C.A.R. Health Insurance Program

General Plan Guidelines

Effective November 1, 2023

C.A.R. Endorsed Agent:

RealCare Insurance Marketing, Inc.

430 West Napa Street, Suite F, Sonoma, CA 95476

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

California License #: 0B23546

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Introduction

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

Insurance Programs Offered

- ***Medical Insurance*** is available for eligible C.A.R. members and their dependents, eligible full-time W-2 employees of C.A.R. members and eligible full-time W-2 employees of local C.A.R. chapters. Medical insurance is guaranteed to be issued for all eligible parties regardless of health history. Eligibility for specific medical plans is determined by the health plan's availability in a specific geographic region.
- ***Dental Insurance*** may be purchased by itself or in combination with any other C.A.R. Insurance Plan.
- ***Vision Insurance*** may be purchased by itself or in combination with any other C.A.R. Insurance Plan.
- ***Group Term Life & AD&D Insurance*** coverage is guaranteed for new REALTOR® members; or newly eligible employees of REALTORS® and local C.A.R. chapters, who enroll during their Initial Eligibility Period and who have not been hospitalized within 90 days of making application. **Affiliate members are not eligible for guaranteed life coverage but may apply for coverage with evidence of medical insurability.** Eligible members enrolling during the Initial Eligibility Period cannot be turned down due to pre-existing medical conditions, unless hospitalized within 90 days of making application. Any eligible member who has been hospitalized within 90 days of making application must submit evidence of medical insurability and could be declined coverage. Eligible members may purchase either $25,000 or $50,000 of coverage. This coverage also includes two times the benefit if death is a result of an accident. Coverage is not guaranteed at any time after the Initial Eligibility Period however, interested members may apply for coverage by completing an enrollment application and health history questionnaire. Please call RealCare for more information.
- ***Voluntary Accidental Death & Dismemberment*** coverage is guaranteed for REALTOR® members and full time W2 employees of members and local C.A.R. chapters. This coverage provides a benefit in the event of death or dismemberment resulting from a covered accident. Members may also purchase AD&D coverage for their spouse and eligible dependent children.

Benefit Eligibility

Who is Eligible

- ***Active C.A.R. members*** who have been members for at least one month.
- ***Regular full-time W-2 employee and their eligible dependents.*** A W-2 employee is considered eligible if s/he works at least 30 hours per week and has been working for an eligible C.A.R. member or local C.A.R. chapter for at least one month. An eligible employee may enroll even if the C.A.R. member does not enroll.
- ***Dependents of eligible members or employees,*** including spouses or domestic partners and dependent children as long as the C.A.R. member or employee remains eligible and is enrolled. It is the member's/employee's responsibility to notify RealCare of changes to eligibility of dependents; such as marriage, birth, adoption, divorce, etc. Members/Employees who fail to notify RealCare of dependents who are no longer eligible will be responsible for premiums for that dependent until the dependent is terminated from the plan. In addition, the Member/Employee may be responsible for payment of dependents' cost share for covered services. See special notes, below:
    - ***Dependent Children –*** Dependent children are eligible up to age 26 regardless of student status, marital status, or eligibility for other group coverage. Dependents must be covered under the same plan you choose and can only enroll if the C.A.R. member enrolls. Disabled dependents age 26 and older may be eligible if proof of disability is provided.
    - ***Domestic Partners.*** All C.A.R. health plans allow a subscriber to enroll his/her domestic partner at the same rate as a spouse. The domestic partner includes the same or opposite sex partnership. If you are under age 62 and have an opposite sex domestic partner relationship, you may have to complete a domestic partner affidavit form to enroll. Anthem Blue Cross requires domestic partnerships to file a Declaration of Domestic Partnership with the State of California. Members may be asked to provide documentation of eligibility at any time.
    - ***"Grandfathered dependents"*** (see definition of "Grandfathered Dependent" in DEFINITIONS section) enrolled prior to January 1, 2017 may continue on the Kaiser or Anthem medical plans and/or dental and vision plans only if they were covered dependents at the time of death or Medicare enrollment or disenrollment due to retirement. If coverage is terminated, these dependents lose eligibility and may not re-enroll.

