Introduction to the MediExcel Health Plan Group Subscriber Agreement

MediExcel Health Plan is a cross-border HMO Plan that is made available to California Employers under a special provision of the Knox-Keene Health Care Service Act. All covered benefit services with the exception of emergency and urgent care will be provided by MediExcel Health Plan in Mexico to Group Employees and their Dependents as Plan Members in accordance with the terms, conditions, limitations and exclusions of this Group Health Service Contract.

Mexican Health Care Standards

Legal requirements for and generally accepted practice standards of medical care in Mexico are different than those of California or elsewhere in the United States. Therefore, the care to be received through providers in Mexico in the MediExcel Health Plan will be care that is consistent with generally accepted medical standards of Mexico, not of California. MediExcel Health Plan contracts only with providers who meet all applicable laws, licensing requirements and professional standards of Mexico and who provide their services in accordance with the generally accepted standards of the organized medical community relating to professional and hospital services in Mexico. Members obtaining Hospice Care Benefits in Mexico may receive different types of services than they would obtain in California. Any Member who is not completely comfortable with the standards of care for the practice of medicine in Mexico should not enroll in the MediExcel Health Plan.

This Health Plan may be limited in benefits, rights and remedies under U.S. Federal and State Law.

Este plan de salud puede tener limitaciones en sus beneficios, derechos y resoluciones bajo las leyes federales estatales de los Estados Unidos.

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MediExcel Health Plan
Group Subscriber Agreement

This **Group Subscriber Agreement** is entered into by and between Medi-Excel, SA de CV ("**MediExcel Health Plan**" or "**Plan**") and the **Group Contract Holder** specified in the attached Execution Sheet. This **Group Subscriber Agreement** shall be effective on the **Effective Date** specified in the Execution Page and shall continue in force until terminated as provided herein.

In consideration of the mutual promises hereunder and the payment of **Premiums** and fees when due, **MediExcel Health Plan** will provide coverage for benefits in accordance with the terms, conditions, limitations and exclusions set forth in this **Group Subscriber Agreement**.

Upon acceptance of **Group Contract Holder's** Group Subscriber Application, and upon receipt of the required initial **Premium,** this **Group Subscriber Agreement** shall be considered to be agreed to by **Group Contract Holder** and **MediExcel Health Plan.**

SECTION 1. DEFINITIONS

1.1 **"Administration Fee"** is defined in Section 3.7.

1.2 The terms **"Effective Date", "Initial Term", "Premium Due Date"** and **"Subsequent Terms"** will have the meaning set forth in the attached Execution Sheet.

1.3 **"Eligible Employee"** means the following:

- Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of an average of 30 hours per week over the course of a month, at the small employer's regular places of business, who has met any statutorily authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the small employer's business and included as employees under a health care service plan contract of a small employer, but does not include employees who work on a part-time, temporary, or substitute basis. It includes any eligible employee, as defined in this paragraph, who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association shall be deemed to be eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer.

- Permanent employees who work at least 20 hours but not more than 29 hours are deemed to be eligible employees if all four of the following apply:

  - They otherwise meet the definition of an eligible employee except for the number of hours worked.

  - The employer offers the employees health coverage under a health benefit plan.

  - All similarly situated individuals are offered coverage under the health benefit plan.

  - The employee must have worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. The health care service plan may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.

- In both cases above, the individual must be a Mexican National with the Employer's business located in San Diego County or Imperial County.

1.4 **"Employer (Group Contract Holder)"** means any person, firm, proprietary or non-profit corporation, partnership, public agency or association that has employees and that is actively engaged in business or service, in which a bona fide employer-employee relationship exists, in which the majority of employees are employed within the State of California, and which was not formed primarily for purposes of buying health care coverage or insurance. There are two sub-classifications of employers, small employers and large employers, which are based on the group size.

- **"Small Employer"** (or **Small Group Employer**) means the following:

  For plan years commencing on or after January 1, 2016, any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 100, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, MediExcel Health Plan shall use the test that ensures eligibility if only one test would establish eligibility. In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health care service plan contract to a small employer pursuant to this article, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. The provisions of this article that apply to a small employer shall continue to apply until the plan contract anniversary following the date the employer no longer meets the requirements of this definition.

- **"Large Employer"** (or **"Large Group Employer"**) means employers that exceed the employee size of **Small Employer**:

1.5 **"EOC"** means the Combined Evidence of Coverage and Disclosure Form issued pursuant to this **Group Subscriber Agreement**. There are separate EOCs for the Medical Plan, the Dental Plan and the Vision Plan. The EOC(s) of the selected coverage(s) will be included in the **Group Subscriber Agreement**.

1.6 **"Grace Period"** means the period of at least 30 consecutive days beginning the day the Notice of Start of Grace Period is dated. The grace period may not begin sooner than the day after the last date of paid coverage.

1.7 "**Group Subscriber Agreement"** or **"Plan Contract"** means this document, this initial application, the attached Cover Sheet; the applicable **EOC** (medical, dental and/or vision)**,** the applicable Schedule of Benefits and any amendments, inserts or attachments issued by **MediExcel Health Plan**.

1.8 **"Mexican National"** means either an individual with a birthplace in Mexico, an individual with Mexican heritage from either parent, an individual who is naturalized in Mexico, or lastly, an individual married to a Mexican National.

1.9 **"Other Party"** means in the case of a group contract, the group representative designated in the contract; and in the case of an individual contract, the subscriber.

1.10 **"Premium(s)"** is defined in Section 3.1.

1.11 **"Premium Period"** is defined in Section 3.1.

1.12 **"Renewal Date"** means the first day following the end of the **Initial Term** or any **Subsequent Term**.

1.13 "**Associated Health Plan**" means another health plan that is available under the employer-sponsored health benefit program (such as Aetna, Anthem, Blue Shield, CIGNA, Health Net, Kaiser, Sharp Health Plan, etc.).

1.14 **"Duplicative Coverage"** means the Employee having employer-sponsored health coverage in MEHP and also in an Associated Health Plan at the same time.

1.15 **"Premium Credit"** means an offset of premium corresponding to the premium amount for coverage at the Employee Only Tier Level.

1.16 **"Notice of Start of Grace Period"** means the notice sent by MediExcel Health Plan to the Group Contract Holder that the plan contract will be terminated unless the premium amount due is received by the Plan no later than the last day of the Grace Period.

1.17 **"Nonpayment of Premiums''** means failure of the Group Contract Holder to pay any premium, or portion of premium, by the due date after having been billed for the charge.

1.18 **"Notice of Cancellation, Rescission or Nonrenewal"** means notice sent by MediExcel Health Plan to the enrollee, subscriber, or Group Contract Holder that the plan contract will be cancelled, rescinded or not renewed for any reason other than nonpayment of premiums.

1.19 **"Notice of End of Coverage"** means the notice sent to the enrollee, subscriber, or Group Contract Holder notifying the recipient that the enrollee's coverage has been cancelled.

1.20 **"Notice of Start of Grace Period"** means the notice sent by MediExcel Health Plan to the enrollee, subscriber, or Group Contract Holder that the plan contract will be terminated unless the premium amount due is received by MediExcel Health Plan no later than the last day of the Grace Period.

1.21 **"Rescission" or "Rescind"** means the retroactive cancellation of coverage.

1.22 **"Cancelled," "Not Renewed" or "Nonrenewal"** means termination of coverage initiated by MediExcel Health Plan during or at the conclusion of the contract term, but does not include: (A) Voluntary termination at the request of the employee; (B) Termination for failure to satisfy any regulatory eligibility requirements; (C) Exhaustion of any time-limited coverage such as COBRA or CalCOBRA; and (D) Prospective termination for failure to satisfy eligibility requirements under this Contract, such as Time-based employment requirements, Attainment of limiting age by dependent child; Group participation requirements; or Service-area requirements.

1.23 **"Billed for the Charge"** means the Group Contract Holder was sent a bill that provides, at a minimum, an accurate itemization of the premium amount(s) due, the due date(s), and the period(s) of time covered.

1.24 **"Summary of Benefits and Coverage (SBC)"** means the form template that details the coverage benefits and associated Member share of costs (Copayments and Coinsurance), deductibles, out-of-pocket maximums, limitations and exclusions for the given plan design.

1.25 **"Subscriber"** means the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan. The Subscriber may also be known as a Member or an Enrollee of the **MediExcel Health Plan** for coverage in its health benefit plan.

1.26 **"Dependent"** means the spouse or registered domestic partner, or child, of an eligible employee, subject to applicable terms of the **MediExcel Health Plan** contract covering the employee, The Dependent may also be known as a Member or an Enrollee of the **MediExcel Health Plan** for coverage in its health benefit plan.

SECTION 2. COVERAGE

2.1 **Benefits.** See the **EOC** and the **Summary of Benefits**. **MediExcel Health Plan** will provide medical, dental and/or vision coverage for **Covered Benefits** to **Members** subject to the terms and conditions of this **Group Subscriber Agreement**. **Members** covered under this **Group Subscriber Agreement** are subject to all its conditions and provisions.

SECTION 3. PREMIUMS

3.1 **Premiums.** **Group Contract Holder** shall pay **MediExcel Health Plan** on or before each **Premium Due Date** a monthly premium (the **"Premium**") as indicated in the Monthly Premium Page of this **Group Subscriber Agreement.** The **Premium Period** is a full calendar month (for example, June 1-30 or July 1-31), starting from 12:00 midnight on the 1st calendar day through 11:59 pm on the last calendar day of the month. **Premium** rates and the manner of calculating **Premiums** may be adjusted in accordance with Section 3.4 below. Membership as of each **Premium Due Date** will be determined by **MediExcel Health Plan**.

3.2 **Past Due Premiums.** If a **Premium** payment is not paid in full by the **Group Contract Holder** on or before the **Premium Due Date**, a late payment charge of 1% of the total amount due per month (or partial month) will be added to the amount due. If all **Premiums** are not received before the end of a 30-day grace period (the "**Grace Period"),** this **Group Subscriber Agreement** will be automatically terminated pursuant to Section 6.3 hereof.

If the **Group Subscriber Agreement** terminates for any reason, the **Group Contract Holder** will continue to be held liable for all **Premiums** due and unpaid before the termination of coverage**. Members** shall also remain liable for **Member** cost sharing and other required contributions to coverage for any period of time the **Group Subscriber Agreement** is in force during the **Grace Period. MediExcel Health Plan** may recover from **Group Contract Holder**

the costs of collecting any unpaid **Premiums**.

3.3 **Prorations.** **Premiums** shall be paid in full for **Members** whose coverage is in effect on the **Premium Due Date** or whose coverage terminates on the last day of the **Premium** period.

3.4 **Changes in Premium.** **MediExcel Health Plan** may also adjust the **Premium** rates and/or the manner of calculating **Premiums** effective as of the contract renewal date, upon 60 days prior written notice to **Group Contract Holder**. Small employers' **Premium** rates will remain in effect for no less than 12 months, for the **Initial Term** and **Subsequent Terms**. For small employers only, the Employee's Premium rates and the Dependent's Premium rates are based on their age as of their coverage renewal date begins. These small group rates may adjust on the renewal date. See Page GSA-iii for current medical coverage rates, if applicable.

3.5 **Membership Adjustments.** **MediExcel Health Plan** may make retroactive adjustments to the **Group Contract Holder's** billings for the termination of **Members** not posted to previous billings. However, **Group Contract Holder** may only receive a maximum of 2 calendar month's credit for **Member** terminations that occurred more than 30 days before the date **Group Contract Holder** notified **MediExcel Health Plan** of the termination. **MediExcel Health Plan** may reduce any such credits by the amount of any payments made on behalf of such **Members** (including capitation payments and other claim payments) before **MediExcel Health Plan** was informed their coverage had been terminated. Retroactive additions will be made based upon eligibility guidelines, as set forth in the **EOC**, and are subject to the payment of all applicable **Premiums**.

