November 1, 2015 C.A.R. Health Insurance Program

General Plan Guidelines

C.A.R. Endorsed Agent:

RealCare Insurance Marketing, Inc.

19310 Sonoma Highway, Ste. A

Phone: (800) 939-8088 Fax: (707) 935-7142

California License #: 0B23546

C.A.R. HEALTH PLAN ELIGIBILITY GUIDELINES

This document summarizes the benefits offered herein. Individual situations may vary. In all cases, the insurance contracts for the specific benefits program you select govern and are the final authority on the terms of the plan. If there are any differences between the information in the summary and the insurance contract, the insurance contract will control. **Contact RealCare Insurance Marketing, Inc., the C.A.R. Insurance Plan Administrator for additional information.**

Insurance Programs

- ***Medical Insurance*** is available for eligible C.A.R. members and their dependents, eligible full-time W-2 employees of C.A.R. members and local C.A.R. chapters. Medical insurance is guaranteed to be issued for all eligible parties regardless of health history.
- ***Dental Insurance*** may be purchased by itself or in combination with any other C.A.R. Insurance Plan.
- ***Life Insurance*** coverage is guaranteed for new REALTOR® members; or newly eligible employees of REALTORS® and local C.A.R. chapters, who elect coverage between their 1st and 60th day of C.A.R. membership and who have not been hospitalized within 90 days of making application. Affiliate members are not eligible for guaranteed life coverage but may apply for coverage with evidence of medical insurability. Eligible members enrolling during this window cannot be turned down due to pre-existing medical conditions, unless hospitalized within 90 days of making application. Any eligible member who has been hospitalized within 90 days of making application must submit evidence of medical insurability and could be declined coverage. Eligible members may purchase either $25,000 or $50,000 of coverage. This coverage also includes two times the benefit if death is a result of an accident. Coverage is not guaranteed at any time after the 60th day of C.A.R. membership or employment; however, interested members may apply for coverage by completing an enrollment application and health history questionnaire. Please call RealCare for more information.
- ***Vision Insurance*** may be purchased by itself or in combination with any other C.A.R. Insurance Plan.

Who is Eligible

- ***Active C.A.R. members*** who have been members for at least 1 day.
- ***Families of active members,*** including spouses or domestic partners and dependent children.
    - ***For All plans –*** Dependent children are eligible up to age 26 regardless of student status, marital status, or eligibility for other group coverage. Dependents must be covered under the same plan you choose and can only enroll if the C.A.R. member enrolls.
- ***Domestic Partners***. All C.A.R. health plans allow a subscriber to enroll his/her domestic partner at the same rate as a spouse. The domestic partner includes the same or opposite sex partnership. If you are under age 62 and have an opposite sex domestic partner relationship, you may have to complete a domestic partner affidavit form to enroll.
- ***Regular full-time employee and their eligible dependents.*** A W-2 employee is considered eligible if s/he works at least 30 hours per week and has been working for an eligible C.A.R. member or local C.A.R. chapter for at least 1 day. An eligible employee may enroll even if the C.A.R. member does not enroll.
- ***Retired C.A.R. members.*** A retired member is one who has attained age 65 but who continues membership in C.A.R.
- ***Dependents of a deceased member or of a retired member who has attained age 65*** **and enrolled in Medicare Parts A and B, but who continues membership in C.A.R.** may continue on the medical plan only if they were covered dependents at the time of death or Medicare enrollment or disenrollment due to retirement. If coverage is terminated, these dependents lose eligibility and may not re-enroll. See also *Retirement* section.

Proof of Eligibility

- ***New C.A.R. members*** must submit proof of membership with the application. A receipt or letter from the local association indicating the member's join date and type of membership will suffice. ***New employees*** of REALTORS® or local C.A.R. chapters must submit payroll records or pay stubs to substantiate their eligibility.
- ***All enrollees applying for coverage outside of Open Enrollment*** must furnish *proof of a qualifying event.*
- ***Qualifying Events*** are outlined in the section "Enrollment Periods**."**

Membership in C.A.R. must be maintained in order to preserve eligibility. Failure to maintain continuous active C.A.R. membership will result in termination of coverage for the REALTOR®, dependents and any enrolled employees and their dependents. An annual audit is performed to confirm continuous C.A.R. membership.

