SHARP HEALTH PLAN
GROUP AGREEMENT

This Group Agreement ("Agreement") is made and becomes effective the first day specified on the Execution Page, between the organization named on the Execution Page to this Agreement ("Employer Group") and Sharp Health Plan ("Plan"). **If Employer Group does not return the Execution Page to Plan, payment by Employer Group of the first Premium payment following the Premium payment due with Employer Group's application shall also constitute Employer Group's agreement to be bound by all of the terms and conditions of this Agreement.**

RECITALS

A. Plan is licensed to operate a health care service plan under and subject to the Knox-Keene Health Care Service Plan Act of 1975, as amended, contained in Sections 1340 et. seq. of the California Health and Safety Code ("the Act"), and the regulations promulgated thereunder, as amended, contained in Title 28 of the California Code of Regulations (the "Regulations").

B. Plan will provide and arrange for the provision of Benefits, in accordance with the terms, conditions, Limitations and Exclusions of this Agreement, to Eligible Employees of Employer Group and their Dependents, who are enrolled in Plan ("Members").

C. Employer Group will pay Premiums to Plan for the provision of Benefits by Plan to Members. Employer groups participating in the Covered California for Small Business (CCSB) program shall remit Premiums to Covered California in accordance with Covered California's policies and standards. Employer groups participating in the California*Choice* Program shall remit Premiums to California*Choice* in accordance with California*Choice* policies and standards.

AGREEMENT

NOW, THEREFORE, the parties mutually agree as follows:

I.

DEFINITIONS

When capitalized throughout this Agreement, the following terms (and the singular or plural forms thereof, as appropriate) shall have the following meanings for purposes of this Agreement:

1.1 "Active Labor" means a labor at a time at which either of the following would occur: (a) There is inadequate time to effect safe transfer to another hospital prior to delivery; or (b) a transfer may pose a threat to the health and safety of the patient or the unborn child.

1.2 "Administrative Manual" means the manual available to employer groups that serves as a guide for effective administration of the group health plan. The manual is updated from time to time and available on Plan's website: sharphealthplan.com.

1.3 "Agreement" means the contract between Plan and Employer Group and includes all of the following: (1) this Agreement and any amendments and Attachments hereto; (2) the Member Handbook and any amendments

thereto; (3) the Employer Group application; and (4) the individual applications of the Members covered hereunder, as may be updated from time to time.

1.4 "Attachments" means Attachments A through D hereto, which are incorporated herein as if set forth in full.

1.5 "Authorization" or "Authorized" means the approval by Plan or a Member's Plan Medical Group for Benefits. (An Authorization request may also be called a pre-service claim.)

1.6 "Benefit Year" means the 12-month period that begins at 12:01 a.m. on the first day of the month of each year established by Employer Group and Plan.

1.7 "Benefits" means the Covered Benefits described in Attachment A and the Supplemental Benefits described in Attachment C, if applicable, to which Members are entitled under this Agreement.

1.8 "Calendar Year" means the 12-month period beginning January 1 and ending December 31 of the same year.

1.9 "California*Choice* Program" means the private sector exchange authorized by the California Department of Corporations in 1995 that offers a choice of plans, both full service and specialized, to employers and employees in the Small Group market.

1.10 "Child" or "Children" means:

(1) The naturally born Children, legally adopted Children, or stepchildren of the Enrolled Employee or the Enrolled Employee's Spouse or Domestic Partner;
(2) Children for whom the Enrolled Employee or the Enrolled Employee's Spouse or Domestic Partner has been appointed a legal guardian by a court;
(3) Children for whom the Enrolled Employee or the Enrolled Employee's Spouse or Domestic Partner is required to provide health coverage pursuant to a qualified medical support order; and
(4) Children, except foster children, for whom the Enrolled Employee has assumed a parent-child relationship, as indicated by intentional assumption of parental status or assumption of parental duties by the Enrolled Employee, and as certified by the Enrolled Employee at the time of enrollment of the Child and annually thereafter.

A Child remains eligible for coverage through the end of the Benefit Year in which he/she turns 26 years of age. A covered Child is eligible to continue coverage beyond the age of 26 if the Child is and continues to be both:

(1) Incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition; and
(2) Chiefly dependent upon the Enrolled Employee for support and maintenance.

1.11 "Coinsurance" means a percentage of the costs of a Covered Benefit (for example, 20%) that a Member pays after the Member has paid the Deductible, if a Deductible applies to the Covered Benefit.

1.12 "Copayment" or "Copay" means a fixed dollar amount (for example, $20) that a Member pays for a Covered Benefit after the Member has paid the Deductible, if a Deductible applies to the Covered Benefit.

1.13 "Cost Share" or "Cost Sharing" means the amount of the Member's financial responsibility as specifically set forth in the Health Plan Benefits and Coverage Matrix (also referred to as the Summary of Benefits) and any supplemental benefit rider, if applicable, attached to this Agreement. Cost Share may include any combination of Deductibles, Coinsurance and Copayments, up to the Out-of-Pocket Maximum.

1.14 "Covered Benefits" means those Medically Necessary services, prescription drugs and supplies that Members are entitled to receive under this Group Agreement and which are described in the Member Handbook.

1.15 "Covered California" means the California Health Benefits Exchange. The California Health Benefits Exchange is an online marketplace established by the State of California to provide access to health plans and health insurance.

1.16 "Covered California for Small Business" or "CCSB" means the program offered by Covered California to provide health insurance and health plan choices to small businesses and their employees. CCSB was formerly known as the Small Business Health Options Program, or SHOP.

1.17 "Deductible" means the amount a Member pays in a Calendar Year for certain Covered Benefits before Plan begins payment for all or part of the cost of those Covered Benefits in that Calendar Year.

1.18 "Department" means the Department of Managed Health Care of the State of California.

1.19 "Dependent" means an Enrolled Employee's legally married Spouse, registered Domestic Partner or Child who meets the eligibility requirements set forth in this Group Agreement.

1.20 "Director" means the Director of the Department of Managed Health Care.

1.21 "Domestic Partner" means a person who has established a domestic partnership as described in Section 297 of the California Family Code by meeting all of the following requirements:

(1) Both persons have chosen to share one another's lives in an intimate and committed relationship of mutual caring.
(2) Neither person is married to someone else nor is a member of another domestic partnership that has not been terminated, dissolved, or adjudged a nullity.
(3) The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
(4) Both persons are at least 18 years of age, except as follows:
    i. A person under 18 years of age who, together with the other proposed Domestic Partner, otherwise meets the requirements for a domestic partnership other than the requirement of being at least 18 years of age, may establish a domestic partnership upon obtaining a court order granting permission to the underage person or persons to establish a domestic partnership.
(5) Both persons are capable of consenting to the domestic partnership.
(6) Both file a Declaration of Domestic Partnership with the Secretary of State.

If Employer Group offers coverage to the Spouses of Enrolled Employees, Employer Group must also offer coverage to the registered Domestic Partners of Enrolled Employees. If documented on the Execution Page of this Group Agreement, Domestic Partner also includes individuals who meet criteria 1-5 above and sign an affidavit attesting to that fact.

1.22 "Eligible Employee" means any permanent employee, employed for the period of time specified by Employer Group (not to exceed 90 calendar days), who is actively engaged on a full-time basis in the conduct of the business of Employer Group with a normal work week of an average of 30 hours per week over the course of a month at Employer Group's regular place or places of business. The term includes sole proprietors or partners in a partnership, if they are actively engaged on a full-time basis in Employer Group's business and included as employees under this Agreement, but does not include employees who work on a temporary or substitute basis or who waive coverage on the grounds that they have other employer-sponsored health coverage or coverage

under Medicare. If Employer Group elects to offer coverage to contracted ("1099") employees, then a contracted employee who meets the criteria outlined in Plan's underwriting guidelines also qualifies as an Eligible Employee. A permanent employee who works at least 20 hours but not more than 29 hours is also an Eligible Employee if all of the following apply: (i) the employee otherwise meets the definition of an Eligible Employee, except for the number of hours worked, (ii) Employer Group offers the employee health coverage under this Group Agreement, (iii) all similarly situated individuals are offered coverage under this Group Agreement, and (iv) the employee has worked at least 20 hours per normal workweek for at least 50% of the weeks in the previous calendar quarter. 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.

1.23 "Emergency Medical Condition" means a medical condition, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

1.24 "Emergency Services" means those Benefits, including Emergency Services and Care, provided inside or outside the Service Area, that are medically required on an immediate basis for treatment of an Emergency Medical Condition.

1.25 "Emergency Services and Care" means: (a) medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician and surgeon, to determine if an Emergency Medical Condition or Active Labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; and (b) an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric Emergency Medical Condition, within the capability of the facility.

1.26 "Employer Group" means the person, firm, proprietary or nonprofit corporation, partnership, or public agency that is named on the Execution Page to this Agreement. Employer Group shall be actively engaged in business or service, not formed primarily for purposes of buying health care service plan contracts, and a bona fide employer-employee relationship exists.

1.27 "Enrolled Employee" means an employee of Employer Group who meets the applicable eligibility requirements, has enrolled in Plan under the provisions of this Agreement, and for whom the applicable Premiums have been received by Plan.

1.28 "Exclusion" means any provision of this Agreement whereby benefits for a specified illness or condition are entirely eliminated.

1.29 "Grace Period" means a period of at least 30 consecutive days, beginning with the day the Notice of Start of Grace Period is dated or the day after the last date of paid coverage, whichever is later, to allow Employer Group to pay an unpaid Premium amount without losing health care coverage. To qualify for the Grace Period, Employer Group must have paid at least one full month's Premium for this Agreement.

1.30 "Hospital Services" means those diagnostic and treatment hospital services that are listed as such in the Member Handbook.

1.31 "Limitation" means any provision of this Agreement that restricts Benefits, other than an Exclusion.

1.32 "Medically Necessary" means a treatment or service necessary to protect life; to prevent illness or disability; to diagnose, treat or control illness, disease, or injury; or to alleviate severe pain. The treatment or service should be: (a) based on generally accepted clinical evidence; (b) consistent with recognized standards of practice; (c) demonstrated to be safe and effective for the Member's medical condition; and (d) provided at the appropriate level of care and in an appropriate treatment setting based on the Member's medical condition.

For purposes of Mental Health or Substance Use Disorders, medically necessary means a service or product addressing the specific needs of that member, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

i. In accordance with the generally accepted standards of mental health and substance use disorder care (as defined below).
ii. Clinically appropriate in terms of type, frequency, extent, site, and duration.
iii. Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

For purposes of determining the Medical Necessity of a Mental Health or Substance Use Disorder, "generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to Section 1374.73. Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

1.33 "Medicare Act" means Title XVIII of the Social Security Act, and all amendments thereto (42 U.S.C. Sections 1395 et seq.).

1.34 "Member" means an Enrolled Employee or a Dependent who has enrolled in Plan under the provisions of this Agreement and for whom the applicable Premiums have been received by Plan.

1.35 "Member Handbook" means Attachment A to this Agreement, as amended from time to time.

1.36 Mental Health and Substance Use Disorders ("MHSUD") means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

1.37 "Notice of Cancellation, Rescission or Nonrenewal" means the notice sent by Plan to Employer Group that this Agreement will be cancelled, Rescinded or not renewed for any reason other than nonpayment of Premiums. With respect to this notice, "cancelled" or "not renewed" shall have the meaning set forth in subdivision (a)(3) of Section 1300.65 of Title 28 of the California Code of Regulations.

1.38 "Notice of End of Coverage" means the notice sent to Employer Group and all Members that coverage under this Agreement has been cancelled.

1.39 "Notice of Start of Grace Period" means the notice sent by Plan to Employer Group that this Agreement will be terminated unless the Premium amount due is received by Plan no later than the last day of the Grace Period.

1.40 "Open Enrollment Period" means a designated period of time each year, established between Employer Group and Plan, during which Eligible Employees and their Dependent(s) can enroll in a health plan or make changes to their coverage. The Open Enrollment Period will be the period of at least 30 days immediately preceding the renewal date of this Agreement.

1.41 "Out-of-Area" means a Member is temporarily outside his or her selected Plan Network's Service Area. Out-of-Area coverage includes coverage for Emergency Services and Urgent Care Services for the sudden onset of symptoms of sufficient severity to require immediate medical attention to prevent serious deterioration of a Member's health resulting from unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member returns to the Service Area.

If services for the medically necessary treatment of a mental health or substance use disorder are not available in network within the geographic and timely access standards set by law or regulation, the health care service plan shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services that, to the maximum extent possible, meet those geographic and timely access standards. As used in this subdivision, to "arrange coverage to ensure the delivery of medically necessary out-of-network services" includes, but is not limited to, providing services to secure medically necessary out-of-network options that are available to the enrollee within geographic and timely access standards. The enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from an in-network provider.

1.42 "Out-of-Pocket Maximum" means the maximum total amount of expenses that a Member will pay for Covered Benefits in a Calendar Year before Plan pays Covered Benefits at 100%. All Member Cost Sharing (including Copayments, Deductibles and Coinsurance) for Covered Benefits, excluding Supplemental Benefits, contributes to the Out-of-Pocket Maximum.

1.43 "Plan Hospital" means an institution licensed by the State of California as an acute care hospital that provides certain Benefits to Members through an agreement with Plan and that is included in the selected Plan Network.

1.44 "Plan Medical Group" or "PMG" means a group of physicians, organized as or contracted through a legal entity, that has met Plan's criteria for participation and has entered into an agreement with Plan to provide and make available Professional Services, and to provide or coordinate the provision of other Benefits to Members and that is included in the selected Plan Network.

1.45 "Plan Network" means a discrete set of network providers, as defined in subsection (b)(10) of the California Code of Regulations Rule 1300.67.2.2, that Sharp Health Plan has designated to deliver all covered services for a specific network Service Area, as selected by Employer Group or the Member, and as indicated on the Execution Page of this Agreement.

1.46 "Plan Physician" means any doctor of medicine, osteopathy, podiatry or dental surgery licensed by the State of California who has agreed to provide Professional Services to Members, either under an agreement with Plan or as a member of a PMG, and who is included in the selected Plan Network. Plan Physicians are listed in the Provider Directory.

