUMHEALTH PHYSICAL HEALTH OF CALIFORNIA ("OHPHCA")
GROUP ENROLLMENT AGREEMENT
COVER SHEET ("Cover Sheet")

(This cover sheet is an integral part of this Agreement)

*If you have purchased coverage for chiropractic and/or acupuncture benefits for your employees, all services will be provided through OHPHCA.

GROUP NAME AND ADDRESS:
CITY OF ROHNERT PARK
130 AVRAM AVENUE
ROHNERT PARK, CA 94928

GROUP COVERAGE EFFECTIVE DATE:
7/01/2017

PLAN DESCRIPTION:
XA04 - Chiropractic and Acupuncture

PREMIUM RATE SCHEDULE:

Rates are incorporated into the Rate Sheet Employer Contributions, Attachment 1 of Sutter Health Plan Group Health Care Contract. Please refer to Attachment 1.

ATTACHMENTS: (The following Attachments are an integral part of this Agreement)

Attachment A OHPHCA Combined Evidence of Coverage and Disclosure Form

Attachment B OHPHCA Schedule of Benefits

ACN GROUP OF CALIFORNIA, INC.
d/b/a OPTUMHEALTH PHYSICAL HEALTH OF CALIFORNIA ("OHPHCA")
GROUP ENROLLMENT AGREEMENT
COVER SHEET ("Cover Sheet")

(This cover sheet is an integral part of this Agreement)

*If you have purchased coverage for chiropractic and/or acupuncture benefits for your employees, all services will be provided through OHPHCA.

GROUP NAME AND ADDRESS:

CITY OF ROHNERT PARK
130 AVRAM AVENUE
ROHNERT PARK, CA 94928

GROUP COVERAGE EFFECTIVE DATE:

7/01/2017

PLAN DESCRIPTION:

XA04 - Chiropractic and Acupuncture

PREMIUM RATE SCHEDULE:

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ATTACHMENTS: (The following Attachments are an integral part of this Agreement)

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Attachment B OHPHCA Schedule of Benefits

ACN GROUP OF CALIFORNIA, INC. doing business as

OptumHealth Physical Health of California

P.O. Box 880009, San Diego, CA 92168-0009

(619) 641-7100

1-800-428-6337

GROUP ENROLLMENT AGREEMENT

By and Between

ACN GROUP OF CALIFORNIA, INC.

and

GROUP

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WITH

ACN GROUP OF CALIFORNIA, INC. doing business as

OptumHealth Physical Health of California

P.O. Box 880009, San Diego, CA 92168-0009

(619) 641-7100

1-800-428-6337

RECITAL

In consideration of the payment of premiums in accordance with the terms and conditions of this Group Enrollment Agreement and all of its attachments (hereinafter collectively referred to as the "Agreement"), ACN Group of California, Inc. doing business as OptumHealth Physical Health of California (hereinafter referred to as "Health Plan"), a California corporation licensed as a Knox-Keene Health Care Service Plan and Group (hereinafter referred to as the "Group"), hereby agree that Health Plan shall provide or arrange for the provision of Chiropractic Services (as hereinafter defined) in accordance with the terms and conditions of this Agreement to Members (as defined herein) enrolled in Health Plan's chiropractic benefits program pursuant to this Agreement.

SECTION 1
DEFINITIONS

1.1 Annual Benefit Maximum

"Annual Benefit Maximum" means an amount specified in the Schedule of Benefits which is the maximum amount that Health Plan is obligated to pay on behalf of a Subscriber for Covered Services of a particular type or category provided to a Subscriber in any given calendar year.

1.2 Chiropractic Disorder

"Chiropractic Disorder" means a condition producing clinically significant symptoms, including Neuromusculoskeletal Disorders wherein Chiropractic Services can reasonably be anticipated to result in improvement.

1.3 Chiropractic Services

"Chiropractic Services" means Medically Necessary services and supplies provided by or under the direction of a Participating Provider for the diagnosis or treatment of Chiropractic Disorders.

1.4 Chiropractor

"Chiropractor" means an individual duly licensed to practice chiropractics in California.

1.5 Combined Evidence of Coverage and Disclosure Form

"Combined Evidence of Coverage and Disclosure Form" means a document provided to each Subscriber which summarizes the key terms and provisions of this Agreement and describes the coverage to which the Subscriber is entitled under this Agreement including, but not limited to, the principle benefits, Exclusions and Limitations applicable to such coverage. The Combined Evidence of Coverage and Disclosure Form for Chiropractic Services is set forth as Attachment A hereto and incorporated herein by this reference.

1.6 Coordination of Benefits/COB

"Coordination of Benefits" or "COB" means those provisions of this Agreement under which Health Plan seeks to recover a portion of the cost of Covered Services from an insurer or other third party payor which also provides indemnity or other coverage for Chiropractic provided to a Member.

1.7 Co-payment

"Co-payment" means a predetermined amount specified in the Schedule of Benefits to be paid by the Member each time a specific Covered Service is received. Co-payments are to be paid by Members directly to the Participating Provider who or which provided the Covered Service(s) to which such Co-payments apply.

1.8 Covered Services

"Covered Services" means those Medically Necessary Chiropractic Services, including Urgent Services to which Members are entitled under this Agreement and the terms of the applicable Combined Evidence of Coverage and Disclosure Form as such documents may be amended from time to time in accordance with their terms.

1.9 Department

"Department" means the California Department of Managed Health Care.

1.10 Disputed Health Care Service

"Disputed Health Care Service" means any health care service eligible for coverage and payment under a health care service plan contract that has been denied, modified, or delayed by a decision of the plan, or by one of its contracting providers, in whole or in part due to a finding that the service is not Medically Necessary.

1.14 Emergency Services

"Emergency Services" means services provided for a medical condition (including a psychiatric medical condition) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) Placing the patient's health in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

1.15 Domestic Partner

"Domestic Partner" is a person who meets the eligibility requirements, as defined by Group, and the following:

- Is eighteen (18) years of age or older;
- Is mentally competent to consent to contract;
- Resides with the Subscriber and intends to do so indefinitely;

- Is jointly responsible with the Subscriber for their common welfare and financial obligations;
- Is unmarried or not a member of another domestic partnership; and
- Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the state of residence.

1.16 Exclusion

"Exclusion" means any service, equipment, supply, or accommodation specifically listed or described as excluded in this Agreement or the Combined Evidence of Coverage and Disclosure Form.

1.17 Family Dependent

"Family Dependent" means an individual who is a member of a Subscriber's family and who is eligible and enrolled in accordance with all applicable requirements of this Agreement, and on whose behalf Health Plan has received premiums.

1.18 Limitation

"Limitation" means any provision, other than an Exclusion, contained in this Agreement or the Schedule of Benefits, which limits the covered Chiropractic Services to which Members are entitled.

1.19 Medically Necessary

"Medically Necessary" means:

Chiropractic: Necesssary and appropriate for the diagnosis or treatment of neuromusculoskeletal disorders; established as safe and effective; and furnished in accordance with generally accepted chiropractic practice and professional standards to treat neuromusculoskeletal disorders.

1.20 Member

"Member" means a Subscriber or a Family Dependent.

1.21 Neuromusculoskeletal Disorders

"Neuromusculoskeletal Disorders" means conditions with associated signs and symptoms related to the nervous, muscular and/or skeletal systems. Neuromusculoskeletal Disorders are conditions typically categorized as structural, degenerative or inflammatory disorders, or biomechanical dysfunction is the joints of the body and/or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related to neurological manifestations or conditions.

1.22 Negotiated Rates Schedule

"Negotiated Rates Schedule" means the schedule of rates, which the Participating Provider has agreed to accept as payment in full for Covered Services provided to Members.

1.23 Participating Provider

"Participating Provider" means any Chiropractor who is qualified and duly licensed or certified by the State of California to furnish Chiropractic Services and has entered into a contract with Health Plan to provide Covered Services to Members.

1.24 Schedule of Benefits

"Schedule of Benefits" means the summary of Co-payments, Annual Benefit Maximums, Exclusions and Limitations applicable to Member's chiropractic benefits program. The Schedule of Benefits is Attachment A to the Combined Evidence of Coverage and Disclosure Form.

1.25 Subscriber

"Subscriber" means an employee or retiree who is eligible and enrolled in accordance with all applicable requirements of this Agreement, and on whose behalf the Group has made premium payments.

1.26 Urgent Services

"Urgent Services" means services (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of a Member's health, alleviate severe pain, or treat an illness or injury with respect to which treatment cannot reasonably be delayed.

SECTION 2
EFFECTIVE DATE AND TERM OF AGREEMENT

This Agreement shall be effective as indicated on the Cover Sheet of this Agreement..

