Step by Step Guide to Switch from Anthem Blue Cross to Kaiser

For members of the California Association of REALTORS®

Step 1 - Complete RealCare Termination Request Form to Cancel Anthem Coverage

- Complete personal information
- Select the box(es) to indicate each type of coverage to terminate
- Select a box to indicate the reason for your request
- Sign and date the bottom of the form

Step 2 - Complete Anthem Employee Waiver Form Sections 1 and 2

- Fill in your personal information and the requested effective date of cancellation.
    - Retroactive cancellations are not allowed.
- **If you are a C.A.R. Member indicate the employer as "C.A.R." and provide your C.A.R. Join date in the space provided for Hire date.**
- If you are a W-2 employee of a C.A.R. member, enter the C.A.R. member's name or firm name.

Anthem Waiver Form Section 2

You must complete this section for all eligible family members who are cancelling coverage. By cancelling coverage you are waiving your eligibility for enrollment at this time.

- DO NOT check the boxes for Dental or Vision or Life, <u>only Medical</u>.
- Check a box in the first column to indicate who you are waiving/cancelling/declining coverage for.
- Check a box in the second section to indicate you are cancelling/declining medical coverage.
- Complete the section identifying the reason you're declining coverage.
- Sign and date the bottom of the page.

Step 3 – Complete and Sign Kaiser Enrollment Form

Submit Completed Application

- If enrolling in or changing Automatic Premium Payment Authorization, you must include a voided check

Email to:	**Fax to:**	**Mail To:**
Enrollment@RealCare.biz	**(707) 939-8450**	**430 West Napa Street, Suite F Sonoma, CA 95476**

If you have questions, please contact us at (800) 939-8088

C.A.R. HEALTH & LIFE PLANS TERMINATION REQUEST FORM

This termination form is for use ONLY with C.A.R. health and life plans.
RealCare is not responsible for termination of coverage outside of the C.A.R. group plans.

Date: ____________________ Member ID or Policy #:________________________________

Subscriber Name: ____
Last First M.I.

Address: ____
Street Address

____
City State Zip

Phone Number: ________________________ Email: _____________________________________

Please terminate the following coverage effective: _______________ ***(Terminations must be effective as of the first of the month. Monthly premium payments <u>are not prorated</u> for terminations and retroactive terminations are usually not allowed.)***

☐ C.A.R. Group Kaiser Medical Plan

☐ C.A.R. Group Anthem Blue Cross Medical Plan *(Include completed/signed Anthem "Employee Waiver Form")*

☐ C.A.R. Group Dental Plan - If dental coverage is terminated, you will not be eligible to re-enroll until the next Open Enrollment following a thirteen-month waiting period.

☐ C.A.R. Group Vision Plan - If vision coverage is terminated, you will not be eligible to re-enroll until the next Open Enrollment following a thirteen-month waiting period.

☐ C.A.R. Group Life Insurance

I am terminating coverage because:

☐ I have obtained replacement coverage from another group

☐ I have obtained replacement coverage from an individual/family plan

☐ I have obtained replacement coverage from Covered California

☐ I don't want the coverage

☐ Other – Please Describe: ____

Subscriber Signature: ____ Date: ________________

Fax your completed termination request form to RealCare Billing Department (707) 939-8450
or e-mail to enrollment@realcare.biz

Use this form to terminate Anthem coverage or drop dependents

California Employee Waiver Form For Small Groups

Health care plans offered by Anthem Blue Cross and Insurance plans offered by Anthem Blue Cross Life and Health Insurance Company.

Instructions: Please complete and return to your Group Administrator. You, the employee, must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, please answer all questions and be sure to sign and date your application.

Group/Case no. (if known)

Section 1: Employee Information

Last name	First name	M.I.	Social Security no.[1]
Home address — (P.O. Box not acceptable unless rural address)	City	State	ZIP code
Employment status (required) ☐ Full-time ☐ Part-time	Hire date (required) (MM/DD/YYYY)	Requested effective date	
Employer name	Occupation/job title (required)		

Do you read and write English? ☐ Yes ☐ No If no, the translator must sign and submit a Statement of Accountability/Translator's Statement.

Section 2: Waiver/Declining coverage — Complete only if any coverage is declined or refused by you and/or your eligible dependents. Proof of coverage may be required.

