CALIFORNIA*CHOICE* PROGRAM
MODEL SUPPLEMENT RIDER
TO
GROUP SUBSCRIBER AGREEMENT

This California*Choice* Program Supplement Rider (the "Supplement") supplements that certain Group Subscriber Agreement (the "Agreement") between Oscar Health Plan of California ("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 in terms are to be resolved in favor of the terms in this Supplement.

WHEREAS, GROUP employs one hundred (100) or fewer full-time and "full-time equivalent" Employees (as defined in applicable law) and desires to offer its Eligible Employees a range of choice of health care plans from which to receive their health care; and

WHEREAS, PLAN is a participant in the "California*Choice* Program," as defined below, which affords Small Group Employers an opportunity of such choice; and

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

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

I. DEFINITIONS

AGGREGATED Single Client BILLING SYSTEM shall mean a billing invoice construct in which more than one Participating Plan monthly premium amount due is stated separately and then all such due premium amounts are added together to reach the total due by the Subscribing Group for such monthly premium amounts due.

CALIFORNIA*CHOICE* PROGRAM or "Program" is that program of health care Program Products concurrently offered by Participating Plans to Small Group Employers, marketed and administered by California*Choice* Benefit Administrators on behalf of PLAN, as described in Article II hereof and detailed in specific features throughout this Supplement.

ENROLLEE shall mean an individual and his or her eligible Dependents, as defined by PLAN, who lives or works in an approved Service Area, who meets the eligibility requirements of GROUP and PLAN, who has made application to PLAN through the California*Choice* 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 PLAN.

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

PARTIAL PAYMENT shall mean a payment made by a Group in response to an aggregated premiums-due invoice from CaliforniaChoice Benefit Administrators, with respect to health care coverage Group has subscribed for through the CaliforniaChoice Program, where the amount of payment remitted by the Group is not sufficient to cover all of the specific itemized Plan premiums invoiced.

PARTICIPATING PLAN shall mean a health care service plan or an insurance carrier, offering health plan and preferred provider organization products, participating in the California*Choice* Program pursuant to requisite regulatory approval. PLAN is a Participating Plan.

PARTICIPATING PROVIDER shall mean a health care provider, individual or institutional, who or which is employed by or under contract with 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 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.

PROGRAM PRODUCTS shall mean the specific health care products offered in and through the California*Choice* Program by PLAN and other Participating Plans, pursuant to the Agreement.

RATE shall mean the premium rate determined for GROUP pursuant to the Small Group Act, as defined hereinbelow.

SERVICE AREA shall mean that geographic area in which PLAN is licensed to offer and provide approved health care service products to Small Group Employers.

SMALL GROUP ACT shall refer, as applicable to specific Participating Plan, to California Health and Safety Code Articles 3.1, 3.15, 3.16 and 3.17 and to California Insurance Code Article 8 or to their successor provisions.

SMALL GROUP EMPLOYER shall mean a “small employer” as defined by the Small Group Act, and applicable federal law.

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

SUBSCRIBING GROUP or SUBSCRIBING EMPLOYER shall mean a person, firm, proprietary or nonprofit corporation, partnership, public agency, or association, which applied for health care coverage by a Participating Plan through the California*Choice* Program, was screened for compliance with PLAN's underwriting criteria (and continues to meet such criteria), and was accepted by PLAN for participation in the California*Choice* Program. The Subscribing Group contracts directly with 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 CALIFORNIA*CHOICE* PROGRAM

The California*Choice* Program (the "Program") is a mechanism in which PLAN and other health care service plans and insurance carriers simultaneously offer certain health care benefit plans to Small Group Employers. These Products possess common factors, including identical participation and contribution requirements, no medical underwriting, initial twelve-month rate guarantees, and an aggregated single client billing system. California*Choice* Benefit Administrators operates as a solicitor and third party administrator for PLAN and the other Participating Plans.

The Program Products of the Participating Plans offered through the California*Choice* Program to Small Group Employers are differentiated mainly by product structure ("HMO" vs. "indemnity" (traditional insurance)), "metal tiers," price, provider network and enrollee services features. Each Program Product requires that at least seventy percent (70%) of the full-time Eligible Employees of a given Subscribing Employer must select their employer-purchased medical health care coverage from one of the Program Product benefit plans offered by a Participating Plan.

A. Benefits

PLAN shall provide health care services to Enrollees of GROUP in PLAN's Service Area from among the benefits described in the enclosed Evidence of Coverage Supplement, subject to the other conditions of this Supplement and to future benefits design changes.

GROUP is required to select one of eight (8) metal tier options (Bronze, Silver, Gold, Platinum, Bronze/Silver, Silver/Gold, Gold/Platinum, Silver/Gold /Platinum). Employees will then have the option to choose the health plans and benefits plans offered within that metal tier.

B. Rates

PLAN may calculate its rates based on metal tier, age, geographic, and family size characteristics.

C. Contribution and Participation Requirements

PLAN and GROUP understand and agree to the following contribution and participation requirements for the provision of services pursuant to the Agreement. (If a group is unable to meet these requirements at other times during the year, they will not be imposed during the period November 15th through December 15th.)

1. For medical coverage, GROUP must contribute a minimum of the equivalent of fifty percent (50%) of the Premium cost of the lowest-priced Employee-only plan rate medical Program Product in the metal tier(s) selected by the Group available to the Employee through the Program.