Proof of Eligibility

- ***New C.A.R. members:*** Membership must be verified by RealCare before enrollment can be processed. Members may be asked to submit proof of membership with the application. A receipt for payment of C.A.R. membership dues or letter from the local association indicating the member's join date and type of membership may suffice.
- ***New employees*** of REALTORS® or local C.A.R. chapters must submit payroll records or pay stubs to substantiate their eligibility. Payroll records must include the payroll period and hours worked.
- ***All enrollees applying for coverage outside of Open Enrollment*** must furnish satisfactory *proof of a qualifying event.*
- ***Dependents of members or employees*** may be required to provide proof of eligibility at any time. This may be in the form of a birth certificate, marriage license, Declaration of Domestic Partnership or other documentation.

Membership in C.A.R. must be maintained in order to preserve eligibility. Failure to maintain continuous active C.A.R. membership will result in termination of coverage for the REALTOR®, dependents and any enrolled employees and their dependents. C.A.R. membership is verified any time an account change is made, and periodic audits are also performed to confirm continuous C.A.R. membership.

Medicare Eligibility

When a covered member reaches age 65, he or she may enroll in Medicare if eligible. If a member enrolls in Medicare, the member must provide RealCare with information on his Medicare coverage. The Anthem or Kaiser group insurance plan will coordinate benefits with Medicare under Medicare rules. Medicare rules determine which coverage pays first or is "Primary." Benefits under the group plan are reduced by any benefits received under Medicare.

Anthem and Kaiser determine which of their plans are "creditable" or "non-creditable" coverage under Medicare Part D guidelines. Members enrolled in non-creditable plans may be subject to a late enrollment penalty for a Part D plan if and when they join a Medicare drug plan after their initial eligibility. Members are provided notices of creditability each year at Open Enrollment and upon request.

Members are charged a premium based on their age as of the contract renewal date regardless of Medicare eligibility. The C.A.R. group policy is not a Medicare Supplement plan. For those who enroll in Medicare at age 65 or later; or for those who enroll at any age due to a disability, Medicare is considered the "Primary" plan and all claims will be processed by Medicare first and then sent to Anthem or Kaiser.

Kaiser offers members enrollment in a Medicare Advantage program, Senior Advantage. A member who enrolls in Senior Advantage is not eligible to continue coverage under the C.A.R. Group Medical Plans.

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

Enrollment & Coverage Effective Dates

Initial Eligibility Period – for new members and employees

1. ***New members of C.A.R.*** may enroll in any health coverage offered as part of the C.A.R. Insurance Plan after one month of membership. Your completed enrollment form and premium payment should be received by RealCare no later than 30 days from your coverage eligibility date. The Coverage Eligibility Date for a new member is the first of the month following one month of membership.
2. ***Newly hired permanent, full-time W-2 employees of C.A.R. members or local C.A.R. chapters*** may enroll in any health coverage offered as part of the C.A.R. Insurance Plan after one month of employment. Your completed enrollment form and premium payment should be received by RealCare no later than 30 days from your coverage eligibility date. The Coverage Eligibility Date for a new employee is the first of the month following one month of full time employment.
3. ***Life Insurance Eligibility - New members and eligible employees*** may enroll in the C.A.R. life insurance program on a guaranteed basis after one month of C.A.R. membership or employment. **Life insurance coverage is only guaranteed if application is received within 31 days of the Coverage Eligibility Date and if the enrollee has not been hospitalized within 90 days of making application. Members who enroll more than 31 days after the Coverage Eligibility Date will be required to submit a Statement of Health application and could be declined due to health history.**
4. ***Voluntary AD&D Eligibility –*** C.A.R. members or permanent, full time W2 employees of members or local C.A.R. chapters may enroll in Voluntary AD&D coverage after one month of membership or employment. Coverage is guaranteed issue and is available any time after the first month of membership or employment. Coverage is renewed annually after receipt of annual renewal premium and verification of eligibility.

