# UnitedHealthcare Insurance Company

# Group Policy

**For**

**County of Los Angeles**

**Enrolling Group Number: 716822**

**Policy Effective Date: January 1, 2022**

# UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

860-702-5000

**NOTICE TO BUYER: This UnitedHealthcare Insurance Company health plan has significant Co-insurance amounts. The Co-insurance percentage is listed in the *Schedule of Benefits* next to the description for each Covered Health Care Service. A Covered Person may have to pay substantial amounts of his or her own money for medical expenses, even if the health condition is serious.**

**NOTICE TO BUYER: This UnitedHealthcare Insurance Company health plan has a significant Out-of-Pocket Limit. A Covered Person may have to pay substantial amounts of his or her own money for medical expenses, even if the health condition is serious.**

**IMPORTANT NOTICE: A religious employer may request a disability insurance policy without coverage for contraceptive methods that are contrary to the religious employer's tenents. If so requested, a disability insurance policy shall be provided without coverage for contraceptive methods. A religious employer is defined as an entity for which each of the following is true:**

**(1) The inculcation of religious values is the purpose of the entity.**

**(2) The entity primarily employs persons who share the religious tenents of the entity.**

**(3) The entity serves primarily persons who share the religious tenants of the entity.**

**(4) The entity is a non-profit organization pursuant to Section 6603(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.**

**Every religious employer that invokes the exemption provided under this section shall provide written notice to any prospective employee once an offer of employment has been made, and prior to that person commencing that employment, listing the contraceptive health care services the employer refuses to cover for religious reasons.**

## Regulated by:

## California Department of Insurance

## Consumer Communication Bureau

## 300 South Spring Street, South Tower

## Los Angeles, CA 90013

## 1-800-927-HELP (4357)

## TTY:1-800-482-4833

**http://www.insurance.ca.gov**

# Group Policy

# UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

860-702-5000

This Policy is entered into by UnitedHealthcare Insurance Company and the "Group," as described in Exhibit 1.

When used in this document, the words "we," "us," and "our" refer to UnitedHealthcare Insurance Company.

Upon our receipt of the signed Group *Application* and payment of the first Policy Charge, this Policy is executed. The Group's *Application* is made a part of this Policy.

We agree to provide Benefits for Covered Health Care Services stated in this Policy, including the attached *Certificate(s) of Coverage* and *Schedule(s) of Benefits*, subject to the terms, conditions, exclusions, and limitations of this Policy. This Policy replaces and overrules any previous agreements relating to Benefits for Covered Health Care Services between the Group and us. The terms and conditions of this Policy will in turn be overruled by those of any future agreements relating to Benefits for Covered Health Care Services between the Group and us.

We are not an employer or plan administrator for any purpose with respect to the administration or provision of benefits under the Group's benefit plan. We are not responsible for fulfilling any duties or obligations of an employer or plan administrator with respect to the Group's benefit plan.

This Policy is effective on the date shown in Exhibit 1 and continues in force by the timely payment of the required Policy Charges when due, subject to the end of this Policy as provided in Article 5.

When this Policy ends, as described in Article 5, this Policy and all Benefits under this Policy will end at 12:00 midnight on the date the Policy ends.

This Policy is issued as described in Exhibit 1.

Issued By:

UnitedHealthcare Insurance Company

William J Golden, President

# Article 1: Glossary of Defined Terms

The terms used in this Policy have the same meanings as those defined in *Section 9: Defined Terms* in the attached *Certificate(s) of Coverage*. In addition, the following terms apply:

**Coverage Classification** - one of the categories of coverage described in Exhibit 2 for rating purposes (for example: Subscriber only, Subscriber and spouse, Subscriber and children, Subscriber and family).

**Material Misrepresentation** - any oral or written communication or conduct, or combination of communication and conduct, that is untrue and is intended to create a misleading impression in the mind of another person. A misrepresentation is material if a reasonable person would attach importance to it in making a decision or determining a course of action, including but not limited to, the issuance of a policy or coverage under a policy, calculation of rates, or payment of a claim.

**Service Area** - the State of California or any other geographical area within the state designated in the Policy within which Network provider services are rendered to Covered Persons for Covered Health Care Services.