2. The following HMO Program Products participation requirements will apply for medical coverage. The specified percentages of GROUP's Eligible Employees must select Program Products, as designated by GROUP. Eligible Employees may select GROUP-designated Program Products from more than one Participating Plan, but the percentage specified below of the Eligible Employees must choose one or another of the GROUP-designated Program Products.

   a. If GROUP has only one or two (2) Employees, 100% of the Employees must participate in the Program.

   b. If GROUP has three (3) to one hundred (100) Employees, seventy percent (70%) of the Eligible Employees, with a minimum of two (2) Employees, must participate in the California*Choice* Program.

3. If GROUP elects to pay one hundred percent (100%) of the Enrollee Premium, then one hundred percent (100%) of its Eligible Employees must select Program Products, except those Employees who have coverage for at least essential health benefits from a second employer other than GROUP, from the employer of the Employee's spouse or domestic partner or from an employer-sponsored program through COBRA, at the time GROUP initially contracts with a Participating Plan.

D. Service Areas

PLAN agrees to provide services to GROUP's Eligible Employees pursuant to the Agreement in PLAN's licensed Service Areas. If PLAN expands its Service Area, PLAN shall make available to Employees of GROUP in that new Area who select PLAN through the California*Choice* Program all relevant Participating Providers and all benefits covered by this Supplement. The availability of such services in such new Service Areas shall commence immediately upon receipt of state regulatory approval.

E. Provider Network

Except as otherwise structured in a given Program Product, PLAN agrees to make available to all Enrollees all of its Participating Providers in its California*Choice* Program Service Areas.

III. ELIGIBILITY AND ENROLLMENT

A. Eligibility

All applicant Employees of GROUP and their Dependents who are determined to be eligible in accordance with current applicable law and with PLAN's underwriting criteria are eligible to enroll in PLAN pursuant to the Agreement, as modified by this Supplement, subject to PLAN's acceptance of GROUP's application. (Group is encouraged to use a reliable "FTE Calculator" in determining the "full-time equivalent" status of its employees.) Coverage becomes effective on the first day of the month following GROUP's designated waiting period of 0, 30 or 60 days.

1. Employee Eligibility

An Eligible Employee is one who lives or works in PLAN's Service Area, who is permanently and actively employed for compensation an average of 30 hours per week over the course of a month, at the Employer's regular place of business, and who has met any applicable waiting period requirements.

- Provided that GROUP has been determined to be a "small employer" without counting them for purposes of making such determination, the term includes sole proprietors or partners of a partnership and their respective spouses, if they are actively engaged on a full-time basis in the small employer's business and included as employees under a health care service plan contract of a small employer, but does not include employees who work on a part-time, temporary or substitute basis.

- Permanent employees who work at least 20 hours but not more than 29 hours are eligible if all four of the following conditions apply:

  • They otherwise meet the definition of an Eligible Employee except for the number of hours worked

  • The employer offers the employees health coverage under a health benefit plan

  • All similarly situated employees are offered coverage under the health benefit plan

• The employee must have worked at least 20 hours per normal work week for at least 50% of the weeks in the previous calendar quarter (documentation required upon request).

Individuals who work on a part-time, temporary or substitute basis are not eligible. Fifty-one percent of GROUP's Employees must work or reside in California.

2. Dependent Eligibility

A Dependent claiming eligibility hereunder as a spouse must be legally married to an Eligible Employee.

A Dependent claiming eligibility hereunder as a domestic partner must be personally related to an Eligible Employee by a domestic partnership as defined below.

Eligible Employee agrees to notify California*Choice* Benefit Administrators immediately upon termination of the marriage or domestic partnership.

A Dependent child claiming eligibility hereunder must be born to, a step-child or legal ward of, adopted by the Eligible Employee or the Eligible Employee's spouse or domestic partner or is a child for whom the Eligible Employee has assumed a parent-child relationship, as indicated by intentional assumption of parental status or assumption of parental duties by the Eligible Employee, as certified by the Eligible Employee at the time of enrollment of the child and annually thereafter (but not to include foster children), subject to the following condition:

- Under age 26 (unless disabled, disability diagnosed prior to age 26)
- This "child" profile describes herein an "eligible dependent child."

A Dependent child who exceeds the age limit for Dependent children and is disabled, that is, who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition diagnosed as such by competent health care professionals prior to such Dependent's 26th birthday, and has remained continuously dependent on the Employee for at least 50% of his/her economic support since he/she became disabled, shall be eligible for coverage hereunder until such disability ceases. Proof of Dependent's disability must be received within 60 days after California*Choice* Benefit Administrators requests it.

California*Choice* Benefit Administrators will provide you a 90-day notice that a dependent is about to reach the age limit for dependent children and will lose coverage unless you provide written certification from a competent health care professional, within 60 days of receiving this 90-day warning notice, that the dependent meets the above conditions of being disabled.

Formal proof of the required eligibility and existence of the relationship of any Dependent to the Employee may be requested at the time of enrollment, time of service authorization request or claim submission, but not more frequently than annually after the two-year period following a child's attainment of the limiting age.

a. New Dependents – Spouse

An eligible spouse may be added to coverage at the time of initial enrollment of the Employee, at each open enrollment period of GROUP or following a proven triggering event such as the involuntary loss of prior coverage or other events as outlined below in subsection "3.a." below. A spouse may also be added at other times during the coverage year provided he or she submits a stamped copy of the Marriage Certificate within 45 days of its issuance, allowing the Employer sufficient time to submit the request to California*Choice* Benefit Administrators within 60 days of the issuance. If the request is made at a time other than initial or open enrollment, and California*Choice* Benefit Administrators receives all required documentation before the 16th day of the month of marriage, Premium is charged for the full month and coverage is effective as of date of marriage; if required documentation is received on or after the 16th day of the month of marriage, the spouse will be enrolled effective as of 1st of the month following the date of receipt. The Enrollee must agree to notify California*Choice* Benefit Administrators immediately upon termination of the marriage.

