Cigna Health and Life Insurance Company Small Group LocalPlus

Group Agreement

This Policy is underwritten by Cigna Health and Life Insurance Company.

Cigna Health and Life Insurance Company
1-860-226-6000
900 Cottage Grove Road
Bloomfield, CT, 06002

This Policy is administered in part by Oscar Health Administrators
1.855.672.2789
P.O. Box 52146
Phoenix, AZ 85072-2146

GROUP INSURANCE POLICY

This group insurance policy (the "Policy"), is entered into by and between Cigna Health and Life Insurance Company (the "Insurance Company") Insurance Company and [GROUPNAME] ("Group").

This Policy is regulated by the California Department of Insurance (CDI). You may contact the CDI at 1-800-927-4357, or 300 South Spring Street, South Tower, Los Angeles, CA 90013, or www.insurance.ca.gov.

The California Department of Insurance should be contacted only after discussions with the Insurance Company, or its agent or other representative, or both, have failed to produce a satisfactory resolution to the problem. If this Policy was issued or delivered by an agent or broker, please contact the agent or broker for assistance.

For customer service, the Group may contact the Insurance Company by phone at 1.855.672.2789 or by mail at:
Cigna Health and Life Insurance Company
c/o Oscar,
PO Box 52146
Phoenix, AZ 85072-2146

A. APPLICATION

The attached Employer Enrollment Form (the "Application") is part of this Policy. It serves as the signature page of this Policy. The terms of the Application will control any conflict between the terms of the Application and this Policy.

B. CERTIFICATE

The attached Certificate is part of this Policy

C. DEFINITIONS

Defined terms are capitalized in this Policy.

Agreement means the contract between the Insurance Company and the Group.

Aggregate Premium means the Premium required for all Members. Aggregate Premiums are shown on all Premium Statements.

Application means the Employer enrollment form. It serves as the signature page of this Policy.

Certificate means the document that contains the eligibility and termination conditions, as well as the benefits, limitations, and exclusions that apply to the Member's coverage under the Policy.

Coverage means the Medically Necessary covered services paid for, arranged, or authorized for the Member by the Insurance Company under the terms and conditions of the Certificate.

Eligible Employee
An eligible employee is any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small Employer with a normal workweek of at least 30 hours, at the small Employer's regular places of business, who has met any statutorily authorized applicable waiting period requirements. Sole proprietors and their spouses, and partners of a partnership and their spouses, are not counted as employees.

Permanent employees who work at least 20 hours but not more than 29 hours are deemed to be eligible employees if all of the following apply:

- They otherwise meet the definition of an eligible employee except for the number of hours worked.
- The employer offers such employees health coverage under a health benefit plan.
- All similarly situated individuals 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 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.

Former employees who are eligible for state or federal continuation may enroll for the period permitted by law.

Employer means the sponsor of this group insurance plan or any subsidiary or affiliate described in this Policy. An employer must employ at least one common-law employee. A business owner and his or her spouse are not considered common-law employees for this purpose if the entity is considered to be wholly owned by one individual or one individual and his or her spouse.

Employer Enrollment Form means the Group's application for Coverage.

Group means the legal entity identified as the "Group" on the face page of the Policy. The Group is the employer and policyholder.

Group Health Plan means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 29 U.S.C. 1002(1)) to the extent that the plan provides medical care (as defined in paragraph (2)) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

Insurance Company means Cigna Health and Life Insurance Company.

Member means the subscriber or a covered dependent who has satisfied the eligibility conditions, applied for coverage, and for whom required Premiums have been paid.

Policy means the document, including the Certificate, together with any riders, amendments and endorsements, which describe the agreement between the Insurance Company and the Group. The "Agreement" also means the Policy.

Policyholder: Means the legal entity identified as the Group on the face page of the Policy who establishes, sponsors and endorses an employee benefit plan for insurance coverage.

Premium means the amount paid by the Group to the Insurance Company for Coverage.

Small Employer: Small employer: Small employer means 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 benefit plans, and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined income tax return for purposes of state taxation shall be considered one employer.

Subscriber means the eligible individual who elects and signs for the insurance coverage.

Total Estimated Premium Amount means an estimate of that amount of money necessary to fund the required Premiums to cover the total number of Members whom the Group estimates will enroll for Insurance Company Coverage under the Policy. Payment of the Total Estimated Premium Amount and execution of the Application is acceptance of this Policy. The Coverage will not begin until the Insurance Company receives the Total Estimated Premium Amount.

D. COVERED SERVICES

The Insurance Company provides Coverage to Eligible Employees. The Coverage is subject to the terms and conditions of this Policy and the Application. The Insurance Company will make benefit determinations pursuant to this Agreement.

E. ENROLLMENT AND TERMINATION OF COVERAGE

- **Enrollment**

The Certificate will describe the eligibility requirements for Eligible Employees (also referred to as Subscribers) and their dependents. All eligible Subscribers and their

eligible dependents listed on the Group's completed Application will be covered on the effective date of the Policy. The Insurance Company relies on the Group to provide accurate information regarding hours worked or scheduled to work exclusively for the Group.
If the Group offers one or more other group health benefit plans for like benefits, to eligible Persons and their eligible dependents, the Group must permit them to enroll in this Policy. The Group: (1) will make equitable contributions to this Policy and any other plans; and (2) will not promote any other Insurance Company over this Policy. The Group will not directly or indirectly encourage, discourage or otherwise attempt to influence eligible Persons or dependents to enroll in the Coverage under this Policy based upon: (1) health status; or (2) anticipated utilization of covered services.
The Group shall allow and eligible Persons can enroll for Coverage for themselves and their eligible dependents during: (1) the initial enrollment period; (2) an annual Open Enrollment Period; or (3) upon a qualifying event. The Parties may agree to an additional Open Enrollment Period.