# Article 2: Benefits

Subscribers and their Enrolled Dependents are entitled to Benefits for Covered Health Care Services subject to the terms, conditions, limitations and exclusions stated in the *Certificate(s) of Coverage* and *Schedule(s) of Benefits* attached to this Policy. Each *Certificate of Coverage* and *Schedule of Benefits*, including any Riders and Amendments, describes the Covered Health Care Services, required Co-payments, and the terms, conditions, limitations and exclusions related to coverage.

We pay Benefits for Emergency Health Care Services that are required to stabilize or initiate treatment in an Emergency as described in the *Certificate of Coverage* and *Schedule of Benefits* to Covered Persons who receive such services outside of the Service Area.

# Article 3: Premium Rates and Policy Charge

## 3.1 Premiums

Monthly Premiums payable by or on behalf of Covered Persons are shown in the *Schedule of Premium Rates* in Exhibit 2 of this Policy or in any attached *Notice of Change*.

We have the right to change the *Schedule of Premium Rates* as described in Exhibit 1 of this Policy. We also have the right to change the *Schedule of Premium Rates* at any time if the *Schedule of Premium Rates* was based upon a Material Misrepresentation relating to health status that resulted in the Premium rates being lower than they would have been if the Material Misrepresentation had not been made. We have the right to change the *Schedule of Premium Rates* for this reason retroactive to the effective date of the *Schedule of Premium Rates* that was based on the Material Misrepresentation.

## 3.2 How Is the Policy Charge Calculated?

The Policy Charge will be calculated based on the number of Subscribers in each Coverage Classification that we show in our records at the time of calculation. The Policy Charge will be calculated using the Premium rates in effect at that time. Exhibit 1 describes the way in which the Policy Charge is calculated.

The Group is solely responsible for enrollment and Coverage Classification changes (including the end of a Covered Person's coverage) and for the timely payment of the Policy Charges.

## 3.3 When Is the Policy Charge Adjusted?

We may make retroactive adjustments for any additions or terminations of Subscribers or changes in Coverage Classification that are not reflected in our records at the time we calculate the Policy Charge. We will not grant retroactive credit for any change happening more than 90 days prior to the date we received notification of the change from the Group. We also will not grant retroactive credit for any calendar month in which a Subscriber has received Benefits.

The Group must notify us in writing within 90 days of the effective date of enrollments, terminations, or other changes. The Group must notify us in writing each month of any change in the Coverage Classification for any Subscriber.

If premium taxes, guarantee or uninsured fund assessments, or other governmental charges relating to or calculated in regard to Premium are either imposed or increased, those charges will be added to the Premium at that time. In addition, any change in law or regulation that affects our cost of operation may result in an increase in Premium.

## 3.4 How Is the Policy Charge Paid?

The Policy Charge is payable to us in advance by the Group as described under "Payment of the Policy Charge" in Exhibit 1. The first Policy Charge is due and payable on or before the effective date of this Policy. Future Policy Charges are due and payable no later than the first day of each payment period shown in item 6 of Exhibit 1, while this Policy is in force.

All payments shall be made in United States currency, in immediately available funds, and shall be sent to us at the address on the invoice, or at another address that we may designate in writing. The Group agrees not to send us payments marked "paid in full", "without recourse", or similar language. In the event that the Group sends such a payment, we may accept it without losing any of our rights under this Policy and the Group will remain obligated to pay any and all amounts owed to us.

Late payment charges are assessed for any Policy Charge not received by the due date. There will be a service charge added to the Group's account for any check returned for non-sufficient funds. The name of all Covered Person must be attached when payment is made.

The Group will reimburse any attorney's fees and costs related to collecting past due Policy Charges.

## 3.5 Does a Grace Period Apply?

A grace period of 31 days will be granted for the payment of any Policy Charge not paid when due. During the grace period, this Policy will continue in force. If we do not receive payment of the Policy Charge after the first day after the last day of coverage for which we have received payment, we will send the Group a notice of intent to nonrenew due to nonpayment. The notice will provide a grace period that begins on the first day after the last day of coverage for which we received payment and extends through the last day of the 30-day period whose first day is the day we send the notice of intent to nonrenew due to nonpayment.

In the event the necessary payment of the Policy Charge is delivered to us on or before the last day of the minimum 30-day grace period, we will continue coverage beyond the grace period without interruption to the terms of the Policy.

The Group is responsible for payment of the Policy Charge during the grace period. If we receive written notice from the Group to end this Policy during the grace period, we will adjust the Policy Charge so that it applies only to the number of days this Policy was in force during the grace period.

