GROUP POLICY OF MEDICAL, SURGICAL, AND HOSPITAL INSURANCE

No. G0037619

THIS AGREEMENT, made and entered into this 1st day of September, 2017 and between PacificSource Health Plans, an Oregon not-for-profit corporation, and Syringa Mountain Charter School (herein called 'Policyholder').

WITNESSETH:

In consideration of the Policyholder's payment of monthly premium in the amounts and at the time required, PacificSource will insure each enrolled person in accordance with the provisions and subject to the conditions of this Group Policy.

This policy does not include coverage for pediatric dental care, which is considered an essential health benefit under the Affordable Care Act (ACA). Pediatric dental care is available in the market and can be purchased as a separate policy. Please contact your insurance agent, PacificSource, or Your Health Idaho if you wish to purchase a stand-alone dental care policy.

This Group Policy, including all certificates of coverage, endorsements, schedules, or amendments affixed hereto, shall be the entire policy of insurance fully as if recited over the signature affixed hereto.

IN WITNESS WHEREOF, PacificSource has caused this Group Policy to be executed as of 12:00:01 a.m. local time this 1st day of September, 2017.

PacificSource Health Plans

Kenneth P. Provencher
By: President, CEO

POLICYHOLDER'S ACCEPTANCE

Payment of premium will constitute acceptance of this policy and the changes contained within.

PacificSource Health Plans
PO Box 7068, Springfield, OR 97475-0068

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SCHEDULE

POLICY INFORMATION

Group Name: Syringa Mountain Charter School
Group Number: G0037619
Group Effective Date: 09/01/2017
Provider Network: BrightPath

EMPLOYEE ELIGIBILITY AND PARTICIPATION REQUIREMENTS

Minimum Hour Requirement: 30 hours per week
Waiting Period Requirement: First of the month following 30 days. If the last day of the waiting period falls on the first calendar day of a month, coverage begins that day.
Minimum Participation: 70% of eligible employees

EMPLOYER PREMIUM CONTRIBUTION

PacificSource Minimum Requirement: Employees: 50% Dependents: 0%

MONTHLY PREMIUM INFORMATION

Plan Name	Per Member Per Month
BrightIdea Silver 3000 Ages 0-20	$153.00
BrightIdea Silver 3000 Age 21	$242.00
BrightIdea Silver 3000 Age 22	$242.00
BrightIdea Silver 3000 Age 23	$242.00
BrightIdea Silver 3000 Age 24	$242.00
BrightIdea Silver 3000 Age 25	$243.00
BrightIdea Silver 3000 Age 26	$247.00
BrightIdea Silver 3000 Age 27	$253.00
BrightIdea Silver 3000 Age 28	$263.00
BrightIdea Silver 3000 Age 29	$270.00
BrightIdea Silver 3000 Age 30	$274.00
BrightIdea Silver 3000 Age 31	$280.00
BrightIdea Silver 3000 Age 32	$286.00
BrightIdea Silver 3000 Age 33	$290.00
BrightIdea Silver 3000 Age 34	$293.00
BrightIdea Silver 3000 Age 35	$295.00
BrightIdea Silver 3000 Age 36	$297.00
BrightIdea Silver 3000 Age 37	$299.00
BrightIdea Silver 3000 Age 38	$301.00
BrightIdea Silver 3000 Age 39	$305.00
BrightIdea Silver 3000 Age 40	$309.00
BrightIdea Silver 3000 Age 41	$315.00
BrightIdea Silver 3000 Age 42	$320.00
BrightIdea Silver 3000 Age 43	$328.00
BrightIdea Silver 3000 Age 44	$338.00

