

September 1, 2010

Re: Revised Group Service Agreement to Reflect Changes Required to Comply with Healthcare Reform

Dear Mr. /Ms. Member:

Changes to healthcare coverage are now being implemented across the country as more information is released from the Federal government about the implementation requirements. Your Healthcare Group GSA has been revised to reflect the Healthcare Reform requirements in effect for your Plan.

Some of the changes which will be added to your Healthcare Group coverage effective September 1, 2010 are:

- There will be no more pre-existing condition exclusion waiting periods for Members under nineteen (19);
- There will be no more annual limits;
- There will be no more lifetime limits;
- There will be no more rescissions of coverage except for intentional misrepresentations or fraud;
- The Adult Dependents of Subscribers from the age of nineteen (19) up to twenty-six (26) who are not eligible for employer sponsored health coverage will be allowed a special enrollment period from October 1, 2010 through October 31, 2010 and every annual open enrollment thereafter to enroll in Healthcare Group coverage.

Health plans which were in effect on March 23, 2010 are “grandfathered” for those Members who were enrolled in the plan on that date. While Healthcare Group is a State Program and not a commercial carrier for whom all of the new Healthcare Reform Rules will apply, we have added as many of the options to Healthcare coverage as the Arizona Statutes and Regulations allow.

For Employer groups which were enrolled in the Healthstyles Benefit Plan Option on March 23, 2010 through December 31, 2010, the Employer Groups will be considered “grandfathered” and will be allowed to remain enrolled in any Healthstyles Grandfathered Plan. You may find the Revised “Grandfathered” Healthstyles GSA on the HCG website at www.hcgaz.com. The “grandfathered” plans will continue to offer the present benefits of Healthstyles Classic and Active with the corresponding Healthstyles premiums and will remain in effect for the Employer groups as long as the Employer groups remain eligible and enrolled in the “grandfathered” plan.

If an Employer Group chooses to enroll into a Copper or Silver “new” plan at its next open enrollment, that Employer group will not be allowed to return to the Healthstyles Classic or Active plans again.

On January 1, 2011, Healthcare Group will offer two new plans which are considered “new” plans and are intended to comply with the Healthcare Reform

requirements for non-grandfathered plans. The “new” Plans, Copper and Silver, will include the benefits required by the Healthcare Reform requirements and will have premiums which reflect the richer benefits. Any new Employer Groups which are enrolled and effective in Healthcare Group with an effective date of January 1, 2011 will be required to enroll the eligible Subscribers and Members either **all** into the Copper or **all** into the Silver plans. There will be no option to enroll Subscribers into different plans.

A summary of the changes to your Healthcare Group GSA Grandfathered Plan follows. The page reference is to the original GSA which was issued prior to the passage of Healthcare Reform. The language which follows is the revised language which is included in the “Grandfathered” Healthstyles Benefit plans.

Page 7 of the original GSA Effective 9/1/10, revised to add,
This Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act.

This group health plan believes this coverage is a “grandfathered health plan under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 602-417-6755.

Page 8 of the original GSA Effective 9/1/10, revised to add,
Endorsements to the GSA will be issued as required

Whenever a benefit change or other administrative change is required after the annual modifications made to the GSA in September, an Endorsement will be issued to all Subscribers. An Endorsement is a written document that is attached to an insurance policy that modifies the policy by changing the coverage afforded or access to the coverage under the policy. The endorsement becomes a part of the policy once it is issued.

One of the reasons an endorsement may be issued is because state or federal laws are changed which require HCGA to modify some aspect of coverage or how coverage is delivered. For instance, the Healthcare Reform laws passed by Congress now require health plans to provide benefits that were not previously mandated by State or Federal law. For any laws to which HCG is subject, the GSA must be modified to be compliant with the new requirements.

Page 9 of the original GSA Effective 9/1/10, revised to delete any reference to a lifetime maximum,
Benefit Plan Summary

The Benefit Plan Summary is a grid containing information about the benefit option plan that was selected. The Benefit Plan Summary provides the Deductible Options, Out-of-Network Benefits, Co-payments and Coinsurance for Primary and Preventive Care, Hospitalization, Outpatient Care, Reproductive Care, Support and Ancillary Care, and Prescription Drugs. Refer to the Benefit Plan Summary to determine what benefits are available under the chosen benefit plan option and what the

out-of-pocket costs will be.

Benefits may be subject to change which might not be reflected in the Benefit Plan Summary. For the most current benefits, contact Healthcare Group at 602.417.6755 or 800.247.2289 (outside Maricopa County) or visit www.hcgaz.com.

Page 9 of the original GSA effective September 1, 2010 revised to add that Employees as well as Employers must live in the State of Arizona every month they are enrolled in HCG coverage.

Employer and Employees Must Reside Full-time in the State of Arizona Every Month Enrolled

Healthcare Group of Arizona is a State sponsored program intended to assist only Arizona residents actively conducting businesses within the State of Arizona or employed by Arizona businesses. In order to be eligible to enroll or remain enrolled in HCG coverage, the Employer and Employees must reside in the State of Arizona full-time for every month enrolled. HCGA reserves the right to demand proof of residency at any time during HCG enrollment. Failure to provide the requested proof of residency or failure to provide proof of Arizona residency will result in termination of HCG coverage due to ineligibility.