The eligible Persons must complete and submit an Enrollment Form to the group administrator for transmittal to the Insurance Company, or enroll through the Insurance Company secure website.

(1) When the Group provides enrollment data and that data does not match the Insurance Company's data, the Insurance Company's data will be used to determine the premium. The Insurance Company will work with the Group to resolve the discrepancy. If no agreement can be reached, the Insurance Company's records will control. Until the dispute is resolved, the Group must pay the premium indicated, based on the Insurance Company's records.

(2) The Group's enrollment data shall not contain ineligible Persons and/or dependents.

- Electronic Enrollment Program. If the Group transmits data electronically (Electronically Transmitted Data, or ETD) to the Insurance Company for enrollment or termination of Members, the Group must follow the Insurance Company's guidelines.

a. Insurance Company's Duties and Responsibilities:

(1) The Insurance Company will work with the Group to initiate and complete acceptance of the ETD process.

(2) The Insurance Company will assist the Group in correcting errors, as identified through the editing process administered by the Insurance Company Insurance Company. The Insurance Company may need to contact the Group to resolve such issues.

(3) After the initial transmission testing is successfully completed, for ongoing updates, valid ETD will be electronically uploaded into the Insurance Company's system by the Insurance Company within 7 calendar days of receipt of a valid file transmission.

(4) Exception errors will be worked by the Insurance Company within 10 calendar days of upload of file transmission.

(5) The Insurance Company reserves the right to terminate the ETD process with a Group when the Group's ETD does not meet a 99% validity/accuracy level, as determined by the Insurance Company.

b. Group's Duties and Responsibilities:

(1) The Group will specify which persons have authority to transmit data to the Insurance Company on behalf of the Group.
(2) The Group must transmit data through Insurance Company-approved medium. The parties shall agree on the medium the Group will use before the program starts.
(3) The Group will submit its ETD data in one of the following formats:
    a. The Insurance's standard format (supplied to the Group).
    b. Custom format, subject to prior approval by the Insurance Company.
    c. HIPAA 834 layout with Insurance Company specifications
    d. On-line transactions through the Insurance Company's secured website.
(4) The Group's ETD will contain the following information:
    a. The appropriate Creditable Coverage data for each Member.
    b. Medicare Secondary Payor enrollment information.
    c. COB data.
(5) The Group is responsible for issuing appropriate HIPAA Pre-Existing Waiting Period notices to Members when data is transmitted electronically, other than through the Insurance Company's secured website.
(6) The Group is responsible for assuring all ETD are 99% accurate/valid.
(7) The Group shall indemnify the Insurance Company to the extent permitted by applicable law in the state of California, including the California Governmental Tort Liability Act for damages or injuries to the Insurance Company caused by the Insurance Company's reliance on ETD from the Group.

- **Electronic Enrollment Through Secured Website**

  If the Group elects to submit enrollment and termination data through the Insurance Company's secured website:

  a. Insurance Company's Duties and Responsibilities

  (1) The Insurance Company will provide website access.
  (2) The Insurance Company will accept data and process enrollment, status change and termination requests in accordance with the eligibility guidelines outlined in the EGA.

  b. Group's Duties and Responsibilities

  The Group will submit data only on eligible Subscribers and/or eligible Dependents as outlined in the Application.

  (1) Group will assure that the data submitted is accurate.
  (2) Group will assume responsibility for notifying the Insurance Company when the group administrator or enrollment contact changes, so that the Insurance Company can revoke that individual's website access. The Insurance Company will revoke access within 5 business days of being notified. If the Group does not inform the Insurance Company of any such change, the Group is responsible for any actions of a former group administrator or enrollment contact.

- **Notification of Termination of Coverage**

  The Group will notify the Insurance Company of the termination of a Member's

Coverage not more than 15 days after the Member is no longer eligible for Coverage.

F. DISTRIBUTION OF MATERIALS

- Group shall handle and distribute enrollment materials in a timely manner and promptly provide to Insurance Company the information necessary to administer this Policy. Group's failure to provide information in a timely manner may substantially delay and/or jeopardize the enrollment of eligible Members.
- Group shall distribute notices to Members that Group and/or Insurance Company are legally required to provide (e.g., notices of special enrollment rights, summary of benefits and coverage documents) in a timely manner and in accordance with all applicable laws. Group shall indemnify Insurance Company and hold Insurance Company harmless from any damages, loss, action, claim or suit (including court costs and attorney's fees) arising from or related to its failure to provide such notices. If Insurance Company provides any summary Insurance Company descriptions, benefit summaries, summary of benefits and coverage, and/or comparison sheets ("Documents") in an electronic medium, and Group delivers Documents electronically to Members or includes Documents on the Group's internal intranet or by similar means or for similar purposes, Group agrees that:

    - electronic access shall be limited to the Group's enrolling employees and covered employees and be restricted to a "read- only" or similar basis;
    - they will replace any hard-copy Forms that have been modified by Insurance Company;
    - the hard-copy documents on file with Insurance Company Insurance Company including the Policy (which includes the Application and the Certificate) shall control in the event of any discrepancy; and

- Insurance Company shall create the Summary of Benefits and Coverage ("SBC") and provide to Group or its legal representative for Group, for distribution to Members within required timeframes. Group shall distribute SBC to Members in manner, method and timeframes required under applicable law. The information in the SBC and other Forms provided by Insurance Company is based only on those services provided by Insurance Company. Group's distribution of the Forms, SBC, or other materials indicates that Group has reviewed and approved the content of such materials. In no circumstance will Members be charged for access to, or creation of the SBC.