3.6 **Return of Premium Pro Rata.** In the event of cancellation by either **MediExcel Health Plan** or the **Group Contract Holder**, **MediExcel Health Plan** shall within 30 days return the pro rata portion of the money paid which corresponds to any unexpired period for which premium had been received together with amounts due on claims, if any, less any amounts due.

3.7 **Administration Fee.** **MediExcel Health Plan** shall impose a monthly administration fee $10.00 per month upon the **Group Contract Holder** when there are three (3) enrolled employees or less (excluding any enrollees enrolled in COBRA or Cal-COBRA) in the **MediExcel Health Plan**. When there are four (4) or more enrolled employees (excluding any enrollees in COBRA or Cal-COBRA) in the **MediExcel Health Plan**, the monthly administration fee will be $0 per month. The **Group Contract Holder** is solely responsible for the cost and payment of the monthly administration fee. Enrolled employees will not share in the cost of the monthly administration fee. If applicable, the monthly administration fee will be billed at the same time as the monthly premium is billed. If applicable, the **Group Contractor Holder** will make payment of the billed monthly administration fee at the same time as payment is made for the billed monthly premium.

SECTION 4. ENROLLMENT

4.1 **Open Enrollment.** As described in the **EOC, Group Contract Holder** will offer enrollment in **MediExcel Health Plan** at least once during every twelve month period during the **Open Enrollment Period**; and within 31 days from the date the individual and any dependent becomes eligible for coverage. Eligible individuals and dependents who are not enrolled within the **Open Enrollment Period** or 31 days of becoming eligible, may be enrolled during any subsequent **Open Enrollment Period**. Coverage will not become effective until confirmed by **MediExcel Health Plan**. The **Group Contract Holder** shall permit **MediExcel Health Plan** representatives to meet with eligible individuals during the **Open Enrollment Period** unless the parties agree upon an alternate enrollment procedure. Other enrollment periods may apply as described in the **EOC**.

4.2 **Eligibility.** The **Group Contract Holder** shall not, during the term of this **Group Subscriber Agreement**, modify the **Open Enrollment Period**, the waiting period as described on the **Schedule of Benefits**, or any other eligibility requirements as described in the **EOC** and on the **Schedule of Benefits**, for the purposes of enrolling **Group Contract Holder's** eligible individuals and dependents under this **Group Subscriber Agreement**, unless **MediExcel Health Plan** agrees.

4.3 **Advance Notification of MediExcel Health Plan's Intent to Renew the Group Subscriber Agreement.** The **Group Contract Holder** shall be notified by **MediExcel Health Plan** of its intent to renew this **Group Subscriber Agreement** at least 90 days prior to the proposed effective date of the renewal.

SECTION 5. RESPONSIBILITIES OF THE GROUP CONTRACT HOLDER

In addition to other obligations set forth in this **Group Subscriber Agreement**, **Group Contract Holder** agrees to:

5.1 **Records**. Furnish to **MediExcel Health Plan** on a monthly basis such information to administer this **Group Subscriber Agreement**. This includes, but is not limited to, information needed to enroll members of the **Group Contract Holder**, process terminations, and effect changes in family status and transfer of employment of **Members**.

Group Contract Holder represents that all enrollment and eligibility information that has been or will be supplied to **MediExcel Health Plan** is accurate. **Group Contract Holder** acknowledges that **MediExcel Health Plan** can and will rely on such enrollment and eligibility information in determining whether an individual is eligible for **Covered Benefits** under this **Group Subscriber Agreement**.

MediExcel Health Plan will not be liable to **Members** for the fulfillment of any obligation prior to information being received in a form satisfactory to **MediExcel Health Plan**. The **Group Contract Holder** must notify **MediExcel Health Plan** of the date in which a **Subscriber's** employment ceases for the purpose of termination of coverage under this **Group Subscriber Agreement**. Subject to applicable law, unless otherwise specifically agreed to in writing, **MediExcel Health Plan** will consider **Subscriber's** employment to continue until the earlier of:

- Stopped by the **Group Contract Holder**;
- Stopped working due to temporary layoff or leave of absence of Subscriber, not beyond the end of the policy month after the policy month in which the absence started; and
- Stopped working due to Subscriber disability, not beyond the end of the 30th policy month after the month in which the absence started.

5.2 **Availability**. Provide employer payroll and other records directly related to **Member's** coverage under this **Group Subscriber Agreement** to **MediExcel Health Plan in** an electronic format (PDF) within seven (7) days of advance request. This provision shall survive termination of this **Group Subscriber Agreement**.

5.3 **Forms.** Distribute materials to **Members** regarding enrollment, health plan features, including **Covered Benefits** and exclusions and limitations of coverage. **Group Contract Holder** shall, within 31 days of receipt from an eligible individual, forward all completed enrollment information and other required information to **MediExcel Health Plan**.

5.4 **Policies and Procedures; Compliance Verification.** Comply with all policies and procedures established by **MediExcel Health Plan** in administering and interpreting this **Group Subscriber Agreement**. **Group Contract Holder** shall, upon request, provide a certification of its compliance with **MediExcel Health Plan** participation and contribution requirements and the requirements for a group as defined under applicable law or regulation.

5.5 **Not Used.**

5.6 **Group Contract Holder Obligations Under COBRA.** Under federal law, an employer who employs twenty (20) or more employees on a typical business day during the prior calendar year must provide **Members** with the opportunity to elect COBRA continuation coverage in certain circumstances where coverage would otherwise terminate. Such **Group Contract Holders** and their group health plan's administrators (in certain cases, the employer may be the plan administrator) have the obligation to: (1) provide **Members** with notice of the opportunity to elect continuation coverage; and (2) administer the continuation coverage. The obligation to provide notice includes both general notification to **Members** of their right to elect continuation of coverage and specific notification of the right to continuation of coverage within a specific time period after the occurrence of the event which triggers the continuation of coverage option.

Group Contract Holder hereby acknowledges its legal obligations and agrees to abide by applicable legal requirements with respect to COBRA continuation coverage. **Group Contract Holder** also agrees to forward to **MediExcel Health Plan** in a timely manner copies of any and all notices provided to **Members** regarding COBRA continuation coverage.

Group Contract Holder Obligations Under Cal-COBRA. Under California law, a health care service plan that

contracts with employers who employ two (2) through nineteen (19) eligible employees on a typical business day during the prior calendar year is required to provide **Members** with the opportunity to elect Cal-COBRA continuation coverage in certain circumstances where coverage would otherwise terminate. **MediExcel Health Plan** will administer or contract for the administration of continuation coverage under Cal-COBRA. Nonetheless, Group Contract Holder must provide certain notices to **MediExcel Health Plan** and to **Members** as described below. **Group Contract Holder** must notify **MediExcel Health Plan** in writing of any employee who has a qualifying event defined in the Continuation and Conversion section, Item 2 – Cal-COBRA Continuation Coverage of the **EOC** within thirty (30) days of the qualifying event. Such notice must be separate from other communications from **Group Contract Holder** and must specifically reference Cal-COBRA. Notations of additions and/or deletions on monthly invoices will not constitute sufficient notice. **Group Contract Holder** must further provide written notice to **MediExcel Health Plan** within thirty (30) days of the date the **Group Contract Holder** becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.

Group Contract Holder must also notify qualified beneficiaries of the ability to continue coverage prior to terminating a Group Subscriber Agreement (such as this **Group Subscriber Agreement**) under which a qualified beneficiary is receiving continuation coverage. This notification shall be provided either thirty (30) days prior to the agreement termination or when all other enrolled employees are notified, whichever is greater. **Group Contract Holder** must notify any successor plan in writing of the qualified beneficiaries currently receiving continuation coverage to enable the successor plan, contracting employer, or administrator to provide such qualified beneficiaries with the premium information, enrollment forms, and disclosures necessary to allow the qualified beneficiaries to continue coverage under other available group plans.

If **Group Contract Holder** fails to meet these obligations, **MediExcel Health Plan** will not provide continuation coverage to qualified beneficiaries under Cal-COBRA. **Group Contract Holder** hereby acknowledges its obligations and agrees to comply with all applicable legal requirements with respect to Cal-COBRA continuation coverage. **Group Contract Holder** also agrees to forward to **MediExcel Health Plan** in a timely manner copies of any notice provided to **Members** regarding Cal-COBRA continuation coverage.

5.7 **ERISA Requirements.** Maintain responsibility for making reports and disclosures required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), including the creation, distribution and final content of summary plan descriptions, summary of material modifications and summary annual reports.

5.8 **Distribution of Summary of Benefits and Coverage (SBC).** An SBC will be issued by **MediExcel Health Plan** to the **Group Contract Holder** for all eligible Employees and Dependents. The **Group Contract Holder** is solely responsible for the timely distribution of a complete SBC for each benefit plan offered. The **Group Contract Holder** will distribute the SBCs free of charge to **Members** and prospective Members as required by applicable federal law and regulations. If the **Group Contract Holder** does not distribute paper SBCs, then the **Group Contract Holder** will ensure that any alternative or electronic distribution method used complies with applicable federal requirements. In the event that the **Group Contract Holder** fails to distribute SBCs to **Members** or prospective Members as required herein, **MediExcel Health Plan** will, after notice to the **Group Contract Holder**, distribute SBCs as necessary to comply with applicable federal statutes and regulations.

5.9 **Distribution of Member ID Cards**. Member identification cards will be issued by **MediExcel Health Plan** for all **Members** and will either be sent to the **Group Contract Holder** for distribution to the **Members**, or sent directly to the **Members**, depending on the **Group Contract Holder's** instructions.

5.10 **Distribution EOCs**. An EOC which summarizes the Benefits of this Contract and how to obtain Covered Services will be issued by **MediExcel Health Plan** for all Subscribers. **MediExcel Health Plan** will send the EOC to the **Group Contract Holder**, and the **Group Contract Holder** is responsible for distributing the EOC to all enrollees (both Subscribers and Dependents) whether in printed, hardcopy or electronic form. EOCs will be provided to the **Group Contract Holder** in electronic form or in paper hard copy form. If **Group Contract Holder** receives the EOC in electronic form, **Group Contract Holder** is not authorized to modify or alter in any way the text or the formatting of the electronic EOC file. **Group Contract Holder** may ensure electronic distribution of the EOC to Subscribers by one of the following methods: (1) by posting the EOC in a read-only format on an intranet site which is accessed by Employees of **Group Contract Holder**; (2) by emailing the EOC directly to Subscribers; or (3) by providing Subscribers with **MediExcel Health Plan**'s instructions for accessing the EOC from the **MediExcel Health Plan** website.

If **Group Contract Holder** posts the electronic EOC on its intranet site, it shall do so in such a way so as to permit

Employees as well as their dependents (all enrollees) of **Group Contract Holder** to download and print a complete and accurate copy of the EOC. **Group Contract Holder** will notify Employees enrolled with **MediExcel Health Plan** that the EOC for their plan is available to review, download and print from **Group Contract Holder** 's intranet site, and will provide Subscribers with reasonable and appropriate instructions by which to access and print the document from its intranet site. **Group Contract Holder** will provide a hard copy of the EOC to an Employee upon request.

SECTION 6. TERMINATION

6.1 **Termination by Group Contract Holder**. This **Group Subscriber Agreement** may be terminated by **Group Contract Holder** as of any **Premium Due Date** by providing **MediExcel Health Plan** with 30 days prior written notice. However, **MediExcel Health Plan** may accept an oral indication by **Group Contract Holder** or its agent or broker of intent to terminate.

