AETNA HEALTH OF CALIFORNIA INC.
(CALIFORNIA)

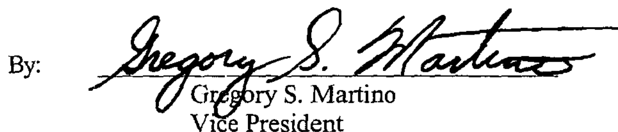
GROUP AGREEMENT COVER SHEET

Contract Holder:	County F San Mateo-Active
Contract Holder Number:	041733 007, 008,010,012 CA04
HMO Referred Benefit Level:	CITIZEN PLAN Benefits Package
Effective Date:	12:01 a.m. on January 1, 2005
Term of **Group Agreement**:	The **Initial Term** shall be: From January 1, 2005 through December 31, 2005 Thereafter, **Subsequent Terms** shall be: From January 1st through December 31st
Premium Due Dates:	The **Group Agreement Effective Date** and the 1st day of each succeeding calendar month.
Governing Law:	Federal law and the laws of California

Notice Address for **HMO**:

Aetna Health of California Inc.
Employer Services Contract Coordinator
1385 East Shaw
Fresno, CA 93710

The signature below is evidence of Aetna Health's acceptance of the **Contract Holder's** Group Application on the terms hereof and constitutes execution of the **Group Agreement(s)** attached hereto on behalf of Aetna Health of California Inc.

By: 
Gregory S. Martino
Vice President

Contract Holder Name: County F San Mateo-Active
Contract Holder Number: 041733
Contract Holder Locations: 007, 008,010,012
Contract Holder Service Areas: CA04
Contract Holder Group Agreement Effective Date: January 1, 2005

AETNA HEALTH OF CALIFORNIA INC.
(CALIFORNIA)

GROUP AGREEMENT

This **Group Agreement** is entered into by and between Aetna Health of California Inc. ("**HMO**") and the **Contract Holder** specified in the attached Cover Sheet. This **Group Agreement** shall be effective on the **Effective Date** specified in the Cover Sheet, and shall continue in force until terminated as provided herein.

In consideration of the mutual promises hereunder and the payment of **Premiums** and fees when due, **We** will provide coverage for benefits in accordance with the terms, conditions, limitations and exclusions set forth in this **Group Agreement**.

Upon acceptance by **Us** of **Contract Holder's** Group Application, and upon receipt of the required initial **Premium,** this **Group Agreement** shall be considered to be agreed to by **Contract Holder** and **Us**, and is fully enforceable in all respects against **Contract Holder** and **Us**.

SECTION 1. DEFINITIONS

1.1 The terms "**Contract Holder**", "**Effective Date**", "**Initial Term**", "**Premium Due Date**" and "**Subsequent Terms**" will have the meaning set forth in the attached Cover Sheet. If any of such terms are undefined in the Cover Sheet, such undefined terms shall have the following meaning:

- "**Effective Date**" would mean the date health coverage commences for the **Contract Holder**.
- "**Initial Term**" would be the period following the **Effective Date** as indicated on the Cover Sheet.
- "**Premium Due Date(s)**" would be the **Effective Date** and each monthly anniversary of the **Effective Date**.
- "**Subsequent Term(s)**" would mean the periods following the **Initial Term** as indicated on the Cover Sheet.

1.2 The terms "**HMO**", "**Us**", "**We**" or "**Our**" mean Aetna Health of California Inc.

1.3 "**EOC**" means the Evidence of Coverage issued pursuant to this **Group Agreement**.

1.4 "**Grace Period**" is defined in Section 3.2.

1.5 "**Group Agreement**" means the **Contract Holder's** Group Application, this document, the attached Cover Sheet; the **EOC** and Schedule of Benefits issued hereunder; the initial rate sheet and any subsequent indication of rates issued by **Us** in connection with this **Group Agreement**; and any riders, amendments, endorsements, inserts or attachments issued pursuant hereto, all of which are incorporated into and made a part of this **Group Agreement**.

1.6 "**Party, Parties**" means **HMO** and **Contract Holder**.

1.7 "**Premium(s)**" is defined in Section 3.1.

1.8 "**Renewal Date**" means the first day following the end of the **Initial Term** or any **Subsequent Term**.

1.9 "**Term**" means the **Initial Term** or any **Subsequent Term**.

1.10 Capitalized and bolded terms not defined in this **Group Agreement** shall have the meaning set forth in the **EOC**. In the event of a conflict between the terms of this **Group Agreement** and the terms of the **EOC**, the terms of this **Group Agreement** shall prevail.

SECTION 2. COVERAGE

2.1 **Covered Benefits.** **We** will provide coverage for **Covered Benefits** to **Members** subject to the terms and conditions of this **Group Agreement**. Coverage will be provided in accordance with the reasonable exercise of **Our** business judgment, consistent with applicable law. **Members** covered under this **Group Agreement** are subject to all of the conditions and provisions contained herein and in the incorporated documents.

2.2 **Policies and Procedures.** **We** have the right to adopt reasonable policies, procedures, rules, and interpretations of this **Group Agreement** and the **EOC** in order to promote orderly and efficient administration.

SECTION 3. PREMIUMS

3.1 **Premiums.** **Contract Holder** shall pay **Us** on or before each **Premium Due Date** a monthly advance premium (the **"Premium"**) determined in accordance with the **Premium** rates and the manner of calculating **Premiums** specified by **HMO**. **Premium** rates and the manner of calculating **Premiums** may be adjusted in accordance with Section 3.4 below. **Premiums** are subject to adjustment, if any, for partial month participation as specified in Section 3.3 below. Membership as of each **Premium Due Date** will be determined by **Us** in accordance with **Our Member** records. A check does not constitute payment until it is honored by a bank. **We** may return a check issued against insufficient funds without making a second deposit attempt. **We** may accept a partial payment of **Premium** without waiving our right to collect the entire amount due.

3.2 **Past Due Premiums.** If a **Premium** payment is not paid in full by **Contract Holder** on or before the **Premium Due Date**, a late payment charge of 1 ½% of the total amount due per month (or partial month) will be added to the amount due. If all **Premiums** are not received before the end of a 30 day grace period (the **"Grace Period"),** this **Group Agreement** will be automatically terminated pursuant to Section 6.3 hereof.

If the **Group Agreement** terminates for any reason, **Contract Holder** will continue to be held liable for all **Premiums** due and unpaid before the termination, including, but not limited to, **Premium** payments for any period of time the **Group Agreement** is in force during the **Grace Period.** **Members** shall also remain liable for **Member** cost sharing and other required contributions to coverage for any period of time the **Group Agreement** is in force during the **Grace Period.** **We** may recover from **Contract Holder Our** costs of collecting any unpaid **Premiums**, including reasonable attorneys' fees and costs of suit.

3.3 **Prorations.** **Premiums** shall be paid in full for **Members** whose coverage is in effect on the **Premium Due Date** or whose coverage terminates on the last day of the **Premium** period.

3.4 **Changes in Premium.** **We** may also adjust the **Premium** rates and/or the manner of calculating **Premiums** effective as of the contract renewal date, upon 30 days prior written notice to **Contract Holder**. Small employers' **Premium** rates will remain in effect for no less than 6 months, for the **Initial Term** and **Subsequent Terms**.

3.5 **Membership Adjustments.** **We** may, at **Our** discretion, make retroactive adjustments to the **Contract Holder's** billings for the termination of **Members** not posted to previous billings. However, **Contract Holder** may only receive a maximum of 2 calendar month's credit for **Member** terminations that occurred more than 30 days before the date **Contract Holder** notified **Us** of the termination. **We** may reduce any such credits by the amount of any payments **We** may have made on behalf of such **Members** (including capitation payments and other claim payments) before **We** were informed their coverage had been

terminated. Retroactive additions will be made at **Our** discretion based upon eligibility guidelines, as set forth in the **EOC**, and are subject to the payment of all applicable **Premiums**.

SECTION 4. ENROLLMENT

4.1 **Open Enrollment.** As described in the **EOC, Contract Holder** will offer enrollment in **HMO**:

- at least once during every twelve month period during the **Open Enrollment Period**; and
- within 31 days from the date the individual and any dependent becomes eligible for coverage.

Eligible individuals and dependents who are not enrolled within the **Open Enrollment Period** or 31 days of becoming eligible, may be enrolled during any subsequent **Open Enrollment Period**. Coverage will not become effective until confirmed by **Us. Contract Holder** agrees to hold the **Open Enrollment Period** consistent with the **Open Enrollment Period** applicable to any other group health benefit plan being offered by the **Contract Holder** and in compliance with applicable law. The **Contract Holder** shall permit **Our** representatives to meet with eligible individuals during the **Open Enrollment Period** unless the parties agree upon an alternate enrollment procedure. As described in the **EOC**, other enrollment periods may apply.

4.2 **Waiting Period**. There may be a waiting period before individuals are eligible for coverage under this **Group Agreement**. The waiting period, if any, is specified on the **Schedule of Benefits**.

4.3 **Eligibility.** The number of eligible individuals and dependents and composition of the group, the identity and status of the **Contract Holder**, the eligibility requirements used to determine membership in the group, and the participation and contribution standards applicable to the group which exist at the **Effective Date** of this **Group Agreement** are material to the execution and continuation of this **Group Agreement** by **Us**. The **Contract Holder** shall not, during the term of this **Group Agreement**, modify the **Open Enrollment Period**, the waiting period as described on the **Schedule of Benefits**, or any other eligibility requirements as described in the **EOC** and on the **Schedule of Benefits**, for the purposes of enrolling **Contract Holder's** eligible individuals and dependents under this **Group Agreement**, unless **We** agree to the modification in writing.

SECTION 5. RESPONSIBILITIES OF THE CONTRACT HOLDER

In addition to other obligations set forth in this **Group Agreement, Contract Holder** agrees to:

5.1 **Records**. Furnish to **Us**, on a monthly basis (or as otherwise required), on our form (or such other form as **We** may reasonably approve) by facsimile (or such other means as **We** may reasonably approve), such information as **We** may reasonably require to administer this **Group Agreement**. This includes, but is not limited to, information needed to enroll members of the **Contract Holder**, process terminations, and effect changes in family status and transfer of employment of **Members**.

Contract Holder represents that all enrollment and eligibility information that has been or will be supplied to **Us** is accurate. **Contract Holder** acknowledges that **We** can and will rely on such enrollment and eligibility information in determining whether an individual is eligible for **Covered Benefits** under this **Group Agreement**. To the extent such information is supplied to Us electronically, **Contract Holder** agrees to:

- Maintain a reasonably complete record of such information (in electronic or hard copy format, including evidence of coverage elections, evidence of eligibility, changes to such elections and terminations) for at least seven years, and to make such information available to **Us** upon request.
- Obtain from all **Subscribers** a "Disclosure of Healthcare Information" authorization in the form currently being used by **Us** in the enrollment process (or such other form as **We** may reasonably approve).

We will not be liable to **Members** for the fulfillment of any obligation prior to information being received in a form satisfactory to **Us**. **Contract Holder** must notify **Us** of the date in which a **Subscriber's** employment ceases for the purpose of termination of coverage under this **Group Agreement**. Subject to applicable law, unless otherwise specifically agreed to in writing, **We** will consider **Subscriber's** employment to continue until the earlier of:

- until stopped by the **Contract Holder**;
- if **Subscriber** has stopped working due to temporary lay off or leave of absence, not beyond the end of the policy month after the policy month in which the absence started; and
- if **Subscriber** stopped working due to disability, not beyond the end of the 30th policy month after the month in which the absence started.

5.2 <u>Access</u>. Make payroll and other records directly related to **Member's** coverage under this **Group Agreement** available to **Us** for inspection, at **Our** expense, at **Contract Holder's** office, during regular business hours, upon reasonable advance request. This provision shall survive termination of this **Group Agreement**.

5.3 **<u>Forms.</u>** Distribute materials to **HMO Members** regarding enrollment, health plan features, including **Covered Benefits** and exclusions and limitations of coverage. **Contract Holder** shall, within 31 days of receipt from an eligible individual, forward all completed enrollment information and other required information to **Us**.

5.4 **<u>Policies and Procedures; Compliance Verification.</u>** Comply with all policies and procedures established by **Us** in administering and interpreting this **Group Agreement**. **Contract Holder** shall, upon request, provide a certification of its compliance with **Our** participation and contribution requirements and the requirements for a group as defined under applicable law or regulation.

5.5 **<u>Continuation Rights and Conversion.</u>** Notify all eligible **Members** of their right to continue or convert coverage pursuant to applicable law.

5.6 **Contract Holder Obligations Under COBRA.** Under federal law, an employer who employs twenty (20) or more employees on a typical business day during the prior calendar year must provide **Members** with the opportunity to elect COBRA continuation coverage in certain circumstances where coverage would otherwise terminate. Such **Contract Holders** and their group health plan's administrators (in certain cases, the employer may be the plan administrator) have the obligation to: (1) provide **Members** with notice of the opportunity to elect continuation coverage; and (2) administer the continuation coverage. The obligation to provide notice includes both general notification to **Members** of their right to elect continuation coverage and specific notification of the right to continuation coverage within a specific time period after the occurrence of the event which triggers the continuation coverage option.

Contract Holder hereby acknowledges its legal obligations and agrees to abide by applicable legal requirements with respect to COBRA continuation coverage. **Contract Holder** also agrees to forward to **HMO** in a timely manner copies of any and all notices provided to **Members** regarding COBRA continuation coverage.

Contract Holder Obligations Under Cal-COBRA. Under California law, a health care service plan that contracts with employers who employ two (2) through nineteen (19) eligible employees on a typical business day during the prior calendar year is required to provide **Members** with the opportunity to elect Cal-COBRA continuation coverage in certain circumstances where coverage would otherwise terminate. **HMO** will administer or contract for the administration of continuation coverage under Cal-COBRA. Nonetheless, Contract Holder must provide certain notices to **HMO** and to **Members** as described below. **Contract Holder** must notify **HMO** in writing of any employee who has a qualifying event defined in the Continuation and Conversion section, Item 2 – Cal-COBRA Continuation Coverage of the **EOC** within

thirty (30) days of the qualifying event. Such notice must be separate from other communications from **Contract Holder** and must specifically reference Cal-COBRA. Notations of additions and/or deletions on monthly invoices will not constitute sufficient notice. **Contract Holder** must further provide written notice to **HMO** within thirty (30) days of the date the **Contract Holder** 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.

Contract Holder must also notify qualified beneficiaries of the ability to continue coverage prior to terminating a group agreement (such as this **Group Agreement**) under which a qualified beneficiary is receiving continuation coverage. This notification shall be provided either thirty (30) days prior to the agreement termination or when all other enrolled employees are notified, whichever is greater. **Contract Holder** must notify any successor plan in writing of the qualified beneficiaries currently receiving continuation coverage to enable the successor plan, contracting employer, or administrator to provide such qualified beneficiaries with the premium information, enrollment forms, and disclosures necessary to allow the qualified beneficiaries to continue coverage under other available group plans.

If **Contract Holder** fails to meet these obligations, **HMO** will not provide continuation coverage to qualified beneficiaries under Cal-COBRA. **Contract Holder** hereby acknowledges its obligations and agrees to comply with all applicable legal requirements with respect to Cal-COBRA continuation coverage. **Contract Holder** also agrees to forward to **HMO** in a timely manner copies of any notice provided to **Members** regarding Cal-COBRA continuation coverage.

5.7 **ERISA Requirements.** Maintain responsibility for making reports and disclosures required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), including the creation, distribution and final content of summary plan descriptions, summary of material modifications and summary annual reports.

SECTION 6. TERMINATION

6.1 Termination by Contract Holder. This **Group Agreement** may be terminated by **Contract Holder** as of any **Premium Due Date** by providing **Us** with 30 days prior written notice. However, **We** may in **Our** discretion accept an oral indication by **Contract Holder** or it's agent or broker of intent to terminate.

6.2 **Non-Renewal by Contract Holder.** **We** may request from **Contract Holder** a written indication of their intention to renew or non-renew this **Group Agreement** at any time during the final three months of any **Term**. If **Contract Holder** fails to reply to such request within the timeframe specified the **Contract Holder** shall be deemed to have provided notice of non-renewal to **Us** and this **Group Agreement** shall be deemed to terminate automatically as of the end of the **Term**. Similarly, upon **Our** written confirmation to **Contract Holder, We** may accept an oral indication by **Contract Holder** or its agent or broker of intent to non-renew as **Contract Holder's** notice of termination effective as of the end of the **Term**.

