This Package Contains the Following Documents

- 2026 Group Agreement Summary of Changes and Clarifications
- California Health Benefit Exchange SHOP Program Model Supplement Rider to Group Subscriber Agreement
- Group Agreement for Covered California for Small Business

2026 *Group Agreement* Summary of Changes and Clarifications Notice For Effective Dates from January 1, 2026 through December 1, 2026

This *Group Agreement Summary of Changes and Clarifications Notice ("Notice")* includes a summary of the changes and clarifications that will be effective when your *Group Agreement* ("*Agreement*") is renewed in 2026, unless a different effective date is stated. Unless otherwise indicated, the changes and clarifications described here apply to each type of coverage that will be effective upon renewal of your *Agreement*.

In certain circumstances, this *Notice* may also include changes that we made to your *Agreement* during the 2025 plan year through an amendment. This *Notice* does not include minor changes and clarifications that Health Plan is making to improve the readability of the *Agreement* or any changes Covered California for Small Business is making. In addition to the changes and clarifications listed below, we will also make any changes required by law or by any state or federal agency.

Note: Some capitalized terms in this *Notice* have special meaning. Please see the "Definitions" section of the applicable *Evidence of Coverage* ("*EOC*") document in your *Agreement* for terms you should know.

Revisions to 2026 Kaiser Permanente *EOCs*

The changes and clarifications to *Evidence of Coverage* ("*EOC*") documents described below are effective on your *Agreement* effective date (unless a different effective date is stated).

Note: Some capitalized terms in this *Notice* have special meaning. Please see the "Definitions" section of the applicable *EOC* document in your *Agreement* for terms you should know.

Changes

Claims Payment (SB 3275)

***In accordance with state law**, we have updated information related to claims timeframes under "Initial Claims" in the "Post-Service Claims and Appeals" section.*

Drugs prescribed to treat PANS/PANDAS (AB 2105)

***In accordance with state law effective January 1, 2025**, Cost Share for drugs prescribed to treat Pediatric Acute-Onset Neuropsychiatric Syndrome and Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections ("PANS/PANDAS") cannot be subject to a Cost Share greater than that applies to other benefits provided in the contract. For most plans, there is no impact to coverage or Cost Share for these drugs. Outpatient prescription drugs prescribed to treat PANS/PANDAS are covered as described in the "Most drugs" table under "Outpatient Pharmacy Services" in the Cost Share Summary. However, in benefit plans where the "Most drugs" table says "Not covered," outpatient prescription drugs prescribed to treat PANS/PANDAS are now covered as described in the "Other state-mandated drugs" row in the "Certain state-mandated drugs" table under "Outpatient Pharmacy Services" in the Cost Share Summary.*

Fertility preservation Services (SB 600)

***In accordance with state law**, in contracts issued, amended, or renewed on or after July 1, 2025, the "Fertility Preservation Services for Iatrogenic Infertility" section of the EOC includes coverage for Standard Fertility Preservation Services.*

Fertility Services (SB 729)

***In accordance with state law,** if your Group purchases the Fertility Services benefit the "Fertility Services" and "Outpatient Pharmacy Services" sections of the EOC include coverage of the following services:*

- *Services required to diagnose infertility, including laboratory and imaging services*
- *Services to treat infertility, including medications, artificial insemination, and in vitro fertilization*
- *Coverage includes one oocyte retrieval per lifetime and one transfer of fresh or cryopreserved embryo per lifetime.*

Under SB 729, cost share for fertility services must be the same as the cost share for those services when provided for non-fertility related conditions.

This change does not apply to grandfathered plans if your Group opts to keep existing coverage.

Human milk (AB 3059)

***In accordance with state law effective January 1, 2025**, under "Outpatient Pharmacy Services" in the "Benefits" section, we have added a new section describing coverage of medically necessary pasteurized human milk:*

> We cover medically necessary pasteurized human milk when prescribed by a Plan Provider and obtained from a designated licensed tissue bank. The day supply dispensed may vary based on availability. You may have to pay for the human milk and file a claim for reimbursement. For information on how to file a claim, please see "Initial Claims" in the "Post-Service Claims and Appeals" section.

Health care treatment following rape or sexual assault (AB 2843)

In accordance with state law effective July 1, 2025*, at the end of Cost Share Summary in the EOC, we have added a new section titled "Health Care Treatment Following Rape or Sexual Assault," explaining that Cost Share for the following services related to rape or sexual assault are covered at no charge (subject to the deductible in HDHP plans only):*

- *Emergency Services related to the rape or sexual assault that are received from Plan Providers or Non-Plan Providers*
- *Related follow-up Services that are received from Plan Providers*

Clarifications

988 crisis line

Under "Emergency Services" in the "How to Obtain Services" section, we have added a sentence explaining that members may call 988 to be connected to a trained crisis counselor if they are experiencing a mental health crisis. 911 services also remain available in any emergency.

Administered COVID-19 therapeutics

In the "Administered drugs and products" table in the Cost Share Summary, we have added rows for administered COVID-19 therapeutics from Plan Providers and Non-Plan Providers (such as monoclonal antibodies). This is a clarification, not a change in coverage.

Age limit of Dependent children

Under "Age limit of Dependent children" in large group *EOCs* and grandfathered small group *EOCs*, we have deleted language indicating that children placed with a Subscriber or Spouse for foster care are not eligible for Dependent coverage under certain circumstances. Foster children are eligible for Dependent coverage if the Subscriber or their Spouse has the legal authority to direct their care. This is not a change in policy, just a clarification in the *EOC*.

Completion of Services

Under "Completion of Services from Non-Plan Providers," we have clarified that a new Member must have been covered under another health plan when services of the Non-Plan Provider ended in order to qualify for completion of services from that provider. This is not a change in policy, just a clarification in the *EOC*.

Cross references

We have made several updates to cross-references in the *EOC*:

- Under "Administered Drugs and Products" in the "Benefits" section, we have clarified that all preventive administered drugs except for contraceptives are covered as described in the "Preventive Services" section. Additionally, we have revised the format of the existing cross references for consistency with other sections of the *EOC.*
- We have added new cross references under "Mental Health Services," "Office Visits," "Outpatient Pharmacy Services," "Rehabilitative and Habilitative Services," and "Substance Use Disorder Treatment" to make it easier to identify which benefit category applies to certain services.

These revisions are editorial only and do not represent a change in policy.

DMHC-required *EOC* language (AB 118)

Under "Definitions," "Exclusions," and "Miscellaneous Provisions," we have revised commercial *EOC* language as required by the California Department of Managed Health Care. Due to state law, health plans are required to use these new defined terms, exclusions, and information about Member rights and responsibilities in their *EOCs*. We have also revised some other provisions to accommodate the mandated terminology:

- The "Outpatient Prescription Drugs, Supplies, and Supplements" section is now called "Outpatient Pharmacy Services"
- The exclusion for Services related to noncovered Services is now described under "Noncovered Services" in the "Your Cost Share" section
- Certain general exclusions and all exclusions within the "Benefits" section have been reformatted to be part of the description of the scope of coverage

Doula Services

Under “Plan Doula Services” in the “Reproductive Health Services” section, we have added a reference to **kp.org/doulacare**, which members can visit for information about how to find a doula. Additionally, we have clarified the services that are not covered as Plan Doula services under “Reproductive health Services exclusions.” This is not a change in coverage, just a clarification in the *EOC*.

Emergency Services and Urgent Care

We have deleted the standalone “Emergency Services and Urgent Care” section of the *EOC* in its entirety, to reduce repetition in the *EOC* and make it easier to find information about these Services. Most of the deleted section was moved to the “How to Obtain Services” section, but details about Cost Share for emergency services and urgent care have been moved to “Emergency Services and Urgent Care” in the “Benefits” section of the *EOC*. These changes are editorial only and there are no changes to coverage or policies.

