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T 1-415-955-8800 | F 1-415-955-8818 | www.CCHPHealthPlan.com

Employer Group
Medical and Hospital Service Agreement
Cover Sheet

GROUP INFORMATION

Group Name:

Group #:

Address:

Telephone: ( ) -

Fax No.: ( ) -

Contact Person:

Title:

Email Address:

Definition of Eligibility: **Full time employee. Please see Evidence of Coverage and Disclosure Form.**

Probationary Period for New Employees:

Open Enrollment Period: to

Effective Date for coverage:

COVERAGE

The Group has selected **Plan** for all eligible Members.

MONTHLY PAYMENTS

Base Rate Structure – see attached rate sheets

Optional Rider – see attached rider sheets

MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT

(Employer Group)

This Medical and Hospital Group Subscriber Agreement is entered into between Chinese Community Health Plan ("**CCHP**"), a California corporation, and the employer, association, or other entity specified as "Group" on the Cover Sheet ("**Group**").

WHEREAS, CCHP is a health care service plan licensed under the California Knox-Keene Health Care Service Plan Act of 1975 which arranges for the provision of medical, hospital, and preventive medical services to persons enrolled as Members through contracts with associations of licensed physicians, hospitals, and other health care providers.

WHEREAS, Group is an employer, union, trust, organization, or association which desires to provide such health care for its eligible Subscribers and Dependents.

WHEREAS, CCHP desires to contract with Group to arrange for the provision of such health care services to Subscribers and Dependents of Group, and Group desires to contract with CCHP to arrange for the provision of such services to its Subscribers and Dependents.

NOW THEREFORE, in consideration of the application of Group for the benefits provided under this Agreement, and in consideration of the periodic payment of Health Plan Premiums on behalf of Members in advance as they become due, CCHP agrees to arrange for or provide medical, surgical, hospital, and related health care benefits subject to all terms and conditions of this Agreement.

1. Definitions. Terms not defined herein shall have the meanings as set forth in the Health Plan Documents.

1.1 Agreement is this Medical and Hospital Group Subscriber Agreement and the Health Plan document, which are incorporated herein by this reference.

1.2 Cover Sheet is the Medical and Hospital Group Subscriber Agreement Cover Sheet which is attached to and an integral part of this Agreement.

1.3 Dependent is the spouse or child of a Subscriber.

1.4 Enrollment is the execution of a CCHP Enrollment Form, by the Subscriber on behalf of the Subscriber and his/her Dependents, and acceptance thereof by CCHP, conditioned upon the execution of this Agreement and the timely payment of applicable Health Plan Premiums by Group.

1.5 Group is the single employer, labor union, trust, organization, or association identified on the Cover Sheet.

1.6 Health Plan is the health plan described in this Agreement, subject to modification pursuant to the terms of this Agreement.

1.7 **Health Plan Documents** include without limitation the Cover Sheet, the rate sheet, the optional rider sheet, the Combined Evidence of Coverage and Disclosure Form, Renewal Sheet, all attachments, addendum, amendments thereto, and other materials containing information regarding the benefits, services, and terms of the Health Plan.

1.8 **Health Plan Premiums** are amounts established by CCHP to be paid to CCHP by Group on behalf of Members in consideration of the benefits provided under this Health Plan; such amounts are set forth in the Cover Sheet or Renewal Sheet.

1.9 **Member** is the Subscriber or any Dependent who is eligible, enrolled, and covered by CCHP.

1.10 **Member Cost Share** means a copayment, deductible, coinsurance or any other charge payable by a Member for covered health care services pursuant to the Member's Health Plan.

1.11 **Open Enrollment Period** is the annual period of not less than thirty (30) days agreed upon by CCHP and Group, during which all eligible and prospective Subscribers and their eligible Dependents may enroll in the Health Plan. The Open Enrollment Period is specified on the Cover Sheet.

1.12 **Subscriber** is the individual enrolled in the Health Plan for whom the appropriate Health Plan Premium has been received by CCHP, and whose employment or other status, except for family dependency, is the basis for enrollment eligibility.

2. **Eligibility and Enrollment**. Please refer to the Health Plan Documents for a complete description. Members or applicants for membership must complete and submit to CCHP such applications and/or other forms or statements that CCHP may reasonably request.

