APPLICATION IS HEREBY MADE TO

Blue Shield of California

(California Physicians' Service)

DRAFT (Prepared 11/16/04)

FOR A GROUP HEALTH SERVICE CONTRACT

BY: COUNTY OF SAN MATEO
455 County Center
Redwood City, CA 94063

This Contract, Group Numbers **MH0080/MH0081/MH0090**, shall be effective **JANUARY 1, 2005**. It has been read and approved, and the terms and conditions are accepted by the Contractholder.

The Contractholder, on behalf of itself and its Subscribers, hereby expressly acknowledges its understanding that this agreement constitutes a Contract solely between the Contractholder and Blue Shield of California (hereafter referred to as "the Plan"), that the Plan is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("Association") permitting the Plan to use the Blue Shield Service Mark in the State of California, and that the Plan is not contracting as the agent of the Association. The Contractholder further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than the Plan and that no person, entity or organization other than the Plan shall be held accountable or liable to the Contractholder or its Subscribers for any of the Plan's obligations created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of the Plan, other than those obligations created under other provisions of this agreement.

This application is executed in duplicate. **The Contractholder shall sign, date and return this original application page to Blue Shield of California, 50 Beale Street, 22nd Floor, San Francisco, California 94105, Attention: Customer Contract Development.** The Contract shall be retained by the Contractholder. Payment of Dues and acceptance of Blue Shield's performance hereunder by the Contractholder shall be deemed to constitute the Contractholder's acceptance of the terms hereof, whether or not this agreement is signed by the Contractholder.

It is agreed that this application supersedes any previous application for this Contract.

Dated at _____ (City, State)

this _____ day of _____ 20 _____

_____

(Legal Name of Contractholder)

By _____

Title _____

As the Contractholder, you are responsible for communicating to Subscribers as soon as possible (and in any case, no later than 30 days after receipt) all changes in benefits and in any provisions affecting benefits.

PLEASE SIGN, DATE AND RETURN THE ORIGINAL APPLICATION PAGE TO BLUE SHIELD OF CALIFORNIA AT THE ABOVE ADDRESS. RETAIN THE CONTRACT.

Inquiries concerning any problems that may develop in the administration of this Contract should be directed to Blue Shield of California at the address provided on page GC-1.

Blue Shield of California
An Independent Member of the Blue Shield Association

Blue Shield of California
An Independent Member of the Blue Shield Association

50 Beale Street
San Francisco, California 94105
(415) 229-5000

GROUP HEALTH SERVICE CONTRACT

BLUE SHIELD POS PLAN

between

COUNTY OF SAN MATEO

("Contractholder")

and

California Physicians' Service
dba Blue Shield of California
a not-for-profit corporation

In consideration of the applications and the timely payment of Dues, Blue Shield agrees to provide benefits of this Contract to covered Employees and their covered Dependents.

This Contract shall be effective as of **July 1, 2005**, for a term of one year, subject to the provisions entitled, "Changes: Entire Contract".

BLUE SHIELD OF CALIFORNIA

Paul Markovich, Senior Vice President
Commercial Business Unit

Group Numbers: MH0080/MH0081/MH0090

Original Effective Date: **October 1, 1995**

IMPORTANT

No person has the right to receive the benefits of this Contract for Services or supplies furnished following termination of coverage, except as specifically provided in the GROUP CONTINUATION OF COVERAGE AND EXTENSION OF BENEFITS sections of the Evidence of Coverage and Disclosure Form. Benefits of this Contract are available only for Services and supplies as included in the applicable sections of the Evidence of Coverage and Disclosure Form, furnished during the term the Contract is in effect and while the individual claiming benefits is actually covered by this Contract. Benefits may be modified during the term of this Contract under the applicable section in PART V. DUES, PART VIII. GENERAL PROVISIONS, D. CHANGES: ENTIRE CONTRACT, or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or the elimination of benefits) apply for Services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the benefits of this Contract.

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(MH0080/MH0081/MH0090 - CobraServ Waived; Non-Discrim./Equal Benefits Clause)

PART I. INTRODUCTION

This Blue Shield of California Health Plan will provide or arrange for the provision of Services to eligible Subscribers and Dependents of the Contractholder in accordance with the terms, conditions, limitations and exclusions of this Group Health Service Contract.

The Evidence of Coverage and Disclosure Form Booklet is included and made part of this Contract.

PART II. DEFINITIONS

In addition to the provisions contained in the Definitions section of the Evidence of Coverage and Disclosure Form Booklet, the following provision applies to this Group Health Service Contract:

FOR ALL POS PLAN GROUP AND SECTION NUMBERS:

Employee - an individual (1) who is in full-time or part-time employment, (2) who receives compensation from the Contractholder in the form of salary, wages, or commissions, (3) whose regular work week with the Contractholder is at least twenty (20) hours, (4) whose duties in such employment are performed at the Contractholder's usual place of business except others whose duties are of a kind and nature that require them to be performed away from such usual place of business, or (5) a retiree under 65 years of age who has taken service or disability requirement in accordance with the applicable provisions of the Contractholder's retirement plan.

PART III. ELIGIBILITY

A. EMPLOYEE ELIGIBILITY, WAITING PERIODS AND OPEN ENROLLMENT

In addition to the provisions contained in the Eligibility section of the Evidence of Coverage and Disclosure Form Booklet, the following provisions apply to this Group Health Service Contract:

1. The date of eligibility of Employees who enroll during the initial enrollment period shall be determined as follows:

   a. Inasmuch as this Contract replaces a Contract between Blue Shield and the Employer, each such individual employed by the Employer on the effective date of this Contract who lives and/or works in the Plan Service Area is eligible on the effective date of this Contract or on the first day of the month coinciding with or the next first day of the month following completion of twenty-eight (28) days in the employ of the Employer; whichever occurs later.

   b. Each such individual who enters the employ of the Employer after the effective date of this Contract who lives and/or works in the Plan Service Area is eligible to enroll on the first day of the month coinciding with or the next first day of the month following completion of twenty-eight (28) days in the employ of the Employer.

   c. If associated Employers are added, the effective date of the amendment adding an associated Employer shall be treated as the effective date of this Contract for the purpose of determining the date of eligibility of the Employees of such Employer.

2. The date of eligibility of a former Employee, who has been re-employed, shall be determined as follows: The Employee's period of service prior to termination of employment shall be included in the determination of his date of eligibility, provided:

   a. he has resumed active work within 12 months after such termination; or

   b. if his previous employment was terminated due to entry into the Armed Forces, he has resumed active work within the time set by law for reinstatement of employment rights; or

   c. if termination was due to disability, he has resumed active work within one month after ceasing to be disabled;

   otherwise he shall be considered as an Employee entering the employ of the Employer on the date he resumed work and shall be eligible on the date he completes the period of service specified in A.1.b.

3. If any class of Employees is not eligible under A.1., and if an Employee transfers from such ineligible class to an eligible class, he shall be considered as having entered the employ of the Employer on the date of such transfer. Service in an ineligible class shall not be included in the determination of the date of eligibility.

4. The Employer agrees to offer health benefits coverage to all eligible Employees during the initial enrollment period, and to get the Employee's signed acknowledgment of an explicit written notice in bold type specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the Employee's later decision to elect coverage, an exclusion from coverage for a period of 12 months, or until the Employer's next Open Enrollment Period, whichever is earlier, unless the Employee meets the criteria specified in Paragraph 1. of the Definition of Late Enrollee. Blue Shield will not consider applications for earlier effective dates.

PART III. ELIGIBILITY

A. EMPLOYEE ELIGIBILITY, WAITING PERIODS AND OPEN ENROLLMENT (CONT'D)

5. An Employee may transfer enrollment for himself and his Dependent(s) from another group health plan sponsored by the Employer to the health plan covered by this Contract **during early October for a period of three weeks for Employees** and **from October 1st through October 31st for retirees**. The effective date of benefits for such Employee shall be the first day of each subsequent **January**. Submission of evidence of acceptability is not required when application is made during this Open Enrollment Period.

B. ASSOCIATED EMPLOYERS

Employees of the following listed Employers associated with the Employer as subsidiaries or affiliates are eligible for benefits in accord with this Contract. For the purposes of this Contract only, service with any associated Employers shall be considered service with the Employer. The Employer may act for and on behalf of any associated Employers in all matters pertaining to this Contract, and every act done by, agreement made with, or notice given to the Employer shall bind all associated Employers.