Page 10 of the original GSA Effective 9/1/10, revised to provide notice to grandfathered groups one that the addition of Members to two or more terminates the grandfathered status,

Sole Proprietor without Employees Enrolled on September 27, 2008 and Grandfathered as a Group of One will Lose Grandfathered Status if the Group goes to a Group of Two or More

A sole proprietor who was enrolled as a group of one on September 27, 2008 and who was grandfathered as a group of one will lose the grandfathered status if the sole proprietor adds one or more employees and becomes a group of two or more. The loss of grandfathered status will become effective the first day of the first month in which a second person is enrolled in HCG coverage for that Employer

Page 10 of the original GSA Effective 9/1/10, revised to include that Schedule Cs and K1s are required to be submitted for proof of business,

Employer Group Proof of Revenue Requirements

All Employer Groups are required to submit Federal and Arizona Individual or Corporate Income Tax Returns or Form 990's with **all schedules and attachments including Schedule Cs and K-1s** to HCG during initial enrollment and annual renewal. If an extension for filing has been requested, Form 4868 or 7004 must be provided as proof of the extension and the returns must be submitted within thirty (30) days of the extended filing date. **The Employer Group agrees as a condition of enrollment to submit the required documents.** Failure to submit the documents in a timely manner may be the basis for termination of the Employer Group coverage, at the discretion of HCGA.

Page 10 of the original GSA Effective 9/1/10, revised to clarify that a Post Office Box address will be acceptable as a mailing address for an Employer Group when the business does not have home or personal mail delivery from the United States Postal Service,

Employer Group Eligibility

An Employer is required to conduct business within the State of Arizona for a minimum of sixty (60) days before enrolling in HCG coverage. If an Employer has conducted business in Arizona for fewer than sixty (60) days, the Employer may submit an application before the sixty (60) day period is met

but the coverage will not be effective until after the sixty (60) day period has been met.

To be eligible to enroll in HCG, an Employer Group may be a sole proprietor with employees, corporation or limited liability company with employees and there must be a minimum of two (2) to a maximum of fifty (50) eligible full-time employees on the effective date of the original enrollment. There is a minimum participation requirement based upon the number of eligible full-time employees (see “Employer Participation Requirements for Eligibility”). 501(c) (3) organizations must have three or more employees at all times of enrollment. All Employer Groups with an initial enrollment after September 27, 2008 must maintain a minimum number of two (2) employees at all times of enrollment or they will no longer be eligible to remain enrolled in HCG. An Employer Group of one eligible Employee that was enrolled in Healthcare Group prior to September 27, 2008, may continue to be enrolled in Healthcare Group if the Employer Group continues to meet all other applicable requirements for enrollment.

The Employer Group must provide a physical address within the State of Arizona for the business and for correspondence which requires a signature for proof of delivery. **Post Office Boxes are not acceptable for any reason unless the Employer Group does not have a geographic area address which receives home or business delivery from the United States Postal Service.**

Page 11 of the original GSA Effective 9/1/10, revised to delete a redundant sentence,

Proof that the Business Continues to be actively conducted within Arizona

Upon initial enrollment, subsequent enrollments and at such other times as requested by HCG, the Employer is required to provide proof that the business continues to be actively conducted within the State of Arizona. Failure to provide the documentation by the requested date or failure to provide proof that the business is actively conducted with the State of Arizona by the requested date will result in termination of the Employer Group Coverage Healthcare Group reserves the right to conduct an audit of the continuing active conduct of the Employer Group’s business within the State of Arizona at any time during enrollment.

Page 12 of the original GSA Effective 9/1/10, revised to clarify that the Employer must meet the minimum participation requirement only at the initial enrollment, **Employer Participation Requirements for Eligibility for Initial Enrollment**

In addition to all other required proof of eligibility an Employer must also meet minimum participation requirements for its eligible employees on initial enrollment as a new Employer Group.

An Employer who employs between two (2) and five (5) full-time employees must enroll one-hundred percent (100%) of all eligible employees. For a group of two (2) to (5) five employees, all employees must either enroll or provide HCGA a valid waiver of current coverage by providing proof of other existing qualified group health coverage as listed below. All employees to be considered in determining the required minimum and maximum number of employees must be listed on an employee roster submitted to HCGA.

An Employer who employs six (6) or more full-time employees must enroll at least eighty (80) percent of eligible employees. For a group of six or more employees, eighty percent (80%) must enroll or provide HCG with a valid waiver of current coverage by providing proof of other existing qualified group health coverage as listed below. All employees to be considered in determining the required minimum and maximum number of employees must be listed on an employee roster submitted to HCGA.

Page 13 of the original GSA Effective 9/1/10, revised to comply with PPACA that only intentional misrepresentation will be considered a cause for termination of coverage,

Employee Eligibility

To be eligible for HCG coverage, an employee of an eligible Employer Group or Sole Proprietor must meet **all** of the following requirements upon each enrollment. The individual must:

- be employed at least twenty (20) hours per week by an eligible enrolled Employer actively conducting business within the State of Arizona, earning and being paid at least the minimum wage for the State of Arizona twice a month, no more than 16 days apart. HCGA reserves the right to require proof of hours worked at any time.
- reside full-time in the State of Arizona for twelve (12) months of every month enrolled
- actively conduct business at least 20 hours per week within the State of Arizona, if a sole proprietor. A sole proprietor without employees who was not enrolled as a group of one on September 27, 2008 is not eligible to enroll as a Group of One
- meet any eligible enrolled Employer's waiting period for health insurance benefits eligibility. (Waiting periods may only be changed for the entire Employer Group at the time of group enrollment and must apply equally to all eligible employees).
- not have had prior healthcare coverage terminated by HCG or any other insurance carrier for intentional misrepresentation, fraud, or threatening or violent behavior.
- submit all requested and required eligibility documentation including, but not limited to, "Employee Enrollment/Change Form", "Member Health History Form" and "Certificate of Creditable Coverage" (if applicable).