3. **Group Obligations, Health Plan Premiums, and Member Cost Share**.

3.1 **Non-Discrimination**. Group shall offer CCHP an opportunity to market the Health Plan to its employees and shall offer its employees an opportunity to enroll in the Health Plan under no less favorable terms or conditions than Group offers enrollment in other health care service plans or employee health benefit plans.

3.2 **Notices to CCHP**.

3.2.1 **Enrollment Material**. Group shall forward all completed or amended Enrollment forms for each Member for receipt by CCHP within sixty (60) days of the Member's initial eligibility. Group acknowledges that any Enrollment applications not received by CCHP within such sixty (60) day period may be rejected by CCHP.

3.2.2 **Termination of Member**. Group shall forward all notices of termination to CCHP within thirty (30) days after Member loses eligibility or elects to terminate membership of the Health Plan. Group agrees to pay any applicable Member Health Plan

Premiums through the last day of the month in which notice of termination is received by CCHP.

3.2.3 Qualifying Events; Notification. In accordance with California Health and Safety Code §1366.25, Group shall notify CCHP in writing within thirty (30) days of any of the following events:

(1) The death of a Member;

(2) The termination of employment or reduction in hours of a Subscriber's employment, except for termination for gross misconduct;

(3) The divorce or legal separation of the Subscriber from the Subscriber's spouse;

(4) The loss of dependent status by a Dependent; or

(5) With respect to a Dependent, the Subscriber's entitlement to benefits under Title XVIII of the United States Social Security Act (Medicare).

3.2.4 Group shall notify CCHP, in writing, within thirty (30) days of the date if Group becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Sec. 1161 et seq.

3.3 Notices to Member.

3.3.1 Health Plan Documents. Group shall make Health Plan Documents available to all Members and all persons eligible for the Health Plan. The Group shall inform Subscribers: (i) of the monthly payment applicable to their coverage; (ii) of conditions of eligibility regarding Subscribers and Dependents; and (iii) when coverage becomes effective and terminates.

3.3.2 Notices. Group shall disseminate notices to Subscribers by the next regular communication to them, but in no event later than thirty (30) days after receipt therefore, of all matters of which Group receives notice from CCHP to which a reasonable person would attach importance in determining the action to be taken upon the matter.

3.3.3 Termination of Contract. If Group or CCHP terminates this Agreement pursuant to Section 7 (Termination), Group shall promptly notify all Members enrolled through Group of the termination of coverage in the Health Plan. Group shall provide such notice by delivering to each Subscriber a true, legible copy of the notice of termination sent from CCHP to Group at the Subscriber's then current address and promptly provided proof of such mailing and the date thereof to CCHP. In the event that CCHP terminates this Agreement for non-payment of Health Plan Premiums, Subscriber will receive notice of termination from CCHP.

3.3.4 Increase or Reductions. If CCHP increases Member Cost Share or reduces covered services provided under the Health Plan, Group shall promptly notify all

Subscribers of the increase or reduction. In addition, Group shall promptly notify Subscribers of any other changes in the terms or conditions of this Agreement affecting Subscriber benefits or obligations under the Health Plan. Group shall provide such notice by delivering to each Subscriber a true, legible copy of the notice of the Member Cost Share increase or reduction in covered services sent from CCHP to Group at the Subscriber's then current address and promptly provided proof of such mailing and the date thereof to CCHP.

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

4. Payments.

4.1 Rates (Prepayment Fees). The Health Plan Premium rates are set forth in the Cover Sheet/Renewal Sheet and supplemental Health Plan Premium notices.

4.2 Due Date. Group shall pay the Health Plan Premiums on a monthly basis by cash or check, and the payment must be paid on or before the first day of the month for which the premium applies. Failure to provide payment on or before the due date may result in termination of Group. CCHP reserves the right to assess an administrative fee of five (5%) percent of the monthly premium prorated on a thirty (30) day month for each day it is delinquent thereafter. This fee will be assessed solely at CCHP's discretion. In the event that deposit of payments not made in a timely manner are received by CCHP after termination of Group, the depositing or applying of such funds does not constitute acceptance, and such funds shall be refunded by CCHP within twenty (20) business days of receipt if CCHP, in its sole discretion, does not reinstate Group.