G. PREMIUMS

- **Amount**
  The initial Premium Amounts payable for Coverage under this Policy are set out in the Application. To begin Coverage, the Group must pay the Total Estimated Premium Amount to the Insurance Company. The Total Estimated Premium Amount is an estimate of that amount of money necessary to fund the required Premiums to cover the total number of Members whom the Group estimates will enroll for Insurance Company Coverage under the Policy. Payment of the Total Estimated Premium Amount and execution of the Application is acceptance of this Policy. The Coverage will not begin until the Insurance Company receives the Total Estimated Premium Amount.
  The Aggregate Premium is the Premium required for all Members. Aggregate Premiums are shown on all Premium Statements.

The Insurance Company may change the Premium amounts upon 60 days written notice to the Group at renewal.
The Group may reject any revised Premium by terminating this Policy as of the date that the revised Premiums would become effective. To do so, the Group must provide written notice of termination not less than 60 days prior to the date that revised Premium would first become payable pursuant to this Policy.

- **Premium Statement**
  The Insurance Company will prepare and submit a monthly Premium statement ("Statement") to the Group, listing: (1) Subscribers shown on its records; (2) type of Coverage selected by each Subscriber (e.g., individual, family, etc.); and (3) the Aggregate Premium payable to the Insurance Company for providing Coverage for all Members for the next billing period. The Insurance Company will prepare this statement not less than 30 days prior to the end of each billing period this Policy remains in effect.
  The Group must pay the Aggregate Premium for anyone Covered or added during the billing period.

- **Subscribers Listed on Premium Statement and Terminations**

a. A Subscriber and his or her Covered dependents will not have Coverage if the Subscriber is not listed on the Premium statement. Any such Subscriber and his or her Covered dependents may still have coverage if:

(1) The Insurance Company receives the Enrollment Form from the Group within 30 days after :

a. the date the Enrollment Form was executed; or

b. the end of the Open Enrollment Period during which the Member is eligible to enroll in Coverage

and

a. the Group promptly submits the Enrollment Form to the Insurance Company; and

b. the Group pays the applicable Premium to the Insurance Company from the date that error occurred upon discovery of that error and a request for such payment from the Insurance Company.

b. The Group may terminate a Member's Coverage by submitting a termination request to the Insurance Company. The Insurance Company will retroactively terminate a Member's Coverage to the extent allowed by law, if:

(1) the Group notifies the Insurance Company of a Member's termination from Coverage within 90 days after the Member's termination. The Insurance Company will refund any remitted Premium.

(2) the Group does not notify the Insurance Company of a Member's termination from Coverage within 90 days after the date of Member's termination. The Insurance Company will only retroactively terminate the Member's Coverage for 90 days from the date of notice to the Insurance Company. The Insurance Company will not refund more than 3 months of Premium

payments to the Group if it fails to notify the Insurance Company of the termination of the Member's Coverage in a timely manner.

If after notification, the Insurance Company fails to terminate that Member's Coverage; then, upon the Group's discovery of the Insurance Company's failure to delete the Member, the Insurance Company will:

(1) terminate the Member's Coverage retroactively; and

(2) credit the Group for Premiums paid during such time period when Coverage was retroactively terminated.

- **Determining Premium**

On approximately the fifteenth day of each month the Insurance Company will determine the number of Members Covered under the Policy, and this will be the basis for the Premium charged by the Insurance Company for the following billing period. The Group will submit monthly a listing of Members for the Insurance Company to reconcile Members covered under the Group's Coverage. The following describes how the Insurance Company will bill for adding and terminating Members:

a) Additions
   1) If a Subscriber or dependent becomes eligible under the Group's Coverage during the billing period, the Subscriber or dependent is added on the first day of the next billing period following the date he or she becomes eligible for Coverage. Subscribers are not added during the billing period, unless they become eligible for Coverage due to a Qualifying Event.

b) Subscriber Terminations
   1) If a Subscriber's or dependent's Coverage terminates during a billing period, and the Premium would be affected by this change, the Premium charged for that Subscriber's Coverage for the last billing period does not reduce.

c) Qualifying Event
   1) If a Member has been added or terminated as a result of a qualifying event, the addition or termination will be handled according to the statutory requirement for the qualifying event. Premiums will be determined in accordance with the provision outlined in Section G.4.a and G.4.b above.

- **Payment of Premium**

The Aggregate Premium is due in full at the Insurance Company's office on or before the first day of each billing period.

After payment of the Total Estimated Premium Amount, subsequent payments have a grace period of 31 days following the Premium due date (the "Grace Period"). The Aggregate Premium may be paid to the Insurance Company during that Grace Period without causing termination of the Policy. If the Aggregate Premium is paid after the Grace Period, the Insurance Company's acceptance or depositing of such funds shall not be construed to mean or equate to a guarantee of or acquiescence to continue Coverage, or waive termination of the Policy by the Insurance Company.

If the Group pays the premium electronically, the Group will transfer the amount specified in the statement into an account or the Insurance Company's designated account so that such funds will be available through the ACH (Automated Clearing

House) by the first day of each billing period.

There will be a charge for any checks for payment of premiums that are returned to the Insurance Company for insufficient funds, closed accounts, or any other reason.