Retirement (See section *Retired C.A.R. Members*)

If a covered C.A.R. member retires and wishes to terminate his/her own enrollment, covered dependents can continue on the medical plan as long as the retiree maintains his/her C.A.R. membership. Retirees should consult with a RealCare agent for assistance in evaluating health

plan options and confirming coverage availability. If dependents subsequently terminate their coverage they will not be allowed to re-enroll at a later time.

Medicare Eligibility

Anthem Blue Cross of California: Eligible subscribers who turn 65 while enrolled in an Anthem Blue Cross medical plan can continue coverage under the group plan. Members are charged a premium based on their age as of the contract renewal date regardless of Medicare eligibility. The C.A.R. group policy is not a Medicare Supplement plan. For those who enroll in Medicare at age 65 or later, Medicare is considered the "Primary" plan and all claims will be processed by Medicare first and then sent to Anthem. For those who enroll in Medicare due to a disability before the age of 65, Medicare is primary and the C.A.R. group plan is secondary.

Kaiser Permanente: When a covered member reaches age 65, the Kaiser group insurance plan may remain as the primary plan. However, the Kaiser group plan does **not** offer a plan secondary to Medicare. Therefore, if a member turns 65 and enrolls in Medicare, he/she may not be eligible for the C.A.R. Kaiser Group plan. In this case the covered member would be eligible to enroll in an individual Kaiser Senior Advantage plan.

Please consult your RealCare agent to determine your options when you become eligible for Medicare.

Coverage for Pre-Existing Conditions

As required under the Affordable Care Act, all pre-existing medical conditions are covered from the first day of health plan coverage.

Plan Changes

Existing subscribers may change plans or add dependents during the applicable Open Enrollment periods. At that time existing subscribers will be notified of upcoming plan and rate changes, and will be given an opportunity to change plans or add dependents without evidence of insurability.

Existing subscribers may also be eligible to make plan changes within 31 days of specific qualifying events. Contact RealCare for clarification of eligibility for plan changes.

Plan changes may result in a rate increase.

Re-Enrollment

Re-Enrollment is contingent on meeting all eligibility requirements.

Kaiser: If your coverage terminates due to voluntary request or non-payment of premium, you may be eligible to re-enroll at the next Open Enrollment or within 31 days of a qualifying event. You will be required to pay all unpaid premiums, dues and fees at the time of enrollment.

Anthem Blue Cross: If your coverage terminates due to voluntary request or non-payment of premium, you may be eligible to re-enroll at the next Open Enrollment or within 31 days of a qualifying event. You will be required to pay all unpaid premiums, dues and fees at the time of enrollment.

MetLife Dental & Vision: If your coverage terminates due to voluntary request or non-payment of premium, you may be eligible to re-enroll at the next applicable Open Enrollment following a 13 month waiting period; or within 61 days of a loss of other coverage. You will be required to pay all unpaid premiums, dues and fees at the time of enrollment.

MetLife Life: If your coverage terminates and you are ineligible for reinstatement, you will not be allowed to re-enroll without submitting evidence of medical insurability. If you must re-apply, coverage is not guaranteed.

ENROLLMENT PERIODS AND EFFECTIVE DATES

Open Enrollment Periods:

Medical, Dental & Vision Plans:

- **SPRING Open Enrollment: April 1st through May 15th each year for coverage effective June 1st.**
- **FALL Open Enrollment: November 1st through December 15th each year for coverage effective January 1st.**

During these periods all eligible members and dependents, and eligible full-time W-2 employees can join the association insurance plans. The REALTOR® or C.A.R. member must have been a member of the association for at least 1 day. *If you and/or your family members decide not to enroll in the plans during one of these enrollment periods, you may be forfeiting the right to enroll until the next open enrollment period.*

Initial Eligibility Period

1. ***New members of C.A.R.*** may enroll in any coverage offered as part of the C.A.R. Insurance Plan between the 1st and 60th day of membership. Your completed enrollment form and premium payment should be received by RealCare no later than 60 days from your C.A.R. membership date.
2. ***Newly hired permanent, full-time employees of C.A.R. members or local C.A.R. chapters*** may enroll in any coverage offered as part of the C.A.R. Insurance Plan between the 1st and 60th day of employment. Your completed enrollment form and premium payment should be received by RealCare no later than 60 days from your employment date.