SECTION 3
RENEWAL PROVISIONS

After the Initial Term, this Agreement will automatically renew from year to year for additional twelve (12)-month periods ("Subsequent Terms") on the same terms and conditions unless terminated by either party in accordance with Section 22 of this Agreement. However, Health Plan has reserved the right to change the Premium Rate Schedule in accordance with Section 5.4 of this Agreement and any other term or condition of this Agreement upon thirty-one (31) days prior written notice to the Group.

SECTION 4
IDENTIFICATION OF BENEFIT PLAN

Benefit Plan Description	Chiropractic an Benefit Plan, as described in Attachment B.

SECTION 5
PREPAYMENT OF FEES

5.1 Premium Rate Schedule

Health Plan shall provide or arrange Covered Services for each Member for which premiums are received by Health Plan and/or Health Plan's designee. The Premium Rate Schedule is set forth on the Cover Sheet. The applicability of any employee contribution toward Health Plan premiums shall be determined by Group.

5.2 Premium Due Date and Payments

The first day of a month of coverage hereunder is the "Premium Due Date". The Group agrees to remit to Health Plan or Health Plan's designee on or before the Premium Due Date the applicable Total Monthly Premium set forth in Section 5.1 immediately above, for each Subscriber enrolled as of such date as determined by Health Plan by reference to Health Plan Member records. If such premium payment is not made in full by the Group on or prior to the

Premium Due Date, a thirty-one (31)-day grace period shall be granted to the Group for payment without interest charge.

Premium payments which remain outstanding subsequent to the end of the grace period shall be subject to a late penalty charge of one percent (1.00%) of the total premium due calculated for each thirty-one (31) day period or portion thereof during which the premium remains outstanding. In addition, coverage of a Member whose premium is unpaid may be terminated by Health Plan and/or Health Plan's designee pursuant to Section 21. Only Members for whom payment is received by Health Plan shall be eligible for Covered Services hereunder, and then only for the period covered by such payments.

If this Agreement is terminated for any reason, Group shall continue to be liable for all premium payments due and unpaid at the time of such termination, including, but not limited to, all applicable premium payments for any time the Agreement was in force during a grace period, or, at Health Plan's or Health Plan's designee's option, for the applicable amounts listed in the Negotiated Rates Schedule for all Covered Services by Members during the period for which premiums were not paid.

5.3 Premium Adjustments

If a Member enrolls on or before the 15th day of a month, Group has agreed to pay to Health Plan on or before the next Premium Due Date an additional total monthly premium for such Member for the month in which the Member enrolled. In the event that a Member enrolls after the 15th day of the month, no total monthly premium is due for such Member for the month in which the Member enrolled.

5.4 Premium Rate Schedule Changes

Health Plan may change the Premium Rate Schedule at the end of the Initial Term or any Subsequent Term by giving no less than thirty-one (31) days prior written notice to the Group. The Premium Rate Schedule will not be revised more often than one (1) time during each Initial Term and one (1) time during each of any Subsequent Term/s. However, if a change in the Group Enrollment Agreement is necessitated by a change in the applicable law or in the interpretation of applicable law, and if such change results in an increase of Health Plan's risk or expenses under the Group Enrollment Agreement, or if there is a material change in the number of eligible subscribers of the Group, Health Plan may change the Premium Rate Schedule at any time upon thirty-one (31) days prior written notice to the Group. Any such

change will not be taken into account in determining whether the foregoing limits on revisions to the Premium Rate Schedule have been reached.

5.5 Group Contribution

Group shall offer Health Plan's benefits program to all employees of the Group on terms no less favorable with respect to the Group's contribution to the total monthly premium than those applicable to the chiropractic portion of any such other benefits program as may be available through the Group. Except as otherwise provided in the Agreement, Group's contribution shall not be changed during the term of this Agreement, unless such change is agreed to in writing by Health Plan. If, however, the Group's contribution attributable to the chiropractic health portion of any such other similar program as may be available through the Group is increased during the term of the Agreement, the Group shall promptly notify Health Plan and Group shall increase its contribution to Health Plan's health benefits program by the same amount, effective the first Premium Due Date following the increase in the Group's contribution to such other chiropractic benefits programs.

SECTION 6
OTHER CHARGES

Each Member is personally responsible for all Co-payments listed in the Schedule of Benefits applicable to Covered Services received by the Member. Members must pay all applicable Co-payments to the Participating Provider who provided the Covered Services to which such payments apply at the time such services are rendered.

SECTION 7
ELIGIBILITY

7.1 Subscriber and Family Dependents

To be eligible to enroll as a Subscriber in this benefit plan, a person must meet the eligibility guidelines established by the Group.

If the Group does not have eligibility guidelines, Health Plan will use the following guidelines for eligibility:

7.1.1 Full-time employees working thirty (30) or more hours per week.

7.1.2 Family Dependents who are persons listed on an enrollment form completed by the Subscriber, and is one of the following:

7.1.2.1 The Subscriber's lawful spouse in a marriage that has been duly licensed and registered in accordance with the laws of the jurisdiction in which it occurred; or

7.1.2.2 A child or stepchild of the Subscriber or the Subscriber's spouse by birth, legal adoption or court appointed legal guardianship, under the age of twenty-six (26) or as required by state or federal law or regulations; if adopted, such child is eligible on the date the child was in custody of the Subscriber or the Subscriber's spouse; or

7.1.2.3 A child as defined in Section 7.1.2.2 above who is, and continues to be, both incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition, and chiefly dependent upon the Subscriber for economic support and maintenance, provided that such child meets the requirements of either (A) or (B) below:

(A) The child is a Family Dependent continuously enrolled hereunder prior to attaining the applicable limiting age, and proof of such incapacity and dependency is furnished to Health Plan by the Subscriber within 120 days of the child's attainment of the applicable limiting age; or

(B) The physically or mentally disabling injury started before the child reached the applicable limiting age, and the Group was previously enrolled in another health benefits program that included chiropractic benefits that covered the child as a physically or mentally disabled dependent immediately prior to the Group enrolling with Health Plan.

Subsequent proof of continuing incapacity and dependency may be required by Health Plan, but not more frequently than annually after the two-year period following the child attaining the applicable limiting age. Health Plan's determination of eligibility is conclusive; or

A newborn child of the Subscriber or Subscriber's spouse. Such newborn children automatically have coverage for the first thirty-one (31) days of life. Coverage after thirty-one (31) days is conditioned on the Subscriber enrolling the newborn as a Family Dependent, and paying any applicable premium and charges due and owing from the date of birth, within thirty-one (31) days following birth.

The following are not considered Family Dependents:

(A) A foster child

(B) A grandchild

7.1.3 Eligible persons must reside in the U.S.

7.1.4 If both spouses are eligible persons of the Group, each may enroll as a Subscriber or be covered as an enrolled Family Dependent of each other, but not both.

7.1.5 If both parents of a dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Family Dependent.

7.2 Changes in Eligibility

The Subscriber is responsible for notifying the Group of any changes that affect the eligibility of the Subscriber or a Family Dependent for coverage. Any changes which affect a Subscriber's eligibility status including, but not limited to, death, divorce, marriage, or attainment of limiting age, require notice to Health Plan from the Subscriber or the Group within thirty-one (31) days of the date of the change in status. Coverage for a Member who no longer meets applicable eligibility requirements shall terminate upon the earlier of (i) Health Plan's receipt of written notice of the Member's change in status, or (ii) the last day of the calendar month in which eligibility ceased.

7.3 Nondiscrimination

Except as otherwise provided in this Agreement, Health Plan shall require Participating Providers to make Covered Services available to Members in the same manner, in accordance with the same standards, and with no less availability as Participating Providers provide

services to their other patients. Participating Providers shall not discriminate against any Members in the provision of Covered Services on account of race, sex, color, religion, national origin, ancestry, age, physical or mental handicap, health status, disability, genetic characteristics, need for medical care, sexual preference, or veteran's status.

7.4 Medicare

Benefits under the benefit plan are not intended to supplement any coverage provided by Medicare. In some circumstances, Members who are eligible for or enrolled in Medicare may also be enrolled under the benefit plan, subject to Section 15.

SECTION 8
ENROLLMENT

8.1 Initial Enrollment

Members who elect enrollment through the Group are automatically enrolled for coverage under the benefit plan by the Group.

8.2 Special Enrollment Period

Subscribers who do not enroll for coverage when first eligible may enroll themselves and Family Dependents for coverage during a special enrollment period. A special enrollment period is available if the following conditions are met: (i) The eligible Subscriber and/or Family Dependents had existing health coverage under another plan at the time of the initial eligibility; or (ii) Coverage under the prior plan was terminated as a result of loss of eligibility. Subscribers must enroll themselves and any eligible Family Dependents by submitting to the Group the applicable enrollment form within thirty-one (31) days of the date that coverage under the prior plan terminated. The Group shall promptly forward to Health Plan a copy of each enrollment form received by the Group in accordance with this Section 8.2.

