

VENTURA COUNTY HEALTH CARE PLAN

GROUP SUBSCRIBER AGREEMENT

EXECUTION PAGE

This Small Group Subscriber Agreement (“**Agreement**”) is entered into by the County of Ventura, as owner and operator of the Ventura County Health Care Plan (“**Plan**”), and the Group listed below, for the following Benefit Plan and in accordance with the following terms:

HMO Benefit Plan: Off-Exchange Small Group Custom Platinum

Initial Term: Commences: January 1, 2021 **Ends:** December 31, 2021

Renewal Terms: One-year terms commencing on January 1st of the following year and ending on December 31st of that year unless terminated in accordance with this Agreement.

Premium Due Dates: As specified in the Premium Schedule.

By the signature below, Group’s representative acknowledges that he/she has read and understands the terms and conditions herein and is authorized to enter into this Agreement on Group’s behalf. For the mutual benefits and promises contained herein, the receipt and sufficiency of which the Parties acknowledge, the Parties hereby accept all terms of this Agreement:

GROUP: Family Health Center of Moorpark, a Medical Corporation (identified in the Agreement as Moorpark Family Medical Group)

Name: John Ippolito, M.D.

Title: Medical Director

Signature: _____ Date: _____

Address for Notices:

Moorpark Family Medical Group

Attn: Justin Magruder

612 Spring Road

Moorpark, CA 93021

COUNTY OF VENTURA:

Name: William T. Foley

Title: Health Care Agency Director

Signature: _____ Date: _____

Address for Notices:

Ventura County Health Care Plan

2220 E. Gonzales Road Suite 210-B

Oxnard, CA 93036

VENTURA COUNTY HEALTH CARE PLAN

SMALL GROUP SUBSCRIBER AGREEMENT – PREMIUM SCHEDULE

Group will pay to Plan the monthly premiums on the 1st day of the Month, by delivering payment to the attention of Plan at 2220 E Gonzales Road, Suite 210-B Oxnard, CA 93036, in accordance with the terms and conditions contained in the Agreement:

Premium Commencement Date: January 1, 2021

Premiums are paid every month and will be based on the attached rate schedule, subject to annual rate increases.

GROUP SUBSCRIBER AGREEMENT

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**COUNTY OF VENTURA, dba
VENTURA COUNTY HEALTH CARE PLAN**

SMALL GROUP SUBSCRIBER AGREEMENT

This Small Group Subscriber Agreement (“**Agreement**”) is entered into by the County of Ventura as owner and operator of the Ventura County Health Care Plan (“**Plan**”) and the Group specified on the Execution Page (“**Group**”) (individually, a “**Party**” and collectively, the “**Parties**”) for the purpose of the Plan providing health benefits for enrolled members of Group. The method of delivery of the health benefits is through a health maintenance organization owned and operated by the County of Ventura. These benefits are subject to all of the terms of this Agreement.

AGREEMENT EFFECTIVE DATE: 12:01 a.m. Pacific Standard Time, on the Commencement Date specified on the Execution Page, until December 31, 2021 at 11:59 p.m., subject to one year renewals upon mutual agreement of the Parties or termination in accordance with the terms of this Agreement, subject to receipt of all necessary budgetary approvals from the Ventura County Board of Supervisors.

1. DEFINITIONS

For purposes of this Agreement, capitalized terms shall have the meanings defined below or if not defined herein, the same meaning as defined in the EOC. In the event of any dispute with regard to the definition of any of the terms within, the Parties agree to make reference to the use or definition of any such disputed term as set forth in the Knox-Keene Health Care Services Plan Act of 1975 (the “**Act**”).

1.1 **Benefit Plan:** The health benefit plan offered by the Plan in which Eligible Employees enroll and which is described in the EOC.

1.2 **Covered Services:** All medically necessary health care services and supplies which a Member is eligible to receive from Plan upon enrollment in the Benefit Plan. This includes all services listed as covered in the EOC. All Covered Services are subject to the copayments and limitations as listed in the EOC.