Special Enrollment Provision: Qualifying Events During The Plan Year

Eligible C.A.R. members and other eligible parties may be able to enroll in the group health plan outside of open enrollment if they have a qualifying event. If you have any questions regarding a possible qualifying event, contact RealCare Insurance Marketing at 800-939-8088. Below is a listing of the most common qualifying events.

I. Loss of other qualified group coverage:
   A. A subscriber and his/her dependents that did not enroll in the plan because they had other group coverage, but who subsequently lose their coverage may enroll under the Special Enrollment Provision. The loss of group coverage may be due to:
      1. Exhaustion of COBRA or CalCOBRA
      2. Loss of eligibility for group coverage due to:
         a) Divorce or legal separation
         b) Termination of domestic partnership agreement
         c) Child's loss of eligibility due to age
         d) Death of an employee
         e) Termination of employment
         f) Reduction of hours
         g) Moving out of the health plan service area

II. Acquisition of a new dependent either through marriage, adoption, placement for adoption or birth
III. The issuance of a court order to provide coverage for a spouse, ex-spouse or dependent child
IV. Loss of "No-Share-Of-Cost" Medi-Cal Eligibility
V. Newly gained status as an "eligible" dependent.

If a party becomes eligible pursuant to a qualifying event described above, s/he must submit completed enrollment materials and premium payment to RealCare within 31 days of the qualifying event.

Effective Dates of Coverage

The effective date of coverage will depend on the enrollment period and the timing of receipt of completed enrollment paperwork and payment.

For Open Enrollment:

- For Spring Open Enrollment the effective date of coverage is **June 1st**
- For Fall Open Enrollment the effective date of coverage is **January 1st**

For Initial Eligibility Periods (for new members/employees), the effective date of coverage will be the first of the month following receipt of completed enrollment materials and payment.

For Special Enrollment Periods (enrollment following a qualifying event), the effective date of coverage will vary depending on the qualifying event. Please consult RealCare for assistance in determining your effective date.

Claims by Participants and Beneficiaries

A claim is a request for a plan benefit. Employees, retirees, dependents and other qualified family members have the right pursuant to the insurance contracts to file a written claim for benefits. If a claim or request for benefits is denied in whole or in part, the claimant will be provided written notice of the denial from the carrier.

If the claimant sends a written request for review of a denied claim, the person sending the request has the right to:

- Review pertinent plan documents which may be obtained by calling or writing RealCare Insurance Marketing, Inc., the Plan Administrator, or the carrier.
- Send a written statement of the issues and any other comments in support of the claim for benefits or other matter under review to the carrier.

The decision of the carrier upon review of an appealed claim is final and not subject to further administrative review. However, you may have further appeal rights through the California Department of Insurance, or the California Department of Managed Health Care.

Filing Claims for Benefits

The specific procedures for pre-authorizations, approval of benefits, or utilization review for benefits offered under this Plan are specifically addressed in the EOC (Evidence of Coverage) pursuant to which benefit is provided. Please consult the appropriate EOC for each plan as it details the procedures for filing claim forms, providing notification of benefit determinations, reviewing any denied claims, applicable time limits, and remedies available for any claims for Plan benefits that are denied in whole or in part.

Miscellaneous Plan Information

The following sections describe some additional information about the Plan and various laws that may impact your right to benefits under the plan.

COBRA and Cal-COBRA

A federal law, known as the Consolidated Omnibus Budget Reconciliation Act ("COBRA") and a California law known as Cal-COBRA, will apply in certain circumstances. Both programs require that you and your covered dependents be given an opportunity to temporarily continue participation in the group health benefits of the plan if you experience a "qualifying event". Group health benefits includes medical, dental and vision, but not life insurance. If you or your covered dependents experience a loss of coverage, please contact RealCare or your employer to determine whether you are eligible for COBRA or CalCOBRA benefits. For W-2 employees, if you experience a qualifying event other than a change in your employment status, it is your obligation to inform your employer within 60 days of the occurrence. The employer, in the case of federal COBRA or the insurance company in the case of Cal-COBRA, has a legal obligation to furnish the Qualifying Beneficiary(ies) with separate, written options to continue the benefit coverage provided at the stated costs with respect to each group health plan in which you are a participant. Without assuming any legal obligation and as an added service, you or your employer may notify RealCare of the COBRA event and RealCare will notify the carrier. Your right to continued participation under COBRA or Cal-COBRA requires you to contribute toward the cost of your continued coverage. Refer to your EOC for the detailed description of your COBRA rights and obligations, including, among other things, information concerning Qualifying Events, Qualified Beneficiaries, premiums, notice and election requirements and procedures, and duration of coverage.