6.3 **Termination by Us.** This **Group Agreement** will terminate as of the last day of the **Grace Period** if the **Premium** remains unpaid at the end of the **Grace Period**.

This **Group Agreement** may also be terminated by **Us** as follows:

- Immediately upon notice to **Contract Holder** if **Contract Holder** has performed any act or practice that constitutes fraud or made any intentional misrepresentation of a material fact relevant to the coverage provided under this **Group Agreement**;

- Immediately upon notice to **Contract Holder** if **Contract Holder** no longer has any enrollee under the Plan who resides or works in the **Service Area**;

- Upon 30 days written notice to **Contract Holder** if **Contract Holder** (i) breaches a provision of this **Group Agreement** and such breach remains uncured at the end of the notice period; (ii) ceases to meet **Our** requirements for an employer group or association; (iii) fails to meet **Our**

contribution or participation requirements applicable to this **Group Agreement** (which contribution and participation requirements are available upon request); (iv) fails to provide the certification required by Section 5.4 within a reasonable period of time specified by **Us**; or (v) changes its eligibility or participation requirements without **Our** consent;

- Upon 90 days written notice to **Contract Holder** (or such shorter notice as may be permitted by applicable law, but in no event less than 30 days) if **We** cease to offer the product to which the **Group Agreement** relates;

- Upon 180 days written notice to **Contract Holder** (or such shorter notice as may be permitted by applicable law, but in no event less than 30 days) if **We** cease to offer coverage in a market in which **Members** covered under this **Group Agreement** reside;

- Upon 30 days written notice to **Contract Holder** for any other reason which is acceptable to the Department of Managed Health Care and consistent with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or by applicable federal rules and regulations, as amended.

6.4 **Effect of Termination.** No termination of this **Group Agreement** will relieve either party from any obligation incurred before the date of termination. When terminated, this **Group Agreement** and all coverage provided hereunder will end at 12:00 midnight on the effective date of termination. **We** may charge the **Contract Holder** a reinstatement fee if coverage is terminated and subsequently reinstated under this **Group Agreement**. Upon termination, **We** will provide **Members** with Certificates of Creditable Coverage which will show evidence of a **Member's** prior health coverage with **Us** for a period of up to 18 months prior to the loss of coverage.

6.5 **Notice to Subscribers and Members**. It is the responsibility of **Contract Holder** to notify the **Members** of the termination of the **Group Agreement** in compliance with all applicable laws. However, **We** reserve the right to notify **Members** of termination of the **Group Agreement** for any reason, including non-payment of **Premium**. In accordance with the **EOC**, the **Contract Holder** shall provide written notice to **Members** of their rights upon termination of coverage.

SECTION 7. PRIVACY OF INFORMATION

7.1 **Compliance with Privacy Laws.** **We** and **Contract Holder** will abide by all applicable laws and regulations regarding confidentiality of individually identifiable health and other personal information, including the privacy requirements of HIPAA.

7.2 **Disclosure of Protected Health Information.** **We** will not provide protected health information ("PHI"), as defined in HIPAA, to **Contract Holder**, and **Contract Holder** will not request PHI from **Us**, unless **Contract Holder** has either:

- provided the certification required by 45 C.F.R. § 164.504(f) and amended **Contract Holder**'s plan documents to incorporate the necessary changes required by such rule; or

- provided confirmation that the PHI will not be disclosed to the "plan sponsor", as such term is defined in 45 C.F.R. § 164.501.

7.3 **Brokers and Consultants.** To the extent any broker or consultant receives PHI in the underwriting process or while advocating on behalf of a **Member**, **Contract Holder** understands and agrees that such broker or consultant is acting on behalf of **Contract Holder** and not **Us**. **We** are entitled to rely on **Contract Holder's** representations that any such broker or consultant is authorized to act on **Contract Holder's** behalf and entitled to have access to the PHI under the relevant circumstances.

SECTION 8. INDEPENDENT CONTRACTOR RELATIONSHIPS

8.1 **Relationship Between Us and Participating Providers**. The relationship between **Us** and **Participating Providers** is a contractual relationship among independent contractors. **Participating Providers** are not agents or employees of **Us** nor are **We** an agent or employee of any **Participating Provider**.

Participating Providers are solely responsible for any health services rendered to their **Member** patients. **We** make no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any **Physician**, **Hospital** or other **Participating Provider**. A **Provider's** participation may be terminated at any time without advance notice to the **Contract Holder** or **Members**, subject to applicable law. **Participating Providers** provide health care diagnosis, treatment and services for **Members**. **We** administer and determine plan benefits.

8.2 **Relationship Between the Parties**. The relationship between the **Parties** is a contractual relationship between independent contractors. Neither **Party** is an agent or employee of the other in performing its obligations pursuant to this **Group Agreement**.

SECTION 9. MISCELLANEOUS

9.1 **Delegation and Subcontracting**. **Contract Holder** acknowledges and agrees that **We** may enter into arrangements with third parties to delegate functions hereunder such as utilization management, quality assurance and provider credentialing, as **We** deem appropriate in **Our** sole discretion and as consistent with applicable laws and regulations. **Contract Holder** also acknowledges that **Our** arrangements with third party vendors (i.e. pharmacy, behavioral health) are subject to change in accordance with applicable laws and regulations.

9.2 **Accreditation and Qualification Status**. **We** may from time to time obtain voluntary accreditation or qualification status from a private accreditation organization or government agency. **We** make no express or implied warranty about **Our** continued qualification or accreditation status.

9.3 **Prior Agreements; Severability**. As of the **Effective Date**, this **Group Agreement** replaces and supersedes all other prior agreements between the **Parties** as well as any other prior written or oral understandings, negotiations, discussions or arrangements between the **Parties** related to matters covered by this **Group Agreement** or the documents incorporated herein. If any provision of this **Group Agreement** is deemed to be invalid or illegal, that provision shall be fully severable and the remaining provisions of this **Group Agreement** shall continue in full force and effect.

9.4 **Amendments.** This **Group Agreement** may be amended as follows:

- This **Group Agreement** shall be deemed to be automatically amended to conform with all rules and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over **Us**;
- By written agreement between both **Parties**; or
- By **Us** upon 30 days written notice to **Contract Holder**.

The **Parties** agree that an amendment does not require the consent of any employee, **Member** or other person. Except for automatic amendments to comply with law, all amendments to this **Group Agreement** must be approved and executed by **Us**. No other individual has the authority to modify this **Group Agreement**; waive any of its provisions, conditions, or restrictions; extend the time for making a payment; or bind **Us** by making any other commitment or representation or by giving or receiving any information.

9.5 **Clerical Errors**. Clerical errors or delays by **Us** in keeping or reporting data relative to coverage will not reduce or invalidate a **Member's** coverage. Upon discovery of an error or delay, an adjustment of

Premiums shall be made. **We** may also modify or replace a **Group Agreement**, **EOC** or other document issued in error.

9.6 <u>Claim Determinations</u>. **We** have complete authority to review all claims for **Covered Benefits** under this **Group Agreement**. In exercising such responsibility, **We** shall have discretionary authority to determine whether and to what extent eligible individuals and beneficiaries are entitled to coverage and to construe any disputed or doubtful terms under this **Group Agreement**, the **EOC** or any other document incorporated herein. **We** shall be deemed to have properly exercised such authority unless **We** abuse our discretion by acting arbitrarily and capriciously. **Our** review of claims may include the use of commercial software (including Claim Check) and other tools to take into account factors such as an individual's claims history, a **Provider's** billing patterns, complexity of the service or treatment, amount of time and degree of skill needed and the manner of billing.

9.7 <u>Misstatements</u>. If any fact as to the **Contract Holder** or a **Member** is found to have been misstated, an equitable adjustment of **Premiums** may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

9.8 <u>Incontestability</u>. Except as to a fraudulent misstatement, or issues concerning **Premiums** due:

- No statement made by **Contract Holder** or any **Member** shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.
- No statement made by **Contract Holder** shall be the basis for voiding this **Group Agreement** after it has been in force for two years from its effective date.

9.9 <u>Assignability</u>. No rights or benefits under this **Group Agreement** are assignable by **Contract Holder** to any other party unless approved by **HMO**.

9.10 <u>Waiver</u>. **Our** failure to implement, or insist upon compliance with, any provision of this **Group Agreement** or the terms of the **EOC** incorporated hereunder, at any given time or times, shall not constitute a waiver of **Our** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of **Premiums** or benefits. This applies whether or not the circumstances are the same.

9.11 <u>Notices</u>. Any notice required or permitted under this **Group Agreement** shall be in writing and shall be deemed to have been given on the date when delivered in person; or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the address set forth in the Group Application or Cover Sheet, or to any more recent address of which the sending party has received written notice or, if delivered by facsimile or other electronic means, on the date sent by facsimile or other electronic means.

9.12 <u>Third Parties</u>. This **Group Agreement** shall not confer any rights or obligations on third parties except as specifically provided herein.

9.13 <u>Non-Discrimination</u>. **Contract Holder** agrees to make no attempt, whether through differential contributions or otherwise, to encourage or discourage enrollment in **HMO** of eligible individuals and eligible **Dependents** based on health status or health risk.

9.14 <u>Applicable Law</u>. This **Group Agreement** shall be governed and construed in accordance with applicable federal law and the law of the state specified in the Cover Sheet or, if no state law is specified, **Our** domicile state.

9.15 <u>Inability to Arrange Services</u>. If due to circumstances not within **Our** reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of **Our Participating Providers** or entities with whom **We** have contracted for services under this **Group Agreement**, or similar causes, the provision of medical or **Hospital** benefits

or other services provided under this **Group Agreement** is delayed or rendered impractical, **We** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **Us** on the date such event occurs. **We** are required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

9.16 **Use of the HMO Name and all Symbols, Trademarks, and Service Marks.** We reserve the right to control the use of **Our** name and all symbols, trademarks, and service marks presently existing or subsequently established. **Contract Holder** agrees that it will not use such name, symbols, trademarks, or service marks in advertising or promotional materials or otherwise without **Our** prior written consent and will cease any and all usage immediately upon **Our** request or upon termination of this **Group Agreement.**

9.17 **Dispute Resolution.** Any controversy, dispute or claim between **Us** on the one hand and one or more **Interested Parties** on the other hand arising out of or relating to the **Group Agreement**, whether stated in tort, contract, statute, claim for benefits, bad faith, professional liability or otherwise ("Claim"), shall be settled by confidential binding arbitration administered by the American Arbitration Association ("AAA") before a sole arbitrator ("Arbitrator"). Judgment on the award rendered by the Arbitrator ("Award") may be entered by any court having jurisdiction thereof. If the AAA declines to administer the case and the parties do not agree on an alternative administrator, a sole neutral arbitrator shall be appointed upon petition to a court having jurisdiction. **We** and **Interested Parties** hereby give up our rights to have Claims decided in a court before a jury.

Any Claim alleging wrongful acts or omissions of **Participating** or **Non-Participating Providers** shall not include **HMO**. A **Member** must exhaust all grievance, appeal and independent external review procedures prior to the commencement of an arbitration hereunder. No person may recover any damages arising out of or related to the failure to approve or provide any benefit or coverage beyond payment of or coverage for the benefit or coverage where (i) **We** have made available independent external review and (ii) **We** have followed the reviewer's decision. Punitive damages may not be recovered as part of a Claim under any circumstances . No **Interested Party** may participate in a representative capacity or as a member of any class in any proceeding arising out of or related to the **Group Agreement**. This agreement to arbitrate shall be specifically enforced even if a party to the arbitration is also a party to another proceeding with a third party arising out of the same matter.

9.18 **Workers' Compensation. Contract Holder** is responsible for protecting **Our** interests in any Workers' Compensation claims or settlements with any eligible individual. **We** shall be reimbursed for all paid medical expenses which have occurred as a result of any work related injury that is compensable or settled in any manner.

On or before the **Effective Date** of this **Group Agreement** and upon renewal, **Contract Holder** shall submit proof of their Workers' Compensation coverage or an exclusion form which has been accepted by the applicable regulatory authority governing Workers' Compensation. Upon **Our** request, **Contract Holder** shall also submit a monthly report to **Us** listing all Workers' Compensation cases. Such list will contain the name, social security number, date of loss and diagnosis of all applicable eligible individuals.

9.19 **Subrogation.** If **HMO** provides health care benefits under this **Group Agreement** to a **Member** for injuries or illness for which a third party is or may be responsible, then **HMO** retains the right to repayment (a lien), to the extend permitted by law for the value of all benefits provided by **HMO** that are associated with the injury or illness for which the third party is or may be responsible, plus the costs to perfect the lien. In some cases, **Participating Providers** may assert the **HMO's** lien. Some **Providers** also have lien rights that are independent of the **HMO's** rights.

HMO's rights of recovery are described in the Third Party Liability and Right of Recovery section of the **EOC**. The sum which **HMO** may actually recover is limited as follows:

- No lien may exceed the sum of the reasonable costs actually paid by **HMO** to perfect the lien and one of the following:

a. for health care services provided on a non-capitated basis, the amount actually paid by **HMO** to any treating **Provider,** or

b. for health care services provided on a capitated basis, the amount equal to 80 percent of the **Reasonable Charge** for the same services by **Providers** that provide health care services on a non-capitated basis in the geographic region in which the services were rendered, or

c. If the **Member** received services on a capitated basis and on a non-capitated basis and the **HMO** covered services on a capitated basis and paid for the services the **Member** received on a non-capitated basis, the lien may not exceed the sum of the reasonable costs actually paid to perfect the lien and the amounts determined according to (a) and (b) above.

- If the **Member** engaged an attorney, then the lien may not exceed the lesser of the following amounts;

a. The maximum amount determined by 1.a, 1.b or 1.c above, whichever is applicable, or

b. One-third of the amount due to the **Member** under any final judgment, compromise, or settlement agreement.

- If the **Member** did not engage an attorney, then the lien may not exceed the lesser of the following amounts.

a. The maximum amount determined by 1.a, 1.b or 1.c above, whichever is applicable, or

b. One-half of the amount due to the **Member** under any final judgment, compromise, or settlement agreement.

- Where a final judgment includes a special finding by a judge, jury or arbitrator, that the **Member** was partially at fault, the lien as determined by 1.a, 1.b or 1.c 3 above shall be reduced by the same comparative fault percentage by which the **Member's** recovery amount was reduced.

- The lien amount determined by 1.a, 1.b or 1.c above is subject to pro rata reduction, commensurate with the **Member's** attorney's fees and costs, in accordance with the common fund doctrine.

- Liens against workers' compensation claims are not subject to the requirements listed above.

AETNA HEALTH OF CALIFORNIA INC.
(CALIFORNIA)

GROUP AGREEMENT AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2005

The section 6.5 of the **Group Agreement** is hereby deleted and replaced with the following:

6.5 Notice to Subscribers and Members. It is the responsibility of **Contract Holder** to notify the **Members** of the termination of the **Group Agreement** in compliance with all applicable laws. In the event we provide notice of cancellation for non-payment of premium to **Contract Holder**, **Contract Holder** agrees to promptly mail a legible, true copy of the notice of cancellation to all **Subscribers** at their current address. The notice of cancellation to **Contract Holder** will include:

- the date and time coverage will terminate
- the cause for cancellation, including reference to the applicable clause in the **Group Agreement**
- a statement that the cause for cancellation was not due to the **Member's** health status or requirements for health care services
- that a **Member** who alleges that cancellation was due to the **Member's** health status may request a review of cancellation by the Department of Managed Health Care
- information regarding the **Member's** COBRA, Cal-COBRA, conversion Coverage and HIPAA Individual coverage.

Such notice must be mailed to **Subscribers** 15 days prior to the date of termination. If the **Contract Holder** fails to deliver the above-referenced notice of cancellation and deliver proof of mailing to **US**, **We** will mail notice directly to the individual **Subscribers:** coverage will not end until the 15th day after **HMO** mails the notice. The **Contract Holder** is required to reimburse **Us** for the costs of such mailing and for all premiums accrued do to the non-performance of this contractual obligation.