1.3 **Dependent:** The spouse or registered domestic partner, or child, of an Eligible Employee, subject to applicable terms of the Benefit Plan.

1.4 **Eligible Employee:** Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the Employer with a normal workweek of an average of 30 hours per week over the course of a month, at the Employer's regular places of business, who has met the Employer's 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 Employer's business and included as employees under the Benefit Plan, 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 three of the following apply:

(A) They otherwise meet the definition of an Eligible Employee except for the number of hours worked.

(B) All similarly situated individuals are offered coverage under the Benefit Plan.

(C) The employee must have worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. Plan 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.

(D) The employer offers the employees health coverage under a health benefit plan.

1.5 **Employer:** The Group listed on the Execution Page.

1.6 **EOC:** The Combined Evidence of Coverage and Disclosure Form, which describes the Benefit Plan enrolled in by the employee and which is incorporated into and made a part of this Agreement.

1.7 **Grace Period:** The period of time defined in Section 5.2.

1.8 **Group:** The Employer.

1.9 **Late Enrollee:** An Eligible Employee or Dependent who has declined enrollment in Benefit Plan during the initial enrollment period and who subsequently requests enrollment in the Benefit Plan, except where the Eligible Employee or Dependent qualifies for a Special Enrollment Period.

1.10 **Member:** The Eligible Employee and/or the Eligible Employee's Dependents who are eligible to receive benefits under the Benefit Plan.

1.11 **Renewal Date:** The first day following the end of the initial term, or any subsequent term, of this Agreement.

1.12 **Special Enrollment Period:** The period of time during which an Eligible Employee or Dependent can enroll in the Benefit Plan, due to the triggering of a qualifying event as defined in the EOC.

2. **ENROLLMENT AND EOC BENEFIT PROVISIONS**

2.1 **Requirements.** Only Eligible Employees who are not Late Enrollees may enroll as Members in the Benefit Plan designated on the Execution Page and on the Member's Health Plan Enrollment Form.

2.2 **Benefit Provisions.** Benefit provisions and other provisions of this Agreement appear in the EOC, which is attached to and incorporated into this Agreement.

2.3 **Subscriber EOC Copies.** Plan agrees to issue an EOC to each Member covered under this Agreement within ten (10) business days of enrollment.

2.4 **Interpretation.** In any interpretation of this Agreement, this Agreement and the EOC will be read together. In the case of conflicts between this Agreement and the EOC, the provisions of the EOC shall prevail.

3. **GROUP-IMPOSED WAITING PERIOD**

A Group-imposed waiting period extends from the first day of a Member's eligibility through the last day of the following month, for a total waiting period of up to sixty (60) days. The Group-imposed waiting period applies to all but the following Members: (a) one administrative manager, (b) all eligible physicians, and (c) individuals who become eligible for coverage under this Agreement within sixty-two (62) days of termination of coverage. During the waiting period, the individual's Benefit Plan enrollment is not in effect and no premiums are charged.

4. **GROUP PARTICIPATION AND CONTRIBUTION RULES**

4.1 **Enrollment.** Group is required to enroll each Eligible Employee in the Benefit Plan or to obtain a declination of Group-sponsored coverage as described below. If any Eligible Employee does not enroll, or if a Member is terminating coverage (disenrolling), Group agrees to obtain a written notice, signed by the Eligible Employee or the Member, that the individual declines the Group-sponsored coverage or is terminating coverage in the Benefit Plan. This notice shall clearly indicate that the Member is aware that if he or she does not enroll or does not enroll any eligible Dependents for coverage in the Benefit Plan within thirty (30) days after the individual's eligibility date, or disenrolls as described, and subsequently requests enrollment as a Late Enrollee, the individual may be excluded from coverage until the Group's next plan year.

4.2 **Premium Payments:** Group is required to pay premiums for each enrolled Member at the "Subscriber" rate. Excluded from this requirement are Members enrolled under COBRA or Members on a Group-approved leave of absence of which Plan has been duly notified.

