oscar

An Exclusive Provider Organization (EPO) Plan

2021 Group Subscriber Agreement

Oscar Health Plan of California
12777 West Jefferson Blvd, 1st Floor
Suite 100, Building D
Los Angeles, CA, 90066

Effective January 1, 2021

For Questions, call Member Services at 1-855-672-2755 or login at www.hioscar.com. Por favor contáctenos al 1-855-672-2755 para obtener una versión en Español.

This Agreement is entered into between Oscar Health Plan of California (hereinafter referred to as "We", "Us" or "Our") and the Group Health Plan contract holder (hereinafter referred to as "You" or "Your"). This Agreement is a contract between You and Us.

This Agreement consists of all provisions set forth in this document as well as the provisions found in the Combined Evidence of Coverage and Disclosure Form including the Schedule of Benefits (collectively, the "Plan Documents") issued to Eligible Employees under the Group Health Plan. Any amendment changing the provisions of the Evidence of Coverage is also made part of this Agreement as of the effective date of the amendment.

READ THIS ENTIRE AGREEMENT CAREFULLY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS AGREEMENT.

This Agreement is governed by the laws of the State of California.

Mario Schlosser
CEO
Oscar Health Plan of California
12777 West Jefferson Blvd, 1st Floor
Suite 100, Building D
Los Angeles, CA, 90066

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SECTION I: DEFINITIONS

Agreement: This contract issued by Oscar Health Plan of California to You and the Plan Documents which are incorporated herein by reference.

Effective Date: The date this Agreement is made and entered into by and between the Group Health Plan contract holder and Oscar.

Eligible Employee: An Eligible Employee is a Full-Time Employee who has met any statutorily authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the Group's business and included as employees under a Group Health Plan of the Group, but does not include employees who work on a part-time, temporary, or substitute basis. Permanent employees who work at least 20 hours but not more than 29 hours are deemed to be Eligible Employees if all four of the following apply: (1) they otherwise meet the definition of an Eligible Employee except for the number of hours worked; (2) the Group offers the employees health coverage under the Group Health Plan; (C) all similarly situated individuals are offered coverage under the Group Health Plan; and (D) the employee has worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. We 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.

Full-Time Employee: A Full-Time Employee is a permanent employee who is actively engaged on a full-time basis in the conduct of the business of the Group with a normal workweek of an average of 30 hours per week over the course of a month, at the Group's regular places of business.

Full-Time Equivalent ("FTE") Employee: This term describes the number of employees counted towards a Group's size determination. For purposes of determining Group eligibility in the Small Employer market, Group size will be determined using the method for counting Full-Time Employees and Full-Time Equivalent Employees set forth in Section 4980H(c)(2) of the Internal Revenue Code.

Group: You or the party that has entered into the Agreement with Us as a Group Health Plan contract holder that meets the definition of a Small Employer.

Group Health Plan: A health care service plan with at least one Eligible Employee enrolled.

Member: The Subscriber or a covered dependent for whom required premiums have been paid. Whenever a Member is required to provide a notice pursuant to a grievance or emergency department visit or admission, "Member" also means the Member's designee.

Small Employer: A Small Employer is any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 100, employees, the majority of whom were employed within the State of California, that was not formed primarily for purposes of buying the Group Health Plan, and in which a bona fide employer-employee relationship exists.

Subscriber: A Eligible Employee of the Group that receives the benefits described in the Plan Documents.

Us, We, Our: Oscar Health Plan of California and anyone to whom We legally delegate performance, on Our behalf, under this Agreement.

You, Your: The Group.

SECTION II: HOW YOUR COVERAGE WORKS

Coverage Under this Agreement.
You have purchased a Group Health Plan from Us. We will provide the benefits described in the Plan Documents to covered Members of the Group, that is, to Your Eligible Employees and their covered dependents. You should keep this Agreement with other important papers so that it is available for future reference.

You have a right to apply for any Group Health Plan contract written, issued, or administered by Oscar at the time of application for a new Group Health Plan contract, or at the time of renewal of a Group Health Plan contract. Oscar will provide, upon request, a listing of all contracts and benefit designs Oscar offers to Small Employers, including the rates for each contract.

