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 the Plan, payment by Employer Group of the first Premium payment following the Premium payment due with the Group's application shall also constitute the Employer Group's agreement to be bound by all of the terms and conditions of this Agreement.**

RECITALS

A. The 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. The 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 the Employer Group and their Dependents, who are enrolled in the Plan ("Members").

C. The Employer Group will pay Premiums to the Plan for the provision of Benefits by the 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.

AGREEMENT

NOW, THEREFORE, the parties mutually agree as follows:

I.

DEFINITIONS

The following terms 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 a 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 "Attachments" means Attachments A through D hereto, which are incorporated herein as if set forth in full.

1.3 "Authorization" or "Authorized" means the approval by the Plan, a Member's Plan Medical Group (PMG) or a Member's Primary Care Physician (PCP) for Benefits.

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

1.5 "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.

1.6 "Copayment" means a fee which a Member is required to pay for a particular Benefit.

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

1.8 "Covered California" means the California Health Benefits Exchange.

1.9 "Department" means the Department of Managed Health Care of the State of California, or any other agency or department that regulates the health care service plans of that state.

1.10 "Dependent" means an Enrolled Employee's Spouse and any child, who is an adopted child, a stepchild, a recognized natural child, a child for whom the Enrolled Employee or the Enrolled Employee's Spouse is (or was before the person's 18th birthday) the court-appointed guardian, or child 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, as certified by the Enrolled Employee at the time of enrollment of the child and annually thereafter, who lives or works in the Service Area. A child attains the status of "Dependent" at birth or upon legal adoption. A child shall be considered to be adopted from the date on which the adoptive child's birth parent or other appropriate legal authority signs a written his document (including, but not limited to, a health facility minor release report, a medical authorization form, or a relinquishment form) granting the Enrolled Employee or his or her Spouse the right to control health care for the adoptive child, or absent this written document, on the date there exists evidence of the Enrolled Employee's, or his or her Spouse's, right to control the health care of the child placed for adoption. A stepchild attains the status of "Dependent" upon the Enrolled Employee's marriage to or establishment of a domestic partnership with the natural or adopted step- child's parent. A child ceases to be a "Dependent" upon attainment of age 26. A child who at the time of attaining age 26 is Totally Disabled from a date prior to attainment of age 26 continues as a Dependent until termination of such disability.

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

1.12 "Domestic Partner" means a person who has established eligibility for the Plan by meeting all of the following requirements. All Employers who offer coverage to the Spouses of employees must also offer coverage to Registered Domestic Partners:

(1) Both persons agree to be jointly responsible for each other's basic living expenses incurred during the domestic partnership.
(2) Neither person is married or a member of another domestic partnership.
(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.
(5) Both persons are capable of consenting to the domestic partnership.
(6) Either of the following:
    i. Both persons are members of the same sex.
    ii. One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both persons are over the age of 62.
(7) Neither person has previously filed a Declaration of Domestic Partnership with the Secretary of State pursuant to this division that has not been terminated under Section 299.
(8) Both file a Declaration of Domestic Partnership with the Secretary of State pursuant to this division.

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.

1.13 "Eligible Employee" means any employee, employed for the period of time specified by the Employer Group, who is actively engaged in the conduct of the business of the Employer Group with a normal work week, as specified by the Employer Group on the Execution Page of this Agreement, at the Employer Group's regular place or places of business, including sole proprietors or partners in a partnership, if they are actively engaged on a full-time basis in the Employer Group's business and included as employees this Agreement, but excluding 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. A contracted ("1099") employee who meets the criteria outlined in the Plan's underwriting guidelines also qualifies as an "eligible employee".

1.14 "Emergency Medical Condition" means a medical condition, manifesting itself by 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.

1.15 "Emergency Services" means those Benefits, including Emergency Services and Care, provided inside or outside the Service Area, which are medically required on an immediate basis for treatment of an Emergency Medical Condition. When provided by a non-Plan Provider, such services are considered to be Emergency Services only if they could not safely and adequately have been provided by a Plan Provider and only for as long as the Member's medical condition precludes transfer to an appropriate Plan Provider.

1.16 "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.

1.17 "Employer Group" means any person, firm, proprietary or nonprofit corporation, partnership, or public agency that is actively engaged in business or service, which was not formed primarily for purposes of buying health care service plan contracts and in which a bona fide employer-employee relationship exists.

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

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

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

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

1.22 "Medically Necessary" means a treatment or service necessary to protect life; to prevent significant illness or disability; to diagnose, treat or control illness, disease or injury; or to alleviate severe pain, which 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.