BrightIdea Silver 3000 Age 45	$349.00
BrightIdea Silver 3000 Age 46	$363.00
BrightIdea Silver 3000 Age 47	$378.00
BrightIdea Silver 3000 Age 48	$395.00
BrightIdea Silver 3000 Age 49	$412.00
BrightIdea Silver 3000 Age 50	$432.00
BrightIdea Silver 3000 Age 51	$451.00
BrightIdea Silver 3000 Age 52	$472.00
BrightIdea Silver 3000 Age 53	$493.00
BrightIdea Silver 3000 Age 54	$516.00
BrightIdea Silver 3000 Age 55	$539.00
BrightIdea Silver 3000 Age 56	$564.00
BrightIdea Silver 3000 Age 57	$589.00
BrightIdea Silver 3000 Age 58	$616.00
BrightIdea Silver 3000 Age 59	$629.00
BrightIdea Silver 3000 Age 60	$656.00
BrightIdea Silver 3000 Age 61	$679.00
BrightIdea Silver 3000 Age 62	$694.00
BrightIdea Silver 3000 Age 63	$713.00
BrightIdea Silver 3000 Ages 64+	$725.00

SCHEDULE OF BENEFITS

See the Medical Benefit Summary in the Member Handbook for more information.

ADMINISTRATIVE PROVISIONS

ELIGIBILITY

Persons within the following classes and no others are eligible to become enrolled and to remain enrolled under the group policy:

- **Employees.** All employees of the policyholder including sole proprietors, partners of a partnership, leased workers, and independent contractors if they are included as an employee under the health benefit plan of the employer, in accordance with the following criteria:
  - **Hourly requirement.** The employee must satisfy the hourly requirement by regularly working at least the number of hours per week stated in the Schedule.
  - **Hourly requirement and waiting period limitations.** Subsequent changes in the hourly requirement and/or waiting period are effective the first of the month following the date PacificSource receives written notification of and agrees to the change. Small employers must apply the hourly requirement and waiting period (which may not exceed 90 days) uniformly to all eligible employees. Under no circumstance may a waiting period be reduced for an individual employee.
- **Family members.** Spouses, qualified domestic partners, and dependent children of a subscriber, subscriber's spouse, or subscriber's qualified domestic partner who meet eligibility requirements outlined in the Eligibility and Enrolling Family Members sections of the Member Handbook are eligible for coverage.
- **Loss of dependent eligibility.** Eligibility for coverage as a dependent ends when they no longer meet the eligibility requirements for a dependent outlined in the Eligibility and Enrolling Family Members sections of the Member Handbook.
- **Persons on continuation.** Members may remain eligible for coverage under this group policy in accordance with the policy's provisions for continuation of insurance. (See Continuation of Insurance.)

ENROLLMENT

- **Enrollment procedures.** Enrollment is a required procedure to become covered under this plan. Application for enrollment must be made on an enrollment form acceptable to PacificSource, and in accordance with the rules and regulations adopted by your state's Department of Insurance.

  Each enrollment form must include the names of all eligible individuals to be covered. The enrollment form must be submitted to PacificSource by the policyholder. All eligible individuals whose enrollment forms and premiums are accepted by PacificSource become enrolled under this policy.

  PacificSource and the policyholder will offer coverage to eligible individuals without regard to health status, medical conditions (physical or mental), receipt of healthcare, medical history, genetic information, evidence of insurability, or disability.

  If this group policy was purchased through Your Health Idaho, the enrollment form must be submitted to PacificSource.

- **Replacement of prior policy.** If this group policy replaces an existing policy or contract of another insurance company, the following applies:
  - Within 60 days from the date of discontinuance of the prior policy, PacificSource will immediately cover all eligible individuals covered under the previous policy at the date of

discontinuance who satisfy the definition of an enrollee and who would have otherwise been eligible for coverage under the previous policy.

  - When a member is hospitalized on the date this policy becomes effective, PacificSource will reduce the benefits of this plan by an amount paid or payable by the prior plan. This applies until the hospitalized member's coverage is terminated according to the terms of this policy.
  - PacificSource will credit any deductibles satisfied or partially satisfied with the prior plan toward this plan's deductibles.
  - In any situation where a determination of the prior plan's benefit is required, the member is responsible for furnishing evidence of the terms of the prior plan, and of claim payments made by the prior plan.

