SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

112

FROM: Human Resources Department

SUBMITTAL DATE:
February 2, 2010

SUBJECT: 2010 Medical Plan Contract Renewal with Blue Shield of California and Healthy Lifestyle Rewards Addendum to the Blue Shield Contract

RECOMMENDED MOTION: That the Board of Supervisors 1) ratify and approve the attached renewal contract effective January 1, 2010, for the Blue Shield of California HMO medical plan offered to eligible County employees, dependents and retirees; 2) ratify and approve the attached First Addendum renewal for the Blue Shield Group Services Contract - Healthy Lifestyle Rewards Program effective January 1, 2010; 3) authorize the Chairperson to sign four (4) copies of the renewal contract and addendum, and; 4) retain one (1) copy of the signed renewal contract and addendum, and return three (3) copies of the renewal contract and addendum to Human Resources for distribution.

BACKGROUND: On September 15, 2009, the Board of Supervisors approved the 2010 plan design changes and rates for the County's medical plans. The attached renewal contract is the official

(continued on Page 2)

Ronald W. Komers
Asst. County Executive Officer/Human Resources Dir.

FINANCIAL DATA				
	Current F.Y. Total Cost:	$ 38,694,764	**In Current Year Budget:**	Yes
	Current F.Y. Net County Cost:	$ 0	**Budget Adjustment:**	No
	Annual Net County Cost:	$ 0	**For Fiscal Year:**	2009/10

SOURCE OF FUNDS: 95% Employee and Retiree Health Insurance Premiums and 5% County Medical Contribution.

Positions To Be Deleted Per A-30 ☐

Requires 4/5 Vote ☐

C.E.O. RECOMMENDATION:

APPROVE

BY: Karen L. Johnson

County Executive Office Signature

FORM APPROVED COUNTY COUNSEL
BY: TAWNY V. LIEU DATE 02/16/10

Departmental Concurrence

☐ Consent ☒ Policy — Dep't Recomm.:

☐ Consent ☒ Policy — Per Exec. Ofc.:

Prev. Agn. Ref.: 09/15/2009, 3.31 | **District:** | **Agenda Number:** 3.15

ATTACHMENTS FILED WITH THE CLERK OF THE BOARD

BACKGROUND (continued):

document confirming the 2010 Blue Shield "Access Plus" Health Maintenance Organization (HMO) plan rates for active and retired members. Currently, there are approximately 4,025 active and 422 retired members enrolled in the Blue Shield plan at an estimated annual cost of $38,694,764.

Healthy Lifestyle Rewards for Blue Shield Members

The Healthy Lifestyle Rewards (HLR) Program was approved by the Board of Supervisors on February 28, 2006 as an additional benefit for employees and retirees enrolled in the Blue Shield plan. Participation in the program requires members to register and complete a health risk assessment that establishes a baseline snapshot of health risks and helps the participant see where lifestyle improvements may be in order. Participants may earn cash incentives ranging from $25 - $150. As of October 31, 2009 the HLR program had 1,198 registered participants and 999 participants who have completed the wellness assessment. The program cost is included in the 2010 Blue Shield premium.

Blue Shield was not prepared to submit their contract or addendum to the County of Riverside until this time. Contract terms have been honored since January 1, 2010.

There is no direct cost to the County for these recommended actions.

APPLICATION IS HEREBY MADE TO

Blue Shield of California
(California Physicians' Service)

FOR A GROUP HEALTH SERVICE CONTRACT

BY: County of Riverside
4080 Lemon Street
Riverside, CA 92502

This Contract, number **H11582/H11584/H54633/H54635**, shall be effective **January 1, 2010**. It has been read and approved, and the terms and conditions are accepted by the Contractholder.

The Contractholder, on behalf of itself and its Subscribers, hereby expressly acknowledges its understanding that this agreement constitutes a Contract solely between the Contractholder and Blue Shield of California (hereafter referred to as "the Plan"), that the Plan is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("Association"), an association of independent Blue Cross and Blue Shield plans permitting the Plan to use the Blue Shield Service Mark in the State of California, and that the Plan is not contracting as the agent of the Association. The Contractholder further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than the Plan and that neither the Association nor any person, entity or organization affiliated with the Association shall be held accountable or liable to the Contractholder or its Subscribers for any of the Plan's obligations created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of the Plan, other than those obligations created under other provisions of this agreement.

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

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

Dated at _____ (City, State)

this _____ day of _____ 20 _____

_____

(Legal Name of Contractholder)

SIGNATURES ON NEXT PAGE.

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

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

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

blue of california

IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Group Health Service Contract.

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

COUNTY OF RIVERSIDE:

By _____
Deputy

By _____
Chairman, Board of Supervisors

Date _____

Date _____

Approved as to form and content:

Pamela J. Walls
County Counsel

By: _____
Deputy County Counsel

California Physicians' Service
dba Blue Shield of California

David S. Joyner

David Joyner, Senior Vice President
Large Group and Specialty Benefits
Blue Shield of California

blue of california

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

GROUP HEALTH SERVICE CONTRACT

BLUE SHIELD ACCESS + HMO® HEALTH PLAN

between

County of Riverside

("Contractholder")

and

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

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

This Contract shall be effective as of **January 1, 2010** for a term of one year, subject to the provisions herein.

David S. Joyner

David Joyner, Senior Vice President
Large Group and Specialty Benefits
Blue Shield of California

Group Number: **H11582/ H11584/H54633/H54635**

Original Effective Date: **January 1, 2010**

IMPORTANT

No person has the right to receive the benefits of this Contract for Services or supplies furnished following termination of coverage, except as specifically provided in the Group Continuation Coverage and Extension of Benefits sections of the Evidence of Coverage and Disclosure Form. Benefits of this Contract are available only for Services and supplies as included in the applicable sections of the Evidence of Coverage and Disclosure Form, furnished during the term the Contract is in effect and while the individual claiming benefits is actually covered by this Contract. Benefits may be modified during the term of this Contract under the applicable section in Part V. Dues, upon mutual agreement of the parties or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or the elimination of benefits) apply for Services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the benefits of this Contract.