6.2 **Non-Renewal by Group Contract Holder.** **MediExcel Health Plan** may request from **Group Contract Holder** a written indication of their intention to renew or non-renewal this **Group Subscriber Agreement** at any time during the final three months of any **Term**. **MediExcel Health Plan** may accept an oral indication from the **Group Contract Holder** or its agent or broker of the **Group Contract Holder's** intent of non-renewal. In such cases, MediExcel Health Plan will provide written confirmation to the **Group Contract Holder** which shall serve as the **Group Contract Holder's** notice of termination effective as of the end of the **Term**.

6.3 **Termination by MediExcel Health Plan.** This **Group Subscriber Agreement** will terminate as of the last day of the **Grace Period** if the **Premium** remains unpaid at the end of the **Grace Period**.

This **Group Subscriber Agreement** may also be terminated by **MediExcel Health Plan** as follows:

- Immediately upon notice to **Group Contract Holder** if **Group Contract Holder** has performed any act or practice that constitutes fraud or made any intentional misrepresentation of a material fact relevant to the coverage provided under this **Group Subscriber Agreement**;

- Immediately upon notice to **Group Contract Holder** if **Group Contract Holder** no longer has any enrollee under the Plan who works in **the County of San Diego or the County of Imperial**;

- Immediately upon notice to **Group Contract Holder** if **Group Contract Holder** no longer has any active enrollees under the Plan;

- Upon 30 days written notice to **Group Contract Holder** if **Group Contract Holder** (i) breaches a provision of this **Group Subscriber Agreement** and such breach remains uncured at the end of the notice period; (ii) ceases to meet **MediExcel Health Plan** requirements for an employer group or association; (iii) fails to meet **MediExcel Health Plan** contribution or participation requirements applicable to this **Group Subscriber Agreement** (which contribution and participation requirements are available upon request); (iv) fails to provide the certification required by Section 5.4 within a reasonable period of time specified by **MediExcel Health Plan**; or (v) changes its eligibility or participation requirements without **MediExcel Health Plan's** consent;

- Upon 30 days written notice to **Group Contract Holder** for any other reason which is acceptable to the Department of Managed Health Care and consistent with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or by applicable federal rules and regulations, as amended.

6.4 **Effect of Termination**. No termination of this **Group Subscriber Agreement** will relieve either party from any obligation incurred before the date of termination. When terminated, this **Group Subscriber Agreement** and all coverage provided hereunder will end at 12:00 midnight on the effective date of termination. **We** may charge the **Group Contract Holder** a reinstatement fee if coverage is terminated and subsequently reinstated under this **Group Agreement**. Upon termination, **we** will provide **Members** with Certificates of Creditable Coverage which will show evidence of a **Member's** prior health coverage with **MediExcel Health Plan** for a period of up to 18 months prior to the loss of coverage.

6.5 **Notice to Subscribers and Members**. It is the responsibility of **Group Contract Holder** to notify the **Members** of the termination of the **Group Subscriber Agreement** in compliance with all applicable laws. In the event we

provide notice of cancellation for non-payment of premium to **Group Contract Holder**, **Group Contract Holder** agrees to promptly mail a legible, true copy of the notice of cancellation to all **Subscribers** at their current address. The notice of cancellation to **Group Contract Holder** will include:

- the date and time coverage will terminate
- the cause for cancellation, including reference to the applicable clause in the **Group Subscriber Agreement**
- a statement that the cause for cancellation was not due to the **Member's** health status or requirements for health care services
- that a **Member** who alleges that cancellation was due to the **Member's** health status may request a review of cancellation by the Department of Managed Health Care
- information regarding the **Member's** COBRA and Cal-COBRA coverage.

Such notice must be mailed to **Subscribers** so it is received at least **30** days prior to the date of termination. If the **Group Contract Holder** fails to deliver the above-referenced notice of cancellation and deliver proof of mailing to **MediExcel Health Plan**, **MediExcel Health Plan** will mail notice directly to the individual **Subscribers:** coverage will not end until the 30th day after **MediExcel Health Plan** mails the notice. The **Group Contract Holder** is required to reimburse **MediExcel Health Plan** for the costs of such mailing and for all premiums accrued do to the non-performance of this contractual obligation.

However, **MediExcel Health Plan** reserves the right to notify **Members** of termination of the **Group Subscriber Agreement** for any reason, including non-payment of **Premium**.

6.6 **Reinstatement**. Upon receipt by **MediExcel Health Plan** of the proper premium after cancellation of the contract for nonpayment, **MediExcel Health Plan** shall reinstate the contract as though it had never been cancelled if such payment is received on or before the due date of the succeeding premium. All past balances must be paid before reinstatement and will only reinstate once in 12 months.

6.7 **Termination of a Provider Contract**. Upon termination of a provider contract, **MediExcel Health Plan** shall be liable for covered services rendered by such provider (other than for co-payments and co-insurance) to a subscriber or enrollee who retains eligibility or by operation of law under the care of such provider at the time of such termination until the services being rendered to the subscriber or enrollee by such provider are completed, unless the plan makes reasonable and medically appropriate provision for the assumption of such services by a contracting provider.

SECTION 7. PRIVACY OF INFORMATION

7.1 **Compliance with Privacy Laws.** **MediExcel Health Plan** and **Group Contract Holder** will abide by all applicable laws and regulations regarding confidentiality of individually identifiable health and other personal information, including the privacy requirements of HIPAA.

7.2 **Disclosure of Protected Health Information.** **We** will not provide protected health information ("PHI"), as defined in HIPAA, to **Group Contract Holder**, and **Group Contract Holder** will not request PHI from **MediExcel Health Plan**, unless **Group Contract Holder** has either:

- provided the certification required by 45 C.F.R. § 164.504(f) and amended **Group Contract Holder**'s plan documents to incorporate the necessary changes required by such rule; or

- provided confirmation that the PHI will not be disclosed to the "plan sponsor", as such term is defined in 45 C.F.R. § 164.501.

7.3 **Brokers and Consultants.** To the extent any broker or consultant receives PHI in the underwriting process or while advocating on behalf of a **Member**, **Group Contract Holder** understands and agrees that such broker or consultant is acting on behalf of **Group Contract Holder** and not **MediExcel Health Plan**. **MediExcel Health Plan** is entitled to rely on **Group Contract Holder's** representations that any such broker or consultant is authorized to act on **Group Contract Holder's** behalf and entitled to have access to the PHI under the relevant circumstances.

SECTION 8. INDEPENDENT CONTRACTOR RELATIONSHIPS

8.1 **Relationship Between MediExcel Health Plan and Participating Providers**. The relationship between

MediExcel Health Plan and **Participating Providers** is a contractual relationship among independent contractors. **Participating Providers** are not agents or employees of **MediExcel Health Plan. MediExcel Health Plan** is not agent or employee of any **Participating Provider**.

Participating Providers are solely responsible for any health services rendered to their **Member** patients. A **Provider's** participation may be terminated at any time without advance notice to the **Group Contract Holder** or **Members**, subject to applicable law. **Participating Providers** provide health care diagnosis, treatment and services for **Members**. **MediExcel Health Plan** administers and determines plan benefits.

8.2 **Relationship Between the Parties**. The relationship between the **Parties** is a contractual relationship between independent contractors. Neither **Party** is an agent or employee of the other in performing its obligations pursuant to this **Group Subscriber Agreement**.

SECTION 9. MISCELLANEOUS

9.1 **Prior Agreements; Severability**. As of the **Effective Date**, this **Group Subscriber Agreement** replaces and supersedes all other prior agreements between the **Parties** as well as any other prior written or oral understandings, negotiations, discussions or arrangements between the **Parties** related to matters covered by this **Group Subscriber Agreement** or the documents incorporated herein. If any provision of this **Group Subscriber Agreement** is deemed to be invalid or illegal, that provision shall be fully severable and the remaining provisions of this **Group Subscriber Agreement** shall continue in full force and effect.

9.2 **Amendments.** This **Group Subscriber Agreement** may be amended as follows:

- This **Group Subscriber Agreement** shall be deemed to be automatically amended to conform with all rules and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over **MediExcel Health Plan**;
- By written agreement between both **Parties**; or
- By **MediExcel Health Plan** upon 30 days written notice to **Group Contract Holder**.

The **Parties** agree that an amendment does not require the consent of any employee, **Member** or other person. Except for automatic amendments to comply with law, all amendments to this **Group Subscriber Agreement** must be approved and executed by **MediExcel Health Plan**. No other individual has the authority to modify this **Group Subscriber Agreement**; waive any of its provisions, conditions, or restrictions; extend the time for making a payment; or bind **MediExcel Health Plan** by making any other commitment or representation or by giving or receiving any information.

9.3 **Claim Determinations. MediExcel Health Plan** has complete authority to review all claims for **Covered Benefits** under this **Group Subscriber Agreement**. In exercising such responsibility, **MediExcel Health Plan** shall have discretionary authority to determine whether and to what extent eligible individuals and beneficiaries are entitled to coverage, and to construe any disputed or doubtful terms under this **Group Subscriber Agreement,** the **EOC** or any other document incorporated herein. **MediExcel Health Plan** shall be deemed to have properly exercised such authority unless **MediExcel Health Plan** abuses its discretion by acting arbitrarily and capriciously.

9.4 **Misstatements.** If any fact as to the **Group Contract Holder** or a **Member** is found to have been misstated, an equitable adjustment of **Premiums** may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

9.5 **Incontestability.** Except as to a fraudulent misstatement, or issues concerning **Premiums** due:

- No statement made by **Group Contract Holder** or any **Member** shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.
- No statement made by **Group Contract Holder** shall be the basis for voiding this **Group Subscriber Agreement** after it has been in force for two years from its effective date.

9.6 **Assignability.** No rights or benefits under this **Group Subscriber Agreement** are assignable by **Group Contract Holder** to any other party unless approved by **MediExcel Health Plan**.

9.7 **Waiver. Our** failure to implement, or insist upon compliance with, any provision of this **Group Subscriber Agreement** or the terms of the **EOC** incorporated hereunder, at any given time or times, shall not constitute a waiver of **MediExcel Health Plan's** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of **Premiums** or benefits.

9.8 **Notices.** Any notice required or permitted under this **Group Subscriber Agreement** shall be in writing and shall be deemed to have been given on the date when delivered in person; or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the address set forth in the Group Application or Execution Page, or to any more recent address of which the sending party has received written notice or, if delivered by facsimile or other electronic means, on the date sent by facsimile or other electronic means.

9.9 **Third Parties.** This **Group Subscriber Agreement** shall not confer any rights or obligations on third parties except as specifically provided herein.

9.10 **Non-Discrimination. Group Contract Holder** agrees to make no attempt, whether through differential contributions or otherwise, to encourage or discourage enrollment in **MediExcel Health Plan** of eligible individuals and eligible **Dependents** based on health status or health risk. In accordance with §1365.5 of the Knox-Keene Health Care Service Plan Act, **MediExcel Health Plan** shall not refuse to enter into this Agreement or shall cancel or decline to renew or reinstate this Agreement because of the race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age of any contracting party, prospective contracting party, or person reasonably expected to benefit from this contract as a subscriber, enrollee, member, or otherwise. Nor shall **MediExcel Health Plan** refuse to cover, or refuse to continue to cover, or limit the amount, extent or kind of coverage available to an individual, or charge a different rate for the same coverage solely because of a physical or mental impairment.

9.11 **Applicable Law.** This **Group Subscriber Agreement** shall be governed and construed in accordance with applicable federal law and the law of the State of California.