This Policy ends as described in Article 5.1 if the grace period expires and the past due Policy Charge remains unpaid.

# Article 4: Eligibility and Enrollment

## 4.1 What Are the Eligibility Rules?

Eligibility rules for each class are stated in Exhibit 2 and in the Group *Application*. The eligibility rules stated in Exhibit 2 are in addition to those shown in *Section 3: When Coverage Begins* of the *Certificate of Coverage*.

## 4.2 Initial Enrollment Period

Eligible Persons and their Dependents may enroll for coverage under this Policy during the Initial Enrollment Period. The Initial Enrollment Period is set by the Group.

## 4.3 Open Enrollment Period

An Open Enrollment Period will be provided for each class, as shown in Exhibit 2. During an Open Enrollment Period, Eligible Persons may enroll for coverage under this Policy.

## 4.4 Effective Date of Coverage

The effective date of coverage for enrolled Eligible Persons and their Dependents is stated in Exhibit 2.

## 4.5 Waiver Form

The Group agrees to provide each individual who declines coverage with a form to be signed at the time they are initially eligible to enroll for coverage. The form states that an individual who declines coverage during the Initial Enrollment Period acknowledges that we may, at the time of the individual's later decision to elect coverage, consider the individual a late enrollee.

The Group agrees to retain a copy of the individual's signed acknowledgment and forward a copy of the acknowledgment to us when requested.

# Article 5: End of Policy

## 5.1 Renewability and When Does the Policy End?

This Policy and all Benefits for Covered Health Care Services is renewable except in the case of the following:

A. Nonpayment of the required Policy Charge by the Group if the Group has been duly notified and billed for the Policy Charge and the 31-day grace period has elapsed since the date of the notification. Coverage will continue during the grace period. The Group remains responsible for payment of the Policy Charge for the period of time this Policy remained in force during the grace period.

B. On the date specified by the Group, after at least 31 days prior written notice to us that this Policy will end.

C. On the date we specify, after at least 31 days prior written notice to the Group, that this Policy will end due to the Group's violation of the participation and contribution rules as shown in Exhibit 1.

D. On the date we specify, after at least 31 days prior written notice to the Group, that this Policy will end because the Group performed an act, practice or omission that constituted fraud or made an intentional misrepresentation of a fact that was material to the execution of this Policy or to the

provision of coverage under this Policy. In this case, we have the right to rescind this Policy back to either:

- The effective date of this Policy.
- The date of the act, practice or omission, if later.

We will send a notice to the Group via certified mail at least 30 days prior to the effective date of the rescission explaining the reason for the rescission and notifying them of their right to appeal as described in Article 5.3. We will not rescind this Policy due to fraud or an intentional misrepresentation of a material fact after twenty-four (24) months from the date of issuance of this Policy.

E. On the date we specify, after at least 90 days prior written notice to the Group, that this Policy will end because we will no longer issue this particular type of group health benefit plan within the applicable market.

F. On the date we specify, after at least 180 days prior written notice to the applicable state authority and to the Group, that this Policy will end because we will no longer issue any employer health benefit plan within the applicable market.

G. On the date we specify, if coverage is offered through a Network plan and there is no longer any covered individual in connection with the plan who lives, resides or works in the Service Area.

H. On the date we specify, if coverage is made available in the individual's market through a bona fide association, the membership of the individual in the association on the basis of which the coverage is provided, ceases, but only if that coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

## 5.2 Payment When the Policy Ends

When the Policy ends, the Group is and will remain responsible to us for the payment of any and all Premiums which are unpaid at the time the Policy ends. This will include a pro rata portion of the Policy Charge for any period this Policy was in force during any grace period preceding the end of the Policy.

Except in the case of fraud or intentional misrepresentation of a material fact, we will refund the pro rata portion of any and all Policy Charges which have been prepaid by the Group to reflect any reduced period of coverage at the time of termination of this Policy. The refund will be reduced by any amount paid for any claims incurred during the period this Policy was in force preceding the termination. Full month proration based on the eligibility rules established by the Group will be used to refund Policy Charges. Exhibit 1 describes the way in which the Policy Charge is calculated.