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

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

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

1.26 "Out-of-Area Coverage" means coverage while a Member is anywhere outside the Service Area, including coverage for Emergency Services and Urgent Care Services to prevent serious deterioration of a Member's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the Member returns to the Service Area.

1.27 "Plan-At-A-Glance" means the Member document which contains specific information regarding Covered Benefits and describes when Copayment amounts apply to a Covered Benefit, which document is included in the Member Handbook and is also referred to as a Health Plan Benefits and Coverage Matrix.

1.28 "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 the Plan and that is included in the selected Plan Network.

1.29 "Plan Medical Group" or "PMG" means a group of physicians, organized as or contracting through a legal entity, that has met the Plan's criteria for participation and has entered into an agreement with the 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.

1.30 "Plan Network" means the network of providers selected by the Employer Group or the Member, as indicated on the execution page of this Agreement.

1.31 "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 the Plan or as a member of a PMG, and who is included in the selected Plan Network.

1.32 "Plan Providers" means the physicians, hospitals, skilled nursing facilities, home health agencies, pharmacies, medical transportation companies, laboratories, X-ray facilities, durable medical equipment suppliers and other licensed health care entities or professionals who are part of the selected Plan Network and which or who provide Benefits to Members through an agreement with the Plan.

1.33 "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 (6) months immediately preceding the effective date of coverage under this Agreement. Sharp Health Plan neither excludes coverage based on pre-existing conditions nor implements a waiting period for such services.

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

1.35 "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.

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

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

1.38 "Provider Directory" means a listing of the Plan approved physicians, hospitals and other Plan Providers in the selected Plan Network, as updated from time to time.

1.39 "Service Area" means the geographic area of San Diego County and southern Riverside County, California.

1.40 "Small Group" means any Employer Group that on at least fifty percent (50%) of its working days during the preceding calendar quarter, or preceding calendar year, employed at least one (1), but no more than one hundred (100)employees, who is not the business proprietor or spouse of the business proprietor, 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, as defined by California Health & Safety Code Section 1357.500(k).

1.41 "Spouse" means an Enrolled Employee's legally married husband or wife or, if coverage for same is indicated on the Execution Pages, an Enrolled Employee's Domestic Partner.

1.42 "Supplemental Benefits" means those Medically Necessary prescription drug, chemical dependency, vision, chiropractic, mind/body and other services described in the Supplemental Benefits brochures contained in Attachment C, if applicable, as amended from time to time.

1.43 "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 is unable to engage in any such activity or any other activity normal or customary for a person of like age and family status on either a full-time or 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.

1.44 "Urgent Care Services" means services intended to provide urgently needed care in a timely manner when your PCP has determined that you require these services or you are out of area and require urgent care services. Urgent Care Services means those services performed, inside or outside the Plan's service area, which are medically required within a short timeframe, usually within twenty-four (24) hours, in order to prevent a serious deterioration of a Member's health due to an illness or 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 enrollee or the enrollee's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee returns to the 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, 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 and a Primary Care Physician from the selected Plan Network on behalf of himself or herself and each of his or her eligible Dependents at the time of enrollment in the Plan. The Enrolled Employee may select a different Plan Medical Group 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 Plan Medical Group at the time of enrollment in the Plan, one will be assigned to him or her, and each of his or her eligible Dependents, at such time.

2.2.1 Enrolled Employees may change Plan Medical Groups and/or Primary Care Physicians by contacting the Plan's Member Services Department. When the Plan's Member Services 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 Sixty (60) days prior to terminating a contract with an entire PMG, the 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 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 each Member is responsible for obtaining all necessary Authorization for Benefits. Except for Emergency and Out of Area Urgent Care Services, if Benefits are not provided by the Plan Providers specified in Sections 2.4 and 2.5, below, or if Benefits are provided without the necessary Authorization, the Member shall be responsible to pay for such Benefits.

2.4 Plan Hospitals. Each Plan Medical Group 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 Plan Medical Group 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.

2.5 Plan Providers. Except for Emergency Out of Area Urgent Care Services, each Member must receive Benefits from Plan Providers affiliated with the Plan Medical Group 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.

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 and Out of Area Urgent Care Services); (d) prescribed by a Plan Physician and Authorized in advance by the Member's PCP or PMG, or the Plan, if required (except for Emergency and Out of Area Urgent Care Services); and (e) part of a treatment plan for covered services or required to treat medical conditions which are direct and predictable complications or consequences of Benefits.