b. New Dependents - Birth/Adoption/Legal Guardianship

An individual who becomes a new Dependent by virtue of birth, adoption or placement for adoption or legal guardianship or is a child for whom the Eligible Employee has assumed a parent-child relationship is eligible for coverage under the Agreement, as modified by this Supplement, at other than the Employer's annual open enrollment, and the appropriate request form should be received by California*Choice* Benefit Administrators within 60 days after such birth, adoption or placement for adoption, or effective date of a guardianship order, or arrival at status of eligible dependent child, with coverage to be effective upon the date of such event. The first 30 days of coverage for such new or adopted child is automatic, regardless of whether the child is enrolled or not after this 30-day period. If the birth/adoption or placement for adoption date or effective date of a guardianship order occurs between the 1st and 15th days of the month, Premium is charged for the full month. If the birth/adoption or placement for adoption date or effective date of the legal guardianship occurs between the 16th day and end of month, no Premium is charged (copy of legal documentation may be required).

c. New Dependents – Stepchild

A child who comes to be the stepchild of an Enrollee is eligible to be a new Dependent at other than the Employer's annual open enrollment provided the appropriate request forms are received by California*Choice* Benefit Administrators within 60 days following the date of the Enrollee's marriage to or establishment of a registered domestic partnership with the parent or legal guardian of the stepchild (actual adoption by the step-parent Enrollee is not required, although a copy of the Marriage Certificate or a State-stamped copy of the Certificate of Registered Domestic Partnership with the parent of the new stepchild may be required). If the marriage or creation of the domestic partnership occurs before the 16th day of the month, Premium is charged for the full month and coverage effective as of date of marriage or creation of the domestic partnership. If the marriage or creation of the domestic partnership occurs on or after the 16th day of the month, the stepchild will be enrolled effective as of the 1st of the month following date of receipt.

d. New Dependents - Domestic Partners

In order for an Employee's domestic partner to be eligible for coverage, the Employee and domestic partner must:

- Not be married under either statutory or common law or part of another domestic partnership;
- Both be 18 years of age or older and of the same or different sex;
- If of opposite sexes one or the other must be over age 62, and one or both must meet the Social Security eligibility requirements referenced in California Family Code Section 297 (b)(4)(B);
- If one is under 18 years of age meet the requirements and follow the procedures prescribed in California Family Code Section 297.1;
- Share an intimate and committed relationship of mutual caring;
- Both be mentally competent;
- Not be related by blood to a degree of closeness that would prohibit marriage in this state;
- Agree to notify California*Choice* Benefit Administrators immediately upon termination of the domestic partnership.

The domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State and at the time of filing both partners meet all of the requirements above.

An eligible domestic partner may be added to coverage at the time of initial enrollment of the Employee, or at each open enrollment period of GROUP or following a proven triggering event such as the involuntary loss of prior coverage or other events as outlined in subsection "3.a." below. A registered eligible domestic partner may also be added at other times during the coverage year provided he or she submits a State-stamped copy of the Certificate of Registered Domestic Partnership to the Employer within 45 days after the creation of the domestic partnership, allowing the Employer sufficient time to submit the request to California*Choice* Benefit Administrators within 60 days of the issuance of the Certificate of Domestic Partnership. If the request is made at a time other than initial or open enrollment, and California*Choice* Benefit Administrators receives all required documentation before the 16th day of the month in which the domestic partnership was established, Premium is charged for the full month and coverage is effective as of the date of the event; if required documentation is received on or after the 16th day of month in which the domestic partnership was established, the domestic partner will be enrolled effective as of the first of the month following the date of receipt.

3. Special and Late Enrollment

a. Special Enrollment

Employees who did not enroll during the initial enrollment period or at the Employer's annual open enrollment may add newly acquired Dependents and themselves to the contract by submitting an application within 60 days from the date of acquisition of the Dependent:

- to add Employee and spouse or domestic partner following the birth of a newborn, adoption or placement for adoption of a child or arrival at status of eligible dependent child, coverage effective on the date of such event;

- to add Employee and spouse or registered domestic partner after marriage or creation of a domestic partnership. If all required documentation is received before the 16th day of the month of marriage/creation of domestic partnership, coverage for Employee and spouse or domestic partner is effective on the date of marriage or creation of the domestic partnership; If all required documentation is received on or after the 16th day of the month of marriage/creation of domestic partnership, coverage is effective on the 1st of the month following the date of receipt.

- to add Employee and Employee's newborn, eligible dependent child, or child placed for adoption, following birth, adoption or placement for adoption, coverage effective on the date of the birth, adoption or placement for adoption or arrival at status of eligible dependent child, coverage effective on effective date of such event;

- to add Employee and Employee's stepchild, if marriage or domestic partner registration occurs before the 16th day of the month, coverage effective as of the date of marriage or domestic partner registration; if marriage or domestic partner registration occurs on or after the 16th day of the month, stepchild will be enrolled effective as of the 1st of the month following date of receipt.