## 5.3 Review by the California Department of Insurance for Improper Cancellation, Rescission or Non-Renewal of Coverage

You may request a review by the California Insurance Commissioner if you believe your Policy or coverage has been or will be wrongly canceled, rescinded or not renewed. Contact the California Insurance Commissioner's Consumer Communications Bureau at **1-800-927-HELP (4357)** or **TTY 1-800-482-4833** to receive assistance with this process, or submit an inquiry in writing to:

**California Department of Insurance**

**Consumer Communications Bureau**

**300 S. Spring Street, South Tower**

**Los Angeles, CA 90013**

Or through the website **http://www.insurance.ca.gov.**

# Article 6: General Provisions

## 6.1 What Is the Entire Policy?

This Policy, including the *Certificate(s) of Coverage*, the *Schedule(s) of Benefits*, the Group *Application*, insured enrollment forms, and any Amendments, *Notices of Change*, and Riders, make up the entire Policy, and any statement made by the Enrolling Group shall, in absence of fraud, be deemed a representation and not a warranty. No statement made by any Subscriber whose eligibility has been accepted by us shall avoid the insurance or reduce the Benefits under this Policy or be used in defense to a claim hereunder.

## 6.2 Dispute Resolution and Binding Arbitration Requirement

This Policy requires that disputes be resolved in binding arbitration. You are waiving your right to sue UnitedHealthcare Insurance Company in court to resolve a dispute. You are waiving your right to a jury trial.

No legal proceeding or action may be brought until the parties have attempted, in good faith, to resolve the dispute amongst themselves. In the event the dispute is not resolved within 30 days after one party has received written notice of the dispute from the other party, and either party wishes to pursue the dispute further, this applies to disputes of any kind whatsoever, including, but not limited to, claims for medical malpractice (that is, as to whether any medical services rendered under Policy were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), the dispute may be submitted to arbitration as noted below.

The parties acknowledge that because this Policy affects interstate commerce, the *Federal Arbitration Act* applies. If the Group wishes to seek further review of the decision or the complaint or dispute, it must submit the decision, complaint or dispute to binding arbitration according to the rules of the *American Arbitration Association*. This is the only right the Group has for further consideration of any dispute that arises out of or is related to this Policy.

If a claim for medical malpractice seeks total damages of $50,000 or less, the claim or dispute shall provide for selection by the parties of a single neutral arbitrator who shall have no jurisdiction to award more than $50,000. If the parties are unable to agree on the selection of a single arbitrator, the following method shall be utilized:

- If the arbitration agreement provides a method of appointing an arbitrator, that method shall be followed.
- If the arbitration agreement does not provide a method for appointing an arbitrator, the parties to the agreement who seek arbitration and against whom is sought may agree on a method of appointing an arbitrator and that method shall be followed.
- In the absence of an agreed method, or if the agreed method fails for any reason cannot be followed, or when an arbitrator appointed fails to act and his or her successor has not been appointed, the court, on petition of a party to the arbitration agreement, shall appoint the arbitrator. When petition is made to the court to appoint a neutral arbitrator, the court shall nominate five persons from lists of persons supplied jointly by the parties to the arbitration or obtained from a governmental agency concerned with arbitration or private disinterested association concerned with arbitration. The parties to the agreement who seek arbitration and against whom arbitration is sought may within five days of receipt of notice of the nominees from the court jointly select the arbitrator whether or not the arbitrator is among the nominees. If the parties fail to select an arbitrator within the five-day period, the court shall appoint the arbitrator from the nominees.

Arbitration will take place in Orange County, California.

The matter must be submitted to binding arbitration within one year of the date notice of the dispute was received. The arbitrators will have no power to award any punitive or exemplary damages or to vary or ignore the provisions of this Policy, and will be bound by federal and/or state law.

## 6.3 Time Limit on Certain Defenses

After it has been in force for a period of more than 24 months, We cannot rescind the policy for any reason, and shall not cancel the policy, limit any of the provisions of the policy, or raise premiums on the policy due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not.

## 6.4 Amendments and Alterations

Amendments and Riders based on changes to state or federal mandates to this Policy are effective upon the Group's next anniversary date, except as otherwise permitted by law. Other than changes to Exhibit 2, no change will be made to this Policy unless made by an Amendment or a Rider to incorporate federal or state mandates which is signed by one of our authorized executive officers and consistent with applicable notice requirements. No agent has authority to change this Policy or to waive any of its provisions.

## 6.5 Our Relationship with Providers and Groups

The relationships between us and Network providers, and relationships between us and Groups, are solely contractual relationships between independent contractors. Network providers and Groups are not our agents or employees, nor are we or any of our employees an agent or employee of Network providers or Groups.