On an **annual basis** and at other times at the discretion of HCG, the Employer shall be required to certify employee eligibility on forms provided by HCGA in addition to any other documentation requested by HCG. The Employer may also be required at any time to provide proof that an employee is working at least twenty (20) hours per week on a continuous basis when requested by HCGA.

Pages 13-14 of the original GSA Effective 9/1/10, revised to comply with PPACA to provide that Adult Dependents of the Subscriber up to the age of twenty-six (26) will be allowed to enroll at the Special Opportunity and every open enrollment after and provides a definition of "Adult Dependent",

Employee Dependent Eligibility

Dependent coverage ends on the last day of the month in the month in which the dependent is no longer eligible; i.e., the adult dependent of the Subscriber reaching twenty-six (26); or the month of divorce for the spouse dependent.

In certain situations, an individual may be eligible to enroll as both a Subscriber and a Dependent. The individual may only enroll as a Subscriber **or** Dependent but not both.

In certain situations, an individual may be eligible to enroll as the Dependent of more than one Subscriber. This individual may only enroll as the Dependent of only one Subscriber and not as a Dependent of both.

A person becomes eligible to enroll in HCG coverage as a Dependent of an eligible enrolled Subscriber through marriage to the Subscriber, birth to the Subscriber, placement for adoption or adoption by the Subscriber, legal guardianship by the Subscriber and becoming eligible pursuant to the Patient Protection and Affordable Care Act. It is the Subscriber's responsibility to provide required supporting documentation for the addition of Dependents prior to the Dependent's enrollment. In the case of intentional misrepresentation and/or fraud in the enrollment of a

Dependent, coverage may be terminated and any services paid for an ineligible Dependent will be recovered from the Subscriber or the adult Dependent of the Subscriber enrolled pursuant to the Patient Protection and Affordable Care Act.

“Child” means a Subscriber’s natural or adopted child under the age of nineteen (19) including a:

- natural child,
- minor child legally placed for adoption with the Subscriber,
- minor child legally adopted by the Subscriber,
- minor child for whom a Subscriber has a legal obligation of support pursuant to a “Qualified Medical Child Support Order (QMCSO)” or
- child for whom the Subscriber has a legal obligation as a permanent legal guardian or with permanent custody by Court Order.

“Adult Dependent” means the natural or adopted child of the Subscriber from the age of nineteen (19) up to the age of twenty-six (26) who is not eligible for employer sponsored health insurance coverage.

Page 14 of the original GSA Effective 9/1/10, revised to provide a separate provision for the newborn and minor natural and adopted child dependents of the Subscriber,

Newborn and Minor Natural or Adopted Child Dependent of Subscriber

The newborn Dependent child of the Subscriber must be enrolled within thirty-one (31) days of the birth date to ensure coverage from the date of birth. After notification to HCGA, a certified copy of the birth certificate showing the Subscriber to be a parent must be provided within sixty (60) days from birth. If the newborn is not enrolled within thirty-one (31) days following birth and/or a copy of the birth certificate is not received within sixty (60) days, the newborn coverage will be terminated retroactive to the original effective date and no services will be paid for the child.

Page 14 of the original GSA Effective 9/1/10, revised to delete the provision for eligibility of the Subscriber’s Spouse’s natural or adopted child. This category of eligibility is no longer available under HCG coverage.

Pages 14-15 of the original GSA Effective 9/1/10, revised to delete any reference to “Student Dependent Eligibility” to comply with PPACA due to the fact that all children of the Subscriber from age nineteen (19) up to twenty-six (26) will be allowed to enroll during special enrollment and every open enrollment thereafter regardless of student status,

Page 15 of the original GSA Effective 9/1/10, revised to add a provision to comply with PPACA to allow Adult Dependents to enroll from nineteen (19) up to the age of twenty-six (26) at special enrollment and every annual open enrollment thereafter,

Adult Dependents of the Subscriber Age Nineteen (19) Up to Twenty-Six Years of Age Eligible Pursuant to Patient Protection and Affordable Care Act

Dependents who were not eligible when the Subscriber first became covered under HCG, whose coverage ended due to a loss of eligibility, who were denied coverage (or were not eligible for coverage) because the availability of dependent coverage of children ended before attainment of age twenty-six (26) or who are currently enrolled in COBRA due to loss of HCG eligibility are eligible to

enroll in HCG coverage during the special opportunity from October 1 through October 31, 2010 and on every open enrollment for the Employer Group following the annual open enrollment.

Subscribers may request enrollment for Adult Dependents by submitting the required enrollment documentation plus any requested proof that the Adult Dependent is not eligible for employer sponsored coverage. Premiums for the Adult Dependent must be submitted by the Subscriber to the Employer in a timely manner.

**Page 15 of the original GSA Effective 9/1/10, revised to comply with PPACA to delete a reference to the natural or adopted child of the dependent being required to live in the household of the Subscriber,
Natural or Adopted Adult Dependent of Subscriber**

To be eligible for HCG coverage as the natural or adopted adult child of the Subscriber-must be nineteen (19) and no older than twenty-six (26) and not eligible for employer sponsored medical coverage.

Page 15-16 of the original GSA Effective 9/1/10, revised to comply with PPACA and delete any reference to the adult disabled dependent being unmarried as well as to clarify that the Subscriber must remain enrolled for the disabled dependent to remain enrolled,

Disabled Dependent Eligibility

A Subscriber's Dependent who is nineteen (19), under the legal guardianship of the Subscriber and was permanently and continuously disabled and incapable of self-support by reason of mental or physical

handicap prior to attaining the age of nineteen (19) may be covered as a Subscriber's Dependent as a Disabled Dependent regardless of age as long as the Subscriber remains enrolled and the Dependent remains disabled by the same disability which was qualified for the initial disabled enrollment. Proof of dependency must be provided to HCG within thirty-one (31) days of the Dependent reaching the age of nineteen (19) or within thirty-one (31) days of the Dependent becoming eligible by reason of disability if enrolled prior to the age of nineteen (19).