Open Enrollment Period:

Medical, Dental & Vision Plans:

- **Open Enrollment: November 1st through December 15th each year for coverage effective January 1st.**

During this period all eligible members, employees and dependents can join the association insurance plans. The REALTOR® or C.A.R. member must have been a member of the association for at least one month. *If you and/or your family members decide not to enroll during the Open Enrollment period, you may be forfeiting the right to enroll until the next Open Enrollment period.*

Additional Open Enrollment for Dental & Vision Plans ONLY:

- **Additional Open Enrollment: April 1st through May 15th each year for coverage effective June 1st.**

During this period all eligible members, employees, and dependents can join the association Dental or Vision insurance plans. The REALTOR® or C.A.R. member must have been a member of the association for at least one month. *If you and/or your family members decide not to enroll during the Open Enrollment period, you may be forfeiting the right to enroll until the next Open Enrollment period.*

- ***Note:*** *Members whose prior coverage under the C.A.R. dental and/or vision plans terminated previously may not re-enroll until the first open enrollment following a 13 month waiting period.*

Special Enrollment Period: Qualifying Events During The Plan Year

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

- Loss of other qualified group coverage: A subscriber and his/her dependents that did not enroll in this plan because they had other group coverage, but who subsequently lose their coverage, may enroll during the Special Enrollment Period. The loss of group coverage may be due to:
    - Exhaustion of COBRA or CalCOBRA
    - Loss of eligibility for group coverage due to:
        - Divorce or legal separation
        - Termination of domestic partnership agreement
        - Child's loss of eligibility due to age
        - Death of an employee
        - Termination of employment
        - Reduction of hours
        - Moving out of the health plan service area

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

*If a party becomes eligible pursuant to a qualifying event other than the birth or adoption of a child, s/he must submit completed enrollment materials and premium payment to RealCare within a specified time frame after the qualifying event. These periods may vary depending on the event and insurer guidelines. A parent has 60 days from the date of birth or adoption to submit completed enrollment and applicable premium payment for the addition of a child. **Note:** Anthem Blue Cross allows 60 days for an individual to apply after a qualifying event. Please check with RealCare to confirm the enrollment time frame applicable to your situation.*

Effective Dates of Coverage

The effective date of coverage will depend on the enrollment period and the timing of receipt of completed enrollment paperwork and payment. Completed enrollment forms and initial premium payment is required for processing. All members and employees must be confirmed eligible prior to completion of enrollment processing.

For Initial Eligibility Period (for new members/employees),

- For all plans: The first of the month following one month of membership or full time employment.

For Annual Open Enrollment during November/December:

- Effective date of coverage is January 1st

For Semi-Annual Dental/Vision Open Enrollment during April/May:

- Effective date of coverage is June 1st

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

For Voluntary AD&D: After meeting eligibility requirements, the effective date is the first of the month following receipt of the completed enrollment form and annual payment (premium plus administrative fee.)

Plan Renewal & Changes

Plan Renewals

The C.A.R. Group Health Plans renew on January 1st. Plans and rates are subject to change on the renewal date, regardless of the date you enrolled in the plan. Existing members will be notified of plan and rate changes 60 days prior to the renewal date.

All plan deductibles and policy limits re-set on January 1st.

Plan & Enrollment Changes

Existing subscribers may change plans or add dependents during the applicable Open Enrollment or Special Enrollment periods. At the annual Open Enrollment period, existing subscribers will be notified of upcoming plan and rate changes, and will be given an opportunity to change plans or add dependents.

Existing subscribers may also be eligible to make plan changes following specific qualifying events. A qualifying event may create a Special Enrollment period which allows the subscriber to enroll, add dependents or make plan changes. Most qualifying events for medical insurance require members to submit enrollment or change requests within 60 days of the qualifying event. Some qualifying events require enrollment or changes to be submitted within 30 days. MetLife requires members to request enrollment or changes within 31 days of a Qualifying Event. Contact RealCare for clarification of eligibility for plan changes.

Some plan changes made after a qualifying event may result in the plan deductible being re-set on the plan change effective date. Consult with RealCare to confirm whether a plan change will affect your policy limits.

Plan changes may result in a rate change (increase or decrease).

RealCare will verify C.A.R. membership when a plan change is made.

Rating, Billing, Cancellation & Reinstatement Policies

General Rating Rules

Member Level Rating

In accordance with the Affordable Care Act guidelines, for C.A.R. members, both Kaiser and Anthem rate each covered family member based on the home zip code for the family, and the age of the covered individual. Note: For W2 employees, Anthem rates the employee and each family member based on the employer's zip code.