SECTION 9
MEMBER EFFECTIVE DATES OF COVERAGE

9.1 Effective Date

Subject to the Group's payment of the applicable Total Monthly Premium for each Member as set forth in Section 5.1, and subject to the Group's submission to Health Plan prior to the first day of each month of a listing of each Member eligible to receive Covered Services, including all prospective Members, within thirty-one (31) days of the date of such Members first becoming eligible, coverage under this Agreement shall become effective for said Members on the effective date of coverage specified by the Group.

9.2 Newborn Children

For newborn children, coverage shall become effective immediately after birth for thirty-one (31) days, and shall continue in effect thereafter only if the newborn is eligible and enrolled by the Subscriber within thirty-one (31) days following the newborn's birth.

9.3 Adopted Children

For adopted children, coverage shall become effective immediately after the child is placed in the custody of the Subscriber or the Subscriber's spouse for adoption for thirty-one (31) days, and shall continue in effect thereafter only if the child is eligible and enrolled by the Subscriber within thirty-one (31) days following the child's placement in the custody of the Subscriber or the Subscriber's spouse for adoption.

SECTION 10
INELIGIBLE MEMBERS

If, upon a Member becoming ineligible, the Group fails to notify Health Plan of such Member's ineligibility and the Group has made or continues to make the premium payment specified herein for such Member, such premium payment(s) shall be credited by Health Plan to the Group, provided that the Group gives Health Plan notice of the ineligibility no later than ninety (90) days after the date eligibility ceased, and provided that Health Plan has not provided, or indemnified the Member for, Covered Services rendered to the Member after the Member's eligibility ceased and before Health Plan received notice of ineligibility.

SECTION 11
PRINCIPAL BENEFITS AND COVERAGE

Members shall be entitled under this Agreement to receive the Covered Services described under the caption "Principle Benefits and Coverages" in the Combined Evidence of Coverage and Disclosure Form set forth in Attachment A, including second opinions, subject to all applicable Exclusions and Limitations described in the Combined Evidence of Coverage and Disclosure Form, as well as all other terms and conditions contained in this Agreement. Prior to decreasing any benefits to which Members are entitled under this Agreement, Health Plan shall give at least thirty-one (31) days written notice to the Group in accordance with Section 23.14.

SECTION 12
PRINCIPAL EXCLUSIONS AND LIMITATIONS OF BENEFITS

Members shall not be entitled under this Agreement to receive any of the services described under the caption "Principal Exclusions and Limitations of Benefits" in the Combined Evidence of Coverage and Disclosure Form set forth in Attachment A.

SECTION 13
CHOICE OF PROVIDERS

13.1 Access to Participating Provider

Each Member who requests that Covered Services be provided will be able to choose from any Participating Provider who will coordinate the Covered Services to be received by the Member. Members may request access to a Participating Provider by contacting Health Plan's Customer Services Department at the toll-free telephone number included in the Combined Evidence of Coverage and Disclosure Form or by calling the toll-free telephone number on the back of the Member's Identification card.

13.2 Liability of Member for Payment

If a Member chooses to obtain Chiropractic Services (other than Urgent Services) from a provider other than a Participating Provider, the Member will be liable for payment for such services. **Services (other than Urgent Services) performed by a Provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child are not covered.**

13.3 Continuity of Care

Upon a Member's request, Health Plan shall arrange for the completion of Covered Services that are being rendered by a terminated Participating Provider or a non-contracting provider when the Member is receiving services from that provider for an acute condition, a serious chronic condition, or care of a newborn child between birth and age 36 months, at the time the Member becomes eligible for coverage or Health Plan's contract with the Participating Provider who is rendering services to the Member terminates. Health Plan shall arrange for the completion of Covered Services in accordance with the standards and procedures described in Section 8.5 of the Combined Evidence of Coverage and Disclosure Form.

13.4 Authorizations

A summary and notice of the availability of the process the Health Plan uses to authorize, modify, or deny services under benefits provided by the Health Plan is included in the Combined Evidence of Coverage and Disclosure Form set forth in Attachment A, and will be made available to enrollees, or persons designated by an enrollee, upon request.

SECTION 14
MANAGED CARE PROGRAM

14.1 Managed Care Program

The Managed Care Program is the program by which Health Plan determines whether services or other items are Medically Necessary and directs care in the most cost-efficient manner. The Managed Care Program includes, but is not limited to, requirements with respect to the following: concurrent and retrospective utilization review, and quality assurance activities. The Managed Care Program requires the cooperation of Members, Participating Providers, and Health Plan. All Participating Providers have agreed to participate in Health Plan's Managed Care Program.

14.2 Managed Care Process

Health Plan's Utilization Management Committees will have program oversight for Chiropractic Services provided, or to be provided, to Members under this Agreement in order to determine: (i) whether the services are/were Medically Necessary; (ii) the appropriateness of the recommended treatment setting; (iii) the required duration of treatment; (iv) whether the recommended treatment qualifies as a Covered Service; and (v) whether any Limitations apply.

14.3 Appeal Rights

All decisions made by Health Plan in connection with the Managed Care Program may be appealed by the Member through the Grievance Procedures set forth in Section 20 of this Agreement.

SECTION 15
COORDINATION OF BENEFITS (COB)

15.1 The Purpose of COB

The provisions of this Section establish a procedure through which Health Plan or a Participating Provider may, in certain instances, recover a portion of the costs of Covered Services from an insurer or other third party payor, which also provides indemnity or other

coverage for Chiropractic Services provided to a Member. The Group and all Members shall cooperate with Health Plan in the administration of these provisions.

15.2 Benefits Subject to COB

All of the benefits provided under this Agreement are subject to COB in accordance with the provisions of this Section 15.

If a Member is eligible for Medicare on a primary basis (Medicare pays before benefits under this Agreement), Member should enroll for and maintain coverage under both Medicare Part A and Part B. If Member doesn't enroll and maintain that coverage and if Health Plan is the secondary payor, Health Plan will pay benefits under this Agreement as if Member was covered under both Medicare Part A and Part B. In such instance, Member shall be responsible for costs that Medicare would have paid and Member will incur a larger out-of-pocket cost.

If Member is enrolled in a Medicare Advantage plan on a primary basis, Member should follow all rules of that plan that require Member to seek service from that plan's participating providers. When Health Plan is the secondary payor, Health Plan will pay benefits available to Member under this Agreement as if Member had followed all rules of the Medicare Advantage plan. Member will be responsible for any additional costs or reduced benefits that result from Member's failure to follow these rules, and Member will incur a larger out-of-pocket cost.

15.3 Definitions

The following definitions are applicable to the provisions of this Section 15 only:

"Plan" means any plan providing chiropractic benefits for, or by reason of, Chiropractic Services, which benefits are provided by (i) group, blanket or franchise insurance coverage, (ii) service plan contracts, group practice, individual practice and other prepayment coverage, (iii) any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans, and (iv) any coverage under governmental programs other than Medi-Cal, or California Children's Services, and any coverage required or provided by any statute.

The term "Plan" shall 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 such 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.

The term "Plan" shall include:

All group policies, group subscriber contracts, selected group disability insurance contracts issued pursuant to Section 10270.97 of the California Insurance Code and blanket insurance contracts, except blanket insurance contracts issued pursuant to 10270.2(b) or (e) which contain non-duplication of benefits or excess policy provisions.

"Medicare" or other similar governmental benefits, provided that:

(A) The definition of "Allowable Expenses" shall only include the chiropractic benefits as may be provided by the governmental program;

(B) Such benefits are not by law excess to this Plan; and

(C) The inclusion of such benefits is inconsistent with any other provision of this Agreement.

The term "Plan" shall not include:

Individual or family policies, or individual or family subscriber contracts, except as otherwise provided herein.

Any entitlements to Medi-Cal benefits under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14500) of Part 3 of Division 9 of the California Welfare and Institutions Code, or benefits under the California Children's Services under Section 10020

of the Welfare and Institutions Code, or any other coverage provided for or required by law when, by law, its benefits are excess to any private insurance or other non-governmental program.

Medical payment benefits customarily included in traditional automobile contracts.

15.3.2 "This Plan" means that portion of this Agreement that provides the benefits that are subject to this Section 15.

15.3.3 "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 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 shall be deemed to be both an Allowable Expense and benefit paid.

15.3.4 "Claim Determination Period" means a calendar year.

15.4 Effect on Benefits

15.4.1 This Section 15 shall 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 during such period, the sum of:

15.4.1.1 The value of the benefits that would be provided by this Plan in the absence of this Section 15, and

15.4.1.2 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.