9.12 **Dispute Resolution.** Any controversy, dispute or claim between **MediExcel Health Plan** and one or more **Interested Parties** arising out of or relating to the **Group Subscriber Agreement**, whether stated in tort, contract, statute, claim for benefits, bad faith, professional liability or otherwise ("Claim"), shall be settled by confidential binding arbitration administered by the American Arbitration Association ("AAA") before a sole arbitrator ("Arbitrator"). Judgment on the award rendered by the Arbitrator ("Award") may be entered by any court having jurisdiction thereof. If the AAA declines to administer the case and the parties do not agree on an alternative administrator, a sole neutral arbitrator shall be appointed upon petition to a court having jurisdiction. **MediExcel Health Plan** and **Interested Parties** hereby give up our rights to have Claims decided in a court before a jury.

Any Claim alleging wrongful acts or omissions of **Participating** or **Non-Participating Providers** shall not include **MediExcel Health Plan**. A **Member** must exhaust all grievance, appeal and independent external review procedures prior to the commencement of an arbitration hereunder. No person may recover any damages arising out of or related to the failure to approve or provide any benefit or coverage beyond payment of or coverage for the benefit or coverage where (i) **MediExcel Health Plan** has made available independent external review and (ii) **MediExcel Health Plan** has followed the reviewer's decision. Punitive damages may not be recovered as part of a Claim under any circumstances. No **Interested Party** may participate in a representative capacity or as a member of any class in any proceeding arising out of or related to the **Group Subscriber Agreement**. This agreement to arbitrate shall be specifically enforced even if a party to the arbitration is also a party to another proceeding with a third party arising out of the same matter.

9.13 **Workers' Compensation. Group Contract Holder** is responsible for protecting **MediExcel Health Plan's** interests in any Workers' Compensation claims or settlements with any eligible individual. This **Group Subscriber Agreement** is not in lieu of Workers' Compensation coverage and shall not affect any requirement for coverage by workers' compensation insurance. **Group Contract Holder** will ensure all eligible Employees must be covered by workers' compensation insurance except those Employees who are not legally required to be covered.

9.14 **Subrogation.** If **MediExcel Health Plan** provides health care benefits under this **Group Subscriber Agreement** to a **Member** for injuries or illness for which a third party is or may be responsible, then **MediExcel Health Plan** retains the right to repayment (a lien), to the extent permitted by law for the reasonable costs actually paid by **MediExcel Health Plan** that are associated with the injury or illness for which the third party is or may be responsible, plus the costs to perfect the lien. The proceeds of any judgement or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether the total amount of the proceeds is less than the actual losses and

damages you incurred. We are entitled under our first-priority lien for repayment even if you are not "made whole" for all of your damages in the recoveries that you receive. In some cases, **Participating Providers** may assert **MediExcel Health Plan's** lien. Some **Providers** also have lien rights that are independent of **MediExcel Health Plan's** rights.

9.15 **Binding Rules. MediExcel Health Plan** is subject to the requirements of Chapter 2.2 of Division 2 of the Code and of Chapter 1 of Title 28 of the California Code of Regulations, and any provision required to be in the **Group Subscriber Agreement** by either of the above shall bind **MediExcel Health Plan** whether or not provided in this contract.

SECTION 10. PREMIUM CREDIT FOR BORDER CROSSING DOCUMENTATION HARDSHIPS

10.1 **Unique Employee Needs.** The Plan recognizes that some employees may face a temporary hardship in the Employee being able to cross into Mexico and return to the US for reasons dealing with the federal processing of documentation status. Some of these employees have Dependents that are located in Mexico or have the necessary documentation to cross the border. In these situations, the Employee needs to obtain employer–sponsored health coverage for himself/herself through an **Associated Health Plan** (such as Aetna, Anthem, Blue Shield, CIGNA, Health Net, Kaiser, Sharp Health Plan, etc.) for health benefit services in California while the Employee's Dependent(s) needs to obtain health coverage from **MediExcel Health Plan** for health benefit services in Mexico. For such an arrangement, the Employee will need to enroll in two employer-sponsored health plans (the Associated Health Plan and **MediExcel Health Plan**). The Employee will need to pay his/her share of contribution for two health plan premiums (one for the **Associated Health Plan** and one for **MediExcel Health Plan**) to the Employer. Such an arrangement causes the Employee to have **duplicative health coverage** as well as payment for coverage that will not be used. To alleviate the Employee's financial burden of **duplicative coverage**, **MediExcel Health Plan** shall provide a Monthly **Premium Credit** to the Employer.

10.2 **Requests for Premium Credit. MediExcel Health Plan** has a process where the Employer can request a **Premium Credit** from **MediExcel Health Plan**. The Employer can submit to **MediExcel Health Plan** an "***Application for Premium Credit for Employee's Duplicative Coverage***" along with the normal **MediExcel Health Plan** Employee Enrollment Application. The "***Application for Premium Credit for Employee's Duplicative Coverage***" confirms the Employee's hardship.

10.3 **Premium Credit Amount.** The Monthly **Premium Credit** will be an amount equal to the Employee-Only Tier Rate as specified in the Group Subscriber Agreement Rate Sheet (Page GSA-iii). 100% of the **Premium Credit** shall be applied to the Employee's monthly premium amount. The application of the **Premium Credit** is immediate and shall be reflected on the **MediExcel Health Plan** Monthly Billing Statement to the Employer. The resulting **MediExcel Health Plan** premium cost for Employer is calculated as follows:

- **For 3-Tier Rate Structure.** The resulting **MediExcel Health Plan** premium for the Employer is based on the subtraction of the Employee-Only EE Rate Tier Amount from Rate Tier Amount of the enrolled Employee and his/her Dependent(s) which will either be the EE+1 Rate Tier Amount for one Dependent or the EE+2 Rate Tier Amount for two or more Dependents.

- **For 4-Tier Rate Structure.** The resulting **MediExcel Health Plan** premium for the Employer is based on the subtraction of the Employee-Only EE Rate Tier Amount from Rate Tier Amount of the enrolled Employee and his/her Dependent(s) which will either be the ES Rate Tier Amount for the Dependent Spouse/Domestic Partner; the EC Rate Tier Amount for one or more Dependent Children, or the EF Rate Tier Amount for Dependent Spouse/Domestic Partner and one or more Dependent Children.

- **For Small Group Employers.** The **MediExcel Health Plan** resulting premium is calculated by subtracting 100% of the Employee Age Rate from the Total Age Rate Amounts that Employee has enrolled with his/her Dependent(s).

10.4 **Employer Contribution to Dependent Coverage.** The Employer warrants to provide his employer-sponsored contribution for the premium cost of **MediExcel Health Plan** health coverage for the Employee's enrolled Dependent(s) at the same dollar amount as the employer-sponsored contribution for the premium cost had the Dependent(s) been enrolled in the employer-sponsored **Associated Health Plan**.

10.5 **Cancellation of Premium Credit.** The **Premium Credit** to the Employer shall continue until **MediExcel Health**

Plan cancels the **Premium Credit**. The table that follows identifies the reasons for which **MediExcel Health Plan** may cancel the **Premium Credit** and the timing of such cancellation.

Premium Credit Cancellation Reasons	Cancellation Effective Date
The Employee's initial application for coverage in the **Associated Health Plan** was never approved.	To the first date of **MediExcel Health Plan** coverage if the Employee's initial application for coverage in the **Associated Health Plan.**
The Employee terminates his/her coverage in the associated health plan.	The first day of the month following the last date of coverage in the **Associated Health Plan**.
The Employee terminates his/her coverage in **MediExcel Health Plan**.	The last date of coverage in **MediExcel Health Plan**.
The Employee accesses **MediExcel Health Plan** covered health care benefit services.	The first day of the month following the date that the Employee accesses **MediExcel Health Plan** covered health care benefit services.

10.6 **Impact of Employee Coverage in Event of Accessing MediExcel Health Plan Covered Benefit Services.** As long as Employee does not terminate his/her coverage in **MediExcel Health Plan**, Employee's and his/her Dependents' coverage shall stay active. The cancellation of the **Premium Credit** does not trigger the cancellation of **MediExcel Health Plan** coverage. The Employer, however, may decide to adjust the required contributions from the Employee for coverage in **MediExcel Health Plan**.

10.7 **Applicable to Large and Small Group Employers.** This entire Section 10 and the **Premium Credit** applies to both Large and Small Group Employers.

SECTION 11. PAPERLESS INITIATIVES AND MEMBER COMMUNICATIONS

11.1 **Going Green.** **MediExcel Health Plan** has incorporated several workflow processes and digital forms as to improve efficiency, reduce paper and postal expenses by using electronic distribution (Email) and pdf file of documents. The **Group Contract Holder** consents to these paperless workflow processes and formats. The **Group Contract Holder** can opt out of one or more of these processes and digital forms by notifying **MediExcel Health Plan**. These workflow processes and digital formats include:

- Electronic Distribution (Email) of Group Subscriber Agreement and associated material to **Group Contract Holder**.
- Electronic Distribution (Email) of Monthly Billing Statement to **Group Contract Holder**.
- Electronic Distribution (Email) of Federal IRS Form 1095-B to **Group Contract Holder**.
- Electronic Distribution (Email) of Employer Renewal Packet to **Group Contract Holder**.

11.2 **Member Portals.** **MediExcel Health Plan** will establish a Member Portal for secure electronic communications between the Subscriber and **MediExcel Health Plan.** Instructions for registering are contained in the EOC. An electronic file of Member's benefit plan, EOC, and all applicable health plan notices shall be place in the Member Portal for retrieval by the Member.

EMPLOYER GROUP (HR) ADMINISTRATION MANUAL

As of: October 15, 2025

GENERAL

Welcome to MediExcel Health Plan. We are pleased that you have selected MediExcel Health Plan to provide health benefits to your employees, who prefer to access their health care services in Mexico. We value your business and strive to offer the highest level of service available in the marketplace.

MediExcel Health Plan is a cross-border health plan which offers high-quality, personal, affordable and convenient medical coverage for your enrolled employees and their families who prefer to access their health benefits in Mexico. MediExcel Health Plan provides for the health care needs of your employees through a network of quality physicians, hospitals and other providers in Tijuana, Tecate and Mexicali, Baja California, Mexico. We also offer access to over 40 contracted urgent care locations throughout San Diego and Imperial counties.

We have prepared this **Employer Group Administration Manual** to assist you in the administration of MediExcel Health Plan coverage. You will find this to be an important reference regarding health plan policies and procedures. This manual has been written with the Employer Group in mind. Your employees are provided with an **Evidence of Coverage** (EOC) that similarly assist them in understanding their health plan benefits and policies.

Another resource is your **Group Subscriber Agreement** (GSA), which constitutes the legal and contractual agreement between MediExcel Health Plan and the Employer Group and lists any special agreements. A GSA is provided to you upon the initial enrollment of the Employer Group and during each subsequent renewal period.

In the event of any discrepancies between the Employer Group Administration Manual and the GSA, the GSA will govern in all cases.

A DEDICATED CLIENT SUPPORT TEAM FOR YOU

MediExcel Health Plan has an Account Management Team available to help provide you with personalized service and timely updates when you need it.

MEMBER SERVICES TEAM FOR YOUR EMPLOYEES

Our Member Services Representatives are available to provide personalized assistance and education for your enrolled employees. Members who need assistance should always contact the Member Services team first. Member Services Representatives are available at (619) 365-4346. This phone number is also referenced on Member ID cards.

HOW TO USE THIS MANUAL

The purpose of this manual is to help simplify the process of administering your MediExcel Health Plan benefits program. The table of contents lists each section by its title, then lists each subcategory within that section. Each section contains information on a specific procedure that you may encounter. Detailed instructions are included along with sample forms where applicable.

STORING YOUR CURRENT GSA AND RATES

For convenience and ease of reference, we suggest that you store a copy of your fully executed GSA and a copy of your Employer Group's current rates in this manual.