The relationship between a Network provider and any Covered Person is that of provider and patient. The Network provider is solely responsible for the services provided. The relationship between any Group and any Covered Person is that of employer and employee, Dependent, or any other category of Covered Person described in the Coverage Classifications shown in this Policy.

The Group is solely responsible for enrollment and Coverage Classification changes (including the end of a Covered Person's coverage) and for the timely payment of the Policy Charges.

## 6.6 Records

We may require information related to the Policy, from the Group. Upon request, the Group must provide us with the requested information and proofs which may include:

- All documents provided to the Group by an individual in connection with coverage.
- The Group's payroll.
- Any other records pertinent to the coverage under this Policy.

By accepting Benefits under this Policy, each Covered Person authorizes and directs any person or institution that has provided services to him or her, to provide us or our designees any and all information and records or copies of records relating to the health care services provided to the Covered Person. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form.

We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are needed to administer the terms of this Policy including records for appropriate medical and quality review or as required by law or regulation.

During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy for research and analytic purposes.

## 6.7 Administrative Services

The services needed to administer this Policy and the Benefits provided under it will be provided in accordance with our standard administrative procedures or those standard administrative procedures of our designee. If the Group requests that administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, the Group must pay for such services or reports at the then current charges for such services or reports.

We may offer to provide administrative services to the Group for certain wellness programs including, but not limited to, fitness programs, biometric screening programs and wellness coaching programs.

## 6.8 Employee Retirement Income Security Act (ERISA)

When this Policy is purchased by the Group to provide benefits under a health and welfare plan governed by the federal *Employee Retirement Income Security Act* 29 U.S.C., 1001 et seq., we will not be named as, and will not be, the plan administrator or the named fiduciary of the health and welfare plan, as those terms are used in ERISA.

## 6.9 Do We Require Examination of Covered Persons?

In the event of a question or dispute concerning Benefits for Covered Health Care Services, we may require that a Network Physician, of our choice examine the Covered Person at our expense.

## 6.10 What Happens When There Is a Clerical Error?

Clerical error will not deprive any individual of Benefits under this Policy or create a right to Benefits. Failure to report enrollments is not a clerical error. We will not provide retroactive coverage for Eligible Persons when the Group fails to report enrollments. Failure to report the end of coverage will not continue the coverage for a Covered Person beyond the date it is scheduled to end. Upon discovery of a clerical error, any needed adjustment in Premiums will be made. However, we will not grant any such adjustment in Premiums or coverage to the Group for more than 90 days of coverage prior to the date we received notification of the clerical error.

## 6.11 Is Workers' Compensation Affected?

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

## 6.12 Conformity with Law

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is deemed to be amended to follow the minimum requirements of those statutes and regulations.

## 6.13 Notice

When we provide written notice regarding Policy administration to the Group's authorized representative. Once delivered, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Group is responsible for giving notice to Covered Persons on a timely basis.

Any notice sent to us under this Policy and any notice sent to the Group must be addressed as described in Exhibit 1.

## 6.14 Continuation Coverage

We agree to provide Benefits under this Policy for those Covered Persons who are eligible to continue coverage under federal or state law, as described in *Section 4: When Coverage Ends* of the *Certificate of Coverage*.

**Federal Continuation Coverage**

We will not provide any administrative duties with respect to the Group's compliance with federal or state law. All duties of the plan sponsor or plan administrator required by federal law remain the sole responsibility of the Group, including but not limited to notification of COBRA and/or state law continuation rights and billing and collection of Premium.

**Extension of Continuation Coverage under State Law (Cal-COBRA) after Exhaustion of Federal COBRA Continuation Coverage**

We will provide all administrative duties required by Cal-COBRA, including but not limited to, notifications to affected Covered Persons and billing and collection of Premium.

## 6.15 Subscriber's Individual Certificate

We will issue *Certificate(s) of Coverage*, *Schedule(s) of Benefits*, and any attachments to the Group for delivery to each Subscriber. The *Certificate(s) of Coverage*, *Schedule(s) of Benefits*, and any attachments will show the Benefits and other provisions of this Policy. In addition, the *Certificate(s) of Coverage* and *Schedule(s) of Benefits* may be available online at www.myuhc.com.