Plan Document

You may obtain a copy of the Plan Document, also known as an EOC or COC, on the web at **www.RealCareCAR.com** or from RealCare Insurance Marketing, Inc., at (800) 939-8088.

Newborns' and Mothers' Health Act

To the extent any applicable program provides benefits for hospital lengths of stay in connection with childbirth, the Plan will cover the minimum length of stay required for deliveries (i.e., a 48-hour hospital stay after a vaginal delivery or a 96-hour stay following a delivery by Cesarean section.) The mother's or newborn's attending physician, after consulting with the mother, may discharge the mother or her newborn earlier than the minimum length of stay otherwise required by law. No provider authorization is required from the Plan or any insurer for prescribing a length of stay less than 48 or 96 hours. This coverage is subject to any applicable deductible, coinsurance amounts or co-payments.

Women's Health and Cancer Rights Act

If a Plan provides benefits for mastectomies, an individual who is receiving mastectomy benefits and who elects breast reconstruction in connection with the mastectomy will receive coverage for all stages of reconstruction on the breast on which the mastectomy was performed, surgery and reconstruction on the other breast to give a symmetrical appearance, any needed prosthesis, and coverage for physical complications of all stages of the mastectomy, including lymphedemas. This coverage is subject to any applicable deductible or coinsurance amounts.

Mental Health Parity Act

To the extent any applicable Plan provides mental health benefits, it will not place annual or lifetime maximums on those benefits which are lower than the annual and lifetime maximum dollar limits for physical health benefits. This coverage is subject to any applicable deductibles and coinsurance, as well as lifetime maximums.

Privacy of Health Information

The Health Insurance Portability and Accounting Act ("HIPAA") provides you with certain rights in connection with the privacy of your health information. Beginning April 14, 2003, ("implementation date") you automatically will receive a summary of these rights from the Plan Administrator. Additionally, you may receive a free copy of this information at any time after the implementation date upon request. Neither RealCare Insurance Marketing, Inc., nor the California Association of REALTORS® will disclose any medical information without your written consent except as permitted by law.

Qualified Medical Child Support Orders

Generally, your benefits under the Plan may not be assigned or alienated. However, an exception applies in the case of a "qualified medical child support order." Basically, a qualified medical child support order is an administrative agency or court-ordered judgment, decree, order, or property settlement agreement in connection with a state domestic relations law which either (1) creates or extends the rights of an "alternate recipient" to participate in a Plan that provides group health benefits, or (2) enforces certain laws relating to medical child support. An "alternate recipient" is any child of a participant who is recognized by a medical support order as having a right to enrollment under a participant's Plan for group health benefits.

A medical child support order has to satisfy certain specific conditions to be qualified. RealCare will notify you if we receive a medical child support order that applies to you. You also will be provided a copy of the Plans' procedures for determining whether the medical child support order is qualified.

If a qualified medical child support order is issued for your child, that child will be eligible for coverage as required by the order. The amount you will be required to pay under the Plan for medical benefits in order to comply with the qualified medical child support order may be changed to reflect the addition of the child. If a qualified medical child support order is issued for your child and you are eligible but not participating in the Plan offering group medical benefits at that time, you must enroll in the Plan offering group medical benefits at that time, you must enroll in the Plan and pay any applicable contributions. RealCare can add you and your child if you are not currently enrolled.

You should consult the Evidence of Coverage (EOC) document for the programs that offer group health benefits for a detailed description of the qualified medical child support provisions, including, among other things, a description of the procedures governing qualified medical support order determinations.