However, **We** reserve the right to notify **Members** of termination of the **Group Agreement** for any reason, including non-payment of **Premium**.

AETNA HEALTH OF CALIFORNIA INC.
(CALIFORNIA)

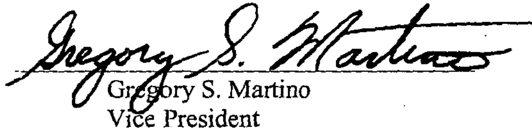
GROUP AGREEMENT COVER SHEET

Contract Holder:	County F San Mateo-Active
Contract Holder Number:	041733 001, 002,004 CA01
HMO Referred Benefit Level:	CITIZEN PLAN Benefits Package
Effective Date:	12:01 a.m. on January 1, 2005
Term of **Group Agreement**:	The **Initial Term** shall be: From January 1, 2005 through December 31, 2005 Thereafter, **Subsequent Terms** shall be: From January 1st through December 31st
Premium Due Dates:	The **Group Agreement Effective Date** and the 1st day of each succeeding calendar month.
Governing Law:	Federal law and the laws of California

Notice Address for **HMO**:

Aetna Health of California Inc.
Employer Services Contract Coordinator
1385 East Shaw
Fresno, CA 93710

The signature below is evidence of Aetna Health's acceptance of the **Contract Holder's** Group Application on the terms hereof and constitutes execution of the **Group Agreement(s)** attached hereto on behalf of Aetna Health of California Inc.

By: 
Gregory S. Martino
Vice President

Contract Holder Name: County F San Mateo-Active
Contract Holder Number: 041733
Contract Holder Locations: 001, 002,004
Contract Holder Service Areas: CA01
Contract Holder Group Agreement Effective Date: January 1, 2005

AETNA HEALTH OF CALIFORNIA INC.
(CALIFORNIA)

GROUP AGREEMENT

This **Group Agreement** is entered into by and between Aetna Health of California Inc. ("**HMO**") and the **Contract Holder** specified in the attached Cover Sheet. This **Group Agreement** shall be effective on the **Effective Date** specified in the Cover Sheet, and shall continue in force until terminated as provided herein.

In consideration of the mutual promises hereunder and the payment of **Premiums** and fees when due, **We** will provide coverage for benefits in accordance with the terms, conditions, limitations and exclusions set forth in this **Group Agreement**.

Upon acceptance by **Us** of **Contract Holder's** Group Application, and upon receipt of the required initial **Premium,** this **Group Agreement** shall be considered to be agreed to by **Contract Holder** and **Us**, and is fully enforceable in all respects against **Contract Holder** and **Us.**

SECTION 1. DEFINITIONS

1.1 The terms **"Contract Holder", "Effective Date", "Initial Term", "Premium Due Date"** and **"Subsequent Terms"** will have the meaning set forth in the attached Cover Sheet. If any of such terms are undefined in the Cover Sheet, such undefined terms shall have the following meaning:

- "**Effective Date**" would mean the date health coverage commences for the **Contract Holder.**
- "**Initial Term**" would be the period following the **Effective Date** as indicated on the Cover Sheet.
- "**Premium Due Date(s)**" would be the **Effective Date** and each monthly anniversary of the **Effective Date.**
- "**Subsequent Term(s)**" would mean the periods following the **Initial Term** as indicated on the Cover Sheet.

1.2 The terms **"HMO", "Us", "We"** or **"Our"** mean Aetna Health of California Inc.

1.3 **"EOC"** means the Evidence of Coverage issued pursuant to this **Group Agreement.**

1.4 **"Grace Period"** is defined in Section 3.2.

1.5 **"Group Agreement"** means the **Contract Holder's** Group Application, this document, the attached Cover Sheet; the **EOC** and Schedule of Benefits issued hereunder; the initial rate sheet and any subsequent indication of rates issued by **Us** in connection with this **Group Agreement**; and any riders, amendments, endorsements, inserts or attachments issued pursuant hereto, all of which are incorporated into and made a part of this **Group Agreement.**

1.6 **"Party, Parties"** means **HMO** and **Contract Holder.**

1.7 **"Premium(s)"** is defined in Section 3.1.

1.8 **"Renewal Date"** means the first day following the end of the **Initial Term** or any **Subsequent Term.**

1.9 **"Term"** means the **Initial Term** or any **Subsequent Term.**

1.10 Capitalized and bolded terms not defined in this **Group Agreement** shall have the meaning set forth in the **EOC**. In the event of a conflict between the terms of this **Group Agreement** and the terms of the **EOC**, the terms of this **Group Agreement** shall prevail.

SECTION 2. COVERAGE

2.1 **Covered Benefits.** **We** will provide coverage for **Covered Benefits** to **Members** subject to the terms and conditions of this **Group Agreement**. Coverage will be provided in accordance with the reasonable exercise of **Our** business judgment, consistent with applicable law. **Members** covered under this **Group Agreement** are subject to all of the conditions and provisions contained herein and in the incorporated documents.

2.2 **Policies and Procedures.** We have the right to adopt reasonable policies, procedures, rules, and interpretations of this **Group Agreement** and the **EOC** in order to promote orderly and efficient administration.

SECTION 3. PREMIUMS

3.1 **Premiums.** **Contract Holder** shall pay **Us** on or before each **Premium Due Date** a monthly advance premium (the "**Premium**") determined in accordance with the **Premium** rates and the manner of calculating **Premiums** specified by **HMO**. **Premium** rates and the manner of calculating **Premiums** may be adjusted in accordance with Section 3.4 below. **Premiums** are subject to adjustment, if any, for partial month participation as specified in Section 3.3 below. Membership as of each **Premium Due Date** will be determined by **Us** in accordance with **Our Member** records. A check does not constitute payment until it is honored by a bank. **We** may return a check issued against insufficient funds without making a second deposit attempt. **We** may accept a partial payment of **Premium** without waiving our right to collect the entire amount due.

3.2 **Past Due Premiums.** If a **Premium** payment is not paid in full by **Contract Holder** on or before the **Premium Due Date**, a late payment charge of 1 ½% of the total amount due per month (or partial month) will be added to the amount due. If all **Premiums** are not received before the end of a 30 day grace period (the "**Grace Period**"), this **Group Agreement** will be automatically terminated pursuant to Section 6.3 hereof.

If the **Group Agreement** terminates for any reason, **Contract Holder** will continue to be held liable for all **Premiums** due and unpaid before the termination, including, but not limited to, **Premium** payments for any period of time the **Group Agreement** is in force during the **Grace Period.** **Members** shall also remain liable for **Member** cost sharing and other required contributions to coverage for any period of time the **Group Agreement** is in force during the **Grace Period.** **We** may recover from **Contract Holder Our** costs of collecting any unpaid **Premiums**, including reasonable attorneys' fees and costs of suit.

3.3 **Prorations.** **Premiums** shall be paid in full for **Members** whose coverage is in effect on the **Premium Due Date** or whose coverage terminates on the last day of the **Premium** period.

3.4 **Changes in Premium.** **We** may also adjust the **Premium** rates and/or the manner of calculating **Premiums** effective as of the contract renewal date, upon 30 days prior written notice to **Contract Holder**. Small employers' **Premium** rates will remain in effect for no less than 6 months, for the **Initial Term** and **Subsequent Terms**.

3.5 **Membership Adjustments.** **We** may, at **Our** discretion, make retroactive adjustments to the **Contract Holder's** billings for the termination of **Members** not posted to previous billings. However, **Contract Holder** may only receive a maximum of 2 calendar month's credit for **Member** terminations that occurred more than 30 days before the date **Contract Holder** notified **Us** of the termination. **We** may reduce any such credits by the amount of any payments **We** may have made on behalf of such **Members** (including capitation payments and other claim payments) before **We** were informed their coverage had been

terminated. Retroactive additions will be made at **Our** discretion based upon eligibility guidelines, as set forth in the **EOC**, and are subject to the payment of all applicable **Premiums**.

SECTION 4. ENROLLMENT

4.1 **Open Enrollment.** As described in the **EOC, Contract Holder** will offer enrollment in **HMO**:

- at least once during every twelve month period during the **Open Enrollment Period**; and
- within 31 days from the date the individual and any dependent becomes eligible for coverage.

Eligible individuals and dependents who are not enrolled within the **Open Enrollment Period** or 31 days of becoming eligible, may be enrolled during any subsequent **Open Enrollment Period**. Coverage will not become effective until confirmed by **Us**. **Contract Holder** agrees to hold the **Open Enrollment Period** consistent with the **Open Enrollment Period** applicable to any other group health benefit plan being offered by the **Contract Holder** and in compliance with applicable law. The **Contract Holder** shall permit **Our** representatives to meet with eligible individuals during the **Open Enrollment Period** unless the parties agree upon an alternate enrollment procedure. As described in the **EOC**, other enrollment periods may apply.

4.2 **Waiting Period**. There may be a waiting period before individuals are eligible for coverage under this **Group Agreement**. The waiting period, if any, is specified on the **Schedule of Benefits**.

4.3 **Eligibility.** The number of eligible individuals and dependents and composition of the group, the identity and status of the **Contract Holder**, the eligibility requirements used to determine membership in the group, and the participation and contribution standards applicable to the group which exist at the **Effective Date** of this **Group Agreement** are material to the execution and continuation of this **Group Agreement** by **Us**. The **Contract Holder** shall not, during the term of this **Group Agreement**, modify the **Open Enrollment Period**, the waiting period as described on the **Schedule of Benefits**, or any other eligibility requirements as described in the **EOC** and on the **Schedule of Benefits**, for the purposes of enrolling **Contract Holder's** eligible individuals and dependents under this **Group Agreement**, unless **We** agree to the modification in writing.

SECTION 5. RESPONSIBILITIES OF THE CONTRACT HOLDER

In addition to other obligations set forth in this **Group Agreement, Contract Holder** agrees to:

5.1 **Records**. Furnish to **Us**, on a monthly basis (or as otherwise required), on our form (or such other form as **We** may reasonably approve) by facsimile (or such other means as **We** may reasonably approve), such information as **We** may reasonably require to administer this **Group Agreement**. This includes, but is not limited to, information needed to enroll members of the **Contract Holder**, process terminations, and effect changes in family status and transfer of employment of **Members**.

Contract Holder represents that all enrollment and eligibility information that has been or will be supplied to **Us** is accurate. **Contract Holder** acknowledges that **We** can and will rely on such enrollment and eligibility information in determining whether an individual is eligible for **Covered Benefits** under this **Group Agreement**. To the extent such information is supplied to **Us** electronically, **Contract Holder** agrees to:

- Maintain a reasonably complete record of such information (in electronic or hard copy format, including evidence of coverage elections, evidence of eligibility, changes to such elections and terminations) for at least seven years, and to make such information available to **Us** upon request.
- Obtain from all **Subscribers** a "Disclosure of Healthcare Information" authorization in the form currently being used by **Us** in the enrollment process (or such other form as **We** may reasonably approve).

We will not be liable to **Members** for the fulfillment of any obligation prior to information being received in a form satisfactory to **Us**. **Contract Holder** must notify **Us** of the date in which a **Subscriber's** employment ceases for the purpose of termination of coverage under this **Group Agreement**. Subject to applicable law, unless otherwise specifically agreed to in writing, **We** will consider **Subscriber's** employment to continue until the earlier of:

- until stopped by the **Contract Holder**;
- if **Subscriber** has stopped working due to temporary lay off or leave of absence, not beyond the end of the policy month after the policy month in which the absence started; and
- if **Subscriber** stopped working due to disability, not beyond the end of the 30th policy month after the month in which the absence started.

5.2 <u>Access</u>. Make payroll and other records directly related to **Member's** coverage under this **Group Agreement** available to **Us** for inspection, at **Our** expense, at **Contract Holder's** office, during regular business hours, upon reasonable advance request. This provision shall survive termination of this **Group Agreement**.

5.3 **<u>Forms.</u>** Distribute materials to **HMO Members** regarding enrollment, health plan features, including **Covered Benefits** and exclusions and limitations of coverage. **Contract Holder** shall, within 31 days of receipt from an eligible individual, forward all completed enrollment information and other required information to **Us**.

5.4 **<u>Policies and Procedures; Compliance Verification.</u>** Comply with all policies and procedures established by **Us** in administering and interpreting this **Group Agreement**. **Contract Holder** shall, upon request, provide a certification of its compliance with **Our** participation and contribution requirements and the requirements for a group as defined under applicable law or regulation.

5.5 **<u>Continuation Rights and Conversion.</u>** Notify all eligible **Members** of their right to continue or convert coverage pursuant to applicable law.

5.6 **Contract Holder Obligations Under COBRA.** Under federal law, an employer who employs twenty (20) or more employees on a typical business day during the prior calendar year must provide **Members** with the opportunity to elect COBRA continuation coverage in certain circumstances where coverage would otherwise terminate. Such **Contract Holders** and their group health plan's administrators (in certain cases, the employer may be the plan administrator) have the obligation to: (1) provide **Members** with notice of the opportunity to elect continuation coverage; and (2) administer the continuation coverage. The obligation to provide notice includes both general notification to **Members** of their right to elect continuation coverage and specific notification of the right to continuation coverage within a specific time period after the occurrence of the event which triggers the continuation coverage option.

Contract Holder hereby acknowledges its legal obligations and agrees to abide by applicable legal requirements with respect to COBRA continuation coverage. **Contract Holder** also agrees to forward to **HMO** in a timely manner copies of any and all notices provided to **Members** regarding COBRA continuation coverage.

Contract Holder Obligations Under Cal-COBRA. Under California law, a health care service plan that contracts with employers who employ two (2) through nineteen (19) eligible employees on a typical business day during the prior calendar year is required to provide **Members** with the opportunity to elect Cal-COBRA continuation coverage in certain circumstances where coverage would otherwise terminate. **HMO** will administer or contract for the administration of continuation coverage under Cal-COBRA. Nonetheless, Contract Holder must provide certain notices to **HMO** and to **Members** as described below. **Contract Holder** must notify **HMO** in writing of any employee who has a qualifying event defined in the Continuation and Conversion section, Item 2 – Cal-COBRA Continuation Coverage of the **EOC** within

thirty (30) days of the qualifying event. Such notice must be separate from other communications from **Contract Holder** and must specifically reference Cal-COBRA. Notations of additions and/or deletions on monthly invoices will not constitute sufficient notice. **Contract Holder** must further provide written notice to **HMO** within thirty (30) days of the date the **Contract Holder** 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.

Contract Holder must also notify qualified beneficiaries of the ability to continue coverage prior to terminating a group agreement (such as this **Group Agreement**) under which a qualified beneficiary is receiving continuation coverage. This notification shall be provided either thirty (30) days prior to the agreement termination or when all other enrolled employees are notified, whichever is greater. **Contract Holder** must notify any successor plan in writing of the qualified beneficiaries currently receiving continuation coverage to enable the successor plan, contracting employer, or administrator to provide such qualified beneficiaries with the premium information, enrollment forms, and disclosures necessary to allow the qualified beneficiaries to continue coverage under other available group plans.

If **Contract Holder** fails to meet these obligations, **HMO** will not provide continuation coverage to qualified beneficiaries under Cal-COBRA. **Contract Holder** hereby acknowledges its obligations and agrees to comply with all applicable legal requirements with respect to Cal-COBRA continuation coverage. **Contract Holder** also agrees to forward to **HMO** in a timely manner copies of any notice provided to **Members** regarding Cal-COBRA continuation coverage.

5.7 **ERISA Requirements.** Maintain responsibility for making reports and disclosures required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), including the creation, distribution and final content of summary plan descriptions, summary of material modifications and summary annual reports.

SECTION 6. TERMINATION

6.1 **Termination by Contract Holder**. This **Group Agreement** may be terminated by **Contract Holder** as of any **Premium Due Date** by providing **Us** with 30 days prior written notice. However, **We** may in **Our** discretion accept an oral indication by **Contract Holder** or it's agent or broker of intent to terminate.

6.2 **Non-Renewal by Contract Holder.** **We** may request from **Contract Holder** a written indication of their intention to renew or non-renew this **Group Agreement** at any time during the final three months of any **Term**. If **Contract Holder** fails to reply to such request within the timeframe specified the **Contract Holder** shall be deemed to have provided notice of non-renewal to **Us** and this **Group Agreement** shall be deemed to terminate automatically as of the end of the **Term**. Similarly, upon **Our** written confirmation to **Contract Holder, We** may accept an oral indication by **Contract Holder** or its agent or broker of intent to non-renew as **Contract Holder's** notice of termination effective as of the end of the **Term**.