Gender-affirming Services

Under “Gender-affirming Services” in the “Mental Health Services” section, we have made editorial revisions for clarity. There are no changes to coverage of gender-affirming Services.

Glucose monitors

Under “Durable Medical Equipment (‘DME’) for home use” in the “Cost Share Summary” and “Benefits” sections of the *EOC*, we have removed the word “blood” from “blood glucose monitors,” to ensure that it is clear that we cover both blood glucose monitors that use test strips and continuous glucose monitors. In accord with this change, we have re-alphabetized the bullet points beginning with “Glucose monitors…” in the bulleted lists in which they appear.

Missed Appointment Fee

We have added a new section called “Provider fees” under “Your Copayments and Coinsurance” informing members that some Plan Providers may charge a fee for missed appointments without 24-hour advance notice, except in the case of an emergency. This is not a change in policy, just a clarification in the *EOC*.

Overage Dependent

We are now using the term “overage dependent” rather than “disabled dependent” in the *EOC*, so that the health status of the dependent can be kept confidential.

Pediatric Dental Services Amendment

Under “Payments that count toward the Plan Out-of-Pocket Maximum” in the “Benefits” section, and “Dental and orthodontic Services” in the “Exclusions” section, we have removed language explaining to Members that if they have pediatric dental coverage, a Pediatric Dental Services Amendment will be attached to their *EOC*. Pediatric dental coverage is described in a separate *EOC* provided by Delta Dental for plans that include this coverage.

Preventive Services

In the “Definitions” section, we have clarified that the definition of “Preventive Services” pertains to services that are defined as preventive under the Affordable Care Act (“ACA”) and any additional services that we deem to be preventive, as described on our website at **kp.org/prevention**. This is not a change in policy, just a clarification in the *EOC*. The required preventive services are based on recommendations by the U.S. Preventive Services Task Force, Health Resources and Services Administration, and the Centers for Disease Control and Prevention.

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

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

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

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

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

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

I. DEFINITIONS

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

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

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

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

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

PARTICIPATING PLAN shall mean a HEALTH PLAN, offering health maintenance organization (HMO) or preferred provider (PPO) products and participating in the SHOP. HEALTH PLAN is a Participating Plan.

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

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

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

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

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

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

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

II. THE SHOP

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

A. Contribution and Participation Requirements

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

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

2. For medical coverage, GROUP must have a minimum of seventy percent (70%) of Eligible Employees enroll in a QHP through the SHOP. If the Group pays 100 percent of its Qualified Employees' QHP premiums, then all Eligible Employees must enroll in health coverage through the SHOP. For purposes of participation, eligible employees are included with Eligible Employees in the calculation for minimum participation requirements if they are enrolled in coverage through another employer, an employee's union, Medicaid, Medicare, any other federal or state health coverage programs, or any health coverage meeting the definition of minimum essential coverage pursuant to Health and Safety Code Section 1345.5

3. If GROUP does not meet such minimum contribution and minimum participation requirements, GROUP may only enroll with HEALTH PLAN

through SHOP from November 15th through December 15th of each year.

III. ELIGIBILITY AND ENROLLMENT

A. Eligibility and Enrollment for Open Enrollment

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

Employee Eligibility

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

Dependent Eligibility

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

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

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

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

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

Documentation of eligibility and existence of the relationship of any dependent to the Qualified Employee may be requested at the time of enrollment and before a child attains the limiting age, but not more frequently than annually after the two-year period following a child's attainment of the limiting age.

B. Eligibility and Enrollment for Special Enrollment

1. Newly Eligible Employee

An employee who becomes a qualified employee outside of the initial employee open enrollment period, the annual employee open enrollment period, or a special enrollment period has a 30-day period to enroll in a QHP beginning from the first day the employee becomes a qualified employee. Coverage will become effective the first day of the month following the month in which the employee becomes a qualified employee.

2. New Dependents – Spouse or Registered Domestic Partnership

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

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

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

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

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

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

4. New Dependents – Unregistered Domestic Partnership

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

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

5. Loss of Coverage – Qualified Employee and Dependents

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

   a. loss of eligibility for health insurance coverage due to:
      1. legal separation;
      2. divorce;
      3. dissolution of domestic partnership
      4. cessation of dependent status;
      5. termination of employment; or
      6. reduction in the number of hours of employment
   b. termination of qualified employer contributions toward the employee's or dependent's health insurance coverage
   c. exhaustion of COBRA or Cal-COBRA coverage.
   d. loss of eligibility for health coverage under a Medi-Cal plan under title XIX of the Social Security Act or a state child health plan under title XXI of the Social Security Act.
   e. loss of pregnancy-related coverage described under Section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)) and Section 14005.18 of the Welfare and Institutions Code. The date of the loss of coverage is the last day the Qualified Employee, eligible spouse or registered domestic partner, or eligible child dependent would have pregnancy-related coverage.

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

6. Other Special Enrollment Events

A. A Qualified Employee, an eligible spouse or registered domestic partner, or eligible child dependent may be added to coverage at a time other than at initial enrollment

of the Qualified Employee or at each open enrollment period of GROUP if they experience one of the events listed below. Receipt of the application for coverage and any supporting documents must be within **30 days** of the event. Coverage will become effective no later than the first day of the following month for applications received between the first and fifteenth day of any month or no later than the first day of the second following month for applications received between the sixteenth and last day of any month except as specified below.

a. The enrollee loses a dependent or is no longer considered a dependent through divorce, dissolution of domestic partnership or legal separation as defined by State law in the State in which the divorce, dissolution of domestic partnership or legal separation occurs, or if the enrollee, or their dependent, dies.

b. The Qualified Employee, spouse or registered domestic partner or eligible dependent child's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, a QHP issuer, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities as evaluated and determined by SHOP. Coverage will become effective either on the date of the event that triggered the special enrollment period or on the first day of the following month for applications received between the first and fifteenth day of any month or no later than the first day of the second following month for applications received between the sixteenth and last day of any month, whichever is the least financially burdensome on the enrollee as determined by SHOP.

c. The Qualified Employee, spouse or registered domestic partner or eligible dependent child adequately demonstrates to SHOP, as determined by SHOP on a case-by-case basis, that the QHP in which they are enrolled substantially violated a material provision of its contract in relation to the enrollee. Coverage will become effective either on the date of the event that triggered the special enrollment period or on the first day of the following month for applications received between the first and fifteenth day of any month or no later than the first day of the second following month for applications received between the sixteenth and last day of any month, whichever is the least financially burdensome on the enrollee as determined by SHOP.

d. The Qualified Employee, spouse or registered domestic partner, or eligible dependent child gains access to new QHPs as a result of a permanent move.

e. The Qualified Employee, spouse or registered domestic partner or eligible dependent child was released from incarceration.

f. The Qualified Employee, spouse or registered domestic partner or eligible dependent child is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active-duty service under Title 32 of the United States Code.

g. A Qualified Employee who is an Indian, as defined by Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603(c)), and their spouse or

registered domestic partner or eligible dependent child who is enrolling in a QHP through SHOP on the same application as the qualified employee, may enroll in a QHP or change from one QHP to another one time per month.

h. A Qualified Employee, spouse or registered domestic partner eligible or eligible dependent child is receiving services from a contracting provider under a health plan, as defined in Section 1399.845(f) of the Health and Safety Code or Section 10965(f) of the Insurance Code, for one of the conditions described in Section 1373.96(c) of the Health and Safety Code or Section 10133.56(a) of the Insurance Code, and that provider is no longer participating in the health plan.