4.3 Effect of Payment. Except as otherwise provided in this Agreement, only Members for whom Health Plan Premiums are received by CCHP are entitled to health care benefits as described in this Agreement, and then only for the period for which such payment is received. Group agrees to pay premium to CCHP for the first month of coverage for newborn or adopted children who become eligible as provided in the Health Plan Document.

4.4 Member Cost Share. Members are responsible to pay the Member Cost Share, and any other costs or charges as described in the Health Plan Documents.

4.5 Modification of Health Plan Premium Rates or Member Cost Share. The Health Plan Premium rates set forth on the Cover Sheet, Renewal Sheet, or Health Plan Documents may be modified by CCHP upon thirty (30) days prior written notice mailed postage prepaid to Group. Any such modification shall take effect commencing the first full month following the expiration of the thirty (30) day notice period. Health Plan Premium Rates and Member Cost Share may not be modified more than once in a twelve (12) month period. Notwithstanding the above, if the State of California or any other taxing authority

imposes upon CCHP a tax or license fee which is levied upon or measured by the monthly amount of Health Plan Premiums or by CCHP's gross receipts or any portions of either, then upon thirty (30) days written notice to Group, Group shall remit to CCHP, with the appropriate payment, a pro rata amount sufficient to cover all such taxes and license fees, rounded to the nearest cent.

5. Benefits and Conditions for Coverage. CCHP shall provide the Health Plan Documents as required by California Health and Safety Code §1363 and Title 28 California Code of Regulations §1300.63.2. The Health Plan Documents are an integral part of this Agreement and include a complete description of the benefits and conditions of coverage of the Health Plan.

5.1 Modification of Benefits or Terms. This Agreement and the Health Plan benefits set forth in the Health Plan Documents may be modified by CCHP upon thirty (30) days written notice mailed postage prepaid to Group. Any such modification shall take effect commencing the first full month following the expiration of the thirty (30) day notice period.

6. Term. The term of this Agreement shall be one (1) year, commencing on the Group Coverage Effective Date set out in the Cover Sheet, unless otherwise indicated on the Cover Sheet or unless this Agreement is terminated as provided herein. This Agreement shall automatically renew for a one (1) year term on each anniversary of the date of commencement of this Agreement or as indicated on the Cover Sheet or the Renewal Sheet, unless terminated as provided herein. Renewal of this Agreement shall be subject to modification of rates and benefits.

7. Termination.

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

7.2 Termination by CCHP.

7.2.1 For Nonpayment of Health Plan Premiums. CCHP may terminate this Agreement in the event Group or its designee fails to remit Health Plan Premiums in full by the due date to CCHP. CCHP will duly notify Group and provide at least a thirty (30) day grace period in accordance with Cal Health and Safety Code §1365. Nonpayment of Health Plan Premiums includes without limitation payments returned due to non-sufficient funds (NSF) and post-dated checks.

7.2.2 Reinstatement Following Termination for Non-Payment of Premium. Receipt by CCHP of all Health Plan Premium payments then due and owing on or before the succeeding Health Plan Premium payment due date will reinstate this Agreement as though it had never been terminated. Notwithstanding anything to the contrary, CCHP may, in its discretion, elect not to reinstate this Agreement in any of the following circumstances:

(1) the notice of termination states that, if Health Plan Premium payment is not received within fifteen (15) days of issuance of the notice of termination, a new application is required and identifies conditions under which a new agreement will be issued or this Agreement reinstated;

(2) if payment of Health Plan Premiums is received by CCHP more than fifteen (15) days after the issuance of notice of termination, and CCHP refunds such payment within twenty (20) business days of receipt; or

(3) if payment of Health Plan Premiums is received more than fifteen (15) days after issuance of the notice of termination, and CCHP issues to Group, within twenty (20) business days of receipt of such Health Plan Premiums, a new Agreement accompanied by written notice stating clearly those respects in which the new Agreement differs from this Agreement in benefits, coverage or otherwise. In the event CCHP receives untimely payments after Group has been terminated, the deposit or application of such funds by CCHP does not constitute acceptance of such funds or reinstate group, and such funds may be refunded by CCHP at its sole discretion.