(LIST OF ASSOCIATED EMPLOYERS)

NONE

C. TERMINATION OF BENEFITS

In addition to the provisions contained in the Termination of Benefits section of the Evidence of Coverage and Disclosure Form Booklet, the following provisions apply to this Group Health Service Contract:

1. The benefits of a Subscriber shall cease on the last day of the month in which the Subscriber ceases to be a member of a class eligible for coverage, unless a different date on which the Subscriber no longer meets the requirements for eligibility has been agreed to between Blue Shield and the Contractholder, except that:
   a. if the Subscriber ceases active work because of a disability due to illness or bodily injury, or because of an approved leave of absence or temporary layoff, payment of Dues for that Subscriber shall continue coverage in force in accordance with the Employer's policy regarding such coverage; or,
   b. if the Employer 1) has a continuation of benefits policy for persons on leave, or 2) is subject to the California Family Rights Act of 1991 and/or the Federal Family & Medical Leave Act of 1993, and the approved leave of absence is for family leave pursuant to such Acts, payment of Dues for that Subscriber shall keep coverage in force for the greater of the duration(s) prescribed by the Employer's continuation of benefits policy or the Acts, as applicable. The Employer is solely responsible for notifying Employees of the availability and duration of family leaves.
2. With respect to a newborn child or a child placed for adoption, coverage will cease on the 32nd day at 12:01 a.m. Pacific Time following the Dependent's effective date of coverage, except that coverage shall not cease if a written application for the addition of the Dependent is submitted to and received by Blue Shield prior to the 31st day following the effective date of coverage.

PART IV. GROUP RENEWAL ADVANCE NOTIFICATION

The Employer shall be notified by Blue Shield of California of its intent to renew this Group Health Service Contract at least **120 days** prior to the proposed effective date of the renewal. However, this renewal advance notification is distinct from, and does not alter the notification periods specified in PART V. DUES, PARAGRAPH D., or in PART VIII. GENERAL PROVISIONS, PARAGRAPH D. CHANGES: ENTIRE CONTRACT.

(MH0080/MH0081/MH0090 – C.1. & C.1.b.)

PART V. DUES

A. MONTHLY DUES

Subscriber	$489.07
Additional for one Dependent	$526.69
Additional for two or more Dependents	$989.01

B. WHEN AND WHERE PAYABLE

1. The first month's Dues must be paid to Blue Shield by the effective date of this Contract and subsequent Dues shall be prepaid in full by the same date of each succeeding month. No Member will be covered under this Contract until the first month's Dues payment has been received by Blue Shield.

2. Dues for Employees and/or Dependents who become eligible on a date other than the bill date are waived for the month during which eligibility for covered benefits is attained. Dues for Employees and/or Dependents whose eligibility for covered benefits terminates on a date other than the bill date are due in full for the month during which eligibility is terminated.

3. All Dues are payable by the Employer to Blue Shield of California. The payment of any Dues shall not maintain the benefits under this Contract in force beyond the date immediately preceding the next transmittal date except as otherwise provided in PART V., F.

C. The terms of this Contract or the Dues payable therefore may be changed from time to time as set forth in PART VIII., D. CHANGES: ENTIRE CONTRACT.

D. The Employer shall remit to Blue Shield the amount specified in PART V., A. ("the base Dues"). If a state or any other taxing authority imposes upon Blue Shield a tax or license fee which is levied upon or measured by the base Dues or by the gross receipts of Blue Shield or any portion of either, then Blue Shield may amend the Contract to increase the base Dues by an amount sufficient to cover all such taxes or license fees rounded to the nearest cent. This amendment shall be effective as of the date stated in the notice which shall not be earlier than the date of the imposition of such tax or license fee, by mailing a postage prepaid notice of the amendment to the Employer at its address of record with Blue Shield at least 31 days before the effective date of the amendment.

E. If benefit amounts are changed due to a change in the terms of this Contract or if a tax is levied under PART V., D., the Dues charged therefor may be made, or the Dues credit therefor may be given, as of the effective date of such change.

F. A grace period of 30 days to pay all delinquent Dues and avoid cancellation will be granted for the payment of Dues accruing, other than those due on the effective date of this Contract, during which period this Contract shall continue in force, but the Employer shall be liable to Blue Shield for the payment of all Dues accruing during the period the Contract continues in force during the grace period. Cancellation for non-payment of Dues shall be in accordance with PART VII.B.

PART VI. OUT-OF-AREA PROGRAM: THE BLUECARD

In addition to the provisions contained in the Out-Of-Area Program: The BlueCard section of the Evidence of Coverage and Disclosure Form Booklet, the following provisions apply to this Group Health Service Contract:

Like all Blue Cross and Blue Shield Licensees, Blue Shield of California participates in a program called "BlueCard". Whenever Subscribers access health care services outside the geographic area Blue Shield of California serves, the claim for those services may be processed through BlueCard and presented to Blue Shield of California for payment in conformity with network access rules of the BlueCard Policies then in effect ("Policies"). Under BlueCard, when Subscribers receive covered health care services within the geographic area served by an on-site Blue Cross and/or Blue Shield Licensee ("Host Blue"), Blue Shield of California will remain responsible to the Contractholder for fulfilling its Contract obligations. However, the Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its participating providers and handling all interaction with its participating providers. The financial terms of BlueCard are described generally below.

LIABILITY CALCULATION METHOD PER CLAIM

The calculation of Subscriber liability on claims for covered health care services incurred outside the geographic area Blue Shield of California serves, and processed through BlueCard will be based on the lower of the provider's billed charges or the negotiated price Blue Shield of California pays the Host Blue.

The methods employed by a Host Blue to determine a negotiated price will vary among Host Blues based on the terms of each Host Blue's provider contracts. The negotiated price paid to a Host Blue by Blue Shield of California on a claim for health care services processed through BlueCard may represent:

(i) the actual price paid on the claim by the Host Blue to the health care provider ("Actual Price"), or

(ii) an estimated price, determined by the Host Blue in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Blue's health care providers or one or more particular providers ("Estimated Price"), or

(iii) an average price, determined by the Host Blue in accordance with BlueCard Policies, based on a billed charges discount representing the Host Blue's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its providers or for a specified group of providers ("Average Price"). An Average Price may result in greater variation to the Subscriber and Contractholder from the Actual Price than would an Estimated Price.

Host Blues using either the Estimated Price or Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over- or underestimation of past prices. However, the amount paid by the Subscriber is a final price and will not be affected by such prospective adjustment.

Statutes in a small number of states may require a Host Blue either (1) to use a basis for calculating Subscriber liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (2) to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the Host Blue would then calculate Subscriber liability for any covered health care services in accordance with the applicable state statute in effect at the time the Subscriber received those services.

PART VI. OUT-OF-AREA PROGRAM: THE BLUECARD

RETURN OF OVERPAYMENTS

Under BlueCard, recoveries from a Host Blue or from participating providers of a Host Blue can arise in several ways, including but not limited to anti-fraud and abuse audits, provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Policies, which generally require correction on a claim-by-claim or prospective basis.

PART VII. CANCELLATION/REINSTATEMENT/GRACE PERIOD

A. CANCELLATION WITHOUT CAUSE

The Employer may cancel this Contract at any time by written notice delivered or mailed to Blue Shield, effective on receipt or on such later date as specified in the notice.

B. CANCELLATION FOR NON-PAYMENT OF DUES

Blue Shield may cancel this Contract for non-payment of Dues. If Dues are not received within fifteen (15) days after the due date as described in PART V. hereof, Blue Shield shall provide written Prospective Notice of Cancellation delivered to the Employer, or mailed to the Employer's last address as shown on the records of Blue Shield, stating when, not less than 15 days thereafter, such cancellation shall be effective. If Dues are not received within the ensuing 15 days, the Contract will be terminated for non-payment on the 15th day following the date of mailing of the Prospective Notice of Cancellation by Blue Shield. In such case, a Notice Confirming Termination of Coverage will be mailed to the Employer by Blue Shield. A new application for coverage will be required by the Employer, and a new contract will be issued only upon demonstration that the Employer meets all underwriting requirements.