5. **PREMIUM PAYMENT PROVISIONS**

5.1 **Payment Dates.** Group shall pay all Plan premiums listed in the Premium Schedule in a timely manner. Plan shall furnish a monthly invoice to Group on the 25th day of each month. Payment is due by Group on or before the first day of each month following receipt of Plan's invoice. Group is responsible for collecting and remitting Member premiums to Plan.

5.2 **Grace Period.** For every premium due date, there is a 30-day Grace Period. This Agreement remains in force during the Grace Period. Group is liable for payment of premiums covering any period of time that this Agreement remains in force. The Grace Period begins on the date that the Notice of Start of Grace Period is dated.

5.3 **Delinquent Premium Payment.** If Group fails to pay premiums by the end of the Grace Period, Plan may seek payment from any amounts otherwise payable to Group by Plan or the County of Ventura. Plan may terminate this Agreement upon first giving Group thirty (30) days prior written notice of cancellation. The notice of cancellation shall state that this Agreement shall not be terminated if Group makes appropriate payment in full within thirty (30) days after Plan issues the notice of cancellation. The notice of cancellation shall also

inform Group that, if this Agreement is terminated for nonpayment and Group wishes to apply for reinstatement, Plan may require a deposit in the amount of up to two months of premiums.

5.4 Refunds of Unearned Premiums. If this Agreement is terminated for any reason other than fraud, as described herein, any premiums received by Plan for periods occurring after the effective date of that termination, less any amounts due to Plan, will be refunded, and Plan shall have no further liability or responsibility with regard to Group or any Member under this Agreement. Plan will make this refund within thirty (30) days after the date of termination.

6. AGREEMENT AMENDMENT, MODIFICATION, OR TERMINATION

6.1 Amendment and Modification. This Agreement shall be subject to amendment modification, or termination in accordance with the provisions below without the consent or concurrence of the Members, subject to such approval as may be required from any state or federal regulatory agency. By electing coverage pursuant to this Agreement or accepting services hereunder, all Members legally capable of contracting and the legal representatives of all Members who are incapable of contracting agrees to all terms, conditions, and provisions hereof. Plan shall not decrease in any manner the benefits stated in the EOC, except after a period of at least thirty (30) days from and after the postage paid mailing of the notice to Members at each Member's most current address of record with the Plan.

6.2 Changes in Premium Rates. Changes to premiums may be made upon annual renewal of this Agreement. Plan also shall have the right to change the Premiums in the event the extent or nature of the risk under this Agreement is materially modified due to any of the following: (a) enactment of any law or other governmental directive that increases Plan costs; (b) imposition of a premium-based tax by any taxing authority; or (c) a change in Group's workforce. Plan shall notify Group in writing at least sixty (60) days in advance of such change in premium.

6.3 Other Changes. Plan and Group may change other provisions of this Agreement at any time by mutual written consent. Plan may change other provisions of this Agreement without the consent or concurrence of Group where such changes are undertaken to increase health benefits or to meet California or federal laws or regulatory requirements upon written notice to Group, at least sixty (60) days in advance of the effective date of the change.

7. GROUP ENROLLMENT PERIOD

Once each year, prior to renewal of this Agreement, a Group enrollment period of not less than thirty (30) days shall be provided during which each Eligible Employee shall be afforded the opportunity to elect, on behalf of themselves and their Eligible Dependents, coverage under the Benefit Plan. A Plan representative may market the Benefit Plan at Group enrollment information meetings arranged by Group.

8. SUBSCRIBER ENROLLMENT FORMS

An enrollment form must be completed by each Member, approved by Group, received, and accepted by Plan. Group agrees to forward promptly all enrollment forms to Plan. New Member enrollments are effective the first day of the month after completion of the Group-imposed waiting period.

Enrollment forms delayed or lost due to clerical error may be received and accepted by Plan no later than sixty (60) days after the Member's eligibility date, upon payment in full of the premiums retroactive to the enrollment effective date.

9. MEMBER IDENTIFICATION CARDS

Plan shall issue to each Member an identification card for the Member and each enrolled Dependent after Plan's receipt and acceptance of an enrollment form (or by Member's effective date of coverage, if this is later). Plan shall issue new identification card(s) to the Member upon any material change in information printed on the card, as made known to Plan.