Type of coverage/Declined for: Select all that apply		**Reason for declining/refusing coverage:** Select all that apply
☐ Employee	☐ Medical ☐ ~~Dental~~ ☐ ~~Vision~~	☐ No coverage ☐ Covered by Spouse's/Domestic Partner's group coverage
☐ Spouse/Domestic Partner	☐ Medical ☐ ~~Dental~~ ☐ ~~Vision~~	☐ Spouse/Domestic Partner covered by their employer's group coverage
☐ Dependent(s)	☐ Medical ☐ ~~Dental~~ ☐ ~~Vision~~ List name of dependents to be waived: ____________	☐ Enrolled in individual coverage ☐ Medicare/Medi-Cal/VA ☐ Enrolled in other Insurance — Please provide company name and plan: ____________ ☐ Other — please explain: ____________

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one, including but not limited to my employer or agent, has tried to influence me or put any pressure on me to waive coverage. BY WAIVING THIS GROUP MEDICAL, DENTAL, AND VISION COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL, DENTAL, AND VISION COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT TO BE ENROLLED IN THIS GROUP'S MEDICAL, DENTAL, AND VISION INSURANCE PLAN UNLESS I QUALIFY FOR A SPECIAL OPEN ENROLLMENT. Please note Spouse/Domestic Partner and Dependent coverage will not be available if the Employee has waived/declined.

Special Open Enrollment

If you declined enrollment for yourself or your dependent(s) (including a spouse/domestic partner), you may be able to enroll yourself or your dependent(s) in this health benefit plan or change health benefit plans as a result of certain triggering events, including: (1) you or your dependent loses minimum essential coverage; (2) you gain or become a dependent; (3) you are mandated to be covered as a dependent pursuant to a valid state or federal court order; (4) you have been released from incarceration; (5) your health coverage issuer substantially violated a material provision of the health coverage contract; (6) you gain access to new health benefit plans as a result of a permanent move; (7) you were receiving services from a contracting provider under another health benefit plan, for one of the conditions described in Section 1373.96(c) of the Health and Safety Code and that provider is no longer participating in the health benefit plan; (8) you are a member of the reserve forces of the United States military or a member of the California National Guard, and returning from active duty service; or (9) you demonstrate to the department that you did not enroll in a health benefit plan during the immediately preceding enrollment period because you were misinformed that you were covered under minimum essential coverage. You must request special enrollment within 60 days from the date of the triggering event to be able to enroll yourself or your dependent(s) in this health benefit plan or change health benefit plans as a result of a qualifying triggering event.

Signature of applicant if declining coverage for yourself or dependents X	Date (MM/DD/YYYY) / /

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect this information.

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Get help in your language

Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version:
IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic
مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم1-888-254-2721. (TTY/TTD: 711)

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese
重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi
مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید. (TTY/TTD: 711)

Hindi
महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong
TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese
重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。1-888-254-2721 (TTY/TDD: 711)

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។
អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ
សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오.
(TTY/TDD: 711)

Punjabi
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵਬੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੌਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ।
(TTY/TDD: 711)

Russian
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

MEDICAL APPLICATION

FOR KAISER PERMANENTE HEALTH CARE PLANS

Please print or type in black ink only***. Fields with (*) are mandatory for enrollment.*** Retain a copy of this enrollment form and use as temporary ID after effective date

A. TO BE COMPLETED BY RealCare Insurance Marketing, Inc.
Company: California Association of REALTORS® Purchaser #: ____________________ (EU): ________
Purchaser Contact: **RealCare Insurance Marketing, Inc.** Phone: **(800) 939-8088**

Enrollment Reason - Check Only ONE:

☐ New C.A.R. Member – Join Date:_____________ ☐ Open Enrollment ☐ New W-2 Hire – Hire Date:_____________

☐ Qualifying Event:_______________________ Event Date:________________ ☐ Other: ____________________________

B. PLAN SELECTION

☐ Bronze 60 HMO 5400/60
☐ Bronze 60 HMO 6300/60
☐ Bronze 60 HDHP-HMO 7050/0 (HSA)
☐ Silver 70 HMO 1900/65
☐ Silver 70 HMO 2300/65
☐ Silver 70 HMO 2500/55
☐ Silver 70 HMO 2950/65
☐ Silver 70 HDHP-HMO 2850/25% HSA)
☐ Gold 80 HMO 0/35
☐ Gold 80 HMO 250/35
☐ Gold 80 HMO 1000/40
☐ Gold 80 HDHP-HMO 1750/15% (HSA)
☐ Gold 80 HRA-HMO 2250/35
☐ Platinum 90 HMO 0/10
☐ Platinum 90 HMO 0/20
Platinum 90 HMO 250/30

C. SUBSCRIBER INFORMATION

Requested Effective Date of Coverage: _____/_____/_____ C.A.R. Join Date: _____/_____/_____ Hire Date: (If W2 Employee)_____/_____/_____

Are you now or have you ever been a Kaiser Permanente member? Yes: ☐ No: ☐ Don't Know: ☐

If so, what is/was your Medical Record Number? ______________________ *CA Real Estate License #: ________________________

*Last Name: ______________________________________ *First Name: ____________________________________ M.I.: _____