C. CANCELLATION/RESCISSION FOR FRAUD, MISREPRESENTATIONS OR OMISSIONS

Blue Shield may cancel this Contract for fraud or misrepresentation by the Employer; or with respect to coverage of Employees or Dependents for fraud or misrepresentation of the Employee, Dependent, or their representative. Misrepresentations or omissions on an application or a health statement (if a health statement is required by the Employer) may result in the cancellation or rescission of this Contract. Blue Shield may rescind this Contract as of the effective date, or cancel this Contract effective on such later date as specified in the notice.

D. REINSTATEMENT OF CONTRACT

If payment for all delinquent Dues is received by Blue Shield more than 15 days after the date of mailing of the Prospective Notice of Cancellation, pursuant to PART VII. B., the Contract will not be reinstated and Blue Shield will refund such payment to the Employer within 20 business days of receipt.

E. GRACE PERIOD

The Employer shall be entitled to a grace period of 30 days for payment of Dues, as described in PART V. E. hereof. If during a grace period written notice is given by the Employer to Blue Shield that the Contract or (subject to the consent of Blue Shield) any part of the Contract is to be discontinued before the expiration date of the grace period, the Contract or such part shall be discontinued as of the date specified by the Employer or the date of receipt of such written notice by Blue Shield, whichever is the later date, and the Employer shall be liable to Blue Shield for the payment of pro rata Dues for the period commencing with the last transmittal date and ending with the date of such discontinuance.

PART VII. CANCELLATION/REINSTATEMENT/GRACE PERIOD

F. PAYMENT OR REFUND OF DUES UPON CANCELLATION

In the event of cancellation, the Employer shall promptly pay any earned Dues which have not previously been paid. Blue Shield shall within 30 days of cancellation (1) return to the Employer the amount of prepaid Dues, if any, that Blue Shield determines have not been earned as of the effective date of cancellation, and (2) provide Benefits of the Plan for Services incurred during the time coverage was in effect up to and including the effective date of cancellation.

G. TERMINATION OF BENEFITS

No benefits shall be provided for Services rendered after the effective date of cancellation, except as specifically provided in the Group Continuation of Coverage and Extension of Benefits sections of the Evidence of Coverage and Disclosure Form Booklet.

In the event this Contract is canceled for any reason, including but not limited to for non-payment of Dues, no further Benefits will be provided after cancellation unless the Person is a registered Inpatient or is undergoing treatment for an ongoing condition and obtains an extension of benefits in accordance with the Extension of Benefits section of the Evidence of Coverage and Disclosure Form Booklet.

H. EMPLOYER TO PROVIDE SUBSCRIBERS WITH NOTICE CONFIRMING TERMINATION OF COVERAGE

If this Contract is rescinded, or cancelled by either party, the Employer shall notify the Subscribers. If rescinded or cancelled by Blue Shield, the Employer shall promptly mail a copy of Blue Shield's Notice Confirming Termination of Coverage to each Subscriber and provide Blue Shield proof of such mailing and the date thereof.

PART VIII. GENERAL PROVISIONS

In addition to the provisions contained in the Evidence of Coverage and Disclosure Form Booklet, the following provisions apply to this Group Health Service Contract:

A. CHOICE OF PROVIDERS

1. The Plan has established a network of Personal Physicians and specialty Physicians, Hospitals, Participating Hospice Agencies, and Non-Physician Health Care Practitioners to provide Covered Services to Members. To receive Tier I Benefits, a Member must obtain or receive approval for all Covered Services from his Personal Physician or the MHSA. Each Member must select a Personal Physician from the list of Personal Physicians in the Directory of HMO Providers. The Directory will be given to Members at the time of enrollment. A Member's Personal Physician will be accessible to the Member on a 24-hour-a-day, 7-day-a-week basis, or will make appropriate arrangements to assure coverage. Emergency Services will be provided on a 24-hour-a-day, 7-day-a-week basis by all Plan Hospitals. The list of Providers in the Directory includes the location and phone numbers of all Personal Physicians, Plan Hospitals and Participating Hospice Agencies in the Personal Physician Service Area. Members should contact Member Services for information on Plan Non-Physician Health Care Practitioners in their Personal Physician Service Area.
2. The Member may obtain medical Services from any Provider under Tier II of the Blue Shield POS Plan without consulting his Personal Physician. However, the Member will be responsible for applicable deductibles, copayments and non-covered charges, and for non-Plan Providers all charges above the Allowable Amount, as stated elsewhere in this Contract.

B. USE OF MASCULINE PRONOUN

Whenever a masculine pronoun is used in this Contract, it shall include the feminine gender unless the context clearly indicates otherwise.

C. WORKERS' COMPENSATION

This Contract is not in lieu of, and shall not affect, any requirements for coverage by Workers' Compensation Insurance.

D. CHANGES: ENTIRE CONTRACT

The terms of this Contract or the Dues payable therefor may be changed from time to time. These changes shall not become effective until at least 30 days after written notice of such change is delivered or mailed to the Employer's last address as shown on the records of Blue Shield. Benefits for Services furnished on or after the effective date of any benefit modification shall be provided based on the modification. No change in this Contract shall be valid unless approved by an executive officer of Blue Shield and a written endorsement is issued. No other representative has authority to change this Contract or to waive any of its provisions.

This Contract, including appendices, attachments, or other documents incorporated by reference constitutes the entire agreement between the parties, and any statement made by the Employer or by any Subscriber shall, in the absence of fraud, be deemed a representation and not a warranty.

Notice of changes in benefits, and any documents that may be delivered to the Employer or the Employer's representative for the purpose of informing members of the details of their coverage under this Contract, will be distributed by the Employer or his representative no later than 30 days after receipt of such material.

E. STATUTORY REQUIREMENTS

This Contract is subject to the requirements of the Knox-Keene Health Care Service Plan Act, Chapter 2.2 of Division 2 of the California Health and Safety Code and Title 28 of the California Code of Regulations. Any provision required to be in this Contract by reason of the Act or Regulations shall bind Blue Shield whether or not such provision is actually included in this Contract. In addition, this Contract is subject to applicable state and federal statutes and regulations, which may include the Employee Retirement Income Security Act and the Health Insurance Portability and Accountability Act. Any provision required to be in this Contract by reason of such state and federal statutes shall bind the Group and Blue Shield whether or not such provision is actually included in this Contract.

PART VIII. GENERAL PROVISIONS

F. LEGAL PROCESS

Legal process or service upon Blue Shield must be served upon a corporate officer of Blue Shield.

G. TIME OF COMMENCEMENT OR TERMINATION

Wherever this Contract provides for a date of commencement or termination of any part or all of this Contract, commencement or termination shall be effective as of 12:01 a.m. Pacific Time of that date.

H. RECORDS AND INFORMATION TO BE FURNISHED

The Employer shall furnish Blue Shield with such information as Blue Shield may require to enable it to administer this plan, to determine the Dues and to enable it to perform this Contract. All of the Employer's records which relate to eligibility for and benefits of this plan shall be made available for inspection by Blue Shield when and so often as reasonably required.

I. MEMBERSHIP CARDS

Membership cards will be issued by the Plan for all Subscribers, in addition to Evidence of Coverage and Disclosure Form Booklet which summarizes the Benefits of this Contract and how to obtain covered Services. The Membership cards will either be sent to the Contractholder for distribution to the Subscribers, or sent directly to the Subscribers, depending on the Contractholder's instructions. The Evidence of Coverage and Disclosure Form Booklet will be sent to the Contractholder for distribution to the Subscribers.

J. INQUIRIES AND COMPLAINTS

Inquiries concerning any problems that may develop in the administration of this Contract should be directed to Blue Shield at the address or telephone number indicated on page GC-1 of this Contract. (See also the Customer Service section of the Evidence of Coverage and Disclosure Form Booklet.)

K. CONFIDENTIALITY

The Contractholder shall comply with all applicable state and federal laws regarding the privacy and confidentiality of the personal and health information of Subscribers and Dependents. The Contractholder shall not require the Plan to release the personal and health information of individual Subscribers or Dependents without written authorization from the Subscriber, unless permitted by law. No information may be disclosed by either party in violation of Cal. Civ. Code §§ 56, et seq. At the request of the Contractholder, the Plan may provide aggregate, encrypted or encoded data regarding Subscribers and Dependents to the Contractholder, unless such data would explicitly or implicitly identify specific Subscribers or Dependents. To the extent the Contractholder receives, maintains or transmits personal or health information of Subscribers or Dependents electronically, the Contractholder shall comply with all state and federal laws relating to the protection of such information including, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) provisions on security and confidentiality.