- **Enrollment vendor**. If the policyholder elects to utilize a business entity (and PacificSource agrees to allow) to electronically transmit enrollment and disenrollment information to PacificSource, then the policyholder hereby affirms that it has entered into a valid business associate agreement with said vendor and that both the policyholder and vendor are in compliance with the Health Insurance Portability and Accountability Act (HIPAA), as amended. The policyholder hereby requests and authorizes PacificSource to exchange protected health information (PHI) with said vendor for the purposes of enrollment and disenrollment in this plan.

PARTICIPATION REQUIREMENTS

- **Minimum participation.** At all times during the term of the group policy, including all renewals and extensions, the policyholder must maintain a participation level equal to or in excess of the amounts or percentages stated as 'Minimum Participation' in the Schedule.
- **Verification of participation requirements.** PacificSource may verify with the policyholder, at reasonable times, that employee participation is in accordance with the terms of this policy. The policyholder agrees to provide census data, waivers of coverage, payroll records, time sheets, and/or other documents when requested by PacificSource for the purpose of confirming eligibility and participation levels of employees.
- **Small employers**. Small employers must enroll all eligible employees, except for employees covered by qualifying existing coverage, who may decline to enroll. To decline coverage, the employee must submit a written statement (Waiver of Coverage) to PacificSource at initial enrollment or at the time of disenrollment. The waiver must state that enrollment is being declined due to the existence of other qualifying health coverage. (See Administrative Provisions – Special Enrollment Periods.) Employees declining coverage due to the existence of other qualifying health coverage as allowed above are not counted when determining if the minimum participation requirement is met. However, an employer that does not employ at least two eligible employees on the date which coverage takes effect, or on the plan's anniversary date, does not meet participation requirements if there is only one employee under coverage.

  Failure to meet participation requirements will cause the policy to terminate on the annual renewal date. (See Term and Termination – Policy Renewal.)

PREMIUM

- **Monthly premium.** The monthly premium amounts and the required employer premium contribution amount or percentage for each member are included in the 'Monthly Premium Information' in the Schedule.
- **Premium modifications.** Premium rates will only be modified once in a 12 month period (on the policy renewal date) unless there is a change in benefits mid-contract year that affects the cost of insurance. The policy renewal date is the first day of a contract year.

PacificSource may modify premium rates on any renewal date by giving the group a 30 day prior written notice. The group may reject the modification by giving written notice to PacificSource at least 15 days before the modification is to take place. Rejection of any modification terminates this policy. Payment of premium after receiving notice of modification constitutes the policyholder's acceptance of the change.

- **When premium is due.** By the first day of each month while the group policy continues in effect, the policyholder will pay to PacificSource monthly premiums as follows:
  - Full monthly premium for each member who is enrolled for all or any part of the month except as provided below.
  - Prorated premium for each member who becomes enrolled after the first of the month in accordance with any policy provision that allows mid-month enrollment. The prorated premium is equal to 1/30 the full monthly premium, multiplied by the number of days remaining in the month from the date of enrollment.

  Premium is not considered paid until PacificSource receives the full premium amount by check, money order, or an accepted electronic transaction. The policyholder is not the agent of PacificSource for the purpose of collecting premiums.
- **Premium tax and/or assessments.** In the event your state or the federal government imposes a tax on premium received from your state sited policyholders, or an assessment is imposed, PacificSource reserves the right to increase such policyholders' premium rates to include the amount of the premium tax or assessment. The increase in premium rates becomes effective on the date the tax or assessment is imposed on the premium of your state sited policyholders.
- **Grace period.** There is a 30 day grace period for payment of each monthly premium. If premium is not paid within the grace period, PacificSource will cancel the group policy at the end of the grace period after the policyholder is notified in writing by PacificSource that premium is past due. (See General Policy Provisions – Term and Termination – Notice of termination.) The group's coverage and all claim liability will end on the last day of the last month for which premiums were paid by the policyholder and accepted by PacificSource. If PacificSource deposits funds remitted by the policyholder after the grace period, that action does not automatically constitute reinstatement of an expired policy. Any premium deposited after the grace period will be refunded to the policyholder.
- **Reinstatement after grace period expires.** If this policy is terminated for non-payment of premium, the policyholder may have the policy reinstated by remitting all past due premium within 15 days after the grace period ends. Reinstatement of this policy may not be made more than twice in one contract year. At its discretion, PacificSource may require that funds remitted by the policyholder to be in the form of a cashier's check.