TABLE OF CONTENTS

Page C-

Refer to the Table of Contents in the Evidence of Coverage and Disclosure Form

The Evidence of Coverage and Disclosure Form includes the following optional benefits/riders:
Outpatient Prescription Drugs

PART I. INTRODUCTION

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

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

PART II. DEFINITIONS

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

Employee - Is (1) an individual engaged in the conduct of the business of Contractholder and who meets the eligibility requirements as established by Contractholder and consented to by Blue Shield of California, or, (2) a retiree or eligible retiree beneficiary of the Contractholder who is eligible for retiree health plan benefits under the rules and regulations established by Contractholder and consented to by Blue Shield of California.

Dependent – Shall have the meaning set forth in the Evidence of Coverage and Disclosure Form.

PART III. ELIGIBILITY

A. Employee Eligibility, Waiting Periods and Open Enrollment

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

1. The date of eligibility of Employees shall be determined as follows:

   a. Each Employee employed by the Employer on the effective date of this Contract who enrolls during the initial enrollment period is eligible on the effective date of this Contract.

   b. Each individual, except as provided in paragraph a. above, shall be eligible to enroll on the first of the month following receipt of their application by the Employer.

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

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

3. An Employee may transfer enrollment for himself or his Dependent(s) from another group health plan sponsored by the Employer to the health plan covered by this Contract only during the open enrollment period in October of each year. The effective date of benefits for such Employee and Dependent(s) shall be the first day of each subsequent January. Submission of evidence of acceptability is not required when application is made during this open enrollment period.

4. (a) Notwithstanding the above, if Contractholder is ordered by a Court, an arbitrator or any other adjudicatory authority of competent jurisdiction to enroll or re-enroll an Employee (and any eligible dependents) on the health plan made available by this Contract with a retroactive effective date of coverage, Blue Shield will comply with that request subject to the following: (1) the Employee (and any eligible dependents) must otherwise meet the eligibility requirements for coverage, (2) applicable Dues, as described in Part V. hereof, must be paid by Contractholder for the retroactive coverage period, and, (3) enrollment will not be retroactive for more than six (6) months back from the date the request for enrollment is submitted to Blue Shield. Enrollment retroactive more than six (6) months, if ordered by an adjudicatory authority, will be accepted only with the express agreement of Blue Shield on a case-by-case basis, which agreement shall not be unreasonably withheld. Nothing herein modifies, expands or alters the Benefits to which an Employee (or eligible dependent) is entitled under this Contract for any services received by the Employee during the period of retroactive coverage.

   (b) If Contractholder determines that it has made an administrative error in the processing of eligibility for an Employee, Blue Shield will accept enrollment of the Employee retroactively for a maximum of 90 days, as long as dues are paid by Contractholder for the entire retroactive enrollment period.

   (c) If an Employee is retroactively enrolled pursuant to Paragraph 4 (a) or (b) above, and the Employee received covered health care services during that retroactive period, Blue Shield will reimburse the Employee for payments made only for Covered Services received in accordance with the rules of the Evidence of Coverage, minus the Member's copayments as stated in the Evidence of Coverage.

B. Who Is Eligible for Coverage

An Employee is eligible to participate in this health benefits plan if he or she is a regular County Employee scheduled to work at least 20 hours per week.

PART III. ELIGIBILITY

An Employee may enroll his or her eligible Dependents in this health benefits plan. Eligible Dependents include: 1) a legal spouse or registered Domestic Partner; 2) the Employee's and/or spouse's or Domestic Partner's dependent natural children, adopted children, foster children, and stepchildren who are under age 23 and who have never been married; 3) any child who is under age 23 and has never been married for whom the Employee has legal custody, or has been required to cover under his or her medical plan as part of a qualified medical child support order, or who resides with the Employee (generally in the absence of the natural or adoptive parent) and is economically dependent upon the Employee; 4) an otherwise eligible child who is over age 23 and is incapable of self-support because of a mental or physical handicap and the Employee continues to claim the child as a dependent on his or her federal income tax return.

C. Required Proof of Eligibility

1. To add a spouse to the health plan, an Employee must provide a copy of his or her marriage certificate and spouse's social security number at the time the spouse is enrolled. If a marriage certificate is not available to meet the 60-day enrollment period or annual enrollment deadline, an Affidavit of Marriage form must be completed and notarized.

2. To enroll a Domestic Partner in the health plan, the Employee and his or her Domestic Partner must meet the criteria listed below. A Domestic Partnership is defined as two people who both:

   a, are at least 18 years of age, unmarried, and not blood relatives close enough to bar marriage in the State of California, and

   b. live in a mutually exclusive relationship in which they are jointly responsible for each other's welfare and financial obligations, and

   c. live in the same principal residence and intend to do so indefinitely, and

   d. are in a domestic partnership as attested by both the Employee and his or her Domestic Partner through a signed California Declaration of Domestic Partnership Agreement. California state registration is limited to same sex Domestic Partners and only those opposite sex partners where one partner is at least 62 years of age and eligible for Social Security based on age.

3. Proof of eligibility is required for natural children, adopted children, and stepchildren who are under the age 23, and have never been married. These children are not required to be enrolled in school and do not need to reside with the employee to be eligible.

   To enroll a dependent child to the health plan, an Employee must provide a copy of an Official Birth Certificate (hospital certificates will not be accepted if the child is six (6) months or older) or Adoption paperwork. If the Employee is required to cover a child due to a Qualified Medical Child Support Order (QMCSO) a copy of the QMCSO must be submitted at the time of enrollment.