L. TERMINATION OF A BLUE SHIELD POS PLAN PROVIDER CONTRACT

1. Blue Shield shall provide written notice to the Contractholder within a reasonable period of time of any termination or breach of Contract of an Blue Shield POS Plan Provider if such termination or breach may materially affect the Contractholder or its Subscribers.

2. Upon termination of a Blue Shield POS Plan Provider's Contract, Blue Shield shall be liable for Benefits rendered by such provider to an eligible Member (other than for Copayments) until the authorized Services being rendered to the Member by the former Blue Shield POS Plan Provider are completed, unless Blue Shield makes reasonable and medically appropriate provision for the assumption of such benefits by another Blue Shield POS Plan Provider.

PART VIII. GENERAL PROVISIONS

M. NON-DISCRIMINATION

No person shall be excluded from participation in, denied benefits of, or be subject to discrimination under this Agreement on the basis of their race, color, religion, national origin, age, sex, sexual orientation, pregnancy, childbirth or related conditions, medical condition, mental or physical disability or veteran's status. Contractor shall ensure full compliance with federal, state and local laws, directives and executive orders regarding non-discrimination for all employees and Subcontractors under this Agreement.

Violation of the non-discrimination provisions of this Agreement shall be considered a breach of this Agreement and subject the Contractor to penalties, to be determined by the County Manager, including but not limited to: i) termination of this Agreement; ii) disqualification of the Contractor from bidding on or being awarded a County contract for a period of up to three (3) years; iii) liquidated damages of $2,500 per violation; iv) imposition of other appropriate contractual and civil remedies and sanctions, as determined by the County Manager.

To effectuate the provisions of this paragraph, the County Manager shall have the authority to: i) examine Contractor's employment records with respect to compliance with this paragraph; ii) set off all or any portion of the amount described in this paragraph against amounts due to Contractor under the Contract or any other Contract between Contractor and County.

Contractor shall report to the County Manager the filing by any person in any court of any complaint of discrimination or the filing by any person of any and all charges with the Equal Employment Opportunity Commission, the Fair Employment and Housing Commission or any other entity charged with the investigation of allegations within 30 days of such filing, provided that within such 30 days such entity has not notified Contractor that such charges are dismissed or otherwise unfounded. Such notification shall include the name of the complainant, a copy of such complaint and a description of the circumstance. Contractor shall provide County with a copy of its response to the Complaint when filed.

N. EQUAL BENEFITS

With respect to the provision of employee benefits, Contractor shall comply with the County Ordinance which prohibits contractors from discriminating in the provision of employee benefits between an employee with a domestic partner and an employee with a spouse.

PART IX. CONTRACTHOLDER NOTIFICATION REQUIREMENTS

The Contractholder has various notification requirements under this Group Health Service Contract. Some of the major Contractholder notification requirements are summarized below. **Note: This summary is not to be construed as an all-inclusive list of the notice requirements of the Contractholder under this Group Health Service Contract nor does it absolve the Contractholder from any obligations specified elsewhere under this Group Health Service Contract.**

A. INITIAL ENROLLMENT

The Employer agrees to offer health benefits coverage to all eligible Employees during the initial enrollment period, and to get the Employee's signed acknowledgment of an explicit written notice in bold type specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the Employee's later decision to elect coverage, an exclusion from coverage for a period of 12 months, or until the Employer's next Open Enrollment Period, whichever is earlier, unless the Employee meets the criteria specified in Paragraph 1. of the Definition of Late Enrollee.

B. NOTIFICATION OF CANCELLATION TO SUBSCRIBERS

If this Contract is rescinded, or canceled by either party, the Employer shall notify the Subscribers. If rescinded or canceled by Blue Shield, the Employer shall promptly mail a copy of Blue Shield's notice of the rescission or cancellation to each Subscriber and provide Blue Shield proof of such mailing and the date thereof. The Employer must also inform each Subscriber that transfer to a Blue Shield individual conversion plan is not permitted when either the Employer is replacing this Contract with another or when the Subscriber or Dependent is covered under a prior extension of benefits.

C. COBRA AND CAL-COBRA

The following provisions are applicable only when the Contractholder is subject to Title X. of the Consolidated Omnibus Budget Reconciliation Act [COBRA] as amended or the California Continuation Benefits Replacement Act [Cal-COBRA]. (See the Continuation of Group Coverage and Extension of Benefits sections of the Evidence of Coverage and Disclosure Form Booklet.)

1. Contractholders subject to the California Continuation Benefits Replacement Act (Cal-COBRA) are responsible for notifying Blue Shield in writing within 30 days when the Contractholder becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.

2. Notification of a Qualifying Event.

   With respect to COBRA enrollees:

   The Contractholder will notify its COBRA administrator (or the Plan administrator if the Contractholder does not have a COBRA administrator) of the Subscriber's death, termination or reduction of hours of employment, or of the Subscriber's Medicare entitlement, or the Employer's (Contractholder's) filing for reorganization under Title XI, United States Code.

3. Duration and Extension of Continuation of Group Coverage.

   The Contractholder or its COBRA administrator is responsible for notifying COBRA enrollees of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end.

PART IX. CONTRACTHOLDER NOTIFICATION REQUIREMENTS

C. COBRA AND CAL-COBRA (CONT'D)

4. Additional Continuation of Benefits Beyond Termination under COBRA and/or Cal-COBRA.

   Notification Requirements:

   The Contractholder must notify the former Employee or Dependent spouse (including a spouse who is divorced from the Employee and/or a spouse who was married to the Employee or former Employee at the time of that Employee's death) regarding availability of continuation of coverage at least 90 calendar days before the end of COBRA or Cal-COBRA coverage. The former Employee (and/or former spouse) must elect to continue coverage by notifying the plan in writing within 30 calendar days before the end of COBRA or Cal-COBRA coverage.

The following provisions are applicable only when the Contractholder, who is subject to Title X. of the Consolidated Omnibus Budget Reconciliation Act [COBRA] as amended or the California Continuation Benefits Replacement Act [Cal-COBRA], has elected to have COBRA benefits administered by the Blue Shield COBRA Administrator. (See the Amendment For COBRA Administrative Services, if applicable.)

The Contractholder retains responsibility for the following COBRA administration duties:

1. Contractholder will complete and timely provide all notices and enrollment forms to all eligible Subscribers and Dependents (including the initial notice of COBRA rights) required under COBRA, using forms or sample forms provided by the COBRA Administrator.

2. Contractholder will provide a copy of the enrollment form to the COBRA Administrator at the same time that it is sent to the eligible Subscribers and Dependents.

D. INDIVIDUAL CONVERSION PLAN

The Contractholder is solely responsible for notifying Employees of the availability, terms and conditions of the Individual Conversion Plan within 15 days of termination of this Contract's coverage. (See the Individual Conversion Plan section of the Evidence of Coverage and Disclosure Form Booklet.)

EVIDENCE OF COVERAGE AND DISCLOSURE FORM

The Evidence of Coverage and Disclosure Form Booklet and any applicable Supplements will be issued by Blue Shield for all Subscribers covered under this Group Health Service Contract. The following pages contain the exact provisions of the Evidence of Coverage and Disclosure Form Booklet and any applicable Supplements and are included as part of this Contract.

Note: In the Evidence of Coverage and Disclosure Form Booklet, references to "you" or "your" shall mean the eligible Subscriber and/or Dependent of these Plans. References to "we" or "us" shall mean the Plan and/or Blue Shield of California.

APPLICATION IS HEREBY MADE TO

Blue Shield of California

(California Physicians' Service)

DRAFT (Prepared 11/18/04)

FOR A GROUP HEALTH SERVICE CONTRACT

BY: COUNTY OF SAN MATEO
455 County Center
Redwood City, CA 94063

This Contract, Group Number **930052-0CB0/0001/0002/0003**, shall be effective **JANUARY 1, 2005**. It has been read and approved, and the terms and conditions are accepted by the Contractholder.