If an Employee did not enroll himself or herself or a Dependent at initial enrollment or at the Employer's annual open enrollment because the Employee or Dependent had coverage under another employer health plan, please refer to the "Late Enrollment" section below and to the "Employee Eligibility" section above for further information regarding rights to request enrollment at a later time.

b. Late Enrollment

Late enrollees (as defined in California Health & Safety Code section 1357.500(f)) must wait until open enrollment to be enrolled unless covered above under the "Special Enrollment" provisions. However, pursuant to H&S section 1357.500(f) and as further articulated in PLAN's Evidence of Coverage, if an Employee did not enroll, or enroll a Dependent, at initial enrollment or at annual open enrollment because Employee:

- or dependent loses minimum essential coverage, as described in California H&S Section 1399.849(d)(1)(A);

- gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption or arrival at status of eligible dependent child;

- is mandated to be covered as a dependent pursuant to a valid state or federal court order;

- has been released from incarceration;

- health coverage issuer substantially violated a material provision of the health coverage contract;

- gains access to new health benefit plans as a result of a permanent move;

- was receiving services from a contracting provider under another health benefit plan, for one of the conditions described in subdivision (c) of H&S Section 1373.96 and that provider is no longer participating in the health benefit plan;

- is a member of the reserve forces of the United (I) States military returning from active duty or a member of the California National Guard returning from active duty service; and

- demonstrates that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period because he or she was misinformed that he or she was covered under minimum essential coverage.

then if such a triggering event occurs, the Employee may enroll in PLAN by submitting an enrollment application to California*Choice* Benefit Administrators within 60 days of loss of other coverage or within 60 days of another triggering event listed immediately above, pursuant to H&S section 1357.500(f) and as articulated further in PLAN's EOC. Coverage with PLAN through California*Choice* Benefit Administrators to become effective 1st day of month following receipt of completed enrollment application.

c. Process of Enrollment

GROUP's application to contract with PLAN for coverage of one or more of its Employees pursuant to the California*Choice* Program will be reviewed by California*Choice* Benefit Administrators, for completion, Rate accuracy and satisfaction of PLAN's underwriting criteria. PLAN's receipt of transmitted application data of GROUP will constitute the filing of that application with PLAN. PLAN agrees to communicate acceptance of GROUP in a prompt and timely manner, but at least seven days before the effective date requested by GROUP, or such shorter time (but not less than two business days) as may be necessitated by circumstances. The California*Choice* Benefit Administrators will notify GROUP of its acceptance and the effective date of coverage for its employees.

The GROUP shall specify the waiting period for coverage, which shall be applicable for all Enrollees, and is 0, 30 or 60 days plus the days until the first of the following month, not to exceed 90 days. The Dependents of Enrollee for whom coverage is requested must also enroll with PLAN. Enrollees and their Dependents are however able to select different primary care physicians.

IV. COVERED SERVICES AND BENEFITS

The enclosed Evidence of Coverage describes the separate plan(s) of covered services and benefits, as well as excluded benefits, which PLAN agrees to provide to GROUP's Enrollees, pursuant to GROUP's choice through the California*Choice* Program. 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 such plans shall all be within the same "metal tier" chosen by the Employer. An Employee and his or her designated Dependents must all select the same benefit plan, although they may select different primary care physicians. The Program Products offered pursuant to the terms of the Agreement and this Supplement are the only benefits which are covered benefits offered by PLAN to GROUP through the California*Choice* Program. PLAN itself shall make all benefit and coverage determinations. All such determinations shall be subject to PLAN's grievance procedures.

A. Cal-COBRA and COBRA

PLAN agrees to provide coverage for GROUP's Cal-COBRA and COBRA-eligible Enrollees at the applicable group Rate. The Subscribing Employer shall authorize California*Choice* Benefit Administrators to administer, or to subcontract for the administration of, the collection of Premiums from Cal-COBRA and COBRA-qualified Enrollees.

B. Co-Payments

Certain covered services and benefits are subject to co-payments by Enrollees and their Dependents, as described in the enclosed Evidence of Coverage.

C. Enrollee Materials

PLAN shall issue or mail to a new Enrollee an identification card and its Evidence of Coverage ("EOC") booklet, including a California*Choice* Supplement, provided, however, that only one EOC booklet and Supplement shall be issued to each Enrollee and his or her Dependents. (In lieu of hard copies, PLAN may notify Enrollee of where to obtain electronic copies of the EOC and Cal*Choice* EOC Supplement.) PLAN shall be responsible for distributing its federally-required Summary of Benefits and Coverage ("SBC"). 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. California*Choice* Benefit Administrators will post on its website a copy of PLAN's current SBC. PLAN agrees to provide to Enrollees and their dependents a copy of its Summary Brochure as required by the Small Group Act. California*Choice* Benefit Administrators will prepare and make available to Enrollees a unified employee brochure containing information on each of the Participating Plans in the California*Choice* Program.

V. FISCAL PROVISIONS

PLAN agrees to arrange for the provision of health care services for GROUP's Enrollees, as described in the enclosed Evidence of Coverage, in exchange for the Net Premiums received from GROUP. PLAN agrees to accept the Net Premium due PLAN and forwarded to PLAN by and received by PLAN from California*Choice* Benefit Administrators, and any applicable Enrollee co-payments, as full and complete payment for services provided under the Agreement and this Supplement thereto. GROUP's Premium may be adjusted to reflect change in the Enrollee's designated address, in the Premium period following notification of such change of address.

A. Premium Collection

1. Premium Collection and Related Procedures

Premium Payment. GROUP's Premiums for its Enrollees in PLAN will be billed to GROUP by California*Choice* Benefit Administrators in an aggregated billing mechanism which will include PLAN-specific itemized Premiums due from GROUP for other California*Choice* Participating Plans selected by GROUP's Employees. On or about the first business day of the month prior to the coverage month, a Premium Notice is sent by California*Choice* Benefit Administrators to GROUP. (A $30 to $50 monthly administration fee will be added to GROUP's aggregated billing statement by California*Choice* Benefit Administrators.) Payment of Premiums will be due on the 20th day of the month prior to the prospective coverage month.