7.2.3 For Providing Misleading or Fraudulent Information. CCHP may terminate this Agreement thirty (30) days after CCHP sends written notice to Group if CCHP demonstrates fraud or an intentional misrepresentation of material fact under the terms of the Agreement by the Group.

7.2.4 For Loss of Group's Location within Service Area. CCHP may terminate Group if Group no longer maintains a physical work location within the Service Area. CCHP shall provide Group with thirty (30) days written notice prior to such termination. Group must notify CCHP of changes of the Group's location provided on the Group application within (30) thirty days of such change.

7.3 Continued Benefits for Disabled Members.

7.3.1 In the event a Member becomes totally disabled while enrolled under Health Plan and continues to be totally disabled at the date of discontinuance of the Health Plan, such Member is entitled to a reasonable extension of benefits in accordance with Cal Health and Safety §1399.62. Please refer to the Health Plan Documents for a complete description. This extension of benefits may be terminated at such time as the Member is no longer totally disabled or at such time as a succeeding carrier may elect to provide replacement coverage to that member without limitation as to the disabling condition. The services provided during any extension of benefits may be subject to all limitations or restrictions contained in this Agreement.

7.3.2 Notwithstanding the foregoing, with respect to Members who were totally disabled on the date of discontinuation of the prior contract or policy, and entitled to an extension of benefits pursuant to Cal. Health and Safety §1399.62 under the prior contract or policy, CCHP shall not be financially responsible for any payment of benefits or provision of services directly related to any condition which caused the total disability. In such a situation, the prior carrier shall continue to be financially responsible for all benefits or

services directly related to any condition which caused the total disability until such extension of benefits is no longer required under California or federal law.

7.4 Termination of Specific Members. A Member may be terminated in accordance with Cal Health and Safety Code §1365(a). Please refer to the Health Plan Documents for a complete description. A Member who alleges that an enrollment or subscription has been or will be improperly canceled, rescinded, or not renewed may request a review by the director of the California Health and Human Services Agency, a Department of Managed Health Care pursuant to Cal Health and Safety Code Section 1365(b).

8. Dispute Resolution; Arbitration

8.1 Arbitration. Subject to the terms of this Agreement, any controversy, dispute or claim of whatever nature and irrespective of the facts or circumstances or the legal theories advanced shall be resolved by binding arbitration at the request of either party. The arbitration shall be administered by JAMS and in accordance with the JAMS Comprehensive Arbitration Rules and Procedures. Such arbitration shall occur in San Francisco, California. The arbitrator shall apply California substantive law and federal substantive law where state law is preempted. The Federal Arbitration Act, 9 U.S.C. §1-16, shall also apply. The arbitrator shall prepare in writing and provide to the parties an award including factual findings and the legal reasons on which the award is based. The decision of the arbitrator shall be final and binding on each of the parties and judgment thereon may be entered in any court of appropriate jurisdiction.

8.2 Costs and Fees. If a party brings an action or proceeding arising out of or relating to this Agreement, the non-prevailing party shall pay to the prevailing party reasonable attorneys' fees and costs incurred in such action, including without limitation, the reasonable direct costs of counsel. Any judgment or order entered shall contain a provision providing for the recovery of attorneys' fees and costs incurred in enforcing such judgment. The prevailing party shall be the party who is entitled to recover its costs of suit (as determined by the court of competent jurisdiction or the arbitrator), whether or not the action or proceeding proceeds to final judgment or award.

8.3 Confidentiality. The arbitration and any information obtained in connection with this Agreement or through discovery is confidential and neither the parties nor the arbitrator shall disclose such information to third parties without the written consent of the parties, except that the parties may disclose such information as necessary to seek confirmation of the arbitration award, to enforce any judgment entered on account of the award or as otherwise is required by law; however, the parties may make such disclosure as is necessary to their respective auditors, accountants, attorneys and insurers.

8.4 Injunctive Relief. Notwithstanding anything herein to the contrary, either party shall have the right to apply for and obtain a temporary restraining order or other temporary, interim or permanent injunctive or equitable relief from a court of competent jurisdiction in order to enforce the provisions of any part of this Agreement as may be necessary to protect its rights.