i. A Qualified Employee, spouse or registered domestic partner or eligible dependent child demonstrates to SHOP, with respect to health plans offered through SHOP, or to the applicable regulator, with respect to health benefit plans offered outside the Exchange, that they did not enroll in a health benefit plan during the immediately preceding enrollment period available to the employee or dependent because they were misinformed that they were covered under MEC;

j. A Qualified Employee, spouse or registered domestic partner or eligible dependent child, demonstrates to SHOP, in accordance with guidelines issued by HHS and as determined by SHOP on a case-by-case basis, that the individual meets other exceptional circumstances. Such circumstances include, but are not limited to, the following circumstances:

(A) If a child who has been determined ineligible for Medi-Cal and CHIP, and for whom a party other than the party who expects to claim them as a tax dependent is required by court order to provide health insurance coverage for the child, the child shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP.

k. A Qualified Employee or their dependent loses eligibility for pediatric dental coverage subsequent to turning nineteen (19) years of age and wishes to continue dental coverage under a standalone dental plan offered by a QDP in the SHOP.

l. A Qualified Employee, spouse or registered domestic partner, eligible dependent child or unmarried victim within the household, is a victim of domestic abuse or spousal abandonment, as specified in 26 CFR Section 1.36B-2 (b)(2)(ii) through (v), is enrolled in MEC, and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment. A dependent of a victim of domestic or spousal abandonment who is on the same application as the victim may enroll in coverage at the same time as the victim.

m. A Qualified Employee, spouse or registered domestic partner, or eligible dependent child applies for coverage on the Exchange during the annual enrollment period or due to a qualifying life event, is assessed by the Exchange as potentially eligible for Medi-Cal or CHIP, and is deemed ineligible for Medi-Cal or CHIP after open enrollment has ended or more than 60 days after the qualifying event.

n. A Qualified Employee, spouse or registered domestic partner, or eligible dependent child applies for coverage with Medi-Cal or CHIP during the annual enrollment period and is deemed ineligible for Medi-Cal or CHIP after open enrollment has ended.

o. A Qualified Employee's, spouse's or registered domestic partner's, or eligible dependent child's enrollment through SHOP was influenced by a material error related to plan benefits, service area, cost-sharing, or premium. A material error is one that is likely to have influenced a Qualified Employee's, spouse's or registered domestic partner's, or eligible dependent child's enrollment in a QHP, as determined by SHOP on a case-by-case basis.

B. A Qualified Employee, an eligible spouse or registered domestic partner, or eligible child dependent may be added to coverage at a time other than at initial enrollment of the Qualified Employee or at each open enrollment period of GROUP if they become eligible for assistance, with respect to health insurance coverage under a SHOP, under a Medi-Cal plan (including any waiver or demonstration project conducted under or in relation to such a plan). Receipt of the application for coverage and any supporting documents must be within 60 days of the event. Coverage will become effective no later than the first day of the following month for applications received between the first and fifteenth day of any month or no later than the first day of the second following month for applications received between the sixteenth and last day of any month.

7. Process of Enrollment

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

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

IV. COVERED SERVICES AND BENEFITS

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

A. Cal-COBRA and COBRA

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

B. Enrollee Materials

HEALTH PLAN shall issue or mail to a new Enrollee an identification card and its Evidence of

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

V. FISCAL PROVISIONS

HEALTH PLAN agrees to arrange for the provision of health care services for GROUP's Enrollees, as described in the Evidence of Coverage, in exchange for the Net Premiums received from GROUP less the monies owed to SHOP. HEALTH PLAN agrees to accept the Net Premium due HEALTH PLAN and forwarded to HEALTH PLAN from the SHOP, and any applicable Enrollee co-payments, as full and complete payment for services provided under the Agreement and this Supplement thereto.

A. Premium Collection

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

a. A Qualified Employer's first premium payment shall be paid in full and must be delivered to the SHOP or postmarked by the due date indicated on the invoice, for effectuation to occur on the date requested on the employer's application.

b. For on-going premiums, on or about the fifteenth of the month prior to the coverage month, an invoice is sent by the SHOP to GROUP, for which payment must be delivered to the SHOP or postmarked by the last day of the invoicing month. On-going monthly premium payments must be made for the total balance due, by the due date on the invoice to avoid delinquency.

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

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

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

The Notice will provide instructions on how to submit the past due premium payment to maintain coverage and will reiterate when such cancellation will be effective. The

notice will also state how and when the GROUP may appeal the cancellation. If the Premium payment is not received by the cancellation effective date, the Agreement will be terminated for non-payment effective 30 days from the date the Notice of Start of Grace Period was sent. In such a case, a "Notice of End of Coverage" will be mailed to GROUP by SHOP on behalf of HEALTH PLAN within 3 days if an electronic notice is sent or 5 business days if a mailed hard copy is sent. HEALTH PLAN, or SHOP on behalf of HEALTH PLAN, will mail an individual Notice of End of Coverage to each of its affected Members, explaining their options for purchasing individual coverage.

All of the notices described above will include statements regarding the reason for the cancellation, the amount of premiums due, a statement of the 30-day grace period, the effective date of the cancellation, and the right of GROUP to seek review by the appropriate regulator, either the California Department of Managed Health Care or the California Department of Insurance (including the responsibility of GROUP to pay premiums during any such review and the right of GROUP to be reinstated back to the effective date of termination if it prevails in such review).

Receipt by SHOP of all Premium payments due and owing by the due date indicated in the Notice of Start of Grace Period will continue the Agreement, as modified by this Supplement, with no interruption in coverage. If full payment of all delinquent Premiums is not received by SHOP by the due date indicated in the Notice of Start of Grace Period, the Agreement will be terminated.

GROUP may request to be reinstated in the same coverage in which it was last enrolled within 30 days after the effective date of the termination. Past due premiums, if any, must be paid before the GROUP may be reinstated without a lapse in coverage.

GROUP may not reinstate coverage 31 or more days following the effective date of termination. GROUP may only reinstate terminated coverage once during the 12-month period beginning on of the original effective date or the most recent renewal date, whichever is more recent.

4. Non-Sufficient Funds
   If a qualified employer makes a premium payment that is returned unpaid for any reason, the SHOP shall apply a $25.00 insufficient funds fee. If a qualified employer makes a second premium payment that is returned unpaid for any reason within six months of the prior returned payment, the qualified employer shall submit premium payment and the insufficient funds fee for returned payment in the form of a cashier's check or money order. This requirement to make monthly premium payments in the form of a cashier's check or money order shall continue for a period of 12 months beginning with the first of the month following the last paid-through date. If premium payment is not submitted in one of these two forms, the qualified employer group may be subject to termination for non-payment of premium as described in 10 CCR § 6538 (c)(2). In no event shall the failure to pay the insufficient funds fee be a basis to terminate, non-renew or cancel coverage pursuant to Health and Safety Code Section 1365 or Insurance Code Section10273.4, as applicable.

5. GROUP Liable for Premiums During Grace Period. During the grace period described in the preceding paragraphs, the Agreement, as modified by this Supplement, shall continue in force, and GROUP shall be liable for the payment of all Premiums accruing during the grace period.

6. Issuance of New Contract. Following cancellation for nonpayment of Premiums, the current Agreement will not be reinstated. Instead, GROUP must submit a new application for coverage.

7. Delinquent Accounts: Collections: In the event GROUP's account becomes delinquent, SHOP shall undertake collections per State Accounting Manual (SAM) Section 8776.6 (non-employee accounts receivable).

B. Premium Rates

HEALTH PLAN's premium rates are guaranteed for twelve (12) months from the initial enrollment date of the Supplement, which shall be the effective date of the Supplement, and from each subsequent anniversary renewal date thereof. Renewal increases will be based on HEALTH PLAN's "new business" rates in effect on the anniversary date of the Supplement effective date with GROUP.