15.4.2 As to any Claim Determination Period to which this Section 15 is applicable, the benefits that would be provided under this Plan in the absence of this provision for Allowable Expenses incurred as to such person during such Claim Determination Period shall 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 Section 15.4.3 immediately below, shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been made therefore.

15.4.3 If another Plan which is involved in Section 15.4.2 immediately above and which contains: provisions 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 the rules set forth in Section 15.5 immediately below 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.

15.5 Rules Establishing Order of Determination

For the purpose of Section 15.4 immediately above, the rules establishing the order of determination are:

15.5.1 The benefits of a Plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers such person as dependent.

15.5.2 Except for cases of a person for whom claim is made as a dependent child whose parents are separated or divorced, the benefits of a Plan which covers the person on whose expenses claim is based as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a Plan which covers such person as dependent 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 paragraph regarding dependents, 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 paragraph shall not apply, and the rule set forth in the Plan which does not have the provisions of this paragraph shall determine the order of the benefits.

15.5.3 In the case of a person for whom claim is made as a dependent 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 dependent 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.

15.5.4 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 shall 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 dependent of the parent without custody.

15.5.5 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 costs of Chiropractic Services with respect to the child, then, notwithstanding Sections 15.5.3 and 15.5.4 immediately above, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

15.5.6 When rules 15.5.1 through 15.5.5 above 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 shall be determined before the benefits of a Plan which has covered such person the shorter period of time, provided that:

15.5.6.1 The benefits of a Plan covering the person on whose expenses claim is based as a laid-off or retired employee, or dependent of such person, shall be determined after the benefits of any other Plan covering such person as an employee, other than a laid-off or retired employee, or dependent of such person; and

15.5.6.2 If either Plan does not have a provision regarding laid-off or retired employees, which results in each Plan determining benefits after the other, then Section 15.5.6.1 immediately above shall not apply.

In determining the length of time an individual has been covered under a given Plan, two successive Plans of a given group shall be deemed to be one continuous Plan so long as the claimant concerned was eligible for coverage within twenty-four (24) hours after the prior Plan terminated. Thus, neither a change in the amount or scope of benefits provided by a Plan, a change in the carrier insuring the Plan, nor a change from one type of Plan to another (e.g., single employer to multiple employer Plan, or vice versa, or single employer to a Taft Hartley Welfare Plan) would constitute the start of a new Plan for purposes of this provision.

If a claimant's effective date of coverage under a given Plan is subsequent to the date the other carrier first contracted to provide the Plan for the group concerned (employer, union, association, etc.), then, in the absence of specific information to the contrary, the carrier shall assume, for purposes of this provision, that the claimant's length of time covered under the Plan shall be measured from the claimant's effective date of coverage. If a claimant's effective date of coverage under a given Plan is the same as the date the carrier first contracted to provide the Plan for the group concerned, then the carrier shall request the group concerned to furnish the date the claimant first became covered under the earliest of any prior Plans the group may have had. If such date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time his or her coverage under that Plan has been in force.

15.6 Reduction of Benefits

When this Section 15 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 provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan. Health Plan may not decrease, in any manner, the benefits stated herein, except after a period of at least thirty (30) days from the date of the postage paid mailing to the Group.

15.7 Right to Receive and Release Necessary Information

For the purposes of determining the applicability of and implementing the terms of this Section 15 of this Plan or any provision of similar purpose of any other Plan, to the extent permitted by applicable law, including the Health Insurance Portability and Accountability Act of 1996 and the Confidentiality of Medical Information Act, the Plan may release to or obtain from any insurance Health Plan or other organization or person any information, with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish such information as may be necessary to implement this provision.

15.8 Facility of Payment

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

15.9 Right of Recovery

Whenever payments have been made by the 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 Section 15, the Plan shall have the right to recover such payments, to the extent of such excess, from one or more of the following, as the Plan shall determine: any persons to, for, or with respect to whom such payments were made, any insurers, any service plans, or any other organizations.

SECTION 16
THIRD PARTY LIABILITY

If any Chiropractic Disorder is caused by any third party and the Member has the right to recover damages from that third party, Health Plan shall provide or make payment for Covered Services. Acceptance of such Covered Services shall constitute consent by the Member to the third party liability provisions set forth in Section 12 of the Combined Evidence of Coverage and Disclosure Form.

SECTION 17
REIMBURSEMENT PROVISIONS

Members may receive Covered Services under the Group Enrollment Agreement only from Participating Providers or as directed by the Health Plan. Claims for reimbursement for Covered Services received by a Member shall be submitted by the Participating Provider. The Member shall not be responsible for submitting claim forms for reimbursement of any Covered Services.

SECTION 18
RESPONSIBILITIES OF THE GROUP

18.1 Offering Coverage

The Group shall offer Health Plan's coverage to all eligible employees and their eligible family members, and to each new employee as a procedure of employment when such person attains eligibility in accordance with the requirements of this Agreement.

18.2 Notice of Change in Coverage

The Group shall give at least thirty-one (31) days prior written notice to Health Plan of any intent to change health benefit coverage.

18.3 Listing of Members

The Group shall furnish to Health Plan on an at least monthly basis, in a form approved by Health Plan, a listing of all eligible Members and a listing of each Member who has been added or deleted that month, including the effective date of each such enrollment or disenrollment, and such other information as may reasonably be required by Health Plan for the administration of Health Plan's chiropractic benefits program. In addition, the Group shall permit Health Plan, at reasonable times, to examine the Group's pertinent records with respect to eligibility and premium payments hereunder. The Group shall also furnish to Health Plan notice of those Family Dependents described in and pursuant to Section 7.1.2.4 above, at least 120 days prior

to the Family Dependent reaching the limiting age of 26 or as required by state or federal law or regulations.

18.4 Dissemination of Notices, Materials and Other Information to Members

The Group shall arrange for a Group representative to serve as a liaison between the Group and Members. Such Group representative shall disseminate to Members with the next regular written communication sent to Members, but in no event later than thirty (30) days following receipt by the Group of any notice intended for Members that is received by the Group from Health Plan pursuant to this Agreement. Such Group representative shall also disseminate to Members all applicable Combined Evidences of Coverage and Disclosure Forms, brochures, newsletters and other materials and information relating to Health Plan's chiropractic benefits plan when requested by Health Plan.

18.5 Indemnification

The Group shall defend, hold harmless and indemnify Health Plan from any and all claims, liabilities, damages or judgments asserted against, imposed upon, or incurred by Health Plan that arise out of the Group's negligence or intentional wrongdoing in the discharge of its responsibilities under this Agreement. The indemnification granted under this paragraph expressly includes indemnification with respect to expenses, legal fees, defense costs, court costs, or amounts paid in settlement or in satisfaction of any judgment or award.

18.6 Required Information

The Group will furnish Health Plan with all information necessary for the calculation of premium and all other information that may be reasonably required by Health Plan. Failure of the Group to furnish such information will not invalidate any insurance, nor will it continue any insurance beyond the date of termination. Health Plan has the right to examine at any reasonable time any records of the Group, any person, health plan, or organization hired to assist in the administration of the Agreement which have a bearing on the Premiums and benefits of the Agreement.

18.7 Compensation of Health Plan

The Group shall compensate Health Plan in accordance with the Premium Rate set forth in Section 5.1 of this Agreement. In the event that Covered Services have been rendered to a Member in good faith based on eligibility information provided by Group, Group shall be liable for payment of any Covered Services rendered to the ineligible Member. Health Plan shall bill Group and payment shall be made upon receipt of the Participating Provider billing for the Covered Services rendered to the ineligible Member.

SECTION 19
RESPONSIBILITIES OF HEALTH PLAN

19.1 Arrangements for Covered Services

Health Plan shall enter into arrangements with Participating Providers in order to make available to Members the Covered Services described in the Schedule of Benefits set forth in the Combined Evidence of Coverage and Disclosure Form contained in Attachment A. Subject to Section 13.3, Health Plan makes no warranty or representation to the Group or to Members regarding the continued availability of any particular Participating Provider to a particular Member or to Members in general.

19.2 Compensation of Providers

Health Plan shall be responsible for compensating Participating Providers for Covered Services provided to eligible Members in accordance with the requirements of this Agreement and the requirements of any contract between Health Plan and the Participating Provider. As required by state law, all contracts between Health Plan and Participating Providers provide that, in the event Health Plan fails to pay the Participating Provider for Covered Services no Member shall be liable to the Participating Provider for Covered Services.

In the event that Health Plan fails to pay a provider who is not a Participating Provider the Member who received such services may be liable to the provider for the cost of the services.

19.3 Toll-Free Telephone Number

Health Plan will make available to Members a published toll-free telephone number to contact Health Plan. This telephone number is available to Members twenty-four hours a day, seven days a week.