   To enroll another person's child under the age of 23, who has never been married, and is economically dependent on the Employee, a copy of Guardianship or Custody Order; and most recent Tax Return listing the dependent(s) as a claimed tax dependent must be submitted at the time of enrollment.

   To enroll a disabled child who is age 23 or over upon initial enrollment or as continuation of coverage beyond age 23, the employee must complete and submit a Member Questionnaire for the Disabled Dependent Form and a Medical Report Form. The Medical Report Form must be completed by the child's physician, and must be submitted to the County of Riverside for processing, along with the employees most recent Tax Return listing the dependent as a claimed tax dependent. These forms must be received within sixty (60) days of the initial enrollment or the child's 23rd birthday. The enrollment will be processed, but will be contingent upon approval of the disability. If the dependent child is later deemed ineligible for benefits, the child's coverage will be terminated on a retroactive basis and the employee will be responsible for any medical services rendered.

D. Enrollment

Newly hired or newly eligible Employees may elect to enroll within 60 days of their date of hire or eligibility. All coverage will be effective the first day of the month following the employer's receipt of their election,

PART III. ELIGIBILITY

Each year an Employee's elections stay in effect from January 1, through December 31, as long as the Employee remains eligible for benefits. During annual enrollment, an employee may change coverage elections for the following plan year. However, after the close of annual enrollment an Employee can make benefit changes only if he or she has a qualified status change. Qualified status changes include:

1. Marriage, or gaining a domestic partner
2. Divorce, or separation from domestic partner
3. Birth or adoption of a child
4. Death of a spouse or a child
5. Change in spouse's employment
6. Significant changes in your spouse's employer's medical coverage
7. Child's loss of eligibility due to age, disabled dependent status, or marital status
8. Full-time/part-time employment status change that results in an insurance eligibility change
9. Commencement of or return from an unpaid leave of absence
10. Employment separation

If one of the above events occurs, and the Employee wants to make a benefit change consistent with the specific event, he or she must submit a new Election Form indicating the new coverage elections within 60 days of the event to the employer.

E. Associated Employers

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

(list of associated Employers)
County of Riverside Special Districts
County of Riverside Law Library

F. Termination of Benefits

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

1. The benefits of a Subscriber shall cease on the last day of the month in which premium deductions were collected by the Employer, including when the Subscriber retires, is pensioned, leaves voluntarily or is dismissed from the employ of the Contractholder or otherwise ceases to be a member of a class eligible for coverage, unless a different date on which the Subscriber no longer meets the requirements for eligibility has been agreed to between Blue Shield and the Contractholder, except that:

   a. if the Subscriber ceases active work because of a disability due to illness or bodily injury, or because of an approved leave of absence or temporary layoff, payment of Dues for that Subscriber shall continue coverage in force in accordance with the Employer's policy regarding such coverage; or,

   b. if the Employer is subject to the California Family Rights Act of 1991 and/or the Federal Family & Medical Leave Act of 1993, and the approved leave of absence is for family leave pursuant to such Acts, payment of Dues for that Subscriber shall keep coverage in force for the duration(s) prescribed by the Acts. The Employer is solely responsible for notifying Employees of the availability and duration of family leaves; or,

   c. if the Subscriber retires and qualifies for retiree health benefits under the rules and regulations established by Contractholder, coverage shall remain in force subject to payment of the appropriate retiree Dues.

2. With respect to a newborn child or a child placed for adoption, coverage will cease on the 32nd day at 12:01 a.m. Pacific Time following the Dependent's effective date of coverage, except that coverage shall not cease if a written

application for the addition of the Dependent is submitted to and received by Blue Shield prior to the 31st day following the effective date of coverage.

3. If Contractholder determines that it has made an administrative error in the processing of eligibility for an Employee, Blue Shield will accept and process a request for termination/disenrollment of the Employee or dependent retroactive for a maximum of 90 days and will refund appropriate dues paid for the retroactive termination period. In any such case, Blue Shield reserves the right to request refund from the Employee for any payments made for services rendered during the retroactive termination period.

G. Eligibility Requirements for Access+ HMO 15 Plans

Retirees over age 65 who are enrolled in Medicare are eligible to enroll in the Access+ HMO 15 Plan.

Active employees and their dependents, and dependents of retirees who are not eligible for Medicare, are eligible to enroll in the Access+ HMO 15 Plan.

PART IV. GROUP RENEWAL

Blue Shield of California shall cooperate with Contractholder in its process for review of proposals for renewal of this Contract for 2011.

PART V. DUES

A. Dues

Active and Early Retiree (under 65 not Medicare eligible)	
Blue Shield Access+ HMO	
Single	$485.29
Two-Party	$970.58
Family	$1,261.75

Early Retiree (under 65 not Medicare eligible) – POST 1/1/2010	
Blue Shield Access+ HMO	
Single	$768.73
Two-Party	$1,537.35
Family	$1,998.61

Over 65 or Medicare eligible)	
Blue Shield Access+ HMO	
Retiree Only	$733.47
Retiree & Spouse, One Medicare	$1,474.35
Retiree & Spouse, Two Medicare	$1,466.85
Retiree & Spouse, One Medicare, Dependents	$1,916.30
Retiree & Spouse, Two Medicare, Dependents	$1,908.80
Retiree & Spouse, Three Medicare, Dependents	$2,200.32

B. When And Where Payable

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

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

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

C. The terms of this Contract or the Dues payable therefore may be changed from time to time as set forth in Part VIII., D. Changes Entire Contract.

D. The Employer shall remit to Blue Shield the amount specified in Part V. A. ("the base Dues"). If a State or any other taxing authority imposes upon Blue Shield a tax or license fee which is levied upon or measured by the base Dues or by the gross receipts of Blue Shield or any portion of either, then Blue Shield may amend the Contract to increase the base Dues by an amount sufficient to cover all such taxes or license fees rounded to the nearest cent. This amendment shall be effective as of the date stated in the notice which shall not be earlier than the date of the imposition of such tax or license fee, by mailing a postage prepaid notice of the amendment to the Employer at its address of record with Blue Shield at least 60 days before the effective date of the amendment.