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 the Plan at 858-499-8300 or 1-800-359-2002.

3.3 Non-Plan Providers. The Plan will not cover Benefits 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 the Plan, as applicable.

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 The Plan and the Member's Plan Medical Group may elect to return the Member to a Plan Provider once such transfer is medically appropriate. If the Plan and the Plan Medical Group authorize such a transfer, either the Plan or the Plan Medical Group 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 Plan Medical Group. For purposes of this Agreement "follow-up care" means any Benefits that are not Emergency Services or Urgent Care Services.

3.6 Copayments. Members are required to make Copayments for Benefits at the time Benefits are rendered. The Copayments for Covered Benefits are set forth in the Member Handbook and shall remain in effect during the Benefit Year. There is a limit to the total amount of Copayments a Member must pay for Covered Benefits in one Benefit Year (the "Annual Maximum Copayment"). The Annual Maximum Copayment for Covered Benefits is stated in the Plan-At-A-Glance. The Member is responsible for maintaining receipts for and records of Copayments paid, and for presenting same to the Plan once the Annual Maximum Copayment has been reached.

3.7 Cash Benefits. The Benefits described in the Member Handbook and Supplemental Benefits brochures, if applicable, are provided by the Plan, subject to payment by the Member of the Copayments indicated. Additionally, except as specifically provided in Section 3.6 and Article XI hereof, neither the 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, Copayments and other matters relating to the Supplemental Benefits.

3.9 No Medical Necessity. Neither the Plan nor any Plan Provider shall bill a Member for services rendered that are determined not to be Medically Necessary or Benefits, unless the services are non-emergent and the Member obtains such services without Authorization or the Member is advised prior to the rendering of those services that the services are not covered, and 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 the Plan hereunder are subject to the following Limitations:

4.2.1 Major Disaster or Epidemic. In the event of any major disaster or epidemic, the Plan and Plan Providers shall provide Benefits to Members to the extent the Plan and Plan Providers deem reasonable and practical given the facilities and personnel then available. Under such circumstance, the 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. The Plan shall refer members to the nearest hospital for emergency services or to available urgent services providers for treatment of medically necessary services and may provide reimbursement for such services. However, neither the 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 the Plan their rights to all sums payable under such laws for Benefits, and such sums shall be payable to and retained by the Plan. Members agree to complete and submit to the Plan such consents, releases, assignments and other documents as may be required to enable the 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 the 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 the Plan for a determination as to whether any Medically Necessary, medically superior (as determined by the Plan), covered alternative procedure(s) or treatment(s) is available to the Member. If the 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 the Plan's decision through the Plan's grievance procedure.

V.

PREMIUMS

5.1 Premiums. The 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 the Plan on or before the first day of the month in which Members are entitled to receive Benefits hereunder and, with respect to newly eligible Members, within thirty-one (31) days of the Member's becoming eligible for Benefits, as described in Section 6.1.2. hereof. Employer Groups participating in Covered California's CCSB Program shall remit Premiums to Covered California in accordance with the standards established by Covered California.

5.2 Employer Group will be given a 30-day grace period of continued coverage after the last day of paid coverage to pay the Premiums owed for the month of coverage. This Agreement is subject to termination at the end of the grace period if the Premiums are not paid by that date. 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 March 1st and shall pay April Premiums by April 1st. If payment is not received by April 1st, the 30-day grace period will begin on April 2nd and end on May 1st. Coverage will end at 12:01am on May 2nd if the April Premiums are not received by May 1st. 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 the Employer Group.

Medicare Payments. Payments owed by Members or the Employer Group under this Agreement are based on the assumption that the 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 the 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 thirty (30) days of written notice from the Plan specifying the action to be taken shall lose eligibility for coverage under the Plan, unless it was not reasonably possible for such Member to take the action specified by the Plan within such thirty (30) day period and the Member takes the specified action as soon as reasonably practicable after expiration of such thirty (30) day period.

VI.
ELIGIBILITY/ENROLLMENT/EFFECTIVE DATE OF COVERAGE

6.1 Enrollment/Effective Date of Coverage.

6.1.1 Annual Open Enrollment Period. The annual open enrollment period under this Agreement is set forth on the Execution Page hereto. All eligible Enrolled Employees and Dependents enrolled during an annual 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 the Plan during an annual open enrollment period must wait until the Employer Group's subsequent annual open enrollment period to enroll. The initial and subsequent open enrollment periods shall be a period of at least thirty (30) days.