- **Grace Period**

  There is a grace period of 31 days for the receipt of any premium due after the first premium. Policy coverage will continue during the grace period, however, if the Insurance Company does not receive the premium due by the end of the grace period, Policy coverage will be terminated as of the last day of the grace period. The grace period will end no sooner than the 31st day following the last day of coverage for which the Insurance Company has received payment.

- **Failure to Pay Premiums**

  If the Aggregate Premium is not paid by the end of the Grace Period, the Insurance Company will: (1) notify the Group of such non-payment and termination date of the Policy and all Coverage there under and terminate the Policy Coverage effective the last day of the grace period; or (2) work with the Group to arrange payment of the Aggregate Premium, for a period of up to 90 days. If the Group fails to pay the Premium when required, the Insurance Company will be entitled to recover Insurance Company Expenses. Insurance Company Expenses include: (1) the total outstanding Aggregate Premium; (2) the finance charge set forth below; and (3) a fee for any checks for payment of Premiums that are returned to Insurance Company for insufficient funds, closed accounts, or any other reason; and (4) any expenses reasonably incurred in recovering the amount owed to the Insurance Company including attorney's fees.

  If the Insurance Company terminates the Policy, it may recoup benefit payments from Members and/or Providers, only if paid for claims incurred after the end of the grace period.

  The Group is still obligated to reimburse the Insurance Company for any claims or charges which the Insurance Company has to pay, as required by: (1) state or federal law; (2) pharmacy benefit management agreement; or (3) provider agreement, plus a reasonable administrative fee, but only if claims were incurred after the end of the grace period.

  Intent to Non-Renew for Non-Payment of Premium

  If the Aggregate Premium is not paid by the first day of the billing period, the Insurance Company will send the Group a notice of intent to nonrenew due to nonpayment.

  The Insurance Company will send the notice no later than the first day after the last day of coverage for which it has received payment. The 31-day grace period begins on the first day after the last day of coverage for which the Insurance Company has received payment and will end on the 31st day following the last day of coverage for which the Insurance Company has received payment.

  If the Insurance Company instead sends the notice after the first day after the last day of

coverage for which it has received payment, the 31-day grace period will begin on that day rather than the first day after the last day of coverage for which it has received payment.

The notice of intent to nonrenew due to nonpayment will provide instructions for making the premium payment necessary in order to maintain coverage in force and will include a notice of the right to request review by the California Department of Insurance of a cancellation due to nonpayment.

In the event the necessary premium payment is delivered to the Insurance Company on or before the last day of the minimum 31-day grace period, the Insurance Company will continue coverage beyond the grace period without interruption pursuant to the terms of the Policy.

- **Termination for Non-Payment of Premium**

  If the payment received does not pay the Aggregate Premium, plus any other due charges in full, the Insurance Company may terminate the Policy, effective on the last day of the grace period. A payment of less than the full amount due will be deemed non- payment. If the Group has access to pharmacy benefits through the Insurance Company's pharmacy benefit manager, and its Members incur claims after the termination date of Coverage, the Group must reimburse the Insurance Company for the cost of these services.

- **Finance Charge**

  The Insurance Company may impose a finance charge of 5% per month. This applies to the amount of any Aggregate Premiums not remitted to the Insurance Company on or before the first day of any billing period after the expiration of the Grace Period. This applies through the duration of this Policy.

H. TERM

The initial term of this Policy is set forth in the Application. The Policy will automatically renew for an additional 12 month period unless terminated by the Group upon not less than 30 days advance written notice prior to the end of the renewal date. The Insurance Company shall give the Group not less than 30 days' written notice of any: (1) change in the Premium for providing Coverage to Members; (2) material changes in the covered services; or (3) other material changes in the provisions of this Policy; that will become effective on a renewal date. Payment of the applicable Aggregate Premium on or after that date shall constitute acceptance of those changes by the Group, individually and on behalf of all Members.

I. TERMINATION OF POLICY

- **For Cause**

  a. If the Insurance Company does not receive payment of any Aggregate Premium,

when due, the Insurance Company may terminate this Policy in accordance with section D of this Agreement.

b. Either party may terminate this Policy, if it ceases doing business as a going concern. If the Insurance Company ceases to do business, it will provide Members with 180 days notice.

c. The Insurance Company may terminate this Policy, upon not less than 60 days prior written notice, if the Group fails to comply with a material Insurance Company provision relating to the Group's contribution or group participation rules.

d. Within 24 months following issuance of the Policy, the Insurance Company may terminate or rescind the Policy for an act or practice constituting fraud or intentional misrepresentation by the Group of a material fact concerning the Group or a Member. The Insurance Company will send a notice to the Group or Member via regular certified mail at least 30 days prior to the effective date of the termination or rescission of coverage explaining the reasons for the intended termination or rescission and notifying the Group or Member of his or her right to appeal that decision to the insurance commissioner.

e. Upon written notice, the Insurance Company may terminate a Subscriber's or Member's Coverage under this Policy for fraud or misrepresentation by the Group or the Member of a material fact concerning the Subscriber or Member. Termination of a Subscriber's Coverage automatically terminates Coverage for all of his or her dependents.

- **For No Cause**

  The Group may terminate this Policy upon providing 30 days' notice in advance of the requested termination date. The Insurance Company, at its option may agree to allow the Group to retroactively terminate the Policy. Should the Insurance Company agree to a retroactive termination date, the Group is still obligated to reimburse the Insurance Company for any claims or charges which the Insurance Company has to pay, as required by:

  (1) state or federal law; (2) pharmacy benefit management agreement; or (3) provider agreement, plus a reasonable administrative fee.