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

F. A grace period of 60 days after the date of eligibility to pay all delinquent Dues and avoid cancellation will be granted for the payment of Dues accruing, other than those due on the effective date of this Contract during which period this Contract shall continue in force, but the Employer shall be liable to Blue Shield for the payment of all Dues accruing during the period the Contract continues in force during the grace period. Cancellation for non-payment of Dues shall be in accordance with PART VII. B.

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

In addition to the provisions contained in section V. Urgent Services of the Evidence of Coverage, the following provisions apply to this Group Health Service Contract:

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

Liability Calculation Method Per Claim

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

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

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

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

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

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

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

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

Return of Overpayments

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

PART VII. CANCELLATION/REINSTATEMENT/GRACE PERIOD

A. Cancellation Without Cause

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

B. Cancellation for Non-Payment of Dues

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

C. Cancellation/Rescission for Fraud, Misrepresentations Omissions or Failure to Provide Records

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

D. Reinstatement of Contract

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

E. Grace Period

The Employer shall be entitled to a grace period of 60 days for payment of Dues, as described in PART V. F. hereof. If during a Dues grace period written notice is given by the Employer to Blue Shield that the Contract or (subject to the consent of Blue Shield) any part of the Contract is to be discontinued before the expiration date of the grace period, the Contract or such part shall be discontinued as of the date specified by the Employer or the date of receipt of such written notice by Blue Shield, whichever is the later date, and the Employer shall be liable to Blue Shield for the full month's payment of Dues if discontinuance of coverage occurs on or after the 15th of the month. If discontinuance of coverage occurs prior to the 15th of the month then Dues payment will be waived and refunded to the group.

PART VII. CANCELLATION/REINSTATEMENT/GRACE PERIOD

F. Payment or Refund of Dues Upon Cancellation

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

G. Termination of Benefits

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

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

H. Employer to Provide Subscribers with Notice Confirming Termination of Coverage

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

PART VIII. GENERAL PROVISIONS
PART VIII. GENERAL PROVISIONS

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

A. Choice of Providers

The Plan has established a network of primary care and specialty Physicians, Hospitals, Participating Hospice Agencies, and Non-Physician Health Care Practitioners to provide Covered Services to Members. A Member must obtain or receive approval for all Covered Services from his Personal Physician. Each Subscriber must select a Personal Physician for himself and each of his Dependents from the list of Personal Physicians in the HMO Physician and Hospital Directory. The Physician and Hospital Directory will be given to Members at the time of enrollment. A Member's Personal Physician will be accessible to the Member on a 24-hour-a-day, 7-day-a-week basis, or will make appropriate arrangements to assure coverage. Emergency Services will be provided on a 24-hour-a-day, 7-day-a-week basis by all Plan Hospitals. The list of Providers in the Physician and Hospital Directory includes the location and phone numbers of all Personal Physicians, Plan Hospitals, and Participating Hospice Agencies in the Personal Physician Service Area. Members should contact Member Services for information on Plan Non-Physician Health Care Practitioners in their Personal Physician Service Area.

B. Use of Masculine Pronoun

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

C. Workers' Compensation

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

D. Changes: Entire Contract

Except as set forth in Part V.D. hereof, this Contract may only be modified by Contractholder and Blue Shield of California pursuant to mutual written amendments. Rate changes or voluntary benefit changes must be Board approved. Amendments shall require the formal approval of the Board of Supervisors of Riverside County to be effective, except as expressly provided herein. Amendments which shall not require the formal approval of the Board of Supervisors to be effective may include, but shall not be limited to, amendments to policies and procedures, and/or operations as required by new laws and regulations, or by a court of competent jurisdiction. Such amendments shall be effective upon the date of approval by the County of Riverside Director of Human Resources.

This Contract, including the appendices, attachments, or other documents incorporated by reference, constitutes the entire agreement between the parties, and any statement made by the Employer or by any Member shall, in the absence of fraud, be deemed a representation and not a warranty. This Contract supersedes any and all prior or contemporaneous negotiations, agreements, or communications, whether written or oral, between Contractholder and Blue Shield of California with respect to the subject matter of this Contract.

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

E. Statutory Requirements

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

or not such provision is actually included in this Contract. The provisions of the Government Claims Act (Government Code Sections 900, et seq.) must be followed first for any disputes arising under this Contract.

F. Legal Process/Venue

Legal process or service upon Blue Shield must be served upon a corporate officer of Blue Shield. All actions and proceedings arising in connection with this Contract shall be tried and litigated exclusively in the state and federal (if permitted by law and a party elects to file an action in federal court) courts located in the County of Riverside, State of California.

G. Time of Commencement or Termination

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

H. Records and Information to be Furnished

The Employer shall furnish Blue Shield with such information as Blue Shield may require to enable it to administer this Plan, to determine the Dues and to enable it to perform this Contract. CMS specifically requires Blue Shield to obtain the following information: Social Security numbers for Subscribers and dependents over forty-five (45) years of age, Subscriber employment status, Employer identification number and Employer size. Failure to provide any such information required by this Section may result in immediate Cancellation of this Contract. Blue Shield of California shall maintain and provide adequate records and information as reasonably necessary to properly administer this Contract consistent with state and federal law. Such records shall be retained by Blue Shield of California for at least five (5) years from the close of Contractholder's fiscal year in which this Contract is in effect. The obligation of this section is not terminated upon a termination of the Contract, for any reason, including by rescission or otherwise.

I. Membership Cards and Evidence of Coverage and Disclosure Form Booklets

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

J. Inquiries and Complaints

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

K. Confidentiality

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

PART VIII. GENERAL PROVISIONS

L. Termination of a Plan Provider Contract

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

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

M. Waiver of Default

The waiver by either party of any one or more defaults shall not be construed as a waiver of any other or future defaults, under the same or different terms, conditions or covenants contained in this Contract.