9. General Terms.

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

9.2 Contracted Provider. In accordance with 28 CCR 1300.67.4(a)(10), if one of CCHP's contract health care providers terminates its contract with CCHP, CCHP will be liable for covered services rendered by such provider (other than for Member Cost Share) to a Member who retains eligibility under the Health Plan or by operation of law under the care of such provider at the time of such termination until the services being rendered to the Member by such provider are completed, unless CCHP makes reasonable and medically appropriate provision for the assumption of such services by a contracting provider.

9.3 Independent Contractors. The relationship between CCHP and Group is an independent contractor relationship. This Agreement shall not be construed to create a relationship of agency, representation, joint venture, ownership, control or employment between the parties other than that of independent parties contracting solely for the purpose of effectuating this Agreement. Nothing contained in this Agreement shall cause either party to be liable or responsible for any debt, liability or obligation of the other party or any third party unless such liability or responsibility is expressly assumed by the party sought to be charged therewith.

9.4 Force Majeure. Neither party shall be liable nor deemed to be in default for any delay or failure in performance under the Agreement or other interruption of service or employment deemed resulting, directly or indirectly, from: Acts of God; acts of civil or military authority; acts of public enemy; war; accidents; fires; explosions; earthquakes; floods; failure of transportation, machinery or supplies; vandalism; strikes or other work interruptions by employees; or any similar or dissimilar cause beyond the reasonable control of either party. Both parties shall, however, make good faith efforts to perform under this Agreement in the event of any such circumstance.

9.5 Indemnification. Each party shall indemnify, defend and hold harmless the other party, and all of the officers, trustees, agents and employees of the foregoing, from and against any and all third party demands, claims, actions, losses, costs, liabilities, damages or deficiencies, including interest, penalties and attorneys' fees, which:

9.5.1 arise out of or are due to a breach by the indemnifying party of any of its representations, warranties, covenants or other obligations contained in this Agreement;

9.5.2 are caused by or resulting from indemnifying party's acts or omissions constituting bad faith, willful misfeasance, negligence or reckless disregard of its duties under this Agreement or applicable laws;

9.5.3 accrue or result to any of indemnifying party's subcontractors, material men, laborers or any other person, firm or entity furnishing or supplying services, material or supplies in connection with the performance of this Agreement; or

9.5.4 arise out of or are due to the failure of the indemnifying party to correctly and completely pay wages or fail to provide workers' compensation insurance coverage to their employees.

9.6 **Confidential Information**. In the course of the parties' performance of its services hereunder, either party may make available to the other party access to certain trade secrets and other confidential engineering, technical and business information. To the extent that such information remains confidential information available to others only with the consent of the disclosing party, or is not generally available to the public from other sources, the receiving party shall maintain such information in strict confidence and shall not disclose any of such information to others, including its employees, except to the extent necessary to enable the receiving party to carry out this Agreement. The receiving party shall similarly obligate any and all persons to whom such information is necessarily disclosed hereunder, to maintain said information in strict confidence. The receiving party agrees to be liable for any breach of this confidentiality obligation by any of its subcontractors or their respective employees or representatives. The receiving party also agrees that, in the event of any breach of this confidentiality obligation, disclosing party shall be entitled to equitable relief, including injunctive relief and specific performance, in addition to all other rights and remedies otherwise available.

9.6.1 **Exceptions to Confidential Information**. **"Confidential Information"** does not include information or material that: (i) is made available to others with the consent of the disclosing party; (ii) is or becomes generally available or known to the public from other sources, through means other than a breach of this Agreement or breach by any person or entity of an obligation to keep such information confidential; (iii) was rightfully known by the receiving party before receipt from the disclosing party; (iv) is independently developed by the receiving party without the use of or reference to Confidential Information of the disclosing party; or (v) is rightfully obtained without restriction from a third party who has the right to make such disclosure and without breach of any duty of confidentiality to the disclosing party.

9.6.2 **Confidential Information Upon Expiration or Termination**. In the event of the expiration or termination of this Agreement for any reason, the receiving party shall promptly return to the disclosing party Confidential Information in the receiving party's possession or control, in the manner specified by the disclosing party.

9.7 **Cumulative Rights**. Any specific right or remedy in this Agreement will not be exclusive but will be cumulative of all other rights and remedies.