VI. VOLUNTARY TERMINATION, RENEWAL AND OTHER CHANGES

A. Termination by GROUP

Group may terminate this Agreement at the end of each month. The last day of coverage shall be the end of the month in which the GROUP provided notice of termination, if the GROUP provides notice to the SHOP on or before the fifteenth of the month, or on a case-by-case basis an earlier date upon agreement between the HEALTH PLAN and the SHOP. If the GROUP does not provide notice to the SHOP on or before the fifteenth of the month, the last day of the month following the month in which the GROUP gave notice of termination, or on a case-by-case basis an earlier date upon agreement between the HEALTH PLAN and the SHOP.

B. Termination by Enrollee

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

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

C. Annual Enrollment and Renewal

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

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

1. GROUP may only make changes to reference plan during the renewal period.
2. If employee does not enroll in a different QHP during their annual employee open enrollment period, the employee will remain in the QHP selected in the previous year

unless the employee notifies employer to terminate their coverage from the QHP.

3. If the Qualified Employee's current QHP is not available, the employee shall be enrolled in a QHP offered by the same HEALTH PLAN at the same metal tier that is the most similar to the Qualified Employee's current QHP, as determined by the SHOP on a case-by-case basis.
    a. If the HEALTH PLAN of the QHP in which the Qualified Employee is currently enrolled is no longer available, or if another QHP is not available from the current insurance carrier in the same metal tier, the Qualified Employee may be enrolled in the lowest cost QHP offered by a different Health Plan in the same metal tier as the Qualified Employee's current QHP, as determined by the SHOP on a case-by-case basis.

D. Open Enrollment

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

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

E. Discontinued Group's Reference Plans

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

F. Miscellaneous

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

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Northern and Southern California Regions

A nonprofit corporation

Group Agreement for
COVERED CALIFORNIA FOR SMALL BUSINESS

Group IDs: 399999 and 799999

Contract Year 2026

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Introduction

This Group Agreement (*Agreement*), including the Covered California for Small Business (CCSB) Program Supplement Rider (*Supplement*) and the *Evidence of Coverage* (*EOC*) document(s) listed below under "Health Plan and Other Ancillary Products," the group application that Group submitted to CCSB, and any amendments to any of them, all of which are incorporated into this *Agreement* by reference, constitute the contract between Kaiser Foundation Health Plan, Inc., (Health Plan), CCSB, and Group.

If Group has applied for Ancillary Coverage through Health Plan, provided under a separate contract, it is the intent of Group and Health Plan that coverage under this Agreement and those other contract(s) be treated as one package of benefits for the purposes of term, renewal, termination and payment of Premiums.

In consideration of timely payment of Premium, Health Plan will provide or arrange for covered Services to Members in accord with the documents listed below under "Health Plan and Other Ancillary Products."

Health Plan and Other Ancillary Products

Health Plan products, including Ancillary Coverage offered by Health Plan

Product name	***EOC #***
Platinum 90 HMO 0/20 PCP + Child Dental	1
Gold 80 HMO 250/35 PCP + Child Dental	2
Silver 70 HMO 2500/55 PCP + Child Dental	3
Bronze 60 HDHP HMO 7200/0 PCP + Child Dental	5
Bronze 60 HMO 5800/60 PCP + Child Dental	6
Silver 70 HMO 2000/65 PCP + Child Dental Alt	74
Platinum 90 HMO 0/10 PCP + Child Dental Alt	97
Chiropractic/Acupuncture Plan-$15 Copay/20 Visits	98
Platinum 90 HMO 0/20 PCP + Child Dental INF	121
Gold 80 HMO 250/35 PCP + Child Dental INF	122
Silver 70 HMO 2500/55 PCP + Child Dental INF	123
Bronze 60 HDHP HMO 7200/0 PCP + Child Dental INF	124
Bronze 60 HMO 5800/60 PCP + Child Dental INF	125
Silver 70 HMO 2000/65 PCP + Child Dental Alt INF	127
Platinum 90 HMO 0/10 PCP + Child Dental Alt INF	128
Silver 70 HDHP HMO 3200/25% PCP + Child Dental	129
Silver 70 HDHP HMO 3200/25% PCP + Child Dental INF	130
Silver 70 HMO 2300/65 PCP + Child Dental Alt	241
Silver 70 HMO 2300/65 PCP + Child Dental Alt INF	242
Gold 80 HMO 0/40 PCP + Child Dental Alt	265
Gold 80 HMO 0/40 PCP + Child Dental Alt INF	266
Gold 80 HMO 1000/40 PCP + Child Dental Alt	267
Gold 80 HMO 1000/40 PCP + Child Dental Alt INF	268
Silver 70 HMO 3100/75 PCP + Child Dental Alt	269
Silver 70 HMO 3100/75 PCP + Child Dental Alt INF	270
Gold 80 HDHP HMO 1900/15% + Child Dental Alt	361
Gold 80 HDHP HMO 1900/15% + Child Dental Alt INF	362
Platinum 90 HMO 250/30 PCP + Child Dental Alt	385
Platinum 90 HMO 250/30 PCP + Child Dental Alt INF	386
Gold 80 HMO 500/35 PCP + Child Dental Alt	409
Gold 80 HMO 500/35 PCP + Child Dental Alt INF	410

Pediatric dental coverage

Product name	***Bundled with EOC #***
DeltaCare USA Group Dental Service Contract*	1
DeltaCare USA Group Dental Service Contract*	2
DeltaCare USA Group Dental Service Contract*	3
DeltaCare USA Group Dental Service Contract*	5
DeltaCare USA Group Dental Service Contract*	6
DeltaCare USA Group Dental Service Contract*	74
DeltaCare USA Group Dental Service Contract*	97
DeltaCare USA Group Dental Service Contract*	121
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*Group has applied for the following product that is provided under a separate contract. When coverage is issued through more than one contract, it is the intent of Group and Health Plan that coverage under this *Agreement* and that other contract be treated as one package of benefits for the purposes of term, renewal, termination and payment of premiums:

- Group has applied for DeltaCare USA Group Dental Service Contract (Delta Dental Contract) through a package offered through Health Plan. Benefits offered through the Delta Dental Contract are underwritten by Delta Dental of California and administered by Delta Dental Insurance Company. Please refer to the Delta Dental Contract available at **www1.deltadentalins.com/kaiserpediatrics** for information about dental plan benefits.

Other Ancillary Coverage

Not applicable

In this *Agreement,* some capitalized terms have special meaning; please see the "Definitions" section in the *EOC* documents for definitions of terms that are used in *EOC* documents and this *Agreement*.

Term of *Agreement* and Renewal

Term of *Agreement*

Unless terminated as set forth in the "Termination of *Agreement"* section, this *Agreement* is effective for contract year 2026 (that 12-month contract period beginning with your Group's renewal date in 2026), unless amended. If your Group's renewal date is not January 1st, this *EOC* is applicable during that 12-month contract period beginning with your Group's renewal date in 2026.

Renewal

This *Agreement* does not automatically renew. If Group complies with all of the terms of this *Agreement*, Health Plan will provide prior written notice of any offer to renew the *Agreement*, in a timely manner consistent with applicable state and federal requirements, by doing one of the following:

- Providing Group with a new *Group Agreement* to become effective immediately after termination of this *Agreement*
- Extending the term of this *Agreement* and making other changes pursuant to "Amendments Effective on your Group's Anniversary Date" in the "Amendment of *Agreement*" section

Health Plan will provide Group a renewal notice, which will include a summary of changes to this *Agreement.* The new or extended-term *Group Agreement* will incorporate the changes summarized in the renewal notice. Health Plan will issue to Group the new or extended-term Group Agreement after Group confirms its intent to renew coverage, or 60 days after Group's Anniversary Date if Group does not provide affirmative confirmation of its intent to renew coverage prior to that date.