6.3 **Termination by Us.** This **Group Agreement** will terminate as of the last day of the **Grace Period** if the **Premium** remains unpaid at the end of the **Grace Period**.

This **Group Agreement** may also be terminated by **Us** as follows:

- Immediately upon notice to **Contract Holder** if **Contract Holder** has performed any act or practice that constitutes fraud or made any intentional misrepresentation of a material fact relevant to the coverage provided under this **Group Agreement**;
- Immediately upon notice to **Contract Holder** if **Contract Holder** no longer has any enrollee under the Plan who resides or works in the **Service Area**;
- Upon 30 days written notice to **Contract Holder** if **Contract Holder** (i) breaches a provision of this **Group Agreement** and such breach remains uncured at the end of the notice period; (ii) ceases to meet **Our** requirements for an employer group or association; (iii) fails to meet **Our**

contribution or participation requirements applicable to this **Group Agreement** (which contribution and participation requirements are available upon request); (iv) fails to provide the certification required by Section 5.4 within a reasonable period of time specified by **Us**; or (v) changes its eligibility or participation requirements without **Our** consent;

- Upon 90 days written notice to **Contract Holder** (or such shorter notice as may be permitted by applicable law, but in no event less than 30 days) if **We** cease to offer the product to which the **Group Agreement** relates;

- Upon 180 days written notice to **Contract Holder** (or such shorter notice as may be permitted by applicable law, but in no event less than 30 days) if **We** cease to offer coverage in a market in which **Members** covered under this **Group Agreement** reside;

- Upon 30 days written notice to **Contract Holder** for any other reason which is acceptable to the Department of Managed Health Care and consistent with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or by applicable federal rules and regulations, as amended.

6.4 **Effect of Termination.** No termination of this **Group Agreement** will relieve either party from any obligation incurred before the date of termination. When terminated, this **Group Agreement** and all coverage provided hereunder will end at 12:00 midnight on the effective date of termination. **We** may charge the **Contract Holder** a reinstatement fee if coverage is terminated and subsequently reinstated under this **Group Agreement**. Upon termination, **We** will provide **Members** with Certificates of Creditable Coverage which will show evidence of a **Member's** prior health coverage with **Us** for a period of up to 18 months prior to the loss of coverage.

6.5 **Notice to Subscribers and Members**. It is the responsibility of **Contract Holder** to notify the **Members** of the termination of the **Group Agreement** in compliance with all applicable laws. However, **We** reserve the right to notify **Members** of termination of the **Group Agreement** for any reason, including non-payment of **Premium**. In accordance with the **EOC**, the **Contract Holder** shall provide written notice to **Members** of their rights upon termination of coverage.

SECTION 7. PRIVACY OF INFORMATION

7.1 **Compliance with Privacy Laws.** **We** and **Contract Holder** will abide by all applicable laws and regulations regarding confidentiality of individually identifiable health and other personal information, including the privacy requirements of HIPAA.

7.2 **Disclosure of Protected Health Information.** **We** will not provide protected health information ("PHI"), as defined in HIPAA, to **Contract Holder**, and **Contract Holder** will not request PHI from **Us**, unless **Contract Holder** has either:

- provided the certification required by 45 C.F.R. § 164.504(f) and amended **Contract Holder's** plan documents to incorporate the necessary changes required by such rule; or

- provided confirmation that the PHI will not be disclosed to the "plan sponsor", as such term is defined in 45 C.F.R. § 164.501.

7.3 **Brokers and Consultants.** To the extent any broker or consultant receives PHI in the underwriting process or while advocating on behalf of a **Member**, **Contract Holder** understands and agrees that such broker or consultant is acting on behalf of **Contract Holder** and not **Us**. **We** are entitled to rely on **Contract Holder's** representations that any such broker or consultant is authorized to act on **Contract Holder's** behalf and entitled to have access to the PHI under the relevant circumstances.

SECTION 8. INDEPENDENT CONTRACTOR RELATIONSHIPS

8.1 Relationship Between Us and Participating Providers. The relationship between **Us** and **Participating Providers** is a contractual relationship among independent contractors. **Participating Providers** are not agents or employees of **Us** nor are **We** an agent or employee of any **Participating Provider**.

Participating Providers are solely responsible for any health services rendered to their **Member** patients. **We** make no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any **Physician, Hospital** or other **Participating Provider**. A **Provider's** participation may be terminated at any time without advance notice to the **Contract Holder** or **Members**, subject to applicable law. **Participating Providers** provide health care diagnosis, treatment and services for **Members**. **We** administer and determine plan benefits.

8.2 Relationship Between the Parties. The relationship between the **Parties** is a contractual relationship between independent contractors. Neither **Party** is an agent or employee of the other in performing its obligations pursuant to this **Group Agreement**.

SECTION 9. MISCELLANEOUS

9.1 Delegation and Subcontracting. **Contract Holder** acknowledges and agrees that **We** may enter into arrangements with third parties to delegate functions hereunder such as utilization management, quality assurance and provider credentialing, as **We** deem appropriate in **Our** sole discretion and as consistent with applicable laws and regulations. **Contract Holder** also acknowledges that **Our** arrangements with third party vendors (i.e. pharmacy, behavioral health) are subject to change in accordance with applicable laws and regulations.

9.2 Accreditation and Qualification Status. **We** may from time to time obtain voluntary accreditation or qualification status from a private accreditation organization or government agency. **We** make no express or implied warranty about **Our** continued qualification or accreditation status.

9.3 Prior Agreements; Severability. As of the **Effective Date**, this **Group Agreement** replaces and supersedes all other prior agreements between the **Parties** as well as any other prior written or oral understandings, negotiations, discussions or arrangements between the **Parties** related to matters covered by this **Group Agreement** or the documents incorporated herein. If any provision of this **Group Agreement** is deemed to be invalid or illegal, that provision shall be fully severable and the remaining provisions of this **Group Agreement** shall continue in full force and effect.

9.4 Amendments. This **Group Agreement** may be amended as follows:

- This **Group Agreement** shall be deemed to be automatically amended to conform with all rules and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over **Us**;
- By written agreement between both **Parties**; or
- By **Us** upon 30 days written notice to **Contract Holder**.

The **Parties** agree that an amendment does not require the consent of any employee, **Member** or other person. Except for automatic amendments to comply with law, all amendments to this **Group Agreement** must be approved and executed by **Us**. No other individual has the authority to modify this **Group Agreement**; waive any of its provisions, conditions, or restrictions; extend the time for making a payment; or bind **Us** by making any other commitment or representation or by giving or receiving any information.

9.5 Clerical Errors. Clerical errors or delays by **Us** in keeping or reporting data relative to coverage will not reduce or invalidate a **Member's** coverage. Upon discovery of an error or delay, an adjustment of

Premiums shall be made. **We** may also modify or replace a **Group Agreement, EOC** or other document issued in error.

9.6 Claim Determinations. **We** have complete authority to review all claims for **Covered Benefits** under this **Group Agreement**. In exercising such responsibility, **We** shall have discretionary authority to determine whether and to what extent eligible individuals and beneficiaries are entitled to coverage and to construe any disputed or doubtful terms under this **Group Agreement,** the **EOC** or any other document incorporated herein. **We** shall be deemed to have properly exercised such authority unless **We** abuse our discretion by acting arbitrarily and capriciously. **Our** review of claims may include the use of commercial software (including Claim Check) and other tools to take into account factors such as an individual's claims history, a **Provider's** billing patterns, complexity of the service or treatment, amount of time and degree of skill needed and the manner of billing.

9.7 Misstatements. If any fact as to the **Contract Holder** or a **Member** is found to have been misstated, an equitable adjustment of **Premiums** may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

9.8 Incontestability. Except as to a fraudulent misstatement, or issues concerning **Premiums** due:

- No statement made by **Contract Holder** or any **Member** shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.
- No statement made by **Contract Holder** shall be the basis for voiding this **Group Agreement** after it has been in force for two years from its effective date.

9.9 Assignability. No rights or benefits under this **Group Agreement** are assignable by **Contract Holder** to any other party unless approved by **HMO**.

9.10 Waiver. **Our** failure to implement, or insist upon compliance with, any provision of this **Group Agreement** or the terms of the **EOC** incorporated hereunder, at any given time or times, shall not constitute a waiver of **Our** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of **Premiums** or benefits. This applies whether or not the circumstances are the same.

9.11 Notices. Any notice required or permitted under this **Group Agreement** shall be in writing and shall be deemed to have been given on the date when delivered in person; or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the address set forth in the Group Application or Cover Sheet, or to any more recent address of which the sending party has received written notice or, if delivered by facsimile or other electronic means, on the date sent by facsimile or other electronic means.

9.12 Third Parties. This **Group Agreement** shall not confer any rights or obligations on third parties except as specifically provided herein.

9.13 Non-Discrimination. **Contract Holder** agrees to make no attempt, whether through differential contributions or otherwise, to encourage or discourage enrollment in **HMO** of eligible individuals and eligible **Dependents** based on health status or health risk.

9.14 Applicable Law. This **Group Agreement** shall be governed and construed in accordance with applicable federal law and the law of the state specified in the Cover Sheet or, if no state law is specified, **Our** domicile state.

9.15 Inability to Arrange Services. If due to circumstances not within **Our** reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of **Our Participating Providers** or entities with whom **We** have contracted for services under this **Group Agreement**, or similar causes, the provision of medical or **Hospital** benefits

or other services provided under this **Group Agreement** is delayed or rendered impractical, **We** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **Us** on the date such event occurs. **We** are required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

9.16 **Use of the HMO Name and all Symbols, Trademarks, and Service Marks.** **We** reserve the right to control the use of **Our** name and all symbols, trademarks, and service marks presently existing or subsequently established. **Contract Holder** agrees that it will not use such name, symbols, trademarks, or service marks in advertising or promotional materials or otherwise without **Our** prior written consent and will cease any and all usage immediately upon **Our** request or upon termination of this **Group Agreement**.

9.17 **Dispute Resolution.** Any controversy, dispute or claim between **Us** on the one hand and one or more **Interested Parties** on the other hand arising out of or relating to the **Group Agreement**, whether stated in tort, contract, statute, claim for benefits, bad faith, professional liability or otherwise ("Claim"), shall be settled by confidential binding arbitration administered by the American Arbitration Association ("AAA") before a sole arbitrator ("Arbitrator"). Judgment on the award rendered by the Arbitrator ("Award") may be entered by any court having jurisdiction thereof. If the AAA declines to administer the case and the parties do not agree on an alternative administrator, a sole neutral arbitrator shall be appointed upon petition to a court having jurisdiction. **We** and **Interested Parties** hereby give up our rights to have Claims decided in a court before a jury.

Any Claim alleging wrongful acts or omissions of **Participating** or **Non-Participating Providers** shall not include **HMO**. A **Member** must exhaust all grievance, appeal and independent external review procedures prior to the commencement of an arbitration hereunder. No person may recover any damages arising out of or related to the failure to approve or provide any benefit or coverage beyond payment of or coverage for the benefit or coverage where (i) **We** have made available independent external review and (ii) **We** have followed the reviewer's decision. Punitive damages may not be recovered as part of a Claim under any circumstances . No **Interested Party** may participate in a representative capacity or as a member of any class in any proceeding arising out of or related to the **Group Agreement**. This agreement to arbitrate shall be specifically enforced even if a party to the arbitration is also a party to another proceeding with a third party arising out of the same matter.

9.18 **Workers' Compensation.** **Contract Holder** is responsible for protecting **Our** interests in any Workers' Compensation claims or settlements with any eligible individual. **We** shall be reimbursed for all paid medical expenses which have occurred as a result of any work related injury that is compensable or settled in any manner.

On or before the **Effective Date** of this **Group Agreement** and upon renewal, **Contract Holder** shall submit proof of their Workers' Compensation coverage or an exclusion form which has been accepted by the applicable regulatory authority governing Workers' Compensation. Upon **Our** request, **Contract Holder** shall also submit a monthly report to **Us** listing all Workers' Compensation cases. Such list will contain the name, social security number, date of loss and diagnosis of all applicable eligible individuals.

9.19 **Subrogation.** If **HMO** provides health care benefits under this **Group Agreement** to a **Member** for injuries or illness for which a third party is or may be responsible, then **HMO** retains the right to repayment (a lien), to the extend permitted by law for the value of all benefits provided by **HMO** that are associated with the injury or illness for which the third party is or may be responsible, plus the costs to perfect the lien. In some cases, **Participating Providers** may assert the **HMO's** lien. Some **Providers** also have lien rights that are independent of the **HMO's** rights.

HMO's rights of recovery are described in the Third Party Liability and Right of Recovery section of the **EOC**. The sum which **HMO** may actually recover is limited as follows:

- No lien may exceed the sum of the reasonable costs actually paid by **HMO** to perfect the lien and one of the following:

a. for health care services provided on a non-capitated basis, the amount actually paid by **HMO** to any treating **Provider,** or

b. for health care services provided on a capitated basis, the amount equal to 80 percent of the **Reasonable Charge** for the same services by **Providers** that provide health care services on a non-capitated basis in the geographic region in which the services were rendered, or

c. If the **Member** received services on a capitated basis and on a non-capitated basis and the **HMO** covered services on a capitated basis and paid for the services the **Member** received on a non-capitated basis, the lien may not exceed the sum of the reasonable costs actually paid to perfect the lien and the amounts determined according to (a) and (b) above.

- If the **Member** engaged an attorney, then the lien may not exceed the lesser of the following amounts;

  a. The maximum amount determined by 1.a, 1.b or 1.c above, whichever is applicable, or

  b. One-third of the amount due to the **Member** under any final judgment, compromise, or settlement agreement.

- If the **Member** did not engage an attorney, then the lien may not exceed the lesser of the following amounts.

  a. The maximum amount determined by 1.a, 1.b or 1.c above, whichever is applicable, or

  b. One-half of the amount due to the **Member** under any final judgment, compromise, or settlement agreement.

- Where a final judgment includes a special finding by a judge, jury or arbitrator, that the **Member** was partially at fault, the lien as determined by 1.a, 1.b or 1.c 3 above shall be reduced by the same comparative fault percentage by which the **Member's** recovery amount was reduced.

- The lien amount determined by 1.a, 1.b or 1.c above is subject to pro rata reduction, commensurate with the **Member's** attorney's fees and costs, in accordance with the common fund doctrine.

- Liens against workers' compensation claims are not subject to the requirements listed above.

AETNA HEALTH OF CALIFORNIA INC.
(CALIFORNIA)

GROUP AGREEMENT AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2005

The section 6.5 of the **Group Agreement** is hereby deleted and replaced with the following:

6.5 Notice to Subscribers and Members. It is the responsibility of **Contract Holder** to notify the **Members** of the termination of the **Group Agreement** in compliance with all applicable laws. In the event we provide notice of cancellation for non-payment of premium to **Contract Holder**, **Contract Holder** agrees to promptly mail a legible, true copy of the notice of cancellation to all **Subscribers** at their current address. The notice of cancellation to **Contract Holder** will include:

- the date and time coverage will terminate
- the cause for cancellation, including reference to the applicable clause in the **Group Agreement**
- a statement that the cause for cancellation was not due to the **Member's** health status or requirements for health care services
- that a **Member** who alleges that cancellation was due to the **Member's** health status may request a review of cancellation by the Department of Managed Health Care
- information regarding the **Member's** COBRA, Cal-COBRA, conversion Coverage and HIPAA Individual coverage.

Such notice must be mailed to **Subscribers** 15 days prior to the date of termination. If the **Contract Holder** fails to deliver the above-referenced notice of cancellation and deliver proof of mailing to **US**, **We** will mail notice directly to the individual **Subscribers:** coverage will not end until the 15th day after **HMO** mails the notice. The **Contract Holder** is required to reimburse **Us** for the costs of such mailing and for all premiums accrued do to the non-performance of this contractual obligation.

However, **We** reserve the right to notify **Members** of termination of the **Group Agreement** for any reason, including non-payment of **Premium**.