  The Insurance Company may terminate the Agreement if it is ceasing to offer this Coverage in the market.

- **Retroactive Terminations**

  The Insurance Company, at its option may agree to allow the Group to retroactively terminate the Policy. Should the Insurance Company agree to a retroactive termination date, the Group is still obligated to reimburse the Insurance Company for any claims or charges which the Insurance Company has to pay, as required by: (1) state or federal law; (2) pharmacy benefit management agreement; or (3) provider agreement, plus a reasonable administrative fee.

- **Effect Upon Incurred Obligations**

The termination of this Policy shall not relieve either party from any obligations incurred prior to the date of termination. The termination will not constitute an election of remedies by the terminating party. Any remedies available upon the termination of this Policy will be cumulative.

If the Insurance Company terminates the Policy back to the last date through which the Group's Premium has been paid, the Insurance Company may recoup benefit payments from Members and/or Providers.

The Group is still obligated to reimburse the Insurance Company for any claims or charges which the Insurance Company has to pay, as required by: (1) state or federal law; (2) pharmacy benefit management agreement; or (3) provider agreement, plus a reasonable administrative fee.

If the Group has access to pharmacy benefits through the Insurance Company's pharmacy benefit manager, and its Members incur claims after the termination date of Coverage, the Group must reimburse the Insurance Company for the cost of these services.

- **Post Termination Premium Balances**

  Within 120 days from the date the Insurance Company is notified of the Group's Coverage termination, the Insurance Company will conduct a final accounting. The final accounting will take into account all payments, funds transfers, etc., necessary to fulfill both parties' obligations under this Policy. If any outstanding payments, funds, transfers, etc. due to the Insurance Company or the Group total less than $25 when the Group's Coverage terminates: (1) the amount shall be forgiven; and (2) the parties agree that any financial obligation to the other party shall end.

- **Post Termination Reports**

  Upon termination of this Policy, the Group must pay charges for the cost of producing any report in advance of receiving the requested report. Among other things, this applies to post- termination audits, requests from replacement insurers or administrators, and requests from the Group itself.

  Right to Review

  If you believe this Policy has been or will be improperly canceled, rescinded, or not renewed, you may request a review by the California Insurance Commissioner. While your request is under review, coverage under this Policy will continue, except for a cancellation due to nonpayment of premium.

- ## CONTINUATION OF COVERAGE

1. **Continuation of Coverage**

   If a Member's Coverage terminates as the result of an event which permits that Member to elect to continue his or her Coverage in accordance with applicable Federal or State laws (a "qualifying event"), ("Continuation Coverage"), that Member will be entitled to remain Covered under this Policy. The Member must comply with the requirements of the laws and pay the applicable Premium for the Coverage. Federal and state laws determine how long the Group is required to continue to provide Coverage to that Member. The Certificate describes the terms and conditions

of such Continuation Coverage in greater detail.

NOTICE TO MEMBERS OF OPPORTUNITY TO ELECT CONTINUITY OF CARE ON POLICY TERMINATION. The Policyholder must provide written notice to Members, who are continuing care patients as defined in §2799A-3(b)(1) of the PHS Act, of the opportunity to elect continuity of care coverage when this Policy is terminated, either by the Policyholder or by the Insurance Company. The Policyholder will provide promptly to the Insurance Company proof of that mailing and the date thereof.

The Group will notify Members of their right to obtain Continuation Coverage following a qualifying event. The Group will collect and remit the Premium for the Coverage to the Insurance Company. If Members do not enroll and pay the Premium for Continuation Coverage, on or before the date their Continuation Coverage would become effective, the Insurance Company will terminate their Coverage. They may be reinstated if they subsequently enroll and pay the applicable Premiums within the enrollment period for Continuation Coverage specified by law. If the Group fails to notify a Member of his or her right to enroll for Continuation Coverage in accordance with applicable laws, the Insurance Company will not extend the enrollment period beyond that required by law had the Group informed the Member of that right in a timely manner. The Insurance Company may consent, in writing, to extend the enrollment period for Continuation Coverage for that Member.

J. RELATIONSHIPS WITH OTHER PARTIES

1. Between Network Providers and the Insurance Company

The Insurance Company may enter into agreements with health care providers, insurers, and any other individuals or entities, as it deems necessary to fulfill its obligations under this Agreement. Such parties are independent contractors. Network Providers are independent contractors who are solely responsible for any services rendered to their Member patients. The Insurance Company makes no express or implied warranties or representations concerning the continued participation of any Network Provider. The Group acknowledges for itself and on behalf of Members that the Insurance Company has established various arrangements to encourage Network Providers to render Covered Services in an appropriate and cost effective manner. Such arrangements include provider penalties.

2. Between the Group and the Insurance Company

The relationship between the Insurance Company and the Group is a contractual relationship between independent contractors. Neither party is a partner, joint venturer, agent or employee of the other when performing its obligations pursuant to this Agreement.

The Insurance Company is not and shall not be deemed to be a fiduciary of the Group's plan, except as necessary to exercise the discretionary authority granted to it by the Group in making authorization, eligibility and coverage determinations and construe the terms of Members' Coverage pursuant to this Policy.