6.1.2 Newly Eligible Enrollments. Any person who becomes newly eligible at a time other than during an annual open enrollment period (e.g., new Spouse, newly hired employee) shall be entitled to Benefits as of 12:01 a.m. on the first day on which eligibility was obtained, as established by the Employer Group, so long as such person enrolls in the Plan within thirty-one (31) days of becoming eligible. Anyone failing to enroll within thirty-one (31) days of becoming eligible may not enroll until the Employer Group's next annual open enrollment period, except as provided in Section 6.1.3. The Employer Group shall be responsible for notifying the Plan of newly eligible persons, for making timely payment of Premiums to the Plan for such persons, and for complying with requirements in applicable state and federal law regarding eligibility determinations and permissible waiting periods. A newborn child Dependent shall be covered from birth if such child is enrolled in the Plan within thirty- one (31) days of birth. An adopted child Dependent shall be covered from the date there exists a written document or evidence that the Enrolled Employee or the Enrolled Employee's spouse has the right to control the health care of the adopted child, if such child is enrolled in the Plan within thirty- one (31) days from that date.

6.1.3 Other Eligible Enrollments. Any Eligible Employee or Dependent who has declined enrollment in the Plan during an annual open enrollment period, and who subsequently requests enrollment in the Plan, shall be entitled to Benefits as of 12:01 a.m. on the first day of the month following the month in which such person requests enrollment in the Plan,

(1) if the person

(a) was covered under COBRA, another group health benefit plan or

governmental coverage at the time the individual was first eligible to enroll in the Plan;

(b) declined to enroll in the Plan because of such other coverage;

(c) has lost or will lose coverage under, or employer contribution toward, COBRA, such other group health benefit plan or governmental coverage; and

(d) requests enrollment in the Plan within sixty (60) days after termination of such coverage or employer contribution toward coverage; or

(2) is an Eligible Employee who previously declined coverage under the Plan and who has subsequently acquired a Dependent who would be eligible for coverage as a Dependent of the Eligible Employee through marriage, domestic partnership, birth, adoption, or placement for adoption, and who enrolls for coverage under the Plan on his or her behalf, and on behalf of his or her Dependent within sixty (60) days following the date of marriage, domestic partnership, birth, adoption or placement for adoption; or is an Eligible Employee who has declined coverage for himself or herself or his or her Dependents during a previous enrollment period because his or her Dependents were covered by COBRA, another group health plan or governmental coverage at the time of the previous enrollment period, which person may enroll himself or herself or his or her Dependents for Plan coverage during a special open enrollment opportunity if: (i) his or her Dependents have lost or will lose that other coverage; and (ii) the Eligible Employee requests the special open enrollment opportunity not more than sixty (60) days after the date that the other health coverage is exhausted or terminated; or

(3) is an Eligible Employee who has declined coverage for himself or herself or his or her Dependents during a previous enrollment period because his or her Dependents were covered by Medicaid or the Child Health Insurance Program (CHIP) coverage at the time of the previous enrollment period, which person may enroll himself or herself or his or her Dependents for Plan coverage during a special open enrollment opportunity if: (i) the Eligible Employee's or Dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or (ii) the Eligible Employee or Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP; and (iii) the Eligible Employee requests the special open enrollment opportunity not more than sixty (60) days after the date that the other health coverage is terminated or that eligibility for premium assistance is determined.

6.2 Eligibility Requirements. Individuals are accepted for enrollment in and are entitled to continuing Benefits under the Plan only if the applicable Premiums have been paid and such individuals meet all eligibility requirements established by the 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 Sections 7.3.2, 7.3.4 or 7.3.5 hereof; and

(4) submit the required Plan enrollment information.

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

(1) the Spouse of an Enrolled Employee;

(2) the Dependent child of an Enrolled Employee or the Enrolled Employee's Spouse, who is either:

(a) under age 26; or

(b) who at the time of attaining age 26 is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition and is chiefly dependent upon the Enrolled Employee for support and maintenance; provided, that proof of such incapacity and dependence is furnished to the Plan by the Enrolled Employee within sixty (60) days of receipt of the Plan notification that the Dependent child's coverage is about to terminate for reaching the limiting age. If, based upon the documentation received, the Plan determines the Dependent child qualifies for continued coverage under this provision, the Enrolled Employee must then submit proof of the Dependent child's incapacity and dependence upon Dependent's attainment of his or her 28th birthday and each birthday thereafter until termination of such disability.