## 6.16 Summary of Benefits and Coverage

We will provide a *Summary of Benefits and Coverage ("SBC")*, as required by the *Affordable Care Act* and related regulations *("ACA")*, to the Group for each benefit plan purchased. The Group is responsible for delivering the *SBC* to all Covered Persons and to other persons eligible for coverage in the manner and at the times required by the *ACA*.

## 6.17 System Access

The term "systems" as used in this provision means systems that we make available to the Group to facilitate the transfer of information in connection with this Policy.

- **System Access**

  We grant the Group the nonexclusive, nontransferable right to access and use the functionalities contained within the systems, under the terms of this Policy. The Group agrees that all rights, title and interest in the systems and all rights in patents, copyrights, trademarks and trade secrets encompassed in the systems will remain ours. To access the systems, the Group will obtain, and be responsible for maintaining, at no expense to us, the hardware, software and Internet browser requirements we provide to the Group, including any amendments to those requirements. The Group is responsible for obtaining internet access.

  The Group will not:

  - Access systems or use, copy, reproduce, modify, or excerpt any of the systems documentation provided by us in order to access or use systems, for purposes other than as expressly permitted under this Policy.
  - Share, transfer or lease its right to access and use systems,to any other person or entity which is not a party to this Policy.

The Group may designate a third party access to the systems on its behalf, provided the third party agrees to these terms and conditions. The Group remains responsible for the third party's compliance with the entire *System Access* provision.

- **Security Procedures**

  The Group will use commercially reasonable physical and software-based measures and comply with our security procedures, as may be amended from time to time, to protect the system, its functionalities, and data accessed through systems from any unauthorized access or damage (including damage caused by computer viruses). The Group will notify us immediately if any breach of the security procedures, such as unauthorized use, is suspected.

- **End of System Access**

  We have the right to end the Group's system access:

  - On the date the Group does not accept the hardware, software and browser requirements provided by us, including any amendments to the requirements.
  - Immediately on the date we reasonably find out that the Group has breached, or allowed a breach of, any applicable provision of this Policy. Upon the date this Policy ends, the Group agrees to cease all use of systems, and we will deactivate the Group's identification numbers and passwords and access to the system.

## 6.18 Important Notice - Disputes

Should a dispute concerning your coverage arise, contact us first. If the dispute is not resolved, contact the California Department of Insurance.

Call us at the phone number shown on your ID card.

Call the **California Department of Insurance** at:

- **1-800-927-HELP (1-800-927-4357)**
- **1-800-482-4833 (TTY)**

You may write the California Department of Insurance at:

**California Department of Insurance**

**Claims Services Bureau, 11th Floor**

**300 South Spring Street**

**Los Angeles, CA 90013**

Or through the website **http://www.insurance.ca.gov**.

## 6.19 Notice of Network Provider Termination

We will provide written notice to the Group, within a reasonable period of time, if we receive notice that any Network provider in the Service Area terminates or breaches its contract with us, or is unable to perform such contract, if the termination, breach, or inability to perform may materially and adversely affect the Group or Covered Persons.

When we provide such written notice of Network provider termination to the Group, the Group is responsible for distributing the substance of the notice to all affected Subscribers and their Enrolled Dependents no later than 30 days after its receipt.

## 6.20 Liability for Continued Treatment by Terminated Network Provider

If, upon termination of a Network provider's contract as described in Article 6.19, a Covered Person is under the care of a terminated Network provider for one of the medical conditions described in the Continuity of Care provision in the Schedule of Benefits, we will be liable for continuation of Covered Health Care Services rendered by the provider until such services are completed, unless reasonable and medically appropriate arrangements for assumption of such Covered Health Care Services are made by another Network provider. Co-payments, deductibles, or other cost sharing components will be the same as the Covered Person would have paid for a Network provider currently contracting with us.

This section does not apply to treatment by a provider or provider group whose contract with us has terminated or not renewed for reasons relating to medical disciplinary cause or reason, fraud or other criminal activity.