Term and Renewal.
This Group Health Plan is guaranteed issue, regardless of health status or age. The initial term of this Group Health Plan begins on the Effective Date. This Group Health Plan shall continue in effect for a period of 12 months and shall automatically renew thereafter for one-year terms, unless terminated pursuant to the Plan Documents.
Pursuant to Section 1357.500(k)(1)(A) of the California Health and Safety Code, any Group that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 100, Employees, the majority of whom were employed within the State of California, that was not formed primarily for the purpose of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists must be issued Small Employer coverage.

This Group Health Plan is guaranteed renewable except in the case of fraud or failure to pay premium, or as permitted to be canceled, rescinded, or not renewed under applicable State and federal law.

Pursuant to 45 C.F.R. 147.106(h), guaranteed renewability rights do not allow a Group to continue its existing coverage if it would not otherwise be permitted to enroll in

such coverage per federal law. Consequently, if You experience a reclassification as a large group on renewal, You are required to be issued coverage appropriate for that size group.

Group Health Plan Services.

Oscar will provide the Group with Plan Documents as required by Section 1363 of the California Health and Safety Code and Section 1300.63.2 of Title 28 of the California Code of Regulations. The Plan Documents are an integral part of this Agreement and include a complete description of the benefits and conditions of coverage of the Group Health Plan. We will provide the benefits described in the Plan Documents (the "Covered Services"). We will maintain a network of participating providers available to Members. These providers will act as independent contractors to render the Covered Services as described in and in accordance with the Plan Documents.

Oscar may make periodic administrative modifications. For example, Oscar may modify its process for filing a grievance, or the address to which correspondence must be sent. Oscar will not modify Your benefits, cost-shares, or premium within a plan year.

Oscar shall not include any preexisting condition provisions in its coverage.

Premiums.

In addition to premiums owed to Us, You must reimburse Us for payment of any applicable federal, state or local sales or excise tax liability relating to claims payments and/or Our administration of coverage under this Agreement. The applicable tax liability includes, but is not limited to, the Comparative Effectiveness Research Fee imposed on Us under Sections 4375-4377 of the Internal Revenue Code, and regulations implementing the same. However, You will not be responsible to pay for incomes taxes, payroll taxes or taxes, fees and assessments based solely on Our net income.

The premiums, copayments, coinsurances, and deductibles set forth upon Your enrollment with Us will be effective for the entire Plan Year, unless required or otherwise allowed by law.

Upon renewal, a change in premium rates or changes in coverage stated in the Group Health Plan contract will not become effective unless We notify You of the change(s) at least 60 days prior to the contract renewal Effective Date.

Oscar will consider a variety of factors in determining its premium, including medical costs and utilization, but may not use specific claims experience in determining that rate change.

Paying Premiums and Grace Periods.
For Subscribers added or terminated before the end of a month, that month's premium will be prorated to reflect the number of days they are covered in that month.

Premium payments are due in full to Us on or before the first day of each month for that month's coverage. Payments may be made electronically as instructed by Us or by mail to:

Oscar Health Plan of California
12777 West Jefferson Blvd, 1st Floor
Suite 100, Building D
Los Angeles, CA, 90066

You are responsible for paying any and all costs and expenses, including reasonable attorney's fees, incurred by Us in collecting any past due premiums from You.

A thirty (30) day grace period for individuals not receiving Advance Payments of the Premium Tax Credit. In this case, the last day of coverage will be 30 consecutive days beginning the day the Notice of Start of Grace Period is dated.

You are responsible for reviewing Your monthly billing invoices and for notifying Us of any corrections within 30 calendar days after the date of each invoice. Failure to promptly notify Us of changes may limit premium adjustments.

SECTION III: WHO IS COVERED

Group Eligibility.

In order to be eligible for Oscar coverage, You must qualify as a Small Employer, defined by the Affordable Care Act ("ACA") in conjunction with California law. A Small Employer is any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 100, employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, We will use the test that ensures eligibility if only one test would establish eligibility.

Subsequent to the issuance of the Group Health Plan to You, and for the purpose of determining Your eligibility, Your Group size will be determined using the method for counting Full-Time Employees and Full-Time Equivalent Employees set forth in Section 4980H(c)(2) of the Internal Revenue Code.

Under this counting method, first calculate the number of Full-Time Employees. Full-Time Employees are permanent employees actively engaged in the conduct of business on a full-time basis. They must have a normal work week averaging 30 hours per week over the course of a month, work at Your regular place of business, and have met their waiting period, if applicable.