If Group does not want to renew the *Agreement*, Group must give Health Plan written notice as described under "Termination on Notice" or "Termination due to Nonacceptance of Amendments" in the "Termination of *Agreement*" section.

Coverage of dental services benefits under the Delta Dental Contract will automatically renew upon the renewal of this *Agreement*.

Note: Your Group's Anniversary Date is the date that your Group's contract renews each year. For example, if this contract renews on January 1, 2025, your Group's Anniversary Date is January 1.

Amendment of *Agreement*

Amendments Effective on your Group's Anniversary Date

Upon 60 days prior written notice to Group, Health Plan may extend the term of this *Agreement* and make other changes by amending this *Agreement* effective on your Group's Anniversary Date. Your Group's Anniversary Date is the date that your Group's contract renews each year. For example, if this contract renews on January 1, 2025, your Group's Anniversary Date is January 1.

Amendments Related to Government Approval

If Health Plan notified Group that Health Plan had not received all necessary governmental approvals related to this *Agreement*, Health Plan may amend this *Agreement* by *giving* written notice to Group after receiving all necessary governmental approvals. Any such government-approved provisions go into effect on your Group's Anniversary Date in 2026 (unless the government requires a later effective date). Your Group's Anniversary Date is the date that your Group's

contract renews each year. For example, if this contract renews on January 1, 2025, your Group's Anniversary Date is January 1).

Amendment Due to Tax or Other Charges

If a government agency or other taxing authority imposes or increases a tax or other charge (other than a tax on or measured by net income) upon Health Plan or Plan Providers (or any of their activities), then upon 60 days prior written notice, Health Plan may increase Group's Premiums to include Group's share of the new or increased tax or charge. Group's share will be determined by dividing the number of Members enrolled through Group by the total number of members enrolled in Health Plan's Northern and Southern California Region.

Other Amendments

Health Plan may amend this *Agreement* at any time by giving written notice to Group, in order to address any law or regulatory requirement, which may include an increase in Premiums to reflect an increase in costs to Health Plan or Plan Providers (Health Plan will give Group 60 days prior written notice of any increase in Premiums or reduction in benefits), or ensure that the deductible amount in any High Deductible Health Plan *EOC* continues to meet the U.S. Department of Treasury's minimum deductible amount required in High Deductible Health Plans.

Acceptance of Amendments

All amendments are deemed accepted by Group unless Group gives Health Plan written notice of nonacceptance within 15 days after the date of Health Plan's amendment notice, in which case this *Agreement* will terminate pursuant to "Termination due to Nonacceptance of Amendments" in the "Termination of *Agreement*" section.

Termination of *Agreement*

This *Agreement* will terminate under any of the conditions listed below. All rights to benefits under this *Agreement* end on the termination date, except as expressly provided in the "Termination of Membership" or "Continuation of Membership" sections of an *Evidence of Coverage*. The termination date is the first day when this *Agreement* is no longer in effect (for example, if the termination date is January 1, 2027, the last minute this *Agreement* was in effect was at 11:59 p.m. on December 31, 2026).

If Health Plan terminates this *Agreement,* Health Plan will give Group written notice. In the case of "Termination for Nonpayment", "Termination for Fraud or Intentionally Furnishing Incorrect or Incomplete Information", and "Termination for Discontinuance of a Product or all Products within a Market," Health Plan will provide both advance notice of the termination in addition to a final notice of termination. Within five business days of receipt of an advance or final notice of termination, Group will provide each Subscriber a legible copy of the notice and will give Health Plan proof of that notice was provided including the date thereof.

Coverage of dental services benefits under the Delta Dental Contract will automatically terminate upon the termination of this *Agreement*.

Termination on Notice

Group may terminate this Agreement effective as of the Anniversary Date by giving prior written notice to Health Plan at least 30 days prior to the Anniversary Date, except that termination will be effective as of the first of the month following the Anniversary Date if the Anniversary Date is not the first of the month. Group remains responsible for remitting all amounts payable relating to this Agreement, including Premiums, for the period through the termination date.

Termination Due to Nonacceptance of Amendments

All amendments are deemed accepted by Group unless Group gives Health Plan written notice of nonacceptance within 15 days after the date of Health Plan's amendment notice and remits all amounts payable related to this *Agreement*, including Premiums, for the period prior to the amendment effective date. This *Agreement* will terminate the day before the effective date of the amendment.

Termination for Nonpayment

Premiums are due for the Full Premium owed as described in the "Premiums" section. If Health Plan does not receive the required Premium payment for all coverage issued under this *Agreement* on or before the due date, we will provide a notice of start of grace period to Group as described under "Notices" in the "Miscellaneous Provisions" section. This notice will include the following information:

- A statement that we have not received Full Premium payment and that we will terminate this *Agreement* for nonpayment if we do not receive the required Premiums by the specified date
- The amount of Premiums past due

If we do not receive the required Premiums by the date indicated in the notice of start of grace period, the *Agreement* will terminate and all coverage issued under the *Agreement* will end on the date specified in the notice of start of grace period, which will be at least 30 days after the date of the notice. The *Agreement* will remain in effect during this grace period, but upon termination Group will be responsible for paying all past due Premiums, including the Premiums for coverage provided during this grace period.

We will provide notice of termination to Group as described under "Notices" in the "Miscellaneous Provisions" section if we do not receive Full Premium payment within 30 days after the date of the notice of start of grace period.

Termination for Fraud or Intentionally Furnishing Incorrect or Incomplete Information

If Group commits fraud or intentionally furnishes incorrect or incomplete material information to Health Plan, Health Plan may terminate this *Agreement* upon 30 days prior written notice to Group, and Group is liable for all unpaid Premiums up to the termination date.

Termination for Violation of Contribution or Participation Requirements

If Group fails to comply with Health Plan's participation or contribution requirements (including those discussed in the "Contribution and Participation Requirements" section), Health Plan may terminate this *Agreement* upon 30 days prior written notice to Group, and Group is liable for all unpaid Premiums up to the termination date.

Termination for Discontinuance of a Product or all Products within a Market

Grandfathered products

Health Plan may terminate a particular product or all products offered in a small or large group market as permitted or required by law. If Health Plan discontinues offering a particular grandfathered product in a market, Health Plan may terminate this *Agreement* with respect to that product upon 90 days prior written notice to Group. Health Plan will offer Group another product that it makes available to groups in the small or large group market, as applicable. If Health Plan discontinues offering all products to groups in a small or large group market, as applicable, Health Plan may terminate this *Agreement* upon 180 days prior written notice to Group and Health Plan will not offer any other product to Group. A "product" is a combination of benefits and services that is defined by a distinct *Evidence of Coverage*.

All other products

Health Plan may terminate a particular product or all products offered in the group market as permitted or required by law. If Health Plan discontinues offering a particular product (other than a grandfathered product) in the group market, Health Plan may terminate this *Agreement* with respect to that product upon 90 days prior written notice to Group. Health Plan will offer Group another product that it makes available in the group market. If Health Plan discontinues offering all products in the group market, Health Plan may terminate this *Agreement* upon 180 days prior written notice to Group and Health Plan will not offer any other product to Group. A "product" is a combination of benefits and services that is defined by a distinct *Evidence of Coverage*.

Contribution and Participation Requirements

No change in Group's contribution or participation requirements listed below is effective for purposes of this *Agreement* unless Health Plan consents in writing. As a condition to consenting to Group's revised contribution and participation requirements, Health Plan may require Group to agree to amend the Premiums, benefits, or other provisions of this *Agreement*.