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Cancellation for Non-Payment of Premiums. A Notice of Consequences for Nonpayment of Premiums will be included in the group's aggregated premium billing. This notice shall contain the date the premiums are due and inform the GROUP of the consequences for failure to pay the premium amounts by the due date. The notice shall also inform the GROUP that coverage will continue during a 30-day grace period that begins on the first day after the last day of paid coverage and lasts at least 30 days. If a billed Premium payment for their Plan is not received on or before the 20th day of the month prior to the month of coverage, a "Notice of Cancellation for Nonpayment of Premiums and Grace Period" will be sent to GROUP by California*Choice* Benefit Administrators on behalf of PLAN by the 25th day of that month, with a cancellation effective date of the last day of the prospective coverage month.

GROUP will have a grace period starting on the first day of the coverage month and lasting for 30 days in order to pay delinquent Premiums and avoid cancellation of the Agreement. If due Premium payments are not received by California*Choice* Benefit Administrators by the 14th day of the prospective coverage month, California*Choice* Benefit Administrators on behalf of PLAN will send GROUP a "Second Notice of Cancellation" to GROUP's last address as shown on the records of PLAN. The Second Notice of Cancellation will reiterate

the information stated in the Notice of Cancellation for Nonpayment of Premiums and Grace Period, which includes the reason for cancellation(s), the effective date of cancellation(s), the dollar amount(s) due to PLAN, the date of the last day of paid coverage, the date the grace period begins and expires, any obligations of GROUP during the grace period, consequences for nonpayment of premiums due within that time frame, as well as the right of GROUP to request a review by the PLAN and/or the California Department of Managed Health Care if GROUP believes coverage has been or will be improperly cancelled. The notice shall also inform GROUP that coverage will continue during a 30-day grace period that begins on the first day after the last day of paid coverage and lasts at least 30 days. If the Premium payment(s) is/are not received by the last day of the coverage month, this Agreement will be terminated for non-payment effective on that day* at 12:00 midnight (Pacific Time) (*Since the month of February consists of only 28/29 days, groups that do not pay February's premiums by the end of the 30-day grace period will terminate on the last day of March). In such a case, a "Notice Confirming Cancellation of Coverage for Nonpayment of Premium" will be mailed to GROUP by California*Choice* Benefit Administrators on behalf of PLAN on the first business day of the month following the effective date of the cancellation(s). PLAN, or California*Choice* Benefit Administrators on behalf of PLAN, will mail an individual Notice of Cancellation to each of its

affected Members also explaining their options for purchasing continuation coverage. The GROUP shall be liable for the payment of all premiums accrued through the last day of coverage.

The 30-day grace period begins the day after the last day of paid coverage and lasts at least 30 days. If the affected premium(s) is(are) not paid by the last day of the grace period, GROUP'S coverage under this Agreement will be terminated prospectively, which in most cases occurs on the last day of the coverage month. The Notice that is mailed to GROUP will include statements regarding the reason for the cancellation(s), the amount(s) of premiums due, a statement of the 30-day grace period that was provided, the effective date of the cancellation(s), and the right of GROUP to request a review by the PLAN and/or the California Department of Managed Health Care if the GROUP believes its coverage has been improperly cancelled (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).

In summary, in the event of non-payment of a due Premium payment, California*Choice* Benefit Administrators on behalf of PLAN will issue a Notice of Cancellation for Nonpayment of Premiums and Grace Period, a Second Notice of Cancellation, and a Notice Confirming Cancellation of Coverage for Nonpayment of Premium to groups that have failed to pay their due Premiums.

GROUP is responsible for notifying each affected individual Member of his or her right to purchase continuation coverage. PLAN, or California*Choice* Benefit Administrators on behalf of PLAN, will mail an individual Notice of Cancellation to each of its affected Members also explaining their options for purchasing

continuation coverage. This Notice of Cancellation would include a State-approved notice regarding the possibility that the member could secure coverage either through the "Covered California" State Exchange or in the State's Medi-Cal Program and also providing toll-free contact telephone numbers and an Internet website where the member could obtain additional information about these opportunities.

However, receipt by California*Choice* Benefit Administrators on behalf of PLAN of all Premium payments due and owing by the last day of the coverage month will continue this Agreement, as modified by this Supplement, with no break in coverage. If payment of some or all delinquent Premiums is received by California*Choice* Benefit Administrators after the last day of the coverage month, this Agreement may be reinstated once, as described below in "Reinstatement".

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.

Issuance of New Contract. Following cancellation for nonpayment of Premiums, and if GROUP is not eligible for the one reinstatement described below, the current Agreement will not be reinstated. Instead, GROUP must submit a new application for coverage.

Reinstatement. California*Choice* Benefit Administrators, on behalf of PLAN, will allow one reinstatement during any twelve-month period, without a change in Premiums because of such reinstatement, if a written request for reinstatement is received by California*Choice* Benefit Administrators and the amounts owed are paid within 15 days of the date on which the Notice Confirming Cancellation of Coverage is mailed, including the amounts specified below. If the GROUP does not obtain reinstatement of the cancelled Agreement within the required 15 days or if the Agreement has been previously cancelled and reinstated for non-payment of Premiums within the last 12 months, then California*Choice* Benefit Administrators, on behalf of PLAN, is not required to reinstate the Agreement, and the GROUP must reapply for coverage. Amounts received and not owed after the termination date will be refunded to the GROUP by California*Choice* Benefit Administrators within 20 business days.