# Exhibit 1

1. **Parties**. The parties to this Policy are UnitedHealthcare Insurance Company and County of Los Angeles, the Group.
2. **Effective Date**. The effective date of this Policy is 12:01 a.m. on January 1, 2022 in the time zone of the Group's location.
3. **Place of Issuance**. We are issuing this Policy in California. This Policy is governed by ERISA. To the extent that state law applies, California law governs this Policy.
4. **Premiums**. We have the right to change the *Schedule of Premium Rates* shown in Exhibit 2, after a 45-day prior written notice at any time.
5. **Computation of Policy Charge**. A full calendar month's Premiums will be charged for Covered Persons whose effective date of coverage falls on or before the 15th of that calendar month. No Premiums will be charged for Covered Persons whose effective date of coverage falls after the 15th of that calendar month. A full calendar month's Premiums will be charged for Covered Persons whose coverage ends after the 15th of that calendar month. No Premiums will be charged for Covered Persons whose coverage ended on or before the 15th of that calendar month.
6. **Payment of the Policy Charge**. The Policy Charge is payable to us in advance by the Group on a monthly basis.
7. **Minimum Participation Requirement**. The Minimum Participation Requirement does not apply.
8. **Minimum Contribution Requirement**. The Minimum Contribution Requirement does not apply.
9. **Notice**. Any notice sent to us under this Policy must be sent to:

   UnitedHealthcare Insurance Company

   185 Asylum Street

   Hartford, Connecticut 06103-0450

   Any notice sent to the Group under this Policy must be sent to:

   County of Los Angeles

   3333 Wilshire Blvd.

   Suite 1000

   Los Angeles, California 90010
10. 716822: Group Number

# Exhibit 2

1. **Class Description**.

   All Employees enrolled in Select Plus plan AKLV.

2. **Eligibility**. The eligibility rules are established by the Group. The following eligibility rules are in addition to the eligibility rules shown in the Group *Application* and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage*:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      None

   B. Other:

      None

   **Important Note Regarding Waiting or Probationary Period**: Any required waiting or probationary period for newly Eligible Persons will not exceed 90 days. A waiting or probationary period may only be a condition of employment if applied equally to all Eligible Persons and Dependents and if consistent with the Patient Protection and Affordable Care Act. A waiting or probationary period may not be based on health status.

3. **Open Enrollment Period**. An Open Enrollment Period of at least 30 days will be provided by the Group when Eligible Persons may enroll for coverage. The Open Enrollment Period will occur on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2022.

   For an Eligible Person who becomes eligible after the effective date of this Policy, the effective date of coverage is the first day of the month following the date the Eligible Person joins the Group. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates**.

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2022 is shown below:

| **Coverage Classification** | **Monthly Premium** |
|---|---|
| Active Employee Only | $4,054.73 |
| Active Employee plus One Dependent | $8,188.42 |
| Active Employee plus Family | $9,487.73 |
| Non-Deducts Employee Only | $4,054.73 |
| Non-Deducts Employee plus One Dependent | $8,188.42 |
| Non-Deducts Employee plus Family | $9,487.73 |
| Direct Bill COBRA Employee Only | $4,135.82 |
| Direct Bill COBRA Employee plus One Dependent | $8,352.19 |
| Direct Bill COBRA Employee plus Family | $9,677.48 |

| | |
|---|---|
| California AB1401 Employee Only | $4,460.20 |
| California AB1401 Employee plus One Dependent | $9,007.26 |
| California AB1401 Employee plus Family | $10,436.50 |

California AB1401 Employee plus One Dependent $8,776.44

California AB1401 Employee plus Family $10,169.06

# NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights and obligations of the Association.

## COVERAGE

- **Persons Covered**

  Generally, an individual is covered by the Association if the insurer was a member of the Association and the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

  The basic coverage protections provided by the Association are as follows:

  - **Life Insurance, Annuities and Structured Settlement Annuities**

    For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

    - Life Insurance

      80% of death benefits but not to exceed $300,000

      80% of cash surrender or withdrawal values but not to exceed $100,000

    - Annuities and Structured Settlement Annuities

      80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

    The maximum amount of protection provided by the Association to an individual, for all life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

  - **Health Insurance**

    The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

## COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract.
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society.
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual.
- Employer and association plans, to the extent they are self-funded or uninsured.
- A policy or contract providing any health care benefits under Medicare Part C or Part D.
- An annuity issued by an organization that is only licensed to issue charitable gift annuities.
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract.
- Any policy of reinsurance unless an assumption certificate was issued.
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

## NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

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| California Life and Health Insurance | California Department of Insurance |
| Guarantee Association | Consumer Communications Bureau |
| P.O. Box 16860 | 300 South Spring Street |
| Beverly Hills, CA 90209-3319 | Los Angeles, CA 90013 |
| (323) 782-0182 | (800) 927-4357 |

**Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.**