Group must:

- Contribute to all health care coverage available through Group on a basis that does not financially discriminate against Health Plan or against people who choose to enroll in Health Plan
- For each Family, contribute no less than 50 percent of the Premiums required for the lowest-priced Kaiser Permanente medical plan offered by Group
- Ensure that:
  - all employees enrolled in Health Plan meet the definition of "eligible employee" in Section 1357.500 or 1357.600 of the California Health and Safety Code
  - all employees enrolled in Health Plan are covered by workers' compensation or the employer's liability benefits, unless not required by law to be covered
  - at least 50 percent of eligible employees are covered by a health care plan that provides Minimum Essential Coverage
  - at least one active employee is enrolled under this *Agreement*
  - all Subscribers live or work inside the Service Area applicable to their coverage when they enroll
- Meet all applicable legal and contractual requirements, such as:
  - meet and continue to meet the definition of "small employer" or "guaranteed association" in Section 1357.500 or 1357.600 of the California Health and Safety Code
  - for Groups enrolled as guaranteed associations, meet and continue to meet all legal requirements applicable to guaranteed associations
  - elect any coverage that Group is required by law to provide
  - distribute disclosures about coverage as described under "Member Information" in the "Miscellaneous Provisions" section
  - adhere to all requirements set forth in the applicable *Evidence of Coverage*
  - obtain Health Plan's prior written approval of any Group eligibility requirements that are not stated in the applicable *Evidence of Coverage*
  - use Member enrollment application forms that are provided or approved by Health Plan
  - offer enrollment in accord with eligibility requirements in state law (for example, domestic partners must be eligible if married spouses are eligible and disabled dependents must be eligible if dependent children are eligible)
- Offer enrollment in Health Plan to all eligible people on conditions no less favorable than those for any other health care plan available through Group

- Upon request, provide Health Plan with documentation that proves each Subscriber is an eligible employee, proprietor, or partner
- Upon request, provide documentation that demonstrates to Health Plan's satisfaction that Group is complying with all contribution and participation requirements

Miscellaneous Provisions

Assignment

Health Plan may assign this *Agreement*. Group may not assign this *Agreement* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without Health Plan's prior written consent. This *Agreement* shall be binding on the successors and permitted assignees of Health Plan and Group.

Attorney Fees and Costs

If Health Plan or Group institutes legal action against the other to collect any sums owed under this *Agreement*, the party that substantially prevails will be reimbursed for its reasonable litigation expenses, including attorneys' fees, by the other party.

Confidential Information about Health Plan or its Affiliates

For the purposes of this "Confidential Information about Health Plan or its Affiliates" section, "Confidential Information" means any oral, written, or electronic information concerning Health Plan or its affiliates, if the information either is marked "confidential" or is by its nature proprietary or non-public, except that it does not include any of the following:

- Information that is or becomes available to the public other than as a result of disclosure by Group or its employees, advisors, or representatives
- Information that was available to Group or within its knowledge before Health Plan disclosed it to Group
- Information that becomes available to Group from a source other than Health Plan, but only if that source is not bound by a confidentiality agreement with Health Plan

If Group receives any Confidential Information, it will use that information only to evaluate Health Plan and actual or proposed group agreements with Health Plan. Group will ensure that the information is not disclosed to anyone other than a limited number of Group's employees and advisors, and only to the extent necessary in connection with the evaluation of Health Plan and actual or proposed group agreements with Health Plan. Group will inform any such employees and advisors that the information is confidential and that they must treat it confidentially.

Upon Health Plan's request Group will promptly return to Health Plan all Confidential Information, and will destroy any other copies and any notes or other Group documents about the information.

If Group is requested or required (by oral questions, interrogatories, request for information or documents, subpoena, civil investigative demand, or similar process) to disclose any Confidential Information, Group will give Health Plan prompt notice of the request or requirement, and Group will cooperate with Health Plan in seeking to legally avoid the disclosure. If, in the absence of a protective order, Group is legally compelled, in the opinion of its counsel, to disclose any of the information, Health Plan either will seek and obtain appropriate protective orders against the disclosure or will be deemed to waive Group's compliance with the provisions of this "Confidential Information about Health Plan or its Affiliates" section to the extent necessary to satisfy the request or requirement.

Group understands (and will inform any employees and advisors who receive Confidential Information) that United States securities laws prohibit anyone who has material non-public information about a company from buying or selling that company's securities in reliance upon that information or from communicating the information to any other person or entity

under circumstances in which it is reasonably foreseeable that the person or entity is likely to buy or sell that company's securities in reliance upon the information. Group agrees that it and its affiliates, associates, employees, agents, and advisors will not rely on any Confidential Information in directly or indirectly buying or selling any Health Plan securities.

Monetary damages would not be a sufficient remedy for any breach or threatened breach of this "Confidential Information about Health Plan or its Affiliates" section. Health Plan will be entitled to equitable relief by way of injunction or specific performance if Group or any of its officers, directors, employees, attorneys, accountants, agents, advisors, or representatives breach, or threaten to breach, any of the provisions of this "Confidential Information about Health Plan or its Affiliates" section.

Group's obligations under this "Confidential Information about Health Plan or its Affiliates" section will continue indefinitely and will survive the termination or expiration of this *Agreement.*

Contract Providers

Health Plan will give Group written notice within a reasonable time of any termination or breach of contract by, or inability to perform of, any health care provider that contracts with Health Plan if Group may be materially and adversely affected thereby.

Delegation of Claims Review

Group delegates to Health Plan the discretion to determine whether a Member is entitled to benefits under this *Agreement*. In making these determinations, Health Plan has discretionary authority to review claims in accord with the procedures contained in this *Agreement* and to construe this *Agreement* to determine whether the Member is entitled to benefits. If coverage under an *EOC* is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), Health Plan is a "named claims fiduciary" to review claims under that *EOC*.

Electronic Delivery of Written Communications, Contracts, and Other Documents

Written communications, contracts, and other documents may be provided electronically to Group, as allowed by law. If provided by posting to an electronic system, Health Plan will inform Group when a document is available for retrieval. A communication or document that is sent electronically shall be deemed received when the Group is able to retrieve the electronic communication or document from the electronic or information processing system designated for the purpose of receiving electronic records or information of the type sent. Communications and documents that may be delivered electronically include this *Agreement*, the annual renewal notice, and other communications between Group and Health Plan as allowed by law to be delivered electronically. A notice of termination will not be delivered electronically.

Group may opt-out of electronic delivery of communications and documents at any time by providing notice to Health Plan.

Enrollment Application Requirements

Group must use enrollment application forms that are provided by Health Plan. If Group wants to use a different form or system for enrolling Members, Group must obtain Health Plan's prior approval of the form or system. Other forms and systems include a "universal" enrollment application form, interactive voice recording (IVR) enrollment system, or intranet online enrollment system. All forms and systems must meet Health Plan requirements for enrolling Members, including disclosure of binding arbitration in accord with Section 1363.1 of the California Health and Safety Code and other applicable law. Group must retain documentation of each Member's acceptance of the use of binding arbitration indefinitely, and upon request, must be able to produce documentation relating to a specific Member to Health Plan at any time. In the event that the contract between Health Plan and Group terminates or Group is unable to comply with this document retention requirement, Group must transfer possession of all such documentation to Health Plan in a mutually

agreeable manner. Group's Kaiser Permanente representative can provide Group with Health Plan's current requirements for enrollment application forms and systems.

Grandfathered Health Plan Coverage

For any coverage identified in an EOC as a "grandfathered health plan" under the Patient Protection and Affordable Care Act and regulations, Group must immediately inform Health Plan if this coverage does not meet (or no longer meets) the requirements for grandfathered status including but not limited to any change in its contribution rate to the cost of any grandfathered health plans during the plan year. Group represents that, for any coverage identified as a "grandfathered health plan" in the applicable *EOC*, Group has not decreased its contribution rate more than five percent (5%) for any rate tier for such grandfathered health plan when compared to the contribution rate in effect on March 23, 2010 for the same plan. Health Plan will rely on Group's representation in issuing and continuing any and all grandfathered health plan coverage.