1.47 "Plan Providers" means the physicians, hospitals, skilled nursing facilities, home health agencies, pharmacies, medical transportation companies, laboratories, radiology and diagnostic facilities, durable medical equipment suppliers and other licensed health care entities or professionals who are part of the selected Plan Network and who provide Benefits to Members through an agreement with Plan. Plan Providers are listed in the Provider Directory. For purposes of Mental Health or Substance Use Disorders, Plan Providers also include :

(a) A person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

(b) An associate marriage and family therapist or marriage and family therapist trainee.

(c) A qualified autism spectrum disorder service provider or qualified autism spectrum disorder service professional certified by a national entity.

(d) An associate clinical social worker.

(e) An associate professional clinical counselor or professional clinical counselor trainee.

(f) A registered psychologist.

(g) A registered psychological assistant.

(h) A psychology trainee.

1.48 "Preexisting Condition" means a condition for which medical advice, diagnosis, care, or treatment, including prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage under this Agreement. Plan neither excludes coverage based on pre-existing conditions nor implements a waiting period for such services.

1.49 "Premiums" means the monthly amounts due and payable in advance to Plan, to Covered California, or to California*Choice*, as applicable, from Employer Group and/or Member for providing Benefits to Member(s).

1.50 "Prevailing Rates" means the rates generally accepted as payment by health care providers in the area where health care services, products and supplies are provided.

1.51 "Primary Care Physician" or "PCP" means a Plan Physician, possibly affiliated with a PMG, who is chosen by or for a Member from the Member's Plan Network and who is primarily responsible for supervising, coordinating and providing initial care to the Member; for maintaining the continuity of the Member's care; and for providing or initiating referrals for Benefits for the Member. Primary Care Physicians include general and family practitioners, internists, pediatricians and qualified OB-GYNs who have the ability to deliver and accept the responsibility for delivering primary care services.

1.52 "Professional Services" means those professional diagnostic and treatment services provided by Plan Physicians and other health professionals and which are listed in the Member Handbook and Supplemental Benefits brochures, if applicable.

1.53 "Provider Directory" means a listing of Plan-approved physicians, hospitals and other Plan Providers in the selected Plan Network, which is updated periodically.

1.54 "Rescission" or "Rescind" means a cancellation of coverage for fraud or intentional misrepresentation of material fact that has a retroactive effect.

1.55 "Service Area" means the geographic location and population points contained therein, in which the Plan is licensed and required to provide health care coverage consistent with network adequacy requirements. "Population points" shall mean a representation of where people live and work in the state of California based on United States Census Bureau population data and United States Postal Service (USPS) delivery route data, and made available annually by the Department on the web portal accessible at www.dmhc.ca.gov. For more information about each Plan Network Service Area, please visit Plan's website at sharphealthplan.com, or call Customer Care.

1.56 "Small Group" or "Small Employer" means any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that meets all of the following:

(1) Is actively engaged in business or service.
(2) On at least 50% of its working days during the preceding calendar quarter or preceding Calendar Year, employed at least one, but no more than 100 employees, the majority of whom were employed within this state. For purposes of determining whether an employer has one employee, sole proprietors or partners in a partnership, and their respective spouses, are not employees.
(3) Was not formed primarily for purposes of buying health care service plan contracts.
(4) A bona fide employer-employee relationship exists.

Subsequent to the execution of this Agreement, and for the purpose of determining eligibility, the size of Employer Group shall be determined annually. Except as otherwise specifically provided in this Agreement, provisions of this Agreement shall continue to apply until the anniversary date of this Agreement following the date Employer Group no longer meets the requirements of this definition.

1.57 "Spouse" means an Enrolled Employee's legally married husband or wife or Domestic Partner.

1.58 "Summary of Benefits" means the Member document that contains a list of the most commonly used Covered Benefits and applicable Cost Shares for the specific benefit plan(s) purchased by Employer Group. The Summary of Benefits may also be referred to as a Health Plan Benefits and Coverage Matrix and is included as Attachment B to this Agreement.

1.59 "Supplemental Benefits" means those Medically Necessary vision, chiropractic, and other services described in the Supplemental Benefits brochures contained in Attachment C, if applicable, as amended from time to time. Required benefits for pediatric vision care, consistent with benefits described in Section 1367.005 of the California Health and Safety Code, are not considered Supplemental Benefits.

1.60 "Totally Disabled" means a Member who is unable to engage in any employment or occupation for which the person is or becomes qualified by education, training or experience. An individual shall not be considered Totally Disabled unless he or she who is unable to engage in any such activity or any other activity normal or customary for a person in good health of like age on either a full-time or a part-time basis. The determination as to whether a Member is Totally Disabled will be made based upon an objective review consistent with professionally recognized medical standards.

1.61 "Urgent Care Services" means services intended to provide urgently needed care in a timely manner when the Member's PCP has determined that he or she requires these services, or the Member is Out-of-Area and requires Urgent Care Services. Urgent Care Services means those services performed, inside or outside Plan's Service Area, that are medically required within a short timeframe, usually within 24 hours or sooner if appropriate for the Member's condition, in order to prevent a serious deterioration of a Member's health due to an illness, injury,

or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgently needed services include maternity services necessary to prevent serious deterioration of the health of the Member or the Member's fetus, based on the Member's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the Member returns to Plan's Service Area. Urgent Care Services are covered worldwide in accordance with the following provisions:

(1) Inside the Service Area: Members must receive this care from the Plan Provider designated by the Member's PCP or PMG as its provider of Urgent Care Services.

(2) Outside the Service Area: This care is covered only during temporary absences from the Service Area in which the receipt of urgently needed services for an unexpected illness or injury cannot safely be delayed until the Member's return to the Service Area. Such care must be rendered by qualified medical personnel.

II.

PLAN PROVIDERS

2.1 All references to Plan Providers, Plan Medical Groups, Plan Hospitals, and Plan Physicians refer to providers and facilities in the selected Plan Network(s), as identified on the Execution Page of this Agreement.

2.2 Choice of Plan Medical Group. Each Enrolled Employee shall select a Plan Medical Group ("PMG") and a Primary Care Physician from the selected Plan Network on behalf of himself or herself and each of his or her Dependents at the time of enrollment in Plan. The Enrolled Employee may select a different PMG and/or Primary Care Physician from the selected Plan Network for himself or herself and for each of his or her Dependents. In the event that an Enrolled Employee fails to select a PMG at the time of enrollment in Plan, one will be assigned to him or her and each of his or her Dependents, at such time.

2.2.1 Enrolled Employees may change PMGs and/or Primary Care Physicians by contacting Plan's Customer Care Department. When Plan's Customer Care Department is contacted by the last day of the month, the change will be effective on the first day of the following month.

2.2.2 60 days prior to terminating a contract with an entire PMG, Plan shall provide written notice of the termination to Members who are, at that time, receiving a course of treatment from a Plan Provider of that PMG or are designated as having selected that PMG for their care.

2.3 Arranging for Benefits. Except for Emergency Services and Out-of-Area Urgent Care Services, each Member must obtain all Benefits from or through the Plan Providers specified in Sections 2.4 and 2.5, below. Additionally, except for Emergency Services and Out-of-Area Urgent Care Services, each Member is responsible for obtaining all necessary Authorization for Benefits. Except for Emergency Services and Out-of-Area Urgent Care Services, if Benefits are not provided by the Plan Providers specified in Sections 2.4 and 2.5, or if Benefits are provided without the necessary Authorization, the Member shall be responsible to pay for such Benefits.

2.4 Plan Hospitals. Each PMG is affiliated with at least one Plan Hospital. Consequently, except for Emergency Services, each Member must receive Hospital Services from the Plan Hospital affiliated with the PMG selected by or for the Member. In the event Hospital Services are not available at such Plan Hospital, the Member will be referred to another Plan Hospital to receive such Hospital Services.

If services for the medically necessary treatment of a mental health or substance use disorder are not available in network within the geographic and timely access standards set by law or regulation, the health care service

plan shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services that, to the maximum extent possible, meet those geographic and timely access standards. As used in this subdivision, to "arrange coverage to ensure the delivery of medically necessary out-of-network services" includes, but is not limited to, providing services to secure medically necessary out-of-network options that are available to the enrollee within geographic and timely access standards. The enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from an in-network provider.

2.5 Plan Providers. Except for Emergency Services and Out-of-Area Urgent Care Services, each Member must receive Benefits from Plan Providers affiliated with the PMG selected by or for the Member. In the event Benefits are not available from such Plan Providers, the Member will be referred to another Plan Provider to receive such Benefits.

If services for the medically necessary treatment of a mental health or substance use disorder are not available in network within the geographic and timely access standards set by law or regulation, the health care service plan shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services that, to the maximum extent possible, meet those geographic and timely access standards. As used in this subdivision, to "arrange coverage to ensure the delivery of medically necessary out-of-network services" includes, but is not limited to, providing services to secure medically necessary out-of-network options that are available to the enrollee within geographic and timely access standards. The enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from an in-network provider.

III.

BENEFITS AND COPAYMENTS

Subject to all of the terms, conditions, Limitations and Exclusions of this Agreement, Members are entitled to receive Benefits as follows:

3.1 Obtaining Benefits. Unless otherwise specifically stated to the contrary, the services and supplies described in the Member Handbook and Supplemental Benefits brochures, if applicable, are Covered Benefits only if, and to the extent that they are: (a) Medically Necessary; (b) not specifically limited or excluded in the Member Handbook or Supplemental Benefits brochures; (c) provided by Plan Providers in the selected Plan Network (except for Emergency Services and Out-of-Area Urgent Care Services); (d) prescribed by a Plan Physician and, if required, Authorized in advance by the Member's PMG or Plan (except for Emergency Services and Out-of-Area Urgent Care Services); and (e) part of a treatment plan for Benefits or required to treat medical conditions that are direct and predictable complications or consequences of Benefits.

If services for the medically necessary treatment of a mental health or substance use disorder are not available in network within the geographic and timely access standards set by law or regulation, the health care service plan shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services that, to the maximum extent possible, meet those geographic and timely access standards. As used in this subdivision, to "arrange coverage to ensure the delivery of medically necessary out-of-network services" includes, but is not limited to, providing services to secure medically necessary out-of-network options that are available to the enrollee within geographic and timely access

standards. The enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from an in-network provider.

3.2 Plan Providers. A list of the names and locations of Plan Providers in the selected Plan Network is contained in the Provider Directory, which may be obtained by calling Plan at 858-499-8300 or 1-800-359-2002.

3.3 Non-Plan Providers. Plan will not cover services and supplies received by Members from Providers who are not in the selected Plan Network unless: (a) they are Emergency Services or Out-of-Area Urgent Care Services; or (b) there is Authorization from Plan.

3.4 Within the Service Area. Subject to the foregoing, Members shall be entitled to receive all Benefits described in the Member Handbook and Supplemental Benefits brochures, if applicable, within the Service Area.

3.5 Outside the Service Area. Outside of the Service Area, Members may receive Emergency Services or Urgent Care Services described in the Member Handbook and Supplemental Benefits brochures, if applicable.

3.5.1 Plan and the Member's PMG may elect to return the Member to a Plan Provider once such transfer is medically appropriate. If Plan and the PMG authorize such a transfer, either Plan or the PMG shall pay the necessary and reasonable costs of transportation to a Plan Provider.

3.5.2 Follow-up care must be provided or arranged by the Member's PMG. For purposes of this Agreement, "follow-up care" means any Benefits that are not Emergency Services or Urgent Care Services.

3.6 Cost Sharing. Members are required to pay Cost Share (e.g., Copayments, Coinsurance and/or Deductible), if any, for Benefits at the time Benefits are rendered. The Cost Shares for Covered Benefits are set forth in the Summary of Benefits and shall remain in effect during the Benefit Year, unless changed in accordance with Section 14.1 hereof. There is a limit to the total amount of Cost Share a Member must pay for Covered Benefits in one Calendar Year. This is referred to as the annual Out-of-Pocket Maximum. The annual Out-of-Pocket Maximum for Covered Benefits is stated in the Summary of Benefits. The Member is responsible for maintaining receipts for and records of Cost Shares paid, and for presenting same to Plan once the annual Out-of-Pocket Maximum has been reached.

3.7 Cash Benefits. The Benefits described in the Member Handbook and Supplemental Benefits brochures, if applicable, are provided by Plan, subject to payment by the Member of the Cost Shares indicated. Additionally, except as specifically provided in Section 3.6 and Article XI hereof, neither Plan nor any Plan Provider will be obligated to provide a Member with cash in lieu of Benefits.

3.8 Supplemental Benefits. The Supplemental Benefits described in the Supplemental Benefits brochures, if applicable, are provided by the companies described therein. Also contained in the Supplemental Benefits brochures are terms, conditions, limitations, exclusions, Cost Shares and other matters relating to the Supplemental Benefits.

3.9 No Medical Necessity. Neither Plan nor any Plan Provider shall bill a Member for services rendered that are determined not to be Medically Necessary or Benefits, unless (i) the services are non-emergent and the Member obtains such services without Authorization; or (ii) the Member is advised prior to the rendering of those services that the services are not covered, and the Member agrees in writing to be financially responsible for those services.

IV.

EXCLUSIONS AND LIMITATIONS

4.1 Exclusions. The services and supplies set forth in the Member Handbook and the Supplemental Benefits brochures, if applicable, that are specifically excluded from Benefits provided under this Agreement.

4.2 Limitations. The rights of Members and the obligations of Plan hereunder are subject to the following Limitations:

4.2.1 Major Disaster or Epidemic. In the event of any major disaster, act of war, or epidemic, Plan and Plan Providers shall provide Benefits to Members to the extent Plan and Plan Providers deem reasonable and practical given the facilities and personnel then available. Under such circumstance, Plan shall use all Plan Providers available to provide Benefits, regardless of whether the particular Member in question had previously selected, been assigned to or received Benefits from a particular Plan Provider. Plan shall refer members to the nearest hospital for Emergency Services or to available urgent care providers for treatment of Medically Necessary services and may provide reimbursement for such services. However, neither Plan nor any Plan Provider shall have any liability to Members for any delay in providing, or failure to provide Benefits under such conditions to the extent that Plan Providers are not available to provide Benefits.