19.4 Combined Evidence of Coverage and Disclosure Forms

Health Plan shall provide the Group with one Combined Evidence of Coverage and Disclosure Form for each Subscriber.

19.5 Summaries of Program Activities

Health Plan shall prepare and provide to the Group statistical summaries of program activities. Health Plan shall provide standard statistical summaries of program activities at no charge.

Upon request of the Group and for an additional fee, Health Plan shall provide, within a time period mutually agreed to by both parties, ad hoc or non-standard specialized reporting of data regarding the services outlined in this Agreement.

19.6 Public Policy Committee

Health Plan's Public Policy Committee will participate in establishing public policy for Health Plan's chiropractic benefits programs including, but not limited to, the comfort, dignity and convenience of Members. Members are invited to participate in the Public Policy Committee and may write to Chair of the Public Policy Committee at the address on the cover of the Agreement for further information.

19.7 Notices to Group Representative

Any notice required to be given by Health Plan to the Group pursuant to this Agreement may be given by Health Plan to the Group representative designated by the Group.

19.8 Termination or Breach of a Provider Contract

19.8.1 Health Plan shall provide Group written notice within 30 days of Health Plan's receipt of any Participating Provider's notice of termination or inability to perform its contract with Health Plan, or within 30 days of Health Plan's providing to any Participating Provider a notice of termination or uncured breach, if the Group or any Member may be materially and adversely affected by such termination, breach, or inability to perform.

19.8.2 In the event that a contract between Health Plan and a Participating Provider terminates while a Member is under the care of such Participating Provider, Health Plan shall retain financial responsibility for such continuation of care in excess of any applicable Co-payments. The Co-payments during the period of continuation of care with a terminated provider shall be the same Co-payments that would be paid by the Member when receiving care from a Participating Provider. Such responsibility shall continue until the Covered Services being rendered are completed, or until Health Plan makes reasonable and clinically appropriate arrangements for the provision of such services by another provider, whichever occurs first.

19.8.3 In the event that the Health Plan fails to pay a non-contracting provider for any amounts owed by the Health Plan, Member may be responsible to the non-contracting provider for the cost of services.

19.9 Indemnification

Health Plan shall defend, hold harmless and indemnify the Group from any and all claims, liabilities, damages or judgments asserted against, imposed upon, or incurred by the Group that arise out of the Health Plan's negligence or intentional wrongdoing in the discharge of its responsibilities under this Agreement. The indemnification granted under this paragraph expressly includes indemnification with respect to expenses, legal fees, defense costs, court costs, or amounts paid in settlement or in satisfaction of any judgment or award.

SECTION 20
GRIEVANCE PROCEDURES

20.1 Applicability of the Grievance Procedures

All Member disputes and controversies arising under the Plan will be resolved pursuant to the Grievance Procedures set forth herein.

20.2 Grievances

Every Member has the right to communicate a grievance to Health Plan by calling the telephone number included in the Combined Evidence of Coverage and Disclosure Form, by submitting a written grievance to the address indicated below, by submitting a written grievance by facsimile or e-mail, or by completing an online grievance form.

Grievance Coordinator
ACN Group of California, Inc.
P.O. Box 880009

San Diego, CA 92168-0009

1-800-428-6337
1-619-641-7185 (Fax)
www.myoptumhealthphysicalhealth ofca.com

A formal complaint or an appeal for a denial of a service or denied claims must be submitted within 180 calendar days of receipt of an initial determination by Health Plan through our Appeals, Complaints, and Grievances Department. Health Plan will review the appeal within a reasonable period of time appropriate to the medical circumstances and make a determination within 30 calendar days of Health Plan's receipt of the appeal. For appeals involving the delay,

denial or modification of health care services related to Medical Necessity, Health Plan's written response will include the specific reason for the decision, describe the criteria or guidelines or benefit provision on which the denial decision was based, and notification that upon request the Member may obtain a copy of the actual benefit provision, guideline protocol or other similar criterion on which the denial is based. For determinations delaying, denying or modifying health care services based on a finding that the services are not Covered Services, the response will specify the provisions in this *Combined Evidence Of Coverage and Disclosure Form* that exclude that coverage.

Health Plan will acknowledge receipt of the grievance in writing for urgent issues on the day of receipt, and all routine grievances within five (5) calendar days of receipt. These deadlines do not apply to grievances that are received by telephone, by facsimile, or by e-mail, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day.

If the grievance pertains to a Quality of Service issue, it may be investigated and resolved by the Grievance Coordinator in collaboration with any other involved Health Plan departments. If the grievance pertains to a Quality of Care issue and is routine, Health Plan has up to three (3) business days to transfer the information to the Medical Director. If the grievance pertains to a Quality of Care issue and is urgent, Health Plan will promptly initiate the Expedited Review process.

Health Plan will provide a written statement on the disposition or pending status of any grievance except for grievances that are received by telephone, by facsimile, or by e-mail, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day. For an urgent grievance in which medical/clinical services are underway, Health Plan will notify the complainant and the Department within twenty-four (24) hours of the Health Plan's receipt of the grievance. For all other urgent grievances, Health Plan will notify the complainant and the Department within three (3) calendar days of the Health Plan's receipt of the grievance. For routine grievances, Health Plan will notify the complainant within thirty (30) calendar days of the Health Plan's receipt of the grievance.

Grievance forms and Health Plan's grievance policies and procedures are available to Members upon request.

20.3 Expedited Review of Grievances

For a Member grievance involving 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, Health Plan shall immediately inform the Member, in writing, of the Member's right to notify the Department, and provide the Member and the Department written notice of the disposition or pending status of the grievance no later than three (3) calendar days from receipt of the grievance.

20.4 Independent Medical Review

In the event the Member is dissatisfied with the findings and decision of Health Plan, the Member is not required to further participate in Health Plan's grievance process thirty (30) days after Health Plan's receipt of the complaint. The Member may request an Independent Medical Review ("IMR") of Disputed Health Care Services from the Department if the Member believes that health care services have been improperly denied, modified, or delayed by the Health Plan or one of its contracting providers. A "Disputed Health Care Service" is any health care service eligible for coverage and payment under the subscriber contract that has been denied, modified, or delayed by the Plan or one of its contracting providers, in whole or in part because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to the Member. The Member pays no application or processing fees of any kind for IMR. The Member has the right to provide information in support of the request for IMR. The Plan must provide the Member 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.

For more information regarding the IMR process, or to request an application form, please call Health Plan's Customer Services Department at (800) 428-6337; or write to ACN Group of California, Inc. at P.O. Box 880009, San Diego, CA 92168-0009

20.5 IMR for Experimental and Investigational Therapies

You may also have the right to an independent medical review through the Department if the Health Plan denies coverage for a requested service on the basis that it is experimental or investigational. Health Plan will notify you within 5 business days of its decision to deny an experimental/investigational therapy. You are not required to participate in the Health Plan's grievance process prior to seeking an independent medical review of this decision.

The Independent Medical Review Organization will complete its review within 30 days of receipt of your application and supporting documentation. If your physician determines that the proposed therapy would be significantly less effective if not promptly initiated, the review will be completed within 7 days.

20.6 Implementation of IMR Decision

If the Member receives a decision by the Director of the Department that a Disputed Health Care Service is Medically Necessary, Health Plan will promptly implement the decision.

In the case of reimbursement for services already provided, Health Plan will reimburse the provider or Member within five (5) working days. In the case of services not yet provided, Health Plan will authorize the services within five (5) working days of receipt of the written decision from the Director or sooner, if appropriate, for the nature of the Member's medical condition, and will inform the Member and Provider of the authorization according to the requirements of Health and Safety Code Section 1367.01(h)(3).

20.7

20.8 Department Review

The Combined Evidence of Coverage and Disclosure Form issued by Health Plan shall include the following statement advising Members of the Department's review of grievances:

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(1-800-428-6337) or for TTY/TDD services call 1-(888) 877-5379 (voice), or 1-(888) 877-5378 (TDDY))** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219) or (1- 888-466-2219) 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.

SECTION 21
TERMINATION OF A MEMBER'S COVERAGE

21.1 Basis for Termination of a Member's Coverage

Health Plan may terminate a Member's coverage under this Agreement for any one or more of the following reasons:

21.1.1 If the Group has failed to pay a premium due within 31 days of the Premium Due Date, Health Plan shall send a notice of cancellation to the Group requesting payment of any past due premiums and providing notice that coverage for a Member whose premium is unpaid shall terminate automatically as of the sixteenth (16th) day following issuance of such notice of cancellation. If the Member is hospitalized or undergoing treatment for an ongoing condition at the time of such termination, Health Plan shall continue to be financially responsible only for those Chiropractic Services provided after such termination that had already received prior written certification as Covered Services, and had already commenced, as of the date of such termination.