Proof of disability must be verified by the Dependent's treating physician who confirms in writing that the Dependent is permanently and continuously disabled and incapable of self-support by reason of mental or physical handicap and such other documentation that HCG may require. HCG reserves the right to require an independent examination for the verification of a Dependent's disability by a physician chosen by HCG. The cost of the independent verification of the Dependent's disability will be paid by HCG if required by HCG.

HCG Coverage for the Subscriber's disabled Dependent will continue as long as the enrolled Dependent is disabled and the Subscriber remains enrolled unless HCG coverage terminates in accordance with other terms of this GSA. HCGA may request proof of continuing disability every two (2) years or at such other times as reasonably required by HCGA.

Pages 16-17 of the original GSA Effective 9/1/10, revised to clarify that the Employee's Employer must submit the full required premium for the Employee and Dependents to be enrolled

Enrollment

"Enrollment" means the process in which an eligible Employee and Dependents are determined by HCGA to be eligible to receive HCG services. The Eligible Employee and Dependents are required to select an HCG Benefit Plan, complete and submit all necessary documentation specified by HCG under Arizona Administrative Code R9-27-302 and the Employee's Employer must submit the full

required premium no later than the date specified by HCGA.

An eligible Employee and Dependent may receive HCG coverage if all of the following occur:

- The eligible Employee selects an HCG Health Plan and Benefit Plan option.
- The eligible Employee completes and submits all necessary documentation specified by HCGA including the Employee enrollment information and Health History Form.
- HCGA receives and accepts the full required premium by the required date.

Page 17 of the original GSA Effective 9/1/10, revised to clarify that the Employer Group is responsible for intentional and unintentional disclosure of the Employer Group's PIN,

Personal Identification Number (PIN)

The PIN number assigned to the Employer Group may not be used by any person other than the contact person named by the Employer Group. This is a secure number for use only by an authorized person within the Employer Group and HCG is not responsible for any intentional or unintentional disclosure by the Employer and its subsequent use by any unauthorized person.

Page 16 of the original GSA Effective 9/1/10, revised to comply with PPACA and to clarify that all employees and dependents who were previously not eligible or declined coverage who become eligible may enroll only during open enrollment.

Annual Open Enrollment

Eligible Employees and their Spouses and Adult Dependents up to the age of twenty-six (26) may be enrolled during the Employer's annual open enrollment period.

All Employees and their Dependents who were not previously eligible, or who were previously declined coverage by HCG and become eligible to enroll may enroll upon eligibility or during the annual open enrollment period. All required paper forms or online enrollment forms plus required premiums for the Employer Group for all employees and employees' Dependent enrollments must be completed and received by HCG within the required timeframes. No health plan or benefit plan changes will be processed unless timely received by HCGA.

Page 17 of the original GSA Effective 9/1/10, revised to comply with PPACA and to clarify that the Subscriber's minor dependents must be enrolled in the same benefit plan option as the Subscriber but the Subscriber's Adult Dependents from the age of nineteen (19) up to twenty-six (26) will be allowed to enroll in any benefit plan option available offered to others similarly situated in the same age range and that the Subscriber may not terminate the HCG contract because the Subscriber becomes eligible for the Spouse's health insurance,

Initial Enrollment

The Employer, Employee(s) and Employee(s)' Dependents are not considered to be enrolled in HCG until all documentation required or requested by HCG has been received and approved by HCGA.

All Subscriber's Minor Dependents must be enrolled in the same benefit plan option as the Subscriber. The Subscriber's children from the age of nineteen (19) up to the age of twenty-six (26) may be enrolled in any benefit plan option offered to other Members in the same age range pursuant to the Patient Protection and Affordable Care Act. In order to receive services as described in this Group Service Agreement (GSA), the Employer must be current on premium payments for all

enrolled Members.

Once a Subscriber has chosen and enrolled in a benefit plan option, the Subscriber must remain in that benefit plan until the Employer's Annual Open Enrollment or until a qualifying event occurs which allows an earlier termination or change of benefits. Members may change their benefit ~~plans~~ options, deductible levels and Health Plan only during the Employer's Open Enrollment. After the Special Opportunity to enroll from October 1, through October 31, 2010, the Subscriber's Dependent(s) from the age of nineteen (19) up to the age of twenty-six (26) may enroll and change benefit options, deductible levels and Health Plans only during the Employer's Open Enrollment.

A Member may terminate prior to the end of the twelve month enrollment ONLY for the following qualifying events:

- employment termination,
- death of the Subscriber,
- divorce from the Subscriber,

If a newly eligible Employee chooses not to enroll or chooses not to enroll his or her Dependents during the thirty-one (31) days following his or her hire date, then the Employee will be considered a Late Enrollee if he or she enrolls after the thirty-one days. A pre-existing condition waiting period will apply to coverage for any condition determined to be a pre-existing condition for any Member nineteen or older. See section "Late Enrollee" for more information.