- Kaiser calculates rates on the age of each covered family member as of the policy renewal date (January 1st)
- Anthem Blue Cross calculates rates on the age of each covered family member as of the coverage effective date.
- Rates are re-calculated for all members on the policy renewal date, January 1st.
- When calculating rates for a family:
    - For children under 21, include a rate for only the three oldest children.
    - For children 21 and older, include a rate for each child separately.

Maximum Eligibility Age for Dependents: Medical, Dental and Vision Plans

The maximum age for a dependent child on the medical, dental and vision plans is age 26. Please read the *Who is Eligible* section in the *General Guidelines* document included on our website for additional details or call RealCare at 1-800-939-8088.

Anthem Blue Cross Rating & Billing

Rates

- For C.A.R. members, Anthem Blue Cross rates are based on the plan selected, the member's home zip code and county, and each covered family member's age *as of the effective date of the coverage.* If a covered family member has a birthday that moves him/her into the next age bracket, the associated rate increase will become effective on the plan renewal date, January 1st. If a C.A.R. member lives out of state but maintains membership in C.A.R., Anthem will base the member's rates on the location of the C.A.R. office in Los Angeles, Rating Region 16.
- For W2 employees, the rates are based on the plan selected, the employer's zip code and county, and each family member's age *as of the effective date of the coverage.* If a covered family member has a birthday that moves him/her into the next age bracket, the associated rate increase will become effective on the plan renewal date, January 1st.
- For those who are Members and W2 employees:
    - Anthem will rate based on the C.A.R. member's home address when the C.A.R. member is both an employee of a C.A.R. member and a C.A.R. member themselves unless the Employer is being billed for the premiums.
- Rating Changes during the year
    - **If a member is added** during the plan year Anthem will use the member's age as of the coverage effective date to determine the rate for that member.
    - **If a member is dropped** during the plan year, Anthem will reduce the billed amount by the cost for the member whose coverage terminated as of the effective date of the change.
    - **If a member changes addresses** to a new rating region during the plan year, all members will be re-rated based on the new region as of the effective date of the change.
    - **If a member changes plans** as a result of a qualifying event, all members will be re-rated based on the new plan as of the effective date of the change.
- Annual Renewal Date
    - The plan renews each year on January 1st. Rate changes take effect on January 1st regardless of the member's initial effective date.

Initial Payment

All applicants are required to pay a minimum of the first month's premium with their enrollment application unless they have authorized RealCare to draft monthly automatic payments from a bank account and their application is completed in time for the automatic payment to be withdrawn for their first month of coverage. Due to the timing of billing cycles, Anthem applicants may be required to send the first two months of premium with their enrollment application.

Monthly Billing Cycle - Anthem Health Coverage (with or without dental/vision)
Bills are generated around the 11th of each month. Premiums are due by the 1st of each month for coverage beginning the next month. (For example, premiums for coverage for the month of June are due on May 1st.) If payment is not received within 10 days of the due date, a late fee of $15 will be applied. If payment is not received within 30 days of the due date, coverage will be terminated effective the last day of the month through which premiums have been paid.

Voluntary AD&D coverage is billed annually based on when coverage was effective.

Kaiser Permanente Rating & Billing

Kaiser Service Areas/Eligibility
To be eligible to enroll in Kaiser a member must live or work within a Kaiser Service Area. However, once enrolled, members may continue coverage with Kaiser even if they move out of, or no longer work in a Kaiser Service Area.

According to Kaiser guidelines, applicants who live outside of a Kaiser Service Area but work in a Kaiser Service Area will use rates for Kaiser's designated "Out of Area" region ("Region 4, 8 and out of area").

Rates

- For C.A.R. Members, Kaiser rates are based on the plan selected, the member's home zip code and county, and each covered family member's age as of the 1st day of the current plan year. If a covered family member has a birthday that moves him/her into the next age bracket, the associated rate increase will become effective on plan renewal date, January 1st.
- For W2 employees, the rates are based on the plan selected, each family member's age as of the 1st day of the current plan year, and the employee's zip code and county. If a covered family member has a birthday that moves him/her into the next age bracket, the associated rate increase will become effective on plan renewal date, January 1st.
- Rating Changes during the year
    - **If a member is added** during the plan year Kaiser will use the member's age as of the 1st of the month of the current plan year to determine the rate.
    - **If a member is dropped** during the plan year, Kaiser will reduce the billed amount by the cost for the member whose coverage terminated as of the effective date of the change.
    - **If a member changes plans** as a result of a qualifying event, all members will be re-rated based on the new plan as of the effective date of the change.
- Annual Renewal Date
    - The plan renews each year on January 1st. Rate changes take effect on January 1st regardless of the member's initial effective date.