Governing Law

Except as preempted by federal law, this *Agreement* will be governed in accord with California law and any provision that is required to be in this *Agreement* by state or federal law, shall bind Group and Health Plan whether or not set forth in this *Agreement*.

Member Information

Group will inform Members and prospective Members of eligibility requirements for Subscribers and Dependents and when coverage becomes effective and terminates.

When Health Plan notifies Group about changes to this *Agreement* or provides Group other information that affects Members, Group will disseminate the information to Members by the next regular communication to them, but in no event later than 30 days after Group receives the information.

For each Health Plan coverage included in this *Agreement*, Health Plan will provide Group with the following disclosures for Group to distribute in accord with applicable laws ("Member Materials"):

- A *Disclosure Form* (*DF*) for each non-Medicare coverage. Group will provide *DFs* (or combined *EOC/DFs*) to Subscribers and potential Subscribers when the coverage is offered
- A *Summary of Benefits and Coverage* (*SBC*) for each non-Medicare coverage other than retiree plans with fewer than two current employees. Group will provide electronic or paper *SBCs* to Members and potential Members to the extent required by law, except that Health Plan will provide *SBCs* to Members who make a request to Health Plan
- An *EOC* for each non-Medicare coverage. Group will provide *EOCs* (or combined *EOC/DFs*) to Subscribers, except that Health Plan will provide *EOCs* (or combined *EOC/DFs*) to Members and potential Members who make a request to Health Plan

If Group receives the *Agreement* or Member Materials in electronic form, Group is not authorized to modify or alter in any way the text or the formatting of the electronic *Agreement* or Member Materials.

Health Plan assumes no responsibility for any changes in text or formatting that may occur in the *Agreement* or Member Materials after they are provided to Group. If Group posts the electronic *Agreement* or Member Materials on its intranet site, it shall do so in such a way so as to permit employees of Group to download and print a complete and accurate copy of the *Agreement* or Member Materials.

In the event Health Plan reasonably concludes that Group is either using the electronic *Agreement* or Member Materials in a manner not permitted by this *Agreement* or is not providing Subscribers with access to the Member Materials in accord with applicable laws, then Health Plan will print copies of the *Agreement* or Member Materials and Group will cooperate

with Health Plan to ensure that printed copies of the *Agreement* or Member Materials are provided in a timely manner to all employees of Group enrolled with Health Plan. Group agrees to reimburse Health Plan for the reasonable cost of printing and delivering the *Agreement* or Member Materials.

No Waiver

Health Plan's failure to enforce any provision of this *Agreement* will not constitute a waiver of that or any other provision, or impair Health Plan's right thereafter to require Group's strict performance of any provision.

Nonduplication Agreement

Health Plan agrees to undertake performance of the following regulatory requirements, and Group may rely on Health Plan's performance in order to satisfy its obligation to perform the same activities with respect to the health plan coverages issued to Group by Health Plan:

- Preparation and publication of machine-readable files on a public website for in-network rates and billed charges and allowed amounts for out-of-network providers in the required form and manner as set forth in applicable regulations and any sub-regulatory guidance
- Provision of an internet, self-service tool as well as paper reports and telephone assistance to provide personalized estimates of cost sharing for 500 shoppable services beginning on January 1, 2023, and for all covered services as of January 1, 2024 as set forth in applicable regulations and any sub-regulatory guidance
- Annual reporting of prescription drug and health care costs reporting required to be furnished in accordance with applicable regulations and any sub-regulatory guidance
- Publication of a consumer notice regarding federal and, when applicable, any state legal requirements related to balance billing by non-participating providers in accordance with applicable regulations and any sub-regulatory guidance
- Annual reporting of data related to the provision and cost of air ambulance services for 2022 and 2023 in the required form and manner as set forth in applicable regulations and any sub-regulatory guidance
- Annual submission of a Gag Clause Prohibition Compliance Attestation in the required form and manner as set forth in applicable regulations, if any, and sub-regulatory guidance

Notice

Notice under this Agreement shall be in writing and is deemed given when delivered in person or deposited in the U.S. mail. Notice may also be provided by email if Group has furnished its email address as part of its address of record, and as allowed by law. Health Plan or Group may change its addresses, or email address, for notices by giving written notice to the other.

Notices from Health Plan to Group will be sent to:

Covered California for Small Business
P.O. Box 7010
Newport Beach, CA 92658

Notices from Group to Health Plan will be sent to:

Groups located in Health Plan's Northern California Region
Kaiser Permanente
California Service Center
P.O. Box 23219
San Diego, CA 92193-3219

Groups located in Health Plan's Southern California Region
Kaiser Permanente
California Service Center
P.O. Box 23250
San Diego, CA 92193-3250

Open Enrollment

Group must hold an annual open enrollment period during which all eligible people, in accord with state law, may enroll in Health Plan or in any other health care plan available through Group. Also, Group must not hold open enrollment for 2027 until Group receives its 2027 group agreement Premium and coverage information from Health Plan. If Group holds the open enrollment without receiving 2027 group agreement Premium and coverage information, Health Plan may change Premiums and coverage (including benefits and Cost Sharing) when it offers to renew Group's Agreement as described under "Renewal" in the "Term of Agreement and Renewal" section.

Other Group coverage that covers Essential Health Benefits

For each non-grandfathered non-Medicare Health Plan coverage, except for any retiree-only coverage, Group must do all of the following if Group provides Health Plan Members with other medical or dental coverage (for example, separate pharmacy coverage) that covers any Essential Health Benefits:

- Notify Health Plan of the out-of-pocket maximum (OOPM) that applies to the Essential Health Benefits in each of the other medical or dental coverage.
- Ensure that the sum of the OOPM in Health Plan's coverage plus the OOPMs that apply to Essential Health Benefits in all of the other medical and dental coverage does not exceed the annual limitation on cost sharing described in 45 CFR 156.130.

Reporting Membership Changes and Retroactivity

Group must report membership changes (including sending appropriate membership forms) within the time limit for retroactive changes and in accord with any applicable "rescission" provisions of the Patient Protection and Affordable Care Act and regulations. The time limit for retroactive membership changes, except retroactive membership additions, is the calendar month when Health Plan's California Service Center receives Group's notification of the change. For example, if Group wants June 1 to be the first day that the Member is not covered, Health Plan's California Service Center must receive Group's notification no later than the end of June.

The time limit for retroactive membership additions is the calendar month when Health Plan's California Service Center receives Group's notification of the change plus the previous two months. For example, if Group wants June 1 to be the first day that the member is to be covered, Health Plan's California Service Center must receive Group's notification no later than the end of August.

Group must send membership changes to the following address:

Kaiser Permanente
California Service Center
P.O. Box 23219
San Diego, CA 92193-3219

Representation regarding communication of membership changes

Group represents that its communication regarding membership changes to Health Plan is accurate. Group and its representative are bound by all membership data, including any changes or updates that it, or its representative, submits to Health Plan via any medium, electronic or otherwise, including but not limited to the following:

- Electronic data submissions regarding enrollment and eligibility
- Health Plan approved online tool for submission of data
- Paper enrollments submitted through postal mail or fax

Health Plan's Administrative Handbook includes the details about how to report membership changes. Group's Kaiser Permanente representative can provide Group with an Administrative Handbook if Group does not have one.

Representation Regarding Waiting Periods

By entering into this Agreement, Group hereby represents that Group does not impose a waiting period exceeding 90 days on employees who meet Group's eligibility requirements. For purposes of this requirement, a "waiting period" is the period that must pass before coverage for an individual who is otherwise eligible to enroll in non-Medicare coverage under the terms of a group health plan can become effective in accord with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.