Page 18 of the original GSA Effective 9/1/10, revised to delete the provision describing on-line or paper enrollment as this is an internal policy and procedure which will not be included in the GSA,

Pages 19-20 of the original GSA Effective 9/1/10, revised to clarify that a late enrollee includes an employee or dependent who was eligible to enroll in HCG during the first thirty-one days after the initial hire date and did not do so
Late Enrollee

A late enrollee is defined as:

- An Employee or Dependent who was eligible to enroll in HCG during the first thirty-one (31) days after the date of initial Employer Group enrollment or was eligible to enroll during Employer Group's Annual Open Enrollment period or was eligible to enroll within thirty-one (31) days of a qualifying event or of initial hire date and did not do so.

An Employee or Dependent over the age of nineteen (19) who requests enrollment after the first thirty-one (31) days of the initial enrollment or after thirty-one (31) days of a qualifying event or initial hire date will be considered a late enrollee. Late enrollees over the age of nineteen (19) are subject to a pre-existing condition waiting period of eighteen (18) months.

An Employee, Employee's spouse or Employee's Dependent will not be considered a late enrollee if the person:

- At the time of the initial enrollment period was covered under Medicaid or private group health insurance policy and applies for coverage within thirty-one (31) days after the termination of that coverage.
- Lost coverage under a group health insurance plan due to the employee's termination of employment, the reduction in the number of hours of employment, the termination of the other plan's coverage, the death of the spouse, divorce from the Subscriber for the other plan or the termination of the Employer contributions toward the coverage and applies for HCG coverage within thirty-one (31) days after the loss of the other group coverage.

- Requests enrollment within thirty-one (31) days after the termination of creditable coverage that is provided under a COBRA continuation provision.

Late enrollees over the age of nineteen are subject to a pre-existing condition waiting period of eighteen (18) months. A pre-existing condition is a condition, regardless of the cause of the condition, for which medical advice, consultations or recommendations in any form, diagnosis or treatment was recommended or received by a licensed healthcare Provider during the six (6) month period immediately preceding the Member's effective date of coverage.

Pages 19-20 of the original GSA Effective 9/1/10, revised to comply with PPACA and to provide that Members over the age of nineteen (19) are subject to a pre-existing condition exclusion and that only intentional misrepresentations and omissions will be subject to cancellation of coverage,

Pre-existing Conditions and Pre-existing Condition Waiting Period, Health History Form and Creditable Coverage

A Member Health History Form is required to be completed as a part of the documentation for initial enrollment. The Member Health History Form is not used to determine insurability. The information provided is used to identify pre-existing conditions for Members over the age of nineteen (19).

The Member Health History form must contain all medical advice, consultations or recommendations in any form, medical procedures or treatments received in person or drugs prescribed from a healthcare Provider by each Member and Dependent within the six months prior to HCG enrollment. A pre-existing condition is a condition, regardless of the cause of the condition, for which medical advice, consultations or recommendations in any form, diagnosis or treatment was recommended or received by a licensed healthcare Provider during the six (6) month period immediately preceding the Member's effective date of coverage.

Pre-existing conditions are identified by the Member Health History Form but HCGA and the HCG Health Plan may also request medical records for a Member or Dependent if a claim is submitted for a chronic disease which was not disclosed on the Health History Form. If there is no Creditable Coverage for the year prior to enrollment, HCG or the HCG Health Plan will request medical records for a Member or Dependent if a claim is submitted for a chronic disease whether or not the chronic disease was identified on the Member Health History Form. If the medical records for the Member or Dependent disclose a chronic condition which was not listed on the Member Health History Form, then the Member or Dependent will receive a letter from HCGA or the HCG Health Plan which informs the person what pre-existing condition has been identified on the basis of medical records and that condition will not be covered for the period of the pre-existing waiting period for Members over the age of nineteen. If the pre-existing condition was not disclosed on the Member Health History Form and a pre-existing condition is later determined to exist based upon a review of the Member's medical records, the Member may owe HCG reimbursement for any claims paid for that pre-existing condition.

The Medical Health History Form contains Section G, "Disclosure Statement and Signature", which requires the applicant to certify that the information provided is true. This section further provides that the application must be **updated** to include any illness or disease that has occurred between the date on the Member Health History Form and the effective date of coverage. The applicant is also put on notice that any intentional misrepresentation or omission regarding the presence of a pre-existing condition may result in the cancellation of coverage and the Member or Dependent will be responsible for the costs incurred for any non-covered services.

Page 22 of the original GSA Effective 9/1/10, revised to comply with PPACA and only intentional misrepresentation will be cause for termination of coverage,

Termination of Coverage and Exclusion from Enrollment

HCGA may exclude an Employer, a Subscriber or a Subscriber's Dependent from enrollment if the prior coverage has been terminated for any of the following reasons:

- Clear and convincing evidence of fraud or intentional misrepresentation,
- Factors listed under A.R.S. §36-2912(P) that impacts the premium when the Member applies for coverage or obtains services,
- Committing violence or threatening to commit violence or being abusive toward the employees or agents of HCGA, an HCG Health Plan or a Provider,
- Repeated and unreasonable demands for unnecessary or uncovered medical services,
- Failure to pay any co-payment, coinsurance or deductible,
- Failure to provide documentation when requested by HCGA,
- Violating any provision of the Member Handbook or GSA

Page 25 of the original GSA Effective 9/1/10, revised to comply with PPACA and provide that only intentional misrepresentation will result in termination of coverage and forfeiture of a refund,

Refunds

An Employer that submits an application to HCG and pays premium in advance of approval for coverage will be refunded the advance premium payment if the Employer application is denied due to the Employer Group failing to meet the eligibility requirements or if a cancellation request is made in writing by the Employer Group prior to the effective date of the coverage. Refunds will only be issued to the Employer and no refunds will be issued to any Employees. Refunds are issued by the State of Arizona Department of Administration and it may take up to six weeks to issue the refund.

