UnitedHealthcare Benefits Plan of California

Group Policy

for

HUNEEUS VINTNERS LLC

UnitedHealthcare Select Plus

Group Number: 1660169

Health Plan: DIAB

Prescription Code: L46S

Effective Date: August 1, 2024

Medical and Hospital Group Subscriber Agreement

UnitedHealthcare Benefits Plan of California

185 Asylum Street

Hartford, Connecticut 06103-3408

1-800-357-1371

This Medical and Hospital Group Subscriber Agreement (the Agreement) is entered into by UnitedHealthcare Benefits Plan of California (UnitedHealthcare), a California corporation, and the "Group," as described in Exhibit 1.

When used in this document, the words "we," "us," and "our" refer to UnitedHealthcare Benefits Plan of California.

Upon our receipt of the signed Group *Application* and payment of the first Agreement Charge, this Agreement is executed. The Group's *Application* is made a part of this Group Subscriber Agreement (Agreement).

We agree to provide Benefits for Covered Health Care Services stated in this Agreement, including the attached *Combined Evidence of Coverage and Disclosure Form(s)* and *Schedule(s) of Benefits*, subject to the terms, conditions, exclusions, and limitations of this Agreement. This Agreement replaces and overrules any previous agreements relating to Benefits for Covered Health Care Services between the Group and us. The terms and conditions of this Agreement will in turn be overruled by those of any future agreements relating to Benefits for Covered Health Care Services between the Group and us.

We are not an employer or plan administrator for any purpose with respect to the administration or provision of benefits under the Group's benefit plan. We are not responsible for fulfilling any duties or obligations of an employer or plan administrator with respect to the Group's benefit plan.

This Agreement is effective on the date shown in Exhibit 1 and continues in force by the timely payment of the required Agreement Charges when due, subject to the end of this Agreement as provided in Article 5.

When this Agreement ends, as described in Article 5, this Agreement and all Benefits under this Agreement will end at 12:00 midnight on the date the Agreement ends.

This Agreement is issued as described in Exhibit 1.

Issued By:

UnitedHealthcare Benefits Plan of California

Jessica Paik, President

Article 1: Glossary of Defined Terms

The terms used in this Agreement have the same meanings as those defined in *Section 9: Defined Terms* in the attached *Combined Evidence of Coverage and Disclosure Form*. In addition, the following terms apply:

Agreement - is this Medical and Hospital Group Subscriber Agreement, including Exhibits and Amendments.

Combined Evidence of Coverage and Disclosure Form - is the document issued to prospective and enrollee Subscribers disclosing and setting for the benefits and terms and conditions of coverage to which the Members of the Health Plan are entitled,

Co-insurance - the charge, stated as a percentage of the Allowed Amount, that you are required to pay for certain Covered Health Care Services.

Co-payments - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Care Services.

Coverage Classification - one of the categories of coverage described in Exhibit 2 for rating purposes (for example: Subscriber only, Subscriber and spouse or Domestic Partner, Subscriber and children, Subscriber and family).

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner, except for the purpose of coordinating Benefits with Medicare. As described in the *Combined Evidence of Coverage and Disclosure Form, Section 3: When Coverage Begins*, the Group determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse or Domestic Partner.
- A child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order.*

Domestic Partner - person who has filed a declaration of domestic partnership with the California Secretary of State or a person who meets the eligibility requirements, as defined by the Enrolling Group, and the following:

- Is eighteen (18) years of age or older. An exception is provided to Eligible Persons and/or Dependents less than 18 years of age who have, in accordance with California law, obtained:
  - Written consent from the underage person's parents or legal guardian and a court order granting permission to the underage person to establish a domestic partnership.
  - A court order establishing a domestic partnership if the underage person does not have a parent or legal guardian or a parent or legal guardian capable of consenting to the domestic partnership.
- Is mentally competent to consent to contract.
- Is unmarried or not a member of another domestic partnership.
- Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the state of residence.

Group - the employer, or other defined or otherwise legally established group, to whom the Agreement is issued

Health Plan -.is the health plan described in the Medical and Hospital Subscriber Agreement, Exhibits and Amendments subject to modifications pursuant to the terms of this Agreement.