9.8 **Entire Agreement**. This Agreement contains the entire agreement of the parties and supersedes all prior agreements, representations or understandings, whether written or oral, between the parties relating to the subject matter hereof.

9.9 **Captions**. Captions in this Agreement are descriptive only and do not affect the intent or interpretation of the Agreement.

9.10 **Survival**. All provisions that logically ought to survive termination of this Agreement shall survive.

9.11 Severability. Should one or more provisions of this Agreement be held by any court to be invalid, void, or unenforceable, such provision(s) will be deemed to be restated to affect the original intentions of the parties as nearly as possible in accordance with applicable laws. The remaining provisions shall not be affected and shall nevertheless remain and continue in full force and effect.

9.12 Interpretation. This Agreement shall be interpreted in accordance with the plain meaning of its terms and not strictly for or against any of the parties hereto.

9.13 Clerical Error. No clerical error shall operate to defeat or alter any terms of this Agreement or defeat or alter any of the rights, privileges or benefits of the parties.

9.14 Waiver. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach or violation.

9.15 Agreement Binding on Members. By this Agreement, the Group makes Health Plan coverage available to persons who are eligible. However, this Agreement is subject to amendment, modification, or termination in accord with any provision hereof or by mutual agreement between CCHP and Group without the consent or concurrence of Members. By electing Health Plan coverage 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.

9.16 Identification Cards. Cards issued by CCHP to Members are for identification only. Possession of a CCHP identification card confers no rights to services or other benefits under this Agreement. To be entitled to such services or benefits, the holder of the card must, in fact, be a Member on whose behalf all applicable charges under this Agreement have been paid. Any person receiving services or benefits to which he or she is not entitled pursuant to the provisions of this Agreement is chargeable for such services at non-Member rates.

9.17 Right to Examine Records. CCHP, upon reasonable notice, may examine during business hours at Group's regular place of business, the Group's pertinent records with respect to eligibility and monthly payments under this Agreement.

9.18 CCHP Names, Logos and Service Marks. CCHP reserves the right to control all use of its name, product names, symbols, logos, trademarks, and service marks currently existing or later established. Group shall not use CCHP's name, product names, symbols, logos, trademarks, or service marks without obtaining the prior written approval of CCHP.

9.19 Assignment. This Agreement and the rights, interests and benefits hereunder shall not be assigned, transferred, pledged, or hypothecated in any way by either party and shall not be subject to execution, attachment or similar process, nor shall the duties imposed herein be subcontracted or delegated without the approval of the other party. Notwithstanding the above, if CCHP are assigns, sells or otherwise transfers substantially all of its assets and business to another corporation, firm or person, with or without recourse,

this Agreement will continue in full force and effect as if such corporation, firm or person were a party to this Agreement, provided such corporation, firm or person continues to provide prepaid health services.

9.20 Incorporation. The Health Plan Documents, exhibits, and attachments are an integral part of this Agreement and are incorporated in full herein by this reference.

9.21 Notices. All notice required or permitted by this Agreement shall be by personal delivery or by U.S. mail, postage pre-paid, certified or registered mail, return receipt requested, addressed to the party at its address set forth below. Either party may change such address upon written notice to the other party. Notice shall be deemed delivered as of the date of personal delivery, or three (3) days after mailing. Any notice under this Agreement may be given by United States mail, postage prepaid, addressed as follows:

If to CCHP: Chinese Community Health Plan
445 Grant Avenue, Suite 700
San Francisco, CA 94108

If to a Subscriber: to the latest address provided for the Subscriber on enrollment or changes of address forms actually delivery to CCHP.

If to the Group: to the address indicated on the Cover Sheet or Renewal Sheet.

9.22 Counterparts. This Agreement may be signed in more than one identical counterpart, each of which shall be deemed to be an original hereof.

9.23 Business Associate Agreement. The parties acknowledge that this Agreement is not intended to create a "**Business Associate**" relationship as that term is define in 45 CFR § 160.103; however if during the term of this Agreement, the Department of Health and Human Services, Office of Civil Rights or any other empowered federal or state agency, court or administrative tribunal determines that a party is the Business Associate of the other, as described in the federal privacy regulations, or if the parties otherwise reasonably determine that they will likely be so defined as a Business Associate under such federal privacy regulations, the parties will execute a business associate agreement and promptly agree upon such procedures and requirements relating to handling private health information as will ensure compliance with applicable governmental requirements and regulations.