The Contractholder, on behalf of itself and its Subscribers, hereby expressly acknowledges its understanding that this agreement constitutes a Contract solely between the Contractholder and Blue Shield of California (hereafter referred to as "the Plan"), that the Plan is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("Association") permitting the Plan to use the Blue Shield Service Mark in the State of California, and that the Plan is not contracting as the agent of the Association. The Contractholder further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than the Plan and that no person, entity or organization other than the Plan shall be held accountable or liable to the Contractholder or its Subscribers for any of the Plan's obligations created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of the Plan, other than those obligations created under other provisions of this agreement.

This application is executed in duplicate. **The Contractholder shall sign, date and return this original application page to Blue Shield of California, 50 Beale Street, 22nd Floor, San Francisco, California 94105, Attention: Customer Contract Development.** The Contract shall be retained by the Contractholder. Payment of dues and acceptance of Blue Shield's performance hereunder by the Contractholder shall be deemed to constitute the Contractholder's acceptance of the terms hereof, whether or not this agreement is signed by the Contractholder.

It is agreed that this application supersedes any previous application for this Contract.

Dated at _____ (City, State)

this _____ day of _____ 20 _____

_____

(Legal Name of Contractholder)

By _____

Title _____

As the Contractholder, you are responsible for communicating to Subscribers as soon as possible (and in any case, no later than 30 days after receipt) all changes in benefits and in any provisions affecting benefits.

PLEASE SIGN, DATE AND RETURN THE ORIGINAL APPLICATION PAGE TO BLUE SHIELD OF CALIFORNIA AT THE ABOVE ADDRESS. RETAIN THE CONTRACT.

Inquiries concerning any problems that may develop in the administration of this Contract should be directed to Blue Shield of California at the address provided on page GC-1.

Blue Shield of California
An Independent Member of the Blue Shield Association

Blue Shield of California
An Independent Member of the Blue Shield Association

50 Beale Street
San Francisco, California 94105
(415) 229-5000

GROUP HEALTH SERVICE CONTRACT

PREFERRED PROVIDER MEDICAL PLAN

between

COUNTY OF SAN MATEO

("Contractholder")

and

California Physicians' Service
dba Blue Shield of California
a not-for-profit corporation

In consideration of the applications and the timely payment of dues, Blue Shield agrees to provide benefits of this Contract to covered Employees and their covered Dependents.

This Contract shall be effective as of **July 1, 2005**, for a term of one year, subject to the provisions entitled, "Changes: Entire Contract".

BLUE SHIELD OF CALIFORNIA

Paul Markovich, Senior Vice President
Commercial Business Unit

Group Number: 930052-0000/0CB0/0001/0002/0003

Original Effective Date: **October 1, 1995**

IMPORTANT

No person has the right to receive the benefits of this Contract for Services or supplies furnished following termination of coverage, except as specifically provided in the GROUP CONTINUATION OF COVERAGE AND EXTENSION OF BENEFITS sections of the Evidence of Coverage and Disclosure Form. Benefits of this Contract are available only for Services and supplies as included in the applicable sections of the Evidence of Coverage and Disclosure Form, furnished during the term the Contract is in effect and while the individual claiming benefits is actually covered by this Contract. Benefits may be modified during the term of this Contract under the applicable section in PART V. DUES, PART VIII. GENERAL PROVISIONS, D. CHANGES: ENTIRE CONTRACT, or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or the elimination of benefits) apply for Services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the benefits of this Contract.

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[930052-0CB0/0001/0002/0003 - CobraServ Waived; Non-Discrim./Equal Benefits Clause]

PART I. INTRODUCTION

This Blue Shield of California Health Plan will provide or arrange for the provision of Services to eligible Subscribers and Dependents of the Contractholder in accordance with the terms, conditions, limitations and exclusions of this Group Health Service Contract.

The Evidence of Coverage and Disclosure Form Booklet is included and made part of this Contract.

PART II. DEFINITIONS

In addition to the provisions contained in the Definitions section of the Evidence of Coverage and Disclosure Form Booklet, the following provision applies to this Group Health Service Contract:

FOR ALL PPO PLAN SECTION NUMBERS:

Employee - a retiree who has taken service or disability retirement in accordance with the applicable provisions of the Contractholder's retirement plan and was employed prior to retirement (a) as a management or confidential employee [who subsequently retired after 1980], or (b) as an elected official, or (c) in the Deputy District Attorney's Unit, or (d) as County Counsel, or (e) as an active employee who following retirement is residing outside of the Blue Shield HMO Service Area.*

*Note, in some instances, this Plan may also cover certain *Active Employees* who reside outside of a Blue Shield Service Area (e.g., Active Employees who are ineligible for the POS Plan because they reside outside of any of the POS Plan's Plan Service Areas).

PART III. ELIGIBILITY

A. EMPLOYEE ELIGIBILITY, WAITING PERIODS AND OPEN ENROLLMENT

In addition to the provisions contained in the Eligibility section of the Evidence of Coverage and Disclosure Form Booklet, the following provisions apply to this Group Health Service Contract:

1. The date of eligibility of Employees who enroll during the initial enrollment period shall be determined as follows:
   a. Inasmuch as this Contract replaces a Contract between Blue Shield and the Employer, each such individual employed by the Employer on the effective date of this Contract who was a Subscriber of Blue Shield by virtue of the Employer's previous Contract on the date immediately preceding the effective date of this Contract, shall be eligible on the effective date of this Contract or on the first day of the month coinciding with or the next first day of the month following completion of twenty-eight (28) days in the employ of the Contractholder; whichever occurs later.
   b. Each such individual except as provided in paragraph a. above, shall be eligible to enroll on the first day of the month coinciding with or the next first day of the month following completion of twenty-eight (28) days in the employ of the Contractholder.
   c. If associated Employers are added, the effective date of the amendment adding an associated Employer shall be treated as the effective date of this Contract for the purpose of determining the date of eligibility of the Employees of such Employer.
2. The date of eligibility of a former Employee, who has been re-employed, shall be determined as follows: The Employee's period of service prior to termination of employment shall be included in the determination of his date of eligibility, provided:
   a. he has resumed active work within 12 months after such termination; or
   b. if his previous employment was terminated due to entry into the Armed Forces, he has resumed active work within the time set by law for reinstatement of employment rights; or
   c. if termination was due to disability, he has resumed active work within one month after ceasing to be disabled;

   otherwise he shall be considered as an Employee entering the employ of the Employer on the date he resumed work and shall be eligible on the date he completes the period of service specified in.A.1.b.
3. If any class of Employees is not eligible under A.1., and if an Employee transfers from such ineligible class to an eligible class, he shall be considered as having entered the employ of the Employer on the date of such transfer. Service in an ineligible class shall not be included in the determination of the date of eligibility.

NOTE: The "Late Enrollee" information in the following provision does not apply to RETIRED EMPLOYEES. When Retired Employees decline or terminate Group coverage, they will not be permitted to enroll for such coverage at a later date*, even during the next Open Enrollment Period. Any Dependents the Retiree acquires *after* declining or terminating Group coverage will also be ineligible for coverage under this plan. [Retired Employees should contact the employer for information about possible coverage under "Continuation of Group Coverage (COBRA)" and "Extension of Benefits".]

4. The Employer agrees to offer health benefits coverage to all eligible Employees during the initial enrollment period, and to get the Employee's signed acknowledgment of an explicit written notice in bold type specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the Employee's later decision to elect coverage, an exclusion from coverage for a period of 12 months, or at the Employer's next Open Enrollment Period, whichever is earlier, unless the Employee meets the criteria specified in Paragraph 1. of the Definition of Late Enrollee. Blue Shield will not consider applications for earlier effective dates.

*** Such Retired Employees may be eligible for Individual Conversion Plan coverage and should contact the County of San Mateo's Employee and Public Services Department for details. [Reference also the "Individual Conversion Plan" section of this contract.]**

[930052-0CB0/0001/0002/0003 – Late Enrollee; No Pre-Exist]

PART III. ELIGIBILITY

A. EMPLOYEE ELIGIBILITY, WAITING PERIODS AND OPEN ENROLLMENT (CONT'D)

5. An Employee may transfer enrollment for himself and his Dependent(s) from another group health plan sponsored by the Employer to the health plan covered by this Contract **during early October for a period of three weeks for Employees** and **from October 1st through October 31st for retirees**. The effective date of benefits for such Employee shall be the first day of each subsequent **January**. Submission of evidence of acceptability is not required when application is made during this Open Enrollment Period.