10. COMMUNICATION OF UPDATED ELIGIBILITY INFORMATION TO PLAN

10.1 Notification of Changes. Group shall promptly notify Plan of Member disenrollment (for any reason including termination of employment or reduction in work hours) and of Dependent loss of eligibility (for any reason except age). Group shall require Members to notify promptly Group and Group shall promptly notify Plan of all changes to enrollment information (for any reason except changes in primary care physician).

10.2 Updated Information. Group is responsible for providing Plan with updated eligibility and benefit information. Such information shall include a monthly report of Member premiums paid by Group, and Dependent, leave of absence ("LOA"), and COBRA premiums paid by Members to Group. Plan may rely upon the latest information received from Group as correct without verification.

10.3 Manner of Notification. Group may fulfill the above requirements by a combination of: (a) annotating the premium invoice with changes, (b) forwarding a completed Benefit Plan enrollment form for each enrollment change, or (c) written correspondence.

11. CONFIDENTIAL INFORMATION

11.1 Disclosure Authorization. Group agrees that Plan has the right to require each Member to sign a Benefit Plan Enrollment Form, or a disclosure authorization in the format required by law, necessary to permit Plan access to Member medical information, at least upon every thirty (30) months of continuous enrollment. Plan has confidentiality policies and procedures to protect a Member's right to privacy by prohibiting unauthorized disclosure of medical information to a third party.

11.2 Confidential Information. During the term of this Agreement, certain Confidential Information of Plan, its Members or contractors may be disclosed to Group. "Confidential Information" is defined to include, without limitation, Member names, medical history, medical records, or claims information (except as provided by Member to Group); contractor rates, agreements or related deliberative proceedings; and all information of Plan protected from public disclosure. Group shall hold Confidential Information in the strictest confidence and shall not, voluntarily or involuntarily, sell, transfer, publish, disclose, display or otherwise make available to others any portion of the Confidential Information or related materials without the express prior written consent of Plan. Group shall comply with all applicable state and federal laws regarding the privacy and confidentiality of the personal and health

information of Members and Dependents. Group shall not require Plan to release the personal health information of individual Members or Dependents without written authorization from the Member, unless permitted by law. No information may be disclosed by either Party in violation of California Civil Code Section 56 et seq. At the request of Group, Plan may provide aggregate, encrypted, or encoded data regarding Members and Dependents to the Group, unless such data would explicitly or implicitly identify specific Members or Dependents. To the extent that Group receives, maintains, or transmits personal health information of Members or Dependents, Group shall comply with all state and federal laws relating to the protection of such information, including, but not limited to, the Health Insurance Portability and Accountability Act.

12. MEMBER GRIEVANCES AND APPEALS

Plan or its designated contractor shall administer the provision of Covered Services under this Agreement. All determinations of Plan and its administrative contractors are subject to the Member grievance process set forth in the EOC. Plan acknowledges that Group is not responsible for the decisions of Plan, to the extent that Group has not participated in making those decisions. Grievances against Plan may be filed in writing or by telephone. Plan will respond in writing with a proposed resolution to all grievances. Group will encourage Members to select a primary care physician who is not responsible for their supervision or employment. Members may also appeal claims and benefit determinations through the internal review process set forth in the EOC.

13. CLAIM DETERMINATIONS

Plan has the authority to review and decide all claims for covered benefits under this Agreement.

14. INDEMNIFICATION

Should One Party be sued upon actions of the other Party, through no fault of and not due to the actions of the first Party, or of the first Party's subcontractors, employees, or agents, the other Party shall indemnify, defend and hold harmless the first Party from any loss, cost, damage, expense or liability which may arise from any such suit.

15. RELATIONSHIP OF PARTIES

Each Party shall be responsible for carrying out its respective obligations and responsibilities hereunder.