AETNA HEALTH OF CALIFORNIA INC.
(CALIFORNIA)

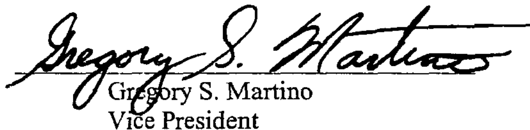
GROUP AGREEMENT COVER SHEET

Contract Holder:	County Of San Mateo-R
Contract Holder Number:	041736 001, 002,004 CA01
HMO Referred Benefit Level:	CITIZEN PLAN Benefits Package
Effective Date:	12:01 a.m. on January 1, 2005
Term of **Group Agreement**:	The **Initial Term** shall be: From January 1, 2005 through December 31, 2005 Thereafter, **Subsequent Terms** shall be: From January 1st through December 31st
Premium Due Dates:	The **Group Agreement Effective Date** and the 1st day of each succeeding calendar month.
Governing Law:	Federal law and the laws of California

Notice Address for **HMO**:

Aetna Health of California Inc.
Employer Services Contract Coordinator
1385 East Shaw
Fresno, CA 93710

The signature below is evidence of Aetna Health's acceptance of the **Contract Holder's** Group Application on the terms hereof and constitutes execution of the **Group Agreement(s)** attached hereto on behalf of Aetna Health of California Inc.

By: 
Gregory S. Martino
Vice President

Contract Holder Name: County Of San Mateo-R
Contract Holder Number: 041736
Contract Holder Locations: 001, 002,004
Contract Holder Service Areas: CA01
Contract Holder Group Agreement Effective Date: January 1, 2005

AETNA HEALTH OF CALIFORNIA INC.
(CALIFORNIA)

GROUP AGREEMENT

This **Group Agreement** is entered into by and between Aetna Health of California Inc. ("**HMO**") and the **Contract Holder** specified in the attached Cover Sheet. This **Group Agreement** shall be effective on the **Effective Date** specified in the Cover Sheet, and shall continue in force until terminated as provided herein.

In consideration of the mutual promises hereunder and the payment of **Premiums** and fees when due, **We** will provide coverage for benefits in accordance with the terms, conditions, limitations and exclusions set forth in this **Group Agreement**.

Upon acceptance by **Us** of **Contract Holder's** Group Application, and upon receipt of the required initial **Premium,** this **Group Agreement** shall be considered to be agreed to by **Contract Holder** and **Us**, and is fully enforceable in all respects against **Contract Holder** and **Us**.

SECTION 1. DEFINITIONS

1.1 The terms "**Contract Holder**", "**Effective Date**", "**Initial Term**", "**Premium Due Date**" and "**Subsequent Terms**" will have the meaning set forth in the attached Cover Sheet. If any of such terms are undefined in the Cover Sheet, such undefined terms shall have the following meaning:

- "**Effective Date**" would mean the date health coverage commences for the **Contract Holder**.
- "**Initial Term**" would be the period following the **Effective Date** as indicated on the Cover Sheet.
- "**Premium Due Date(s)**" would be the **Effective Date** and each monthly anniversary of the **Effective Date**.
- "**Subsequent Term(s)**" would mean the periods following the **Initial Term** as indicated on the Cover Sheet.

1.2 The terms "**HMO**", "**Us**", "**We**" or "**Our**" mean Aetna Health of California Inc.

1.3 "**EOC**" means the Evidence of Coverage issued pursuant to this **Group Agreement**.

1.4 "**Grace Period**" is defined in Section 3.2.

1.5 "**Group Agreement**" means the **Contract Holder's** Group Application, this document, the attached Cover Sheet; the **EOC** and Schedule of Benefits issued hereunder; the initial rate sheet and any subsequent indication of rates issued by **Us** in connection with this **Group Agreement**; and any riders, amendments, endorsements, inserts or attachments issued pursuant hereto, all of which are incorporated into and made a part of this **Group Agreement**.

1.6 "**Party, Parties**" means **HMO** and **Contract Holder**.

1.7 "**Premium(s)**" is defined in Section 3.1.

1.8 "**Renewal Date**" means the first day following the end of the **Initial Term** or any **Subsequent Term**.

1.9 "**Term**" means the **Initial Term** or any **Subsequent Term**.

1.10 Capitalized and bolded terms not defined in this **Group Agreement** shall have the meaning set forth in the **EOC**. In the event of a conflict between the terms of this **Group Agreement** and the terms of the **EOC**, the terms of this **Group Agreement** shall prevail.

SECTION 2. COVERAGE

2.1 **Covered Benefits.** **We** will provide coverage for **Covered Benefits** to **Members** subject to the terms and conditions of this **Group Agreement**. Coverage will be provided in accordance with the reasonable exercise of **Our** business judgment, consistent with applicable law. **Members** covered under this **Group Agreement** are subject to all of the conditions and provisions contained herein and in the incorporated documents.

2.2 **Policies and Procedures.** **We** have the right to adopt reasonable policies, procedures, rules, and interpretations of this **Group Agreement** and the **EOC** in order to promote orderly and efficient administration.

SECTION 3. PREMIUMS

3.1 **Premiums.** **Contract Holder** shall pay **Us** on or before each **Premium Due Date** a monthly advance premium (the **"Premium"**) determined in accordance with the **Premium** rates and the manner of calculating **Premiums** specified by **HMO**. **Premium** rates and the manner of calculating **Premiums** may be adjusted in accordance with Section 3.4 below. **Premiums** are subject to adjustment, if any, for partial month participation as specified in Section 3.3 below. Membership as of each **Premium Due Date** will be determined by **Us** in accordance with **Our Member** records. A check does not constitute payment until it is honored by a bank. **We** may return a check issued against insufficient funds without making a second deposit attempt. **We** may accept a partial payment of **Premium** without waiving our right to collect the entire amount due.

3.2 **Past Due Premiums.** If a **Premium** payment is not paid in full by **Contract Holder** on or before the **Premium Due Date**, a late payment charge of 1 ½% of the total amount due per month (or partial month) will be added to the amount due. If all **Premiums** are not received before the end of a 30 day grace period (the **"Grace Period")**, this **Group Agreement** will be automatically terminated pursuant to Section 6.3 hereof.

If the **Group Agreement** terminates for any reason, **Contract Holder** will continue to be held liable for all **Premiums** due and unpaid before the termination, including, but not limited to, **Premium** payments for any period of time the **Group Agreement** is in force during the **Grace Period.** **Members** shall also remain liable for **Member** cost sharing and other required contributions to coverage for any period of time the **Group Agreement** is in force during the **Grace Period.** **We** may recover from **Contract Holder Our** costs of collecting any unpaid **Premiums**, including reasonable attorneys' fees and costs of suit.

3.3 **Prorations.** **Premiums** shall be paid in full for **Members** whose coverage is in effect on the **Premium Due Date** or whose coverage terminates on the last day of the **Premium** period.

3.4 **Changes in Premium.** **We** may also adjust the **Premium** rates and/or the manner of calculating **Premiums** effective as of the contract renewal date, upon 30 days prior written notice to **Contract Holder**. Small employers' **Premium** rates will remain in effect for no less than 6 months, for the **Initial Term** and **Subsequent Terms**.

3.5 **Membership Adjustments.** **We** may, at **Our** discretion, make retroactive adjustments to the **Contract Holder's** billings for the termination of **Members** not posted to previous billings. However, **Contract Holder** may only receive a maximum of 2 calendar month's credit for **Member** terminations that occurred more than 30 days before the date **Contract Holder** notified **Us** of the termination. **We** may reduce any such credits by the amount of any payments **We** may have made on behalf of such **Members** (including capitation payments and other claim payments) before **We** were informed their coverage had been

terminated. Retroactive additions will be made at **Our** discretion based upon eligibility guidelines, as set forth in the **EOC**, and are subject to the payment of all applicable **Premiums**.

SECTION 4. ENROLLMENT

4.1 **Open Enrollment.** As described in the **EOC, Contract Holder** will offer enrollment in **HMO**:

- at least once during every twelve month period during the **Open Enrollment Period**; and
- within 31 days from the date the individual and any dependent becomes eligible for coverage.

Eligible individuals and dependents who are not enrolled within the **Open Enrollment Period** or 31 days of becoming eligible, may be enrolled during any subsequent **Open Enrollment Period**. Coverage will not become effective until confirmed by **Us**. **Contract Holder** agrees to hold the **Open Enrollment Period** consistent with the **Open Enrollment Period** applicable to any other group health benefit plan being offered by the **Contract Holder** and in compliance with applicable law. The **Contract Holder** shall permit **Our** representatives to meet with eligible individuals during the **Open Enrollment Period** unless the parties agree upon an alternate enrollment procedure. As described in the **EOC**, other enrollment periods may apply.

4.2 **Waiting Period**. There may be a waiting period before individuals are eligible for coverage under this **Group Agreement**. The waiting period, if any, is specified on the **Schedule of Benefits**.

4.3 **Eligibility.** The number of eligible individuals and dependents and composition of the group, the identity and status of the **Contract Holder**, the eligibility requirements used to determine membership in the group, and the participation and contribution standards applicable to the group which exist at the **Effective Date** of this **Group Agreement** are material to the execution and continuation of this **Group Agreement** by **Us**. The **Contract Holder** shall not, during the term of this **Group Agreement**, modify the **Open Enrollment Period**, the waiting period as described on the **Schedule of Benefits**, or any other eligibility requirements as described in the **EOC** and on the **Schedule of Benefits**, for the purposes of enrolling **Contract Holder's** eligible individuals and dependents under this **Group Agreement**, unless **We** agree to the modification in writing.

SECTION 5. RESPONSIBILITIES OF THE CONTRACT HOLDER

In addition to other obligations set forth in this **Group Agreement, Contract Holder** agrees to:

5.1 **Records**. Furnish to **Us**, on a monthly basis (or as otherwise required), on our form (or such other form as **We** may reasonably approve) by facsimile (or such other means as **We** may reasonably approve), such information as **We** may reasonably require to administer this **Group Agreement**. This includes, but is not limited to, information needed to enroll members of the **Contract Holder**, process terminations, and effect changes in family status and transfer of employment of **Members**.

Contract Holder represents that all enrollment and eligibility information that has been or will be supplied to **Us** is accurate. **Contract Holder** acknowledges that **We** can and will rely on such enrollment and eligibility information in determining whether an individual is eligible for **Covered Benefits** under this **Group Agreement**. To the extent such information is supplied to **Us** electronically, **Contract Holder** agrees to:

- Maintain a reasonably complete record of such information (in electronic or hard copy format, including evidence of coverage elections, evidence of eligibility, changes to such elections and terminations) for at least seven years, and to make such information available to **Us** upon request.
- Obtain from all **Subscribers** a "Disclosure of Healthcare Information" authorization in the form currently being used by **Us** in the enrollment process (or such other form as **We** may reasonably approve).

We will not be liable to **Members** for the fulfillment of any obligation prior to information being received in a form satisfactory to **Us**. **Contract Holder** must notify **Us** of the date in which a **Subscriber's** employment ceases for the purpose of termination of coverage under this **Group Agreement**. Subject to applicable law, unless otherwise specifically agreed to in writing, **We** will consider **Subscriber's** employment to continue until the earlier of:

- until stopped by the **Contract Holder**;
- if **Subscriber** has stopped working due to temporary lay off or leave of absence, not beyond the end of the policy month after the policy month in which the absence started; and
- if **Subscriber** stopped working due to disability, not beyond the end of the 30th policy month after the month in which the absence started.

5.2 <u>Access</u>. Make payroll and other records directly related to **Member's** coverage under this **Group Agreement** available to **Us** for inspection, at **Our** expense, at **Contract Holder's** office, during regular business hours, upon reasonable advance request. This provision shall survive termination of this **Group Agreement**.

5.3 **<u>Forms.</u>** Distribute materials to **HMO Members** regarding enrollment, health plan features, including **Covered Benefits** and exclusions and limitations of coverage. **Contract Holder** shall, within 31 days of receipt from an eligible individual, forward all completed enrollment information and other required information to **Us**.

5.4 **<u>Policies and Procedures; Compliance Verification.</u>** Comply with all policies and procedures established by **Us** in administering and interpreting this **Group Agreement**. **Contract Holder** shall, upon request, provide a certification of its compliance with **Our** participation and contribution requirements and the requirements for a group as defined under applicable law or regulation.

5.5 **<u>Continuation Rights and Conversion.</u>** Notify all eligible **Members** of their right to continue or convert coverage pursuant to applicable law.

5.6 **Contract Holder Obligations Under COBRA.** Under federal law, an employer who employs twenty (20) or more employees on a typical business day during the prior calendar year must provide **Members** with the opportunity to elect COBRA continuation coverage in certain circumstances where coverage would otherwise terminate. Such **Contract Holders** and their group health plan's administrators (in certain cases, the employer may be the plan administrator) have the obligation to: (1) provide **Members** with notice of the opportunity to elect continuation coverage; and (2) administer the continuation coverage. The obligation to provide notice includes both general notification to **Members** of their right to elect continuation coverage and specific notification of the right to continuation coverage within a specific time period after the occurrence of the event which triggers the continuation coverage option.

Contract Holder hereby acknowledges its legal obligations and agrees to abide by applicable legal requirements with respect to COBRA continuation coverage. **Contract Holder** also agrees to forward to **HMO** in a timely manner copies of any and all notices provided to **Members** regarding COBRA continuation coverage.

Contract Holder Obligations Under Cal-COBRA. Under California law, a health care service plan that contracts with employers who employ two (2) through nineteen (19) eligible employees on a typical business day during the prior calendar year is required to provide **Members** with the opportunity to elect Cal-COBRA continuation coverage in certain circumstances where coverage would otherwise terminate. **HMO** will administer or contract for the administration of continuation coverage under Cal-COBRA. Nonetheless, Contract Holder must provide certain notices to **HMO** and to **Members** as described below. **Contract Holder** must notify **HMO** in writing of any employee who has a qualifying event defined in the Continuation and Conversion section, Item 2 – Cal-COBRA Continuation Coverage of the **EOC** within

thirty (30) days of the qualifying event. Such notice must be separate from other communications from **Contract Holder** and must specifically reference Cal-COBRA. Notations of additions and/or deletions on monthly invoices will not constitute sufficient notice. **Contract Holder** must further provide written notice to **HMO** within thirty (30) days of the date the **Contract Holder** 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.

Contract Holder must also notify qualified beneficiaries of the ability to continue coverage prior to terminating a group agreement (such as this **Group Agreement**) under which a qualified beneficiary is receiving continuation coverage. This notification shall be provided either thirty (30) days prior to the agreement termination or when all other enrolled employees are notified, whichever is greater. **Contract Holder** must notify any successor plan in writing of the qualified beneficiaries currently receiving continuation coverage to enable the successor plan, contracting employer, or administrator to provide such qualified beneficiaries with the premium information, enrollment forms, and disclosures necessary to allow the qualified beneficiaries to continue coverage under other available group plans.

If **Contract Holder** fails to meet these obligations, **HMO** will not provide continuation coverage to qualified beneficiaries under Cal-COBRA. **Contract Holder** hereby acknowledges its obligations and agrees to comply with all applicable legal requirements with respect to Cal-COBRA continuation coverage. **Contract Holder** also agrees to forward to **HMO** in a timely manner copies of any notice provided to **Members** regarding Cal-COBRA continuation coverage.

5.7 **ERISA Requirements.** Maintain responsibility for making reports and disclosures required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), including the creation, distribution and final content of summary plan descriptions, summary of material modifications and summary annual reports.

SECTION 6. TERMINATION

6.1 **Termination by Contract Holder**. This **Group Agreement** may be terminated by **Contract Holder** as of any **Premium Due Date** by providing **Us** with 30 days prior written notice. However, **We** may in **Our** discretion accept an oral indication by **Contract Holder** or it's agent or broker of intent to terminate.

6.2 **Non-Renewal by Contract Holder. We** may request from **Contract Holder** a written indication of their intention to renew or non-renew this **Group Agreement** at any time during the final three months of any **Term**. If **Contract Holder** fails to reply to such request within the timeframe specified the **Contract Holder** shall be deemed to have provided notice of non-renewal to **Us** and this **Group Agreement** shall be deemed to terminate automatically as of the end of the **Term**. Similarly, upon **Our** written confirmation to **Contract Holder, We** may accept an oral indication by **Contract Holder** or its agent or broker of intent to non-renew as **Contract Holder's** notice of termination effective as of the end of the **Term**.