HIPAA Certification

HIPAA currently requires your health plan to provide you with a written confirmation of your health care coverage under a Plan, if applicable. To verify eligibility after a loss of coverage, you may be asked to provide proof of your prior "creditable coverage." Creditable coverage includes coverage under a Plan for a self-insured employer group health plan, an individual or group health insurance indemnity or HMO plan, a state or federal continuation coverage plan, individual or group health plan, a state or federal continuation coverage plan, individual or group health conversion plans, Part A or Part B of Medicare, Medicaid (except for coverage for pediatric vaccines), the Indian Health Service, the Peace Corps Act, a state health benefits risk pool, a public health plan, health coverage for current or former members of the armed forces and any dependents, medical savings accounts, and health insurance for federal employees and any dependents.

Proof of creditable coverage is generally demonstrated through a certificate generated by your prior plan, which shows evidence of your prior health coverage. However, if you cannot obtain a certificate, you may demonstrate creditable coverage if,

- You attest to the period of creditable coverage.
- You present corroborating evidence of some creditable coverage for the period (such as pay stubs that reflect a deduction for health insurance, explanation of benefits forms ("EOBs"), or verification by a doctor or former health care benefits provider that the individual had prior health coverage), and
- You cooperate in verifying the information provided.

You also may demonstrate proof of dependent creditable coverage without a certificate if:

- You attest to such dependency and the period of such status as a dependent, and
- You cooperate with the verification of dependent status.

If you cease to be eligible for the C.A.R. Insurance Plan and you are hired by another employer, you may need to provide proof of prior health care coverage to offset the limitation. If you lose coverage under a Plan that provides health care benefits that is offered by the California Association of REALTORS®, you are entitled to a certificate that shows evidence of your prior health coverage.

A certificate automatically will be issued by the insurance carrier should you lose your health care coverage. In addition, a certificate will be provided to you promptly upon request. If you need a certificate, please contact the insurance carrier.

A certificate of prior coverage identifies the following:

- Individuals covered under the Plan
- The period of coverage
- Any waiting periods

This certification is provided when:

- You no longer qualify as a member of C.A.R.
- You or your covered dependent loses coverage
- You or your dependent's COBRA coverage is exhausted
- You request it up to 24 months after you are no longer eligible for benefits
- You or your covered dependent becomes eligible for coverage under another plan.

If you terminate your participation in the Plan for any reason and you obtain coverage under another health care plan, check with your new plan's administrator to determine if you need to provide a certificate or other information regarding your prior health care coverage or benefits.

CHOICE OF MEDICAL PROVIDERS

HMO plans offered in the C.A.R. Group Health Insurance Program require the designation of a primary care provider. You have the right to designate any primary care provider who participates in your plan's network and who is available to accept you or your family members. Until you make this designation, Anthem Blue Cross of California or Kaiser Permanente will designate one for you. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact:

- Anthem Blue Cross of California at (800) 627-8797 or visit www.anthem.com/ca; or
- Kaiser Permanente at (800) 464-4000 or visit www.kp.org

You do not need prior authorization from Anthem Blue Cross or Kaiser Permanente; or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in your plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact:

- Anthem Blue Cross of California at (800) 627-8797 or visit www.anthem.com/ca; or
- Kaiser Permanente at (800) 464-4000 or visit www.kp.org

Plan Administration

Plan Administrator **–** The C.A.R. Insurance Plan is administered by the California Association of REALTORS® (C.A.R.) On behalf of C.A.R., RealCare Insurance Marketing, Inc., a licensed Third Party Administrator, handles all eligibility, enrollment and billing. The RealCare office is located at 19310 Sonoma Highway, Suite A, Sonoma, CA 95476. Calls and inquires can be directed to this office at 800-939-8088. Information on plans and rates; forms, administrative policies and Explanation of Coverage documents can be found on the RealCare website, www.RealCareCAR.com. RealCare is licensed as a third party administrator by the California Department of Insurance, license Number 0B23546.

Amendment or Termination of the Plan

The California Association of REALTORS® intends to continue the Plan described within this summary, but reserves the right to amend or terminate the Plan at any time and for any reason. In addition, the carrier reserves the right to terminate the Plan at the end of the policy year.

IMPORTANT DEFINITIONS

CALENDAR YEAR DEDUCTIBLE: The period each year from January through December. The health, dental and vision programs offered in the C.A.R. Insurance Plan calculate deductibles and co-insurance based on the calendar year.

CERTIFICATE OF CREDITABLE COVERAGE: A document that indicates the length of time you were continuously covered under a qualifying previous healthcare plan. This document may be obtained from your prior health plan or plan administrator.