N. Notices

Any notice required to be given under this Contract shall be in writing and either delivered personally or by United States mail at the addresses set forth below or at such other addresses as the parties may hereafter designate:

If to Contractholder: County of Riverside
Human Resources, 1st Floor
P.O. Box 1569
Riverside, CA 92502-1569
Attn: Benefits Manager

If to Blue Shield of California: To the address on the first page of the Contract

O. Independent Contractor

The relationship between Contractholder and Blue Shield of California is an independent contractor relationship. Neither party nor its employees and/or agents shall be considered to be an employee and/or agent of the other party. None of the provisions of this Contract shall be construed to create a relationship of agency, representation, joint venture, ownership, control or employment between the parties other than that of independent parties contacting for the purposes of effectuating this Contract.

P. Invalidity and Severability

If any provision of this Contract is found to be invalid or unenforceable by any court, such provision shall be in effect only to the extent that it is not in contravention of applicable laws without invalidating the remaining provisions hereof. In the event the removal of a provision rendered invalid or unenforceable or declared null and void has the effect of materially altering the obligations of either party, the part so affected shall have the right to terminate this Contract upon providing thirty (30) days prior written notice to the other party.

Q. Time is of the Essence

Time shall be of the essence of each and every term, obligation, and condition of this Contract.

R. Conflict of Interest

The parties hereto and their respective employees or agents shall have no interest, and shall not acquire any interest, direct or indirect, which shall conflict in any manner or degree with the performance of services required under this Contract.

S. Assignment

Neither party shall assign the rights, duties or obligations under this Contract.

PART VIII. GENERAL PROVISIONS

T. Licenses

Blue Shield of California shall, at all times while performing services under this Contract, maintain all licenses required by the laws of the State of California.

U. Indemnification

Blue Shield of California shall indemnify and hold harmless Contractholder, its Agencies, Districts, Special District and Departments, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives from any liability whatsoever, based or asserted upon any services of Blue Shield of California, its officers, employees, subcontractors, agents or representatives arising out of or in any way relating to this Contract, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever and resulting from any reason whatsoever arising from the performance of Blue Shield of California, its officers, agents employees, subcontractors, agents or representatives from this Contract; Blue Shield of California shall defend at its sole expense (including all costs and fees including but not limited to attorney fees, cost of investigation, defense and settlements or awards) Contractholder, its Agencies, Districts, Special Districts and Departments, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives in any claim or action based upon such alleged acts or omissions.

With respect to any action or claim subject to indemnification herein by Blue Shield of California, Blue Shield of California shall, at its sole cost, have the right to use counsel of its own choice and shall have the right to adjust, settle, or compromise any such action or claims without the prior consent of Contractholder; provided, however, that any such adjustment, settlement or compromise in no manner whatsoever limits or circumscribes Blue Shield of California's indemnification of Contractholder as set forth herein. Blue Shield of California's obligation hereunder shall be satisfied when Blue Shield of California has provided to Contractholder appropriate form of dismissal relieving Contractholder from any liability for the action or claim involved.

In the event there is a conflict between this clause and California Civil Code Section 2782, this clause shall be interpreted to comply with Civil Code 2782. Such interpretation shall not relieve Blue Shield of California from indemnifying Contractholder to the fullest allowed by law.

Contractholder shall indemnify and hold harmless Blue Shield of California, its officers, Board of Directors, employees and representatives from any liability whatsoever, based or asserted upon any services of Contractholder, Agencies, Districts, Special District and Departments, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives arising out of or in any way relating to this Contract, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever and resulting from any reason whatsoever arising from the performance of Contractholder, Agencies, Districts, Special Districts and Departments, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives from this Contract; Contractholder shall defend at its sole expense (including all costs and fees including but not limited to attorney fees, cost of investigation, defense and settlements or awards) Blue Shield of California, its officers, Board of Directors, employees and representatives in any claim or action based upon such alleged acts or omissions.

With respect to any action or claim subject to indemnification herein by Contractholder, Contractholder shall, at its sole cost, have the right to use counsel of its own choice and shall have the right to adjust, settle, or compromise any such action or claims without the prior consent of Blue Shield of California; provided, however, that any such adjustment, settlement or compromise in no manner whatsoever limits or circumscribes Contractholder's indemnification of Blue Shield of California as set forth herein. Contractholder's obligation hereunder shall be satisfied when Contractholder has provided to Blue Shield of California the appropriate form of dismissal relieving Blue Shield of California from any liability for the action or claim involved.

In the event there is a conflict between the clause and California Civil Code Section 2782, this clause shall be interpreted to comply with Civil Code 2782. Such interpretation shall not relieve Contractholder from indemnifying Blue Shield of California to the fullest allowed by law.

PART VIII. GENERAL PROVISIONS

V. Insurance

Without limiting or diminishing the Blue Shield of California's obligation to indemnify or hold Contractholder harmless, Blue Shield of California shall procure and maintain or cause to be maintained, at its sole cost and expense, the following insurance coverage's during the term of this Contract.

1. Worker's Compensation:

   If Blue Shield of California has employees as defined by the State of California, Blue Shield of California shall maintain statutory Workers" Compensation Insurance (Coverage A) as prescribed by the laws of the State of California. The policy shall include Employers' Liability (Coverage B) including Occupational Disease with limits not less than $1,000,000 per person per accident.

2. Commercial General Liability:

   Commercial General Liability insurance coverage, including but not limited to, premises liability, contractual liability, products and completed operations liability, personal and advertising injury, and cross liability coverage covering claims which may arise from or out of Blue Shield of California's performance of its obligations hereunder. The policy's limit of liability shall not be less than $1,000,000 per occurrence combined single limit, if available at commercially reasonable costs.