4.2.2 Workers' Compensation Coverage. Benefits available to Members who are also eligible for payments under California Workers' Compensation Law are not designed to be duplicative. To the extent permitted by such laws, Members shall assign to Plan their rights to all sums payable under such laws for Benefits, and such sums shall be payable to and retained by Plan. Members agree to complete and submit to Plan such consents, releases, assignments and other documents as may be required to enable Plan to obtain monies payable under such laws.

4.2.3 Third Party Liability. If a Member is injured or suffers an ailment or disease allegedly caused by an act or omission of a third party that gives rise to a claim for money damages against the third party, Plan (a) reserves the right to bring an action directly against the Member in the maximum amount permitted by applicable law, including California Civil Code Section 3040 or any successor provision of law, to the extent applicable and as amended, including without limitation, amounts for the maximum value of benefits conferred by Plan for the care and treatment of such injury, ailment, or disease sustained by the Member, regardless of whether any portion of those proceeds is designated as payment of medical expenses or whether the Member has been made whole or fully compensated for the Member's loss (collectively, the "Plan Costs"), immediately upon the Member's collection of damages, payments, or benefits of any kind from the third party, whether by judgement, damages award, settlement, or otherwise (collectively "Third-Party Recovery").. The Member shall cooperate in such efforts by: (a) promptly informing the Plan of the Member's claim against the allegedly responsible third party; (b) not entering into any settlement agreement with the third party; (c) informing Plan promptly upon issuance of a judgment or damages award against a responsible third party; and (d) executing such assignments, lien confirmation documents, and other forms as are required for Plan to perfect its lien and to recover Plan Costs. Notwithstanding any language or provision to the contrary here or elsewhere, out-of-pocket maximums and other Member payment limitations established by contract or otherwise do not restrict Plan's rights to recover the full amount of Plan Costs from a Third-Party Recovery. Plan may assign the right to recover Plan Costs from a Third-Party Recovery to Plan Providers and/or others.

4.2.4 Refusal to Accept Treatment. Plan Physicians use their best efforts to recommend Medically Necessary and appropriate services in a manner compatible with a Member's wishes, insofar as this can be done consistently with the Plan Physician's judgment regarding proper medical practice in accordance with prevailing medical standards. Certain Members may, for personal reasons, refuse to accept procedures or treatments recommended by Plan Physicians. Plan Physicians may regard such refusal as incompatible with the continuance of a satisfactory physician-patient relationship and as obstructing the providing of proper medical care. If a Member refuses to follow a recommended treatment(s) or procedure(s), and the Plan Physician believes that no professionally acceptable alternative exists, the Member will be so advised. The Member may then contact Plan to obtain assistance in either: (a) choosing a new Primary Care Physician; or (b) seeking a referral to a specialty Plan Physician, as appropriate. If, after consulting with such other Plan Physician, the Member still refuses to follow a recommended treatment(s) or procedure(s), then the Member may contact Plan for a determination as to whether any Medically Necessary, medically superior (as determined by Plan), covered alternative procedure(s) or treatment(s) is available to the Member. If Plan advises the Member to the contrary, or if the Member refuses to undergo any such other Medically Necessary, medically superior covered alternative procedure(s) or treatment(s), the Member may appeal Plan's decision through Plan's grievance procedure.

V.

PREMIUMS

5.1 Premiums. Employer Group shall remit, prior to the date specified on the Execution Page, the applicable Premiums set forth on the Execution Page of this Agreement for each Member entitled to receive Benefits as of that date. Thereafter, during the term of this Agreement, applicable Premiums shall be remitted to Plan on or before the 25 calendar day of the month prior to the month in which Members are entitled to receive Benefits hereunder (e.g., February Premiums are due January 25). With respect to newly eligible Members, Employer Group shall remit the applicable Premiums within 31 days of the Members becoming eligible for Benefits, as described in Section 6.1.1 hereof. All subsequent Premiums shall be remitted to Plan on or before the 25 calendar day of the month prior to the month in which the Members are entitled to receive Benefits hereunder. Employer groups participating in Covered California's CCSB program shall remit Premiums to Covered California in accordance with the policies and standards established by Covered California. Employer groups participating in the California*Choice* Program shall remit Premiums to California*Choice* in accordance with the policies and standards established by California*Choice*.

Upon determining that Employer Group has failed to pay all applicable Premiums by the due date, Plan will send a Notice of Start of Grace Period, notifying Employer Group that a payment delinquency has triggered a Grace Period. Employer Group shall promptly disseminate a copy of the Notice of Start of Grace Period to each Enrolled Employee. Employer Group will be given a Grace Period of at least 30 consecutive days, beginning with the day the Notice of Start of Grace Period is dated or on the day after the last date of paid coverage, whichever is later, during which Employer Group shall pay the Premiums owed for the month of coverage. Plan will continue coverage under this Agreement during the Grace Period. This Agreement is subject to termination at the end of the Grace Period if the Premiums are not paid in full by the last day of the Grace Period. Employer Group will be financially responsible for the full month's Premiums for coverage provided during any portion of the Grace Period. For example, an employer group paid March Premiums on February 25 and shall pay April Premiums by March 25. If payment is not received by March 25, Plan will send Employer Group a Notice of Start of Grace Period. The Grace Period will begin on the day the notice is dated or on April 1 (the day after the last date of paid coverage), whichever is later. If the April Premiums are not received by April 30, coverage will end at 12:01 a.m. on May 1. Employer Group will remain financially responsible for payment of April's Premiums.

The Premiums set forth on the Execution Page shall remain in effect for the term of this Agreement, unless changed in accordance with Sections 14.1 and 14.2 hereof. Any contributions required of Enrolled Employees shall be arranged with the Enrolled Employees by Employer Group.

5.2 Medicare Payments. Payments owed by Members or Employer Group under this Agreement are based on the assumption that Plan and Plan Providers, or their designees, will receive Medicare payments for Medicare-covered services provided to Members eligible for benefits under Part A of Medicare, Part B of Medicare, or both, as applicable. Members may become eligible for Medicare benefits due to age, disability or end-stage renal disease. Each such eligible Member must complete any document, and take any action, necessary: (a) to enroll in all Parts of Medicare for which he or she is eligible and continue that enrollment while a Member; and (b) to permit Plan and Plan Providers, or their designees, to obtain Medicare payments for Medicare-covered services provided to the Member. Any Member who fails to do either of the above within 30 days of written notice from Plan specifying the action to be taken shall lose eligibility for coverage under Plan, unless it was not reasonably possible for such Member to take the action specified by Plan within such 30 day period and the Member takes the specified action as soon as reasonably practicable after expiration of such 30 day period.

VI.

ELIGIBILITY/ENROLLMENT/EFFECTIVE DATE OF COVERAGE

6.1 Enrollment/Effective Date of Coverage. Except for enrollment forms from those Eligible Employees or their Dependent(s) who meet the requirements for late enrollment as set forth in Section 6.1.3, all enrollment forms must be submitted within the Eligible Employee's or Dependent's initial enrollment period or during Employer Group's Open Enrollment Period. Enrollment forms not received during the initial enrollment period or Open Enrollment Period are subject to rejection by Plan. Employer Group shall provide notice to Eligible Employees of the applicable initial enrollment period and Open Enrollment Periods.

6.1.1 Initial Enrollment Period. Employees who become eligible for coverage after Employer Group's effective date (e.g., newly hired, increase in hours of employment) and their Dependents shall be entitled to Benefits as of 12:01 a.m. on the first day on which eligibility was obtained, as established by Employer Group, so long as such person enrolls in Plan within 31 days of becoming eligible. Any person who fails to enroll within 31 days of becoming eligible may not enroll until Employer Group's next annual Open Enrollment Period, except as provided in Section 6.1.3. Employer Group shall be responsible for notifying Plan of newly eligible persons, for making timely payment of Premiums to Plan for such persons, and for complying with requirements in applicable state and federal law regarding eligibility determinations and permissible waiting periods.

6.1.2 Open Enrollment Period. The annual Open Enrollment Period under this Agreement is set forth on the Execution Page hereto. All Eligible Employees and Dependents enrolled during an Open Enrollment Period shall be entitled to Benefits as of the effective date of coverage for Benefits set forth on the Execution Page. Except as provided in Section 6.1.3, any then-eligible person failing to enroll in Plan during an Open Enrollment Period must wait until Employer Group's subsequent annual Open Enrollment Period to enroll. The Open Enrollment Period shall be a period of at least 30 days.

6.1.3 Special Enrollment Period. Eligible Employees, Enrolled Employees and their Dependents who experience one of the qualifying events below may enroll in Plan or may change benefit plans offered by Employer Group during a special enrollment period, consistent with this section. Employer Group may require documentation to support a qualifying event. Employer Group shall

provide notice of the special enrollment rights contained in this section to the Eligible Employee at or before the time the employee is offered an opportunity to enroll in Plan.

6.1.3.1 New Dependents. An Enrolled Employee who gains a new Dependent through marriage, establishment of a domestic partnership, birth, adoption, placement for adoption, assumption of a parent-child relationship, or through a court order shall have 30 days from the date of such event to enroll the new Dependent. If so enrolled, coverage for a new Spouse or Domestic Partner will be effective not later than the first day of the first calendar month beginning after the date the request for enrollment is received. Coverage for a new Child Dependent will be effective as of 12:01 a.m. on the date of birth, adoption, placement for adoption, assumption of a parent-child relationship or date of guardianship as ordered by a court, unless the employee requests the coverage to be effective on the first day of the month following the date of such event.

(1) An Eligible Employee who previously declined coverage during the initial enrollment period or annual Open Enrollment Period and who subsequently acquires a Dependent may enroll in Plan along with the new Dependent.

(2) When an Eligible Employee gains a Child Dependent, the employee may enroll a Spouse or Domestic Partner for coverage under Plan during the same special enrollment period as the newly gained Child Dependent.

6.1.3.2 Loss of Coverage. An Eligible Employee or Enrolled Employee and/or his/her Dependent(s) who experience a loss of minimum essential coverage (as defined in Section 1345.5 of the California Health and Safety Code or subsection (f) of Section 5000A of the Internal Revenue Code) may enroll in Plan or change benefit plans offered by Employer Group if the loss of coverage is due to one of the following:

(1) Exhaustion of COBRA or Cal-COBRA coverage (does not include termination due to failure to pay premiums on a timely basis).

(2) Termination of employer-contributions for non-COBRA or non-Cal-COBRA coverage.

(3) Loss of eligibility for non-COBRA or non-Cal-COBRA coverage (not including termination for cause or termination for nonpayment of premiums). For example, loss of eligibility may be due to a reduction in hours of employment, termination of employment, moving out of the plan's service area, a Dependent reaching the limiting age for coverage, death of the Enrolled Employee, or legal separation or divorce.

(4) Reaching a lifetime maximum on all benefits.

(5) Loss of coverage, including a substantial elimination of benefits, within one year before or after the date of commencement of a bankruptcy proceeding under title 11 of the United States Code, consistent with paragraph (6) of Section 1163 of the United States Code.

An Eligible Employee and/or his or her Dependent(s) shall have 30 days from the date of loss of coverage to enroll in Plan, except loss of Medi-Cal or Children's Health Insurance Program (CHIP) coverage, for which the Eligible Employee and/or his or her Dependent(s) shall have 60 days to enroll. If the employee requests enrollment on or before the last day of coverage, coverage shall be effective as of 12:01 a.m. on the first day of the month following loss of such coverage. Otherwise, coverage will be effective

as of 12:01 a.m. on the first day of the month following the month in which the employee requests enrollment in Plan. For example, an Eligible Employee loses his other coverage on March 31. If that Eligible Employee requests enrollment in Plan on or before March 31, his coverage will be effective under this Agreement on April 1. If that Eligible Employee requests enrollment in Plan anytime between April 1 and April 30, his coverage will be effective May 1.

6.1.3.3 Loss of Medi-Cal Coverage for Pregnancy or the Medically Needy. An Eligible Employee or Enrolled Employee or his/her Dependent who loses pregnancy-related coverage described under Section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act and Section 14005.18 of the Welfare and Institutions Code shall have 30 days from the last date of such coverage to enroll in Plan. An Eligible Employee or Enrolled Employee or his/her Dependent who loses Medi-Cal coverage for the medically needy, as described under Section 1902(a)(10)(C) of the Social Security Act and Section 14005.21 of the Welfare and Institutions Code, shall have 30 days from the last date of such coverage to enroll in Plan. A special enrollment period due to loss of Medi-Cal coverage for the medically needy shall be provided no more than once per Calendar Year.

6.1.3.4 Court or Administrative Order. An Enrolled Employee shall have 30 days after the date of a court or administrative order requiring the Enrolled Employee to provide health care coverage for a Spouse or Child who meets the eligibility requirements as a Dependent to enroll the Spouse or Child in Plan. If so enrolled, coverage will be effective not later than the first day of the first calendar month beginning after the date of request for enrollment is received, unless otherwise required by the court or administrative order.

6.1.3.5 Medi-Cal Premium Assistance. An Eligible Employee may enroll himself or herself and his/her Dependent(s), and an Enrolled Employee may enroll his/her Dependent(s), if the employee or his/her Dependent becomes eligible for premium assistance through the Medi-Cal program (i.e., when the Medi-Cal program pays all or part of premiums for employer group coverage for a Medi-Cal beneficiary). The employee shall have 60 days from the date he/she, or his/her Dependent, becomes eligible for the premium assistance to enroll in Plan. If so enrolled, coverage will be effective not later than the first day of the first calendar month beginning after the date the request for enrollment is received.

6.1.3.6 Returning from Active Duty. An Eligible Employee or Dependent returning from active duty shall have 30 days from the date of return to enroll himself or herself and his/her Dependents in Plan. If so enrolled, coverage will be effective not later than the first day of the first calendar month beginning after the date the request for enrollment is received.