16. GROUP RECORDS

Group is responsible for keeping records relating to this Agreement including, but not limited to, Group's employment and payroll records, and notices of declination of Group coverage for Eligible Employees. Plan has the right to inspect and audit those records, upon reasonable notice to Group. For a period of five years after the termination of this Agreement, Plan maintains the right to inspect Group's records for the period of time this Agreement was in effect.

17. TERMINATION WITH CAUSE

Either Party may terminate this Agreement if the other Party has materially breached this Agreement, or if the circumstances described elsewhere herein giving rise to termination rights have occurred, provided that the terminating Party must provide the other Party with written notice and an explanation of the alleged breach. The Party receiving this notice shall have a 30- day period to cure the alleged breach beginning on the date of receipt of notification. The cure period may be extended upon agreement of the Parties. Upon expiration of the cure period, this Agreement shall terminate unless the breach has been cured. The cure period does not apply to termination of this Agreement for Group's non-payment of premiums.

18. TERMINATION BY PLAN

18.1 Plan shall have the right to terminate this Agreement upon written notice to Group of any of the following: (a) Group's failure to pay Premiums, subject to a Grace Period, as described herein; (b) Group commits fraud, makes an intentional misrepresentation of material fact under the terms of coverage, or knowingly permits such fraud or deception by another, including without limitation any Member; (c) Plan ceases to provide or arrange for the provision of health care services under new small group contracts; (d) Plan withdraws a health care service plan contract of the same type as the Benefit Plan from the market; or (e) Plan is not financially capable of continuing to offer the Benefit Plan(s).

18.2 Rescission, Cancellation, or Nonrenewal of Your Enrollment or Subscription for Nonpayment of Premium:

VCHCP shall send a notice of Cancellation, Rescission, and Nonrenewal for nonpayment of premiums, as follows:

A. If the group fails to pay, or fails to make satisfactory arrangements to pay, any amount due VCHCP for Coverage, including but not limited to Premiums and Copayments, VCHCP may terminate Coverage, subject to the reinstatement provisions below. VCHCP will promptly send written notice of the termination to the group at least thirty (30) days before the termination date. If full payment is received before the termination date, coverage will continue uninterrupted.

B. If the group receives notice that coverage is being canceled or non-renewed due to failure to pay premium, VCHCP will provide the group with a 30-day "grace period". The grace period begins the date that the Start of Grace Period Notice is dated. The Start of Grace Period Notice shall not be dated any earlier than the first date of unpaid coverage. VCHCP will continue to provide coverage during the grace period, though the group will be financially responsible for the premium for the coverage provided during the grace period. The grace period must last at least 30 days from the date of the notice. During the grace period, the group can avoid cancellation or nonrenewal by paying all premiums due before the 30-day grace period ends.

C. If the group does not pay the Premium by the end of the grace period, the group's coverage will be terminated at the end of the grace period. VCHCP will send

such notice via certified mail. The group will still be legally responsible for any unpaid premiums owed to VCHCP. If the group wishes to terminate coverage immediately, it shall contact VCHCP as soon as possible.

D. In the event of termination, the group contract holder shall be responsible for promptly serving each subscriber with all such termination notices including the Notice of start of Grace Period and Notice of End of Coverage.

18.3 Cancellation, Rescission, or Nonrenewal for Reasons Other than Nonpayment of Premiums

VCHCP shall send a notice of Cancellation, Rescission, and Nonrenewal for reasons other than for nonpayment of premiums, as follows:

A. VCHCP shall promptly send a Notice of Cancellation, Rescission, or Nonrenewal to the group contract holder.

B. Notice will be sent at least 30 days before the cancellation, rescission, or nonrenewal for fraud or intentional misrepresentation.

C. Notice will be sent at least 30 days before the cancellation, rescission, or nonrenewal for (insert what this is not the reference.)

D. Notice will be sent at least 180 days before the discontinuation or termination of a contract if the cancellation or nonrenewal is due to VCHCP ceasing to provide or arrange for the provision of health benefits for new plan contracts in the individual or group market in this state. A notice sent pursuant to this subdivision shall also be sent concurrently to the DMHC.

E. Notice will be sent at least 90 days before the withdrawal of a health benefit plan from the market. A notice sent pursuant to this subdivision shall also be sent concurrently to the DMHC.