6.3 **Termination by Us.** This **Group Agreement** will terminate as of the last day of the **Grace Period** if the **Premium** remains unpaid at the end of the **Grace Period**.

This **Group Agreement** may also be terminated by **Us** as follows:

- Immediately upon notice to **Contract Holder** if **Contract Holder** has performed any act or practice that constitutes fraud or made any intentional misrepresentation of a material fact relevant to the coverage provided under this **Group Agreement**;

- Immediately upon notice to **Contract Holder** if **Contract Holder** no longer has any enrollee under the Plan who resides or works in the **Service Area**;

- Upon 30 days written notice to **Contract Holder** if **Contract Holder** (i) breaches a provision of this **Group Agreement** and such breach remains uncured at the end of the notice period; (ii) ceases to meet **Our** requirements for an employer group or association; (iii) fails to meet **Our**

contribution or participation requirements applicable to this **Group Agreement** (which contribution and participation requirements are available upon request); (iv) fails to provide the certification required by Section 5.4 within a reasonable period of time specified by **Us**; or (v) changes its eligibility or participation requirements without **Our** consent;

- Upon 90 days written notice to **Contract Holder** (or such shorter notice as may be permitted by applicable law, but in no event less than 30 days) if **We** cease to offer the product to which the **Group Agreement** relates;

- Upon 180 days written notice to **Contract Holder** (or such shorter notice as may be permitted by applicable law, but in no event less than 30 days) if **We** cease to offer coverage in a market in which **Members** covered under this **Group Agreement** reside;

- Upon 30 days written notice to **Contract Holder** for any other reason which is acceptable to the Department of Managed Health Care and consistent with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or by applicable federal rules and regulations, as amended.

6.4 **Effect of Termination.** No termination of this **Group Agreement** will relieve either party from any obligation incurred before the date of termination. When terminated, this **Group Agreement** and all coverage provided hereunder will end at 12:00 midnight on the effective date of termination. **We** may charge the **Contract Holder** a reinstatement fee if coverage is terminated and subsequently reinstated under this **Group Agreement**. Upon termination, **We** will provide **Members** with Certificates of Creditable Coverage which will show evidence of a **Member's** prior health coverage with **Us** for a period of up to 18 months prior to the loss of coverage.

6.5 **Notice to Subscribers and Members**. It is the responsibility of **Contract Holder** to notify the **Members** of the termination of the **Group Agreement** in compliance with all applicable laws. However, **We** reserve the right to notify **Members** of termination of the **Group Agreement** for any reason, including non-payment of **Premium**. In accordance with the **EOC**, the **Contract Holder** shall provide written notice to **Members** of their rights upon termination of coverage.

SECTION 7. PRIVACY OF INFORMATION

7.1 **Compliance with Privacy Laws.** **We** and **Contract Holder** will abide by all applicable laws and regulations regarding confidentiality of individually identifiable health and other personal information, including the privacy requirements of HIPAA.

7.2 **Disclosure of Protected Health Information.** **We** will not provide protected health information ("PHI"), as defined in HIPAA, to **Contract Holder**, and **Contract Holder** will not request PHI from **Us**, unless **Contract Holder** has either:

- provided the certification required by 45 C.F.R. § 164.504(f) and amended **Contract Holder**'s plan documents to incorporate the necessary changes required by such rule; or

- provided confirmation that the PHI will not be disclosed to the "plan sponsor", as such term is defined in 45 C.F.R. § 164.501.

7.3 **Brokers and Consultants.** To the extent any broker or consultant receives PHI in the underwriting process or while advocating on behalf of a **Member**, **Contract Holder** understands and agrees that such broker or consultant is acting on behalf of **Contract Holder** and not **Us**. **We** are entitled to rely on **Contract Holder's** representations that any such broker or consultant is authorized to act on **Contract Holder's** behalf and entitled to have access to the PHI under the relevant circumstances.

SECTION 8. INDEPENDENT CONTRACTOR RELATIONSHIPS

8.1 <u>Relationship Between Us and Participating Providers</u>. The relationship between **Us** and **Participating Providers** is a contractual relationship among independent contractors. **Participating Providers** are not agents or employees of **Us** nor are **We** an agent or employee of any **Participating Provider**.

Participating Providers are solely responsible for any health services rendered to their **Member** patients. **We** make no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any **Physician**, **Hospital** or other **Participating Provider**. A **Provider's** participation may be terminated at any time without advance notice to the **Contract Holder** or **Members**, subject to applicable law. **Participating Providers** provide health care diagnosis, treatment and services for **Members**. **We** administer and determine plan benefits.

8.2 <u>Relationship Between the Parties</u>. The relationship between the **Parties** is a contractual relationship between independent contractors. Neither **Party** is an agent or employee of the other in performing its obligations pursuant to this **Group Agreement**.

SECTION 9. <u>MISCELLANEOUS</u>

9.1 <u>Delegation and Subcontracting.</u> **Contract Holder** acknowledges and agrees that **We** may enter into arrangements with third parties to delegate functions hereunder such as utilization management, quality assurance and provider credentialing, as **We** deem appropriate in **Our** sole discretion and as consistent with applicable laws and regulations. **Contract Holder** also acknowledges that **Our** arrangements with third party vendors (i.e. pharmacy, behavioral health) are subject to change in accordance with applicable laws and regulations.

9.2 <u>Accreditation and Qualification Status</u>. **We** may from time to time obtain voluntary accreditation or qualification status from a private accreditation organization or government agency. **We** make no express or implied warranty about **Our** continued qualification or accreditation status.

9.3 <u>Prior Agreements; Severability</u>. As of the **Effective Date**, this **Group Agreement** replaces and supersedes all other prior agreements between the **Parties** as well as any other prior written or oral understandings, negotiations, discussions or arrangements between the **Parties** related to matters covered by this **Group Agreement** or the documents incorporated herein. If any provision of this **Group Agreement** is deemed to be invalid or illegal, that provision shall be fully severable and the remaining provisions of this **Group Agreement** shall continue in full force and effect.

9.4 <u>Amendments</u>. This **Group Agreement** may be amended as follows:

- This **Group Agreement** shall be deemed to be automatically amended to conform with all rules and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over **Us**;
- By written agreement between both **Parties**; or
- By **Us** upon 30 days written notice to **Contract Holder**.

The **Parties** agree that an amendment does not require the consent of any employee, **Member** or other person. Except for automatic amendments to comply with law, all amendments to this **Group Agreement** must be approved and executed by **Us**. No other individual has the authority to modify this **Group Agreement**; waive any of its provisions, conditions, or restrictions; extend the time for making a payment; or bind **Us** by making any other commitment or representation or by giving or receiving any information.

9.5 <u>Clerical Errors</u>. Clerical errors or delays by **Us** in keeping or reporting data relative to coverage will not reduce or invalidate a **Member's** coverage. Upon discovery of an error or delay, an adjustment of

Premiums shall be made. **We** may also modify or replace a **Group Agreement**, **EOC** or other document issued in error.

9.6 Claim Determinations. **We** have complete authority to review all claims for **Covered Benefits** under this **Group Agreement**. In exercising such responsibility, **We** shall have discretionary authority to determine whether and to what extent eligible individuals and beneficiaries are entitled to coverage and to construe any disputed or doubtful terms under this **Group Agreement**, the **EOC** or any other document incorporated herein. **We** shall be deemed to have properly exercised such authority unless **We** abuse our discretion by acting arbitrarily and capriciously. **Our** review of claims may include the use of commercial software (including Claim Check) and other tools to take into account factors such as an individual's claims history, a **Provider's** billing patterns, complexity of the service or treatment, amount of time and degree of skill needed and the manner of billing.

9.7 Misstatements. If any fact as to the **Contract Holder** or a **Member** is found to have been misstated, an equitable adjustment of **Premiums** may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

9.8 Incontestability. Except as to a fraudulent misstatement, or issues concerning **Premiums** due:

- No statement made by **Contract Holder** or any **Member** shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.
- No statement made by **Contract Holder** shall be the basis for voiding this **Group Agreement** after it has been in force for two years from its effective date.

9.9 Assignability. No rights or benefits under this **Group Agreement** are assignable by **Contract Holder** to any other party unless approved by **HMO**.

9.10 Waiver. **Our** failure to implement, or insist upon compliance with, any provision of this **Group Agreement** or the terms of the **EOC** incorporated hereunder, at any given time or times, shall not constitute a waiver of **Our** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of **Premiums** or benefits. This applies whether or not the circumstances are the same.

9.11 Notices. Any notice required or permitted under this **Group Agreement** shall be in writing and shall be deemed to have been given on the date when delivered in person; or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the address set forth in the Group Application or Cover Sheet, or to any more recent address of which the sending party has received written notice or, if delivered by facsimile or other electronic means, on the date sent by facsimile or other electronic means.

9.12 Third Parties. This **Group Agreement** shall not confer any rights or obligations on third parties except as specifically provided herein.

9.13 Non-Discrimination. **Contract Holder** agrees to make no attempt, whether through differential contributions or otherwise, to encourage or discourage enrollment in **HMO** of eligible individuals and eligible **Dependents** based on health status or health risk.

9.14 Applicable Law. This **Group Agreement** shall be governed and construed in accordance with applicable federal law and the law of the state specified in the Cover Sheet or, if no state law is specified, **Our** domicile state.

9.15 Inability to Arrange Services. If due to circumstances not within **Our** reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of **Our Participating Providers** or entities with whom **We** have contracted for services under this **Group Agreement**, or similar causes, the provision of medical or **Hospital** benefits

or other services provided under this **Group Agreement** is delayed or rendered impractical, **We** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **Us** on the date such event occurs. **We** are required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

9.16 **Use of the HMO Name and all Symbols, Trademarks, and Service Marks.** **We** reserve the right to control the use of **Our** name and all symbols, trademarks, and service marks presently existing or subsequently established. **Contract Holder** agrees that it will not use such name, symbols, trademarks, or service marks in advertising or promotional materials or otherwise without **Our** prior written consent and will cease any and all usage immediately upon **Our** request or upon termination of this **Group Agreement.**

9.17 **Dispute Resolution.** Any controversy, dispute or claim between **Us** on the one hand and one or more **Interested Parties** on the other hand arising out of or relating to the **Group Agreement**, whether stated in tort, contract, statute, claim for benefits, bad faith, professional liability or otherwise ("Claim"), shall be settled by confidential binding arbitration administered by the American Arbitration Association ("AAA") before a sole arbitrator ("Arbitrator"). Judgment on the award rendered by the Arbitrator ("Award") may be entered by any court having jurisdiction thereof. If the AAA declines to administer the case and the parties do not agree on an alternative administrator, a sole neutral arbitrator shall be appointed upon petition to a court having jurisdiction. **We** and **Interested Parties** hereby give up our rights to have Claims decided in a court before a jury.

Any Claim alleging wrongful acts or omissions of **Participating** or **Non-Participating Providers** shall not include **HMO**. A **Member** must exhaust all grievance, appeal and independent external review procedures prior to the commencement of an arbitration hereunder. No person may recover any damages arising out of or related to the failure to approve or provide any benefit or coverage beyond payment of or coverage for the benefit or coverage where (i) **We** have made available independent external review and (ii) **We** have followed the reviewer's decision. Punitive damages may not be recovered as part of a Claim under any circumstances . No **Interested Party** may participate in a representative capacity or as a member of any class in any proceeding arising out of or related to the **Group Agreement**. This agreement to arbitrate shall be specifically enforced even if a party to the arbitration is also a party to another proceeding with a third party arising out of the same matter.

9.18 **Workers' Compensation. Contract Holder** is responsible for protecting **Our** interests in any Workers' Compensation claims or settlements with any eligible individual. **We** shall be reimbursed for all paid medical expenses which have occurred as a result of any work related injury that is compensable or settled in any manner.

On or before the **Effective Date** of this **Group Agreement** and upon renewal, **Contract Holder** shall submit proof of their Workers' Compensation coverage or an exclusion form which has been accepted by the applicable regulatory authority governing Workers' Compensation. Upon **Our** request, **Contract Holder** shall also submit a monthly report to **Us** listing all Workers' Compensation cases. Such list will contain the name, social security number, date of loss and diagnosis of all applicable eligible individuals.

9.19 **Subrogation.** If **HMO** provides health care benefits under this **Group Agreement** to a **Member** for injuries or illness for which a third party is or may be responsible, then **HMO** retains the right to repayment (a lien), to the extend permitted by law for the value of all benefits provided by **HMO** that are associated with the injury or illness for which the third party is or may be responsible, plus the costs to perfect the lien. In some cases, **Participating Providers** may assert the **HMO's** lien. Some **Providers** also have lien rights that are independent of the **HMO's** rights.

HMO's rights of recovery are described in the Third Party Liability and Right of Recovery section of the **EOC**. The sum which **HMO** may actually recover is limited as follows:

- No lien may exceed the sum of the reasonable costs actually paid by **HMO** to perfect the lien and one of the following:

a. for health care services provided on a non-capitated basis, the amount actually paid by **HMO** to any treating **Provider,** or

b. for health care services provided on a capitated basis, the amount equal to 80 percent of the **Reasonable Charge** for the same services by **Providers** that provide health care services on a non-capitated basis in the geographic region in which the services were rendered, or

c. If the **Member** received services on a capitated basis and on a non-capitated basis and the **HMO** covered services on a capitated basis and paid for the services the **Member** received on a non-capitated basis, the lien may not exceed the sum of the reasonable costs actually paid to perfect the lien and the amounts determined according to (a) and (b) above.

- If the **Member** engaged an attorney, then the lien may not exceed the lesser of the following amounts;

a. The maximum amount determined by 1.a, 1.b or 1.c above, whichever is applicable, or

b. One-third of the amount due to the **Member** under any final judgment, compromise, or settlement agreement.

- If the **Member** did not engage an attorney, then the lien may not exceed the lesser of the following amounts.

a. The maximum amount determined by 1.a, 1.b or 1.c above, whichever is applicable, or

b. One-half of the amount due to the **Member** under any final judgment, compromise, or settlement agreement.

- Where a final judgment includes a special finding by a judge, jury or arbitrator, that the **Member** was partially at fault, the lien as determined by 1.a, 1.b or 1.c 3 above shall be reduced by the same comparative fault percentage by which the **Member's** recovery amount was reduced.

- The lien amount determined by 1.a, 1.b or 1.c above is subject to pro rata reduction, commensurate with the **Member's** attorney's fees and costs, in accordance with the common fund doctrine.

- Liens against workers' compensation claims are not subject to the requirements listed above.

AETNA HEALTH OF CALIFORNIA INC.
(CALIFORNIA)

GROUP AGREEMENT AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2005

The section 6.5 of the **Group Agreement** is hereby deleted and replaced with the following:

6.5 Notice to Subscribers and Members. It is the responsibility of **Contract Holder** to notify the **Members** of the termination of the **Group Agreement** in compliance with all applicable laws. In the event we provide notice of cancellation for non-payment of premium to **Contract Holder**, **Contract Holder** agrees to promptly mail a legible, true copy of the notice of cancellation to all **Subscribers** at their current address. The notice of cancellation to **Contract Holder** will include:

- the date and time coverage will terminate
- the cause for cancellation, including reference to the applicable clause in the **Group Agreement**
- a statement that the cause for cancellation was not due to the **Member's** health status or requirements for health care services
- that a **Member** who alleges that cancellation was due to the **Member's** health status may request a review of cancellation by the Department of Managed Health Care
- information regarding the **Member's** COBRA, Cal-COBRA, conversion Coverage and HIPAA Individual coverage.

Such notice must be mailed to **Subscribers** 15 days prior to the date of termination. If the **Contract Holder** fails to deliver the above-referenced notice of cancellation and deliver proof of mailing to **US**, **We** will mail notice directly to the individual **Subscribers:** coverage will not end until the 15th day after **HMO** mails the notice. The **Contract Holder** is required to reimburse **Us** for the costs of such mailing and for all premiums accrued do to the non-performance of this contractual obligation.

However, **We** reserve the right to notify **Members** of termination of the **Group Agreement** for any reason, including non-payment of **Premium**.