6.1.3.7 Other Special Enrollment Events. An Eligible Employee and his/her Dependent(s) may enroll in Plan, or an Enrolled Employee may add his/her eligible Dependent(s), outside the initial enrollment period or Open Enrollment Period if the employee or Dependent experiences one of the events listed below. The employee must request enrollment in Plan within 30 days of the event. If so enrolled, coverage will be effective not later than the first day of the first calendar month beginning after the date the request for enrollment is received.

(1) The employee or his/her Dependent gains access to new benefit plans due to a permanent move.

(2) The employee's or his/her Dependent's previous health coverage issuer substantially violated a material provision of the health coverage contract.

(3) The employee or his/her Dependent has been released from incarceration.

(4) The employee or his/her Dependent was receiving services from a contracting provider under another health benefit plan for one of the conditions described in subdivision (c) of Section 1373.96 of the California Health and Safety Code and that provider is no longer participating in the health benefit plan.

(5) The employee or his/her Dependent failed to enroll during the immediately preceding enrollment period because the employee or Dependent was misinformed that they were covered under minimum essential coverage (as determined by Covered California, with respect to health benefit plans offered through Covered California, or by the Department, with respect to health benefit plans offered outside Covered California).

(6) The employee or his/her Dependent is a victim of domestic abuse or spousal abandonment, as defined by 26 CFR 1.36B-2 or a dependent or unmarried victim within a household, is enrolled in minimum essential coverage, and is seeking to enroll in coverage separate from the perpetrator of the abuse or abandonment. The Dependent of a victim of domestic abuse or spousal abandonment may enroll in coverage at the same time as the victim and on the same application as the victim.

(7) The employee or his/her Dependent applied for Medi-Cal or CHIP coverage through Covered California or through the state Medicaid or CHIP Agency, but determination their ineligibility was not communicated to them until after the annual Open Enrollment Period.

(8) The employee or his/her Dependent loses coverage under a non-Calendar Year group health plan or individual health insurance plan, even if the employee or Dependent had the option to renew such coverage.

(9) The employee or his/her Dependent newly gains access to an individual coverage HRA (as defined in 45 CFR 146.123(b)) or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code). The triggering event is the first day on which coverage for the employee or Dependent under the individual coverage HRA can take effect, or the first day on which coverage under the QSEHRA takes effect. An employee or Dependent will qualify for this special enrollment period regardless of whether they were previously offered or enrolled in an individual coverage HRA or previously provided a QSEHRA, so long as he/she is not enrolled in the individual coverage HRA or covered by the QSEHRA on the day immediately prior to the triggering event.

(10) For employer groups participating in the CCSB Program, in addition to the qualifying events described above, any other special enrollment periods established by Covered California.

6.2 Eligibility Requirements. Individuals are accepted for enrollment in and are entitled to continuing Benefits under Plan only if the applicable Premiums have been paid and such individuals meet all eligibility requirements established by Employer Group and the applicable requirements set forth below:

6.2.1 Enrolled Employee. To become an Enrolled Employee, a person must:

(1) be an Eligible Employee;

(2) reside or work within the Service Area for a significant portion of the year, as defined in Section 6.3.2;

(3) not have had his or her Benefits terminated previously for any of the reasons specified in Section 7.3.3 hereof; and

(4) submit the required Plan enrollment information.

6.2.2 Dependents. To be a Dependent, a person must meet the requirements of Sections 6.2.1(2), (3) and (4) and be one of the following:

(1) the Spouse or Domestic Partner of an Enrolled Employee;

(2) the Dependent Child of an Enrolled Employee or the Enrolled Employee's Spouse or Domestic Partner who is either:

(a) under age 26; or

(b) 26 years of age or older who, at the time of attaining age 26, met both of the following criteria and continues to meet both of the following criteria: (i) is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; and (ii) is chiefly dependent upon the Enrolled Employee for support and maintenance.

Plan will notify the Enrolled Employee at least 90 days prior to an enrolled Child attaining the limiting age of 26 that the Child's coverage will terminate. The notification will inform the Enrolled Employee that the enrolled Child's coverage will terminate upon the end of the Benefit Year in which he/she turns 26 years of age, unless the Enrolled Employee requests continued coverage of the disabled Child within 60 days of the date the Enrolled Employee receives the notification. Such request must include a written statement and supporting clinical documentation from the Child's Plan Physician describing the disability. Upon receipt of a request by the Enrolled Employee for continued coverage of the Child and the Plan Physician's documentation, Plan will determine if the Child meets the criteria described above. Coverage for such Child will continue until Plan makes its determination. Plan may request documentation to verify that the Child continues to meet the criteria above, but no more frequently than annually after the two-year period following the Child's reaching age 26.

Dependents are not required to live with the Enrolled Employee. However, Dependents must maintain their primary residence or work within Plan's licensed Service Area, unless enrolled as a full-time student at an accredited institution or unless coverage is provided under a medical support order.

6.2.3 Covered California Eligibility Rules for Employer Groups Participating in the CCSB Program: Employer Group, employees and Dependents shall meet the eligibility standards established by Covered California.

6.3 Other Rules of Eligibility.

6.3.1 No person is eligible to re-enroll hereunder if he or she has had Benefits terminated under Section 7.3.3 hereof.

6.3.2 For purposes of this Agreement, a person shall be considered by Plan to reside at a location "for a significant portion of the year" if that person uses that location as a residence and is physically present at that location for residential purposes for nine months of every 12 consecutive months. An enrolled Child shall not be required to reside in the Service Area so long as he or she is in full-time attendance at a post-secondary or trade school; however, absent full-time residence within the Service Area, such enrolled Child is not covered for Benefits received outside of the Service Area, except for Emergency Services and Urgent Care Services.

6.3.3 Coverage for an Eligible Employee who is not actively at work on the date coverage would otherwise become effective shall be deferred until the Eligible Employee returns to an active work status (unless the employee is not at work due to illness, injury or disability).

6.4 Employer Group Obligations.

6.4.1 Participation Requirements. Employer Group with 1-4 subscribers enrolled shall have at least 60% of its Eligible Employees enrolled in Employer Group's employer-sponsored plan(s), and at least 25% if 5+ subscribers enrolled, except as provided in Section 6.4.9.

6.4.2 Contribution Requirements. Employer Group shall contribute an amount, as specified on the Execution Page, toward equal to at least 50% of the monthly "employee only" rate due for each of the lowest "employee only" rate available to the Eligible Employee or equal to a defined contribution amount outlined in Plan's underwriting guidelines, except as provided in Section 6.4.9.

6.4.3 Workers' Compensation Requirements. 100% of the Eligible Employees enrolling in Employer Group's employer-sponsored plan(s) shall be covered by Workers' Compensation insurance, except those Eligible Employees who are not legally required to be covered by such insurance.

6.4.4 Enrollment Applications Submission Requirements. Employer Group shall forward to Plan all applications for enrollment in Plan under this Agreement no later than 30 days after the effective date of eligibility, as provided above. Employer Group's failure to forward enrollment applications to Plan within 30 days of the effective date of eligibility shall make Employer Group responsible: (a) to the employee for any claims for services provided to the employee and/or his/her Dependents prior to the effective date of coverage; and (b) for all Premiums beginning with the Member's effective date of coverage as determined by Plan. Employer groups participating in Covered California's CCSB program shall forward all applications for enrollment to Covered California in accordance with the standards established by Covered California. Employer groups participating in the California*Choice* Program shall forward all applications for enrollment to California*Choice* in accordance with the standards established by California*Choice*.

6.4.5 Requalification/Renewal Requirements. Employer Group shall submit to Plan at least 30 days prior to the anniversary date of this Agreement provided for on the Execution Page hereof, information on the number/status of employees/Dependents and verification that Employer Group continues to meet the definition of an Employer Group under the Act and of the eligibility criteria of such Employer Group. Employer groups participating in Covered California's CCSB program shall submit renewal information to Covered California in accordance with the standards established by Covered California. Employer groups participating in the California*Choice* Program shall submit renewal information to California*Choice* in accordance with the standards established by California*Choice*.

6.4.6 Eligibility Changes Requirements. Any change to any eligibility requirements of Employer Group must be submitted to Plan at least 30 days prior to the start of Employer Group's annual open enrollment period provided for on the Execution Page hereof, and shall become effective on the

annual effective date of coverage for open enrollment Members provided for thereon. Employer groups participating in Covered California's CCSB program shall submit any change to eligibility requirements to Covered California in accordance with the standards established by Covered California. Employer groups participating in the California*Choice* Program shall submit any change to eligibility requirements to California*Choice* in accordance with the standards established by California*Choice*.

6.4.7 Notices to Members. Employer Group agrees to disseminate all notices regarding material matters with respect to this Agreement and Plan to Members within 10 days after the receipt of notice of such matters from Plan. In the event that any such notice from Plan involves the cancellation or termination of, or decision not to renew this Agreement, Employer Group shall provide notice of such to Members promptly and shall provide Plan with written evidence of such notification. If Employer Group claims to be, and is determined by Plan to be, a "religious employer", as defined in section 1367.25 of the Act, and Employer Group requests not to provide coverage for the contraceptive methods required under such section that are contrary to Employer Group's religious tenets, Employer Group shall provide written notice to prospective Members prior to enrollment with Plan, listing the contraceptive health care services Employer Group refuses to cover for religious reasons.

6.4.8 Notification to Enrolled Employees Requirements. In addition to its other obligations hereunder to provide notifications to Members, Employer Group shall be responsible for informing and shall inform Enrolled Employees of the following:

(1) conditions of eligibility for enrollment in Plan;

(2) when coverage under this Agreement becomes effective and terminates;

(3) any continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA");

(4) any continuation coverage under Plan purchased or arranged for by Employer Group; and

(5) any change in the terms or conditions of this Agreement.

6.4.9 Limited Election Period: An employer group that does not meet the criteria outlined in Sections 6.4.1 or 6.4.2 may only elect to offer coverage through Plan from November 15 through December 15 of each year.

6.4.10 Plan's Liability in the Event of Conversion from a Prior Carrier. With respect to Eligible Employees or Dependents who were Totally Disabled on the date of discontinuation of the prior contract or policy, and entitled to an extension of benefits pursuant to Section 1399.62 of the California Health & Safety Code under the prior contract, Plan shall not be financially responsible for any payment of benefits or provision of services directly related to any condition which caused the total disability. In such a situation, the prior carrier shall continue to be financially responsible for all benefits or services directly related to any condition that caused or resulted from the total disability until such extension of benefits is no longer required under California or federal law.

VII.

TERM AND TERMINATION

7.1 Term. The initial term of this Agreement, for the provision of Benefits to Members enrolled in Plan in accordance with Article VI hereof, is set forth on the Execution Page. Thereafter, this Agreement shall automatically renew

for successive one year periods; provided, however, that for a renewal term, Plan may change the terms and conditions of this Agreement, including without limitation, the Benefits provided hereunder, and the Copayments and Premiums required hereunder, by delivering a written notice to Employer Group indicating the changes, at least 60 days prior to the effective date of renewal. Except as expressly provided in this Article, all rights to Benefits under this Agreement end upon termination of this Agreement.

7.2 Amendments No agent or other person, except an authorized representative of Plan, has authority to waive any condition or restriction of this Agreement, to extend the time for making a payment, or to bind Plan by making any promise or representation or by giving or receiving any information. This Agreement and any Amendments are subject to all laws, regulations, and contractual obligations that are incumbent upon Plan which include, but are not limited to: the Knox Keene Healthcare Services Act of 1975, as amended; Title 28 of the California Code of Regulations; and applicable federal law and regulation. Any provision required to be in this Agreement by any of the above shall bind the parties whether or not provided in this Agreement. Amendments made to this agreement due to regulatory or legal requirement shall be effective as stated. Employer Group and Plan agree to cooperate in efforts to comply with the requirements as stated above. This Agreement may be amended by Plan with 30 days prior written notice to Employer Group by Plan.

7.3 Termination of Individual Member.

7.3.1 Loss of Eligibility. If a Member ceases to meet the eligibility requirements of Article VI, then coverage for Benefits under this Agreement for such Member terminates automatically. Employer Group shall be responsible for notifying Plan, and agrees to notify Plan immediately, if a Member ceases to meet the eligibility requirements. Employer groups participating in Covered California's CCSB program shall notify Covered California if a Member ceases to meet eligibility requirements in accordance with the standards established by Covered California. Employer groups participating in the California*Choice* Program shall notify California*Choice* if a Member ceases to meet eligibility requirements in accordance with the standards established by California*Choice*. Employer Group shall continue to be liable for Premiums during the period between loss of eligibility and receipt of notice thereof by Plan. Plan Providers may bill a Member for services rendered to such Member subsequent to the Plan Provider's advisement by Plan of the Member's ineligibility.

7.3.2 Disenrollment. If an Enrolled Employee elects coverage under any other plan which is offered by, through, or in connection with Employer Group in lieu of Benefits under this Agreement, then Benefits for such Enrolled Employee and his or her enrolled Dependents terminate automatically on the last day for which the Premiums received by Plan cover that Enrolled Employee and his or her Dependents. Employer Group and the Enrolled Employee agree to notify Plan immediately when the Enrolled Employee elects other coverage.

7.3.3 Fraud or Deception. Members shall warrant in their enrollment applications that all information contained in applications, questionnaires, forms or statements submitted to Plan incident to enrollment under this Agreement, or to the administration of this Agreement, is true, correct and complete. If Plan demonstrates that any Member has performed an act or practice constituting fraud or made an intentional misrepresentation of material fact, or knowingly permits such fraud or intentional misrepresentation of material fact by another, then Plan may cancel, Rescind or not renew the coverage of such Member, and of his or her enrolled Dependents. Plan shall send a Notice of Cancellation, Rescission, or Nonrenewal to Employer Group and the Member at least 30 calendar days before the cancellation, Rescission, or nonrenewal. The termination effective date will be listed on such notice. Examples of fraud or intentional misrepresentation of material fact include, but are not limited to:

(1) Misrepresentation of eligibility information about the Enrolled Employee or his or her enrolled Dependents;

(2) Presenting an invalid prescription or physician order;

(3) Misusing a Plan ID card or allowing another individual to use the Member's ID card;

(4) Intentionally providing Employer Group or Plan with incorrect or incomplete material information; and

(5) Failing to notify Employer Group or Plan of changes in family status or other information that may affect eligibility.