Premiums paid in advance when the Employer Group coverage is terminated by HCGA for a reason that allows the refund of premium pursuant to this GSA will only be refunded when the Employer's last premium payment has been paid by the bank. Refunds are issued by the State of Arizona Government Accounting Office which may take up to six weeks to issue the refund.

An Employer or Member who has coverage terminated for fraud or intentional misrepresentation will not receive any refund for premiums paid.

Page 25 of the original GSA Effective 9/1/10, revised to comply with PPACA and to provide that only preexisting condition exclusions only are in effect for

Members over the age of nineteen (19),

Enrollment after Termination of Employer Group for Non-Payment of Premium not allowed for 90 Days

An Employer Group that is terminated for Non-Payment of Premium is not eligible to re-enroll for coverage until 90 days after the termination. This means that the Employer Group will be required to reapply as if a new Employer Group and will be subject to pre-existing condition exclusion limitations, maternity cap, and the first year medical cap for each Member of the Group. This application for coverage will require the same documentation, forms and disclosure as for any new application. All benefit limitations, deductibles, pre-existing condition exclusion waiting periods for Members over the age of nineteen (19) will be re-set. The Employer Group will receive a new Employer Group number.

Page 30 of the original GSA Effective 9/1/10, revised to comply with PPACA and to provide that only intentional misrepresentation will result in the termination of coverage and it will be with thirty (30) days notice,

Termination of Employer Group by HCGA for Cause without Notice

The Employer Group coverage may be terminated by HCGA upon the occurrence of any of the following events:

- Non-payment of premium. No notice is required from HCG to the Employer for termination due to non-payment of premium.
- Fraud or intentional misrepresentation. If the Employer commits an act or practice that constitutes fraud or commits an act of intentional misrepresentation, HCG may terminate the Employer Group coverage with thirty (30) days notice. The date of the termination may be retroactive to the original effective date and actions taken to recover the costs paid by HCG for services received. There will be no refund of any prepaid premium. In the event that Employer Group coverage is terminated for fraud or intentional misrepresentation, the Employer will be referred by HCGA to the AHCCCS Office of Program Integrity for a determination of whether to file civil or criminal charges and to pursue recoupment of monies paid for services for ineligible members.
- Violation of any provision in the Group Service Agreement. If the Group violates any conditions or requirements in the Group Service Agreement, HCG may terminate the Employer Group coverage without notice.

Page 31 of the original GSA Effective 9/1/10, revised to comply with PPACA and to provide that only intentional misrepresentation will result in the referral to the Office of the Inspector General,

Termination for Fraud or Intentional Misrepresentation

In the event that an Employer Group is terminated for Fraud or Intentional Misrepresentation, the Employer will be referred to the AHCCCS Office of Inspector General for a determination of whether to file civil or criminal charges and to pursue recoupment of monies paid for services for ineligible members.

Page 31 of the original GSA Effective 9/1/10, revised to comply with PPACA and to provide that the Member's coverage will only be terminated for intentional misrepresentation and with thirty (30) days notice,

Member Termination

HCGA Termination of Member's Coverage for Fraud, Intentional Misrepresentation or Abusive Behavior without Notice

The HCGA or HCG Plan may terminate a Member's coverage, with thirty (30) days notice for clear and convincing evidence of fraud or intentional misrepresentation material to enrollment or factors listed in A.R.S. §35-2912(P) (age, gender) that would have affected the premium when the Member applied for coverage or obtained services. HCGA may terminate a Member's coverage without notice for threats to commit or commission of violence or abusive behavior such as swearing or personal verbal attacks against employees or agents of HCGA, an HCG Plan, Network Providers or Out-of-Network Providers.

Page 42 of the original GSA Effective 9/1/10, revised to comply with PPACA and provides that only the intentional failure to provide complete and accurate information will be cause for termination of coverage,

Right to Covered Services Conditioned upon all Information in Application, Member Health History Form and Other Documents Being True and Correct

All individuals enrolling in HCG must complete a Member Health History Form in order for the

application to be considered complete. Intentional failure to provide complete and accurate information on the Member Health History Form may be cause for termination of the Member from the HCG Plan. An eligible Employee or the eligible Employee's Dependents will not be denied enrollment due to conditions described on the Member Health History Form.

Eligible Employees and their Dependent(s) warrant that all information in their Applications, Member Health History Forms and all other forms and statements is true, correct and complete. If the Employee or the Employee's Dependent(s) discovers that any information provided to the HCGA is not true, correct or complete, the Employee or the Employee's Dependent(s) must contact HCGA within three (3) working days to provide the correct information in order for the HCG coverage to remain in effect. All rights to covered services are subject to all information provided to HCGA being true, correct and complete.

If HCGA should determine that an enrolled Employee or that Employee's Dependent(s) intentionally omitted or misrepresented any material fact on any document filed for enrollment, the coverage for that Employee and /or that Employee's Dependent(s) shall be terminated from the original effective date. Any covered services or benefits that have been provided during the enrollment shall be repaid by the Employee to HCG.