TABLE OF CONTENTS

SECTION 1

UNIQUE ASPECTS - MEDIEXCEL HEALTH PLAN

OVERVIEW

MediExcel Health Plan is special as enrollees receive their health care in México, **except for emergency and urgent care** which are covered in California (as well as worldwide). It is specifically for eligible employees and their eligible dependents who prefer to access their health care benefits in Mexico. Although the premiums and employee contributions for MediExcel Health Plan are generally much more affordable than for California health plan offerings, there are other factors that each employee should take into consideration before enrolling.

MEDIEXCEL HEALTH PLAN SERVICE AREA

MediExcel Health Plan has a service area. This is the area in which MediExcel Health Plan provides health care coverage which consists of the border cities of Tijuana, Tecate and Mexicali, Baja California, Mexico.

GENERAL QUALIFICATIONS OF ENROLLING EMPLOYEES

- The licensing regulations for MediExcel Health Plan state that the enrolling Employee be a Mexican National and work or reside in San Diego County or Imperial County.
- Additionally, Federal and State Non-Discrimination laws require MediExcel Health Plan to not refuse enrollment for coverage for several protected categories which includes a Member's race, color, religion, national origin, ancestry, sex, marital status, sexual orientation, age, or health status of any person who can expect to benefit from this coverage.

MEDIEXCEL HEALTH PLAN FOCUSES ON TWO ASPECTS:

1) Enrolling employees and their eligible dependents understand how MediExcel Health Plan works and are comfortable with the health care standards in Mexico, and
2) Enrolling employees and their eligible dependents who reside in the US must have the proper documentation to cross into Mexico and return to the US (employee signs an attestation to this requirement on the employee application form).

MEXICAN HEALTH CARE STANDARDS

Legal requirements for and generally accepted practice standards of medical care in Mexico are different than those of California or elsewhere in the United States. Therefore, the care to be received through providers in Mexico in the MediExcel Health Plan will be care that is consistent with generally accepted medical standards of Mexico, not of California. MediExcel Health Plan contracts only with providers who meet all applicable laws, licensing requirements and professional standards of Mexico and who provide their services in accordance with the generally accepted standards of the organized medical community relating to professional and hospital services in Mexico. **Any Member who is not completely comfortable with the standards of care for the practice of medicine in Mexico should not enroll in the MediExcel Health Plan.**

SECTION 2

ENROLLMENT/CANCELLATION PROCEDURES

NEW EMPLOYEES
To be eligible to enroll as a Member in MediExcel Health Plan, an employee must:

- ✓ Be a full-time, active employee whose normal work week is at least 30 hours, and whose duties in such employment are performed at the Employer's regular places of business.
- ✓ The employee's worksite location or residence must be in San Diego or Imperial Counties.
- ✓ Satisfy all eligibility requirements as defined in your Group Subscriber Agreement (GSA).
- ✓ Elect health care coverage through MediExcel Health Plan by submitting a completed and signed MediExcel Health Plan Enrollment Form within 30 days of the eligibility effective date.

Each employee should be provided an enrollment kit upon reaching eligibility. Please submit new Enrollment Forms to MediExcel Health Plan as soon as they are completed. The Enrollment Form can also be completed on-line. Please contact sales@mediexcel.com for a supply of these kits and to register for the online enrollment capability.

FORMERLY INELIGIBLE EMPLOYEES
An employee changing from part-time to full-time status will be eligible for coverage the first day of the month following the completion of the waiting period after becoming full-time, as defined in the GSA.

REHIRED EMPLOYEES
Employees who have been rehired will be subject to the re-hire waiting period as defined in your GSA.

WAITING PERIOD
The standard waiting period for newly hired employees and their eligible dependents is 60 days, unless the Employer Group elects a shorter waiting period (0 or 30 days). This election shall be reflected in the Master Application during the New Employer Group Application Process. Waiting Periods are for all employees and will not be changed for any particular employee. The Employer Group can change its Waiting Period at its next Open Enrollment Period. See Waiting Period Example at the End of this Section.

DEPENDENTS
A Dependent's eligibility for enrollment is contingent upon the Employee's (Subscriber's) eligibility for membership in MediExcel Health Plan. Eligible Dependents include:

- ✓ Spouse
- ✓ Domestic partner. You must file a Declaration of Domestic Partnership
- ✓ Children: The employee's or those of the spouse or domestic partner
  - The children must be under the age of 26 who are not otherwise eligible for coverage on their own under an employer program. They may be the employee's natural children, legally adopted children, or stepchildren.
  - A disabled child can be covered past age 26 if the child is unable to work, because of a physically or mentally disabling injury, illness, or condition. The employee must be the main source of support and maintenance of the child.

- Any other person under age 26 for whom the Enrolled Employee or the Enrolled Employee's Spouse is (or was before the person's 18th birthday) the court-appointed guardian.

Please note that spouses of dependent children are **not** eligible for coverage. Additionally, newborns of dependent children (other than the first 30 days following birth) are not eligible for enrollment.

OPEN ENROLLMENT

Open (Initial) Enrollment is held before the effective date that your contract coverage commences or renews. This is the time Eligible Employees may choose to enroll in MediExcel Health Plan as well as add or delete family members to their coverage.

As an Employer Group, you may also make changes to the current plan design during this renewal period. Any changes made during Open Enrollment become effective on the commencement or renewal date of the GSA period.

As mentioned previously, the Employer Group may also change its Waiting Period.

To make Open Enrollment easier, our MediExcel Sales Support Team is available to assist you, both in English and Spanish, by participating in the presentation of how the Plan works and benefits to employees through on-site question and answer sessions.

ENROLLING NEWLY ELIGIBLE MEMBERS AND DEPENDENTS

Eligible Employees who wish to enroll themselves and their Dependents in MediExcel Health Plan must complete, sign and date the Enrollment Form. Enrollment Forms are available in English and in Spanish.

Please submit all completed forms to MediExcel Health Plan. To avoid unnecessary delays in processing enrollment forms, please ensure the Enrollment Form is fully completed and includes all of the following information:

- Group Name, Effective Date, and Reason for Application (e.g., hire date or rehire)
- All required Employee-specific information.
- All required Dependent coverage selection information
- Employee signature in signature section at the bottom of the form

Completed Enrollment Forms should be sent immediately by email to:

Applications@mediexcel.com

or by mail to:

MediExcel Health Plan Enrollment
750 Medical Center Court, Suite 2
Chula Vista, CA 91911

A supply of Enrollment Forms and enrollment kits can be requested from the MediExcel Sales Support Team.

ON-LINE ENROLLMENT

MediExcel Health Plan has the capability to submit applications and/or request changes through the MediExcel Health Plan online portals. Please contact (sales@mediexcel.com) in order to be

registered in the MediExcel Health Plan electronic enrollment system to allow your company to access this capability.

ADDING NEW DEPENDENTS TO COVERAGE

Adding New Dependents

Employees can add the following new dependents after the health plan coverage period has started:

A spouse. If the employee marries, the employee can add his/her spouse on the health plan.

- MediExcel Health Plan must receive a completed enrollment form within 30 days of the date of the marriage.
- Coverage will begin on the first day of the month following the date MediExcel Health Plan receives the completed enrollment form.

A domestic partner. If the employee enters a domestic partnership, the employee can enroll his/her domestic partner on the health plan.

- MediExcel Health Plan must receive a completed enrollment form within 30 days of the date of the filed Declaration of Domestic Partnership with the Secretary of State, or within 30 days after the employee forms the partnership according to the employer's rules.
- MediExcel Health Plan has an "Affidavit for Enrollment of Domestic Partners Form" in the event there is not a Filed Declaration of Domestic Partnership with the Secretary of State.
- Coverage will begin on the first day of the month following the date MediExcel Health Plan receives the completed enrollment form.

A newborn child. A newborn child is covered on the employee's health plan for the first 30 days after birth.

- To keep the newborn on the health plan, MediExcel Health Plan must receive a completed enrollment form within 60 days after the birth.
- If this deadline is missed, the newborn will not have health benefits under MediExcel Health Plan after the first 30 days following birth.

An adopted child. A child that is adopted by the employee and his/her spouse or domestic partner is covered on the health plan for the first 30 days after the adoption is complete.

- To keep the adopted child on the health plan, MediExcel Health Plan must receive a completed enrollment form within 60 days after the adoption.
- If this deadline is missed, the adopted child will not have health benefits under MediExcel Health Plan after the first 30 days.

A stepchild. A child of the employee's spouse or domestic partner can also be added on the health plan.

- The enrollment form must be completed and sent to MediExcel Health Plan within 30 days after the date of marriage or Declaration of Domestic Partnership with the stepchild's parent.
- Coverage will begin on the first day of the month following the date MediExcel Health Plan receives the completed enrollment form.

Example of Premium charges for a newborn or newly adopted child will be as follows:

- Date baby was born or child legally adopted: April 10, 2025
- Automatic coverage: through May 10, 2025
- Enrollment deadline: June 9, 2025
- **Adjusted premium start date: May 1, 2025** (instead of July 1 under the previous process)

Special Times Employees and Their Dependents Can Join MediExcel Health Plan

Employees and their Dependents can enroll in MediExcel Health Plan in these situations:

When employee did not enroll in MediExcel Health Plan before because:

- He/She had Cal-COBRA or COBRA, and now the coverage has ended.
- He/She had Healthy Families or Medi-Cal with no share-of-cost, and now they no longer qualify for it.
- He/She were covered by another group health plan, and now that coverage has ended.
- When a court orders that employee covers a current spouse or a minor child on his/her health plan.

How to apply at these additional times:

- MediExcel Health Plan must receive a completed enrollment form within 30 days of that date on which the employee/dependents no longer have coverage.
- Coverage will be in effect the first day of the month following receipt of the completed enrollment application.

LATE ENROLLMENT

Employees or their Dependents initially eligible for enrollment that do not enroll during an Open Enrollment period or within thirty (30) days of first becoming eligible, may enroll during the next Open Enrollment period.

If an employee or Dependent suffers an involuntary loss of other medical coverage, late enrollment is accepted if submitted within thirty (30) days of loss of coverage. In this case, MediExcel Health Plan requires proof of loss of coverage (e.g., letter from insurance carrier). Coverage would be effective the first day of the month following the loss of other medical coverage.

WAIVING COVERAGE

Employees waiving coverage should complete a Waiver Form (also known as a Coverage Declination Form). MediExcel Health Plan will accept another carrier's Waiver Form (if the other carrier also requires employee to complete Waiver Form). MediExcel also has its own waiver form (Form B142) which is available on the MediExcel Website (www.mediexcel.com) and also via a link in the last section of this Manual. It is advisable to keep a copy of signed forms on file for reference as needed.

CANCELING EMPLOYEE AND DEPENDENT COVERAGE

MediExcel Health Plan will terminate coverage for your employee and/or their Dependents upon directive from you (the Employer Group designated Benefits Coordinator). Any change that occurs after the initial enrollment must be submitted to MediExcel Health Plan within thirty (30) days of the change using the Enrollment Form. Your Employer Group will continue to be liable for premiums during the period between loss of eligibility and receipt of this notice by MediExcel Health Plan. MediExcel Health Plan will not terminate a Member retroactively for any period during which your Employer Group has collected the Member's share towards Premiums. Your Employer Group is responsible for ensuring that the Member has not paid the Member's share of Premiums before notifying MediExcel Health Plan of any retroactive terminations.

If you are an employer with under 20 full-time employees, the terminated employee may be eligible for continuation of coverage under Cal-COBRA. Please send MediExcel the Employer Notification of Qualifying Event (Form B150) or MediExcel may not be required to provide such continuation coverage to the terminated member.