CO-INSURANCE: The portion of a medical expense that a patient must pay after the deductible is met. It is generally expressed as a percentage of the total cost.

CO-PAYMENT: The portion of a medical expense that a patient is expected to pay for physician visits and some other services. Typically, co-payments are fixed-dollar amounts and do not count toward the out of pocket maximum.

DEDUCTIBLE: The amount you must pay before the plan pays certain benefits.

ELIGIBLE DEPENDENT: The spouse, domestic partner, or dependent child (natural or adopted) of an eligible member. **For All plans:** Dependent children up to 26 years of age can be covered without regard to student status, marital status or eligibility for other group coverage. See *Who is Eligible* in the *Eligibility Guidelines* section for more details. Dependents of a deceased member; or of a retired member who has attained age 65 and enrolled in Medicare Parts A and B, but who continues membership in C.A.R. are also eligible. Disabled dependents age 26 and older may be eligible if proof of disability is provided.

ELIGIBLE EMPLOYEE: A regular full time W-2 employee of a C.A.R. member or local C.A.R. chapter who has been employed for at least 1 day. The employee must work a minimum of 30 hours per week.

ELIGIBLE MEMBER:

1. Active C.A.R. member who has been a member for at least 1 day
2. Retired C.A.R. member who maintains membership in C.A.R..

EMERGENCY CARE: Medical care provided after the sudden onset of a medical condition causing acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result: a) placing the patient's health in jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.

HEALTH MAINTENANCE ORGANIZATION (HMO): A plan that offers a variety of services (e.g. physical exams, tests, education, preventive care), in exchange for a fixed dollar copay. Members either select or are assigned a primary care physician who is responsible for all referrals regarding care.

IN NETWORK: Health care providers who are contracted by the insurance company's Preferred Provider (PPO) or HMO network.

HEALTH SAVINGS ACCOUNT (HSA): A federal tax incentive program that allows you to contribute up to 100% of your annual insurance deductible each year into a qualified HSA. You can deduct HSA contributions on your federal but not your California state income tax return. If you use the funds for qualified medical expenses, you do not pay taxes on the distribution from the HSA. You may open the HSA and fund it anytime before you file your return for that tax year, similar to an IRA. If you have funds in your account when you reach age 65 you may withdraw them for non-medical purposes without penalty. If you withdraw funds for non-qualified medical expenses before age 65, you will pay taxes on the withdrawal and an additional 20% IRS penalty. Only the Anthem Blue Cross Bronze HSA 3500, Bronze HSA 5500, and Bronze HSA 4500; and the Kaiser Permanente Bronze HSA 3500/30, Bronze HSA 4500/40%, and Silver HSA 1500/20% plans may be used with an HSA. You may enroll in one of these plans and not open an HSA. The HSA is separate from the insurance and may be set up with the institution of your choice. For further information on setting up an HSA account, please call your RealCare representative.

OUT-OF-NETWORK: Health care providers that are not affiliated with a PPO or HMO network.

OUT OF POCKET MAXIMUM: The total amount an insured will pay during a calendar year for covered charges. Some co-payments or deductibles do not count toward the out of pocket maximum. Refer to the Explanation of Coverage for additional information.

PLAN ADMINISTRATOR: California Association of REALTORS® (C.A.R.) On behalf of C.A.R. RealCare Insurance Marketing, Inc. 19310 Sonoma Hwy., Suite A, Sonoma, CA 95476 administers all eligibility, enrollment and billing. RealCare's phone number is: 800-939-8088.

PRE-EXISTING CONDITION: A condition for which medical advice, diagnosis or treatment was recommended or received during the 6 months immediately preceding your enrollment date.

PREFERRED PROVIDER ORGANIZATION (PPO): A network of physicians and hospitals that provides discounts for its services. Members covered by a PPO are allowed to use providers outside the PPO network, including specialists whenever they choose, for an additional out of pocket expense.

PRIMARY CARE PHYSICIAN (PCP): A PCP is generally a family practitioner, internist, pediatrician or OB/GYN chosen by the plan member to provide general health services and coordinate referrals for appropriate testing and specialty care.

PRIMARY INSURED: The C.A.R. member or the employee of a C.A.R. member or local C.A.R. chapter. Rates are based on the attained age of the Primary Insured.