9.24 State of California Review of Member Complaints. Cal Health and Safety §1368.02 requires that the following statement appear in this Agreement. The word "you" refers to Members:

"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 (415-955-8800) 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 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."

IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Agreement as of the latest date stated below.

Group		CCHP Chinese Community Health Plan	
Signature:	_____	Signature:	_____
NAME:	_____	NAME:	Deena Louie
TITLE:	_____	TITLE:	Chief Executive Officer
DATE:	_____	DATE:	_____

Agent Name: _____

Agent Code: _____

Agent Company: _____

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

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

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

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

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

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

I. DEFINITIONS

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

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

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

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

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

PARTICIPATING PLAN shall mean a health care service plan or an insurance carrier, offering health maintenance organization (HMO) or preferred provider (PPO) products and participating in the SHOP. H E A L T H PLAN is a Participating Plan.

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

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

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

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

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

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

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

II. THE SHOP PROGRAM

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

B. Contribution and Participation Requirements

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

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

2. For medical coverage, GROUP must have a minimum of seventy percent (70%) of Eligible Employees enroll in a QHP through the SHOP. If the Group pays 100 percent of its Qualified Employees' QHP premiums, then all Eligible Employees must enroll in health insurance coverage through the SHOP. For purposes of participation, Eligible Employees do not include an employee who is enrolled in coverage through another employer, an employee's union, Medicaid, Medicare, or any other federal or state health coverage programs –other than coverage through a QHP sold in the Individual Exchange at the time GROUP initially contracts with HEALTH PLAN

3. If GROUP does not meet such minimum contribution and minimum participation requirements, GROUP may only enroll with HEALTHPLAN through SHOP from November 15th through December 15th of each year.

III. ELIGIBILITY AND ENROLLMENT

A. Eligibility and Enrollment for Open Enrollment

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

Employee Eligibility

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

Dependent Eligibility

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

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

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

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

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

Documentation of eligibility and existence of the relationship of any dependent to the Qualified Employee

may be requested at the time of enrollment and before a child attains the limiting age, but not more frequently than annually after the two-year period following a child's attainment of the limiting age.

B. Eligibility and Enrollment for Special Enrollment

1. Newly Eligible Employee

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

2. New Dependents – Spouse or Registered Domestic Partnership

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

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

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

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

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

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

4. New Dependents – Unregistered Domestic Partnership

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

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

5. Loss of Coverage – Qualified Employee and Dependents

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

a. termination of employment
b. termination of an employer sponsored plan
c. reduction in hours that results in a loss of eligibility
d. exhaustion of COBRA or Cal-COBRA coverage.

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

6. Other Special Enrollment Events

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

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

b. The Qualified Employee, spouse or registered domestic partner or eligible dependent child's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS or its

instrumentalities as evaluated and determined by the Exchange.

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

d. A qualified employee or enrollee, or his or her dependent, gains access to new QHPs as a result of a permanent move and either-
(A) Had MEC as described in 26 CFR Section 1.5000A-1(b) (December 26, 2013), hereby incorporated by reference, for one or more days during the 60 days preceding the permanent move; or
(B) Was living outside of the United States or in a United States territory at the time of the permanent move; or
(C) Was released from incarceration, or is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code;

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

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

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

h. A qualified employee, or his or her dependent, demonstrates to the Exchange, in accordance with guidelines issued by HHS and as determined by the Exchange on a case-by-case basis, that the individual meets other exceptional circumstances. Such circumstances include, but are not limited to, the following circumstances:
(A) If a child who has been determined ineligible for Medi-Cal and CHIP, and for whom a party other than the party who expects to claim him or her as a tax dependent is required by court order to provide health insurance coverage for the child, the child shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP; and
(B) A qualified employee or dependent demonstrates to the Exchange, with respect to health benefit plans offered through the Exchange, or to the applicable regulator, with respect to health benefit plans offered outside the Exchange, that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the employee or dependent because he or she was misinformed that he or she was covered under MEC;