AETNA HEALTH OF CALIFORNIA INC.
(CALIFORNIA)

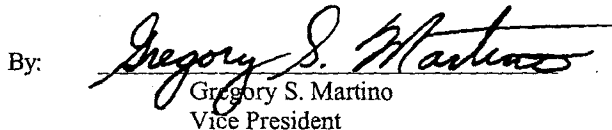
GROUP AGREEMENT COVER SHEET

Contract Holder:	County Of San Mateo-Cobra
Contract Holder Number:	041736 008, 009,010,011 CA02
HMO Referred Benefit Level:	CITIZEN PLAN Benefits Package
Effective Date:	12:01 a.m. on January 1, 2005
Term of **Group Agreement**:	The **Initial Term** shall be: From January 1, 2005 through December 31, 2005 Thereafter, **Subsequent Terms** shall be: From January 1st through December 31st
Premium Due Dates:	The **Group Agreement Effective Date** and the 1st day of each succeeding calendar month.
Governing Law:	Federal law and the laws of California

Notice Address for **HMO**:

Aetna Health of California Inc.
Employer Services Contract Coordinator
1385 East Shaw
Fresno, CA 93710

The signature below is evidence of Aetna Health's acceptance of the **Contract Holder's** Group Application on the terms hereof and constitutes execution of the **Group Agreement(s)** attached hereto on behalf of Aetna Health of California Inc.

By: 
Gregory S. Martino
Vice President

Contract Holder Name: County Of San Mateo-Cobra
Contract Holder Number: 041736
Contract Holder Locations: 008, 009,010,011
Contract Holder Service Areas: CA02
Contract Holder Group Agreement Effective Date: January 1, 2005

AETNA HEALTH OF CALIFORNIA INC.
(CALIFORNIA)

GROUP AGREEMENT

This **Group Agreement** is entered into by and between Aetna Health of California Inc. ("**HMO**") and the **Contract Holder** specified in the attached Cover Sheet. This **Group Agreement** shall be effective on the **Effective Date** specified in the Cover Sheet, and shall continue in force until terminated as provided herein.

In consideration of the mutual promises hereunder and the payment of **Premiums** and fees when due, **We** will provide coverage for benefits in accordance with the terms, conditions, limitations and exclusions set forth in this **Group Agreement**.

Upon acceptance by **Us** of **Contract Holder's** Group Application, and upon receipt of the required initial **Premium,** this **Group Agreement** shall be considered to be agreed to by **Contract Holder** and **Us,** and is fully enforceable in all respects against **Contract Holder** and **Us**.

SECTION 1. DEFINITIONS

1.1 The terms "**Contract Holder**", "**Effective Date**", "**Initial Term**", "**Premium Due Date**" and "**Subsequent Terms**" will have the meaning set forth in the attached Cover Sheet. If any of such terms are undefined in the Cover Sheet, such undefined terms shall have the following meaning:

- "**Effective Date**" would mean the date health coverage commences for the **Contract Holder**.
- "**Initial Term**" would be the period following the **Effective Date** as indicated on the Cover Sheet.
- "**Premium Due Date(s)**" would be the **Effective Date** and each monthly anniversary of the **Effective Date**.
- "**Subsequent Term(s)**" would mean the periods following the **Initial Term** as indicated on the Cover Sheet.

1.2 The terms "**HMO**", "**Us**", "**We**" or "**Our**" mean Aetna Health of California Inc.

1.3 "**EOC**" means the Evidence of Coverage issued pursuant to this **Group Agreement**.

1.4 "**Grace Period**" is defined in Section 3.2.

1.5 "**Group Agreement**" means the **Contract Holder's** Group Application, this document, the attached Cover Sheet; the **EOC** and Schedule of Benefits issued hereunder; the initial rate sheet and any subsequent indication of rates issued by **Us** in connection with this **Group Agreement**; and any riders, amendments, endorsements, inserts or attachments issued pursuant hereto, all of which are incorporated into and made a part of this **Group Agreement**.

1.6 "**Party, Parties**" means **HMO** and **Contract Holder**.

1.7 "**Premium(s)**" is defined in Section 3.1.

1.8 "**Renewal Date**" means the first day following the end of the **Initial Term** or any **Subsequent Term**.

1.9 "**Term**" means the **Initial Term** or any **Subsequent Term**.

1.10 Capitalized and bolded terms not defined in this **Group Agreement** shall have the meaning set forth in the **EOC**. In the event of a conflict between the terms of this **Group Agreement** and the terms of the **EOC**, the terms of this **Group Agreement** shall prevail.

SECTION 2. COVERAGE

2.1 Covered Benefits. **We** will provide coverage for **Covered Benefits** to **Members** subject to the terms and conditions of this **Group Agreement**. Coverage will be provided in accordance with the reasonable exercise of **Our** business judgment, consistent with applicable law. **Members** covered under this **Group Agreement** are subject to all of the conditions and provisions contained herein and in the incorporated documents.

2.2 Policies and Procedures. **We** have the right to adopt reasonable policies, procedures, rules, and interpretations of this **Group Agreement** and the **EOC** in order to promote orderly and efficient administration.

SECTION 3. PREMIUMS

3.1 Premiums. **Contract Holder** shall pay **Us** on or before each **Premium Due Date** a monthly advance premium (the "**Premium**") determined in accordance with the **Premium** rates and the manner of calculating **Premiums** specified by **HMO**. **Premium** rates and the manner of calculating **Premiums** may be adjusted in accordance with Section 3.4 below. **Premiums** are subject to adjustment, if any, for partial month participation as specified in Section 3.3 below. Membership as of each **Premium Due Date** will be determined by **Us** in accordance with **Our Member** records. A check does not constitute payment until it is honored by a bank. **We** may return a check issued against insufficient funds without making a second deposit attempt. **We** may accept a partial payment of **Premium** without waiving our right to collect the entire amount due.

3.2 Past Due Premiums. If a **Premium** payment is not paid in full by **Contract Holder** on or before the **Premium Due Date**, a late payment charge of 1 ½% of the total amount due per month (or partial month) will be added to the amount due. If all **Premiums** are not received before the end of a 30 day grace period (the "**Grace Period**"), this **Group Agreement** will be automatically terminated pursuant to Section 6.3 hereof.

If the **Group Agreement** terminates for any reason, **Contract Holder** will continue to be held liable for all **Premiums** due and unpaid before the termination, including, but not limited to, **Premium** payments for any period of time the **Group Agreement** is in force during the **Grace Period.** **Members** shall also remain liable for **Member** cost sharing and other required contributions to coverage for any period of time the **Group Agreement** is in force during the **Grace Period. We** may recover from **Contract Holder Our** costs of collecting any unpaid **Premiums**, including reasonable attorneys' fees and costs of suit.

3.3 Prorations. **Premiums** shall be paid in full for **Members** whose coverage is in effect on the **Premium Due Date** or whose coverage terminates on the last day of the **Premium** period.

3.4 Changes in Premium. **We** may also adjust the **Premium** rates and/or the manner of calculating **Premiums** effective as of the contract renewal date, upon 30 days prior written notice to **Contract Holder**. Small employers' **Premium** rates will remain in effect for no less than 6 months, for the **Initial Term** and **Subsequent Terms**.

3.5 Membership Adjustments. **We** may, at **Our** discretion, make retroactive adjustments to the **Contract Holder's** billings for the termination of **Members** not posted to previous billings. However, **Contract Holder** may only receive a maximum of 2 calendar month's credit for **Member** terminations that occurred more than 30 days before the date **Contract Holder** notified **Us** of the termination. **We** may reduce any such credits by the amount of any payments **We** may have made on behalf of such **Members** (including capitation payments and other claim payments) before **We** were informed their coverage had been

terminated. Retroactive additions will be made at **Our** discretion based upon eligibility guidelines, as set forth in the **EOC**, and are subject to the payment of all applicable **Premiums**.

SECTION 4. ENROLLMENT

4.1 **Open Enrollment.** As described in the **EOC, Contract Holder** will offer enrollment in **HMO**:

- at least once during every twelve month period during the **Open Enrollment Period**; and
- within 31 days from the date the individual and any dependent becomes eligible for coverage.

Eligible individuals and dependents who are not enrolled within the **Open Enrollment Period** or 31 days of becoming eligible, may be enrolled during any subsequent **Open Enrollment Period**. Coverage will not become effective until confirmed by **Us**. **Contract Holder** agrees to hold the **Open Enrollment Period** consistent with the **Open Enrollment Period** applicable to any other group health benefit plan being offered by the **Contract Holder** and in compliance with applicable law. The **Contract Holder** shall permit **Our** representatives to meet with eligible individuals during the **Open Enrollment Period** unless the parties agree upon an alternate enrollment procedure. As described in the **EOC**, other enrollment periods may apply.

4.2 **Waiting Period**. There may be a waiting period before individuals are eligible for coverage under this **Group Agreement**. The waiting period, if any, is specified on the **Schedule of Benefits**.

4.3 **Eligibility.** The number of eligible individuals and dependents and composition of the group, the identity and status of the **Contract Holder**, the eligibility requirements used to determine membership in the group, and the participation and contribution standards applicable to the group which exist at the **Effective Date** of this **Group Agreement** are material to the execution and continuation of this **Group Agreement** by **Us**. The **Contract Holder** shall not, during the term of this **Group Agreement**, modify the **Open Enrollment Period**, the waiting period as described on the **Schedule of Benefits**, or any other eligibility requirements as described in the **EOC** and on the **Schedule of Benefits**, for the purposes of enrolling **Contract Holder's** eligible individuals and dependents under this **Group Agreement**, unless **We** agree to the modification in writing.

SECTION 5. RESPONSIBILITIES OF THE CONTRACT HOLDER

In addition to other obligations set forth in this **Group Agreement, Contract Holder** agrees to:

5.1 **Records**. Furnish to **Us**, on a monthly basis (or as otherwise required), on our form (or such other form as **We** may reasonably approve) by facsimile (or such other means as **We** may reasonably approve), such information as **We** may reasonably require to administer this **Group Agreement**. This includes, but is not limited to, information needed to enroll members of the **Contract Holder**, process terminations, and effect changes in family status and transfer of employment of **Members**.

Contract Holder represents that all enrollment and eligibility information that has been or will be supplied to **Us** is accurate. **Contract Holder** acknowledges that **We** can and will rely on such enrollment and eligibility information in determining whether an individual is eligible for **Covered Benefits** under this **Group Agreement**. To the extent such information is supplied to **Us** electronically, **Contract Holder** agrees to:

- Maintain a reasonably complete record of such information (in electronic or hard copy format, including evidence of coverage elections, evidence of eligibility, changes to such elections and terminations) for at least seven years, and to make such information available to **Us** upon request.
- Obtain from all **Subscribers** a "Disclosure of Healthcare Information" authorization in the form currently being used by **Us** in the enrollment process (or such other form as **We** may reasonably approve).

We will not be liable to **Members** for the fulfillment of any obligation prior to information being received in a form satisfactory to **Us**. **Contract Holder** must notify **Us** of the date in which a **Subscriber's** employment ceases for the purpose of termination of coverage under this **Group Agreement**. Subject to applicable law, unless otherwise specifically agreed to in writing, **We** will consider **Subscriber's** employment to continue until the earlier of:

- until stopped by the **Contract Holder**;
- if **Subscriber** has stopped working due to temporary lay off or leave of absence, not beyond the end of the policy month after the policy month in which the absence started; and
- if **Subscriber** stopped working due to disability, not beyond the end of the 30th policy month after the month in which the absence started.

5.2 <u>**Access**</u>. Make payroll and other records directly related to **Member's** coverage under this **Group Agreement** available to **Us** for inspection, at **Our** expense, at **Contract Holder's** office, during regular business hours, upon reasonable advance request. This provision shall survive termination of this **Group Agreement**.

5.3 <u>**Forms.**</u> Distribute materials to **HMO Members** regarding enrollment, health plan features, including **Covered Benefits** and exclusions and limitations of coverage. **Contract Holder** shall, within 31 days of receipt from an eligible individual, forward all completed enrollment information and other required information to **Us**.

~~5.4 **Policies and Procedures; Compliance Verification.** Comply with all policies and procedures established~~ by **Us** in administering and interpreting this **Group Agreement**. **Contract Holder** shall, upon request, provide a certification of its compliance with **Our** participation and contribution requirements and the requirements for a group as defined under applicable law or regulation.

5.5 <u>**Continuation Rights and Conversion.**</u> Notify all eligible **Members** of their right to continue or convert coverage pursuant to applicable law.

5.6 **Contract Holder Obligations Under COBRA.** Under federal law, an employer who employs twenty (20) or more employees on a typical business day during the prior calendar year must provide **Members** with the opportunity to elect COBRA continuation coverage in certain circumstances where coverage would otherwise terminate. Such **Contract Holders** and their group health plan's administrators (in certain cases, the employer may be the plan administrator) have the obligation to: (1) provide **Members** with notice of the opportunity to elect continuation coverage; and (2) administer the continuation coverage. The obligation to provide notice includes both general notification to **Members** of their right to elect continuation coverage and specific notification of the right to continuation coverage within a specific time period after the occurrence of the event which triggers the continuation coverage option.

Contract Holder hereby acknowledges its legal obligations and agrees to abide by applicable legal requirements with respect to COBRA continuation coverage. **Contract Holder** also agrees to forward to **HMO** in a timely manner copies of any and all notices provided to **Members** regarding COBRA continuation coverage.

Contract Holder Obligations Under Cal-COBRA. Under California law, a health care service plan that contracts with employers who employ two (2) through nineteen (19) eligible employees on a typical business day during the prior calendar year is required to provide **Members** with the opportunity to elect Cal-COBRA continuation coverage in certain circumstances where coverage would otherwise terminate. **HMO** will administer or contract for the administration of continuation coverage under Cal-COBRA. Nonetheless, Contract Holder must provide certain notices to **HMO** and to **Members** as described below. **Contract Holder** must notify **HMO** in writing of any employee who has a qualifying event defined in the Continuation and Conversion section, Item 2 – Cal-COBRA Continuation Coverage of the **EOC** within

thirty (30) days of the qualifying event. Such notice must be separate from other communications from **Contract Holder** and must specifically reference Cal-COBRA. Notations of additions and/or deletions on monthly invoices will not constitute sufficient notice. **Contract Holder** must further provide written notice to **HMO** within thirty (30) days of the date the **Contract Holder** 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.

Contract Holder must also notify qualified beneficiaries of the ability to continue coverage prior to terminating a group agreement (such as this **Group Agreement**) under which a qualified beneficiary is receiving continuation coverage. This notification shall be provided either thirty (30) days prior to the agreement termination or when all other enrolled employees are notified, whichever is greater. **Contract Holder** must notify any successor plan in writing of the qualified beneficiaries currently receiving continuation coverage to enable the successor plan, contracting employer, or administrator to provide such qualified beneficiaries with the premium information, enrollment forms, and disclosures necessary to allow the qualified beneficiaries to continue coverage under other available group plans.

If **Contract Holder** fails to meet these obligations, **HMO** will not provide continuation coverage to qualified beneficiaries under Cal-COBRA. **Contract Holder** hereby acknowledges its obligations and agrees to comply with all applicable legal requirements with respect to Cal-COBRA continuation coverage. **Contract Holder** also agrees to forward to **HMO** in a timely manner copies of any notice provided to **Members** regarding Cal-COBRA continuation coverage.

5.7 **ERISA Requirements.** Maintain responsibility for making reports and disclosures required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), including the creation, distribution and final content of summary plan descriptions, summary of material modifications and summary annual reports.

SECTION 6. TERMINATION

6.1 **Termination by Contract Holder**. This **Group Agreement** may be terminated by **Contract Holder** as of any **Premium Due Date** by providing **Us** with 30 days prior written notice. However, **We** may in **Our** discretion accept an oral indication by **Contract Holder** or it's agent or broker of intent to terminate.

6.2 **Non-Renewal by Contract Holder.** **We** may request from **Contract Holder** a written indication of their intention to renew or non-renew this **Group Agreement** at any time during the final three months of any **Term**. If **Contract Holder** fails to reply to such request within the timeframe specified the **Contract Holder** shall be deemed to have provided notice of non-renewal to **Us** and this **Group Agreement** shall be deemed to terminate automatically as of the end of the **Term**. Similarly, upon **Our** written confirmation to **Contract Holder**, **We** may accept an oral indication by **Contract Holder** or its agent or broker of intent to non-renew as **Contract Holder's** notice of termination effective as of the end of the **Term**.