Page 43 of the original GSA Effective 9/1/10, revised to comply with PPACA and provides that only intentional misrepresentation will be cause for rescission and deletes the last sentence of the paragraph due to a question as to whether or not this will prove to be enforceable under PPACA,

Intentional Misrepresentation or Fraud by Member or Employer in Application for Coverage may Result in Rescission of Coverage to Original Effective Date

Rescission is the cancellation of a contract and the return of the parties to the positions they would have occupied if the contract had not been made. If a Member intentionally misrepresents a material fact or commits fraud in any document submitted for the application or enrollment which would have affected the decision to provide coverage, affected the decision to decide to investigate further or affected the decision to pay claims under that coverage, the coverage may be rescinded to the original date of the coverage

Page 44 of the original GSA Effective 9/1/10, revised to clarify that If an Employer Group relocates to another county in Arizona it is the obligation of the Employer to find out if there is a network for services in the new county and if there is no network in the new county, the coverage will be terminated,

Relocation of Employer Group to another County

NOTICE: Not all counties in Arizona have a network to provide coverage for HCG Members. When the Employer Group provides notice of the relocation to HCG, the Group should inquire about the availability of a HCG network in the county to which it is moving. If the Employer Group relocates to a county that has no HCG network, the contract for coverage will be terminated.

The premiums for Healthcare Group coverage differ from county to county. The premiums calculated and paid for one county may not be the same in another county.

When a business and/or its eligible Employees and Members relocate to another county, the Employer Group is responsible to provide written notification to HCGA sixty (60) days prior to the relocation. The Employer must notify HCGA of the relocation by submitting an "Enrollment Change" form and any other forms or documents required by or requested by HCGA. The Employer must notify HCGA of the change in

address, change in county and the date the relocation is to be effective.

The Employer must pay for any increase in premiums for the new county if the premium rate is higher in the new county. The new premium rate is due as of the effective date of the relocation. The Employer is also responsible for any administrative costs incurred by HCGA for the relocation including, but not limited to, new Member ID cards.

Page 46 of the original GSA Effective 9/1/10, revised to comply with PPACA and to delete the reference to a first year dollar cap on medical benefits,

Page 46 of the original GSA Effective 9/1/10, revised to comply with PPACA and to delete the reference to a lifetime maximum,

Page 49 of the original GSA Effective 9/1/10, revised to comply with PPACA and to provide that the preexisting condition exclusion waiting period will not be applied to Members under the age of nineteen (19),

Transition of Care, Coordination of Care

HCGA and your HCG Plan will attempt to identify needs and facilitate coordination of care for Members who are impacted by changes in benefits or transitions between HCG Benefit Plans, changes in Provider networks and/or HCGA contracts. These changes could be caused by such things as a physician contract terminating or a plan being discontinued.

Under certain circumstances, a member may be able to temporarily continue to receive services. The care must be medically necessary and the non-Contracted Provider must agree to the terms and conditions of the continuing treatment. The Transition of Care must be prior authorized. **Only emergency services will be covered out-of state for transition of care.**

The Member is entitled to request and may be allowed Transition of Care services including, but not limited to, the following circumstances:

- Pregnancy of greater than twenty (20) weeks gestation through the post-partum follow-up.
- Currently undergoing chemotherapy or radiation therapy for treatment of cancer through the completion of current cycle.
- Members with a terminal illness and anticipated life expectancy of fewer than six (6) months.

Services are subject to the terms of the GSA related to pre-existing condition waiting periods for Members over the age of nineteen (19), co-payments, coinsurance and deductibles as well as prior authorization at the time medical care is provided. It is not sufficient to prefer to receive treatment from a prior Physician or other non-Contracted Provider to qualify for transition of care approval; even for a chronic condition.

Upon receipt of a request for Transition of Care, the Member will be sent a written acknowledgement letter including the timeframe for making a decision. The Health Plan will issue a written determination within fourteen (14) days of receiving the request or within seventy-two (72) hours (expedited) if the Health Plan determines that following the fourteen (14) day timeframe would seriously jeopardize the Member's life or health or ability to attain, maintain, or regain function. Notice of the expedited determination will be given verbally within the seventy-two (72) hours and in writing not later than three (3) working days after the receipt of the request.

Page 62 of the original GSA Effective 9/1/10, revised to comply with PPACA and to provide that as a grandfathered plan HCG will not impose a pre-existing

condition exclusion for children under the age of nineteen (19), only intentional misrepresentations will result in termination of coverage and filling of prescription medications will be considered in the establishment of pre-existing conditions,

As a grandfathered plan under the Patient Protection and Affordable Care Act, HCG will not impose a pre-existing condition exclusion for children under the age of nineteen (19) commencing October 1, 2010.

A pre-existing condition is a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received in any form by a licensed healthcare Provider during the six-month period immediately preceding the Member's enrollment date. For purposes of determining a pre-existing condition and pre-existing condition waiting periods for Members nineteen (19) and older, enrollment date means the individual's effective date of coverage, or, if earlier, the first day of the employee's eligibility waiting period. A refill of maintenance prescriptions without a face-to-face encounter with a licensed healthcare Provider during the six-month period is not considered a pre-existing condition.

A Member Health History Form is required to be completed as a part of the documentation for enrollment. The Member Health History Form is not used to determine insurability. The information provided is used to identify pre-existing conditions as well as for the disease management and the wellness program.

The Member Health History Form must contain all medical advice, medical procedures or treatments received in any form from a healthcare Provider by each Member and Dependent within the six months prior to HCG enrollment. A pre-existing condition is a condition, regardless of the cause of the condition, for which medical advice, diagnosis or treatment was recommended or received in any form by a licensed healthcare Provider during the six (6) month period immediately preceding the Member's effective date of coverage under the GSA.