3. Professional Liability Insurance:

   Blue Shield of California shall maintain Professional Liability Insurance providing coverage for the Blue Shield of California's performance of work included within this Contract, with a limit of liability of not less than $1,000,000 per occurrence and $2,000,000 annual aggregate. If Blue Shield of California's Professional Liability Insurance is written on a claims made basis rather than an occurrence basis, such insurance shall continue through the term of this Contract and Blue Shield of California shall purchase at his sole expense either 1) an Extended Reporting Endorsement (also known as Tail Coverage); or 2) Prior Dates Coverage from new insurer with a retroactive date back to the date of, or prior to, the inception of this Contract; or 3) demonstrate through Certificates of Insurance that Blue Shield of California has maintained continuous coverage with the same or original insurer. Coverage provided under items: 1), 2) or 3) will continue for a period of five (5) years beyond the termination of this Contract.

4. General Insurance Provisions – All lines:

   (a) Any insurance carrier providing insurance coverage hereunder shall be admitted to the State of California and have the financial equivalent of an A M BEST rating of not less than A:VIII (A:8) unless such requirements are waived, in writing, by Contractholder's Risk Manager. If Contractholder's Risk Manager waives a requirement for a particular insurer such waiver is only valid for that specific insurer and only for one policy term.

   (b) Blue Shield of California's must declare if its insurance deductibles or self-insured retentions exceed $500,000 per occurrence.

   (c) Blue Shield of California shall cause Blue Shield of California 's insurance carrier (s) to furnish Contractholder with either 1) a properly executed original Certificate(s) of Insurance, and 2) if requested, summaries showing such insurance is in full force and effect. In the event of an adverse material modification, cancellation, expiration, or reduction in coverage, this Contract shall terminate forthwith, unless Contractholder receives, prior to such effective date, another properly executed original Certificate of Insurance and original copies of endorsements or certified original policies, including all endorsements and attachments thereto evidencing coverage's set forth herein and the insurance required herein is in full force and effect.

   (d) It is understood and agreed to by the parties hereto and the insurance company(s), that the Certificate(s) of Insurance and policies shall be construed as primary insurance, and Contractholder's insurance and/or deductibles and/or self-insured retention's or self-insured programs shall not be construed as contributory.

   (e) The insurance requirements contained in this Contract may be met with a program(s) of self-insurance acceptable to Contractholder.

PART IX. CONTRACTHOLDER NOTIFICATION REQUIREMENTS

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

A. Initial Enrollment

The Employer agrees to offer health benefits coverage to all eligible Employees during the initial enrollment period.

B. Notification of Cancellation to Subscribers

If this Contract is rescinded, or canceled by either party, the Employer shall notify the Subscribers. If rescinded or canceled by Blue Shield, the Employer shall promptly mail a copy of Blue Shield's notice of the rescission or cancellation to each Subscriber and provide Blue Shield proof of such mailing and the date thereof. The Employer must also inform each Subscriber regarding their right to transfer to a Blue Shield individual conversion plan.

C. COBRA and Cal-COBRA

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

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

2. Notification of a Qualifying Event.

   With respect to COBRA enrollees:

   The Contractholder will notify Blue Shield of California of the Subscriber's death, termination or reduction of hours of employment, or of the Subscriber's Medicare entitlement, or the Employer's (Contractholder's) filing for reorganization under Title Xl, United States Code.

3. Duration and Extension of Continuation of Group Coverage.

   Blue Shield of California is responsible for notifying COBRA enrollees of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end.

PART IX. CONTRACTHOLDER NOTIFICATION REQUIREMENTS

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

The Contractholder retains responsibility for the following COBRA administration duties:

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

2. Contractholder will promptly provide Blue Shield with any enrollment forms returned to it by Subscribers and Dependents and with copies of any other written communications with enrollees regarding COBRA rights or election of COBRA coverage.

D. Individual Conversion Plan

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

PART X. AMENDMENT FOR COBRA ADMINISTRATIVE SERVICES

This Amendment is to be attached to and made a part of the Subscriber's current Blue Shield of California Group Health Service Contract and any Amendment or Riders attached thereto. The Contract is hereby amended to include this new section entitled "COBRA Administrative Services."

The obligations of the Contractholder, Blue Shield of California ("Blue Shield"), the COBRA Administrator and the Subscriber, in the event that federal continuation of coverage requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, apply to the Contractholder, are as set forth below:

A. Contractholder

1. The Contractholder is responsible for all aspects of the administration of COBRA with respect to the group health coverage provided by this Contract, except as otherwise provided in this Amendment.

2. The Contractholder delegates to Blue Shield the responsibility to perform those COBRA administration responsibilities as provided herein at Section B.

3. The Contractholder retains responsibility for the following COBRA administration duties:

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

   b. Contractholder will promptly provide Blue Shield with any enrollment forms returned to it by Subscribers and Dependents and with copies of any other written communications with enrollees regarding COBRA rights or election of COBRA coverage.

4. The Contractholder agrees to assume responsibility for any and all COBRA violations resulting from the failure of the Contractholder to perform its COBRA administration responsibilities not specifically delegated to Blue Shield in Section B. of this Amendment.

B. Blue Shield of California

1. Blue Shield is not the plan administrator or plan sponsor, as those terms are defined by ERISA, for any purpose, including but not limited to COBRA, and has no responsibility for the Contractholder's COBRA administration obligations except as set forth in this Section B.

2. To the extent required by COBRA, and upon timely receipt of dues and proper enrollment forms, Blue Shield will continue the group coverage to qualified beneficiaries after the period that their coverage would normally terminate under the Contract.

3. If the Contractholder or any Subscriber or Dependent fails to meet its obligations under the Contract and COBRA, Blue Shield shall not be liable for any claims of the Subscriber or Dependent after his/her termination of coverage, except as expressly provided in other applicable provisions of the Contract.