(3) any other person under age 26 for whom the Enrolled Employee or the Enrolled Employee's Spouse is (or was before the person's 18th birthday) the court-appointed guardian. The Plan may require the Eligible Employee to furnish evidence, on a periodic basis, of the IRS status, residency or guardianship of such person.

6.2.3 Covered California Eligibility Rules: For Employer Groups participating in Covered California's CCSB program, the Employer Group and Enrollee has met 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 7.3.2, 7.3.4, or 7.3.5 hereof.

6.3.2 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. The Employer Group shall have at least seventy percent (70%) of its Eligible Employees enrolled in employer-sponsored plans, except as provided in section 6.4.9.

6.4.2 Contribution Requirements. The Employer Group shall contribute an amount, as specified on

the Execution Page, toward equal to at least fifty percent (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 the Plan's underwriting guidelines except as provided in section 6.4.9.

6.4.3 Workers' Compensation Requirements. One hundred percent of the Eligible Employees enrolling in the Employer Group's employer-sponsored plans 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. The Employer Group shall forward to the Plan all applications for enrollment in the Plan under this Agreement no later than thirty (30) days after the effective date of eligibility, as provided above. Employer Group's failure to forward enrollment applications to the Plan within thirty (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 the 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.

6.4.5 Requalification/Renewal Requirements. The Employer Group shall submit to the Plan at least thirty(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 the 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.

6.4.6 Eligibility Changes Requirements. Any change to any eligibility requirements of the Employer Group must be submitted to the Plan at least thirty (30) days prior to the start of the 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.

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

(1) conditions of eligibility for enrollment in the Plan;

(2) when coverage under this Agreement becomes effective and terminates, per Section 6.4.7 and 7.4.1;

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

(4) any continuation coverage under the Plan purchased or arranged for by the 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 the Plan from November 15th through December 15th of each year

VII.

TERM AND TERMINATION

7.1 Term. The initial term of this Agreement, for the provision of Benefits to Members enrolled in the Plan in accordance with Article VI hereof, is set forth on the Execution Page. Thereafter, this Agreement shall automatically renew for successive one (1) year periods; provided, however, that for a renewal term, the 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 the Employer Group indicating the changes, at least sixty (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 the Plan, has authority to waive any condition or restriction of this Agreement, to extend the time for making a payment, or to bind the 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 the 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 thirty (30) days prior written notice to the 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. The Employer Group shall be responsible for notifying and agrees to notify the 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. The Employer Group shall continue to be liable for Premiums during the period

between loss of eligibility and receipt of notice thereof by the Plan. Plan Providers may bill a Member for services rendered to such Member subsequent to the Plan Provider's advisement by the Plan of the Member's ineligibility.

7.3.2 Termination for Cause. If a Member threatens the safety of Plan employees, Providers, Members or other patients, or the Member's repeated behavior has substantially impaired the Plan's ability to furnish or arrange services for the Member or other Members, or a Providers' ability to provide services to other patients, then the Plan may terminate the membership of the Member effective as of fifteen (15) days following written notice of termination.

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

7.3.4 Failure to Furnish or Furnishing Incomplete Information. If a Member fails to furnish information required under this Agreement, such as evidence of legal marriage or domestic partnership under California law, proof of mental or physical handicap, or current documents verifying IRS status, residency, or guardianship, within thirty (30) days of written notice from the Plan specifying the required information to be provided, then the Plan may terminate the rights of the Member, effective on the last day of the month in which such thirty (30) day period expires, and after receipt by the Member and the Employer Group of written notice of termination from the Plan, unless the Member furnishes the requested information to the Plan prior to the date on which coverage terminates. The above notwithstanding, the Plan may not terminate a Member's coverage hereunder for the Member's failure to provide the requested information within the thirty (30) day period if it was not reasonably possible for such Member to provide the specified information within such period, and the Member provides such information as soon as reasonably practicable after expiration thereof.Fraud or Deception. Members shall warrant in their enrollment applications that all information contained in applications, questionnaires, forms or statements submitted to the Plan incident to enrollment under this Agreement, or to the administration of this Agreement, is true, correct and complete. If, in the Plan's sole determination, any Member has engaged in fraud or intentional misrepresentation of material fact in the use of the services or facilities of the Plan, or knowingly permits such fraud or intentional misrepresentation of material fact by another, then the Plan may terminate the rights of such Member, and of his or her enrolled Dependents, effective immediately upon the mailing of written notice of termination by the Plan to such Member and to the Employer Group.

7.3.5 Right to Review. A Member who alleges that his or her rights hereunder were terminated or not renewed because of the Member's health status or requirements for Benefits, may request a review of the termination by the Director pursuant to Section 1365(b) of the California Health and Safety Code.