Material Misrepresentation - any oral or written communication or conduct, or combination of communication and conduct, that is untrue and is intended to create a misleading impression in the mind of another person. A misrepresentation is material if a reasonable person would attach importance to it in making a decision or determining a course of action, including but not limited to, the issuance of an Agreement or coverage under a policy, calculation of rates, or payment of a claim.

Member - is the Subscriber or any Covered Dependents who is eligible, enrolled and covered by the Health Plan.

Open Enrollment Period - a period of time, after the Initial Enrollment Period, when Eligible Persons may enroll themselves and Dependents under the Agreement. The Group sets the period of time that is the Open Enrollment Period

Premiums - the amounts established by UnitedHealthcare Benefits Plan of California to be paid by the Group on behalf of Members in consideration of the benefits provided under the Health Plan and set forth in the Schedule of Premium Rate in Exhibit 2 of this Agreement.

Service Area - the State of California or any other geographical area within the state designated in the Agreement within which Network provider services are rendered to Covered Members for Covered Health Care Services.

Subscriber - an Eligible Employee who is properly enrolled under the Agreement for whom the appropriate Premium has been received by UnitedHealthcare Benefits Plan of California, and whose employment or other status, except for family dependency, is the basis for enrollment eligibility. The Subscriber is the person (who is not a Dependent) on whose behalf the Agreement is issued to the Group.

Article 2: Benefits

Subscribers and their Enrolled Dependents are entitled to Benefits for Covered Health Care Services subject to the terms, conditions, limitations and exclusions stated in the *Combined Evidence of Coverage and Disclosure Form(s)* and *Schedule(s) of Benefits* attached to this Agreement. Each *Combined Evidence of Coverage and Disclosure Form* and *Schedule of Benefits*, including any Riders and Amendments, describes the Covered Health Care Services, required Co-payments, and the terms, conditions, limitations and exclusions related to coverage.

Article 3: Premium Rates and Agreement Charge

3.1 Premiums

Monthly Premiums payable by or on behalf of Covered Members are shown in the *Schedule of Premium Rates* in Exhibit 2 of this Agreement or in any attached *Notice of Change.*

We have the right to change the *Schedule of Premium Rates* as described in Exhibit 1 of this Agreement.

3.2 How Is the Agreement Charge Calculated?

The Agreement Charge will be calculated based on the number of Subscribers in each Coverage Classification that we show in our records at the time of calculation. The Agreement Charge will be calculated using the Premium rates in effect at that time. Exhibit 1 describes the way in which the Agreement Charge is calculated.

The Group is solely responsible for enrollment and Coverage Classification changes (including the end of a Covered Member's coverage) and for the timely payment of the Agreement Charges.

3.3 When Is the Agreement Charge Adjusted?

We may make retroactive adjustments for any additions or terminations of Subscribers or changes in Coverage Classification that are not reflected in our records at the time we calculate the Agreement Charge. We will not grant retroactive credit for any change happening more than 60 days prior to the date we received notification of the change from the Group. We also will not grant retroactive credit for any calendar month in which a Subscriber has received Benefits.

The Group must notify us in writing, through our electronic systems, or by other methods as determined by us within 60 days of the effective date of enrollments, terminations, or other changes. The Group must notify us in writing, through our electronic systems, or by other methods as determined by us each month of any change in the Coverage Classification for any Subscriber.

If premium taxes, guarantee or uninsured fund assessments, or other governmental charges relating to or calculated in regard to Premium are either imposed or increased, those charges will be added to the Premium at that time. In addition, any change in law or regulation that affects our cost of operation may result in an increase in Premium in an amount we determine.

3.4 How Is the Agreement Charge Paid?

The Agreement Charge is payable to us in advance by the Group as described under "Payment of the Agreement Charge" in Exhibit 1. The Group agrees to remit to us the Agreement Charge due which is based on our enrollment records as provided by the Group at the time the invoice for the Agreement Charge is issued. The first Agreement Charge is due and payable on or before the effective date of this Agreement. Future Agreement Charges are due and payable no later than the first day of each payment period shown in item 6 of Exhibit 1, while this Agreement is in force. If the Agreement Charge remains unpaid, the Policy will end as described below under *5.1 When Does the Group Subscriber Agreement End?*

All payments shall be made in United States currency, in immediately available funds, and shall be sent to us at the address on the invoice, or at another address that we may designate in writing. The Group agrees not to send us payments marked "paid in full", "without recourse", or similar language. In the event that the Group sends such a payment, we may accept it without losing any of our rights under this Agreement and the Group will remain obligated to pay any and all amounts owed to us.