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

B. A Qualified Employee and/or an eligible spouse or registered domestic partner and/or

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

7. Process of Enrollment

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

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

IV. COVERED SERVICES AND BENEFITS

The Evidence of Coverage describes the separate plan(s) of covered services and benefits, as well as excluded benefits, which HEALTH PLAN agrees to provide to GROUP's Enrollees, pursuant to GROUP's choice through SHOP. GROUP understands that one Employee and his or her designated dependents may select one of these plans, and other GROUP Employees and their respective designated dependents may select the same or another of the described benefit plans, but an Employee and his or her designated dependents must all select the same benefit plan, although they may select different medical groups and primary care physicians. The SHOP plans offered pursuant to the terms of the Agreement and this Supplement are the only benefits which are covered benefits offered by HEALTH PLAN to GROUP through SHOP. HEALTH PLAN itself shall make all benefit and coverage determinations. All such determinations shall be subject to HEALTH PLAN's grievance procedures.

A. Cal-COBRA and COBRA

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

B. Enrollee Materials

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

V. FISCAL PROVISIONS

HEALTH PLAN agrees to arrange for the provision of health care services for GROUP's Enrollees,

as described in the Evidence of Coverage, in exchange for the Net Premiums received from GROUP minus the participation fee due to the SHOP. HEALTH PLAN agrees to accept the Net Premium due HEALTH PLAN and forwarded to HEALTH PLAN by and received by HEALTH PLAN from the SHOP, and any applicable Enrollee co-payments, as full and complete payment for services provided under the Agreement and this Supplement thereto.

A. Premium Collection

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

a. Employer's first premium payment is due in full but must be at least 85 percent of the total amount due, and must be delivered to the SHOP or postmarked by the due date indicated on the invoice, for effectuation to occur on the date requested on the employer's application.

b. For on-going premiums, on or about the fifteenth of the month prior to the coverage month, an invoice is sent by the SHOP to GROUP, which payment must be received or postmarked by the last day of the invoicing month. On-going premium payments are due in full but must be no less than 85 percent of the total balance due, including any amounts past due, by the due date on the invoice to avoid delinquency.

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

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

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

The Notice will provide instructions for making the premium payment necessary in order to maintain coverage in force, and will repeat when such cancellation will be effective and will also state how and when GROUP may appeal the cancellation. If the Premium payment is not received by cancellation effective date, the Agreement will be terminated for non-payment effective 30 days from the date the Notice was sent. In such a case, a "Notice Confirming Cancellation of Coverage" will be mailed to GROUP by SHOP on behalf of HEALTH PLAN on the first business day of the month following the effective date of the cancellation. PLAN, or SHOP on behalf of HEALTH PLAN, will mail an individual Notice Confirming Cancellation of Coverage to each of its affected Members and also explaining their options for purchasing individual coverage.

All of the cancellation notices described above will include statements regarding the reason for the cancellation, the amount of premiums due, a statement of the 30-day grace period, the effective date of the cancellation, and the right of GROUP to seek

review by the appropriate regulator, either the California Department of Managed Health Care or the California Department of Insurance (including the responsibility of GROUP to pay premiums during any such review and the right of GROUP to be reinstated back to the effective date of termination if it prevails in such review).

Receipt by SHOP of all Premium payments due and owing by the due date indicated in the Notice of Cancellation for Nonpayment of Premium and Grace Period will continue the Agreement, as modified by this Supplement, with no interruption in coverage. If payment of at least 85 percent of all delinquent Premiums is received by SHOP after the due date in the Notice, the Agreement will not be reinstated 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 in which the GROUP gave notice of termination, or on a case-by-case basis an earlier date upon agreement between the Health Plan and the SHOP.

B. Termination by Enrollee

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

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

C. Annual Enrollment and Renewal

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

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

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

D. Open Enrollment

HEALTH PLAN, through SHOP, will provide a period of at least ten (10) days for the annual employer election period and at least twenty (20) days for employee annual open enrollment period prior to the anniversary date of the Agreement, with such requested changes to be effective on such anniversary date. During the employer election period, the employer may change its offering of dependent coverage, its contribution level to employee coverage, and level of coverage within which its employees and dependents can select a QHP.

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

b. Requests to the SHOP received on the sixteenth day of the month up to the thirtieth day of the month after effective date shall become effective on the first day of the following month.

E. Discontinued Group's Reference Plans

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

F. Miscellaneous

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