7.3.4 Right to Submit a Grievance. A Member who alleges that his or her coverage was, or will be, improperly or unfairly cancelled, Rescinded, or not renewed has the right to submit a grievance to Plan or to the Director. Plan will resolve grievances regarding an improper cancellation, Rescission or nonrenewal of coverage, or provide the Member with a pending status, within three calendar days of Plan's receipt of the grievance. For more information regarding Plan's grievance policy and procedure, see Article IX.

7.3.5 Refunds to Members. If the rights of a Member hereunder are terminated, monies, if any, received from the terminated Member applicable to periods after the effective date of termination, plus amounts due the Member on claims, if any, less any amounts due Plan or Plan Providers from the Member shall be refunded to the Member within 30 days of such termination.

7.3.6 Refunds to Employer Group. If the rights of a Member hereunder are terminated, Premiums received from Employer Group on account of the terminated Member applicable to periods after the effective date of termination, plus amounts due on claims, if any, less any amounts due to Plan or Plan Providers shall be refunded to Employer Group within 30 days of Plan's receipt of notice of such termination.

7.4 Termination of Employer Group.

7.4.1 Nonpayment. Payment is due in accordance with Section 5.1. If Employer Group fails to pay the full amount due by the end of the Grace Period as described in Section 5.1, then Plan may cancel this Agreement and terminate the rights of the Members involved. Such rights may be reinstated only in accordance with Section 7.4.2. Plan shall continue to provide Benefits to the Members until the effective date of cancellation. If Members are hospitalized on the effective date of cancellation, then Plan shall continue to provide Benefits for the remainder of the hospital stay, if such Members continue to pay all applicable Premiums and Copayments, unless the Member(s) become covered earlier under other group or COBRA coverage. Plan shall issue to Employer Group a 30-day advance written notice of prospective cancellation (i.e., a Notice of Start of Grace Period) if payment is not received by the due date set forth in Section 5.1. If full payment for the unpaid, invoiced Premiums is not received by 11:59 p.m. on the last day of the Grace Period, then Plan shall issue a Notice of End of Coverage to Employer Group and to all individual Members of Employer Group.

7.4.2 Reinstatement. Per Section 7.4.1 above, if Plan issues to Employer Group a written Notice of End of Coverage informing Employer Group of the cancellation of this Agreement, then Employer Group may reinstate this Agreement if payment is received within 15 days of Plan's Notice of End of Coverage. Employer Group shall pay to Plan all of the following fees and payments, as a condition of reinstatement:

b. Unpaid invoiced Premiums — 100%

c. Reinstatement administrative surcharge — 10% of one month's Premiums
d. Next month's Premiums — 100%

7.4.2.1 If Plan receives payment from Employer Group more than 15 days after issuing the Notice of End of Coverage, then Plan is not required to reinstate this Agreement. Plan shall refund the amounts received to Employer Group within 20 business days.

7.4.2.2 In the event that the reinstatement period in Section 7.4.2 has passed and Employer Group wishes to obtain coverage from Plan, Employer Group must submit a new application to Plan for coverage. Plan shall issue a new contract to Employer Group, accompanied by a written notice clearly stating those respects in which the new contract differs from the cancelled contract in Covered Benefits and coverage. If a new application to Plan is submitted, Employer Group shall not be required to pay the reinstatement fees set forth in Section 7.4.2.

7.4.2.3 Plan will allow one reinstatement of the Agreement during any 12-month period.

7.4.3 Fraud or Deception. If Plan demonstrates fraud or intentional misrepresentation of material fact under the terms of this Agreement by Employer Group, Plan may cancel, Rescind or not renew this Agreement. Plan shall send a Notice of Cancellation, Rescission, or Nonrenewal to Employer Group and all Members at least 30 calendar days before the cancellation, Rescission, or nonrenewal. The termination effective date will be listed on such notice.

7.4.4 Noncompliance. If Employer Group is not in compliance with Plan's Premium payment requirements, participation or employer contribution requirements at the time of renewal of this Agreement, or if Employer Group is not in compliance with a material provision of this Agreement, then Plan may terminate this Agreement.

7.4.5 Plan Withdrawal from the Small Group Market. If Plan ceases to provide or arrange for the provision of health benefits for new health care service plan contracts in the Small Group market, or all markets, in this state, then Plan may terminate this Agreement. Plan shall send a Notice of Cancellation, Rescission or Nonrenewal to Employer Group at least 180 days prior to the termination of this Agreement. Employer Group shall promptly send such notice to each Enrolled Employee.

7.4.6 Withdrawal of Benefit Plan. If Plan withdraws the benefit plan selected by Employer Group, as indicated on the Execution Page of this Agreement, from the Small Group market, Plan may terminate this Agreement. Plan shall send a Notice of Cancellation, Rescission or Nonrenewal to Employer Group at least 90 days prior to the termination of this Agreement. Employer Group shall promptly send such notice to each Enrolled Employee. In the event Plan withdraws Employer Group's selected benefit plan, Plan will make available to Employer Group all health benefit plans that Plan makes available to new Small Group business.

7.4.7 Notice of End of Coverage. If this Agreement is cancelled, rescinded or not renewed for any reason described above, Plan shall send a Notice of End of Coverage to Employer Group and all Members. Such notice shall be sent after the date coverage ended, but not later than five calendar days after the date coverage ended.

7.4.8 Right to Submit a Grievance. If Employer Group alleges that this Agreement has been, or will be, improperly or unfairly cancelled, Rescinded, or not renewed, Employer Group has the right to submit a grievance to Plan or to the Director. Plan will resolve grievances regarding an improper cancellation, Rescission or nonrenewal of this Agreement, or provide Employer Group with a

pending status, within three calendar days of Plan's receipt of the grievance. For more information regarding Plan's grievance policy and procedure, see Article IX.

7.4.9 Notice of Cancellation by Group: If Employer Group decides to terminate its coverage with Plan, it shall notify Plan in writing of its intent to terminate at least 31 calendar days prior to the requested termination date. If Employer Group does not notify Plan before the first day of the Grace Period outlined in Section 5.1, Employer Group will be financially responsible for the full month's Premium for coverage provided during any portion of the Grace Period. Employer groups participating in Covered California's CCSB program shall notify Covered California of its intention to terminate in accordance with the policies and standards established by Covered California. Employer groups participating in the California*Choice* Program shall notify California*Choice* of its intention to terminate in accordance with the policies and standards established by California*Choice*.

7.5 Extension of Benefits Upon Termination.

7.5.1 Member Totally Disabled. Except as expressly provided in this Article, all rights to Benefits hereunder shall terminate as of the effective date of termination of this Agreement. If, when this Agreement is terminated, any Member has a condition for which Benefits are available under this Agreement, which condition has rendered the Member Totally Disabled as of the date of termination, then such Member shall be covered, subject to all Limitations, Exclusions and conditions of this Agreement, including payment of Copayments and Premiums, for the disabling condition until the earlier of: (a) the end of the 12th month after termination of this Agreement; (b) the Member is no longer Totally Disabled; or (c) such time as the Member obtains coverage under a replacement contract or policy issued without limitation as to the disabling condition.

7.5.2 Termination of Provider Agreement. Upon termination of an agreement with a Plan Provider, Plan shall be liable for Benefits rendered by such Plan Provider, other than for Cost Shares, to Members who retain eligibility under this Agreement, or by operation of law, under the care of such Plan Provider at the time of such termination, until the services being rendered to such Members are completed, or until Plan makes reasonable and medically appropriate provision for the assumption of such services by another Plan Provider.

VIII.

INDIVIDUAL CONTINUATION COVERAGE

8.1 Continuation Coverage Under Federal Law. Subject to continuing eligibility as specified in Section 6.2 and 6.3.2 above, coverage for Benefits continues from month to month subject to payment of applicable Premiums. Upon loss of eligibility under Section 6.2 above, continuation of Employer Group coverage, subject to terms as stated below, and, at the option of the Member, additional coverage under Cal-COBRA (per Sections 8.1.3(4) and 8.1.3(5) below) is available.

8.1.1 COBRA Continuation Coverage. If Employer Group has 20 or more employees, a Member who would otherwise lose coverage for Benefits may continue uninterrupted coverage hereunder upon arrangement with Employer Group in compliance with COBRA and upon payment of the applicable monthly Premiums to Employer Group, if:

(1) the Member's coverage is through an Enrolled Employee who dies, divorces or legally separates from or terminates a domestic partnership with the Member, or becomes entitled to Medicare benefits; or

(2) the Member is an enrolled Child who ceases to qualify as a Dependent hereunder; or

(3) the Member is an Enrolled Employee, or the Member's coverage is through an Enrolled Employee, whose employment terminates (other than for gross misconduct) or whose hours of employment are reduced.

8.1.2 Cal-COBRA Coverage for COBRA Members. Per Sections 8.1.3(4) & 8.1.3(5) of this Agreement, additional Cal-COBRA continuation coverage is available to Members who have exhausted COBRA coverage. Combined COBRA and Cal-COBRA continuation coverage shall not exceed 36 months.

8.1.3 Termination of COBRA Continuation Coverage. Coverage under this Section 8.1 continues only upon payment of applicable Premiums to Employer Group at the time specified by Employer Group, and terminates on the earlier of:

(1) termination of this Agreement and all other group health plans by Employer Group;

(2) coverage of the Member under any other group health plan that does not contain any exclusion or limitation with respect to any Preexisting Condition or the Member's entitlement to benefits under Medicare.

(3) expiration of 36 calendar months after an event described in Section 8.1.1(1) or (2).

(4) expiration of 18 calendar months after an event described in 8.1.1(3) unless Section 8.1.3(5) is applicable. The Member may opt for an additional 18 months of Cal- COBRA coverage, as defined in Section 8.1.2 of this Agreement.

(5) expiration of 29 months after an event described in Section 8.1.1(3) for a Member determined by the Social Security Administration to have been disabled at the time of the event described in Section 8.1.1(3). The Member may opt for an additional seven months of Cal-COBRA coverage, as defined in Section 8.1.2 of this Agreement.

(6) conduct of the Member that would justify Plan in terminating coverage of a similarly situated Member not receiving COBRA coverage, such as fraud.

8.1.4 COBRA Continuation Coverage Upon Group Bankruptcy. A Member who is a retired Enrolled Employee, an enrolled Dependent of a retired Enrolled Employee, or the surviving Spouse of a deceased retired Enrolled Employee may continue coverage hereunder if: (a) Employer Group has more than 20 employees; and (b) the Member would otherwise lose coverage hereunder within one year of the date a proceeding under Title 11 of the United States Code is commenced with respect to Employer Group.

8.1.5 Failure to Pay. Plan may terminate any Member obtaining COBRA coverage under this Section 8.1 for whom Plan does not receive Premiums when due.

8.1.6 COBRA Notification/Letter Services. If Employer Group elects Direct Bill COBRA services, as indicated on the Execution Page of this Agreement, Plan will send the following notices or letters to COBRA enrollees on behalf of Employer Group. All other COBRA notices, letters, and forms are the responsibility of Employer Group.

(1) 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.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.
   (e) 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 7.3.3.

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

(3) 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.

(4) 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 Plan will provide a notice of termination of COBRA coverage, as mentioned above.

8.2 Cal-COBRA Continuation Coverage. Plan may only provide coverage for Benefits under Cal-COBRA to Members who reside or work within the Service Area. Subject to continuing eligibility as specified in Section 6.2 and 6.3.2 above, Cal-COBRA allows Members who are employed by employer groups with 2-19 Eligible Employees to extend their coverage, upon payment of the applicable monthly Premiums to Plan, if they would otherwise lose their coverage because:

(1) the Member's coverage is through an Enrolled Employee who dies, or becomes entitled to Medicare benefits;

(2) the Member is a Spouse whose coverage is through an Enrolled Employee from whom the Spouse divorces or legally separates;

(3) the Member is an enrolled Child who ceases to qualify for employer-sponsored Benefits; or

(4) the Member is an Enrolled Employee, or the Member's coverage is through an Enrolled Employee, whose employment terminates (other than for gross misconduct) or whose hours of employment are reduced rendering the Member ineligible for Benefits.

8.2.1 Notification of Cal-COBRA Qualifying Event. Employer Group agrees to notify Plan, in writing, within 30 days of an Enrolled Employee's qualifying event, which results in eligibility for Cal-COBRA. Employer Group acknowledges that failure to notify Plan within 30 days shall create an obligation on the part of Employer Group to pay the usual Premiums for the Member for each and every month notification is not received.

8.2.2 Notification of Group Becoming Subject to COBRA. Employer Group agrees to notify Plan, in writing, within 30 days of Employer Group becoming subject to COBRA.

8.2.3 Notification of Current Cal-COBRA Members. Employer Group agrees to notify all qualified beneficiaries currently receiving Cal-COBRA continuation coverage, and those qualified beneficiaries who have been notified of their ability to continue their coverage and who may still elect coverage within the specified 63 day period, whose continuation coverage will terminate under the previous group benefits plan prior to the period the qualified beneficiary would have remained covered, of the qualified beneficiary's ability to continue coverage under Plan for the balance of the period that the qualified beneficiary would have remained covered under the previous group benefit plan. This notice shall be provided either 30 days prior to termination of the previous group benefit plan or when all Enrolled Employees are notified, whichever is later. In addition, Employer Group agrees to notify Plan, in writing, of all such qualified beneficiaries currently receiving Cal-COBRA continuation coverage.

8.2.4 Termination of Cal-COBRA Continuation Coverage. Coverage under Cal-COBRA continues only upon payment of applicable Premiums to Plan by the Member and may be discontinued before the end of the maximum period for any of the following reasons:

(1) Employer Group no longer provides group health plan coverage to any of its employees.