There will be a service charge added to the Group's account for any check returned for non-sufficient funds.

The Group will reimburse any attorney's fees and costs related to collecting past due Agreement Charges.

3.5 Does a Grace Period Apply?

A grace period of 31 days will be granted for the payment of any Agreement Charge not paid when due. During the grace period, this Agreement will continue in force. The grace period will not extend beyond the date this Agreement ends.

The Group is responsible for payment of the Agreement Charge during the grace period. If we receive written notice from the Group to end this Agreement during the grace period, we will adjust the Agreement Charge so that it applies only to the number of days this Agreement was in force during the grace period.

This Agreement ends as described in Article 5.1 after the grace period expires. UnitedHealthcare will send a Notice of End of Coverage with appeal rights to the Group and directly to the Subscribers. A new application for coverage is required upon termination of coverage.

Article 4: Eligibility and Enrollment

4.1 What Are the Eligibility Rules?

The eligibility rules are the requirements the Group must use to determine who is eligible for coverage under the Agreement. The eligibility rules must be applied consistently and can be found in this Agreement, Group Application, and within the *Combined Evidence of Coverage and Disclosure Form*.

We provide coverage, from and after the moment of birth, to each newborn infant of any Subscriber or spouse covered and to each minor child placed for adoption from and after the date on which the adoptive child's birth parent or other appropriate legal authority signs a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or a relinquishment form, granting the Subscriber or spouse the right to control health care for the adoptive child or, absent this written document, on the date there exists evidence of the Subscriber's or spouse's right to control the health care of the child placed for adoption.

Coverage is provided for a dependent child of a Subscriber up to age 26 with exceptions for a total disability.

In the event a child whose coverage ends under a group or individual contract or who was denied coverage or not eligible for coverage under a group or individual contract before reaching 26 years and becomes eligible prior to reaching age 26 will have a 30 day special enrollment period as determined eligible by the Group. The Group is obligated to provide notice to the Subscriber, on behalf of the dependent, of the right to enroll in coverage.

4.2 Initial Enrollment Period

Eligible Subscribers and their Dependents may enroll for coverage under this Agreement during the Initial Enrollment Period. The Initial Enrollment Period is set by the Group.

4.3 Open Enrollment Period

An Open Enrollment Period will be provided for each class, as shown in Exhibit 2. During an Open Enrollment Period, Eligible Members may enroll for coverage under this Agreement.

4.4 Effective Date of Coverage

The effective date of coverage for enrolled Eligible Members and their Dependents is stated in Exhibit 2.

4.5 Application Form

A completed Application provided by UnitedHealthcare or on a non-standard form approved by UnitedHealthcare must be submitted to UnitedHealthcare by Group for each eligible and/or prospective Subscriber on behalf of the eligible and or prospective Subscriber and eligible Dependents. UnitedHealthcare may accept enrollment through electronic submission from Group.

4.6 Waiver Form

The Group agrees to provide each individual who declines coverage with a form to be signed at the time they are initially eligible to enroll for coverage. The form states that an individual who declines coverage during the Initial Enrollment Period acknowledges that we may, at the time of the individual's later decision to elect coverage, consider the individual a late enrollee.

The Group agrees to retain a copy of the individual's signed acknowledgment and forward a copy of the acknowledgment to us when requested.

4.7 Late Enrollment

Late enrollment is addressed in Section 3: When Coverage Begins of in the attached *Combined Evidence of Coverage and Disclosure Form*.

4.8 Liability in the Event of Conversion from a Prior Carrier

In the event UnitedHealthcare replaces a prior carrier responsible for the payment of benefits or provision of services under a group contract within a period of sixty (60) days from the date of discontinuation of the prior contract or policy, UnitedHealthcare will immediately cover all employees and dependents who were validly covered under the previous contract or policy at the date of discontinuation, and who are eligible for enrollment under this Agreement, without regard to health status or hospital confinement. Notwithstanding the foregoing, with respect to employees or dependents who were totally disabled on the date of discontinuation of the prior contract or policy, and entitled to an extension of benefits pursuant to Section 1399.62 of the California Health & Safety Code or Section 10128.2 of the California Insurance Code under the prior contract or policy, UnitedHealthcare shall not be financially responsible for any payment of benefits or provision of services directly related to any condition which caused the total disability. In such a situation, the prior carrier shall continue to be financially responsible for all benefits or services directly related to any condition which caused the total disability until such extension of benefits is no longer required under California or federal law.