K. GROUP ADMINISTRATION ASSIGNMENT TO BROKER OR OTHER

THIRD PARTY AND HOLD HARMLESS ARRANGEMENT

If the Group has assigned some or all of those functions, as indicated below, to a third party and if the Group has appointed such third party to act on its behalf for those functions, the Group understands and agrees that the third party is the contractor and/or agent of the Group and not the Insurance Company. This Group is responsible and shall hold the Insurance Company harmless as a result of any actions resulting from such delegation and appointment. The Group affirms that it has properly executed a Business Associate Agreement (as defined in 45 CFR Part 160) with such third party.

1. Third Party to Provide Enrollment Information

If the Group has contracted with a third party to provide enrollment information to the Insurance Company on the Group's Members, the third party shall submit such enrollment information to the Insurance Company in either paper or electronic form. The third party must submit the enrollment information using the Insurance Company's approved forms or electronic guidelines. In the event the Group and the third party submit duplicate or conflicting information, the Insurance Company will rely on the latest information provided.

If the third party submits such enrollment information to the Insurance Company in electronic format (including but not limited to on-line enrollment via the web or other electronic media), then the Insurance Company may provide a password for use by the third party in accessing the electronic system to provide enrollment information. If granted, this password is for the exclusive use of the third party and will expire, at the latest, when the Group's relationship with the third party expires. A separate and distinct password will be supplied to the Group. All access and activity to the electronic system will be monitored by the Insurance Company. Such access may be limited or confined to certain information according to the agreement between the Group and the third party. The Insurance Company reserves the right to block access to information contained in the electronic system.

The Group authorizes the Insurance Company to accept such enrollment information. The Group shall be responsible for the validity and accuracy of the information provided to the Insurance Company and shall indemnify and hold the Insurance Company harmless from any and all liability, loss, damages, claims and expenses, including attorney's fees, as a result of the actions or inactions of the third party, including without limitation, any incorrect information provided.

2. Third Party to Receive Premium Statement and/or Make Premium Remittance

If the Group has contracted with a third party to receive the Premium Statement and/or make premium remittances to the Insurance Company, the Group understands that this does not relieve the Group from remittance of the amount due by the due date. The Group will be held responsible for the premium remittance. The Group will be responsible for any late fees or finance charges imposed for late payment. Any payment delinquency notices or coverage termination notices for non-payment of premium will be sent to the third party for notice and delivery to Group

Members.

The Group authorizes the Insurance Company to send such Premium Statements to and receive and accept such premium remittances from the third party. The Group shall be responsible for the validity and accuracy of the information provided to the Insurance Company and shall indemnify and hold the Insurance Company harmless from any and all liability, loss, damages, claims and expenses, including attorney's fees, as a result of the actions or inactions of the third party, including without limitation, any incorrect information provided.

If the Group assigns other functions to the third party, this Agreement shall control the performance of those functions.

The Insurance Company is not a party to the agreement between the Group and the third party. The Insurance Company may refuse to accept information from the third party.
The Insurance Company shall make reasonable accommodation to assist the Group in the administration of its assigned duties and responsibilities.

With regard to Electronic Protected Health Information (as defined in 45 CFR Parts 160 and 162 ("Security Standards")), the Group shall:

(i) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Group creates, receives, maintains or transmits as required by the Security Standards;

(ii) ensure that any agent, including third party or any subcontractor to whom the Group provides such information agrees to implement reasonable and appropriate safeguards to protect it;

(iii) report to the Insurance Company any Security Incident (as defined in the Security Standards) involving the Group's data of which the Group becomes aware within seven (7) days of the Security Incident.

This section will take effect on the effective date of the Agreement and will end on the earlier of:

- The date the Group's Insurance Company terminates.
- The date the Group notifies the Insurance Company in writing 31 days of the termination of such agreement that is has terminated the relationship with the third party.
- The information provided is consistently unusable by the Insurance Company in the administration of the Group's Insurance Company.
- The information provided is not in the format required by the Insurance Company.
- The inability of the third party to perform obligation(s) of the agreement between it and the Group.

Any password provided to the third party will be blocked when this arrangement terminates. Any notice required to be sent to either the Insurance Company or the Group may be sent to the address of that party as shown in this Agreement or it attachments.

L. DISPUTE RESOLUTION

BINDING ARBITRATION

All disputes including but not limited to disputes relating to the delivery of services under the Agreement or any other issues related to the agreement and claims of medical malpractice must be resolved by binding arbitration (with the sole exception of Adverse Benefit Determinations, as defined in Section 147.136 of Title 45 of the Code of Federal Regulation), if the amount in dispute exceeds the jurisdictional limit of small claims court and the dispute can be submitted to binding arbitration under applicable federal and state law, including but not limited to, the patient protection and affordable care act. It is understood that any dispute including disputes relating to the delivery of services under the Agreement or any other issues related to the Agreement, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered will be determined by submission to arbitration as permitted and provided by federal and California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

You and Cigna agree to be bound by this arbitration provision and acknowledge that the right to a jury trial or to participate in a class action is waived for both disputes relating to the delivery of service under the Agreement or any other issues related to the Agreement and medical malpractice claims (with the sole exception of Adverse Benefit Determinations, as defined in Section 147.136 of Title 45 of the Code of Federal Regulation).

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this **BINDING ARBITRATION** section. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The arbitration findings will be final and binding except to the extent that State or federal law provides for the judicial review of arbitration proceedings.

The arbitration is initiated by the Member making a written demand on Us. The arbitration will be conducted by a single neutral arbitrator from Judicial Arbitration and Mediation Services (“JAMS”), according to JAMS’ applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by a single neutral arbitrator from another neutral arbitration entity, by agreement of the Member and Cigna, or by order of the court, if the Member and Cigna cannot agree. If the parties cannot agree on the individual neutral arbitrator, the arbitrator will be selected in accordance with JAMS Rule 15 (or any successor rule).