Initial Payment
All applicants are required to pay a minimum of the first month's premium with their enrollment application unless they have authorized RealCare to draft monthly automatic payments from a bank account and their application is completed in time for the automatic payment to be withdrawn for their first month of coverage.

Monthly Billing Cycle – Kaiser (with or without dental/vision)
Bills are generated around the 6th of each month. Premiums are due the 25th of the month prior to the coverage month. If payment is not received within 10 days of the due date, a late fee of $15 will be applied. If payment is not received within 30 days of the due date, coverage will be terminated effective the last day of the month through which premiums have been paid.

Voluntary AD&D coverage is billed annually based on when coverage was effective.

MetLife Dental, Vision, Life and Voluntary AD&D Rating & Billing

Rates

- For C.A.R. Members or W2 employees, dental and vision rates are based on the plan selected, the member's county, and the family members covered, (e.g. Member only, Member + Spouse, Member + Child(ren), Member + Family). Rates do not vary by age.
    - Life insurance rates are based on the plan selected and the member's/employee's attained age. These rates will change when a member's age change moves him/her into a new age/rate bracket.
    - Voluntary AD&D rates are based on the Coverage amount and the protection chosen (Member/Employee vs. Family). Since Voluntary AD&D rates are not based on age, they do not change when a member's age changes.

Voluntary AD&D is renewed *annually* after receipt of annual payment (premium plus administrative fee) and verification of eligibility.

- Rating Changes during the year
  - **Dental & Vision**
    - **If a member is added or dropped** during the plan year, MetLife will use the member's family status as of the effective date of the change to determine the new rate. Some changes do not change the rate. For example if a family of five drops a child from the coverage, the rate is still calculated as the member plus family.
    - **If a member changes addresses** to a new rating region during the plan year, rates will be re-calculated based on the new region as of the 1st of the month of the change.
    - **If a member changes plans** during an Open Enrollment period rates will be re-calculated based on the new plan and family status as of the renewal date, January 1st.
  - **Life Insurance**
    - **When a member has a birthday that moves him into a new age/rate bracket,** the rate will change as of the first of the month following the age change.
    - **If a member is approved for a plan change,** rates will be re-calculated based on the member's attained age and the new plan as of the effective date of the plan change.
- Annual Renewal Date
  - The plan renews each year on January 1st. Rate changes take effect on January 1st regardless of the member's initial effective date.

Initial Payment
All applicants are required to pay a minimum of the first month's premium with their enrollment application unless they have authorized RealCare to draft monthly automatic payments from a bank account and their application is completed in time for the automatic payment to be withdrawn for their first month of coverage.

Monthly Billing Cycle – MetLife (Note: If covered with Anthem, Anthem Monthly Billing Cycle applies)
Bills are generated around the 6th of each month. Premiums are due the 25th of the month prior to the coverage month. If payment is not received within 10 days of the due date, a late fee of $15 will be applied. If payment is not received within 30 days of the due date, your coverage will be terminated effective the last day of the month through which premiums have been paid.

Voluntary AD&D coverage is billed annually based on when coverage was effective.

Payments

Monthly payments may be made by check or Automatic Premium Payment Authorization.

Check Payments

Checks should be made **payable to RealCare Insurance Trust Account (RITA)**

- If Mailed, send to: 430 West Napa Street, Suite F, Sonoma, CA, 95476.
- If Faxed, add the $5.00 processing fee to the total premium and fax your check to: (707) 939-8450
- If Scanned/Emailed, add the $5.00 processing fee to the total premium and scan/email to: enrollment@realcare.biz

Automatic Premium Payment Authorization (APPA)

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

Cancellation of Coverage

Voluntary Termination

A subscriber may voluntarily cancel coverage for themselves and/or covered dependents. A subscriber who wishes to terminate coverage for any covered person must submit the completed termination form to RealCare Insurance Marketing, Inc. The termination form is available on our member websites, www.RealCareOnline.com or www.RealCareCAR.com. The effective date of termination will be no earlier than the first of the month following receipt of the completed form unless a retroactive termination date is approved by RealCare and the insurance carrier(s).