Article 5: End of Group Subscriber Agreement

5.1 When Does the Group Subscriber Agreement End?

This Agreement and all Benefits for Covered Health Care Services will automatically end on the earliest of the dates shown below:

A. Prospectively only after the end of the grace period. For failure to pay premiums, please refer to Section 3.5. We will send a notice of termination with appeal rights to the Group. We will provide coverage during the grace period. The Group remains responsible for payment of the Agreement Charge for the period of time this Group Subscriber Agreement remained in force during the grace period.

B. On the date specified by the Group, after at least 31 days prior written notice to us that this Agreement will end.

C. On the date we specify, after at least 30 days prior written notice to the Group, that this Agreement will end due to a violation of a material contract provision relating to the Group's contribution or Group's participation rates as shown in Exhibit 1.

D. On the date we specify, after at least 30 days prior written notice to the Group, that this Agreement will end because the Group performed an act, practice or omission that constituted fraud or made an intentional misrepresentation of a fact that was material to the execution of this Agreement or to the provision of coverage under this Agreement. In this case, we have the right to rescind this Agreement, subject to the requirements of § 1389.21(c) of the Knox-Keene Act governing this Agreement back to either:

   - The effective date of this Agreement.
   - The date of the act, practice or omission, if later.

   UnitedHealthcare will send a notice to the Group and Subscriber via mail at least 30 days prior to the effective date of the rescission explaining the reason for the rescission and notifying them of their right to appeal pursuant to Section 5.3.

   UnitedHealthcare shall not rescind this Agreement for any reason after 24 months from the date of issuance of this Agreement pursuant to Section 6.3.

E. On the date we specify, after at least 90 days prior written notice to the Director of the Department of Managed Health Care and Group and Subscribers, that this Agreement will end because we will no longer issue this particular type of group health benefit plan within the applicable market. We shall make available to the Group all other health plans offered to new group business. In offering the option of other health plans, UnitedHealthcare shall act uniformly without regard to the claims experience of the Group or any health-status related factor relating to Members, Eligible Employees or their eligible Dependents.

F. On the date we specify, after at least 180 days prior written notice to the Director of the Department of Managed Health Care, the Subscribers and to the Group, and that this Agreement will end because we will no longer issue any employer health benefit plan within the applicable market in the state of California.

The Group is required (i) to promptly mail to each Subscriber a legible, true copy of any notice of cancellation of this Agreement which may be received from us, and (ii) to provide promptly to us proof of such mailing and the date thereof.

For questions on appeals, please refer to your *Combined Evidence of Coverage and Disclosure Form*, *Section 6: Question, Complaints and Appeals* for more information.

5.2 Payment When the Group Subscriber Agreement Ends

When the Agreement ends, the Group is and will remain responsible to us for the payment of any and all Premiums which are unpaid at the time the Agreement ends. This will include a pro rata portion of the Agreement Charge for any period this Agreement was in force during any grace period preceding the end of the Agreement.

In the event of cancellation by either the plan (except in the case of fraud or deception in the use of services or facilities of the plan or knowingly permitting such fraud or deception by another) or the other party, we will within 30 days return to the Group the pro rata portion of the money paid to us which corresponds to any unexpired period for which payment had been received together with amounts due on claims, if any, less any amounts due to us.

If group coverage is terminated, the Group must file a new application for coverage and meet the requirements of § 1357.503(e).

5.3 Review by the California Department of Managed Health Care for Improper Cancellation, Rescission or Non-Renewal of Coverage

Group or Member may request a review by the California Department of Managed Health Care in the event of an alleged improper cancellation, rescission or non-renewal of this Agreement by UnitedHealthcare. The California Department of Managed Health Care shall notify UnitedHealthcare or Member if a proper complaint exists and its final determination. If the Group or Member requests a review of UnitedHealthcare's determination to cancel, rescind or non-renew this Agreement, UnitedHealthcare will continue to provide coverage to the Member under the terms of this Agreement until a final determination is made by the California Department of Managed Health Care.