21.1.2 The Member fails to pay or make appropriate arrangements to pay a required Co-payment after the Member has been billed by the provider for two different billing cycles. Health Plan will provide the Member with written notice, and the Member will be subject to termination if payment or appropriate payment arrangements are not made within the thirty (30) day notice period.

21.1.3 If the Member permits the misuse of his or her identification documents by any other person, or misuses another person's identification, coverage of the Member may be terminated immediately upon notice to the Member. The Member shall be liable to Health Plan for all costs incurred as a result of any misuse of identification documents.

21.1.4 A Member's coverage will be terminated upon mailing of notice if a Member threatens the safety of any provider, his or her office staff, or the Health Plan if such behavior does not arise from a diagnosed illness or condition. In addition, a Member's coverage may be immediately terminated upon mailing of notice if the Member repeatedly or materially disrupt the operations of the Health Plan to the extent that the Member's behavior substantially impairs Health Plan's ability to furnish or arrange services for the Member or other Members or substantially impairs the ability of any provider, or his or her office staff, to provide services to other patients.

21.1.5 The Member moves out of the service area without the intention to return. Termination shall be effective on the sixteenth (16th) day following issuance of such notice.

21.1.6 The Member voluntarily disenrolls, provided the Group allows voluntary disenrollment. Termination shall take effect on the last day of the month in which the Member voluntarily disenrolls

21.1.7 The notice of cancellation issued by Health Plan shall be in writing and dated, and shall state:

(A) The cause for cancellation, with specific reference to the clause of this Agreement giving rise to the right of cancellation;

(B) That the cause for cancellation was not the Member's health status or requirements for health care services;

(C) The time when the cancellation is effective; and

(D) That a Member who alleges that an enrollment or subscription has been cancelled or not renewed because of the Member's health

status or requirements for health care services may request a review of cancellation by the Director of the Department.

21.2 Reinstatement of Member

Subject to Section 21.4, the reinstatement of any Member whose coverage under this Agreement has terminated for any reason shall be within the sole discretion of Health Plan. This Section does not apply to reinstatement of the Group, but rather to reinstatement of a Member whose coverage has terminated for reasons unrelated to cancellation of this Agreement for non-payment.

21.3 Return of Premiums for Unexpired Period

In the event of termination or rescission of a Member's coverage by Health Plan, Health Plan shall, within thirty (30) days following such termination, return to the Group the pro rata portion of any premium paid to Health Plan that corresponds to any unexpired period for which payment had been made less any amounts due to Health Plan from the Group.

21.4 Director Review of Termination

Any Member who in good faith believes that his or her coverage has been terminated or not renewed because of the Member's or a Subscriber's health status or requirements for Chiropractic Services may request a review of such termination or non-renewal by the Director of the California Department of Managed Health Care. If the Director determines that a proper complaint exists under Section 1365 of the California Health and Safety Code, the Director will so notify Health Plan. Health Plan shall, within fifteen (15) days after receipt of such notice, either request a hearing or reinstate the Member. If after the hearing the Director determines that the termination or non-renewal is contrary to applicable law, Health Plan shall reinstate the Member retroactive to the time of the termination or non-renewal and shall be liable for the expenses incurred by the Member after such termination or non-renewal for Chiropractic Services that would otherwise have received authorization as Covered Services.

21.5 Rescission

Member coverage is subject to rescission in the event that a Member fraudulently or intentionally provides incomplete or incorrect material information to Health Plan, or fraudulently or intentionally fails to inform Health Plan about changes to the information the Member submitted in their enrollment application that occurred before the Member's coverage became effective, and Health Plan would have denied the Member's enrollment if the Member had informed Health Plan about the changes. Further notice of the grounds of rescission are provided in Section 17.3 of the Combined Evidence of Coverage and Disclosure Form.

SECTION 22
TERMINATION OF THIS AGREEMENT

22.1 Termination at Will

This Agreement may be terminated for any reason by the Group upon giving thirty-one (31) days written notice to Health Plan prior to the end of the Initial Term or any Subsequent Term. This Agreement may be terminated for any reason by the Health Plan upon giving one hundred eighty (180) days written notice to Group prior to the end of the Initial Term or any Subsequent Term. In such event, benefits hereunder shall terminate for all Members as of the effective date of termination.

22.2 Termination for Cause by Health Plan

Health Plan may terminate this Agreement for any one or more of the following reasons:

22.2.1 Failure by the Group to pay the Total ` Premium as set forth in Section 5.1 if the Group has been duly notified and billed for the charge and at least 15 days has elapsed since the date of notification.

Receipt by the Health Plan of the proper Total Monthly Premium specified in Section 5.1 after cancellation of the Agreement for nonpayment shall reinstate the Agreement as though it had never been canceled if such payment is received on or before the succeeding monthly Premium Due Date. Provided, however, the Agreement shall not be reinstated if any of the following condition are met:

(A) In the notice of cancellation, Health Plan notifies Group that if payment is not received within fifteen (15) days a new application is required;

(B) If such payment is received more than fifteen (15) days after issuance of the notice of cancellation, Health Plan refunds such payment within twenty (20) business days; or

(C) If such payment is received more than fifteen (15) days after issuance of the notice of cancellation, Health Plan issues to Group, within twenty (20) business days of receipt of payment, a new contract accompanied by written notice stating clearly those respects in which the new contract differs from the canceled contract in benefits, coverage or otherwise.

22.2.2 Fraud or deception by the Group in the use of services or facilities of the Health Plan or knowingly permitting such fraud or deception by another.

22.3 Notice of Termination of This Agreement

The Group shall promptly mail to each Member a legible, true copy of any notice of termination of this Agreement received by the Group from Health Plan, and shall promptly provide Health Plan with proof of such mailing including, but not limited to, the date thereof.

22.4 Return of Premiums for Unexpired Period

In the event of termination of this Agreement, Health Plan shall, within thirty (30) days following such termination, return to the Group the pro rata portion of any premium paid to Health Plan that corresponds to any unexpired period for which payment had been made less any amounts due to Health Plan from the Group.

22.5 Continuation of Coverage under Federal Law (COBRA)

If Member's coverage ends, Member may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal law. Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Groups that are subject to the terms of COBRA. Member can contact his or her plan administrator to determine if Member's Group is subject to the provisions of COBRA. If Member's selected continuation coverage under a prior plan which was then replaced by coverage under this plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed below, whichever is earlier. Health Plan is not the Group's designated "plan administrator" as that term is used in federal law, and Health Plan does not assume any responsibilities of a "plan administrator" according to federal law.

Health Plan is not obligated to provide continuation coverage to Member if the Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Group or its plan administrator are: Notifying Member in a timely manner of the right to elect continuation coverage; and notifying Health Plan in a timely manner of Member's election of continuation coverage.

22.5.1 Qualified Beneficiary

In order to be eligible for continuation coverage under federal law, Member must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the plan on the day before a qualifying event:

(A) A Subscriber.

(B) A Subscriber's Family Dependent, including with respect to the Subscriber's children, a child born to or placed for adoption with the Subscriber during a period of continuation coverage under federal law.

(C) A Subscriber's former spouse.

22.5.2 Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

(A) Termination of the Subscriber from employment with the Group, for any reason other than gross misconduct, or reduction of hours; or

(B) Death of the Subscriber; or

(C) Divorce or legal separation of the Subscriber; or

(D) Loss of eligibility by a Family Dependent who is a child; or

(E) Entitlement of the Subscriber to Medicare benefits; or

(F) The Group filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Subscriber and his or her Family Dependents. This is also a qualifying event for any retired Subscriber and his or her Family Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

22.5.3 Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

The Subscriber or other Qualified Beneficiary must notify the Group's designated plan administrator within 60 days of the Subscriber's divorce, legal separation or a Family Dependent's loss of eligibility as a Family Dependent. If the Subscriber or other Qualified Beneficiary fails to notify the designated plan administrator of these events within the 60 day period, the Group and its plan administrator are not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Subscriber is continuing coverage under Federal Law, the Subscriber must notify the Group's designated plan administrator within 60 days of the birth or adoption of a child.

Continuation must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the Group's designated plan administrator. If the Qualified Beneficiary's coverage was terminated due to a qualifying event, then the initial Premium due to the Group's designated plan administrator must be paid on or before the 45th day after electing continuation.

22.5.4 Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under this document will end on the earliest of the following dates:

(A) Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Subscriber's employment was terminated or hours were reduced (i.e., qualifying event A.). If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at anytime within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional 11 months of continuation coverage (for a total of 29 months of continued coverage) subject to the following condition: (i) notice of such disability must be provided within 60 days after the determination of the disability, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

(B) Thirty-six months from the date of the qualifying event for a Family Dependent whose coverage ended because of the death of the Member, divorce or legal separation of the Subscriber, loss of eligibility by a Family Dependent who is a child (i.e. qualifying events B., C., or D).