F. VCHCP shall send a Notice of End of Coverage for all cancellations. This Notice shall be sent to the group contract holder after the date coverage ended, and no later than five (5) calendar days after the date coverage ended.

18.4 Notice of Right of Group or Member to Submit a Grievance:

RIGHT TO SUBMIT GRIEVANCE REGARDING CANCELLATION, RESCISSION, OR NONRENEWAL OF YOUR PLAN ENROLLMENT, SUBSCRIPTION, OR CONTRACT.

If you believe your health care coverage has been, or will be, improperly cancelled, rescinded, or not renewed, you have the right to file a grievance with VCHCP and/or the Department of Managed Health Care (DMHC).

A. YOU MAY SUBMIT A GRIEVANCE TO VCHCP.

1. You may submit a grievance to VCHCP by calling (805) 981-5050 or (800) 647-8247 or online at <http://www.vchealthcareplan.org/members/memberIndex.aspx>, or by mailing your written grievance to 2220 E. Gonzales Road, Suite 210-B; Oxnard, CA 93036.

You may want to submit your grievance to VCHCP first if you believe your cancellation, rescission, or nonrenewal is the result of a mistake. Grievances should be submitted as soon as possible.

VCHCP will resolve your grievance or provide a pending status within three (3) calendar days. If you do not receive a response from VCHCP within three (3) calendar days, or if you are not satisfied in any way with VCHCP's response, you may submit a grievance to the Department of Managed Health Care as detailed under Option 2 below.

B. YOU MAY SUBMIT A GRIEVANCE DIRECTLY TO THE DEPARTMENT OF MANAGED HEALTH CARE (DMHC).

1. You may submit a grievance to the Department of Managed Health Care (DMHC) without first submitting it to VCHCP or after you have received VCHCP's decision on your grievance.
2. You may submit a grievance to the Department of Managed Health Care online at: WWW.HEALTHHELP.CA.GOV
3. You may submit a grievance to the Department of Managed Health Care by mailing your written grievance to:
HELP CENTER
DEPARTMENT OF MANAGED HEALTH CARE
980 NINTH STREET, SUITE 500
SACRAMENTO, CALIFORNIA 95814-2725
4. You may contact the Department of Managed Health Care for more information on filing a grievance at:
PHONE: 1-888-466-2219
TDD: 1-877-688-9891
FAX: 1-916-255-5241

Please refer to Section 12 above and the Evidence of Coverage for further guidance.

18.5 Continuation of Coverage

- A. If the group files a grievance before the effective date of a cancellation, rescission, or nonrenewal, for reasons other than nonpayment of premiums, VCHCP shall continue to provide coverage to the group pursuant to the terms of the plan contract while the grievance is pending with VCHCP and/or the DMHC.
- B. During the period of continued coverage, the group remain responsible for paying premiums and any copayments, coinsurance, or deductible obligations as required under the contract.
- C. If the DMHC determines the cancellation or nonrenewal for nonpayment of premiums is consistent with existing law, the cancellation date shall take effect the day after the last day of the grace period. (For more on grace period, please also reference Section 5.2 of this contract.) The group shall be responsible only for the required premium and cost sharing obligations incurred during the continued coverage period.
- D. If the DMHC determines the rescission is consistent with existing law, VCHCP shall return all premiums paid after date of rescission. The Member and/or group are responsible for the cost of all medical services received after the effective date of the rescission.

18.6 Reinstatement of Coverage

- A. If the DMHC determines the cancellation, rescission, or nonrenewal, including a cancellation for nonpayment of premium, does not comply with existing law, and the group submitted the grievance after the plan contract was cancelled, rescinded, or not renewed, the VCHCP shall reinstate the group, retroactive to the effective date of cancellation, rescission, or nonrenewal.
- B. Within 15 days after receipt of the order for reinstatement, VCHCP shall either request an administrative hearing from the DMHC or reinstate coverage.
- C. If the DMHC orders reinstatement, VCHCP shall be liable for the expenses incurred by the Member or group for covered health care services, less any applicable deductibles, copayments, or coinsurance pursuant to the Evidence of Coverage, from the effective date of cancellation, rescission, or nonrenewal through the date of reinstatement. The plan shall reimburse the Member or group for any medical expenses incurred by the Member or group within 30 days of receipt of the complete claim.
- D. The group shall be responsible for any and all premium payments accrued from the effective date of cancellation, rescission, or nonrenewal. The group must pay all outstanding premiums before reinstatement.