A Member or Group may submit a request for review to UnitedHealthcare regarding a cancellation, rescission or nonrenewal. UnitedHealthcare will provide the California Department of Managed Health Care, the Member or the Group, as applicable, with disposition or status within three (3) calendar days of receipt.

5.4 Reinstatement Following Determination of Improper Cancellation, Rescission or Non-Renewal of Coverage

In the event the California Department of Managed Health Care determines UnitedHealthcare improperly canceled, rescinded or non-renewed this Agreement or a Member's coverage under the Health Plan, UnitedHealthcare will reinstate this Agreement or the Member's coverage under the Health Plan as though it had never been terminated. UnitedHealthcare will reimburse the Member within 30 days of receipt of a completed claim for any expenses incurred for covered services, as set forth in the *Combined Evidence of Coverage and Disclosure Form*, the Schedule of Benefits, and the Schedule of Supplemental Benefits. This provision does not apply to termination due to non-payment of Health Plan Premiums. A member or the group, as applicable, must pay all outstanding premiums before reinstatement.

Within 15 days after receipt of a Department order to reinstate coverage, UnitedHealthcare will reinstate this Agreement or the Member's coverage under the Health Plan or request for hearing with the Department.

Article 6: General Provisions

6.1 What Is the Entire Group Subscriber Agreement?

This Agreement, the Combined Evidence of Coverage and Disclosure Form(s), the Schedule(s) of Benefits, the Group Application, and any Amendments, Notices of Change, and Riders, make up the entire Group Subscriber Agreement. A description of Benefits and conditions of coverage of this Health Plan are included in the *Combined Evidence of Coverage and Disclosure Forms* and Riders.

6.2 Dispute Resolution and Binding Arbitration Requirements

This Agreement requires that disputes be resolved in binding arbitration. You are waiving your right to sue UnitedHealthcare Benefits Plan of California in court to resolve a dispute. You are waiving your right to a jury trial.

No legal proceeding or action may be brought until the parties have attempted, in good faith, to resolve the dispute amongst themselves. In the event the dispute is not resolved within 30 days after one party has received written notice of the dispute from the other party, and either party wishes to pursue the dispute further, the dispute may be submitted to arbitration as noted below.

The parties acknowledge that because this Agreement affects interstate commerce, the Federal Arbitration Act applies. If the Group wishes to seek further review of the decision or the complaint or dispute, it must submit the decision, complaint or dispute to binding arbitration according to the rules of the American Arbitration Association. This is the only right the Group has for further consideration of any dispute that arises out of or is related to this Agreement.

If a claim for medical malpractice seeks total damages of $50,000 or less, the claim or dispute shall provide for selection by the parties of a single neutral arbitrator who shall have no jurisdiction to award more than $50,000. If the parties are unable to agree on the selection of a single arbitrator, the following method shall be utilized:

- If the arbitration agreement provides a method of appointing an arbitrator, that method shall be followed.
- If the arbitration agreement does not provide a method for appointing an arbitrator, the parties to the agreement who seek arbitration and against whom is sought may agree on a method of appointing an arbitrator and that method shall be followed.
- In the absence of an agreed method, or if the agreed method fails for any reason cannot be followed, or when an arbitrator appointed fails to act and his or her successor has not been appointed, the court, on petition of a party to the arbitration agreement, shall appoint the arbitrator. When petition is made to the court to appoint a neutral arbitrator, the court shall nominate five persons from lists of persons supplied jointly by the parties to the arbitration or obtained from a governmental agency concerned with arbitration or private disinterested association concerned with arbitration. The parties to the agreement who seek arbitration and against whom arbitration is sought may within five days of receipt of notice of the nominees from the court jointly select the arbitrator whether or not the arbitrator is among the nominees. If the parties fail to select an arbitrator within the five-day period, the court shall appoint the arbitrator from the nominee.

Arbitration will take place in Orange County, California.

The matter must be submitted to binding arbitration within one year of the date notice of the dispute was received. The arbitrators will have no power to award any punitive or exemplary damages or to vary or ignore the provisions of this Agreement, and will be bound by controlling law.