However, in the case of a medical malpractice dispute in which the total amount of damages claimed is fifty thousand dollars ($50,000) or less, the parties may select a single neutral arbitrator who shall have no jurisdiction to award more than fifty thousand dollars ($50,000). If the parties are unable to agree on the selection of a neutral arbitrator, the method provided in Section 1281.6 of the CA Code of Civil Procedure should be utilized.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations.
Unless You and Cigna agree otherwise, the arbitrator may not consolidate more than one person's claims, and may not otherwise preside over any form of a representative or class proceeding. In cases of extreme hardship, We will assume some of the Member's or subscriber's share of the fees and expenses of the arbitrator.
Please send all binding arbitration demands in writing to:

Cigna
c/o Oscar
Attention: Cigna
Arbitration
1-855-672-2789
P.O. Box 52146
Phoenix, AZ
85072-2146

M. Insurance Company's Right to Audit

The Insurance Company has the right to randomly audit for compliance with participation and eligibility requirements. This audit will take place no more than twice a year.

The Insurance Company has the right to randomly audit if misrepresentation or fraud is suspected.

The Group shall have the right to review the Insurance Company's audit for participation and eligibility requirements to verify that it has conducted the audit according to the Insurance Company's guidelines.

N. MISCELLANEOUS

1. Information Request from Insurance Company

Group shall promptly provide Insurance Company with any and all information requested by Insurance Company for the purposes of Insurance Company's compliance with any state or federal law or regulation, including, but not limited to Group's Premium Contribution Rate and amount. GROUP MUST IMMEDIATELY NOTIFY INSURANCE COMPANY OF ANY AND ALL CHANGES IN GROUP'S PREMIUM CONTRIBUTION RATE AND CONFIRM THE CONTRIBUTION RATE AT RENEWAL.

2. Premium Rebates

If Insurance Company is required by law to provide a premium rebate to Group's Members and former Subscribers, Insurance Company will choose one of the following methods of distribution, as allowed by law:
a) Insurance Company will distribute the required rebate to Group and Group will

distribute the rebate to its Members and former Subscribers any in such a manner as to comply with applicable laws.

b) Group will provide Insurance Company with any information that is necessary for Insurance Company to pay the rebates to Members and former Subscribers in accordance with applicable law, including, but not limited to information relating to premium contribution amounts and contact information. If Group fails to provide Insurance Company with premium contribution information that is necessary to calculate a rebate to Members and former Subscribers on a pro rata basis based on the percentage of premium paid, Insurance Company will distribute 100% of the rebate for Group's coverage to Members and former Subscribers, without regard to the pro-rata share of the premium contribution made by Group and Group waives any claim it has to a share of the rebate.

To the extent applicable, if Group is a non-ERISA and a non-governmental benefit Insurance Company, Group shall distribute the employee contribution portion of any MLR rebate to employees in a method consistent with applicable laws and Federal regulations or guidance. If Group decides to use or distribute the rebate in a different manner than the one agreed to above, Group shall notify Insurance Company of such decision, in writing, and any MLR rebate due Group will be paid directly to Subscribers instead, as required by PPACA and other applicable laws.

3. Entire Contract, Changes

This policy, the Application of the Group, and the individual applications, if any, of the Members shall constitute the entire contract between the parties, and all statements made by the Group, or by Members shall, in the absence of fraud, be deemed representations and not warranties, and no such statement shall be used in defense to a claim under the Policy, unless it is contained in a written application.

No change in this policy shall be valid unless approved by an executive officer of the Insurance Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

This policy is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

4. Effective Date of This Policy

This Policy will be effective as of the date indicated after the Insurance Company accepts the Application and accepts the Total Estimated Premium Amount. The Group's execution of the Application and payment of the total estimated premium amount will be its acceptance of this Policy. The Application is the signature page of this Policy.

5. Renewals

The parties may agree to extend the term of this Policy. The Group will indicate its acceptance of any change in terms of the Agreement by the payment of the next due Aggregate Premium.

6. Amendments

This Policy may be amended, in writing, by an authorized representative of both parties. The Insurance Company may also amend the Policy, upon notice to the Group, as necessary to comply with: (1) applicable laws; (2) regulations; or (3) lawful orders of governmental agencies. Only an officer of the Insurance Company has the authority to: (1) modify this Policy; (2) waive any of its provisions; or (3) extend the time for taking any action required by this Policy.

Any amendments to this Policy require submission to the California Department of Insurance for approval prior to enactment.

7. Claim Adjudication.

The Insurance Company adjudicates claims in accordance with its internal administrative guidelines. Any rebates or refunds on Member's Covered Services are credited against the Group's experience for rating purposes.

8. **Notice of Claim:** Written notice of claim must be given within 60 days after the occurrence or commencement of any loss covered by the Policy. The notice can be given to the Insurance Company at the ID card address or mailed to the following:

Cigna Health and
Life Insurance
Company

c/o Oscar

Attn: Claims
P.O. Box 52146,
Phoenix, AZ
85072-2146

9. **Claim Forms:** When the Insurance Company receives the notice of claim, it will send the claimant forms for filing proof of loss. If these forms are not given to the claimant within 15 days after the giving of such notice, the claimant shall meet the proof of loss requirements by giving Insurance Company a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

10. **Proof of Loss:** The Insurance Company must receive written proof of loss within 15 months after the date of the loss. Proof of loss is a claim form or letter as described above. Canceled checks or receipts are not acceptable. The Insurance Company will not be liable for benefits if it does not receive written proof of loss within this time period. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonable and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

11. **Time of Payment of Claims:** Benefits will be paid immediately upon receipt of due written proof of loss.