Employee

Coverage for an Employee may be terminated for any of the following reasons:

- Employment has ended
- Employee has a reduction in hours resulting in loss of eligibility
- Employee voluntarily requests to terminate coverage
- Employee takes a leave of absence (MediExcel Health Plan will allow an employee to retain coverage upon your Group leave of absence policy.)
- Employee no longer resides or works in the MediExcel Health Plan Service Area

Termination date of benefits is always the last day of the last month the employee was eligible (e.g., employee terminates employment September 21, health coverage ends September 30)

Spouses/Domestic Partners

Coverage for a Spouse/Domestic Partner of a Employee may be terminated for any of the following:

- An employee voluntarily requests coverage to be terminated
- A divorce decree has been finalized
- The spouse no longer resides or works in the MediExcel Health Plan Service Area

Dependent Children

Coverage for a Dependent child of a Member may be terminated for any of the following:

- An employee voluntarily requests coverage to be terminated
- The Dependent child no longer resides or works in the MediExcel Health Plan Service Area, unless there is a standing health coverage court order
- The Dependent child reaches the maximum Dependent age as defined by the GSA or ceases to meet other Dependent eligibility requirements.

CANCELING COVERAGE FOR CAUSE

A Member's eligibility in MediExcel Health Plan ends when your Group policy coverage ends. However, individual membership may be terminated by MediExcel Health Plan for any of the following reasons:

- Member commits an act of fraud or intentional misrepresentation of material fact to circumvent state or federal laws or the policies of the Plan, such as providing materially incomplete or incorrect enrollment or required updated information deliberately, including but not limited to incomplete or incorrect information regarding date of hire, date of birth, relationship to Enrolled Employee or Dependent, place of residence, other group health insurance or Workers' Compensation benefits, disability or student status.
- Member allows someone else to use their Member ID card.
- Member threatens the safety of MediExcel Health Plan employees, Plan Providers, Members or other patients or engages in repeated behavior that substantially impairs MediExcel Health Plan's ability to furnish or arrange services to the Member or other Members, or a Plan Provider's ability to provide services to other patients.
- If a Dependent is the sole offending party for any occurrence outlined above, then the Plan may terminate only the offending Dependent's coverage and coverage for the remaining Members in the family unit will remain effective.

If membership is terminated, the Member will be notified in writing and will be informed of the termination date. If eligibility is lost due to fraud or deception, MediExcel Health Plan may recover from the Member the charges paid by MediExcel Health Plan for covered services provided to the Member, plus MediExcel Health Plan's cost for recovering those charges, including fees for legal counsel.

A Member may file a grievance disputing the cancellation of coverage, as described in the "What is the Grievance Process" section of the Member Handbook, within 180 working days after receiving notice that MediExcel Health Plan has or will terminate coverage for cause.

Under no circumstances will membership be terminated due to health status or need for health care services. If a Member believes coverage was terminated or not renewed because of health status, a Member may request a review of cancellation by the Department of Managed Health Care.

TERMINATING EMPLOYER GROUP COVERAGE
Your Employer Group policy may be terminated by MediExcel Health Plan under any of the following circumstances:

1. **The Employer Group no longer meets the qualification requirements of MediExcel Health Plan.**
   - If this occurs, MediExcel Health Plan will notify you in writing and explain the disqualifying event(s), the date of termination and the final date of coverage. The Enrolled Employees and Dependents of your Employer Group policy will be disenrolled within thirty (30) days of your notification date.

2. **The Employer Group fails to pay any amount due MediExcel Health Plan by due date.**
   - Your Employer Group will be given at least a 30-day grace period of continued coverage after the last day of paid coverage to pay the Premium owed for the month of coverage. The Employer Group policy is subject to termination at the end of the 30-day grace period if the Premium is not paid by that date. Employer Group will be financially responsible for the full month's Premium for coverage provided during any portion of the grace period. For example, Premiums for the month of April are due by April 1st. If payment is not received by April 1st, the 30-day grace period will begin on April 2nd and end on April 30. Coverage will end at 12:01am on April 30 if the April Premiums are not received by April 30. Employer Group will remain financially responsible for payment of April's Premium. For any premium received after the 10th of the coverage month, a late fee will be assessed.

   - Your Employer Group may be eligible for reinstatement. Please contact your Account Manager to confirm your eligibility for reinstatement. If eligible, your Employer Group will be required to pay all past due premiums, including any applicable late/reinstatement fees to MediExcel Health Plan within fifteen (15) days of being terminated.

   - If your Employer Group wishes to reinstate after the 15-day period, you must apply for coverage as a new Group. MediExcel Health Plan may accept or reject such application at its sole discretion. MediExcel Health Plan will reinstate Employer Group only once during any twelve- month period.

3. Your Employer Group notifies MediExcel Health Plan in writing of the intent to terminate coverage at least thirty-one (31) calendar days prior to the requested termination date. NOTE: As per California law (Health and Safety Code Section 1365), MediExcel Health Plan is not permitted to retroactively terminate your group for non-payment of premium. Therefore, if your Employer Group does not notify MediExcel Health Plan of its intent to terminate coverage before the 1st day of the next coverage month, your Group will be responsible for payment for that coverage month. Example: Payment for April coverage is due on April 1st. Your Employer Group asked MediExcel Health Plan for a 4 day extension to submit payment but then determined not to continue coverage. Your Employer Group notifies MediExcel Health Plan on April 2 of its decision and asks for coverage to be terminated retroactively to March 31. Since the April coverage month has already begun, MediExcel Health Plan is required by law to continue coverage until April 30 and your Group will be responsible for payment of the full April premium.

4. Your Employer Group engages in fraud or deception in the use of services or facilities of MediExcel Health Plan, or knowingly permits another to engage in fraud or deception. MediExcel Health Plan may terminate your Employer Group policy immediately upon written notification of termination to your Employer Group.

WAITING PERIOD EXAMPLE

1. Assumptions for Waiting Period Scenario
    a. Employer Group Effective Date is March 1, 2022
    b. Employer Group has the standard 60 day Waiting Period.
    c. New Employee Hire Date is May 10, 2022.
    d. New Employee Waiting Period: May 10, 2022 thru July 10, 2022

2. New employee waiting period is 60 days from May 10, 2022 to July 10, 2022. Coverage can start on the first day of the Eligibility Month (August 1, 2022) immediately following the end of the 60 day waiting period (which would be July 10, 2022).

3. If the new employee enrollment application is not received by MediExcel Health Plan prior to the last day of the New Employee's Eligibility month (which in this scenario is August 31, 2022), the New Employee will need to wait to enroll in coverage at the next open enrollment period (Feb 2023) for a coverage date of March 1, 2023.

4. We highly recommend that you submit the new Employee's Enrollment Application to MediExcel Health Plan at least 20 days prior to the start of coverage to ensure new Employee and all eligible Dependents are properly enrolled.

SECTION 3
MEMBERSHIP INFORMATION

MEMBER SERVICES

Member Services is designed to provide information and assistance to all MediExcel Health Plan Members. The Member Services Department telephone number is (619) 365-4346. Service hours are 24/7, Monday through Sunday. The Member Services team can also be contacted through email at memberservice@mediexcel.com.

The following information and assistance is available from our Member Services team:

- Eligibility/benefit information
- Provider Directory updates and information
- Claim inquiries
- MediExcel Health Plan policies and procedures
- Appeal & Grievance procedures
- Employer Group coverage information
- Primary Care Physician changes
- Out-of-Pocket Maximum Inquiries
- Contract language interpretation
- ID card replacement

NEW MEMBER KIT

Upon enrolling in the MediExcel Health Plan, all newly enrolled employees will receive a New Member Kit. The kit will be mailed via USPS to the employer address on file unless otherwise requested. The New Member Kit will have several items including:

- A personalized welcome letter that serves as a temporary ID Card
- An Introduction/How to Use the Plan Guide
- U.S. Urgent Care Network List
- Summary of Benefits and Coverage
- Additional benefits/services available to members (Mobile Application, Patient Portal, SENTRI Program)

All Members are invited to attend a Member Orientation.

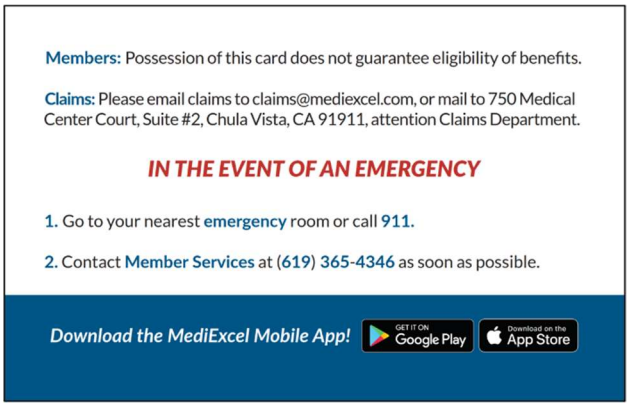
MEMBER ORIENTATION PROGRAM

We have instituted an orientation program for all newly enrolled Members to visit us to learn how to best use their membership coverage. We believe that through this member engagement activity, our Members will get much more value and benefit out of their MediExcel Health Plan coverage. Member orientations are facilitated by MediExcel Health Plan's enrollment specialist team. We offer the following member orientation options:

- In-person meetings at employer worksite locations
- Virtual orientations
- Over-the-phone orientation
- In person at our member center located at our administrative office: 750 Medical Center Ct. Ste 2 Chula Vista CA 91911

MEMBER ID CARD

Member ID cards have the Member's ID number, date of birth, type of Plan(s), Out of Pocket Maximum, and coverage effective date. The Plan contact information is also found on the Member ID Card. It is important for the Member to also show a government-issued proof of identity when accessing health care benefit services. A sample Membership ID Card is shown as follows:



FRONT OF CARD BACK OF CARD

The back of card includes important information on how to utilize and access Plan providers, emergency services, and lists important telephone numbers.

MEDIEXCEL APP

Our mobile app can also be downloaded to your iPhone or Android Phone. Members may access their digital ID card through the app.

COPAYMENTS

When a Member accesses care, Copayments are required at the time of service. The Copayments applicable to your Group are described in your Summary of Benefits and Coverage (SBC). To protect Members from large out-of-pocket expenses, a limit called the Annual Maximum Copayment is placed on the dollar amount of Copayments a Member might have to pay during a calendar year.

CLAIMS INFORMATION

All Providers contracted with the Plan are to bill MediExcel Health Plan directly for covered benefits provided to Members. Members are not responsible to pay for covered benefits (except for Copayments and co-insurance amounts as applicable) unless a Member fails to obtain required pre-authorization when required, for non-emergency services, or has agreed in advance to pay for non-covered benefits.

A member may receive a bill under certain circumstances as follows:

- When a Member does not present a MediExcel Health Plan ID card upon receiving care.
- Out-of-area medical care is provided.

A Member who receives a bill should call the billing provider's number, which should be listed on the statement, and advise them that he/she is a Member of MediExcel Health Plan. The members should provide insurance information to the billing provider and a copy of their

ID card. If a Member receives a "final" bill or collection notice, the Member should **immediately** contact MediExcel Health Plan's Member Services Department at (619) 365-4346. The Member Services Department will advise the provider of the Member's insurance information and direct him/her to withdraw the account from collections.

Members who pay for services that should have been covered by the Plan can submit these charges for reimbursement. All reimbursement requests should be submitted within one hundred and eighty (180) days from the date of service to:

MediExcel Health Plan
Claims Department
750 Medical Center Ct, Suite 2
Chula Vista, CA 91911

CHANGE OF MEMBERS' PERSONAL INFORMATION

All Member name, address and Social Security Number changes should be reported to MediExcel Health Plan as soon as possible. Your Employees can do this by submitting a MediExcel Health Plan Enrollment Application. A permanent address change outside of the MediExcel Health Plan Service Area terminates coverage for a Subscriber and/or eligible Dependent(s) thirty-one (31) days following the change of address. However, if the Subscriber or Dependent is working in the Service Area or there is a standing health coverage court order for a Dependent the Subscriber/or Dependent may remain eligible.