7.3.6 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 the Plan or Plan Providers from the Member shall be refunded to the Member within thirty (30) days of such termination.

7.3.7 Refunds to Employer Group. If the rights of a Member hereunder are terminated, Premiums received from the 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 the Plan or Plan Providers shall be refunded to the Employer Group within thirty (30) days of the 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. The unpaid invoiced Premiums are the current month's Premiums. If the Employer Group fails to pay the full amount due by the end of the 30-day grace period as described in Section 5.1, then the Plan may cancel this Agreement and terminate the rights of the Members involved, per Section 7.4.2. Such rights may be reinstated only in accordance with Section 7.4.3. The 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 the 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.

7.4.2 Notice of Cancellation by Plan. The Plan shall issue to the Employer Group a 30-day advance written notice of prospective cancellation if payment is not received by the due date set forth in section 5.1. If full payment for the unpaid invoiced Premiums, as defined in 7.4.1, is not received by 11:59pm on the last day of the 30-day grace period, then the Plan shall issue a Notice Confirming Termination of Coverage to the Employer Group and to all individual Members of the Employer Group.

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

a. Unpaid invoiced Premiums – 100%
b. Reinstatement administrative surcharge – 10% of one month's Premiums
c. Next month's Premiums –100%

7.4.3.1. If the Plan receives payment from the Employer Group more than 15 days after issuing the Notice Confirming Termination of Coverage, then the Plan is not required to reinstate this Agreement. The Plan shall refund the amounts received to the Employer Group within twenty (20) business days.

7.4.3.2 In the event that the reinstatement period in Section 7.4.3 has passed and the Employer Group wishes to obtain coverage from the Plan, the Employer Group must submit a new application to the Plan for coverage. Plan shall issue a new contract to the 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 the Plan is submitted, the Employer Group shall not be required to pay the reinstatement fees set forth in Section 7.4.3.

7.4.3.3 The Plan will allow one reinstatement of the Agreement during any twelve-month period.

7.4.4 Notice of Cancellation by Group: If the Employer Group decides to terminate its coverage with the Plan, it shall notify the Plan in writing of its intent to terminate at least thirty-one (31) calendar days prior to the requested termination date. If the Employer Group does not notify the Plan before the 1st day of the 30-day grace period outlined in section 5.1, the 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 standards established by Covered California.

7.4.5 Termination of Employer Group Plan.

(1) In the event that the Plan ceases to arrange for the provision of health care services for new Small Group contracts, and the Employer Group is a Small Group, the Plan may terminate this Agreement by notifying the Employer Group of this decision and providing it with at least one hundred eighty (180) days notice of termination.

(2) In the event the Plan withdraws a health care service plan contract of the type represented by this Agreement, and the Employer Group is a Small Group, the Plan may terminate this Agreement by giving the Employer Group at least ninety (90) days prior written notice.

7.4.6 Failure to Furnish or Furnishing Incomplete Information. If an Employer Group fails to furnish information required under this Agreement within thirty (30) days of written notice from the Plan specifying the required information to be provided, then the Plan may terminate the rights of the Employer Group, effective on the last day of the month in which such thirty (30) day period expires, and after receipt by the Employer Group and the Employer Group of written notice of termination from the Plan, unless the Employer Group furnishes the requested information to the Plan prior to the date on which coverage terminates. The above notwithstanding, the Plan may not terminate an Employer Group's coverage hereunder for the Employer Group's failure to provide the requested information within the thirty (30) day period if it was not reasonably possible for such Employer Group to provide the specified information within such period, and the Employer Group provides such information as soon as reasonably practicable after expiration thereof.

7.4.7 Fraud or Deception. If, in the Plan's sole determination, the Employer Group engages in fraud or misrepresentation, then the Plan may terminate this Agreement effective immediately upon the mailing of written notice of termination by the Plan to the Employer Group.

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

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 twelfth (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, the Plan shall be liable for Benefits rendered by such Plan Provider, other than for Copayments, 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 the 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 the Employer Group coverage is subject to terms as stated below to include, 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 the Employer Group has twenty (20) or more employees, a Member who would otherwise lose coverage for Benefits may continue uninterrupted coverage hereunder upon arrangement with the Employer Group in compliance with COBRA and upon payment of the applicable monthly Premiums to the 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 a Dependent 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 the Employer Group at the time specified by the Employer Group, and terminates on the earlier of:

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

(2) coverage of the Member under any other group health plan which 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 thirty-six (36) calendar months after an event described in Section 8.1.1(1) or (2).