PRIOR CREDITABLE COVERAGE: State and federal law require health plans to give credit for prior qualifying coverage towards the pre-existing conditions waiting period. See **General Plan Provisions** under HIPAA Certification of this booklet for more information on this subject or call your RealCare representative.

SERVICE AREA: The geographic area defined by the insurer or health plan that outlines communities served by the plan.

ANTHEM BLUE CROSS – METLIFE – VSP
BILLING, CANCELLATION & REINSTATEMENT POLICIES

RealCare Insurance Marketing, Inc. Billing Department: (800) 939-8088, Ext. 201 • Fax: (707) 939-8450

If you are enrolled in an **Anthem Blue Cross** medical plan, (with or without MetLife dental or VSP vision plan or MetLife life plan), premiums are billed based on the Anthem Blue Cross-MetLife-VSP Billing Cancellation and Reinstatement Policies. If you are not enrolled in an Anthem Blue Cross medical plan, refer to the **Kaiser Permanente-MetLife-VSP** Billing, Cancellation and Reinstatement Policies.

Initial Payment

Applicants may be required to send the first two months of premium with their **initial enrollment application**.

Monthly Billing

- Bills are sent to plan members around the 11th of each month. Premiums are due by the 1st of each month for coverage beginning the next month. (For example, premiums for coverage for the month of June are due on May 1st.) If payment is not received by the 10th day following the premium due date, a late fee of $15 will be applied. If payment is not received within 30 days of the due date, coverage will be terminated effective the last day of the month through which premiums have been paid.
- Anthem Blue Cross rates are based on each covered family member's age, and the subscriber's zip code and county. If a covered family member has a birthday that moves him/her into the next age bracket, the rate increase will become effective on the next group policy renewal date.
  - If a member is added during the plan year Anthem will use the member's age as of the coverage effective date to determine the rate.
  - If a member changes addresses to a new rating region during the plan year; or makes a plan change during the year, all members will be re-rated based on the new region AND their ages as of the effective date of the change.
- Checks should be made payable to RealCare Insurance Trust Account (RITA) and remitted to 19310 Sonoma Highway, Suite A, Sonoma, CA 95476.

Automatic Premium Payment Authorization (APPA)

Plan members electing APPA will have all applicable premiums, dues, fees and adjustments debited on the due date. If an automatic debit is dishonored, a $25 fee will be assessed and the premium payment and applicable fees must be remitted to RITA by cashier's check or money order and received before the end of the 30-day grace period to avoid cancellation of your health care and/or insurance coverage.

Cancellation

Coverage may be cancelled for:

- ✓ Failing to pay premium and applicable administrative fees before the end of the grace period
- ✓ Providing false information about membership in C.A.R.
- ✓ Providing false information about eligibility
- ✓ Providing false information about a qualifying event
- ✓ Failing to maintain active membership in C.A.R.

Voluntary Termination

A subscriber may voluntarily cancel coverage for himself or covered dependents. A subscriber who wishes to terminate coverage for any covered person must submit the completed termination form to RealCare Insurance Marketing - available on our member website, www.RealCareOnline.com. The effective date of termination will be no earlier than the first of the month following receipt of the completed form.

Reinstatement/Re-Enrollment Policy

- Subject to approval from Anthem Blue Cross of California, a subscriber may be allowed to reinstate his/her coverage twice in a plan year (June 1 through May 31) if the subscriber submits an appeal letter to the Plan Administrator and a cashier's check or money order for all premiums, dues and administrative fees due, plus a $25 fee for the first reinstatement and $50 for the second reinstatement payable to RealCare Insurance Trust Account, (RITA). If a reinstatement request is approved by Anthem Blue Cross of California, coverage will be reinstated effective as of the cancellation date.
- If your **medical** coverage is not reinstated, you may be eligible to re-enroll at the next Open Enrollment or within 31 days of a qualifying event. If your **life** coverage is not reinstated, you may be eligible to re-enroll; however medical underwriting will be required and coverage is not guaranteed. If your **dental or vision** coverage is terminated for any reason, you may be eligible to re-enroll at the first Open Enrollment following a thirteen month waiting period or within 60 days of a loss of other coverage. You will be required to pay all unpaid premiums, dues and fees at the time of enrollment.
- No lapses in coverage between the cancellation date and the reinstatement date are allowed.
- If your coverage is not reinstated, please contact RealCare to review your health care coverage options.