6.3 **Termination by Us.** This **Group Agreement** will terminate as of the last day of the **Grace Period** if the **Premium** remains unpaid at the end of the **Grace Period**.

This **Group Agreement** may also be terminated by **Us** as follows:

- Immediately upon notice to **Contract Holder** if **Contract Holder** has performed any act or practice that constitutes fraud or made any intentional misrepresentation of a material fact relevant to the coverage provided under this **Group Agreement**;
- Immediately upon notice to **Contract Holder** if **Contract Holder** no longer has any enrollee under the Plan who resides or works in the **Service Area**;
- Upon 30 days written notice to **Contract Holder** if **Contract Holder** (i) breaches a provision of this **Group Agreement** and such breach remains uncured at the end of the notice period; (ii) ceases to meet **Our** requirements for an employer group or association; (iii) fails to meet **Our**

contribution or participation requirements applicable to this **Group Agreement** (which contribution and participation requirements are available upon request); (iv) fails to provide the certification required by Section 5.4 within a reasonable period of time specified by **Us**; or (v) changes its eligibility or participation requirements without **Our** consent;

- Upon 90 days written notice to **Contract Holder** (or such shorter notice as may be permitted by applicable law, but in no event less than 30 days) if **We** cease to offer the product to which the **Group Agreement** relates;

- Upon 180 days written notice to **Contract Holder** (or such shorter notice as may be permitted by applicable law, but in no event less than 30 days) if **We** cease to offer coverage in a market in which **Members** covered under this **Group Agreement** reside;

- Upon 30 days written notice to **Contract Holder** for any other reason which is acceptable to the Department of Managed Health Care and consistent with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or by applicable federal rules and regulations, as amended.

6.4 <u>**Effect of Termination.**</u> No termination of this **Group Agreement** will relieve either party from any obligation incurred before the date of termination. When terminated, this **Group Agreement** and all coverage provided hereunder will end at 12:00 midnight on the effective date of termination. **We** may charge the **Contract Holder** a reinstatement fee if coverage is terminated and subsequently reinstated under this **Group Agreement**. Upon termination, **We** will provide **Members** with Certificates of Creditable Coverage which will show evidence of a **Member's** prior health coverage with **Us** for a period of up to 18 months prior to the loss of coverage.

6.5 <u>**Notice to Subscribers and Members**</u>. It is the responsibility of **Contract Holder** to notify the **Members** of the termination of the **Group Agreement** in compliance with all applicable laws. However, **We** reserve the right to notify **Members** of termination of the **Group Agreement** for any reason, including non-payment of **Premium**. In accordance with the **EOC**, the **Contract Holder** shall provide written notice to **Members** of their rights upon termination of coverage.

SECTION 7. PRIVACY OF INFORMATION

7.1 <u>**Compliance with Privacy Laws.**</u> **We** and **Contract Holder** will abide by all applicable laws and regulations regarding confidentiality of individually identifiable health and other personal information, including the privacy requirements of HIPAA.

7.2 <u>**Disclosure of Protected Health Information.**</u> **We** will not provide protected health information ("PHI"), as defined in HIPAA, to **Contract Holder**, and **Contract Holder** will not request PHI from **Us**, unless **Contract Holder** has either:

- provided the certification required by 45 C.F.R. § 164.504(f) and amended **Contract Holder**'s plan documents to incorporate the necessary changes required by such rule; or

- provided confirmation that the PHI will not be disclosed to the "plan sponsor", as such term is defined in 45 C.F.R. § 164.501.

7.3 <u>**Brokers and Consultants.**</u> To the extent any broker or consultant receives PHI in the underwriting process or while advocating on behalf of a **Member**, **Contract Holder** understands and agrees that such broker or consultant is acting on behalf of **Contract Holder** and not **Us**. **We** are entitled to rely on **Contract Holder's** representations that any such broker or consultant is authorized to act on **Contract Holder's** behalf and entitled to have access to the PHI under the relevant circumstances.

SECTION 8. INDEPENDENT CONTRACTOR RELATIONSHIPS

8.1 <u>**Relationship Between Us and Participating Providers**</u>. The relationship between **Us** and **Participating Providers** is a contractual relationship among independent contractors. **Participating Providers** are not agents or employees of **Us** nor are **We** an agent or employee of any **Participating Provider**.

Participating Providers are solely responsible for any health services rendered to their **Member** patients. **We** make no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any **Physician, Hospital** or other **Participating Provider**. A **Provider's** participation may be terminated at any time without advance notice to the **Contract Holder** or **Members,** subject to applicable law. **Participating Providers** provide health care diagnosis, treatment and services for **Members. We** administer and determine plan benefits.

8.2 <u>**Relationship Between the Parties**</u>. The relationship between the **Parties** is a contractual relationship between independent contractors. Neither **Party** is an agent or employee of the other in performing its obligations pursuant to this **Group Agreement**.

SECTION 9. <u>MISCELLANEOUS</u>

9.1 <u>**Delegation and Subcontracting.**</u> **Contract Holder** acknowledges and agrees that **We** may enter into arrangements with third parties to delegate functions hereunder such as utilization management, quality assurance and provider credentialing, as **We** deem appropriate in **Our** sole discretion and as consistent with applicable laws and regulations. **Contract Holder** also acknowledges that **Our** arrangements with third party vendors (i.e. pharmacy, behavioral health) are subject to change in accordance with applicable laws and regulations.

9.2 <u>**Accreditation and Qualification Status**</u>. **We** may from time to time obtain voluntary accreditation or qualification status from a private accreditation organization or government agency. **We** make no express or implied warranty about **Our** continued qualification or accreditation status.

9.3 <u>**Prior Agreements; Severability**</u>. As of the **Effective Date**, this **Group Agreement** replaces and supersedes all other prior agreements between the **Parties** as well as any other prior written or oral understandings, negotiations, discussions or arrangements between the **Parties** related to matters covered by this **Group Agreement** or the documents incorporated herein. If any provision of this **Group Agreement** is deemed to be invalid or illegal, that provision shall be fully severable and the remaining provisions of this **Group Agreement** shall continue in full force and effect.

9.4 <u>**Amendments**</u>. This **Group Agreement** may be amended as follows:

- This **Group Agreement** shall be deemed to be automatically amended to conform with all rules and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over **Us**;
- By written agreement between both **Parties**; or
- By **Us** upon 30 days written notice to **Contract Holder**.

The **Parties** agree that an amendment does not require the consent of any employee, **Member** or other person. Except for automatic amendments to comply with law, all amendments to this **Group Agreement** must be approved and executed by **Us**. No other individual has the authority to modify this **Group Agreement**; waive any of its provisions, conditions, or restrictions; extend the time for making a payment; or bind **Us** by making any other commitment or representation or by giving or receiving any information.

9.5 <u>**Clerical Errors**</u>. Clerical errors or delays by **Us** in keeping or reporting data relative to coverage will not reduce or invalidate a **Member's** coverage. Upon discovery of an error or delay, an adjustment of

Premiums shall be made. **We** may also modify or replace a **Group Agreement**, **EOC** or other document issued in error.

9.6 Claim Determinations. **We** have complete authority to review all claims for **Covered Benefits** under this **Group Agreement**. In exercising such responsibility, **We** shall have discretionary authority to determine whether and to what extent eligible individuals and beneficiaries are entitled to coverage and to construe any disputed or doubtful terms under this **Group Agreement**, the **EOC** or any other document incorporated herein. **We** shall be deemed to have properly exercised such authority unless **We** abuse our discretion by acting arbitrarily and capriciously. **Our** review of claims may include the use of commercial software (including Claim Check) and other tools to take into account factors such as an individual's claims history, a **Provider's** billing patterns, complexity of the service or treatment, amount of time and degree of skill needed and the manner of billing.

9.7 Misstatements. If any fact as to the **Contract Holder** or a **Member** is found to have been misstated, an equitable adjustment of **Premiums** may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

9.8 Incontestability. Except as to a fraudulent misstatement, or issues concerning **Premiums** due:

- No statement made by **Contract Holder** or any **Member** shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.

- No statement made by **Contract Holder** shall be the basis for voiding this **Group Agreement** after it has been in force for two years from its effective date.

9.9 Assignability. No rights or benefits under this **Group Agreement** are assignable by **Contract Holder** to any other party unless approved by **HMO**.

9.10 Waiver. **Our** failure to implement, or insist upon compliance with, any provision of this **Group Agreement** or the terms of the **EOC** incorporated hereunder, at any given time or times, shall not constitute a waiver of **Our** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of **Premiums** or benefits. This applies whether or not the circumstances are the same.

9.11 Notices. Any notice required or permitted under this **Group Agreement** shall be in writing and shall be deemed to have been given on the date when delivered in person; or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the address set forth in the Group Application or Cover Sheet, or to any more recent address of which the sending party has received written notice or, if delivered by facsimile or other electronic means, on the date sent by facsimile or other electronic means.

9.12 Third Parties. This **Group Agreement** shall not confer any rights or obligations on third parties except as specifically provided herein.

9.13 Non-Discrimination. **Contract Holder** agrees to make no attempt, whether through differential contributions or otherwise, to encourage or discourage enrollment in **HMO** of eligible individuals and eligible **Dependents** based on health status or health risk.

9.14 Applicable Law. This **Group Agreement** shall be governed and construed in accordance with applicable federal law and the law of the state specified in the Cover Sheet or, if no state law is specified, **Our** domicile state.

9.15 Inability to Arrange Services. If due to circumstances not within **Our** reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of **Our Participating Providers** or entities with whom **We** have contracted for services under this **Group Agreement**, or similar causes, the provision of medical or **Hospital** benefits

or other services provided under this **Group Agreement** is delayed or rendered impractical, **We** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **Us** on the date such event occurs. **We** are required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

9.16 **Use of the HMO Name and all Symbols, Trademarks, and Service Marks.** **We** reserve the right to control the use of **Our** name and all symbols, trademarks, and service marks presently existing or subsequently established. **Contract Holder** agrees that it will not use such name, symbols, trademarks, or service marks in advertising or promotional materials or otherwise without **Our** prior written consent and will cease any and all usage immediately upon **Our** request or upon termination of this **Group Agreement**.

9.17 **Dispute Resolution.** Any controversy, dispute or claim between **Us** on the one hand and one or more **Interested Parties** on the other hand arising out of or relating to the **Group Agreement**, whether stated in tort, contract, statute, claim for benefits, bad faith, professional liability or otherwise ("Claim"), shall be settled by confidential binding arbitration administered by the American Arbitration Association ("AAA") before a sole arbitrator ("Arbitrator"). Judgment on the award rendered by the Arbitrator ("Award") may be entered by any court having jurisdiction thereof. If the AAA declines to administer the case and the parties do not agree on an alternative administrator, a sole neutral arbitrator shall be appointed upon petition to a court having jurisdiction. **We** and **Interested Parties** hereby give up our rights to have Claims decided in a court before a jury.

Any Claim alleging wrongful acts or omissions of **Participating** or **Non-Participating Providers** shall not include **HMO**. A **Member** must exhaust all grievance, appeal and independent external review procedures prior to the commencement of an arbitration hereunder. No person may recover any damages arising out of or related to the failure to approve or provide any benefit or coverage beyond payment of or coverage for the benefit or coverage where (i) **We** have made available independent external review and (ii) **We** have followed the reviewer's decision. Punitive damages may not be recovered as part of a Claim under any circumstances . No **Interested Party** may participate in a representative capacity or as a member of any class in any proceeding arising out of or related to the **Group Agreement**. This agreement to arbitrate shall be specifically enforced even if a party to the arbitration is also a party to another proceeding with a third party arising out of the same matter.

9.18 **Workers' Compensation.** **Contract Holder** is responsible for protecting **Our** interests in any Workers' Compensation claims or settlements with any eligible individual. **We** shall be reimbursed for all paid medical expenses which have occurred as a result of any work related injury that is compensable or settled in any manner.

On or before the **Effective Date** of this **Group Agreement** and upon renewal, **Contract Holder** shall submit proof of their Workers' Compensation coverage or an exclusion form which has been accepted by the applicable regulatory authority governing Workers' Compensation. Upon **Our** request, **Contract Holder** shall also submit a monthly report to **Us** listing all Workers' Compensation cases. Such list will contain the name, social security number, date of loss and diagnosis of all applicable eligible individuals.

9.19 **Subrogation.** If **HMO** provides health care benefits under this **Group Agreement** to a **Member** for injuries or illness for which a third party is or may be responsible, then **HMO** retains the right to repayment (a lien), to the extend permitted by law for the value of all benefits provided by **HMO** that are associated with the injury or illness for which the third party is or may be responsible, plus the costs to perfect the lien. In some cases, **Participating Providers** may assert the **HMO's** lien. Some **Providers** also have lien rights that are independent of the **HMO's** rights.

HMO's rights of recovery are described in the Third Party Liability and Right of Recovery section of the **EOC**. The sum which **HMO** may actually recover is limited as follows:

- No lien may exceed the sum of the reasonable costs actually paid by **HMO** to perfect the lien and one of the following:

a. for health care services provided on a non-capitated basis, the amount actually paid by **HMO** to any treating **Provider,** or
b. for health care services provided on a capitated basis, the amount equal to 80 percent of the **Reasonable Charge** for the same services by **Providers** that provide health care services on a non-capitated basis in the geographic region in which the services were rendered, or
c. If the **Member** received services on a capitated basis and on a non-capitated basis and the **HMO** covered services on a capitated basis and paid for the services the **Member** received on a non-capitated basis, the lien may not exceed the sum of the reasonable costs actually paid to perfect the lien and the amounts determined according to (a) and (b) above.

- If the **Member** engaged an attorney, then the lien may not exceed the lesser of the following amounts;

a. The maximum amount determined by 1.a, 1.b or 1.c above, whichever is applicable, or
b. One-third of the amount due to the **Member** under any final judgment, compromise, or settlement agreement.

- If the **Member** did not engage an attorney, then the lien may not exceed the lesser of the following amounts.

a. The maximum amount determined by 1.a, 1.b or 1.c above, whichever is applicable, or
b. One-half of the amount due to the **Member** under any final judgment, compromise, or settlement agreement.

- Where a final judgment includes a special finding by a judge, jury or arbitrator, that the **Member** was partially at fault, the lien as determined by 1.a, 1.b or 1.c 3 above shall be reduced by the same comparative fault percentage by which the **Member's** recovery amount was reduced.

- The lien amount determined by 1.a, 1.b or 1.c above is subject to pro rata reduction, commensurate with the **Member's** attorney's fees and costs, in accordance with the common fund doctrine.

- Liens against workers' compensation claims are not subject to the requirements listed above.

AETNA HEALTH OF CALIFORNIA INC.
(CALIFORNIA)

GROUP AGREEMENT AMENDMENT

Contract Holder Group Agreement Effective Date: January 1, 2005

The section 6.5 of the **Group Agreement** is hereby deleted and replaced with the following:

6.5 Notice to Subscribers and Members. It is the responsibility of **Contract Holder** to notify the **Members** of the termination of the **Group Agreement** in compliance with all applicable laws. In the event we provide notice of cancellation for non-payment of premium to **Contract Holder**, **Contract Holder** agrees to promptly mail a legible, true copy of the notice of cancellation to all **Subscribers** at their current address. The notice of cancellation to **Contract Holder** will include:

- the date and time coverage will terminate
- the cause for cancellation, including reference to the applicable clause in the **Group Agreement**
- a statement that the cause for cancellation was not due to the **Member's** health status or requirements for health care services
- that a **Member** who alleges that cancellation was due to the **Member's** health status may request a review of cancellation by the Department of Managed Health Care
- information regarding the **Member's** COBRA, Cal-COBRA, conversion Coverage and HIPAA Individual coverage.

Such notice must be mailed to **Subscribers** 15 days prior to the date of termination. If the **Contract Holder** fails to deliver the above-referenced notice of cancellation and deliver proof of mailing to **US**, **We** will mail notice directly to the individual **Subscribers:** coverage will not end until the 15th day after **HMO** mails the notice. The **Contract Holder** is required to reimburse **Us** for the costs of such mailing and for all premiums accrued do to the non-performance of this contractual obligation.

However, **We** reserve the right to notify **Members** of termination of the **Group Agreement** for any reason, including non-payment of **Premium**.