18.7 Format and Transmission Requirements Under this Article

Notices shall be sent by paper via U.S. mail with tracking and electronic mail with read receipt. Group contract holder must immediately notify all Members of such cancellation, rescission, or nonrenewal. Please see Section 20 for further details regarding Member notification.

19. OBLIGATIONS UPON TERMINATION OF AGREEMENT

In the event of termination of this Agreement, such termination shall not release Group or Plan from their respective obligations accruing prior to the date of termination, including, without limitation, the following: (a) Group's obligation to pay Plan Premiums for enrollment prior to termination; (b) Group's obligation to retain, and to provide Plan access to, records as provided herein; and (c) Plan's obligation to pay for Covered Services provided prior to termination.

20. DISTRIBUTION OF INFORMATION TO MEMBERS

Group contract holder agrees to promptly notify Members of the cancellation or nonrenewal of this Agreement and to provide Plan with proof of such notice. Group contract holder also agrees to facilitate Plan's distribution of any and all written material that Plan is 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. Plan shall not in any event be required to issue to Members any notice of termination, cancellation, or non-renewal of this Agreement, except as required by law. Plan shall instead issue such required notices – including notice for Termination for Nonpayment, Cancellation, Rescission, or Nonrenewal, End of Coverage, and Start of Grace Period- to the group contract holder. Notices shall be sent by paper via U.S. mail with tracking and electronic mail with read receipt. Group contract holder must immediately notify all Members of such cancellation, rescission, or nonrenewal.

21. LEAVE OF ABSENCE ("LOA") ADMINISTRATION

Group may continue a Member's eligibility for the time permitted under LOA from employment approved by Group and administered in accordance with the Family Medical Leave Act and the Moore-Brown Roberti Family Rights Act. Group shall promptly notify and update Plan in writing regarding effective dates of Group-approved Member LOAs. Group shall administer LOA benefits to include providing information to Members about Group's LOA policies, requiring timely completion of Group's LOA applications, and administration of premium payments.

22. PROVIDER NETWORK

Plan shall at least annually update and publish a Plan Provider Directory, which is a list of participating providers. Each provider shall be deemed added to or deleted from this list, respectively as of the date on which each provider's contract with Plan begins or ends. Plan shall distribute to each Member, upon enrollment and periodically thereafter, a copy of the Plan Provider Directory.

23. COBRA ADMINISTRATION

23.1 Upon termination of a Member's coverage, Group shall promptly notify the Member of the availability of continuation coverage under the Benefit Plan and procedures for application. Group shall notify Plan, in writing, within thirty (30) days, of any Member who has had a qualifying event, that, but for the election of continuation coverage, would result in a loss of coverage under the Benefit Plan. Group shall administer COBRA continuation coverage, including determining Member eligibility, billing and collecting premiums, and providing monthly written eligibility reports to Plan. A notification of the guaranteed access to coverage for Members who exhaust COBRA continuation coverage and meet other eligibility criteria shall be included in the EOC. It shall be the responsibility of the Group to notify terminating Members about this provision. Plan will not be responsible for determining whether a Member or Dependent is eligible to receive continuation coverage; such determination is based on the requirements of COBRA and the procedures established by Group or its COBRA administrator. If Group or any Member or Dependent fails to meet its obligations under this Agreement and COBRA, Plan shall not be liable for any claims of the Member or Dependent after his/her termination of coverage, except as expressly provided in other applicable provisions of the Agreement, or where otherwise required by law.