Involuntary Termination

RealCare may cancel coverage for:

- Failing to pay premium and applicable administrative fees before the end of the grace period
- Failing to maintain active membership in C.A.R.
- Providing false information about membership in C.A.R.
- Providing false information about eligibility
- Providing false information about a qualifying event
- Reaching maximum allowable age for a dependent child
- Failing to continue to meet eligibility requirements as a member, employee or dependent

Reinstatement

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

Eligibility for Re-Enrollment

Re-Enrollment is contingent on meeting all eligibility requirements.

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

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

MetLife Dental & Vision: If your coverage terminates due to voluntary request or non-payment of premium, you may be eligible to re-enroll at the next applicable Open Enrollment following a 13 month waiting period; or within 31 days of a loss of other coverage. You will be required to pay all unpaid premiums, dues and fees at the time of enrollment.

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

Plan Administration

Plan Administrator

The C.A.R. Insurance Plan is administered by the California Association of REALTORS® (C.A.R.) On behalf of C.A.R., RealCare Insurance Marketing, Inc., a licensed Third Party Administrator, handles all eligibility, enrollment and billing. The RealCare office is located at 430 West Napa Street, Suite F, Sonoma, CA 95476. Calls and inquires can be directed to this office at 800-939-8088. Information on plans and rates; forms, administrative policies and Explanation of Coverage documents can be found on the RealCare website, www.RealCareCAR.com.

RealCare is licensed as a third party administrator by the California Department of Insurance, license Number 0B23546.

Amendment or Termination of the Plan

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

C.A.R. Health Plan Administrative Fees

As a licensed Third Party Administrator, RealCare handles all administrative functions of the plan on behalf of C.A.R. This includes managing eligibility (including periodic audits), processing applications, conducting Open Enrollments, generating monthly billing, collection and remittance of premium, terminations, etc. All of these functions would normally be handled by an employer in a traditional group insurance plan. The following is a list of administrative fees charged by RealCare.

Monthly Automatic Premium Payment Authorization	No Fee
Check By Fax or Scan/Email	$ 5.00
Credit or Debit Card transaction fee (charged by ePay)	3.25%
ACH Transaction fee (charged by ePay)	$3.00
Late Fee (for past due payments)	$15.00
Monthly Administration Fees:	
Accounts that include medical coverage	$22.00
Accounts that include dental coverage and no medical coverage	$ 5.00
Accounts that include vision and/or life insurance without medical or dental coverage	$ 2.00
Annual Administration Fee for Voluntary AD&D:	$ 5.00
Reinstatement Fee	$25.00
Reinstatement Fee (Second and subsequent reinstatement in a plan year)	$50.00
Returned Bank Payment Fee	$25.00

General Plan Provisions

Claims by Participants and Beneficiaries

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

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

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

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

Filing Claims for Benefits

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

Miscellaneous Plan Information

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

COBRA and Cal-COBRA

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

Plan Document

You may obtain a copy of the Plan Document, also known as an Evidence of Coverage, at www.RealCareCAR.com/notices or from RealCare Insurance Marketing, Inc., at (800) 939-8088.

Pre-Existing Conditions

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

Newborns & Mother's Health Act

To the extent any applicable program provides benefits for hospital lengths of stay in connection with childbirth, the Plan will cover the minimum length of stay required for deliveries (i.e., a 48-hour hospital stay after a vaginal delivery or a 96-hour stay following a delivery by Cesarean section.) The mother's or newborn's attending physician, after consulting with the mother, may discharge the

mother or her newborn earlier than the minimum length of stay otherwise required by law. No provider authorization is required from the Plan or any insurer for prescribing a length of stay less than 48 or 96 hours. This coverage is subject to any applicable deductible, coinsurance amounts or co-payments.