(2) the Premiums for the continuation coverage are not paid within the time frames(s) specified.

(3) the Member has other hospital, medical, or surgical coverage or is or becomes covered under another group benefit plan that: (i) does not contain any Exclusion or Limitation with respect to any Preexisting Condition he/she may have; or (ii) is prohibited from enforcing the Exclusion or Limitation.

(4) the Member is or becomes entitled to Part A Medicare benefits.

(5) the Member is or becomes covered or eligible for coverage under COBRA.

(6) the Member is or becomes covered or is eligible for coverage under Chapter 6A of the Public Health Service Act, 42 U.S.C. Section 300bb-1 et seq.

(7) expiration of 36 months of Cal-COBRA continuation coverage.

(8) the Member no longer lives in the Service Area.

(9) the Member fails to satisfy the terms and conditions of Plan contract.

(10) the Member commits fraud or deception in the use of Plan services.

IX.

GRIEVANCE POLICY AND PROCEDURE

A grievance or appeal may be filed with Plan up to 180 days following any incident that is the subject of a Member's dissatisfaction. Plan's grievance and appeal policy and procedures are available by calling Plan's Customer Care Department or a Plan Provider. The attached Member Handbook includes a complete description of Plan's appeals and grievance procedures and dispute resolution processes for Members.

X.

RECORDS

Employer Group agrees to maintain, in the State of California, such records and to provide such information to Plan, and/or to the Director as may be necessary for compliance by Plan with the provisions of the Act and the Regulations. Employer Group further agrees that such obligation is not terminated upon termination of this Agreement, whether by Rescission or otherwise, and that such records shall be retained by Employer Group for at least five years. Employer Group agrees to permit Plan and the Director access to such records and information at all reasonable times, upon demand.

XI.

REIMBURSEMENT PROVISIONS

11.1 Member Reimbursement. It is not anticipated that Members will make payment to any person or institution for Benefits provided under this Agreement, except as expressly stated herein. However, if a Member furnishes a claim form and written evidence satisfactory to Plan that he or she received Benefits covered under this Agreement, and that he or she made payment to the provider of such Benefits for same, Plan shall reimburse the Member for the Benefits rendered, upon verification of coverage by Plan that the Benefits were appropriately Authorized or constituted Emergency Services or Urgent Care Services.

11.2 Claims for Reimbursement. Claims for such reimbursements should be submitted to Plan at: 8520 Tech Way, Suite 200, San Diego, CA 92123, within 60 days of receipt of the Benefits for which payment was made by the Member. Failure to furnish such proof within the required time shall not invalidate or delay reimbursement for any claim.

11.3 Limitation on Reimbursement. When both a husband and wife are employed as employees, and both have enrolled themselves and their Dependents under a group health care service plan provided by their respective employers, and each spouse is covered under the terms of this Agreement as an Enrolled Employee, each Spouse may claim on his or her behalf, and on behalf of his or her enrolled Dependents no more in the aggregate than 100% of the charges for Benefits, including Copayments.

XII.

COORDINATION OF BENEFITS

12.1 Plan will coordinate benefits with any other health plan (as defined below) covering a Member which allows for coordination of benefits. Employer Group and Members agree to provide Plan with such information and assistance as Plan may require to enable it to coordinate benefits.

12.2 The rules establishing the order of benefit determination between this Agreement and any other health plan covering the Member on whose behalf a claim is made are set forth below. None of these rules will serve as a

barrier to the Member's first receiving Benefits under this Agreement from Plan. Further, in no event shall a Member be required, as a result of these rules, to pay any amount other than as required by this Agreement for any Benefit.

12.3 The term "health plan" as used in this Agreement is defined to include any health care service plan, nonprofit hospital service plan, insurer, group practice, individual practice or other prepayment plan, employee benefit plan, employer organization plan, union welfare plan, labor-management trustee plan, and any other governmental or private program which provides or arranges for the provision of, or pays, reimburses, or indemnifies for the cost of, any health care services, whether pursuant to statutory requirement or provision or otherwise.

12.4 If another health plan does not provide for coordination of benefits, Plan shall always have primary responsibility for the provision of Benefits covered by this Agreement.

12.5 For those health plans which provide for coordination of benefits, the following rules establishing the order of benefits determination shall apply:

12.5.1 The benefits of a health plan which covers the person on whose expenses claim is based other than as a Dependent shall be determined before the benefits of a health plan which covers such person as a Dependent, except that if the person is also a Medicare beneficiary and as a result of the rules established for the Medicare Program and implementing regulations, Medicare is (a) secondary to the health plan covering the person as a dependent; and (b) primary to the health plan covering the person as other than a Dependent (e.g., retired employee), then the benefits of the health plan covering the person as a Dependent are determined before those of the health plan covering that person as other than a Dependent.

12.5.2 Except for cases of a person for whom a claim is made as a Dependent Child whose parents are separated or divorced, the benefits of a health plan which covers the person on whose expenses claim is based as a Dependent of a person whose date of birth, excluding year of birth, occurs earlier in a Calendar Year, shall be determined before the benefits of a health plan which covers such person as a Dependent of a person whose date of birth, excluding year of birth, occurs later in a Calendar Year. If either health plan does not have the provision of this Section regarding Dependents, which results either in each health plan determining its benefits before the other or in each health plan determining its benefits after the other, the provisions of this Section shall not apply, and the rule set forth in the health plan which does not have the provisions of this Section shall determine the order of benefits.

12.5.3 In the case of a person for whom claim is made as a Dependent Child whose parents are separated or divorced and the parent with custody of the Child has not remarried, the benefits of a health plan which covers the Child as a Dependent of the parent with custody of the Child shall be determined before the benefits of a health plan which covers the Child as a Dependent of the parent without custody.

12.5.4 In the case of a person for whom claim is made as a Dependent Child whose parents are divorced and the parent with custody of the Child has remarried, the benefits of a health plan which covers the Child as a Dependent of the parent with custody shall be determined before the benefits of a health plan which covers that Child as a Dependent of the stepparent, and the benefits of a health plan which covers the Child as a Dependent of the stepparent shall be determined before the benefits of a health plan which covers the Child as a Dependent of the parent without custody.

12.5.5 In the case of a person for whom claim is made as a Dependent Child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the Child, then, notwithstanding Sections 12.5.3 and 12.5.4, above, the benefits of a health plan which covers the Child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other health plan which covers the Child as a Dependent Child.

12.5.6 If a health plan does not have a provision regarding laid-off or retired employees, which results in each health plan determining its benefits after the other, then the rule under Section 12.5.5 shall not apply.

12.5.7 If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another health plan, the following shall be the order of benefit determination: (a) first, the benefits of a health plan covering the person as an employee, member, or subscriber, or as that persons' Dependent; and (b) second, the benefits under continuation coverage. If the other health plan does not have the rules described above, and if, as a result, the health plans do not agree on the order of benefits, the rule under this Section shall be ignored.

12.5.8 When rules 12.5.1 through 12.5.7 do not establish an order of benefit determination, the benefits of a health plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a health plan which has covered such person the shorter period of time.

12.5.9 When the provisions of this Article XII operate to reduce the total amount of Benefits otherwise payable to a person covered under Plan during any Benefit Year, each Benefit that would be payable in the absence of such provisions shall be reduced proportionately, and such reduced amount shall be charged against any applicable Benefit limit of Plan.

XIII.

DISPUTE RESOLUTION

In the event either party is dissatisfied with the other party's performance under this Agreement, or in the event of any dispute, claim, question, or disagreement ("dispute") arising from or relating to this Agreement or the claimed or actual breach thereof, the parties hereto shall use their best efforts to settle the dispute without resort to court. To this end, the parties shall consult and negotiate with each other in good faith and, recognizing their mutual interest, attempt to reach a just and equitable solution satisfactory to both parties, in as expeditious and non-confrontational manner as possible. Therefore Employer Group and Plan agree to the following dispute resolution procedures:

- Step I – Informal Discussion. Should any dispute arise, the complaining party shall first attempt to arrange for an informal discussion with the other to come to a mutually agreeable resolution within 30 days of notice of the dispute to the other party.

- Step II – Arbitration. If any dispute or controversy shall arise between the parties with respect to the making, construction, terms, application, or interpretation of this Agreement or the rights of either party, or with respect to any transaction contemplated by this Agreement, either party shall refer the dispute or controversy to an appropriate Arbitration entity for resolution. Any complaint that may arise must be resolved through binding arbitration rather than a lawsuit. Binding arbitration means that the parties agree to waive rights to a jury trial.

The arbitration shall be initiated by one party serving the other with written notice of the nature of the claim and a demand for arbitration. The scope of the arbitration shall be limited to the claims stated in the demand for arbitration, plus attorneys' fees if required by the arbitrator.

The arbitration shall take place in San Diego, California, unless some other location is mutually agreed upon by the parties, and shall be governed by the rules of the appropriate arbitration entity, except as may otherwise be expressly provided herein. The expenses of the arbitrator shall be shared equally by the parties.

XIV.

MISCELLANEOUS

14.1 Change of Premiums or Cost Shares. Plan shall not provide any further changes to Premiums or Cost Shares during the following time periods: after Employer Group delivered written notice of acceptance of this Agreement to Plan, after the start of Employer Group's open enrollment period, and after Plan received Employer Group's first Premium payment in accordance with the effective date of coverage, unless Plan and Employer Group otherwise mutually agree in writing, or unless required by law or regulation.

14.2 Change of Premiums or Coverage. Plan may change Premiums or coverage hereunder, effective no earlier than 60 days after receipt by Employer Group of written notice from Plan setting forth any such change. Premiums shall remain in effect no less than six months.

14.3 Member Consent. By this Agreement, Employer Group makes Benefits available to persons who are eligible under Article VI. However, this Agreement shall be subject to amendment, modification or termination, in accordance with the provisions hereof, or by mutual agreement between Plan and Employer Group, without the consent or concurrence of the Members. By electing Benefits pursuant to this Agreement, or accepting Benefits hereunder, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions and provisions hereof.

14.4 Identification Cards. Plan shall provide an identification card for each Member. Cards issued by Plan to Members pursuant to this Agreement are for identification purposes only. To be entitled to Benefits under this Agreement, the holder of the card must, in fact, be a Member on whose behalf current Premiums have actually been paid. Any person receiving Benefits to which he or she is not then entitled pursuant to the provisions of this Agreement shall be responsible for payment therefore at Prevailing Rates.

14.5 Member Handbook. Plan shall provide Employer Group with copies of a Member Handbook and Provider Directory and Supplemental Benefits brochures, if applicable, setting forth the Benefits to which the Members are entitled hereunder, and with copies of all amendments to such documents. Employer Group shall be responsible for distributing and shall distribute such forms, and all amendments thereto, to Enrolled Employees.

14.6 Notice of Certain Events. Plan shall give Employer Group written notice within a reasonable time of any termination or breach of contract by, or inability to perform of a Plan Provider, or any person with whom Plan has a contract to provide Benefits hereunder, if Employer Group can be materially and adversely affected thereby.

14.7 Liability of Plan. In the event Plan fails to pay Plan Providers for Benefits provided to Members, Members shall not be liable to Plan Providers for any sums owed by Plan.

14.8 Plan's Policies. Plan may adopt reasonable policies, procedures, rules and interpretations to promote orderly and efficient administration of this Agreement.

14.9 Administrative Manual. Employer Group agrees to adhere to all policies, procedures and rules in Plan's Administrative Manual. Plan shall give Employer Group at least 30 calendar days' advance notice of any changes to the Administrative Manual.

14.10 Entire Agreement. This Agreement and any amendments and Attachments hereto; the Member Handbook and any amendments thereto; Employer Group's application; and the individual applications of the Members covered hereunder, as may be updated from time to time, constitute the entire contract between Plan, Employer Group and Members and, as of the effective date hereof, supersede all other agreements between such parties. In the event of any direct conflict between the information contained in this Agreement and other collaterals, the terms of this Agreement shall govern.

14.11 Notices. Any notice under this Agreement may be given, addressed to the applicable party at the address provided on the Execution Page, or at such other address as may be given by such party in accordance with this Section. Unless otherwise provided in this Agreement, all notices shall be deemed effective when received.

14.12 Discrimination. Plan may not refuse to enter any contract, cancel or decline to renew or reinstate any contract or modify the terms of a contract because of the race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, physical or mental impairment, genetic characteristics, or age of any contracting party, or person reasonably expected to benefit from such contract.

14.13 Medical Records. Each Member consents to and authorizes every hospital, skilled nursing facility, physician and other health care provider to permit the examination and duplication of all or any portion of the Member's medical records when requested by Plan. Plan agrees to use reasonable means to assure and protect the confidentiality of any medical records received.

14.14 Headings. The headings of the Articles and Sections of this Agreement are for information purposes only and shall not limit or otherwise restrict the meaning of any provision of this Agreement.

14.15 Interpretations and Governing Law.

14.15.1 Plan is subject to the requirements of the following:

(1) Knox Keene Healthcare Service Plan Act of 1975, as amended (California Health and Safety Code, Section 1340, et seq.);

(2) Chapter 2, Division 1, of Title 28, California Code of Regulations; Code of Federal Regulations;

(3) United States Code; and

(4) any provision required to be in this Agreement by any of the above shall bind Plan whether or not set forth herein.

14.15.2 This Agreement shall be governed by and construed in accordance with federal law and the laws of the State of California.

XV.

COVERED CALIFORNIA

Employer groups participating in the Covered California for Small Business (CCSB) program shall comply with the policies and standards established by Covered California, including but not limited to, the standards relating to Premium payment, eligibility and enrollment, and termination, whether or not specifically stated in this Agreement.

XVI.

CALIFORNIA*CHOICE* PROGRAM

Employer groups participating in the California*Choice* Program shall comply with the policies and standards established by California*Choice*, including but not limited to, the standards relating to Premium payment, eligibility and enrollment, and termination, whether or not specifically stated in this Agreement.