*Date of Birth: ___________________ *Gender: Male: ☐ Female: ☐ Marital Status: Single: ☐ Married: ☐

*Social Security Number: ___________________________ Email Address: _____________________________________

*Home Address: ____ City: __________________ State: ______ Zip: ___________

*Mailing Address (if different than home): _______________________________ City: __________________ State: ______ Zip: __________

Home Phone: _____________________ Business Phone: _____________________ Cell Phone: ______________________

D. LIST FAMILY MEMBERS TO BE ENROLLED (Attach additional sheets if necessary)

LIST FAMILY MEMBERS TO BE ENROLLED (attach additional sheet, if needed). Dependent children may be covered up to age 26 and may be married and not attending school full-time. A dependent child who has access to other employer-sponsored health coverage is not eligible under this plan.

Relationship	Last Name	First Name	MI	Social Security Number	Date of Birth MM/DD/YY	Gender	Medical Record Number if Known
☐ Spouse ☐ Domestic Partner						M F	
☐ Child ☐ Other						M F	
☐ Child ☐ Other						M F	
☐ Child ☐ Other						M F	

E. Kaiser Foundation Health Plan Arbitration Agreement:

To the best of my knowledge and belief, all information on this form is correct and true.

Kaiser Foundation Health Plan Arbitration Agreement:
I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that can't be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

Employee/Subscriber Signature Required _________________________________ **Date** _____________

____
Print Employer/C.A.R. Member name (if subscriber is W-2 employee)

APPLICATION CHECKLIST

- Remember to **answer** all questions and **sign** the application(s) for the plan(s) you are choosing.
- Enclose initial month's premium payment **(even if you are selecting the Automatic Premium Payment option)**. Include premiums/fees for all applicable insurance plans (medical, dental, vision, and life insurance).

  If you are enrolling with Anthem Blue Cross, you may be required to **send two months of premium with your application.** After your initial payment you will pay a single monthly premium. Please check with your agent, or call RealCare to confirm the minimum payment due with your application.
- Make your check payable to RealCare Insurance Trust Account (R.I.T.A.).
- If you are choosing the Automatic Premium Payment method, enclose check for your first premium payment PLUS **a voided check.** Complete the form below and return to RealCare with your initial premium check**.**
- Include **proof of eligibility** if you are a new C.A.R. member or W-2 employee of a C.A.R. member. If you are enrolling outside of open enrollment, you must have a qualifying event. Please refer to the General Guidelines "Special Enrollment Provision" section to review a list of qualifying events.
- Have questions or need assistance? Call 1-800-939-8088

Submit Completed Application and Initial Payment

Mail To:	Fax to:	Email to:
430 West Napa Street, Suite F Sonoma, CA 95476	(707) 939-8450	Enrollment@RealCare.biz

MONTHLY CHECKING/SAVINGS ACCOUNT AUTOMATIC PREMIUM PAYMENT AUTHORIZATION

As a convenience to me, I request and authorize RealCare Insurance Marketing, Inc. to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my C.A.R health care dues and/or insurance premiums, adjustments and administration fees due. I agree that your rights in respect to each such debit shall be the same as if it were a check signed by an authorized signer on the bank account. This authority is to remain in effect until revoked by me by providing RealCare Insurance Marketing, Inc. a 10-day advance written notice. I agree that RealCare shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, RealCare Insurance Marketing, Inc. shall be under no liability whatsoever even though such dishonor results in forfeiture of health care or insurance coverage.

If I am enrolled in an Anthem Blue Cross plan, payments will be debited from my account on the first of the month prior to the month of coverage. If I am enrolled in a Kaiser plan or only enrolled in a dental, vision, and/or life insurance plan, payments will be debited from my account on the first of the month of coverage. If any such debits are dishonored, I agree to make payment to RealCare Insurance Trust Account (RITA) by cashier's check or money order before the end of the 30-day grace period in order to keep my health care and/or insurance coverage in force. I authorize any changes in premium and administration fees to be debited unless I notify RealCare Insurance Marketing, Inc. to terminate my health care and/or insurance coverage.

C.A.R. Health & Life Insurance Plans Account Information

C.A.R. Member/Employee Name: ____

Phone: ___________________________ Email Address: _______________________________

Banking Information

Name of Bank or Financial Institution: ____________________________________

Name on Bank Account: ____

Bank Routing Number: _________________________________ ☐Checking Account

Account Number: ____________________________________ ☐Savings Account

Authorized Signature

____ Date:_____________________

Signature of Authorized Signer on Above Bank Account

(As it appears in the financial institution's records)

PLEASE ATTACH A COPY OF YOUR VOIDED CHECK AND SUBMIT WITH YOUR ENROLLMENT APPLICATION.

Note: The $5.00 Electronic Check Fee normally charged for payments submitted via fax or email is *waived* for the initial payment.

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.

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.

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