In addition, Group represents that eligibility data provided by the Group to Health Plan will include coverage effective dates for Group's employees that correctly account for eligibility in compliance with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations and will not exceed the waiting period established by Group. For example, if the hire date of an otherwise-eligible employee is January 19, the waiting period begins on January 19 and the effective date of coverage cannot be any later than April 19. Note: Because the effective date of your Group's coverage is always on the first day of the month, in this example the effective date cannot be any later than April 1.

Right to Examine Records

Upon reasonable notice, Health Plan may examine Group's records with respect to contribution and participation requirements, eligibility, and payments under this *Agreement***.**

Social Security and Tax Identification Numbers

Within 60 days after Health Plan sends Group a written request, Group will send Health Plan a list of all Members covered under this Agreement, along with the following:

- The Social Security number of the Member
- The tax identification number of the employer of the Subscriber in the Member's Family
- Any other information that Health Plan is required by law to collect

Premiums

Only Members for whom Health Plan (or its designee) has received the Full Premium payment as described below are entitled to coverage under this *Agreement*, and then only for the period for which Health Plan (or its designee) has received required Premium payment. Group is responsible for paying Premiums, except that Members who have Cal-COBRA coverage under an *EOC* that is included in this *Agreement* are responsible for paying Premiums for Cal-COBRA coverage.

Premiums due under this *Agreement* include premiums for dental services underwritten by Delta Dental of California, as described in the Delta Dental Contract.

Due Date and Payment of Premiums

The payment due date for each enrollment unit (or subgroup) associated with Group will be reflected on the monthly membership invoice if applicable to Group (if not applicable, then as specified in writing by Health Plan). If Group does not pay Full Premiums by the first of the coverage month, the Premiums may include an additional administrative charge upon renewal. "Full Premiums" means 100 percent of monthly Premiums for all of the coverage issued to each enrolled Member, as set forth under "Calculating Premiums" in this "Premiums" section.

New Members

Premiums are payable for a new Member for the entire month when the Member's coverage effective date is any day during that month.

Note: Membership begins at the beginning (12:00 a.m.) of the effective date of coverage.

Membership Termination

Premiums are payable for the entire month for a Member whose last day of coverage is any day during that month.

Note: The membership termination date is the first day a Member is not covered (for example, if the termination date is January 1, 2027, the last minute of coverage was at 11:59 p.m. on December 31, 2026).

Premium Rebates

If state or federal law requires Health Plan to rebate premiums from this or any earlier contract year and Health Plan rebates premiums to Group, Group represents that Group will use that rebate for the benefit of Members, in a manner consistent with the requirements of the Public Health Service Act and the Affordable Care Act and if applicable with the obligations of a fiduciary under the Employee Retirement Income Security Act (ERISA).

Calculating Premiums

To calculate the amount of Full Premiums that apply to a Family, first determine whether the Family is enrolled under a grandfathered plan or a metal tier plan (metal tier plans have "Platinum," "Gold," "Silver," or "Bronze" in the plan name):

- If the Family is enrolled under a grandfathered plan, follow the steps under "Rate rules for grandfathered coverage" below
- If the Family is enrolled under a metal tier plan, follow the steps under "Rate rules for metal tier coverage" below

Rate rules for grandfathered coverage

To calculate the amount of Full Premiums that apply to a Family (a Subscriber and all of their Dependents):

1. For the medical plan, identify Premiums in the applicable table below based on the age of the Subscriber and the family role type of each Member (see the "Definitions" section of the EOC for the definition of Subscriber, Dependent, and Spouse). If there are more than one dependent children under age 26, then no extra premium cost is applied to the second or more children.
2. If the Family has any Ancillary Coverage (chiropractic, acupuncture, and dental coverage), identify the Premiums based on the family role type of each Member. If Ancillary Coverage has been issued under a separate contract and Premiums for that coverage are not listed in the tables below, refer to that contract for Premiums. This Ancillary Coverage is part of the contract options selected by Group, and Group submits payment for this Ancillary Coverage as part of Full Premiums. If there are more than one dependent children under age 26, then no extra premium cost is applied to the second or more children.
3. For each member of the Family, add the amount of Premiums for medical and Ancillary Coverage together to arrive at the total, Full Premiums required for the Family.

Rate rules for metal tier coverage

To calculate the amount of Full Premiums that apply to a Family (a Subscriber and all of their Dependents):

1. For the medical plan, identify the Premiums in the applicable table below based on each Member's age. For Dependent children under age 26, the following applies:
   - **Children under age 21:** Include Premiums for no more than three children (additional Dependent children under age 21 are covered at no additional Premium).
   - **Children age 21 to 25:** Include Premiums for all children.
2. If the Family has family dental coverage, identify the Premiums based on the family role type of each Member (see the "Definitions" section of the EOC for the definition of Subscriber, Dependent, and Spouse). If the family dental coverage has been issued under a separate contract and Premiums for that coverage are not listed in the Premium tables below, refer to that contract for Premiums. This family dental coverage is part of the contract options selected by Group, and Group submits payment for this family dental coverage as part of Full Premiums.
3. For each member of the Family, add the amount of Premiums for medical and family dental coverage together to arrive at the total, Full Premiums required for the Family.

Delta Dental Contract

The Delta Dental Contract provides important information about pediatric dental coverage. To view or download a copy of the Delta Dental Contract or a Summary of Dental Benefits and Coverage, go to **www1.deltadentalins.com/kaiserpediatrics**. To obtain printed versions of these documents, call Delta Dental Customer Care at 800-589-4618.

Agreement Signature Page

Acceptance of *Agreement*

Group acknowledges acceptance of this *Agreement* by signing the Signature Page and returning it to Health Plan. If Group does not return it to Health Plan, Group will be deemed as having accepted this *Agreement* if Group pays Health Plan any amount toward Premiums.

Group may **not** change this *Agreement* by adding or deleting words, and any such addition or deletion is void. Health Plan might not respond to any changes or comments submitted on or with this Signature Page. Group may not construe Health Plan's lack of response to any submitted changes or comments to imply acceptance. If Group wishes to change anything in this *Agreement*, Group must contact its Kaiser Permanente representative. Health Plan will issue a new *Agreement* or amendment if Health Plan and Group agree on any changes.

A signature on this *Agreement* serves to bind Group to the dental coverage underwritten by Delta Dental of California, as described in the Delta Dental Contract as though Group had separately executed the Delta Dental Contract.

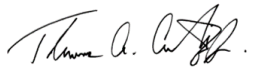
Binding Arbitration

As more fully set forth in the arbitration provision in the applicable *Evidence of Coverage*, disputes between Members, their heirs, relatives, or associated parties (on the one hand) and Health Plan, Kaiser Permanente health care providers, or other associated parties (on the other hand) for alleged violation of any duty arising out of or related to this *Agreement*, including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this *Agreement*, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. Members enrolled under this *Agreement* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the applicable *Evidence of Coverage* except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeals procedure as applicable to Kaiser Permanente Senior Advantage Members
- Claims that cannot be subject to binding arbitration under governing law

Signatures

Kaiser Foundation Health Plan, Inc., Northern and Southern California Regions



Thomas A. Curtin Jr.
Authorized officer
Senior Vice President, Commercial Group Business
July 9, 2025

COVERED CALIFORNIA FOR SMALL BUSINESS

Authorized Group officer signature

Print name and title Date

Please keep this copy of the signature page with your *Agreement*. An extra copy is included in your contract package to sign and return:

- **By mail:** Kaiser Permanente, California Service Center, P.O. Box 23448, San Diego, CA 92193-3448.
- **By fax:** 1-855-355-5334