B. ASSOCIATED EMPLOYERS

Employees of the following listed Employers associated with the Employer as subsidiaries or affiliates are eligible for benefits in accord with this Contract. For the purposes of this Contract only, service with any associated Employers shall be considered service with the Employer. The Employer may act for and on behalf of any associated Employers in all matters pertaining to this Contract, and every act done by, agreement made with, or notice given to the Employer shall bind all associated Employers.

(LIST OF ASSOCIATED EMPLOYERS)

NONE

C. TERMINATION OF BENEFITS

In addition to the provisions contained in the Termination of Benefits section of the Evidence of Coverage and Disclosure Form Booklet, the following provisions apply to this Group Health Service Contract:

1. The benefits of a Subscriber shall cease on the last day of the month in which the Subscriber ceases to be a member of a class eligible for coverage, unless a different date on which the Subscriber no longer meets the requirements for eligibility has been agreed to between Blue Shield and the Contractholder, except that:
   a. if the Subscriber ceases active work because of a disability due to illness or bodily injury, or because of an approved leave of absence or temporary layoff, payment of dues for that Subscriber shall continue coverage in force in accordance with the Employer's policy regarding such coverage; or,
   b. if the Employer 1) has a continuation of benefits policy for persons on leave, or 2) is subject to the California Family Rights Act of 1991 and/or the Federal Family & Medical Leave Act of 1993, and the approved leave of absence is for family leave pursuant to such Acts, payment of dues for that Subscriber shall keep coverage in force for the greater of the duration(s) prescribed by the Employer's continuation of benefits policy or the Acts, as applicable. The Employer is solely responsible for notifying Employees of the availability and duration of family leaves.
2. With respect to a newborn child or a child placed for adoption, coverage will cease on the 32nd day at 12:01 a.m. Pacific Time following the Dependent's effective date of coverage, except that coverage shall not cease if a written application for the addition of the Dependent is submitted to and received by Blue Shield prior to the 31st day following the effective date of coverage.

PART IV. GROUP RENEWAL ADVANCE NOTIFICATION

The Employer shall be notified by Blue Shield of California of its intent to renew this Group Health Service Contract at least **120 days** prior to the proposed effective date of the renewal. However, this renewal advance notification is distinct from, and does not alter the notification periods specified in PART V. DUES, PARAGRAPH D., or in PART VIII. GENERAL PROVISIONS, PARAGRAPH D. CHANGES: ENTIRE CONTRACT.

(930052 – C.1. & C.1.b.)

PART V. DUES

A. MONTHLY DUES

Sections 0000; 0CB0 - Active Employees & Retirees Over Age 65/ Spouse Over Age 65

Subscriber	$361.10
Additional for 1 Dependent	$361.10
Additional for 2 or more Dependents	$630.80

Section 0001 - Active Employees & Retirees Over Age 65/Spouse Under Age 65

Subscriber	$361.10
Additional for 1 Dependent	$363.65
Additional for 2 or more Dependents	$682.85

Section 0002 - Active Employees & Retirees Under Age 65/Spouse Under Age 65 (Out-of-Area)

Subscriber	$544.34
Additional for 1 Dependent	$588.61
Additional for 2 or more Dependents	$1,128.09

Section 0003 - Active Employees & Retirees Under Age 65/ Spouse Over Age 65 (Out-of-Area)

Subscriber	$544.34
Additional for 1 Dependent	$361.10
Additional for 2 or more Dependents	$909.43

B. WHEN AND WHERE PAYABLE

1. The initial dues are due on the effective date of this Contract and subsequent dues shall be due on the same date of each succeeding month ("the transmittal date") thereafter, provided that the dues due on any transmittal date shall not be deemed to have been paid unless the total dues for all parts in force on such transmittal date have been paid.
2. Dues for Employees and/or Dependents who become eligible on a date other than the bill date are waived for the month during which eligibility for covered benefits is attained. Dues for Employees and/or Dependents whose eligibility for covered benefits terminates on a date other than the bill date are due in full for the month during which eligibility is terminated.
3. All dues are payable by the Employer to Blue Shield of California. The payment of any dues shall not maintain the benefits under this Contract in force beyond the date immediately preceding the next transmittal date except as otherwise provided in PART V., F.

C. The terms of this Contract or the dues payable therefore may be changed from time to time as set forth in PART VIII., D. CHANGES: ENTIRE CONTRACT.

D. The Employer shall remit to Blue Shield the amount specified in PART V., A. ("the base dues"). If a state or any other taxing authority imposes upon Blue Shield a tax or license fee which is levied upon or measured by the base dues or by the gross receipts of Blue Shield or any portion of either, then Blue Shield may amend the Contract to increase the base dues by an amount sufficient to cover all such taxes or license fees rounded to the nearest cent. This amendment shall be effective as of the date stated in the notice which shall not be earlier than the date of the imposition of such tax or license fee, by mailing a postage prepaid notice of the amendment to the Employer at its address of record with Blue Shield at least 30 days before the effective date of the amendment.

E. If benefit amounts are changed due to a change in the terms of this Contract or if a tax is levied under PART V., D., the dues charged therefor may be made, or the dues credit therefor may be given, as of the effective date of such change.

F. A grace period of 30 days to pay all delinquent Dues and avoid cancellation will be granted for the payment of Dues accruing other than those due on the effective date of this Contract, during which period this Contract shall continue in force, but the Employer shall be liable to Blue Shield for the payment of all Dues accruing during the period the Contract continues in force during the grace period. Cancellation for non-payment of Dues shall be in accordance with PART VII. B.

PART VI. OUT-OF-AREA PROGRAM: THE BLUECARD

In addition to the provisions contained in the Out-Of-Area Program: The BlueCard section of the Evidence of Coverage and Disclosure Form Booklet, the following provisions apply to this Group Health Service Contract:

Like all Blue Cross and Blue Shield Licensees, Blue Shield of California participates in a program called "BlueCard". Whenever Subscribers access health care services outside the geographic area Blue Shield of California serves, the claim for those services may be processed through BlueCard and presented to Blue Shield of California for payment in conformity with network access rules of the BlueCard Policies then in effect ("Policies"). Under BlueCard, when Subscribers receive covered health care services within the geographic area served by an on-site Blue Cross and/or Blue Shield Licensee ("Host Blue"), Blue Shield of California will remain responsible to the Contractholder for fulfilling its Contract obligations. However, the Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its participating providers and handling all interaction with its participating providers. The financial terms of BlueCard are described generally below.

LIABILITY CALCULATION METHOD PER CLAIM

The calculation of Subscriber liability on claims for covered health care services incurred outside the geographic area Blue Shield of California serves, and processed through BlueCard will be based on the lower of the provider's billed charges or the negotiated price Blue Shield of California pays the Host Blue.

The methods employed by a Host Blue to determine a negotiated price will vary among Host Blues based on the terms of each Host Blue's provider contracts. The negotiated price paid to a Host Blue by Blue Shield of California on a claim for health care services processed through BlueCard may represent:

(i) the actual price paid on the claim by the Host Blue to the health care provider ("Actual Price"), or

(ii) an estimated price, determined by the Host Blue in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Blue's health care providers or one or more particular providers ("Estimated Price"), or

(iii) an average price, determined by the Host Blue in accordance with BlueCard Policies, based on a billed charges discount representing the Host Blue's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its providers or for a specified group of providers ("Average Price"). An Average Price may result in greater variation to the Subscriber and Contractholder from the Actual Price than would an Estimated Price.

Host Blues using either the Estimated Price or Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over- or underestimation of past prices. However, the amount paid by the Subscriber is a final price and will not be affected by such prospective adjustment.

Statutes in a small number of states may require a Host Blue either (1) to use a basis for calculating Subscriber liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (2) to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the Host Blue would then calculate Subscriber liability for any covered health care services in accordance with the applicable state statute in effect at the time the Subscriber received those services.

PART VI. OUT-OF-AREA PROGRAM: THE BLUECARD

RETURN OF OVERPAYMENTS

Under BlueCard, recoveries from a Host Blue or from participating providers of a Host Blue can arise in several ways, including but not limited to anti-fraud and abuse audits, provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Policies, which generally require correction on a claim-by-claim or prospective basis.

PART VII. CANCELLATION/REINSTATEMENT/GRACE PERIOD

A. CANCELLATION WITHOUT CAUSE

The Employer may cancel this Contract at any time by written notice delivered or mailed to Blue Shield, effective on receipt or on such later date as specified in the notice.