Once You determine the number of Full-Time Employees, You then calculate the number of FTE Employees. FTE Employees are a combination of employees, each of whom individually is not a Full- Time Employee (because they're not employed on average at least 30 hours per week) but who, in combination, are counted as the equivalent of a Full-Time Employee. To calculate FTE Employees, take the total hours worked by non-full time employees in a month and divide that amount by 120. That number (rounded down to the nearest whole number) equals the number of FTE

Employees.

Finally, add the number of FTE Employees to the total number of Full-Time Employees to determine Your Group size. Mid-year fluctuations in the number of employees do not affect the determination of Group size. Group size is only determined on issuance and at the time of renewal. To confirm you Group size, We will ask and may rely upon the information You provide, including appropriate tax documentation.

Oscar is guaranteed issue and will not consider any health status-related factor or age in determining eligibility upon enrollment or renewal.

Employee Eligibility and Enrollment.

Once You have determined that You, the Group, are eligible for Oscar's Group Health Plan, you may offer coverage to Your Eligible Employees. An Eligible Employee is any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the Group with a normal workweek averaging 30 hours over the course of a month, at the Group's regular place of business. An Eligible Employee may be a sole proprietor or partners of a partnership, if they are actively engaged on a full-time basis in the Group's business and are included as employees under a health care service plan contract of the Group. An Eligible Employee is not an employee who works on a part-time, temporary, or substitute basis. Permanent employees who work at least 20 hours but not more than 29 hours per week may be Eligible Employees if (1) They otherwise meet the definition of Eligible Employee except for the number of hours worked, (2) the Group offers the employees health coverage under the Group Health Plan, (3) all similarly situated individuals are offered coverage under the Group Health Plan, and (4) the employee has worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. We 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.

Only Eligible Employees described above may enroll as Subscribers in the Group Health Plan. The Group must enroll each Eligible Employee in the Group Health Plan or obtain a declination of Group- sponsored coverage as described below. If an

Eligible Employee does not enroll, or if a Subscriber is terminating coverage (disenrolling), the Group must obtain a written notice, signed by the Eligible Employee or Subscriber, that the individual declines the Group-sponsored coverage or is terminating coverage in the Group Health Plan. This notice must clearly indicate that the individual is aware that if he or she does not enroll or does not enroll any eligible dependents for coverage in the Group Health Plan within 30 days after the individual's eligibility date, or disenrolls, the individual may be excluded from coverage until the Group's next plan year.

Any exceptions to standard eligibility and enrollment procedures applicable to You must be documented with Us upon either enrollment with Us or for a renewal period. Any revised eligibility and enrollment procedures will amend this Agreement and supersede any previous eligibility and enrollment procedures for this Agreement.

You must notify Oscar in writing when an employee has a Qualifying Event pursuant to 1366 (2)(d) of the California Health and Safety Code, within 30 days of the Qualifying Event and within 30 days of the date, when the employer becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Sec. 1161 et seq.

As between Us and You, You are responsible for complying with the terms of this Section even if You have contracted with a third party administrator to administer Your enrollment functions.

Furnishing of Necessary Information to Employees.
You must forward all applicable enrollment forms that You receive from employees to Us within 10 business days of receipt from any employee. After we receive and accept an employee's enrollment, We will provide an identification card to each Subscriber. The identification card will contain Our address and telephone number, and serves as evidence of enrollment.

We will prepare and deliver, at no cost to You, the Schedule of Benefits documents (the "SOB"), as well as the Summary of Benefits and Coverage documents (the "SBC"). SOBs and SBCs will be delivered to You in electronic format, unless a paper copy is requested. You will distribute the SOBs and SBCs to Your employees at the time the Group Health Plan is offered, enrolled in, renewed, in accordance with law, or as otherwise requested. A single SBC may be provided for an employee and all relevant beneficiaries.

If, at the time of renewal, Oscar increases copayments or coinsurance, or reduces Covered Services provided under the Group Health Plan, You must promptly notify all Subscribers of the increase or reduction. In addition, You shall promptly notify Subscribers of any other changes in the terms or conditions of this Agreement affecting the Subscriber benefits or obligations under the Group Health Plan. You must provide such notice by delivering to each Subscriber a true, legible copy of the notice of the copayments or coinsurance increase or reduction in Covered Services sent from Oscar to You at the Subscriber's then current address and promptly provided proof of such mailing and the date thereof to Oscar.