ATTACHMENT A

MEMBER HANDBOOK
(COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM)

[COPY ENCLOSED]

ATTACHMENT B

SUMMARY OF BENEFITS
(HEALTH PLAN BENEFITS AND COVERAGE MATRIX)

[COPY ENCLOSED]

ATTACHMENT C

SUPPLEMENTAL BENEFITS BROCHURE(S)

[COPY(COPIES) ENCLOSED IF APPLICABLE]

ATTACHMENT D

PREMIUMS

[COPY ENCLOSED]

CALIFORNIA HEALTH BENEFIT EXCHANGE SHOP PROGRAM
MODEL SUPPLEMENT RIDER
TO
GROUP SUBSCRIBER AGREEMENT

This California Health Benefit Exchange Small Business Health Options (SHOP) Program Supplement Rider (the "Supplement") supplements that certain Group Subscriber Agreement (the "Agreement") between Health Plan or Insurance Issuer (HEALTH PLAN) and GROUP. This Supplement is an integral part of the Agreement and is intended by the Parties hereto to be interpreted to be consistent therewith; any inconsistencies or conflicts in terms with the Agreement are to be resolved in favor of the terms in this Supplement.

WHEREAS, GROUP is eligible to participate in the Small Business Health Options Program Exchange and desires to offer its Employees a range of choice of health care plans from which to receive their health care; and

WHEREAS, HEALTH PLAN is a participant in the SHOP Program, as defined below; and

WHEREAS, at least one Employee of GROUP has selected HEALTH PLAN, through HEALTH PLAN's participation in the SHOP Program, as the health care service plan or insurance issuer from which to receive his or her health care.

THEREFORE, HEALTH PLAN and GROUP have entered into the Agreement, as supplemented by this Supplement.

I. DEFINITIONS

SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP) is that program operated by the California Health Benefit Exchange, also known as Covered California through which a small employer can provide its employees and their dependents with access to one or more products offered by HEALTH PLAN.

ELIGIBLE EMPLOYEE is an employee as defined in Section 1357.500(c) of California Health and Safety Code and in Section 10753(f) of California Insurance Code

ENROLLEE shall mean an individual and his or her eligible dependents, as defined by HEALTH PLAN, who lives or works in an approved Service Area, who meets the eligibility requirements of GROUP and HEALTH PLAN, who has made application to HEALTH PLAN through the SHOP Program, and for whom premiums have been paid by GROUP or individually as a COBRA or Cal-COBRA participant.

MEMBER shall mean an individual who is covered for health care services by HEALTH PLAN, but who may or may not have obtained coverage through the SHOP.

NET PREMIUM shall mean the monthly amount paid to HEALTH PLAN by GROUP through SHOP for health care coverage of GROUP's Enrollees, which shall consist of the Premium minus authorized expenses of SHOP deducted pursuant to this Supplement.

PARTICIPATING PLAN shall mean a HEALTH PLAN, offering health maintenance organization (HMO) or preferred provider (PPO) products and participating in the SHOP. HEALTH PLAN is a Participating Plan.

PARTICIPATING PROVIDER shall mean a health care provider, individual or institution, who or which is employed by or under contract with HEALTH PLAN to provide designated health care services to HEALTH PLAN's Members.

PREMIUM shall mean the monthly amount charged to and payable by Subscribing Groups or COBRA or Cal-COBRA subscribers for health care coverage from HEALTH PLAN (including commissions, administrative expenses, billing fees, taxes or license fees, if any), and the payment of which entitles Enrollees to the health care coverage offered under the terms of the Agreement.

QUALIFIED HEALTH PLAN (QHP) has the same meaning as that term is defined in Patient Protection and Affordable Care Act Section 1301 (42 USC § 18021).

SERVICE AREA shall mean that geographic area in which HEALTH PLAN is licensed to offer and provide QHPs to Small Group Employers.

SMALL GROUP EMPLOYER shall mean a "small employer" as defined in Section 1357.500(k) of California Health and Safety Code and Section 10753(q) of California Insurance Code.

SMALL GROUP MARKET shall mean the aggregation of Small Group Employers in the state of California.

SUBSCRIBING GROUP or SUBSCRIBING EMPLOYER shall mean an organization or firm, which applied for health care coverage by a PARTICIPATING PLAN through the SHOP, was screened for compliance with SHOP's eligibility criteria, and was accepted by SHOP for participation. The Subscribing Group contracts directly with HEALTH PLAN to arrange for the provision of health care services for its Employees or Members and/or their spouses or domestic partners and/or their dependents. GROUP upon execution of the Agreement, as modified by this Supplement, is a Subscribing Group.

II. THE SHOP

The SHOP is a mechanism in which HEALTH PLAN and other health care service plans and insurance issuers simultaneously offer Qualified Health Plans (QHP) to Small Group Employers.

A. Contribution and Participation Requirements

HEALTH PLAN and GROUP understand and agree to the following contribution and participation requirements for the provision of services pursuant to the Agreement.

1. For medical coverage, GROUP must contribute a minimum of the equivalent of fifty percent (50%) of the Premium cost of the Employee-only rate in the reference plan selected by the Employer.

2. For medical coverage, GROUP must have a minimum of seventy percent (70%) of Eligible Employees enroll in a QHP through the SHOP. If the Group pays 100 percent of its Qualified Employees' QHP premiums, then all Eligible Employees must enroll in health coverage through the SHOP. For purposes of participation, eligible employees are not included in the calculation for minimum participation requirements if they are enrolled in coverage through another employer, an employee's union, Medicaid, Medicare, any other federal or state health coverage programs, or any health coverage meeting the definition of minimum essential coverage pursuant to Health and Safety Code Section 1345.5

3. If GROUP does not meet such minimum contribution and minimum participation requirements, GROUP may only enroll with HEALTH PLAN

through SHOP from November 15th through December 15th of each year.

III. ELIGIBILITY AND ENROLLMENT

A. Eligibility and Enrollment for Open Enrollment

SHOP is responsible for determining eligibility for all GROUPs and applicant Employees of GROUP and their dependents. Except for special enrollments addressed below, coverage effective dates will be determined pursuant to 10 CCR Section 6536.

Employee Eligibility

A Qualified Employee is an employee who has been offered coverage by his or her employer and who is an Eligible Employee.

Dependent Eligibility

1. A dependent claiming eligibility hereunder as a spouse must be legally married to a Qualified Employee.

2. A dependent claiming eligibility hereunder as a domestic partner must be a registered domestic partner, as defined in section 297 and 299.2 of the California Family Code. For an Employee's unregistered domestic partner to be eligible for coverage, the Employer must make an offer of coverage to the Employee's unregistered domestic partner and the eligibility of unregistered domestic partners must be documented in Employer's Employee Benefit Plan documents. It is the Employer's responsibility to ensure that unregistered domestic partnerships are eligible under the terms and conditions of the Employer's plan.

3. A dependent child claiming eligibility hereunder must be born to, a stepchild or legal ward of, adopted by or placed in the foster care of the Eligible Employee or the Eligible Employee's spouse or domestic partner, a minor child ordered by a court to be covered by an employee's Plan, or a child for whom the employee has assumed a parent-child relationship and under the age of 26 unless disabled.

4. A dependent child who exceeds the age limit for dependent children and is disabled, who is incapable of self-support because of a physical or mental disability which existed continuously from a date prior to attainment of age, until termination of such incapacity shall be considered eligible. A disabled child who is age 26 or over will be enrolled at the time of initial enrollment of the employee provided that satisfactory evidence of such disability is provided to the PLAN, if requested by the PLAN, within 60 days of the initial enrollment. The PLAN shall provide this information to SHOP within 60 days.

5. For a child that is enrolled, SHOP will provide a 90-day notice that a dependent is about to reach the age limit for dependent children and will lose coverage unless provided with written certification from a competent health care professional, within 60 days of receiving this 90-day notice, that the dependent meets the above conditions of being disabled.

Documentation of eligibility and existence of the relationship of any dependent to the Qualified Employee may be requested at the time of enrollment and before a child attains the limiting age, but not more frequently than annually after the two-year period following a child's attainment of the limiting age.

B. Eligibility and Enrollment for Special Enrollment

1. Newly Eligible Employee

An employee who becomes a qualified employee outside of the initial employee open enrollment period, the annual employee open enrollment period, or a special enrollment period shall have a 30-day period to enroll in a QHP beginning from the first day the employee becomes a qualified employee.

2. New Dependents – Spouse or Registered Domestic Partnership

An eligible spouse or registered domestic partner may be added to coverage at the time of initial enrollment of the Employee, at each open enrollment period of GROUP or due to one of the following special enrollment qualifying events if the application for coverage, along with any supporting documentation is received by SHOP within 30 calendar days of the event. Coverage will become effective on the first day of the month following the receipt of the application for coverage.

When an employee is newly married or has a newly registered domestic partnership, he or she must submit a stamped copy of the Marriage Certificate or the date the Declaration of Domestic Partnership is filed with the California Secretary of State if requested by SHOP.

When an employee gains a child dependent, the employee may enroll a spouse or registered domestic partner to the Plan during the same special enrollment period as the newly gained child dependent.

3. New Dependents - Birth/Adoption/Legal Guardianship/Assumption of a Parent-Child Relationship

An individual who becomes a new dependent by virtue of birth, placement for adoption or foster care, assumption of a parent-child relationship, or legal guardianship is eligible for coverage under the Agreement, as modified by this Supplement, at other than the Employer's initial or annual open enrollment, and the appropriate request form should be received by SHOP within 30 days after such birth, placement for adoption, placement in foster care or effective date of a guardianship order, with coverage to be effective upon the date of the birth, placement for adoption, foster care placement, assumption of parent-child relationship, or legal guardianship assignment unless the Employee requests the coverage to be effective on the first day of the month following the date of the birth, placement for adoption, foster care placement, assumption of parent-child relationship, or legal guardianship assignment. The first 31 days of coverage for such new or adopted child is automatic, regardless of whether the child is enrolled or not after this 31-day period.

If application is not received by the 30th day after the birth, adoption, placement, assignment, or assumption of parent-child relationship, the HEALTH PLAN providing coverage for the covered parent will only provide coverage for the first 31 days from the event under that parent's policy. After that time, the dependent child will no longer have coverage.

4. New Dependents – Unregistered Domestic Partnership

If an employer offers coverage to unregistered domestic partners, the SHOP must receive an application for coverage of an unregistered domestic partner by the 30th day after the establishment of the unregistered domestic partnership. Coverage will be effective on the first of the month following the receipt of the application for coverage of the unregistered domestic partner by SHOP.

Employers must agree to notify SHOP immediately upon termination of the unregistered domestic partnership.

5. Loss of Coverage – Qualified Employee and Dependents

A. A Qualified Employee or an eligible spouse or registered domestic partner and/or eligible child dependent may be added to coverage at a time other than at initial enrollment of the Qualified Employee or at each open enrollment period of GROUP if they experience a loss of Minimum Essential Coverage due to one of the events listed below. Receipt of the application for coverage and any supporting documents must be within 30 days of the event. Coverage will become effective on the first day of the month following the loss of coverage:

a. loss of eligibility for health insurance coverage due to:
1. legal separation;
2. divorce;
3. cessation of dependent status;
4. termination of employment; or
5. reduction in the number of hours of employment

b. Termination of qualified employer contributions toward the employee's or dependent's health insurance coverage

c. exhaustion of COBRA or Cal-COBRA coverage.

B. A Qualified Employee and/or an eligible spouse or registered domestic partner and/or eligible child dependent may be added to coverage at a time other than at initial enrollment of the Qualified Employee or at each open enrollment period of GROUP if they experience a loss of Minimum Essential Coverage due to the loss of coverage through Medicare or Medi-Cal or other government sponsored health care program. Receipt of the application for coverage and any supporting documents must be within **60 days** of the event. Coverage will become effective on the first day of the month following the loss of coverage.

6. Other Special Enrollment Events

A. A Qualified Employee and/or an eligible spouse or registered domestic partner and/or eligible child dependent may be added to coverage at a time other than at initial enrollment of the Qualified Employee or at each open enrollment period of GROUP if they experience one of the events listed below. Receipt of the application for coverage and any supporting documents must be within **30 days** of the event. Coverage will become effective on the first day of the month following the loss of coverage.

a. The enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the enrollee, or his or her dependent, dies.

b. The Qualified Employee, spouse or registered domestic partner or eligible dependent child's enrollment or non-enrollment in a QHP is unintentional,

inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS or its instrumentalities as evaluated and determined by the Exchange.

c. The Qualified Employee, spouse or registered domestic partner or eligible dependent child adequately demonstrates to the Exchange that the QHP in which he or she is enrolled, substantially violated a material provision of its contract in relation to the qualified employee.

d. A Qualified Employee or enrollee, or his or her dependent, gains access to new QHPs as a result of a permanent move and either-
(A) Had MEC as described in 26 CFR Section 1.5000A-1(b) (December 26, 2013), hereby incorporated by reference, for one or more days during the 60 days preceding the permanent move; or
(B) Was living outside of the United States or in a United States territory at the time of the permanent move.

e. Was released from incarceration, or is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active-duty service under Title 32 of the United States Code;

f. An Indian, as defined by Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603(c)), may enroll in a QHP or change from one QHP to another one time per month.

g. A Qualified Employee or dependent is receiving services from a contracting provider under a health benefit plan, as defined in Section 1399.845(f) of the Health and Safety Code or Section 10965(f) of the Insurance Code, for one of the conditions described in Section 1373.96(c) of the Health and Safety Code and that provider is no longer participating in the health benefit plan;

h. A Qualified Employee or dependent loses pregnancy-related coverage described under Section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)) and Section 14005.18 of the Welfare and Institutions Code. The date of the loss of coverage is the last day the consumer would have pregnancy-related coverage.

i. A Qualified Employee or dependent demonstrates to the Exchange, with respect to health plans offered through the Exchange, or to the applicable regulator, with respect to health benefit plans offered outside the Exchange, that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the employee or dependent because he or she was misinformed that he or she was covered under MEC;

j. A Qualified Employee, or his or her dependent, demonstrates to the Exchange, in accordance with guidelines issued by HHS and as determined by the Exchange on a case-by-case basis, that the individual meets other exceptional circumstances. Such circumstances include, but are not limited to, the following circumstances:
(A) If a child who has been determined ineligible for Medi-Cal and CHIP, and for whom a party other than the party who expects to claim him or her as a tax dependent is required by court order to provide health insurance coverage for the child, the child shall be eligible for a special enrollment period if otherwise

eligible for enrollment in a QHP.

k. A Qualified Employee or his or her dependent loses eligibility for pediatric dental coverage subsequent to turning nineteen (19) years of age and wishes to continue dental coverage under a standalone dental plan offered by a QDP in the SHOP.

l. A Qualified Employee, or his or her dependent, is a victim of domestic abuse or spousal abandonment, is enrolled in MEC, and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment. A dependent of a victim of domestic or spousal abandonment who is on the same application as the victim may enroll in coverage at the same time as the victim;

m. Applies for coverage on the Exchange during the annual enrollment period, is deemed eligible for Medi-Cal or CHIP, and is deemed ineligible for Medi-Cal or CHIP after open enrollment has ended or more than 60 days after the qualifying event;

n. Applies for coverage with Medi-Cal or CHIP during the annual enrollment period and is deemed ineligible for Medi-Cal or CHIP after open enrollment has ended.