  Funds that are received by PacificSource after the 15 day reinstatement period will not be accepted for the purpose of reinstatement but will either be refunded to the policyholder or applied to claims expense paid by PacificSource after the policy's coverage ended, if any. If the group health policy is terminated for non-payment of premium, the policyholder may reapply to PacificSource for a new group health policy at the next anniversary date of this policy.
- **When premium is mistakenly paid.** PacificSource will refund to the policyholder premium that was paid in error but only to a maximum of two months' premium and less any claims expense paid by PacificSource on behalf of the enrolled individual for which a refund is requested. All refund requests must be made in writing, and payroll records may be required to substantiate the request.
- **Refund of unused premium.** If for any reason the policyholder cancels coverage under this policy, the policyholder shall notify PacificSource on a timely basis. PacificSource will refund to

the policyholder any unused premium received for the period of ineligibility. 'Unused collected premium' means that portion of any premium collected which is not used, on a pro rata basis to the beginning of the next billing cycle at the time of cancellation, by PacificSource to insure against loss when there is no risk of loss, or that portion of any collected premium which would have not been collected had the policyholder paid monthly.

GENERAL POLICY PROVISIONS

TERM AND TERMINATION

- **Policy term.** The group policy becomes effective at 12:00:01 a.m. local time on the date written opposite 'Group Effective Date' in the Schedule, and continues in effect for a period of 12 months, provided premiums are paid when due and in the required amounts. The group policy is automatically renewed from month to month thereafter unless modified or terminated as described below.
- **Policy renewal.** The policy is renewable with respect to all eligible members at the option of the policyholder, unless:
  - The policyholder fails to pay the required premium. Termination is effective on the last day of the last month for which premium was paid.
  - The policyholder with respect to coverage of individual members, or the policyholder's or member's representative engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of this plan.
  - The number of members is less than the number or percentage of eligible employees required by the policy's participation requirements.
  - The policyholder fails to maintain the minimum employer premium contribution required.
  - When PacificSource elects not to renew all of its health benefit plans delivered or issued in the small group market in your state, provided all of the following conditions are satisfied:
    - Advanced notice of the decision is provided to your state's Department of Insurance and to all group policyholders;
    - Notice of the decision to all affected employers at least 180 days prior to the nonrenewal of any health benefit plans and notice to your state's Director of the Department of Insurance at least three working days prior to the notice to the affected policyholder; and

      When the employer no longer satisfies the definition of a small employer.
  - The Department of Insurance finds continuation of this policy's coverage would not be in the interest of the members, or would impair PacificSource's ability to meet contractual obligations.
  - In the case of a group health benefit plan that delivers covered services through a specified network of healthcare providers, there is no longer any member who lives, resides, or works in the service area of the provider network.
  - In the case of a health benefit plan that is offered in the group market only through one or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any member.
  - The policyholder terminates the policy on any premium due date with a 30 day prior written notice to PacificSource.

- **Rescissions.** PacificSource may not rescind the policyholder's group health benefit plan unless the policyholder or representative of the policyholder, performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of this plan, and PacificSource gives a 30 day prior written notice to all affected members covered under the plan. Rescissions do not include a cancellation or discontinuance of coverage that is prospective or to the extent it is attributable to a failure to timely pay required premiums towards the cost of coverage.
- **Policy modifications.** PacificSource may modify any provision of the policy on the policy's renewal date by giving the policyholder a 60 day prior written notice. Rejection of any modification terminates this policy. Payment of premium after receiving notice of modification constitutes the policyholder's acceptance of the change.