6.3 Time Limit on Certain Defenses

After it has been in force for a period of more than 24 months, We cannot rescind the policy for any reason, and shall not cancel the policy, limit any of the provisions of the policy, or raise premiums on the policy due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not.

6.4 Amendments and Alterations

Amendments and new Riders to this Agreement are effective upon the Group's next anniversary date, except as otherwise permitted by law. Amendments based on changes to state or federal mandates to this Amendment are effective 31 days after we send written notice to the Group. Other than changes to Exhibit 2 stated in a *Notice of Change* to Exhibit 2, no change will be made to this Agreement unless made by an Amendment or a Rider which is signed by one of our authorized executive officers and consistent with applicable notice requirements. No agent has authority to change this Agreement or to waive any of its provisions.

6.5 Our Relationship with Providers and Groups

The relationships between us and Network providers, and relationships between us and Groups, are solely contractual relationships between independent contractors. Network providers and Groups are not our agents or employees, nor are we or any of our employees an agent or employee of Network providers or Groups.

The relationship between a Network provider and any Covered Member is that of provider and patient. The Network provider is solely responsible for the services provided. The relationship between any Group and any Covered Member is that of employer and employee, Dependent, or any other category of Covered Member described in the Coverage Classifications shown in this Agreement.

The Group is solely responsible for enrollment and Coverage Classification changes (including the end of a Covered Member's coverage) and for the timely payment of the Agreement Charges.

6.6 Records

We may require information related to the Agreement, from the Group. Upon request, the Group must provide us with the requested information and proofs which may include:

- All documents provided to the Group by an individual in connection with coverage.
- The Group's payroll.
- Any other records pertinent to the coverage under this Agreement.

By accepting Benefits under this Agreement, each Covered Member authorizes and directs any person or institution that has provided services to him or her, to provide us or our designees any and all information and records or copies of records relating to the health care services provided to the Covered Member. We have the right to request this information at any reasonable time. This applies to all Covered Members, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form.

We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are needed to administer the terms of this Agreement including records for appropriate medical and quality review or as required by law or regulation.

During and after the term of this Agreement, we and our related entities may use and transfer the information gathered under this Agreement for research and analytic purposes subject to applicable state and federal confidentiality laws.

6.7 Administrative Services

The services needed to administer this Agreement and the Benefits provided under it will be provided in accordance with our standard administrative procedures or those standard administrative procedures of our designee. If the Group requests that administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, the Group must pay for such services or reports at the then current charges for such services or reports.

We may offer to provide administrative services to the Group for certain wellness programs including, but not limited to, fitness programs, biometric screening programs and wellness coaching programs.

6.8 Employee Retirement Income Security Act (ERISA)

When this Agreement is purchased by the Group to provide benefits under a health and welfare plan governed by the federal *Employee Retirement Income Security Act 29* U.S.C., 1001 et seq., we will not be named as, and will not be, the plan administrator or the named fiduciary of the health and welfare plan, as those terms are used in ERISA.

6.9 What Happens When There Is a Clerical Error?

Clerical error will not deprive any individual of Benefits under this Agreement or create a right to Benefits. Failure to report enrollments is not a clerical error. We will not provide retroactive coverage for Eligible Members when the Group fails to report enrollments. Failure to report the end of coverage will not continue the coverage for a Covered Member beyond the date it is scheduled to end. Upon discovery of a clerical error, any needed adjustment in Premiums will be made. However, we will not grant any such adjustment in Premiums or coverage to the Group for more than 60 days of coverage prior to the date we received notification of the clerical error.

6.10 Is Workers' Compensation Affected?

Benefits provided under this Agreement do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

6.11 Notice

We provide written notice regarding Agreement administration to the Group's authorized representative. Once delivered, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Group is responsible for giving notice to Covered Members on a timely basis.

Any notice sent to us under this Agreement and any notice sent to the Group must be addressed as described in Exhibit 1.

6.12 Continuation Coverage

We agree to provide Benefits under this Agreement for those Covered Members who are eligible to continue coverage under federal or state law, as described in Section 4: When Coverage Ends of the *Combined Evidence of Coverage and Disclosure Form.* Group will provide Covered Members with written notice of available continuation coverage as required by and in accordance with Consolidated Omnibus Budget Reconciliation Act (COBRA) and amendments thereto.