Pre-existing conditions are identified by the Member Health History Form but a HCG Health Plan or HCGA will also request medical records for a Member or Dependent if a claim is submitted for a chronic disease which was not identified on the Health History Form. If there is no Creditable Coverage for the year prior to enrollment, HCG will request medical records for a Member or Dependent if a claim is submitted for a chronic disease, whether or not the chronic disease was identified on the Member Health History Form. If the medical records for the Member or Dependent disclose a chronic condition which was not identified on the Member Health History Form, then the Member or Dependent will receive a letter from HCGA which informs the person what pre-existing condition has been identified on the basis of medical records and that condition will not be covered for the period of the pre-existing waiting period for Members over the age of nineteen (19). If the pre-existing condition was not disclosed on the Member Health History Form and a pre-existing condition is later determined to exist based upon a review of the Member's medical records, the Member may owe HCG reimbursement for any claims paid for that pre-existing condition.

The Medical Health History Form contains Section G, "Disclosure Statement and Signature", which requires the applicant to certify that the information provided is true. This section further provides that the application must be **updated** to include any illness or disease that has occurred between the date of the application and the effective date of coverage. The applicant is also put on notice that any intentional misrepresentation or omission, regarding the presence of a pre-existing condition may result in the cancellation of coverage and the Member or Dependent will be responsible for the costs incurred for any non-covered services.

Coverage for services related to a pre-existing condition or complications relating to the condition will not begin until twelve (12) consecutive months or, in the case of a late enrollee, eighteen (18) months, have elapsed from the Member's enrollment length of time may be shortened or eliminated by the amount of credit given for periods date for Members over the age of nineteen (19). The length of time may be shortened or eliminated by the amount of credit given for periods of prior Creditable Healthcare Coverage. For prior coverage to apply toward this pre-existing condition waiting period, a Member's effective date of coverage with HCG must occur within 63 days (excluding the employer's eligibility waiting period or any other mandatory waiting period) of any prior creditable coverage ending. Any coverage occurring prior to a break in coverage of 63 days or more will not be credited towards the pre-existing waiting period.

Creditable Coverage includes the following:

- a person who had continuous healthcare coverage for a one year period and
- during that year had no breaks in coverage totaling more than 31 days or
- a person whose prior coverage ended within 63 days of a Member's effective date of coverage with HCG.

Creditable Coverage for an individual may be obtained from any of the following benefit programs:

- A group health plan (insured or self-insured)
- An individual insurance policy
- Medicare
- Medicaid (AHCCCS)
- A public health plan (AHCCCS)
- TRICARE
- A health benefits risk pool
- Peace Corps
- A bona fide association
- Indian Health Services (IHS), or
- Federal Employee Health Benefits Plan (FEHBP)

Exceptions to Pre-Existing Condition Coverage

The following will not be considered pre-existing conditions:

- Newborns enrolled within 31 days of birth or adoption and all Members under the age of nineteen (19).
- A child placed for adoption with the Subscriber and enrolled within 31 days of placement.
- Pregnancy, family planning, and prescriptions for contraceptive medication or devices

Page 65 of the original GSA Effective 9/1/10, revised to comply with PPACA and to provide that pre-existing conditions do not apply to Members under nineteen (19),

28. Drugs or medications that are not on the HCG Plan's formulary, over-the-counter medications and supplies, that do not require a prescription by federal or State law; prescriptions more than one year from date of issue of the prescription; medications that are equivalent (in strength, regardless of form) to an over-the-counter medication; drugs that are experimental or investigational; new FDA approved drugs prior to review by HCG, that have not been incorporated into the HCG Plan formulary; drugs that are not approved by the FDA; replacement of prescription drugs due to loss or theft; prescriptions for pre-existing conditions for Members over the age of nineteen (19) during the pre-existing

condition waiting period; immunosuppressant drugs that are a part of a postoperative management of any non-covered transplant; medical foods except prescription drugs for eosinophilic gastrointestinal disorder subject to limitations, parenteral nutrition; synthetic blood products or derivatives, including but not limited to, artificial or genetic derivatives and coagulation factors.

Page 71 of the original GSA Effective 9/1/10, revised to comply with PPACA and to provide a definition of Adult Dependent,

“Adult Dependent” means the natural or adopted child of the Subscriber from the age of nineteen (19) up to the age of twenty-six (26) who is not eligible for employer sponsored health insurance coverage.

Page 71 of the original GSA Effective 9/1/10, revised to comply with PPACA and to provide that Members under nineteen (19) are not subject to pre-existing condition waiting periods,

“Benefit Exception”: means an exception to a covered benefit determination by the HCG Medical Director that determines a service should be provided even though it is not a covered benefit under the Member’s plan, is subject to a pre-existing condition waiting period if the Member is nineteen or older, is a benefit exclusion or an exhausted benefit due to benefit limitations.

Page 76 of the original GSA Effective 9/1/10, revised to comply with PPACA and to delete reference to the Lifetime Maximum,

“HCG Benefit Plan Summary”: grid containing information about the Plan that you selected. The Benefit Plan Summary provides the Deductible Options, Out-of-Pocket Maximums after the Deductibles, Out-of –Network Benefits, Co-payments and Coinsurance for Primary and Preventive Care, Hospitalization, Outpatient Care, Reproductive Care, Support and Ancillary Care, Mental Health and Substance Abuse Care and Prescription Drugs.

Page 77 of the original GSA Effective 9/1/10, revised to comply with PPACA and to delete the definition of Lifetime Dollar Limit,

Page 80 of the original GSA Effective 9/1/10, revised to comply with PPACA and to add that the pre-existing condition waiting period applies only to Members nineteen (19) or older,

“Pre-Existing Condition Waiting Period”: The length of time a Member nineteen or older must wait for services to be covered under the GSA for conditions for which the Member sought medical advice or treatment, face to face from a licensed healthcare Provider, in the six months prior to HCG coverage, and did not have creditable coverage sufficient to eliminate the waiting period.