CHANGE OF PRIMARY CARE PHYSICIAN

Your Employees may change their Primary Care Physician (PCP) by contacting our Member Services Department. MediExcel Health Plan will change the Member's PCP effective immediately.

ACCESS TO CARE FOR STANDARD BENEFITS

MediExcel Health Plan is a Health Maintenance Organization (HMO). In an HMO, Members have access to a network of medical providers for their health care. MediExcel Health Plan's physician network consists of primary care and specialty physicians. Each Member should select a Primary Care Physician (PCP) from the Plan's Provider Directory. Subscribers and Dependents may select different PCPs.

The Member's PCP directs and arranges for all health care services. The Member's PCP will assess the Member's medical condition(s) which may require specialty care. If specialty care or hospitalization is required, the Member's PCP will coordinate services with MediExcel Health Plan.

REFERRALS

It is very important that Members understand the physician referral process. If the following guidelines are not adhered to, the Member may become financially responsible for medical care.

1. The Member must have a referral from his/her PCP for specialty services or services rendered other than through their PCP. Please note that some specialty services do not require a referral, such as OB/GYN services for women, mental health services, and supplemental benefit services (if applicable) such as vision services.

2. When the Member receives a referral from the PCP, the first visit must occur within sixty (60) days from the date of the referral.

3. All referral visits must be completed within the time frame indicated by the PCP on the referral form. If referral visits are not completed, the Member must obtain a new referral from the PCP.

4. The Member must be referred to a participating provider unless the PCP has received authorization from MediExcel Health Plan to refer the Member elsewhere. All authorizations must be approved in advance, and all referrals and continuations of referrals must be coordinated through the PCP.

5. Referrals are valid only for the services specified. For example, if a referral states "consultation only" and a Member receive consultation and treatment, the Member may be responsible for payment associated with the treatment. All referral forms should be read carefully. A Member should consult with his/her PCP prior to obtaining services if a referral form is not issued to the patient.

6. If a Member changes a PCP while under the care of a specialist, all previous referrals become void. The Member must consult his/her new PCP to determine if additional referrals are medically necessary.

7. The PCP is responsible for notifying the Member of the status of a referral. Should the PCP's office fail to contact the Member, the Member should contact the PCP's office to follow-up.

EMERGENCY CARE

In an emergency, members should call 911 or go to the nearest hospital emergency room. An emergency room Copayment is due at the time of the visit, unless the visit results in a hospital admission.

EMERGENCY FOLLOW-UP CARE

Members should not return to a hospital emergency room for follow-up care unless it is a new medical emergency, or a Member is specifically instructed to do so by his/her PCP. If these guidelines are not followed, charges for medical services may become the Member's responsibility.

URGENT CARE

Unforeseen injuries or acute illnesses that require immediate attention but are not life- threatening are considered urgent care situations. When an urgent care situation occurs, the Member may visit any in-network urgent care facility. An Urgent Care Copayment is due at the time of the visit. Urgent Care is also covered out of network; members will just need to submit for reimbursement.

HOSPITAL SERVICES

Inpatient and Outpatient hospital services are covered when provided by a Plan hospital (or other hospital in connection with Emergency Services) and authorized by MediExcel Health Plan. A Copayment may be applicable, as defined by the SBC.

Non-emergency hospital services are covered if arranged by a Plan Physician and includes semi-private room and board (private room when Medically Necessary), general nursing care (special duty nursing when Medically Necessary), and related services, facilities and supplies associated with a hospital admission.

MENTAL HEALTH

MediExcel Health Plan provides coverage for the diagnosis and Medically Necessary treatment of mental illnesses, including but not limited to Severe Mental Illnesses in Members of any age and Serious Emotional Disturbances in children.

- Severe Mental Illnesses include: schizophrenia, schizoaffective disorder, bi-polar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive- compulsive disorder, pervasive development disorder, or autism, anorexia nervosa and bulimia nervosa.

- Serious Emotional Disturbance (SED) means one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, to include Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and other pervasive developmental disorders no otherwise specified (including Atypical Autism), in accordance with diagnostic and statistical manual for Mental Disorders–IV- Text revisions(June 2000), other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. One or more of the following must also be true:

    1) as a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community; and either of the following occur:
        a) the child is at risk of removal from the home or has already been removed from the home; or
        b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year if not treated; or
    2) the child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; or
    3) the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code).

Mental health benefits include inpatient hospital services, partial hospital services and outpatient services when ordered and performed by a participating mental health professional. Members have direct access to Plan Providers of mental health services without obtaining a Primary Care Physician referral. Covered mental health benefits must be obtained through Plan Providers. Mental health services that are not provided by Plan Providers are not covered, and the Member will be responsible to pay for those services. Members should call our Member Services Department at (619) 365-4346 whenever they need mental health services. All calls are confidential.

DENTAL CARE SERVICES AND COVERAGE

The MediExcel Health Plan (Medical Coverage program) has limited dental care services (dental exam and cleaning). The MediExcel Small Group Plan offers enrollees under 18 years of age pediatric dental coverage within the Medical Coverage program.

MediExcel also offers an optional dental coverage plan. There is a separate Dental EOC and Dental SBC which outlines the dental coverage benefits. If Members ever have a question or concern, they can call our Member Services Department toll-free at (619) 365-4346, and a Member Services Representative will make every effort to assist.

VISION CARE SERVICES AND COVERAGE

The MediExcel Health Plan (Medical Coverage program) has limited vision care services (vision exam). The MediExcel Small Group Plan offers enrollees under 18 years of age pediatric vision coverage within the Medical Coverage program.

MediExcel also offers an optional vision coverage plan. There is a separate Vision Plan EOC and Vision Benefit Matrix which outlines the vision Plan coverage benefits. If Members ever have a question or concern, they can call our Member Services Department (619) 365-4346 and a Member Services Representative will make every effort to assist.

WHAT IS THE GRIEVANCE PROCESS?

If Members are having problems with a Plan Provider or our health plan, we encourage them to give us a chance to help. MediExcel Health Plan can assist in working out any issues. If Members ever have a question or concern, they can call our Member Services Department toll-free at 1-855-633-4392 and a Member Services Representative will make every effort to assist.

Members may file a grievance with the Plan at any time. To begin the grievance process, Members can call toll-free, write or fax the Plan at:

MediExcel Health Plan
Grievance Department
750 Medical Center CT, Suite 2
Chula Vista, CA 91911
Toll-Free: (619) 365-4346 Email: memberservice@mediexcel.com

If Members prefer to send a written grievance, they can send a detailed letter describing the grievance, or complete a Grievance Form that is available on the Plan's Website: www.mediexcel.com, from any Plan Provider or directly from a Plan representative. Members may also call our Member Services Department, and we will assist them in completing the form over the telephone.

Please refer to the EOC (included with this Group Administration Manual) for more detailed information about the Plan's grievance process, including a description of all the resources available to Members who have a grievance or appeal with the Plan.

COORDINATING BENEFITS

If a Subscriber or enrolled Dependent is covered by both MediExcel Health Plan and another health plan, MediExcel Health Plan will coordinate benefits between the two plans. The goal of this kind of coordination is to maximize coverage for allowable expenses, minimize out-of-pocket costs, and prevent any payment duplication. Total payment from all coverage should never exceed 100% of the allowable expenses. MediExcel Health Plan coordinates benefits in accordance with the National Association of Insurance Commissioners' guidelines and California law. So that proper coordination is ensured, Subscribers must inform MediExcel Health Plan of any other health coverage for which they or their enrolled Dependents may be eligible.

ORDER OF DETERMINATION

Certain rules are used to determine which of the plans will pay benefits first. The following rules will be applied in the order given below:

1. A plan with no Coordination of Benefits (COB) provision will determine its benefits before a plan with a COB provision.

2. A plan that covers a person as a Subscriber, rather than as a Dependent, will determine its benefits first.

3. When a claim is made for a covered Dependent child who is covered by more than one plan, the method of determining the order of benefits is known as the "Birthday Rule." Benefits are paid under the Birthday Rule as follows: The plan of the parent whose birthday falls earlier in the year pays first as the "primary payor." The year in which the parents were born is not a determining factor. If both parents have the same birthday, the plan which covered the parent longer will pay first as the "primary payor."

COORDINATING WITH MEDICARE

Subscribers will also need to advise MediExcel Health Plan if they are eligible for Medicare benefits. Under certain circumstances, MediExcel Health Plan may reduce its coverage to avoid duplication of benefits available from Medicare.

COORDINATING WITH WORKERS' COMPENSATION

If a Member is entitled to benefits as a result of Workers' Compensation, MediExcel Health Plan will not duplicate those benefits. It is the Member's responsibility to take whatever action is necessary to receive payment under Workers' Compensation laws, when such payments can reasonably be expected. If MediExcel Health Plan happens, for whatever reason, to duplicate benefits to which a Member is entitled to under Workers' Compensation laws, the Member is required to reimburse MediExcel Health Plan.

In the event of a dispute arising between the Member and Workers' Compensation coverage regarding the ability to collect under Workers' Compensation laws, MediExcel Health Plan will provide the benefits described in the SBC until the dispute is resolved.

SECTION 4
CONTINUATION OF COVERAGE

CAL COBRA – APPLIES TO EMPLOYER GROUPS WITH 2 – 19 ELIGIBLE EMPLOYEES*

California law requires that insurers and HMOs provide continuation coverage which is known as Cal COBRA.

*You employed fewer than 20 eligible employees on at least 50% of its working days during the previous calendar year.

YOUR OBLIGATIONS

Notify MediExcel Health Plan of Certain Qualifying Events: You must notify MediExcel Health Plan in writing within thirty-one (31) days of an Enrolled Employee's Cal COBRA Qualifying Event. Qualifying Events include:

- Termination of employment
- Reduction in hours worked

Such notification to MediExcel Health Plan shall be made with MediExcel's Employer Notification of Qualifying Event (Form B150).

Notify Current Cal COBRA Qualified Beneficiaries of Your Intent to Terminate the GSA: If you terminate the GSA with MediExcel Health Plan and replace it with other coverage through another insurance carrier, you must notify all Cal COBRA Qualified Beneficiaries that they have the ability to choose to continue coverage through the new plan for the balance of their Cal COBRA coverage. They may not continue coverage under MediExcel Health Plan. MediExcel Health Plan will provide you upon request, with the names and last known addresses of enrolled Cal COBRA Qualified Beneficiaries upon request.

After you notify MediExcel Health Plan of an Enrolled Employee's Cal COBRA Qualifying Event in writing within thirty-one (31) days of its occurrence, MediExcel Health Plan will mail the Member a statement of Cal COBRA rights and obligations along with the necessary premium information, enrollment forms and instructions regarding Cal COBRA Continuation Coverage.

If the Qualified Beneficiary chooses to enroll in Cal COBRA continuation coverage, he or she must apply for coverage within sixty (60) days following the later of (1) the Qualifying Event or (2) the date he or she received a Cal COBRA notice from MediExcel Health Plan of his or her right to elect coverage or (3) the date that coverage through the employer plan terminated. The Member must mail or deliver the application to:

MediExcel Health Plan
Enrollment Department
750 Medical Center Ct, Suite 2
Chula Vista, CA 91911

If the Member fails to apply for Cal COBRA within sixty (60) days of the event, that Member will be disqualified from receiving Cal COBRA Continuation Coverage.

WHO MAY CHOOSE CAL COBRA

A Subscriber may choose Cal COBRA for one or all of the family members who were enrolled at the time of the qualifying event. In other words, the Subscriber can elect coverage for the spouse or one or more Dependent children without being covered under the Cal COBRA continuation coverage as a Subscriber.