4. With the exception of those obligations retained by the Contractholder in Section A. hereof, Blue Shield agrees to provide all administrative services, including billing and collection of dues, provisions of notices, etc. as required by COBRA, which will include the following functions:

   a. Receive COBRA election forms from Qualified Beneficiaries.

   b. Maintain records of COBRA continuation coverage dues.

   c. Bill and collect dues from COBRA Qualified Beneficiaries.

   d. Provide timely notification of nonpayment of COBRA continuation coverage dues, per the terms of the Contract and the COBRA law.

PART X. AMENDMENT FOR COBRA ADMINISTRATIVE SERVICES

e. Provide notification of conversion rights or other continuation of coverage rights to the extent required by COBRA or any other federal or state laws as applicable, on termination of COBRA coverage.

f. Establish and maintain records of COBRA continuation coverage.

g. Provide necessary forms, materials and manuals to Contractholder initially and thereafter upon request.

h. Establish procedures to verify eligibility for COBRA coverage.

i. Develop correspondence and notices to COBRA beneficiaries required under COBRA.

j. Provide a reasonable level of customer service with respect to its COBRA responsibilities.

k. Retain records as required by federal law, maintain confidentiality of the records, provide a reasonable disaster recovery program, and provide reasonable access to the records by the Contractholder, subject to federal and California law on the confidentiality of medical information.

l. Inform eligible Subscribers and Dependents of changes in the COBRA law as they occur, including an explanation of the impact of these changes upon COBRA coverage.

m. Provider to Contractholder a list of current COBRA Qualified Beneficiaries and their current mailing address annually at Open enrollment.

5. Blue Shield is not responsible for notifying Subscribers or Dependents or any other parties entitled to notices with regard to COBRA continuation coverage rights, or for providing them with enrollment forms.

6. Blue Shield is not responsible for determining whether a participant Qualified Beneficiary has been charged with gross misconduct, for determining whether a Participant Qualified Beneficiary is or has been incompetent or for comparing the plan or policy with the group health plan sponsored by another employer or Medicare.

7. Blue Shield agrees to assume responsibility if a violation of COBRA occurs due to Blue Shield's failure to perform the obligations specified in Part X.

C. This Amendment shall not be interpreted to grant to any Subscriber or Dependent any continuation rights in excess of those required by COBRA. Additionally, this Contract and the Amendment shall be deemed to have been modified, and shall be interpreted, so as to comply with COBRA and any changes to COBRA that are mandatory with respect to the Contractholder.

Except as amended herein, all terms and conditions of the County Contract remain in full force and effect.

(Amendment - COBRA Administrator)

PART XI. AMENDMENT FOR MEDICARE PRESCRIPTION DRUG PLAN (PDP) BENEFITS

This Amendment for Medicare Prescription Drug Plan (PDP) Benefits ("Amendment") is to be attached to and made a part of the Contractholder's current Blue Shield of California Group Health Service Contract and any Amendment or Riders thereto. The Contract is hereby amended to include this new Part XI., for "Medicare Prescription Drug Plan Benefits."

In the event that Contractholder has elected Benefits that include prescription drug benefits for former employees who are over 65 and are retired ("Retirees"), Blue Shield of California ("Blue Shield") will provide such prescription drug benefits under a Medicare Part D group prescription drug plan ("Group PDP") to those Retirees who are eligible and accepted for enrollment in Medicare Part D by the Centers for Medicare and Medicaid Services ("CMS"). Any Retiree who is not eligible for Medicare Part D, or who enrolls in Medicare Part D on an individual basis, is not eligible for coverage under the Group PDP.

Contractholder acknowledges that Blue Shield must provide such Group PDP benefits in accordance with the terms of a contract with CMS and further acknowledges that such contract imposes affirmative obligations on Blue Shield which can be satisfied only if Contractholder agrees to certain additional obligations. Therefore, the Contractholder and Blue Shield agree to the following additional obligations with respect to the Group PDP benefits as set forth below:

A. **Enrollment Requirements.** Contractholder and Blue Shield will work cooperatively to ensure that Group PDP enrollments are handled in accordance with the CMS Enrollment and Disenrollment Guidance. If the Contractholder elects to enroll Part D eligible Retirees in the Group PDP through a group enrollment process, Blue Shield and Contractholder will mutually determine which party is responsible for providing CMS-required notices to Part D eligible individuals.

Contractholder agrees to provide each Part D eligible Retiree with a CMS-required notice that includes the following elements: (1) a statement indicating that the Retiree will be enrolled in the Group PDP through a group enrollment process; (2) a statement indicating that the Retiree may affirmatively opt-out of the group enrollment, including a description of the process for opting-out and a description of the consequences of opting-out of Group PDP coverage; (3) a summary of benefits offered under the Group PDP; (4) an explanation of how to get more information about the Group PDP; (5) an explanation on how to contact Medicare for information on other Part D options that might be available to the Retiree; and (6) the information included on page 3 of Exhibit 1 of the CMS Enrollment and Disenrollment Guidance. Contractholder will provide this notice at least 30 days prior to the effective date of the Retiree's enrollment in the Group PDP.

B. **Disenrollment Requirements.** In certain circumstances, a Part D eligible Retiree who is enrolled in the Group PDP may be disenrolled on either a voluntary or involuntary basis. Contractholder and Blue Shield will work cooperatively to ensure that Group PDP disenrollments are handled in accordance with the CMS Enrollment and Disenrollment Guidance. At a minimum, disenrollments will be conducted in accordance with one of the following procedures:

1. For voluntary disenrollments and for involuntary disenrollments other than those described in (2.) and (3.) below, Blue Shield will process the disenrollment under the individual disenrollment requirements specified in the CMS Enrollment and Disenrollment Guidance. If the individual does not elect to participate in another PDP, the Retiree may become a member of an Individual PDP offered by Blue Shield.