Payments and Fees. If California*Choice* Benefit Administrators on behalf of PLAN reinstates the Agreement as specified in the previous paragraph, receipt by California*Choice* Benefit Administrators of all of the following payments and fees, which must be paid to California*Choice* Benefit Administrators itself to cover its administrative expenses incurred in such reinstatement, will be required as a precondition of reinstatement:

100% of all unpaid invoiced Premiums and Fees relating to PLAN's coverage

Reinstatement administrative surcharge of 10% of one month's Premium

100% of the next month's Premium(s) relating to PLAN's coverage

Obligation to Pay Earned Premiums. In the event of cancellation, GROUP shall promptly pay any earned PLAN Premiums which have not previously been paid. Within 30 days of cancellation, PLAN (or California*Choice* Benefit Administrators on behalf of PLAN) shall return to GROUP the amount of prepaid Premiums, if any, that have not been earned as of the effective date of cancellation.

2. Partial Payment Protocol

In the event GROUP remits in response to a monthly invoice from Choice Administrators an amount insufficient to cover the aggregated total of the premiums due for the various coverage contracts it has through the California*Choice* Program, Choice Administrators will apply that Partial Payment amount according to the following Partial Payment Protocol, per the instructions of GROUP stated immediately hereinbelow.

GROUP hereby directs Choice Administrators to apply GROUP's Partial Payment amount and to cancel its contract(s) for nonpayment of specific premium(s) per the following Partial Payment Protocol. Choice Administrators shall first apply a Partial Payment amount to Medical contract premiums, and any remaining amount shall be applied to due dental, vision, chiropractic/acupuncture, and life contract premium(s) according to the below hierarchy of application designated by GROUP. If a Partial Payment is insufficient to cover all Medical contract premiums, then all Medical contracts shall terminate effective at the end of the "grace period" described above in Section V.A.1., and Choice Administrators shall apply the Partial Payment amount to Specialty contract premium(s) due, based on the hierarchy of application stated below.

Payments shall be applied to specific Specialty contract(s) in the order of highest membership count to lowest membership count in the following order of coverage categories: dental, vision, chiropractic/acupuncture, life.

By way of illustration only, if a Group has two separate dental coverage options, Partial Payment shall be applied to the dental contract with the highest membership count first, unless the Partial Payment amount is insufficient to cover that dental contract's due premium. Whether it is sufficient to cover the first dental contract premium or not, Choice Administrators shall then apply the Partial Payment amount or the remainder of the Partial Payment amount to the dental contract premium with the next highest membership count. If at this point of application there remains a Partial Payment amount then that amount shall be applied to any remaining dental coverage contract premiums due, ranked by membership count. If after application to dental premiums due there remains a

Partial Payment amount, then it shall be applied to the vision contract with the highest membership count, and any remaining Partial Payment amount shall then be applied to the premium due for the vision contract with the next highest membership. This progression of Partial Payment amount application shall continue down through the premiums due for additional vision coverage contracts, and then in similar fashion to premiums due for chiropractic/acupuncture coverage and then for life insurance coverage. If two contracts within the same line of coverage (*e.g.*, dental) have the same membership count, Choice Administrators shall first apply available Partial Payment amounts to the coverage contract with the highest premium due.

Choice Administrators shall apply Partial Payment amounts to coverage contracts in the order designated in the hierarchy below until no additional full contract premium-due payments can be made. Contracts, whether Medical or Specialty, whose premiums are not paid in full shall terminate for nonpayment of premium in compliance with the existing processes of notice and grace periods described above in Section V.A.1. Unapplied Partial Payment amounts will be credited to GROUP's account and applied to GROUP's premiums due in the following month, beginning with Medical premiums (or refunded if no other Plan coverage remains active).

If after this application of Partial Payment amounts certain Specialty coverage contract(s) remain(s) in place, that coverage shall terminate at the end of the contract period. GROUP understands that this Specialty coverage will not be invalidated since the otherwise applicable participation requirement of Medical coverage will have been deemed by GROUP and PLAN inapplicable for such duration.

Partial Payment Hierarchy:
1) All Medical contract(s) (all must be paid in full or all terminate)
2) Dental contract with highest membership count
3) Dental contract with next highest membership count (repeated through all dental contracts)
4) Vision contract with highest membership count
5) Vision contract with next highest membership count (repeated through all vision contracts)
6) Chiropractic/acupuncture contract with highest membership count
7) Chiropractic/acupuncture contract with next highest membership count (repeated through all chiropractic contracts)
8) Life contract with the highest membership count
9) Life contract with the next highest membership count (repeated through all life contracts)

GROUP shall ensure that its employees are informed of the potential of this hierarchical application of a Partial Payment received by Choice

Administrators from GROUP and also in the event that such an application is actually made.

B. Rates

1. PLAN's 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 PLAN's "new business" rates in effect on the anniversary date of the Supplement effective date with GROUP.

2. PLAN agrees that on GROUP's anniversary date the Rates for its Program Products shall be its Best Prices, that is, Rates no higher than PLAN's Rates for products offered to Small Group Employers outside the California*Choice* Program which have an actuarial value equal to or higher than the products offered through the California*Choice* Program. For purposes of this subsection, "Actuarial Value" refers to the dollar value of the benefits included in the plan design, which value shall be calculated for Program Products by the same methodology used for PLAN's other health care service plan products.

VI. TERMINATION, RENEWAL AND OTHER CHANGES

A. Termination by GROUP

Notice of GROUP's voluntary termination of the Agreement must be given to California*Choice* Benefit Administrators no earlier than 30 days in advance of the intended termination date.

B. Termination of Individuals

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 California*Choice* Benefit Administrators within 55 days after the date of termination of coverage of an Enrollee and/or his or her Dependents.