  A modification to the policy, except as may be required by law, that is offered by PacificSource at any time other than the policy renewal date may be accepted or rejected at the discretion of the policyholder. The policyholder may reject the modification by giving written notice to PacificSource at least 15 days before the modification is to take place.
- **Small employer plan changes.** Unless otherwise agreed to by PacificSource, a small employer policyholder may replace its current coverage with another small employer plan offered by PacificSource only on the anniversary date of the current coverage. This limitation also applies if the small employer discontinues their PacificSource coverage, or forfeits coverage with PacificSource. (See Definitions – Small employer in the Member Handbook.)
- **Notice of termination.** When the PacificSource coverage is not being replaced by another group policy, PacificSource will mail a notice of termination to the group policyholder within ten business days after the date on which the group policy terminates in accordance with the terms of the policy. PacificSource will supply the policyholder with the necessary information to properly notify members of their right to continuation coverage.

  If PacificSource fails to give notice, the policy will remain in force and premium owed for the period will be waived from the date notice should have been provided until the date the notice is received by the group policyholder. The time period within which members may exercise their right to continuation coverage commences on the date notice is received by the group policyholder.

OTHER GENERAL PROVISIONS

- **Changes in eligibility, participation, or employer premium contribution requirements.** Changes in waiting periods, hourly requirements, employer premium contribution, or participation requirements must be agreed upon by PacificSource and the policyholder before being applied by the policyholder. Requests for such changes must be submitted to PacificSource in writing.
- **Entire policy, including changes.** This group policy, including the certificate of coverage (Member Handbook), endorsements and attached papers, if any, constitutes the entire policy of insurance. No change in the group policy is valid unless approved by an executive officer of PacificSource and unless such approval is endorsed hereon or attached hereto. No agent has the authority to change the group policy or to waive any of its provisions.
- **Summary policy description.** The certificate of coverage (Member Handbook) is hereby incorporated into this policy. The certificate of coverage outlines the covered services, limitations, and exclusions provided to eligible individuals. In the event there is a conflict between the terms of this policy and the certificate of coverage, the terms of the certificate of coverage will prevail.

- **Plan administrator.** The group policyholder will act as the plan administrator and an agent of those individually enrolled under this policy and is not in any way considered the agent of PacificSource Health Plans.
- **Additional insured persons.** Newly eligible individuals may be added to the group originally insured from time to time in accordance with the terms of this group policy.
- **Certificates of coverage.** PacificSource will furnish to the policyholder, for delivery to each eligible and enrolled employee, copies of the certificate of coverage (Member Handbook) containing a summary of the essential features of the coverage offered and the applicable rights and conditions set forth in your state's statutes.
- **Claims payment and communication practices.** After receipt of a claim, PacificSource will make every effort to pay the claim within 30 days after receipt, and will reply, within 30 days of receipt, to any other pertinent communication about a claim from a claimant that reasonably indicates a response is expected. If a claim cannot be paid within 30 days of receipt because additional information is needed, PacificSource will acknowledge receipt of the claim and explain why payment is delayed. PacificSource will complete its claims investigation within 45 days of receipt of the claim unless the investigation cannot reasonably be completed within that time. PacificSource has the sole right to pay benefits to the member, the provider, or both jointly. Neither this policy nor a claim for payment of benefits under this policy is assignable in whole or in part to any person or entity.
- **Members held harmless.** Providers contracting with PacificSource agree to look only to PacificSource for payment of the part of the expense for services and supplies that are covered by the insurance policy. The contracted provider may not bill a member in the event PacificSource fails to pay the provider, for whatever reason. The provider may bill the member for applicable co-insurance, co-payments, and deductibles and for non-covered expenses, except as may be restricted in the provider contract.
- **Legal actions.** No legal procedure to enforce any of the provisions of the group policy may be instituted by a member during a period of 60 days after written proof of loss has been furnished to PacificSource. You may not take legal action against PacificSource more than three years after the deadline for claim submission has expired.
- **PacificSource not liable for quality of medical care.** Members have the sole right to choose their healthcare providers. PacificSource is not responsible for the quality of medical care a person receives since all those who provide care do so as independent contractors. PacificSource cannot be held liable for any claim or damages connected with injuries suffered by a member while receiving medical services or supplies.
- **Right to examine records**. It is specifically understood and agreed that each member, by enrolling and/or accepting benefits under this policy, grants to PacificSource the right to examine all medical, hospital, and other records pertaining to the eligibility of an individual, or any cases for which the benefits of the agreement are claimed and for purposes of utilization review, quality assurance, and peer review by PacificSource or its designee.
- **Administration of agreement**. PacificSource may adopt policies, procedures, rules, and interpretations to promote orderly and efficient administration of this agreement.
- **Governing law.** The validity and interpretation of this agreement, and the rights and obligations of the parties hereunder, will be governed by the laws of your state and the federal government. Therefore, coverage is subject to change as required by law. If any provision of this agreement is held to be invalid, void, or unenforceable, the remaining provisions will continue in full force and effect.