In accordance with Section 1366.27 of the California Health and Safety Code, You must notify qualified beneficiaries currently receiving continuation coverage, whose continuation coverage will terminate under one group benefit plan prior to the end of the period the qualified beneficiary would have remained covered, of the qualified beneficiary's ability to continue coverage under a new group benefit plan for the balance of the period the qualified beneficiary would have remained covered under the prior group benefit plan. This notice shall be provided either 30 days prior to the termination or when all enrolled employees are notified, whichever is later.

The Group must facilitate Our distribution of any and all written material that We are required to provide to Members to comply with the terms of this Agreement, state or federal laws or regulations, or to fulfill health plan accreditation standards. We will send a Notice of Start of Grace Period to the Group, and We require that the Group promptly send any such Notice to each Subscriber.

Non-Discriminatory Terms.

You must offer Eligible Employees coverage under the Group Health Plan on terms no less favorable than those on which You offer any other health benefits plan. You agree to make no attempt, whether through differential premium contributions or otherwise, to encourage or discourage coverage of employees and their eligible dependents under this Agreement. If Your contributions to coverage under any other health benefits plan are increased during the term of this Group Health Plan, You agree to make a similar change in Your contribution rate to coverage under this Agreement.

We agree that We will not provide for coverage under conditions less favorable for employees than coverage provided for covered spouses dependent upon the employees.

Notice Requirements.

If the Group or We terminate this Agreement pursuant to Section V (below), the Group shall promptly notify all Members enrolled through the Group of the termination of coverage in the Group Health Plan. The Group shall provide to each Subscriber a true, legible copy of any Notice of Start of Grace Period or Notice of Cancellation, Rescission or Nonrenewal (whichever is applicable and received from Us) to the Group at the Subscriber's then current address and promptly provide proof of such mailing and the date thereof to Us.

You will notify Us of an employee's loss of eligibility within 30 days following such employee's loss of eligibility. By notifying Us, You acknowledge that You have informed such employee of his or her loss of eligibility at the time the loss occurred. Your failure to provide such notification may limit premium refund.

We may grant retroactive premium credit for enrollment changes that are effective more than 30 days before We received notification of the change if You certify to Us that You notified the affected employee at the time of loss of eligibility. This provision is intended to comply with the ACA regarding rescissions, as amended and pursuant to regulations promulgated thereunder.

You are responsible for compliance with all notice requirements including, but not limited to, notices that are Your obligation under the ACA, COBRA, Knox-Keene Act, Title 28 of the California Code of Regulations, Cal-COBRA and the Health Insurance Portability and Accountability Act ("HIPAA"), and any amendments thereto. You are not responsible for notices that must be provided by Oscar. Oscar will send the Cal-COBRA Initial Rights notice to You, and will send the Election Notice to any Members eligible for Cal-COBRA.

We will provide Certificates of Creditable Coverage required at the time Our coverage terminates unless otherwise agreed by Us and You. You are responsible for notifying Us of all terminations of coverage as set forth in the Plan Documents.

SECTION IV: EXCLUSIONS AND LIMITATIONS

Exclusions.

Notwithstanding anything contained in this Agreement, We will have no obligations to You for any coverage not specified in the Plan Document's nor any coverage that You, in whole or in part, contract with other carriers to provide on Your behalf.

SECTION V: TERMINATION OF COVERAGE

Termination by the Group.
The Group may terminate this Agreement with or without cause by giving a minimum of 30 days written notice of termination to Oscar. Group termination must be effective on the first day of the month. The Group shall continue to be liable for Group Health Plan premiums for all Members enrolled in this Group Health Plan through the Group until the date of termination.

Termination by Oscar for Nonpayment of Premium.
Oscar may terminate this Agreement in the event the Group or its designee fails to remit Group Health Plan premiums in full by the due date to Oscar. Oscar will send a Notice of Start of Grace Period and provide at least a 30 day grace period in accordance with Section 1365 of the California Health and Safety Code. Nonpayment of Group Health Plan premiums includes without limitation payments returned due to insufficient funds and checks post-dated beyond the 30 day grace period. If We terminate this Agreement for nonpayment of premium, We will first give the Group 30 days prior written notice of cancellation. The notice of cancellation will state that this Agreement will not be terminated if the Group makes appropriate payment in full before the end of the 30 day grace period.