C. Re-Enrollment or Renewal

If GROUP wishes to renew in PLAN or enroll with another Participating Plan upon the anniversary date of the Agreement, GROUP must have the number of eligible employees required by the Small Group Act and seventy percent (70%) of those not covered elsewhere by an employer-sponsored plan must be enrolled in a Participating Plan. The contribution requirements described above in Section

II.C. must also be met for purposes of renewal or re-enrollment. If GROUP does not meet such re-enrollment or renewal requirements, GROUP may renew with PLAN or re-enroll with another Participating Plan at such later date as GROUP meets such requirements.

D. Open Enrollment

PLAN's open enrollment period shall be sixty (60) days prior to the anniversary date of the Agreement, and any changes requested must be received thirty (30) days prior to such date, with such requested changes to be effective on such anniversary date.

E. Miscellaneous

1. Enrollees may not change plan benefit levels within PLAN, if GROUP has made such option available, other than during the open enrollment period, except as otherwise allowed in Section 3 above ("Special and Late Enrollment").

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 California*Choice* Program and who did not have coverage from another source at that time must wait to enroll until the next open enrollment period, except as otherwise allowed in Section 3 above ("Special and Late Enrollment").

3. An Eligible Employee of GROUP who had declined coverage through the California*Choice* Program because of other coverage from another source and who subsequently loses his or her current coverage for reasons not under his or her control will be permitted, upon receipt of satisfactory evidence thereof, to submit a request for enrollment with no waiting period, within 60 days of the loss of the other coverage. Coverage for such an Eligible Enrollee will become effective upon the first day of the month following the receipt of such Employee's completed enrollment application.

VII. STATUTORY CHANGES

Upon written notice to GROUP, PLAN may unilaterally amend this Agreement as necessary to bring it into compliance with any applicable federal or state statutes or regulations or jurisdictional judicial decisions.

Oscar Health Plan of California
Subscriber Agreement

2019

An Exclusive Provider Organization (EPO) Plan

Oscar Health Plan of California
3535 Hayden Ave.
Suite 230
Culver City, CA 90232

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

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

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

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

Mario Schlosser
CEO, Oscar Insurance Corporation
295 Lafayette Street
NY, NY 10012

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SECTION I: DEFINITIONS

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

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

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

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

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

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

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

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

SECTION I: DEFINITIONS

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

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

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

You, Your: The Group.

SECTION II: HOW YOUR COVERAGE WORKS

A. Coverage Under this Agreement.

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

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

B. Term and Renewal.

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

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

Pursuant to 45 C.F.R. 147.106(h), guaranteed renewability rights do not allow a Group to continue its existing coverage if it would not otherwise be permitted to enroll in such coverage per federal law. Consequently, if You experience a reclassification as a large group on renewal, You are required to be issued coverage appropriate for that size group.

C. Group Health Plan Services.

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

available to Members. These providers will act as independent contractors to render the Covered Services as described in and in accordance with the Plan Documents.

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

D. Premiums.

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

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

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

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

E. Paying Premiums and Grace Periods.

For Subscribers added or terminated before the end of a month, that month’s premium will be prorated to reflect the number of days they are covered in that month.

Premium payments are due in full to Us on or before the first day of each month for that month's coverage. Payments may be made electronically as instructed by Us or by mail to 9942 Culver City Blvd., PO Box 1279, Culver City, CA 90232. You are responsible for paying any and all costs and expenses, including reasonable attorney's fees, incurred by Us in collecting any past due premiums from You.

After the initial payment, premium payments to Us are subject to a 30 day grace period , during which time premiums may be paid to Us without lapse of coverage. If premiums are not paid by the end of the grace period, We will notify You that coverage will terminate the day after the last day of the

grace period. . If You fail to pay the required premiums and coverage is terminated, Members will be responsible for the costs of all Covered Services received by them after the termination date.

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

SECTION III: WHO IS COVERED

A. Group Eligibility.

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

Subsequent to the issuance of the Group Health Plan to You, and for the purpose of determining Your eligibility, Your Group size will be determined using the method for counting Full-Time Employees and Full-Time Equivalent Employees set forth in Section 4980H(c)(2) of the Internal Revenue Code. Under this counting method, first calculate the number of Full-Time Employees. Full-Time Employees are permanent employees actively engaged in the conduct of business on a full-time basis. They must have a normal work week averaging 30 hours per week over the course of a month, work at Your regular place of business, and have met their waiting period, if applicable.

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

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

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

B. Employee Eligibility and Enrollment.

Once You have determined that You, the Group, are eligible for Oscar's Group Health Plan, you may offer coverage to Your Eligible Employees. An Eligible Employee is any permanent employee who is

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

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

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

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

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

C. Furnishing of Necessary Information to Employees.

You must forward all applicable enrollment forms that You receive from employees to Us within 10 business days of receipt from any employee. After we receive and accept an employee's enrollment,

SECTION III: WHO IS COVERED

We will provide an identification card to each Subscriber. The identification card will contain Our address and telephone number, and serves as evidence of enrollment.

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

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

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

The Group must facilitate Our distribution of any and all written material that We are required to provide to Members to comply with the terms of this Agreement, state or federal laws or regulations, or to fulfill health plan accreditation standards. We are not required to issue to Members any notice of termination, cancellation, or non-renewal of this Agreement, except as required by law.