- **Waiver of provisions.** The waiver by either party to this agreement of any breach of any of the provisions of this agreement will not constitute a continuing waiver, or a waiver of any subsequent breach of the same or of a different provision of this agreement.
- **ERISA responsibility.** If this policy is part of a 'welfare benefit plan' regulated under the Employee Retiree Income Security Act of 1974 (ERISA) as amended , the policyholder's responsibilities and PacificSource's responsibilities include the following:
  - The policyholder is responsible for furnishing summary plan descriptions, annual reports, and summary annual reports to subscribers and other plan participants and to the government as required by ERISA.
  - PacificSource will furnish the policyholder with a description of the benefits available under this policy.
  - PacificSource's claims appeal procedures are described in the sections entitled 'Claims Payment' and 'Grievances and Appeals' in the Member Handbook.
  - The policyholder, not PacificSource, is the 'plan administrator' as defined in ERISA. The policyholder, not PacificSource, is responsible for providing all notices required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended.
- **Special rights upon childbirth.** This plan complies with the Newborns' and Mothers' Health Protection Act of 1996. Length of stay for the mother or newborn child is not restricted to less than 48 hours after vaginal delivery, or to less than 96 hours after cesarean section delivery. The provider does not need to obtain authorization from PacificSource for a length of stay up to 48 hours (or 96 hours, when applicable). However, the law does not prohibit the mother's or newborn's attending provider from discharging the mother or newborn earlier than 48 hours (or 96 hours) after consulting with the mother.
- **Notifications and disclosures**. PacificSource will furnish notification and disclosure documents to members as required by HIPAA including initial notices regarding special enrollment rights.

  PacificSource will provide initial disclosure notices regarding the plan's special enrollment rights to the policyholder for distribution to members. The policyholder, not PacificSource, is responsible for distributing the initial disclosure notices in accordance with HIPAA requirements.
- **Representations not warranties.** In the absence of fraud, all statements made by the applicant, policyholder, or member will be considered representations and not warranties. No statement made for the purpose of effecting insurance will void the insurance or reduce benefits unless it is contained in a written document signed by the policyholder or the member, a copy of which has been furnished to that person.
- **Fraud warning.** A person may be guilty of insurance fraud if they submit an enrollment form or claim containing a false or deceptive statement with either the intent to defraud PacificSource, or the knowledge that they are facilitating a fraud. Misrepresentations, omissions, concealments of facts, and incorrect statements shall not prevent a recovery under this policy unless the misrepresentations, omissions, concealments of facts, and incorrect statements are shown by PacificSource to be either material to the risk assumed by PacificSource or fraudulent.