B. A Qualified Employee and/or an eligible spouse or registered domestic partner and/or eligible child dependent may be added to coverage at a time other than at initial enrollment of the Qualified Employee or at each open enrollment period of GROUP if they become eligible for assistance, with respect to health insurance coverage under a SHOP, under a Medi-Cal plan (including any waiver or demonstration project conducted under or in relation to such a plan). Receipt of the application for coverage and any supporting documents must be within 60 days of the event. Coverage will become effective on the first day of the month following the loss of coverage.

7. Process of Enrollment

GROUP's application to contract with HEALTH PLAN for coverage of one or more of its Employees will be reviewed by the SHOP for completeness and eligibility. HEALTH PLAN's receipt of transmitted application data of GROUP from the SHOP will constitute the filing of that application with HEALTH PLAN. The SHOP will notify GROUP and its employees of its acceptance and the effective date of coverage for its employees.

The GROUP shall specify the waiting period for coverage in the Employer's Employee Benefit Plan documents, which shall be equally applicable to all Employees and dependents. The waiting period shall not exceed 90 days.

IV. COVERED SERVICES AND BENEFITS

The Evidence of Coverage describes the separate plan(s) of covered services and benefits, as well as excluded benefits, which HEALTH PLAN agrees to provide to GROUP's Enrollees, pursuant to GROUP's choice through SHOP. GROUP understands that one Employee and his or her designated dependents may select one of these plans, and other GROUP Employees and their respective designated dependents may select the same or another of the described benefit plans, but an Employee and his or her designated dependents must all select the same benefit plan,

although they may select different medical groups and primary care physicians. The SHOP plans offered pursuant to the terms of the Agreement and this Supplement are the only benefits which are covered benefits offered by HEALTH PLAN to GROUP through SHOP. HEALTH PLAN itself shall make all benefit and coverage determinations. All such determinations shall be subject to HEALTH PLAN's grievance procedures.

A. Cal-COBRA and COBRA

HEALTH PLAN agrees to provide coverage for GROUP's Cal-COBRA and COBRA-eligible Enrollees at the applicable group rate.

B. Enrollee Materials

HEALTH PLAN shall issue or mail to a new Enrollee an identification card and its Evidence of Coverage booklet provided, however, that only one Evidence of Coverage booklet shall be issued to each Enrollee and his or her dependents, unless the Enrollee or his or her dependent requests an additional Evidence of Coverage booklet be sent. HEALTH PLAN shall be responsible for distributing, or making available for distribution, its federally required Summary of Benefits and Coverage ("SBC"). HEALTH PLAN agrees to provide copies of its Evidence of Coverage, Supplement and SBC to any person requesting such materials, within seven (7) business days of PLAN's receipt of such request. SHOP will post on its website a copy of HEALTH PLAN's current SBC and Evidence of Coverage. HEALTH PLAN agrees to provide to Enrollees and their dependents a copy of its Summary Brochure.

V. FISCAL PROVISIONS

HEALTH PLAN agrees to arrange for the provision of health care services for GROUP's Enrollees, as described in the Evidence of Coverage, in exchange for the Net Premiums received from GROUP less the monies owed to SHOP. HEALTH PLAN agrees to accept the Net Premium due HEALTH PLAN and forwarded to HEALTH PLAN from the SHOP, and any applicable Enrollee co-payments, as full and complete payment for services provided under the Agreement and this Supplement thereto.

A. Premium Collection

1. Premium Payment. GROUP's Premiums for its Enrollees in HEALTH PLAN will be billed to GROUP by the SHOP in a unified billing mechanism which will include itemized Premiums due from GROUP for other SHOP Participating Plans selected by GROUP's Employees.

    a. A Qualified Employer's first premium payment shall be paid in full and must be delivered to the SHOP or postmarked by the due date indicated on the invoice, for effectuation to occur on the date requested on the employer's application.

    b. For on-going premiums, on or about the fifteenth of the month prior to the coverage month, an invoice is sent by the SHOP to GROUP, for which payment must be delivered to the SHOP or postmarked by the last day of the invoicing month. On-going monthly premium payments must be made for the total balance due, by the due date on the invoice to avoid delinquency.

2. Notice of Consequences for Nonpayment of Premiums
SHOP on behalf of HEALTH PLAN will send a "Notice of Consequence for Nonpayment of Premiums" concurrently with the invoice to GROUP informing GROUP that the group contract may be cancelled or not renewed if the premium amount due is not received by SHOP.

3. Cancellation for Nonpayment of Premiums. If a billed Premium payment is not received on or before the last day of the month prior to the month of coverage, a "Notice of Start of Grace Period" will be sent via USPS to GROUP by SHOP on behalf of HEALTH PLAN on the first day of that month, identifying the date the 30 day grace period begins and ends, the effective date of cancellation if payment is not received by the end of the grace period, dollar amount past due, and the employer's right to appeal.

   GROUP shall promptly send such Notice to each subscriber receiving coverage under the GROUP's policy.

   The Notice will provide instructions on how to submit the past due premium payment to maintain coverage and will reiterate when such cancellation will be effective. The notice will also state how and when the GROUP may appeal the cancellation. If the Premium payment is not received by the cancellation effective date, the Agreement will be terminated for non-payment effective 30 days from the date the Notice of Start of Grace Period was sent. In such a case, a "Notice of End of Coverage" will be mailed to GROUP by SHOP on behalf of HEALTH PLAN within 3 days if an electronic notice is sent or 5 business days if a mailed hard copy is sent. HEALTH PLAN, or SHOP on behalf of HEALTH PLAN, will mail an individual Notice of End of Coverage to each of its affected Members, explaining their options for purchasing individual coverage.

   All of the notices described above will include statements regarding the reason for the cancellation, the amount of premiums due, a statement of the 30-day grace period, the effective date of the cancellation, and the right of GROUP to seek review by the appropriate regulator, either the California Department of Managed Health Care or the California Department of Insurance (including the responsibility of GROUP to pay premiums during any such review and the right of GROUP to be reinstated back to the effective date of termination if it prevails in such review).

   Receipt by SHOP of all Premium payments due and owing by the due date indicated in the Notice of Start of Grace Period will continue the Agreement, as modified by this Supplement, with no interruption in coverage. If full payment of all delinquent Premiums is not received by SHOP by the due date indicated in the Notice of Start of Grace Period, the Agreement will be terminated.

   GROUP may request to be reinstated in the same coverage in which it was last enrolled within 30 days after the effective date of the termination. Past due premiums, if any, must be paid before the GROUP may be reinstated without a lapse in coverage.

   GROUP may not reinstate coverage 31 or more days following the effective date of termination. GROUP may only reinstate terminated coverage once during the 12-month period beginning on of the original effective date or the most recent renewal date, whichever is more recent.

4. Non-Sufficient Funds
   If a qualified employer makes a premium payment that is returned unpaid for any reason, the SHOP shall apply a $25.00 insufficient funds fee. If a qualified employer makes a second premium payment that is returned unpaid for any reason within six months of the prior returned payment, the qualified employer shall submit premium payment and the insufficient funds fee for returned payment in the form of a cashier's check or money order. This requirement to make monthly premium payments in the form of a cashier's check or money order shall continue for a period of 12 months

beginning with the first of the month following the last paid-through date. If premium payment is not submitted in one of these two forms, the qualified employer group may be subject to termination for non-payment of premium as described in 10 CCR § 6538 (c)(2). In no event shall the failure to pay the insufficient funds fee be a basis to terminate, non-renew or cancel coverage pursuant to Health and Safety Code Section 1365 or Insurance Code Section10273.4, as applicable.

5. GROUP Liable for Premiums During Grace Period. During the grace period described in the preceding paragraphs, the Agreement, as modified by this Supplement, shall continue in force, and GROUP shall be liable for the payment of all Premiums accruing during the grace period.

6. Issuance of New Contract. Following cancellation for nonpayment of Premiums, the current Agreement will not be reinstated. Instead, GROUP must submit a new application for coverage.

7. Delinquent Accounts: Collections: In the event GROUP's account becomes delinquent, SHOP shall undertake collections per State Accounting Manual (SAM) Section 8776.6 (non-employee accounts receivable).

B. Premium Rates

HEALTH PLAN's premium rates are guaranteed for twelve (12) months from the initial enrollment date of the Supplement, which shall be the effective date of the Supplement, and from each subsequent anniversary renewal date thereof. Renewal increases will be based on HEALTH PLAN's "new business" rates in effect on the anniversary date of the Supplement effective date with GROUP.

VI. VOLUNTARY TERMINATION, RENEWAL AND OTHER CHANGES

A. Termination by GROUP

Group may terminate this Agreement at the end of each month. The last day of coverage shall be the end of the month in which the GROUP provided notice of termination, if the GROUP provides notice to the SHOP on or before the fifteenth of the month, or on a case-by-case basis an earlier date upon agreement between the HEALTH PLAN and the SHOP. If the GROUP does not provide notice to the SHOP on or before the fifteenth of the month, the last day of the month following the month in which the GROUP gave notice of termination, or on a case-by-case basis an earlier date upon agreement between the HEALTH PLAN and the SHOP.

B. Termination by Enrollee

An Enrollee may terminate his or her coverage at the end of each month by providing GROUP with written notice of such intent to terminate up to the last day of the month in which the termination is to be effective. An Enrollee's coverage will terminate on the last day of the month in which the written notice is received or on a later date requested by the Enrollee as long as that date is the last day of the month. GROUP to notify SHOP of enrollee's termination request upon receipt of that request.

The coverage of an Enrollee terminating employment with GROUP or losing eligibility for coverage shall extend through the last day of the month in which his or her employment terminated, or such eligibility was lost. GROUP must inform the SHOP within 30 days after the date of termination of coverage of an Enrollee and/or his or her dependents.

C. Annual Enrollment and Renewal

SHOP will send GROUP a renewal package 60 days in advance of the end of the GROUP's current plan year. The renewal package will consist of the QHPs available to the GROUP, changes to current QHPs, and the rates for the following plan year.

If GROUP wishes to renew its coverage through SHOP upon the anniversary date of the Agreement, GROUP must meet the minimum contribution and participation requirements in Section II.A above. If GROUP does not meet such minimum contribution and minimum participation requirements, GROUP may only enroll with HEALTH PLAN through SHOP from November 15th through December 15th of each year.

1. GROUP may only make changes to reference plan during the renewal period.
2. If employee does not enroll in a different QHP during his or her annual employee open enrollment period, the employee will remain in the QHP selected in the previous year unless the employee notifies employer to terminate his or her coverage from the QHP.
3. If the Qualified Employee's current QHP is not available, the employee shall be enrolled in a QHP offered by the same HEALTH PLAN at the same metal tier that is the most similar to the Qualified Employee's current QHP, as determined by the SHOP on a case-by-case basis.
    a. If the HEALTH PLAN of the QHP in which the Qualified Employee is currently enrolled is no longer available, or if another QHP is not available from the current insurance carrier in the same metal tier, the Qualified Employee may be enrolled in the lowest cost QHP offered by a different Health Plan in the same metal tier as the Qualified Employee's current QHP, as determined by the SHOP on a case-by-case basis.

D. Open Enrollment

HEALTH PLAN, through SHOP, will provide a period of at least twenty (20) days for the annual employer election period and at least twenty (20) days for employee annual open enrollment period prior to the anniversary date of the Agreement, with such requested changes to be effective on such anniversary date. During the employer election period, the employer may change its offering of dependent coverage, its contribution level to employee coverage, and level of coverage within which its employees and dependents can select a QHP.

1. Enrollees electing to make open enrollment changes shall provide the Change Form to their employer for submission to the SHOP prior to 1st of the renewal month.
2. Enrollees Open Enrollment changes submitted to SHOP during the first thirty (30) days of the new plan year are only permitted to make changes within the same Health Plan.
    a. Requests to the SHOP received on the first through the fifteenth day of the month after effective date shall become retroactively effective to the first day of the month, unless the employer requests an effective date of the first of the following month.
    b. Requests to the SHOP received on the sixteenth day of the month up to the thirtieth day of the month after effective date shall become effective on the first day of the following month.

E. Discontinued Group's Reference Plans

If GROUP's reference plan is no longer available, GROUP must select a new reference plan during the annual election period. If GROUP fails to select a reference plan a default alternative reference plan will be auto-selected for the GROUP in accordance with 10 CCR section 6526.

F. Miscellaneous

1. Enrollees may not change plan benefit levels within HEALTH PLAN, if GROUP has made such option available, other than during the open enrollment period.
2. An Eligible Employee of GROUP who, at the time GROUP initially enters into the Agreement, as modified by this Supplement, had declined coverage through the SHOP and who did not have coverage from another source at that time must wait to enroll until the next open enrollment period unless he or she experiences a special enrollment qualifying event in the interim.