Women's Health and Cancer Rights Act

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

Mental Health Parity Act

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

Privacy of Health Information

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

Qualified Medical Child Support Orders

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

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

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

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

HIPAA Certification

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

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

- You attest to the period of creditable coverage.
- You present corroborating evidence of some creditable coverage for the period (such as pay stubs that reflect a deduction for health insurance, explanation of benefits forms ("EOBs"), or verification by a doctor or former health care benefits provider that the individual had prior health coverage), and
- You cooperate in verifying the information provided.
- You also may demonstrate proof of dependent creditable coverage without a certificate if:
    - You attest to such dependency and the period of such status as a dependent, and
    - You cooperate with the verification of dependent status.

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

A certificate will be provided to you promptly upon request. If you need a certificate, please contact RealCare. A certificate of prior coverage identifies the following:

- Individuals covered under the Plan
- The period of coverage

This certification can be provided when:

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

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

Choice of Medical Providers

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

- Anthem Blue Cross of California at (855) 383-7248 or visit www.anthem.com/ca; or
- Kaiser Permanente at (800) 464-4000 or visit www.kp.org

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

- Anthem Blue Cross of California at (855) 383-7248 or visit www.anthem.com/ca; or
- Kaiser Permanente at (800) 464-4000 or visit www.kp.org

Important Definitions

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

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

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

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

COVERAGE ELIGIBILITY DATE: The Coverage Eligibility Date is the effective date assigned based on the join date or the date of hire. The eligibility date for new members or employees is the first of the month following one month of membership or employment. The Coverage Eligibility Date for those enrolling during a Special Enrollment Period may vary.

CREDITABLE COVERAGE FOR MEDICARE PART D: Creditable Coverage is coverage which, on average, is expected to pay out as much as standard Medicare prescription drug coverage pays. Members with Creditable Coverage will not pay a higher premium (a penalty) if they decide to join a Medicare drug plan after their initial eligibility for Medicare. Creditability is determined by the health plan.

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

ELIGIBILITY DATE: For new members or employees: The first of the month following one month of membership or full time (30 hours/week) W2 employment. For those enrolling during a Special Enrollment Period: Date will vary depending on the Qualifying Event.

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

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

ELIGIBLE MEMBER: Active C.A.R. member who has been a member for at least 1 month

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

GRANDFATHERED DEPENDENT: A grandfathered dependent is a covered dependent who was allowed to continue enrollment after the death or retirement of a C.A.R. member that occurred prior to December 1, 2016 pursuant to the guidelines in effect at the time of the C.A.R. member's death or retirement.

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

INITIAL ELIGIBILITY PERIOD: The period of time that new members may enroll for coverage. The Initial Eligibility Period begins on the member's join date, or the eligible employee's date of hire.

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

HEALTH SAVINGS ACCOUNT (HSA): A federal tax incentive program that allows you to contribute up to 100% of your annual insurance deductible each year into a qualified HSA. You can deduct HSA contributions on your federal but not your California state income tax return. If you use the funds for qualified medical expenses, you do not pay taxes on the distribution from the HSA. You may open the HSA and fund it any time before you file your return for that tax year, similar to an IRA. If you have funds in your account when you reach age 65 you may withdraw them for non-medical purposes without penalty. If you withdraw funds for non-qualified medical expenses before age 65, you will pay taxes on the withdrawal and an additional 20% IRS penalty. Only certain health plans may be used with an HSA. Please review your benefit summary to determine if your plan is a qualified high deductible health plan (HDHP). You may enroll in one of these plans and not open an HSA. The HSA is separate from the insurance and may be set up with the institution of your choice. For further information on setting up an HSA account, please call your RealCare representative.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP): A plan that meets federal minimum and maximum IRS guidelines for deductibles, out of pocket maximums, and coverage provisions. An HDHP can be combined with a Health Savings Account (HSA) to allow members to pay certain medical expense on a pre-tax basis.

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

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

PLAN ADMINISTRATOR: California Association of REALTORS® (C.A.R.) On behalf of C.A.R. RealCare Insurance Marketing, Inc. 430 West Napa Street, Suite F, Sonoma, CA 95476 administers all eligibility, enrollment and billing. RealCare's phone number is: 800-939-8088.

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

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

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

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

QUALIFYING EVENT: A change in your situation that can make you eligible for a Special Enrollment Period allowing you to enroll in health insurance outside of Open Enrollment.

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

SPECIAL ENROLLMENT PERIOD: A time outside of Open Enrollment in which you can get coverage due to qualifying life events.