24. NON-GROUP (INDIVIDUAL) CONVERSION COVERAGE

24.1 If Group is subject to the California Continuation Benefits Replacement Act (CalCOBRA), Group is responsible for notifying Plan in writing within thirty (30) days when Group becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.

25. KNOX-KEENE ACT PROVISIONS

Plan is subject to the requirements of the Act, as set forth in section 1340 et seq. of Chapter 2.2 of Division 2 of the Health and Safety Code and of Chapter 1 of Title 28 of the California Code of Regulations. Any provision required to be in this Agreement by the Act shall bind Plan whether or not provided in this Agreement. This Agreement shall be construed and enforced in accordance with the laws of the State of California.

26. GROUP COMPLIANCE

Group agrees to comply with all policies and procedures established by Plan in administering and interpreting this Agreement. Upon Plan's request, Group shall provide a certification of its compliance with Plan participation and contribution requirements and the requirements for a small employer, as defined under applicable laws.

27. ENTIRE AGREEMENT

This Agreement and the exhibits and attachments hereto and any other agreements delivered in connection with this Agreement or referred to herein, represent the entire agreement of the parties hereto with respect to the subject matter hereof, and supersede all prior letters of understanding, agreements, understandings, discussions, negotiations and commitments of any kind relating to the subject matter of this Agreement.

28. ASSIGNMENT

This Agreement shall be binding on, and shall inure to the benefit of, the parties to it and their respective heirs, legal representatives, successors and permitted assigns. Group may not assign this Agreement or delegate its obligations hereunder without the prior written consent of Plan.

29. WAIVER AND SEVERABILITY

No waiver of any of the provisions of this Agreement shall be deemed, or shall constitute, a waiver of any other provision, whether or not similar, nor shall any waiver constitute a continuing waiver. If any provision or any part of any provision of this Agreement is held to be illegal, invalid or unenforceable, such illegality, invalidity or unenforceability shall not affect the validity or enforceability of any other provision or part hereof.

30. NOTICES

Any notices to be given by either Party to the other must be in writing and may be affected by personal delivery, by mail, registered or certified, postage prepaid, with return receipt, or by facsimile. Notices shall be sent to the address listed on the Execution Page, or to such other address as shall be furnished in writing by one Party to the other from time to time. Personally delivered notices shall be deemed communicated as of actual receipt; facsimile transmitted notices shall be deemed communicated as of verbal confirmation with the recipient; mailed notices shall be deemed communicated as of two (2) days after mailing. Notices to be given to a Member shall be sent to the latest address provided by Group or Member to Plan.

31. ADMINISTRATION BY PLAN

The Health Care Agency Director of the County of Ventura or his/her designee shall administer this Agreement on behalf of Plan.

32. BINDING ARBITRATION

32.1 Arbitration. Any controversy, dispute or claim of whatever nature and irrespective of the facts or circumstances or the legal theories advanced, between Plan and Group or Plan and Members (in this Section 32, the “parties” or a “party”), in which the amount in controversy exceeds the jurisdiction of small claims court shall be resolved by binding arbitration at the request of either party. The arbitration shall be administered by JAMS, the American Arbitration Association or another mutually agreed upon arbitrator. Such arbitration shall occur in Ventura County, California. The arbitrator shall apply California substantive law and federal substantive law where state law is preempted. The Federal Arbitration Act, 9 U.S.C. § 1-16, shall apply. The arbitrator shall prepare in writing and provide to the parties an award including factual findings and the legal reasons on which the award is based. Nothing herein shall prohibit a party from seeking equitable relief in a court of law while arbitration is pending hereunder.

32.2 Costs and Fees. The parties shall divide equally the cost of the arbitration, including but not limited to the arbitrator’s fee and any related administrative fees and charges. The

parties shall each bear their respective attorneys' fees and costs incurred in the arbitration.

32.3 **Waiver.** Each party knowingly acknowledges and agrees that the foregoing constitutes a waiver of their constitutional right to a jury trial.

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

32.5 **Discovery.** Civil discovery may be taken in such arbitration as provided by California law and civil procedure. The arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California including, but not limited to, the imposition of sanctions.