We will not provide any administrative duties with respect to the Group's compliance with federal or state law. All duties of the plan sponsor or plan administrator remain the sole responsibility of the Group, including but not limited to notification of COBRA and/or state law continuation rights and billing and collection of Premium.

Extension of Continuation Coverage under State Law (California Continuation Coverage/AB1405) after Exhaustion of Federal COBRA Continuation Coverage

We will provide all administrative duties required by California Continuation Coverage including but not limited to, notifications to affected Covered Persons and billing and collection of Premium.

6.13 Subscriber's Individual *Combined Evidence of Coverage and Disclosure Form*

We will issue *Combined Evidence of Coverage and Disclosure Form, Schedule(s) of Benefits*, and any attachments to the Group for delivery to each Subscriber. The *Combined Evidence of Coverage and Disclosure Forms(s), Schedule(s) of Benefits,* and any attachments will show the Benefits and other provisions of this Agreement are available online at www.myuhc.com.

6.14 Summary of Benefits and Coverage

We will provide a *Summary of Benefits and Coverage ("SBC")*, as required by the *Affordable Care Act* and related regulations *("ACA")*, to the Group for each benefit plan purchased. The Group is responsible for delivering the *SBC* to all Covered Members and to other persons eligible for coverage in the manner and at the times required by the *ACA*.

6.15 System Access

The term "systems" as used in this provision means systems that we make available to the Group to facilitate the transfer of information in connection with this Agreement.

System Access

We grant the Group the nonexclusive, nontransferable right to access and use the functionalities contained within the systems, under the terms of this Agreement. The Group agrees that all rights, title and interest in the systems and all rights in patents, copyrights, trademarks and trade secrets encompassed in the systems will remain ours. To access the systems, the Group will obtain, and be responsible for maintaining, at no expense to us, the hardware, software and Internet browser requirements we provide to the Group, including any amendments to those requirements. The Group is responsible for obtaining internet access.

The Group will not:

- Access systems or use, copy, reproduce, modify, or excerpt any of the systems documentation provided by us in order to access or use systems, for purposes other than as expressly permitted under this Agreement.
- Share, transfer or lease its right to access and use systems, to any other person or entity which is not a party to this Agreement.

The Group may designate a third party access to the systems on its behalf, provided the third party agrees to these terms and conditions. The Group remains responsible for the third party's compliance with the entire *System Access* provision.

Security Procedures

The Group will use commercially reasonable physical and software-based measures and comply with our security procedures, as may be amended from time to time, to protect the system, its functionalities, and data accessed through systems from any unauthorized access or damage (including damage caused by computer viruses). The Group will notify us immediately if any breach of the security procedures, such as unauthorized use, is suspected.

End of System Access

We have the right to end the Group's system access:

- On the date the Group does not accept the hardware, software and browser requirements provided by us, including any amendments to the requirements.
- Immediately on the date we reasonably determine that the Group has breached, or allowed a breach of, any applicable provision of this Agreement. Upon the date this Agreement ends, the Group agrees to cease all use of systems, and we will deactivate the Group's identification numbers and passwords and access to the system.

6.16 Notice of Network Provider Termination

We will provide written notice to the Group if we receive notice that any Network provider in the Service Area terminates or breaches its contract with us, or is unable to perform such contract, if the termination, breach, or inability to perform may materially and adversely affect the Group or Covered Member. We will provide the written notice to the Group within a week of our receipt of any notice of a Network Provider termination.

When we provide written notice of provider group or general acute care hospital termination to the Group, the Group is responsible for distributing the substance of the notice to all affected Subscribers and their Enrolled Dependents no later than 60 days prior to the termination date of the provider group of hospital.

6.17 Liability for Continued Treatment by Terminated Network Provider

Upon termination of any provider contract, we will make reasonable and medically appropriate assumption of services by a Network provider. If a Covered Member is under the care of a terminated Network provider for one of the medical conditions described in the Continuity of Care provision in the Combined Evidence of Coverage and Disclosure Form, we will be liable for continuation of Covered Health Care Services rendered by the provider. For a copy of the written policy, Members may call the number on the back of a Member's ID Card.