(4) expiration of eighteen (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 twenty-nine (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 7 months of Cal-COBRA coverage, as defined in Section 8.1.2 of this Agreement.

(6) the Member no longer resides or works in the Service Area.

8.1.4 COBRA Continuation Coverage Upon Group Bankruptcy. A Member who is a retired Enrolled Employee, a Dependent of a retired Enrolled Employee, or the surviving Spouse of a deceased retired Enrolled Employee may continue coverage hereunder if: (a) the Employer Group has more than twenty (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 the Employer Group.

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

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

(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.
(e) A disabled qualified beneficiary whose disability extends the maximum covered period to 29 months is determined not to be disabled before the end of the extended period.
(f) The qualified beneficiary's COBRA coverage is terminated for cause (e.g., for submitting fraudulent claims) on the same basis as would apply to a similarly situated non-COBRA enrollee, as indicated in Section 7.3.5.

(2) Notice of Availability of Open Enrollment Materials & Change in COBRA Premium

Notice sent upon the 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 the Plan will provide a notice of termination of COBRA coverage, as mentioned above.

8.2 Cal-COBRA Continuation Coverage. The 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 the 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 a Dependent 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. The Employer Group agrees to notify the Plan, in writing, within thirty (30) days of an Enrolled Employee's qualifying event, which results in eligibility for Cal-COBRA. The Employer Group acknowledges that failure to notify the Plan within thirty (30) days shall create an obligation on the part of the 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. The Employer Group agrees to notify the Plan, in writing, within thirty (30) days of the Employer Group becoming subject to COBRA.

8.2.3 Notification of Current Cal-COBRA Members. The 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 sixty (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 the 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 thirty (30) days prior to termination of the previous group benefit plan or when all Enrolled Employees are notified, whichever is later. In addition, the Employer Group agrees to notify the 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 the Plan by the Member and may be discontinued before the end of the maximum period for any of the following reasons:

(1) the 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 Pre-existing 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 the Plan contract.

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

8.3 Group Continuation Coverage.

8.3.1 (1) If a former Enrolled Employee who worked for the Employer Group for at least five (5) years prior to the date of termination of employment and who is sixty (60) years of age or older on the date employment ends is entitled to and so elects to continue benefits under COBRA or Cal-COBRA for himself or herself and for any Spouse, the Enrolled Employee or Spouse may further continue Benefits beyond the date coverage under COBRA or Cal-COBRA ends, under the same benefit terms and conditions as if the continuation coverage under COBRA or Cal-COBRA had remained in force.

(2) If a former Spouse of an Enrolled Employee or former Enrolled Employee was covered as a qualified beneficiary under COBRA or Cal-COBRA, the former Spouse may further continue Benefits beyond the date coverage under COBRA or Cal-COBRA ends, under the same benefit terms and conditions as if the continuation coverage under COBRA or Cal-COBRA had remained in force. Continuation coverage following the end of COBRA or Cal-COBRA is subject to payment of premiums to the Plan.

(3) The continuation coverage provided for above shall end automatically on the earlier of: (i) the date the individual reaches sixty-five (65) years of age; (ii) the date the individual is covered under any group health plan not maintained by the Employer Group or any other health plan, regardless of whether that coverage is less valuable; (iii) the date the individual becomes entitled to Medicare; (iv) five (5) years from the date on which continuation coverage under COBRA or Cal-COBRA was scheduled to end for the Spouse or former Spouse; or (v) the date on which the Employer Group terminates this Agreement and ceases to provide coverage for any active employees through the Plan.

8.3.2 (1) Premiums for continuation coverage shall be billed by, and remitted to, the Plan. Failure to pay the requisite Premiums may result in termination of the continuation coverage in accordance with the applicable provisions of this Agreement.

(2) The Employer Group shall notify the former Enrolled Employee or Spouse or both (or the former Spouse of the Enrolled Employee or former Enrolled Employee) of the availability of the continuation benefits in accordance with Section 2800.2 of the California Labor Code. To continue coverage for Benefits, the individual shall elect to do so by notifying the Plan in writing within thirty (30 days prior to the date continuation coverage under COBRA) or Cal- COBRA is scheduled to end.

IX.