B. CANCELLATION FOR NON-PAYMENT OF DUES

Blue Shield may cancel this Contract for non-payment of Dues. If Dues are not received within fifteen (15) days after the due date as described in PART V. hereof, Blue Shield shall provide written Prospective Notice of Cancellation delivered to the Employer, or mailed to the Employer's last address as shown on the records of Blue Shield, stating when, not less than 15 days thereafter, such cancellation shall be effective. If Dues are not received within the ensuing 15 days, the Contract will be terminated for non-payment on the 15th day following the date of mailing of the Prospective Notice of Cancellation by Blue Shield. In such case, a Notice Confirming Termination of Coverage will be mailed to the Employer by Blue Shield. A new application for coverage will be required by the Employer and a new contract will be issued only upon demonstration that the Employer meets all underwriting requirements.

C. CANCELLATION/RESCISSION FOR FRAUD, MISREPRESENTATIONS OR OMISSIONS

Blue Shield may cancel this Contract for fraud or misrepresentation by the Employer; or with respect to coverage of Employees or Dependents for fraud or misrepresentation of the Employee, Dependent, or their representative. Misrepresentations or omissions on an application or a health statement (if a health statement is required by the Employer) may result in the cancellation or rescission of this Contract. Blue Shield may rescind this Contract as of the effective date, or cancel this Contract effective on such later date as specified in the notice.

D. REINSTATEMENT OF CONTRACT

If payment for all delinquent Dues is received by Blue Shield more than 15 days after the date of mailing of the Prospective Notice of Cancellation, pursuant to PART VII. B., the Contract will not be reinstated and Blue Shield will refund such payment to the Employer within 20 business days of receipt.

E. GRACE PERIOD

The Employer shall be entitled to a grace period of 30 days for payment of Dues, as described in PART V. F. hereof. If during a grace period written notice is given by the Employer to Blue Shield that the Contract or (subject to the consent of Blue Shield) any part of the Contract is to be discontinued before the expiration date of the grace period, the Contract or such part shall be discontinued as of the date specified by the Employer or the date of receipt of such written notice by Blue Shield, whichever is the later date, and the Employer shall be liable to Blue Shield for the payment of pro rata Dues for the period commencing with the last transmittal date and ending with the date of such discontinuance.

PART VII. CANCELLATION/REINSTATEMENT/GRACE PERIOD

F. PAYMENT OR REFUND OF DUES UPON CANCELLATION

In the event of cancellation, the Employer shall promptly pay any earned Dues which have not previously been paid. Blue Shield shall within 30 days of cancellation (1) return to the Employer the amount of prepaid Dues, if any, that Blue Shield determines have not been earned as of the effective date of cancellation, and (2) provide Benefits of the Plan for Services incurred during the time coverage was in effect up to and including the effective date of cancellation.

G. TERMINATION OF BENEFITS

No benefits shall be provided for Services rendered after the effective date of cancellation, except as specifically provided in the Group Continuation of Coverage and Extension of Benefits sections of the Evidence of Coverage and Disclosure Form Booklet.

In the event this Contract is canceled for any reason, including but not limited to for non-payment of dues, no further Benefits will be provided after cancellation unless the Person is a registered Inpatient or is undergoing treatment for an ongoing condition and obtains an extension of benefits in accordance with the Extension of Benefits section of the Evidence of Coverage and Disclosure Form Booklet.

H. EMPLOYER TO PROVIDE SUBSCRIBERS WITH NOTICE CONFIRMING TERMINATION OF COVERAGE

If this Contract is rescinded or cancelled by either party, the Employer shall notify the Subscribers. If rescinded or cancelled by Blue Shield, the Employer shall promptly mail a copy of Blue Shield's Notice Confirming Termination of Coverage to each Subscriber and provide Blue Shield proof of such mailing and the date thereof.

PART VIII. GENERAL PROVISIONS

In addition to the provisions contained in the Evidence of Coverage and Disclosure Form Booklet, the following provisions apply to this Group Health Service Contract:

A. CHOICE OF PROVIDERS

A Subscriber or Dependent may select any Hospital or Physician to provide covered Services hereunder, including providers outside of California. Benefits differ depending on whether a Preferred Provider or a Non-Preferred Provider is selected. It is to the Subscriber's advantage to select Preferred Providers whenever possible. A Preferred Provider Directory is available to all Subscribers by calling Blue Shield at (800) 331-2001 or writing to them at:

P.O. Box 7168
San Francisco, CA 94120

or

P.O. Box 92945
Los Angeles, CA 90009

In the event that the inability to perform of a Preferred Provider, the breach of the Contract to furnish Services by a Preferred Provider, or the termination of a Preferred Provider's Contract with Blue Shield may materially and adversely affect the Employer, Blue Shield will, within a reasonable time, advise the Employer in writing of such inability to perform, breach, or termination.

B. USE OF MASCULINE PRONOUN

Whenever a masculine pronoun is used in this Contract, it shall include the feminine gender unless the context clearly indicates otherwise.

C. WORKERS' COMPENSATION

This Contract is not in lieu of, and shall not affect, any requirements for coverage by Workers' Compensation Insurance.

D. CHANGES: ENTIRE CONTRACT

The terms of this Contract or the dues payable therefor may be changed from time to time. These changes shall not become effective until at least 30 days after written notice of such change is delivered or mailed to the Employer's last address as shown on the records of Blue Shield. Benefits for Services furnished on or after the effective date of any benefit modification shall be provided based on the modification. No change in this Contract shall be valid unless approved by an executive officer of Blue Shield and a written endorsement is issued. No other representative has authority to change this Contract or to waive any of its provisions.

This Contract, including appendices, attachments, or other documents incorporated by reference constitutes the entire agreement between the parties, and any statement made by the Employer or by any Subscriber shall, in the absence of fraud, be deemed a representation and not a warranty.

Notice of changes in benefits, and any documents that may be delivered to the Employer or the Employer's representative for the purpose of informing members of the details of their coverage under this Contract, will be distributed by the Employer or his representative no later than 30 days after receipt of such material.

E. STATUTORY REQUIREMENTS

This Contract is subject to the requirements of the Knox-Keene Health Care Service Plan Act, Chapter 2.2 of Division 2 of the California Health and Safety Code and Title 28 of the California Code of Regulations. Any provision required to be in this Contract by reason of the Act or Regulations shall bind Blue Shield whether or not such provision is actually included in this Contract. In addition, this Contract is subject to applicable state and federal statutes and regulations, which may include the Employee Retirement Income Security Act and the Health Insurance Portability and Accountability Act. Any provision required to be in this Contract by reason of such state and federal statutes shall bind the Group and Blue Shield whether or not such provision is actually included in this Contract.

PART VIII. GENERAL PROVISIONS

F. LEGAL PROCESS

Legal process or service upon Blue Shield must be served upon a corporate officer of Blue Shield.

G. TIME OF COMMENCEMENT OR TERMINATION

Wherever this Contract provides for a date of commencement or termination of any part or all of this Contract, commencement or termination shall be effective as of 12:01 a.m. Pacific Time of that date.

H. RECORDS AND INFORMATION TO BE FURNISHED

The Employer shall furnish Blue Shield with such information as Blue Shield may require to enable it to administer this plan, to determine the dues and to enable it to perform this Contract. All of the Employer's records which relate to eligibility for and benefits of this plan shall be made available for inspection by Blue Shield when and so often as reasonably required.

I. MEMBERSHIP CARDS

Membership cards will be issued by the Plan for all Subscribers, in addition to Evidence of Coverage and Disclosure Form Booklet which summarizes the Benefits of this Contract and how to obtain covered Services. The Membership cards will either be sent to the Contractholder for distribution to the Subscribers, or sent directly to the Subscribers, depending on the Contractholder's instructions. The Evidence of Coverage and Disclosure Form Booklet will be sent to the Contractholder for distribution to the Subscribers.

J. INQUIRIES AND COMPLAINTS

Inquiries concerning any problems that may develop in the administration of this Contract should be directed to Blue Shield at the address or telephone number indicated on page GC-1 of this Contract. (See also the Customer Service section of the Evidence of Coverage and Disclosure Form Booklet.)