This section does not apply to treatment by a provider or provider group whose contract with us has terminated or not renewed for reasons relating to medical disciplinary cause or reason, fraud or other criminal activity.

Exhibit 1

1. **Parties.** The parties to this Agreement are UnitedHealthcare Benefits Plan of California and HUNEEUS VINTNERS LLC, the Group.
2. **Effective Date.** The effective date of this Agreement is 12:01 a.m. on August 1, 2024 in the time zone of the Group's location. UnitedHealthcare is subject to the requirements of Chapter 2.2 of Division 2 of the Code and of Chapter 1 of Title 28 of the California Code of Regulations, and any provision required to be in the contract by either of the Code shall bind us whether or not provided in the agreement.
3. **Place of Issuance and Conformity with Law.** We are issuing this Agreement in California and reserve the right to review place of issuance determinations. This Group Subscriber Agreement is governed by ERISA. To the extent that state law applies, California law including the requirements of Chapter 2.2 of Division 2 of the California Code and of Chapter 1 of Title 28 of the California Code of Regulations governs this Group Subscriber Agreement.
4. **Premiums.** We have the right to change the *Schedule of Premium Rates* or cost summary shown in Exhibit 2, at least a 60-days prior to the renewal date.
5. **Computation of Agreement Charge.** A full calendar month's Premiums will be charged for Covered Members whose effective date of coverage falls on or before the 15th of that calendar month. No Premiums will be charged for Covered Members whose effective date of coverage falls after the 15th of that calendar month. A full calendar month's Premiums will be charged for Covered Members whose coverage ends after the 15th of that calendar month. No Premiums will be charged for Covered Members whose coverage ended on or before the 15th of that calendar month.
6. **Payment of the Agreement Charge.** The Agreement Charge is payable to us in advance by the Group on a monthly basis.
7. **Minimum Participation Requirement.** The minimum participation requirement for the Group is 75% of Eligible Members excluding spousal waivers but no less than 25% of all Eligible Members must be enrolled for coverage under this Agreement.
8. **Minimum Contribution Requirement.** The Group must maintain a minimum contribution requirement of 80% of the Premium for each Eligible Member.
9. **Notice.** Any notice sent to us under this Agreement must be sent to:

   UnitedHealthcare Insurance Company

   185 Asylum Street

   Hartford, Connecticut 06103-3408

   1-800-357-1371

   Any notice sent to the Group under this Group Subscriber Agreement must be sent to:

   HUNEEUS VINTNERS LLC

   1224 ADAMS ST

   SAINT HELENA CA 94574
10. 1660169: Group Number

Exhibit 2

1. **Class Description.**

   See Group *Application.*

2. **Eligibility.** The eligibility rules are applied by the Group. The eligibility rules are the requirements the Group must use to determine who is eligible for coverage under the Agreement. In addition to the requirements below, the eligibility rules can be found in this Agreement, Group *Application,* and within the *Combined Evidence of Coverage and Disclosure Form*:

   A. The waiting or probationary period for newly Eligible Members is as follows:

      None

   B. Notwithstanding the eligibility rules for health plan participation, continued coverage under this Agreement for a Covered Member on a leave of absence (LOA) will be available in accordance with the following, unless state, local or federal law requires a longer period of time:

      - For a Covered Member on a non-medical LOA, coverage will be available for no longer than 13 consecutive weeks from the beginning of the LOA.
      - For a Covered Member on a medical LOA, coverage will be available for no longer than 26 consecutive weeks from the beginning of the LOA.

   C. Minimum required hours per week as outlined in the Group *Application* or as agreed to by the Group and us, and as required by applicable law.

   D. Other:

      None

3. **Open Enrollment Period.** An Open Enrollment Period of at least 30 days will be provided by the Group when Eligible Members may enroll for coverage. The Open Enrollment Period will occur on an annual basis.

4. **Effective Date for Eligible Members.** The effective date of coverage for Eligible Members who are eligible on the effective date of this Agreement is August 1, 2024.

   For an Eligible Member who becomes eligible after the effective date of this Agreement, the effective date of coverage is as determined by the Group. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates.**

   Monthly Premiums payable by or on behalf of Covered Members are specified in the cost summary detailed through the new business premium confirmation process and renewal package.