Amendment or Termination of the Plan

The California Association of REALTORS® intends to continue the Plan described within this summary, but reserves the right to amend or terminate the Plan at any time and for any reason. In addition, the carrier reserves the right to terminate the Plan at the end of the policy year.

KAISER PERMANENTE – METLIFE – VSP
BILLING, CANCELLATION & REINSTATEMENT POLICIES

RealCare Insurance Marketing, Inc. Billing Department: (800) 939-8088, Ext. 201 • Fax: (707) 939-8450

If you are enrolled in a **Kaiser Permanente** medical plan, (with or without MetLife dental or VSP vision or MetLife life coverage), premiums are billed based on the Kaiser Permanente-MetLife-VSP Billing, Cancellation and Reinstatement Policies. If you are enrolled in a dental, life or vision plan *without medical coverage,* premiums are billed based on the Kaiser Permanente-MetLife-VSP Billing, Cancellation and Reinstatement Policies. If you are enrolled in an Anthem Blue Cross medical plan, (with or without MetLife dental or VSP vision or MetLife life coverage), refer to the Anthem Blue Cross-MetLife-VSP Billing, Cancellation and Reinstatement Policies.

Monthly Billing

- Bills are sent to Plan members around the 8th of each month. Premiums are due the 25th of the month prior to the coverage month. If payment is not received within 10 days of the due date, a late fee of $15 will be applied. If payment is not received within 30 days of the due date, your coverage will be terminated effective the last day of the month through which premiums have been paid.
- Kaiser rates are based on each covered family member's age, and the subscriber's zip code and county. If a covered family member has a birthday that moves him/her into the next age bracket, the rate increase will become effective on the next group policy renewal date. If a member is added during the plan year Kaiser will use the member's age as of June 1st of the current plan year to determine the rate.
- Checks should be made payable to RealCare Insurance Trust Account (RITA) and remitted to 19310 Sonoma Highway, Suite A, Sonoma, CA 95476.

Automatic Premium Payment Authorization (APPA)

- Plan members electing APPA will have all applicable premiums, dues, fees and adjustments debited on the first business day of the coverage month. If an automatic debit is dishonored, a $25 fee will be assessed and the premium payment and applicable fees must be remitted to RITA by cashier's check or money order and received before the end of the 30-day grace period to avoid cancellation of your health care and/or insurance coverage.

Cancellation

- Coverage may be cancelled for:
  - ✓ Failing to pay premium and applicable administrative fees before the end of the grace period.
  - ✓ Providing false information about membership in C.A.R.
  - ✓ Providing false information about eligibility.
  - ✓ Providing false information about a qualifying event.
  - ✓ Failing to maintain active membership in C.A.R.

Voluntary Termination

- A subscriber may voluntarily cancel coverage for himself or covered dependents. Requests to terminate coverage for any covered person must be made in writing to RealCare Insurance Marketing. It is recommended that members use the Termination Request Form available on our member website, www.RealCareOnline.com. The effective date of termination will be no earlier than the first of the month following receipt of the written request to terminate.

Reinstatement/Re-Enrollment Policy

- A subscriber may reinstate his/her coverage twice in a plan year (June 1 to May 31) if the subscriber submits a cashier's check or money order for all premiums, dues and administrative fees due plus a reinstatement fee of $25 for the first reinstatement and $50 for the second reinstatement payable to RealCare Insurance Trust Account (RITA). All reinstatement payments must be received by RealCare within 45 days of the cancellation date.
- No lapses in coverage between the cancellation date and the reinstatement date are allowed.
- If your **medical** coverage is not reinstated, you may be eligible to re-enroll at the next Open Enrollment or within 31 days of a qualifying event. If your **life** coverage is not reinstated, you may be eligible to re-enroll; however medical underwriting will be required and coverage is not guaranteed. If your **dental or vision** coverage is terminated for any reason, you may be eligible to re-enroll at the first Open Enrollment following a thirteen month waiting period or within 31 days of a loss of other coverage. You will be required to pay all unpaid premiums, dues and fees at the time of enrollment.

Amendment or Termination of the Plan

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