(C) For the Family Dependents of a Subscriber who was entitled to Medicare prior to a qualifying event that was due to either the termination of employment or work hours being reduced, eighteen months from the date of the qualifying event, or, if later, 36 months from the date of the Subscriber's Medicare entitlement.

(D) The date coverage terminates under the Policy for failure to make timely payment of the Premium.

(E) The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

(F) The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Group filed for bankruptcy, (i.e. qualifying event F.)

(G) The date this document ends.

(H) The date coverage would otherwise terminate under this document.

If a Qualified Beneficiary is entitled to 18 months of continuation and a second qualifying event occurs during that time, the Qualified Beneficiary's coverage may be extended up to a maximum of 36 months from the date coverage ended because employment was terminated or hours were reduced. If the Qualified Beneficiary was entitled to continuation because the Group filed for bankruptcy, (i.e. qualifying event F) and the retired Subscriber dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for 36 months from the date of the Subscriber's death. Terminating events B through G described in this section will apply during the extended continuation period.

Continuation coverage for Qualified Beneficiaries whose continuation coverage terminates because the Subscriber becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact the Group's designated plan administrator for information regarding the continuation period.

22.6 Cal-COBRA.

Group with two (2) to nineteen (19) subscribers who do not qualify for federal COBRA, continuation coverage under this Health Plan shall comply with the requirements of the California Continuation Benefits Replacement Act, as amended ("Cal-COBRA"). Continuation coverage under Cal-COBRA shall be provided in accordance with section 1366.20 et seq. of the California Health and Safety Code, and shall be equal to, and subject to the same limitations as, the benefits provided to other Group Members regularly enrolled in this Health Plan. Group shall provide affected Members with written notice of available continuation coverage as required by, and in accordance with, Cal-COBRA and amendments thereto.

22.6.1 Notice Upon Termination.

Upon the termination of continuation coverage under Cal-COBRA, Group shall notify affected Members receiving Cal-COBRA continuation coverage whose continuation coverage will terminate under Health Plan prior to the end of statutory continuation coverage period of the Member's ability to continue coverage under a new group plan for the balance of the statutory period. Notice shall be provided 30 days prior to the termination or when all Members are notified, whichever is later Group shall notify a successor plan in writing of the Members receiving Cal-COBRA continuation coverage.

SECTION 23
GENERAL PROVISIONS

23.1 Compliance with Applicable Law

Health Plan is subject to the requirements of Chapter 2.2 of Division 2 of the California Health and Safety Code and Subchapter 5.5 of Chapter 3 of Title 28 of the California Code of Regulations, as well as any successor provisions to any of the foregoing provisions. Any term or condition required by such provisions to be included in the Agreement shall be incorporated into this Agreement by this reference, whether or not specifically provided in this Agreement.

23.2 Relationship Between Health Plan and Each Participating Provider

The relationship between Health Plan and each Participating Provider is an independent contractor relationship. Participating Providers are not agents or employees of Health Plan, nor is Health Plan, or any employee of Health Plan, an employee or agent of any Participating Provider. Health Plan shall not be liable for any claims or demands on account of damages

arising out of, or in any manner connected with, any injury suffered by a Member relating to Chiropractic Services received by the Member from any Participating Provider.

23.3 Members Bound by This Agreement

By this Agreement, the Group makes coverage under Health Plan's chiropractic benefits program available to Members who are eligible and duly enrolled in accordance with the requirements of this Agreement. This Agreement shall be subject to amendment and termination in accordance with the terms of this Agreement without the necessity of either party obtaining the consent or concurrence of any Member. By electing such coverage or accepting its benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to be bound by all of the terms and conditions of this Agreement. In the case of conflicts between this Agreement and the Combined Evidence of Coverage and Disclosure Form, the provisions of the Combined Evidence of Coverage and Disclosure Form shall be binding upon Health Plan notwithstanding any provisions of this Agreement that may be less favorable to Members.

23.4 Nondisclosure and Confidentiality

Neither Health Plan nor the Group shall release any information regarding the terms set forth in this Agreement to any person or entity without the prior written consent of the other, except such information as may be necessary to disclose to agents, affiliates, attorneys, accountants, governmental regulatory agencies, non-covered custodial parents of covered children, or Members in order to carry out the terms of this Agreement. Except as otherwise required by applicable law or provisions of this Agreement, Health Plan and the Group shall keep confidential, and shall take the usual precautions to prevent the unauthorized disclosure of any and all records required to be prepared or maintained in accordance with this Agreement.

23.5 Member Records

Health Plan and the Group shall maintain the confidentiality of any information relating to Members in accordance with any applicable statutes and regulations. No Member identifying information obtained as a result of providing services to Members under this Agreement shall be shared with third parties including Group, unless the Member consents to the disclosure of such information or as otherwise permitted under applicable law.

Members, who are adult patients, have the right to inspect their medical records and provide Health Plan, in writing, with corrections to any item or statement that the Member believes to be incomplete or incorrect in their medical records.

Corrections for each incomplete or incorrect item in the Member's record is limited to 250 words.

The Member must also clearly state in writing that the Member wishes his or her written corrections to be made part of his or her record.

Health Plan will attach the Member's corrections to the Member's records and include such corrections whenever Health Plan makes a disclosure of the incomplete or incorrect portion of a Member's records to any third party.

A STATEMENT DESCRIBING HEALTH PLAN'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO MEMBERS UPON REQUEST.

To request a copy, call ACN Group of California, Inc. at (800) 428-6337.

23.6 Overpayments

Member shall agree to reimburse Health Plan, on demand, for any and all such amounts Health Plan pays to or on behalf of a Member:

(A) For services or accommodations which do not qualify as Covered Services;

(B) With respect to a Subscriber's family member or a person believed to be a Subscriber's family member, who is not entitled to Covered Services under this Agreement; or

(C) Which exceeds the amounts to which the Member is entitled under this Agreement.

23.7 Clerical Error

Clerical error in connection with any record pertaining to coverage under this Agreement, whether such error is made by the Group or by Health Plan, shall neither invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

23.8 Amendments

This Agreement may be amended at any time by the mutual written consent of both parties. Any amendments to this Agreement shall be in writing and must be approved and executed by Health Plan. Health Plan specifically reserves the right to amend this Agreement upon thirty-one (31) days prior written notice to the Group. Such amendment shall be final and binding on the Group and on all Members covered under the Agreement unless the Group objects in writing to the amendment within thirty-one (31) days from receipt thereof. Health Plan may also amend this Agreement to comply with requirements of state and federal regulatory authorities, and shall give written notice to Group of such amendment and its effective date. Unless such regulatory authorities direct otherwise, the signature of the Group will not be required.

23.9 Waiver

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

23.10 Severability

If any clause, sentence, provision, or other portion of this Agreement is, or becomes, illegal, null, void, or unenforceable for any reason, or is held by a court of competent jurisdiction to be so, the remainder of this Agreement shall remain in full force and effect.

23.11 Assignment

Neither Health Plan nor the Group may assign any of its rights and responsibilities under this Agreement to any person or entity without the prior written consent of the other party, which consent shall not be unreasonably withheld. The Group acknowledges that persons and entities under contract or affiliated with Health Plan may perform certain services under this Agreement. The Group acknowledges that, subject to applicable regulatory requirements, assignment by Health Plan of all or any of its rights and responsibilities under this Agreement to any entity controlling, controlled by or under common control with Health Plan shall not require the Group's prior written consent.

23.12 Successors and Assigns

This Agreement shall be binding upon the heirs, executors, administrators, or other legal representatives of the Group and is for the benefit of Health Plan, its successors and assigns.

23.13 Governing Law

The validity and interpretation of this Agreement and the rights and obligations of the parties under this Agreement shall be governed by the laws of the State of California.

23.14 Notice

All notices required by this Agreement shall be in writing and shall be sent by first-class mail or hand-delivered to the parties at their respective addresses set forth below. The date a notice is mailed or hand-delivered shall be considered the effective date of the notice.

To Health Plan:

ACN Group of California, Inc.

P.O. Box 880009, San Diego, CA 92168-0009

Attn: Chief Executive Officer

To the Group:

Address listed below.

Attn: Chief Executive Officer

A notice by Health Plan to a Member shall be mailed to the last address for the Member that was provided to Health Plan by the Group.

23.15 Entire Agreement

This Agreement, including the documents attached hereto and herein referenced contains the entire agreement between the parties with respect to the subject matter of this Agreement and supersedes all prior agreements and understandings, written or oral, between the parties with respect to the same subject matter.