GRIEVANCE POLICY AND PROCEDURE

A grievance or appeal may be filed with the Plan at any time. The Plan's Grievance and Appeal Policy and Procedures are available by calling our Customer Service Department or a Plan Provider. To begin the grievance process, call, write or fax the Plan at:

Sharp Health Plan
Appeal/Grievance Department
8520 Tech Way, Suite 200
San Diego, CA 92123
Toll-Free: 800-359-2002
FAX: 619-740-8572

If a written grievance is preferred, please send a detailed letter describing the grievance, or complete a Grievance Form available on the Plan's website: www.sharphealthplan.com, at any Plan Provider's office or directly from a Plan representative. The Plan's Customer Service Department will assist in completing the form over the telephone**.**

There are separate processes for clinical and administrative grievances. Clinical grievances are those that require a clinical body of knowledge to render a decision. Only a physician or committee of physicians can render a decision about a clinical grievance.

The Plan will acknowledge receipt of a grievance within 5 days, and will send a decision letter within 30 days. If the grievance involves an imminent and serious threat to a Member's health, including, but not limited to, severe pain, potential loss of life, limb or major bodily function (urgent grievance), the Plan will render a decision within 72 hours.

Any dispute or controversy involving the Plan and arising out of or concerning membership in the Plan, whether based on a claim of medical malpractice, any other tort, any breach of contract, any violation of statute or regulation, or any other matter, shall be resolved by final and binding arbitration in accordance with the terms and conditions of the Grievance Process in effect at the time of the demand for arbitration. Binding arbitration shall be conducted in San Diego County in accordance with the rules and regulations of the appropriate arbitration entity, as amended from time to time. A copy of the Plan's grievance process, called the Grievance Policy and Procedure, includes the form to be used to file a complaint or appeal, and is available from the Plan upon request.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-359-2002** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help

with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are 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.

X.

RECORDS

The Employer Group agrees to maintain, in the State of California, such records and to provide such information to the Plan, and/or to the Director as may be necessary for compliance by the Plan with the provisions of the Act and the Regulations. The 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 the Employer Group for at least five (5) years. The Employer Group agrees to permit the 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 the 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, the Plan shall reimburse the Member for the Benefits rendered, upon verification of coverage by the 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 the Plan at: 8520 Tech Way, Suite 200, San Diego, CA 92123, within sixty (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 eligible 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 one hundred percent (100%) of the charges for Benefits, including Copayments.

XII.

COORDINATION OF BENEFITS

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

XIII.

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 Copayments. The Plan shall not provide any further changes to Premiums or Copayments during the following time periods: after Employer Group delivered written notice of acceptance of this contract to Plan, after the start of the 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 the Plan and Employer Group otherwise mutually agree in writing.

14.2 Change of Premiums or Coverage. The Plan may change Premiums or coverage hereunder, effective no earlier than sixty (60) days after receipt by the Employer Group of written notice from the Plan setting forth any such change within the Benefit Year. Premiums shall remain in effect no less than six (6) months.

14.2 Member Consent. By this Agreement, the 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 the Plan and the 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.

14.3 Identification Cards. The Plan shall provide an identification card for each Member. Cards issued by the 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.

14.4 Member Handbook. The Plan shall provide the 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. The Employer Group shall be responsible for distributing and shall distribute such forms, and all amendments thereto, to Enrolled Employees.

14.5 Notice of Certain Events. The Plan shall give the 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 the Plan has a contract to provide Benefits hereunder, if the Employer Group can be materially and adversely affected thereby.

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

14.7 Member's Liability to Non-Plan Providers. In the event the Plan fails to pay non-Plan Providers, Members shall be liable to such non-Plan Providers for the cost of services rendered.

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

14.9 Entire Agreement. This Agreement and the individual applications of the Members covered hereunder constitute the entire contract between the parties and, as of the effective date hereof, supersede all other agreements between such parties.

14.10 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.

14.11 Discrimination. The 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.

14.12 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 the Plan. The Plan agrees to use reasonable means to assure and protect the confidentiality of any medical records received.

14.13 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.

14.14 Interpretations and Governing Law.

14.14.1 The 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 the Plan whether or not set forth herein.

14.14.2 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.

ATTACHMENT A

MEMBER HANDBOOK
(COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM)

[COPY ENCLOSED]

ATTACHMENT B

PLAN-AT-A-GLANCE
(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

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 Sharp Health Plan (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. 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 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 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. 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.

a. 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 and a new application for coverage will be required.

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
A $25.00 insufficient funds fee will be applied to each check returned unpaid for any reason. In no event shall the failure to pay the insufficient funds fee be a basis to terminate, non-renew or otherwise cancel coverage, pursuant to Health and Safety Code Section 1365.

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.

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 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.