Termination by Oscar when the Group Provides Misleading or Fraudulent Information.
Oscar may terminate this Agreement 30 days after Oscar sends written notice to the Group if Oscar demonstrates fraud or an intentional misrepresentation of material fact under the terms of the Agreement by the Group.

Post-Termination.
No termination will relieve Us of any obligation imposed upon Us by the terms of the Plan Documents for health care services rendered before the date of termination, or relieve You of any obligation incurred prior to the date of termination of the Plan Documents.

In the event that You become the subject of a bankruptcy or similar proceeding, You agree that any pre-petition benefits provided by Us on credit will be allowed under 11 U.S.C. § 502 and entitled to Your maximum priority under 11 U.S.C. § 507(a)(4) and § 507(a)(5). You further agree that any post- petition benefits that are provided by Us on

credit will be allowed under 11 U.S.C. § 503(b) and entitled to administrative expense priority.

You are responsible for notifying Your employees and their covered dependents of any termination of the Group Health Plan.

In the event that You and/or a Member is determined to have engaged in fraud or material misrepresentation, premium will not be refunded.

SECTION VI: GENERAL PROVISIONS

Acceptance of the Agreement.
The Group accepts this Agreement by execution of this Agreement. Member accepts the terms, conditions and provisions of this Agreement upon completion and execution of the enrollment form. Acceptance by any of these methods shall render all terms and provisions of this Agreement binding on Oscar, the Group, and Members.

Amendments.
The Plan Documents may be amended by either party upon written notice to the other if amendment is necessary in order to comply with applicable laws and regulations. It may be amended by Us on an annual basis, effective upon renewal of the Group Health Plan, with not less than 60 days' prior written notice to You.

Confidential Information.
The parties acknowledge that, in the performance of this Agreement, they may share confidential and proprietary information belonging exclusively to the other. For the purposes of this Agreement, confidential and proprietary information shall include but not be limited to the personal, financial or business affairs of either party, know how, processes, procedures, technology, and any other information, which under the circumstances ought reasonably to be treated as confidential and/or proprietary ("Confidential Information"). Confidential Information shall not include information:

- ! Which has become generally known to the public other than by a breach of this Section;
- ! Which is or becomes known to the other on a non-confidential basis from a third party, provided that the third party is not known to the receiving party to be prohibited from disclosing such information by a contractual, fiduciary or other duty owned;
- ! Independently developed by the receiving party without the use of any of the information received from disclosing party; or
- ! Information required to be disclosed by law or judicial order.

With respect to Confidential Information, and except as expressly authorized herein, the parties agree that during the term of the Group Health Plan and at all times thereafter, they shall not use or otherwise disclose such Confidential Information to any person, except its own employees, contractors and/or agents having a "need to know" or other such recipients as agreed to in writing by the parties prior to disclosure. The parties and their employees, contractors and/or agents shall use at least the same degree of care in safeguarding the Confidential

Information of each other as they use in safeguarding their own confidential information, but in no event shall less than due diligence and care be exercised.

This Section shall survive the termination of the Group Health Plan.

Contracted Provider.
In accordance with Section 1300.67.4(a)(10) of the California Code of Regulations, if one of Oscar's contract health care providers terminates its contract with Oscar, Oscar will be liable for Covered Services rendered by such provider (other than for copayments and coinsurance) to a Member who retains eligibility under the Group Health Plan or by operation of law under the care of such provider at the time of such termination until the services being rendered to the Member by such provider are completed, unless Oscar makes reasonable and medically appropriate provision for the assumption of such services by a contracting provider

Dispute Resolution.
If a dispute between the Group Health Plan contract holder and Oscar concerning the Group Health Plan cannot be resolved by the parties, the dispute will be resolved by arbitration in accordance with the commercial arbitration rules of the American Arbitration Association then in effect. Such arbitration may be initiated by any party by making a written demand for arbitration on the other party within 30 days of the time the dispute arises. Within 30 days of that demand, the parties will designate an arbitrator and give written notice of such designation to the other. The two arbitrators selected by this process will select a third arbitrator and give notice of the selection to Us and You. The three arbitrators will hold a hearing and decide the matter within 30 days thereafter. The results of the arbitration will be final and binding on both parties. Judgment upon and award rendered by the arbitrators may be entered in any court having jurisdiction thereof. Each party will pay the fee of the arbitrator it chooses, and the parties will share equally the fee of the third arbitrator. The requirements of this Section shall survive termination of the Group Health Plan.