23.16 Arbitration

23.16.1 **Disputes Between Group and Health Plan.** All disputes between Group and Health Plan shall be resolved by binding arbitration before JAMS, a non-judicial arbitration and mediation service. If the amount at issue is less than $200,000, then the arbitrator will have no jurisdiction to award more than $200,000. The JAMS Comprehensive Arbitration Rules and Procedures ("Rules") in effect at the time a demand for arbitration is made will be applied to the arbitration. The parties will seek to mutually agree on the appointment of an arbitrator; however, if an agreement cannot be reached within thirty (30) days following the date demanding arbitration, the parties will use the arbitrator appointment procedures in the Rules. Arbitration hearings will be held at the neutral administrator's offices in San Diego County, California or at another location agreed upon in writing by the parties. Civil discovery may be taken in such arbitration as provided by California law and civil procedure. The arbitrator(s) selected will have the power to control the timing, scope and manner of the taking of discovery and will have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California. This includes, but is not limited to, the imposition of sanctions. The arbitrator(s) will have the power to grant all remedies provided by California law. The arbitrator(s) will prepare in writing an award that includes the legal and factual reasons for the decision. The parties will divide equally the fees and expenses of the arbitrator(s) and the neutral administrator. The arbitrator(s) will not have the power to commit errors of law or legal reasoning, and the award may be vacated or corrected pursuant to California law. The Federal Arbitration Act, 9 U.S.C. §§ 1-16, will also apply to the arbitration.

23.16.2 **Disputes Between Member and Health Plan.**

(A) **Member Appeals and Grievances.** The attached Health Plan Combined Evidence of Coverage and Disclosure Form includes a complete description of the Health Plan appeals and grievance procedures and dispute resolution processes for Members.

(B) **Binding Arbitration.** Any and all disputes of any kind whatsoever, including, but not limited to, claims for medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered) between Member (including any heirs, successors, or assigns of Member) and Health Plan except for claims subject to ERISA shall be submitted to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Member and Health Plan are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and are instead accepting the use of binding arbitration by a single arbitrator in accordance with the Comprehensive Rules of JAMS, and administration of the arbitration shall be performed by JAMS or such other arbitration service as the parties may agree in writing. The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) days following the date demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Rules will be utilized.

Arbitration hearings shall be held in San Diego County, California or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration as provided by California law and the Code of Civil Procedure. The arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies provided by California law. The parties shall divide equally the expenses of JAMS and the arbitrator. In cases of extreme hardship, Health Plan may assume all or part of the Member's share of the fees and expenses of JAMS and the arbitrator, provided the Member submits a hardship application to JAMS. The approval or denial of the hardship application will be determined solely by JAMS.

The arbitrator shall prepare in writing an award that includes the legal and factual reasons for the decision. The Federal Arbitration Act, 9 U.S.C. §§ 1-16, shall also apply to the arbitration.

23.16.3 **Mandatory Arbitration.** Group, Member, and Health Plan agree and understand that any and all disputes, including claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), except for claims subject to ERISA, shall be determined by submission to binding arbitration in accordance with the terms of this Agreement. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Group, Member, and Health Plan are giving up the constitutional right to have any such dispute decided in a court of law before a jury, and instead is accepting the use of binding arbitration.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the effective date referenced on the first page of this Agreement.

ACN Group of California, Inc.
(the "Health Plan")

By: _____

Authorized Signature

Print Name: _____

Title: _____

Date: _____

GROUP
(the "Group")

By: _____

Authorized Signature

Print Name: _____

Address: _____

_____

Title: _____

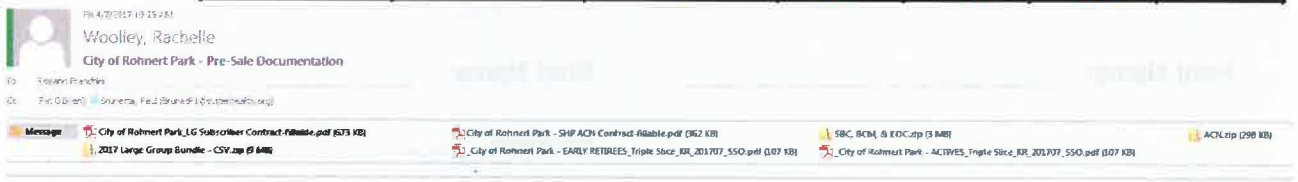
Date: _____

ATTACHMENT A

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

ACTIVES ANCILLARY BENEFIT PLAN SELECTION (12 payments per year)						
Chiropractic and Acupuncture - Final Plan and Tier Rate Information						
Product ID	Max Visits	Copayment	EE Only	EE + 1	EE + 2 or More	Sold (X)
XAD4	Unlimited	20	$3.64	$7.42	$10.73	

EARLY RETIREES ANCILLARY BENEFIT PLAN SELECTION (12 payments per year)						
Chiropractic and Acupuncture - Final Plan and Tier Rate Information						
Product ID	Max Visits	Copayment	EE Only	EE + 1	EE + 2 or More	Sold (X)
XAD4	Unlimited	20	$3.64	$7.42	$10.73	



ATTACHMENT B

SCHEDULE OF BENEFITS

Chiropractic and Acupuncture Schedule of Benefits Offered by ACN Group of California, Inc.

Benefit Plan:

$20 Copayment per Visit

Unlimited Visit Annual Combined Maximum Benefit Acupuncture and Chiropractic

Claims Determination Period:

Benefit Year

Your Group makes available to you and your eligible dependents a complementary health benefits program for chiropractic and acupuncture. This program is provided through an arrangement with the ACN Group of California, Inc. dba OptumHealth Physical Health of California (OptumHealth). OptumHealth monitors the quality of the care provided by participating OptumHealth providers.

How to Use the Program

With OptumHealth, you have direct access to more than 3,500 credentialed chiropractors and over 950 credentialed acupuncturists servicing California. You are not required to predesignate an OptumHealth provider or to obtain a medical referral from your primary care physician prior to seeking chiropractic or acupuncture services. Additionally, you may change participating chiropractors or acupuncturists at any time.

Our program is designed for your convenience. You simply pay your copayment or coinsurance at each visit. There are no deductibles or claim forms to fill out. Your OptumHealth provider coordinates all services and billing directly with OptumHealth.

Annual Benefits

Benefits include chiropractic services and acupuncture services that are Medically Necessary services rendered by an OptumHealth participating provider. In the case of acupuncture services, the services must be for Medically Necessary diagnosis and treatment to correct body imbalances and conditions such as low back pain, sprains and strains (such as tennis elbow or sprained ankle), nausea, headaches, menstrual cramps, carpal tunnel syndrome, and other conditions. In the case of chiropractic services, the services must be for Medically Necessary diagnosis and treatment to reduce pain and improve functioning of the neuromusculoskeletal system.

Calculation of Annual Maximum Benefit Limits

Each visit to an OptumHealth participating provider, as described below, requires a copayment by the member. A maximum number of visits to either an OptumHealth participating chiropractor or participating acupuncturist, or any combination of both, per Claims Determination Period will apply to each member.

Chiropractic Services: Adjunctive therapy is allowed at each office visit. If adjunctive therapy is provided without a chiropractic adjustment, the adjunctive therapy will count as an office visit toward the maximum benefit. If an examination or re-examination is supplied without an adjustment, the examination or re-examination will count as an office visit toward the maximum benefit.

Acupuncture Services: Adjunctive therapy is allowed at each office visit. If adjunctive therapy is provided without acupuncture treatment, the adjunctive therapy will count as an office visit toward the maximum benefit. If an examination or re-examination is supplied without acupuncture treatment, the examination or re-examination will count as an office visit toward the maximum benefit.

Provider Eligibility

OptumHealth only contracts with duly licensed California chiropractors and acupuncturists. Members must use OptumHealth participating providers to receive their maximum benefit.

Types of Covered Services

Chiropractic Services:

1. An initial examination is performed by the OptumHealth participating chiropractor to determine the nature of the member's problem, and to provide, or commence, in the initial examination, Medically Necessary services that are Covered Services, to the extent consistent with professionally recognized standards of practice, and to prepare a treatment plan of services to be furnished. An initial examination will be provided to a member if the member seeks services from an OptumHealth participating chiropractor for any injury, illness, disease, functional disorder or condition with regard to which the member is not, at the time, receiving services from the OptumHealth participating chiropractor. A copayment will be required for such examination.
2. Subsequent office visits, as set forth in a treatment plan, may involve a chiropractic adjustment, a brief re-examination and other services, in various combinations. A copayment will be required for each visit to the office.
3. Adjunctive therapy, as set forth in a treatment plan, may involve therapies such as ultrasound, electrical muscle stimulation and other therapies.

Questions? Call OptumHealth's Customer Service Department: 1-800-428-6337 (HMO) Monday through Friday, 8 a.m. – 5 p.m. PST

www.myoptumhealthphysicalhealthofca.com