D. Non-Discriminatory Terms.

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

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

E. Notice Requirements.

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

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

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

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

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

SECTION IV: EXCLUSIONS AND LIMITATIONS

A. Exclusions.

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

SECTION V: TERMINATION OF COVERAGE

A. Termination by the Group.

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

B. Termination by Oscar for Nonpayment of Premium.

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

C. Termination by Oscar when the Group Provides Misleading or Fraudulent Information.

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

D. Post-Termination.

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

In the event that You become the subject of a bankruptcy or similar proceeding, You agree that any pre-petition benefits provided by Us on credit will be allowed under 11 U.S.C. § 502 and entitled to Your maximum priority under 11 U.S.C. § 507(a)(4) and § 507(a)(5). You further agree that any post-petition benefits that are provided by Us on credit will be allowed under 11 U.S.C. § 503(b) and entitled to administrative expense priority.

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

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

SECTION VI: GENERAL PROVISIONS

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

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

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

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

With respect to Confidential Information, and except as expressly authorized herein, the parties agree that during the term of the Group Health Plan and at all times thereafter, they shall not use or otherwise disclose such Confidential Information to any person, except its own employees, contractors and/or agents having a "need to know" or other such recipients as agreed to in writing by the parties prior to disclosure. The parties and their employees, contractors and/or agents shall use at least the same degree of care in safeguarding the Confidential Information of each other as they use in safeguarding their own confidential information, but in no event shall less than due diligence and care be exercised.

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

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

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

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

7. ERISA Fiduciaries.
If Your Group Health Plan is subject to ERISA, You, or Your designee (other than Us), will be the plan administrator of Your Group Health Plan under ERISA and will have all the responsibilities and authority of that position including ensuring compliance with ERISA, preparing and distributing summary plan descriptions, and advising all Members of (i) available benefits and any changes in benefits; (ii) termination of coverage for any reason, including the failure to make any payments when due; and (iii) their COBRA rights, if any. We may not be named as, and will not be considered to be, a "named fiduciary" or "plan administrator" within the meaning of ERISA for Your Group Health Plan governed by ERISA.

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

SECTION VI: GENERAL PROVISIONS

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

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

9. Furnishing Information and Audit.
You shall make payroll and other records available to Us for inspection for the purpose of confirming Member eligibility or whether You meet Our underwriting guidelines pursuant to this Agreement. When necessary, inspection will be conducted at Your offices, during regular business hours, and upon reasonable advance request from Us. If necessary to resolve outstanding issues, this provision shall survive the termination of this Agreement.

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

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

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

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

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

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

16. State of California Review of Member Grievances.
Pursuant to Section 1368.02 of the California Health and Safety Code, the California Department of Managed Health Care is responsible for regulating health care service plans. If Subscribers have a grievance against Oscar, Subscribers should first telephone Oscar at 1-855-Oscar-55 and use Oscar's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available. If a Subscriber needs help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Oscar, or a grievance that has remained unresolved for more than 30 days, the Subscriber may call the Department for assistance. The Subscriber may also be eligible for an Independent Medical Review ("IMR"). If the Subscriber is eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or

treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

17. Workers' Compensation.

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

Notice of Non-Discrimination: Discrimination is Against the Law

Oscar complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Oscar does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Oscar:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services, at all points of contact, at all times, to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Member Services at 1-855-OSCAR-55 (TTY: 7-1-1).

If you believe that Oscar has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

NY/NJ/TX/OH/TN Members: Oscar Insurance, Attention Grievances PO Box 52146, Phoenix AZ, 85072

CA Members: Oscar Health Plan of California, Attention Grievances 9942 Culver City Blvd., PO Box 1279, Culver City, CA 90232

1-855-OSCAR-55 (TTY: 7-1-1), Mon - Fri 8 am - 8 pm/ Sat - Sun 9 am - 5 pm (EST), Fax: 1-888-977-2062, Email: help@hioscar.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Oscar's Grievances Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F,
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services for the Deaf or Hard of Hearing

ATTENTION: If you are deaf or hard of hearing, talk to text services, free of charge, are available to you. Call 1-855-Oscar-55 and dial 711 to receive TTY/TDD services.

Multi-language interpreter services

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-OSCAR-55.

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-OSCAR-55.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1–855–OSCAR–55.

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-OSCAR-55.

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-OSCAR-55 번으로 전화해 주십시오.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-OSCAR-55.

אידיש (Yiddish): אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-855-OSCAR-55.

বাংলা (Bengali): লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১ -855-OSCAR-55.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-OSCAR-55.

العربية (Arabic): ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1–855–RACSO–55.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-OSCAR-55.

اُردُو (Urdu): خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-855-OSCAR-55

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-OSCAR-55.

Ελληνικά (Greek): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-855-OSCAR-55.

Shqip (Albanian): KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-855-OSCAR-55.

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-OSCAR-55.

हिंदी (Hindi): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-OSCAR-55 पर कॉल करें।

فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما .بگیرید ت 1-855–OSCAR-55.

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-OSCAR-55.

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-OSCAR-55.

日本語 (Japanese): 注意事項： 日本語を話される場合、無料の言語支援をご利用いただけます。1-855-OSCAR-55 まで、お電話にてご連絡ください。

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ້ງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-OSCAR-55.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-OSCAR-55.

አማርኛ (Amharic): ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-OSCAR-55.

Հայերեն (Armenian): ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-855-OSCAR-55.

ਪੰਜਾਬੀ (Punjabi): ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-855-OSCAR-55 'ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ (Cambodian): ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-OSCAR-55. ។

Hmoob (Hmong): LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-OSCAR-55.

ภาษาไทย (Thai): ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-OSCAR-55.

Deitsch (Pennsylvania Dutch): Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1–855–OSCAR–55.

Oroomiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-OSCAR-55.

Nederlands (Dutch): AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-855-OSCAR-55.

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-855-OSCAR-55.

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-855-OSCAR-55.