Effect of Payment or Providing Services.
Whether or not signed by You, this Agreement shall be effective upon the payment of premiums by You or the furnishing of covered services by Us.

ERISA Fiduciaries.
If Your Group Health Plan is subject to ERISA, You, or Your designee (other than Us), will be the plan administrator of Your Group Health Plan under ERISA and will have all the responsibilities and authority of that position including ensuring compliance with ERISA, preparing and distributing summary plan descriptions, and advising all

Members of (i) available benefits and any changes in benefits; (ii) termination of coverage for any reason, including the failure to make any payments when due; and (iii) their COBRA rights, if any. We may not be named as, and will not be considered to be, a "named fiduciary" or "plan administrator" within the meaning of ERISA for Your Group Health Plan governed by ERISA.

You may delegate the responsibility and discretionary authority to process and pay claims to Us as "claims administrator" and retain all other responsibilities and duties under ERISA not specifically delegated to Us. We agree to assume such responsibility and authority, including any responsibility

We may have as a "named fiduciary" (as defined under ERISA § 402) for purposes of Our claims administration duties, to the extent that under the Group Health Plan and ERISA We meets the definition of a "named fiduciary." As the named administrator, We will have the power and discretion to construe the terms of the Plan Documents and to determine all questions pertaining to the administration, interpretation, and application of the Plan Documents that involve eligibility for benefits and the payment or denial of claims. In addition, the parties agree that We will have the responsibility for ensuring that Our claim procedures comply with the Department of Labor's Claims Procedures (described in 29 C.F.R. § 2560) and for handling all levels of appeals.

Entire Agreement.

This Agreement, including the Plan Documents, any new or renewal Group applications (if applicable), any rate proposals, letters, and amendments or attachments/exhibits thereto, constitutes the entire Agreement between You and Us. On the Effective Date, this Agreement supersedes all other agreements for health care services and benefits between the parties. However, if this Agreement, including but not limited to any document referenced herein, contains a typographical error which is a mistake that is known or should have been known by the parties, the parties agree that this Agreement will be amended to correct such error.

Furnishing Information and Audit.

You shall make payroll and other records available to Us for inspection for the purpose of confirming Member eligibility or whether You meet Our underwriting guidelines pursuant to this Agreement.

When necessary, inspection will be conducted at Your offices, during regular business hours, and upon reasonable advance request from Us. If necessary to resolve outstanding issues, this provision shall survive the termination of this Agreement.

Governing Law.

Oscar is subject to the requirements of Chapter 2.2 of Division 2 of the California Health and Safety Code and Chapter 1 of Title 28 of the California Code of Regulations, and any provision required to be in this Agreement by either of the above shall bind the Us whether or not set forth herein. This Agreement and the rights and obligations of the parties hereunder shall be construed, interpreted, and enforced in accordance with, and governed by, the laws of the State of California and the United States of America, including, without limitation, the Knox-Keene Health Care Service Plan Act of 1975, as amended, and the regulations adopted thereunder by the California Department of Managed Health Care.

Group as Agent.

For all purposes of this Agreement, including the payment of premiums, You are the agent for all Members covered under the Group Health Plan. Notice by or to You will satisfy any notice requirements of this Agreement or the Plan Documents, unless Oscar is required to give notice directly to Members.

HIPAA Privacy Notices.

We will prepare Notices of Privacy Practices appropriate for You under 45 C.F.R. Parts 160 and 167 ("Privacy Standards"). You represent and warrant that You do not create or receive Protected Health Information ("PHI") (as defined in 45 C.F.R. § 164.501) and are not entitled to receive any PHI from Us, except as permitted in 45 C.F.R. § 164.520(a)(2)(iii), or the law of the State of California where more stringent, so that the burden to maintain and provide Notices of Privacy Practices is entirely that of Us. You will cooperate with Us in the preparation of Notices of Privacy Practices and will not prepare any such notices independently.

Maximum Contractual Benefits.