If a child is born or placed for adoption with the former Subscriber during the period of Cal COBRA coverage, the child would be a Qualified Beneficiary and could be added to the Cal COBRA policy.

QUALIFYING EVENTS & SUBSEQUENT ELIGIBLE PERIOD OF COVERAGE

Termination of Employment	18 months*
Reduction in Hours	18 months*
Transfer to Ineligible Class	18 months*
Death of the Employee	36 months
Employee Becomes Eligible for Medicare	36 months
Dependent Child Becomes Ineligible (e.g. overage)	36 months

*If COBRA coverage was initially effective on or after January 1, 2015, and the eligible period of coverage is less than 36 months, members may elect to continue coverage through Cal COBRA for a period up to 36 months from the date that COBRA coverage was originally effective

PAYMENT FOR CAL COBRA

The Member must pay MediExcel Health Plan 110% of the applicable group rate charged for employees and their Dependents.

If the coverage is extended due to a determination by the Social Security Administration that the Qualified Beneficiary is totally disabled, pursuant to Title II or Title XVI of the Social Security Act, the Member must pay 150% of the applicable group rate for the additional period of coverage.

The Member must remit the first payment within forty-five (45) days of submitting the completed enrollment form to MediExcel Health Plan. The first payment must cover the period from the last day of prior coverage to the present. There can be no gap between prior coverage and Cal COBRA continuation Coverage.

All subsequent payments must be made on the first day of each month. If payment is not received by the first of the month, MediExcel Health Plan will send a letter warning that coverage may terminate if payment is not received by the Plan.

CHANGES IN BENEFITS UNDER CAL COBRA COVERAGE

If a Subscriber or any Dependents elect COBRA coverage, benefits will remain the same as the benefits for active Members of your current Group policy. If you change the benefits provided to active Members enrolled in your current Group policy, benefits will also change for Subscribers and Dependents on COBRA.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) *The information presented below provides only a broad overview and is not intended to be legal advice or direction. COBRA contains complex rules and administrative procedures. You can obtain more information regarding COBRA administration from your legal counsel, Broker, COBRA Administrator or your regional office of the United States Department of Labor.*

COBRA is a federal law that requires Employers with 20 or more employees to allow employees and their Dependents to continue enrollment in their employer-sponsored health plan upon the occurrence of a Qualifying Event. MediExcel Health Plan will make COBRA coverage available to Members who are qualified according to COBRA law. However, MediExcel Health Plan does not ensure your organization's full compliance with COBRA law.

ELIGIBILITY

COBRA coverage is available to Employees and their Dependents who are covered under the group plan at the time a Qualifying Event occurs. Members may elect to continue coverage immediately following one of the Qualifying Events listed below, in the event that the Qualifying Event causes a loss of coverage.

QUALIFYING EVENT AND SUBSEQUENT ELIGIBLE PERIOD OF COVERAGE

Termination of Employment	18 months*
Reduction in Hours	18 months*
Transfer to Ineligible Class	18 months*
Death of the Employee	36 months
Employee Becomes Eligible for Medicare	36 months
Dependent Child Becomes Ineligible (e.g. overage)	36 months

*If COBRA coverage was initially effective on or after January 1, 2003, and the eligible period of coverage is less than 36 months, members may elect to continue coverage through Cal COBRA for a period up to 36 months from the date that COBRA coverage was originally effective

CONTINUATION OF COVERAGE

Members eligible for continuation coverage must submit a COBRA election form according to your own guidelines along with a **MediExcel Health Plan enrollment form.** Members will have sixty (60) days from notification of COBRA eligibility to make an election. This period is measured from the later of:

- The date the coverage is lost; or
- The date the COBRA election notice is sent.

If the **MediExcel Health Plan enrollment form**, identifying COBRA election, is not received within the sixty (60) days, the right to elect COBRA continuation coverage will cease.

COBRA BILLING

MediExcel Health Plan offers two billing options. Please refer to the Execution Page of the GSA for further details of your contract with MediExcel Health Plan.

- **Premium Bill -** MediExcel Health Plan will include Federal COBRA Premium dues on your regular billing statement for your group policy.
- **Direct Bill -** MediExcel Health Plan will bill CAL-COBRA enrollees directly. The Member will be charged a 10% administrative fee in addition to the standard premium for the direct bill option. For Members receiving an extension of coverage after the initial period because they are disabled, the premium for the additional period will be increased to 150% of the applicable group rate.

MediExcel Health Plan's billing options do not ensure your organization's full compliance with COBRA law.

COBRA NOTICES

The Employer Group is responsible for sending all notices, letters, and forms required under COBRA.

Notice of Termination of COBRA Coverage: Notice sent when COBRA coverage terminates before the end of the maximum coverage period for any of the following reasons:

a) Failure to make timely payment of COBRA premiums.
b) The Employer Group ceases to provide any group health plan to any employee.
c) The qualified beneficiary becomes covered under another group health plan after electing COBRA.
d) The qualified beneficiary becomes covered under Medicare after electing COBRA.
e) A disabled qualified beneficiary whose disability extends the maximum covered period to 29 months is determined not to be disabled before the end of the extended period.
f) The qualified beneficiary's COBRA coverage is terminated for cause (e.g., for submitting fraudulent claims) on the same basis as would apply to a similarly situated non-COBRA enrollee, as indicated in Section 7.3.5.

Notice of Availability of Open Enrollment Materials & Change in COBRA Premium: Notice sent upon the Employer Group's open enrollment period.

Notice of Availability of Individual Conversion: Notice sent 60 days prior to termination of the maximum period of COBRA coverage.

Notice of Premium not Received: Notice sent when Premium not received by due date or Premium received, but is 50% less than total amount due.

Letter of Qualified Beneficiaries Attaining Age 65: Notice sent when COBRA may terminate early if, after the date of the COBRA election, a qualified beneficiary becomes entitled to Medicare. The letter will remind the beneficiary that COBRA coverage stops at Medicare entitlement, and it would require certification, as a condition of continuing COBRA, that the beneficiary has not yet become entitled to Medicare. If COBRA coverage is terminated early because of Medicare entitlement, then the Plan will provide a notice of termination of COBRA coverage, as mentioned above.

COBRA BENEFIT CHANGES

If a Subscriber or any Dependents elect COBRA coverage, benefits will remain the same as the benefits for active Members of your group policy. If benefits provided to active Members of the Group change, benefits will also change for Subscribers and Dependents on COBRA.

SECTION 5
BILLING PROCEDURES

BILLING SET-UP
Please note the vast majority of employer group accounts are set up where MediExcel Health Plan provides the billing directly to the Employer Group. In a few cases (as with Trusts), the Group entity shall perform "Self-Billing". Self-billing procedures are discussed at the end of this section.

THE MONTHLY BILLING
Your bill is prepared and sent out the second week of each month for the following calendar month's coverage. As indicated on the Group Subscriber Agreement (GSA) Acceptance Page (Page GSA-ii), Payment is due on the 1st day of the month of coverage. For example, for the coverage month of July, the billing statement will be sent out the second week in June. Payment for the coverage month of July will be due the 1st day of July. Late fees will be applied for any payments received after the **tenth** day of the calendar month of coverage.

PAY AS BILLED METHOD
You should always use the "Pay-as-Billed" payment method. This is the most accurate and efficient method for you and MediExcel Health Plan. Review your bill, report any changes, and pay the total amount listed as due. Please do not alter your premium payment to account for changes. Any adjustments that you have made to your account will reflect on the next billing cycle. For instructions on how to report changes, please refer to the Correction to Group Statement section of this manual.

SUBMITTING PAYMENT
- Make your check payable to **MediExcel Health Plan**. Please write your group number on the face of the check and remit payment to:

  MediExcel Health Plan
  750 Medical Center Ct, Suite 2
  Chula Vista, CA 91911

- Make an Electronic Funds Transfer (EFT) or Direct Deposit (ACH), please contact MediExcel Health Plan at (619) 421-1659 or visit www.mediexcel.com for more information.

CORRECTION TO GROUP STATEMENT FORM
Do not record premium adjustments on the Employer Group/Subscriber Summary Report. The Correction to Group Statement Form is provided in order for you to report additions, deletions or corrections of Members not reflected on the current Group Statement. Any premium adjustments will be reflected on the next bill.

The Correction to Employer Group Statement Form only adjusts the Employer Group Statement or bill. Please refer to the section titled Membership Changes for the procedures to report individual Member changes.

Please note the following regarding adjustments to the Group Statement:

- Retroactive premium adjustments can only occur within a thirty-one (31) day period of the current billing period.

- Please ensure all Enrollment and Change forms are forwarded to MediExcel Health Plan on a timely basis.

- Your Group is responsible for premiums incurred as a result of late n otification of terminations that exceed thirty-one (31) days.

- Terminated Subscribers and Dependents are responsible for payment of all claims and services incurred after their termination date. MediExcel Health Plan is not responsible for claims or services paid due to errors in eligibility reporting or late reporting by you.

Please notify MediExcel Health Plan's Enrollment Department of any adjustments not reflected on the Group Statement by completing the Correction to Employer Group Statement or Employee Termination Form. Adjustments will be retroactively adjusted on the next billing statement.

Notifications of terminations are expected to be received by MediExcel Health Plan in a timely manner. Any notification of termination that is not reported within thirty-one (31) days from the date of termination will not receive full credit of premiums paid.

Your Correction to Employer Group Statement and supporting documentation (e.g. enrollment applications, copy of marriage license or birth certificate) can be **emailed to** **billing@mediexcel.com** or mailed to:

MediExcel Health Plan
750 Medical Center Ct, Suite 2
Chula Vista, CA 91911

SELF-BILLING SET-UP

On Trust arrangements, the Trust may elect a Self-Billing Set-up. This arrangement is discussed with MediExcel Health Plan in advance of the coverage start date.

On initial setup, the trust will have to confirm all who are enrolling, along with the corresponding amount to be billed. Post set-up, the trust will need to send an eligibility report to reconcile the payment received. All discrepancies will be communicated to the group administrator by our implementation team via email. Eligibility reports must be submitted by the 20th of every month.

SECTION 6
NOTICES, COMMUNICATIONS & FORMS

NOTICES
Important and Required Notices for employees are found in the EOC and also posted on the MediExcel Health Plan Website (www.mediexcel.com).

GOING GREEN - PAPERLESS INITIATIVES:
MediExcel Health Plan has incorporated workflow processes and digital forms to improve efficiency, reduce paper and postal expenses by using electronic distribution (Email) and pdf files of documents. The Member is assumed to consent to these paperless workflow processes and formats. The Member can opt out of one or more of these processes and digital forms by notifying Member Services.

MediExcel Health Plan has established a Patient Portal for secure electronic communications between the member and MediExcel Health Plan. An electronic file of member's benefit plans, EOC, SBC, IRS 1095B Tax Form and all applicable health plan notices shall be placed in the Patient Portal for easy retrieval by the member.

To register, please go to the following link: https://saludexcel.com/mediexcel/signup/ or contact Member Services at (619) 365-4346, (664) 633-8555 if dialing from México, or by email at memberservices@mediexcel.com.

IRS FORM 1095B
Unless the Employer Group elects otherwise, MediExcel Health Plan will distribute electronically to the Employer Group a consolidated PDF of all the Form 1095Bs for its enrolled employees in January of each year. Employer Group shall distribute to its employees. To communicate directly with the Team that produces the 1095B Forms, Employer Group and Employees can send an email to: 1095@mediexcel.com.

COMMONLY USED FORMS
The forms below are hyperlinked.

- Enrollment Form
- Evidence of Coverage (EOC)
- Summary of Benefits and Coverage (SBC)
- Affidavit for Enrollment of Domestic Partner
- Coverage Declination Form