CONTINUATION OF INSURANCE

USERRA CONTINUATION

With respect to provisions of the Uniformed Services Employment and Reemployment Rights Act (USERRA) that apply to continuation of coverage rights for employees on leave of absence for military service, the following will apply to all groups regardless of size:

- **Eligibility.** Covered employees who are absent from employment due to service in the 'uniform services' may elect continuation if coverage is lost due to their absence. 'Service in the uniformed services' includes active or reserve duty, whether voluntary or involuntary, and time off for training or instruction. The term 'uniform services' means the Armed Forces, the Army National Guard and the Air National Guard, the commissioned corps of the Public Health Services, and any other category of persons designated by the President of the United States in time of war or national emergency.
- **Maximum continuation period.** An employee who is covered under the health plan and absent due to military service may elect continuation coverage under USERRA for eligible individuals for a maximum period of 24 months. However, if the employee fails to return to work at the end of his or her leave for military service, then the right to continuation coverage ends when the time period for applying for reemployment expires.
- **Premium.** The employee is responsible for the full cost of continuation coverage. Premium must be submitted to PacificSource by the employer each month with the group's regular premium payment.
- **Termination.** Continuation of coverage for a qualified individual will terminate before the expiration of the maximum coverage period when any of the following events occurs:
  - The employer ceases to maintain a group health plan for any employee; or
  - The qualified individual fails to make timely payment of premium.
- **Notification requirements**. The plan administrator should notify an employee of their right to continue coverage under USERRA at the time the plan administrator becomes aware of the employee's absence due to military service. PacificSource may require the election for continuation to be in writing and will not accept a continuation election submitted later than 60 days from the first day of a military leave of absence.
- **USERRA and COBRA**. Although an eligible individual may have continuation of coverage rights under USERRA and COBRA, coverage periods permitted under each law will run concurrently. Only the longer of the coverage periods will be allowed under this policy.

COBRA CONTINUATION

- **Premium**. Premium charged for continued coverage under this provision is limited to 102 percent of premium charged for like coverage of active employees. The initial premium is due within 45 days of the date of election, and subsequent premium payments are due by the first of the month for which coverage is to be effective or within the grace period as provided in this policy.
- **Notification requirements**. Failure by the subscriber, qualified beneficiary, plan administrator, or employer to make the required notification within the specified time periods will end PacificSource's obligation to provide continued coverage for a qualified beneficiary under this policy. In addition, the plan administrator or employer must provide PacificSource a copy of the 'Continuation Election Form' within 30 days after receipt from the subscriber or qualified beneficiary. The following are required notifications:
  - The plan administrator (or employer if they are the same entity) must provide each qualified beneficiary with notice of continuation election rights within 14 days of receipt of notice that a qualifying event has occurred.
  - A subscriber or qualified beneficiary must notify the plan administrator within 60 days of a divorce or legal separation of the subscriber from a spouse, or of an enrolled dependent child ceasing to be eligible as a dependent under this policy.

- A COBRA qualified beneficiary who is determined to be disabled (under title II or XVI of the Social Security Act) at any time during the 60 day period after termination or reduction in hours must notify the plan administrator within the initial 18 month period, but not later than 60 days after the date of determination.
- When the plan administrator and the employer are not the same entity, the employer must notify the plan administrator within 30 days of the date of the death of a subscriber, the termination or reduction of hours of a subscriber, a subscriber's entitlement to Medicare, or the commencement of a bankruptcy proceeding of the employer.
- The subscriber or qualified beneficiary must notify the plan administrator of their continuation election within 60 days of the qualifying event.

EXTENSION OF BENEFITS

Extension of benefits for disability. If the member is totally disabled on the date of termination of this group policy, coverage may continue for up to 12 months. Once PacificSource receives medical documentation of disability, PacificSource will continue to provide benefits for covered expenses related to disabiling conditions until any one of the following occurs:

- The member is no longer totally disabled;
- The policy's maximum benefits have been paid; or
- The policy has been discontinued for 12 months.