When a husband and wife are both employed as employees, and both have enrolled themselves and their eligible family members under a group health care service plan provided by their respective employers, and each spouse is covered as an employee under the terms of the same master contract, each spouse may claim on his or her behalf, or on behalf of his or her enrolled dependents, the combined maximum contractual benefits to which an employee is entitled under the terms of the master contract, not to exceed in the aggregate 100 percent of the charge for the covered expense or service.

Renewal Date.
The renewal date for this Agreement is the anniversary of the Effective Date of the Group Health Plan of each year. This Agreement will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this Agreement or by the Subscriber upon 45 days' prior written notice to Us.

Right to Use Vendors.
We reserve the right to administer Our plans through the use of third party administration and other vendors.

State of California Review of Member Grievances.
Pursuant to Section 1368.02 of the California Health and Safety Code, the California Department of Managed Health Care is responsible for regulating health care service plans. If Subscribers have a grievance against Oscar, Subscribers should first telephone Oscar at 1-855-Oscar-55 and use Oscar's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available. If a Subscriber needs help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Oscar, or a grievance that has remained unresolved for more than 30 days, the Subscriber may call the Department for assistance. The Subscriber may also be eligible for an Independent Medical Review ("IMR"). If the Subscriber is eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

Workers' Compensation.
Upon Our request, You will submit proof of Your workers' compensation coverage or an exclusion form which has been accepted by the Workers' Compensation Board. You will cooperate with Us to secure Oscar's right to subrogation and reimbursement related to workers' compensation claims or settlements involving any employee under this Agreement.

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 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 care service plan or an insurance carrier, offering health maintenance organization (HMO) or preferred provider (PPO) products and participating in the SHOP. H E A L T H 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 PLAN's Members.

PREMIUM shall mean the monthly amount charged to and payable by Subscribing Groups or 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 PROGRAM

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

B. 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 insurance coverage through the SHOP. For purposes of participation, Eligible Employees do not include an employee who is enrolled in coverage through another employer, an employee's union, Medicaid, Medicare, or any other federal or state health coverage programs – other than coverage through a QHP sold in the Individual Exchange at the time GROUP initially contracts with HEALTH PLAN

3. If GROUP does not meet such minimum contribution and minimum participation requirements, GROUP may only enroll with HEALTHPLAN 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. In order 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 step-child 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 on 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 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 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. termination of employment
    b. termination of an employer sponsored plan
    c. reduction in hours that results in a loss of eligibility
    d. 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; or
(C) 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;

e. 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;

f. 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;

g. 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;

h. 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; and
(B) A qualified employee or dependent demonstrates to the Exchange, with respect to health benefit 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;

i. 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;

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 minus the participation fee due to the SHOP. HEALTH PLAN agrees to accept the Net Premium due HEALTH PLAN and forwarded to HEALTH PLAN by and received by 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. Employer's first premium payment is due in full but must be at least 85 percent of the total amount due, 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, which payment must be received or postmarked by the last day of the invoicing month. On-going premium payments are due in full but must be no less than 85 percent of the total balance due, including any amounts past 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 Consequences 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 Cancellation for Nonpayment of Premiums and 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, 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 for making the premium payment necessary in order to maintain coverage in force, and will repeat when such cancellation will be effective and will also state how and when GROUP may appeal the cancellation. If the Premium payment is not received by cancellation effective date, the Agreement will be terminated for non-payment effective 30 days from the date the Notice was sent. In such a case, a "Notice Confirming Cancellation of Coverage" will be mailed to GROUP by SHOP on behalf of HEALTH PLAN on the first business day of the month following the effective date of the cancellation. PLAN, or SHOP on behalf of HEALTH PLAN, will mail an individual Notice Confirming Cancellation of Coverage to each of its affected Members and also explaining their options for purchasing individual coverage.

    All of the cancellation 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 Cancellation for Nonpayment of Premium and Grace Period will continue the Agreement, as modified by this Supplement, with no interruption in coverage. If payment of at least 85 percent of all delinquent Premiums is received by SHOP after the due date in the Notice, the Agreement will not be reinstated.

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 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 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 Section 10753.13, 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. A new contract will be issued only upon demonstration that GROUP meets all eligibility requirements, including payment of any and all outstanding earned Premium payments still owing and due.

7. Delinquent Accounts: Collections: In the event GROUP's account becomes delinquent, SHOP shall undertake collections as 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 QHP 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.C 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 ten (10) 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.