12. **Payment of Claims:** Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Member. Any other accrued indemnities unpaid at the Member's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Member.

    Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the Member's option and unless the Member requests otherwise in writing not later than the time of filing proofs of that loss, be paid directly to the person or persons having paid for the hospitalization or medical or surgical aid, or to the hospital or person rendering those services; but it is not required that the service be rendered by a particular hospital or person.

13. **Change of Beneficiary:** Unless the Member makes an irrevocable designation of beneficiary, the right to change a beneficiary is reserved to the Member and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this Policy.

14. Clerical Errors

Clerical errors will not change the rights or obligations of either party under this Policy. They also will not grant additional benefits to Members. The parties shall cooperate, in good faith, to promptly correct such errors.

15. Waiver

The terms or conditions of this Policy may only be waived by express written consent of the party from whom such a waiver is requested. Any waiver of a breach of any provision shall not constitute a waiver of any subsequent breach of the same or any other provision of this Policy.

16. Assignability

No rights or duties under this Policy are assignable by the Group to any other party unless the Insurance Company consents to such assignment in writing.

17. Notices

Any notice required or permitted under this Policy shall be in writing. Such notice will be deemed to have been given on the date when delivered to the other party's most recent address: (1) in person; or (2) by certified or overnight mail, return receipt requested. Notice from the Insurance Company to the Group will be deemed to be notice to all Members.

18. Third Parties

This Policy does not confer any rights or obligations on third parties except as specifically provided herein.

19. Construction

This Policy will be construed without regard to the party that drafted it. Any ambiguity will not be interpreted against either party but will, instead, be resolved in accordance with other applicable rules concerning the interpretation of contracts.

20. Governing Law and Severability

This Policy is executed and is to be performed in accordance with applicable federal and California laws. If any provision of this Policy is deemed to be invalid or illegal by a court or regulatory agency having jurisdiction over such matters, the surviving provisions of this Policy shall remain in effect unless the severance of that provision shall deprive a party of the material benefits of this Policy.

21. Legal Action

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

22. Confidentiality

The parties acknowledge that this Policy and information provided to the other party that is identified as confidential information, including, but not limited to, reimbursement information, group membership lists, marketing information and information obtained from and/or about the Insurance Company ("Confidential Information"); shall be treated as confidential, proprietary or trade secret information. A party may release Confidential Information to providers or its affiliates, or their respective directors, partners, officers, employees, advisors and other representatives ("Representatives") who: have a need to know such Confidential Information, for purposes of their participation in or oversight of matters within the scope of this Policy; and are under a duty or obligation of confidentiality at least as restrictive as those set forth in this Policy. Each party shall advise its Representatives of their obligation to maintain the confidentiality of such information. Each party is responsible if its Representative breaches this Section. Neither party shall otherwise release nor disclose such Confidential Information to third parties without the other party's prior written consent, except as required by law. This paragraph shall survive the termination of this Policy.

Notwithstanding anything herein to the contrary, the following shall not constitute Confidential Information for the purposes of this Policy: (a) Confidential Information that is or becomes generally available to the public other than as a result of a disclosure by a party or its Representatives;

(b) Confidential Information that was available to the parties on a non- confidential basis prior to its disclosure by a party or its Representatives; or (c) Confidential Information that becomes available to the parties on a non- confidential basis from a third party, provided that third party is not known to be subject to any prohibition against transmitting that information.

23. Other Acceptable Forms of this Document and its Attachments.

The following shall have the same legal effect as an original: facsimile copy, imaged copy, scanned copy, and/or an electronic version, including a digital or electronic signature.

24. **Additional Programs**. The Insurance Company may, from time to time, offer or arrange for various entities to offer discounts, benefits or other consideration to Employees for the purpose of promoting their general health and wellbeing. Contact the Insurance Company for details of these programs.

25. **Physical Examination and Autopsy:** Insurance Company, at their own expense, shall have the right and the opportunity to examine any Member for whom a claim is made, when and so often as the Insurance Company may reasonably require during the pendency of a claim under this Policy. In the case of death of a Member, the Insurance Company will have the right and opportunity to make an autopsy where it is not prohibited by law.

O. Network Provisions

1. The Insurance Company will give written notice to the Group, within a reasonable period of time, of any termination or permanent breach of contract by, or permanent inability to perform of, any network provider if such termination, breach or inability would materially and adversely affect the Group or Member or will result in the Insurance Company's network not being in compliance with Article 6 of Subchapter 2 of Chapter 5 of Title 10 of the California Code of Regulations.

2. The Group shall distribute aforementioned notice to the subscribing Members the substance of any notice given to the Group not later than 30 days after its receipt.

3. Pursuant to California Insurance Code Section 10133.56, upon termination of a network provider contract, the Insurance Company will be liable for covered services rendered by such provider to a Member under the care of such provider at the time of termination until such services are completed, unless reasonable and medically appropriate arrangements for assumption of such services by another network provider are made. The Insurance Company is not responsible for any services rendered to Member after he or she ceases to be eligible for coverage under the Policy.

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4. The Network for this Plan is the LocalPlus Network
   The California LocalPlus Service Area is counties of Alameda, Contra Costa, El Dorado, Imperial, Kern, Los Angeles, Marin, Napa, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Solano, Sonoma, Stanislaus, Ventura, Yolo.