K. CONFIDENTIALITY

The Contractholder shall comply with all applicable state and federal laws regarding the privacy and confidentiality of the personal and health information of Subscribers and Dependents. The Contractholder shall not require the Plan to release the personal and health information of individual Subscribers or Dependents without written authorization from the Subscriber, unless permitted by law. No information may be disclosed by either party in violation of Cal. Civ. Code §§ 56, et seq. At the request of the Contractholder, the Plan may provide aggregate, encrypted or encoded data regarding Subscribers and Dependents to the Contractholder, unless such data would explicitly or implicitly identify specific Subscribers or Dependents. To the extent the Contractholder receives, maintains or transmits personal or health information of Subscribers or Dependents electronically, the Contractholder shall comply with all state and federal laws relating to the protection of such information including, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) provisions on security and confidentiality.

L. NON-DISCRIMINATION

No person shall be excluded from participation in, denied benefits of, or be subject to discrimination under this Agreement on the basis of their race, color, religion, national origin, age, sex, sexual orientation, pregnancy, childbirth or related conditions, medical condition, mental or physical disability or veteran's status. Contractor shall ensure full compliance with federal, state and local laws, directives and executive orders regarding non-discrimination for all employees and Subcontractors under this Agreement.

Violation of the non-discrimination provisions of this Agreement shall be considered a breach of this Agreement and subject the Contractor to penalties, to be determined by the County Manager, including but not limited to: i) termination of this Agreement; ii) disqualification of the Contractor from bidding on or being awarded a County contract for a period of up to three (3) years; iii) liquidated damages of $2,500 per violation; iv) imposition of other appropriate contractual and civil remedies and sanctions, as determined by the County Manager.

[930052-0CB0/0001/0002/0003 - Non-Discrim./Equal Benefits Clause]

PART VIII. GENERAL PROVISIONS

L. NON-DISCRIMINATION, Continued

To effectuate the provisions of this paragraph, the County Manager shall have the authority to: i) examine Contractor's employment records with respect to compliance with this paragraph; ii) set off all or any portion of the amount described in this paragraph against amounts due to Contractor under the Contract or any other Contract between Contractor and County.

Contractor shall report to the County Manager the filing by any person in any court of any complaint of discrimination or the filing by any person of any and all charges with the Equal Employment Opportunity Commission, the Fair Employment and Housing Commission or any other entity charged with the investigation of allegations within 30 days of such filing, provided that within such 30 days such entity has not notified Contractor that such charges are dismissed or otherwise unfounded. Such notification shall include the name of the complainant, a copy of such complaint and a description of the circumstance. Contractor shall provide County with a copy of its response to the Complaint when filed.

M. EQUAL BENEFITS

With respect to the provision of employee benefits, Contractor shall comply with the County Ordinance which prohibits contractors from discriminating in the provision of employee benefits between an employee with a domestic partner and an employee with a spouse.

PART IX. CONTRACTHOLDER NOTIFICATION REQUIREMENTS

The Contractholder has various notification requirements under this Group Health Service Contract. Some of the major Contractholder notification requirements are summarized below. **Note: This summary is not to be construed as an all-inclusive list of the notice requirements of the Contractholder under this Group Health Service Contract nor does it absolve the Contractholder from any obligations specified elsewhere under this Group Health Service Contract.**

NOTE: The "Late Enrollee" information in the following provision does not apply to RETIRED EMPLOYEES. When Retired Employees decline or terminate Group coverage, they will not be permitted to enroll for such coverage at a later date*, even during the next Open Enrollment Period. Any Dependents the Retiree acquires *after* declining or terminating Group coverage will also be ineligible for coverage under this plan. [Retired Employees should contact the employer for information about possible coverage under "Continuation of Group Coverage (COBRA)" and "Extension of Benefits".]

A. INITIAL ENROLLMENT

The Employer agrees to offer health benefits coverage to all eligible Employees during the initial enrollment period, and to get the Employee's signed acknowledgment of an explicit written notice in bold type specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the Employee's later decision to elect coverage, an exclusion from coverage for a period of 12 months, or until the Employer's next Open Enrollment Period, whichever is earlier, unless the Employee meets the criteria specified in Paragraph 1. of the Definition of Late Enrollee.

*** Such Retired Employees may be eligible for Individual Conversion Plan coverage and should contact the County of San Mateo's Employee and Public Services Department for details. [Reference also the "Individual Conversion Plan" section of this contract.]**

B. NOTIFICATION OF CANCELLATION TO SUBSCRIBERS

If this Contract is rescinded, or canceled by either party, the Employer shall notify the Subscribers. If rescinded or canceled by Blue Shield, the Employer shall promptly mail a copy of Blue Shield's notice of the rescission or cancellation to each Subscriber and provide Blue Shield proof of such mailing and the date thereof. The Employer must also inform each Subscriber that transfer to a Blue Shield individual conversion plan is not permitted when either the Employer is replacing this Contract with another or when the Subscriber or Dependent is covered under a prior extension of benefits.

C. COBRA AND CAL-COBRA

The following provisions are applicable only when the Contractholder is subject to Title X. of the Consolidated Omnibus Budget Reconciliation Act [COBRA] as amended or the California Continuation Benefits Replacement Act [Cal-COBRA]. (See the Continuation of Group Coverage and Extension of Benefits sections of the Evidence of Coverage and Disclosure Form Booklet.)

1. Contractholders subject to the California Continuation Benefits Replacement Act (Cal-COBRA) are responsible for notifying Blue Shield in writing within 30 days when the Contractholder becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.
2. Notification of a Qualifying Event.

   With respect to COBRA enrollees:

   The Contractholder will notify its COBRA administrator (or the Plan administrator if the Contractholder does not have a COBRA administrator) of the Subscriber's death, termination or reduction of hours of employment, or of the Subscriber's Medicare entitlement, or the Employer's (Contractholder's) filing for reorganization under Title XI, United States Code.
3. Duration and Extension of Continuation of Group Coverage.

   The Contractholder or its COBRA administrator is responsible for notifying COBRA enrollees of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end.

PART IX. CONTRACTHOLDER NOTIFICATION REQUIREMENTS

C. COBRA AND CAL-COBRA (CONT'D)

4. Additional Continuation of Benefits Beyond Termination under COBRA and/or Cal-COBRA.

   Notification Requirements:

   The Contractholder must notify the former Employee or Dependent spouse (including a spouse who is divorced from the Employee and/or a spouse who was married to the Employee or former Employee at the time of that Employee's death) regarding availability of continuation of coverage at least 90 calendar days before the end of COBRA or Cal-COBRA coverage. The former Employee (and/or former spouse) must elect to continue coverage by notifying the plan in writing within 30 calendar days before the end of COBRA or Cal-COBRA coverage.

The following provisions are applicable only when the Contractholder, who is subject to Title X. of the Consolidated Omnibus Budget Reconciliation Act [COBRA] as amended or the California Continuation Benefits Replacement Act [Cal-COBRA], has elected to have COBRA benefits administered by the Blue Shield COBRA Administrator. (See the Amendment For COBRA Administrative Services, if applicable.)

The Contractholder retains responsibility for the following COBRA administration duties:

1. Contractholder will complete and timely provide all notices and enrollment forms to all eligible Subscribers and Dependents (including the initial notice of COBRA rights) required under COBRA, using forms or sample forms provided by the COBRA Administrator.

2. Contractholder will provide a copy of the enrollment form to the COBRA Administrator at the same time that it is sent to the eligible Subscribers and Dependents.

D. INDIVIDUAL CONVERSION PLAN

The Contractholder is solely responsible for notifying Employees of the availability, terms and conditions of the Individual Conversion Plan within 15 days of termination of this Contract's coverage. (See the Individual Conversion Plan section of the Evidence of Coverage and Disclosure Form Booklet.)

EVIDENCE OF COVERAGE AND DISCLOSURE FORM

The Evidence of Coverage and Disclosure Form Booklet and any applicable Supplements will be issued by Blue Shield for all Subscribers covered under this Group Health Service Contract. The following pages contain the exact provisions of the Evidence of Coverage and Disclosure Form Booklet and any applicable Supplements and are included as part of this Contract.

Note: In the Evidence of Coverage and Disclosure Form Booklet, references to "you" or "your" shall mean the eligible Subscriber and/or Dependent of these Plans. References to "we" or "us" shall mean the Plan and/or Blue Shield of California.