2. For involuntary disenrollments that occur when Contractholder determines that a Retiree is no longer eligible to participate in the Group PDP or when Contractholder terminates this Contract, then Contractholder and Blue Shield agree to the following:

a. Contractholder agrees that it will: (1) send a letter or notification to the affected Retiree(s) alerting them of the termination event and describing other health plan or health insurance options that may be available through Contractholder; and (2) provide prospective notice of enrollee ineligibility or Contract termination to Blue Shield 60 days or as soon as reasonably possible prior to the termination date.

b. Blue Shield agrees that it will: (1) inform the affected Retiree(s) that they have the option to become a member of an Individual PDP offered by Blue Shield at least 30 days prior to the date of Contract termination or the date the individual will become ineligible for participation in the Group PDP; and (2) provide the affected individual(s) with instructions on how to become a member of an Individual PDP offered by Blue Shield.

3. If Contractholder elects to use a group disenrollment process, then Contractholder agrees to: (1) provide a notice to each affected Retiree indicating that the Contractholder intends to disenroll the Retiree from the Group PDP and including an explanation of how to contact Medicare for information on other Medicare Part D options; and (2) collect and provide Blue Shield with all information necessary for Blue Shield to submit a complete disenrollment request transaction to CMS.

C. **Geographic Analysis.** Within 30 days of the Effective Date of this Amendment, Blue Shield will conduct a geographic analysis to identify where the most substantial portion of the Contractholder's employees/participants reside. Contractholder will work cooperatively with Blue Shield to ensure that this geographic analysis is completed on a timely basis.

D. **CMS Contract.** Upon Contractholder's request, Blue Shield will provide Contractholder with a copy of Blue Shield's contract with CMS.

E. **Monthly Dues for Group PDP.** Monthly dues for Retirees enrolled in the Group PDP are attached to this Amendment. Monthly dues include coverage under both a Blue Shield medical plan and the Group PDP.

Contractholder understands that the dues charged by Blue Shield for the Group PDP may include two rate components: (1) a Part D rate for basic prescription drug coverage, and (2) an additional rate for any enhanced prescription drug coverage negotiated by the Contractholder ("Enhanced PDP Benefit").

Contractholder acknowledges and agrees that these dues will be adjusted by Blue Shield every January 1 to reflect changes in Part D premium paid by CMS. Blue Shield will provide 30 days notice to Contractholder of any change in dues under this provision.

1. **Low-Income Subsidy.** Contractholder also understands that certain low income individuals may qualify for Part D rate subsidies ("Low Income Subsidy"). Blue Shield will advise Contractholder of the two rate components applicable for the Group PDP, and the amount of any Low Income Subsidy available for a Retiree. Contractholder acknowledges that it may subsidize one or both rate components, subject to the following restrictions:

a. Contractholder may subsidize different rate amounts for different classes of enrollees in the Group PDP based on reasonable and objective business criteria such as years of service, date of retirement, business location, job category, and nature of compensation (i.e., salaried or hourly). However, the different classes of enrollees cannot be based on eligibility for the Part D low income subsidy;

b. Contractholder may not vary the premium subsidy for Retirees within the same class of enrollees;

c. Contractholder may not charge Retirees more than the sum of the Part D premium and one hundred percent (100%) of the additional premium for enhanced prescription drug benefits;

d. Contractholder agrees that, for all Retirees eligible for the Low Income Subsidy, the Low Income Subsidy will first be used to reduce the portion of the Part D dues paid by the Retiree and any remaining Low Income Subsidy will then be applied to reduce the portion of the Part D dues paid by Contractholder;

e. Contractholder agrees that, if the Low Income Subsidy for any Retiree is less than the portion of the Part D dues paid by the Retiree, Contractholder will provide a communication to the Retiree comparing the

consequences of enrolling in the Group PDP with the consequences of enrolling in other Medicare Part D plans that have a monthly beneficiary premium that is equal to or less than the Retiree's Low Income Subsidy. This communication will be provided within 30 days after Contractholder learns of the Retiree's Low Income Subsidy.

2. **Late Enrollment Penalty.** Retirees are charged a late enrollment penalty by CMS for each month they are eligible for and failed to enroll in a Medicare prescription drug plan, and if they did not have other creditable prescription drug coverage during that time. CMS will subtract the base premium paid on behalf of that Retiree by the amount of the Retiree's late enrollment penalty in the premium paid to Blue Shield. In such instances, Blue Shield will notify Contractholder of any late enrollment penalties applicable to its Retirees, and Contractholder agrees to pay to Blue Shield the late enrollment penalty in addition to monthly dues owed. In addition, Contractholder agrees to apportion such penalty to that Retiree's share of cost for dues owed for the Group PDP.

F. Evidence of Coverage and Plan Description.

1. **EOC.** The Evidence of Coverage and Disclosure Form addendum for Group PDP coverage is attached to this Amendment.

2. **Plan Description.** Contractholder agrees that it will timely disclose the terms and conditions of the Group PDP to Retirees in accordance with the disclosure requirements imposed by the Employee Retirement Income Security Act of 1974 ("ERISA") or, if ERISA does not apply, in accordance with any disclosure requirements imposed by state or local law. Upon Blue Shield's request, Contractholder agrees to make copies of all such disclosures available to Blue Shield.

G. Group PDP Formulary. Contractholder acknowledges that Blue Shield is required to utilize a different formulary for the Group PDP based on CMS required coverage of drugs in selected therapeutic classes. Contractholder further acknowledges and agrees that Blue Shield will not modify its formulary approved by CMS by removing drugs or by adding additional utilization management restrictions without approval from CMS.

H. Data Provided to Blue Shield. Contractholder recognizes that some additional data elements in addition to the standard enrollment file must be provided to Blue Shield in order to facilitate enrollment in the Group PDP. These data elements include, but are not limited to, a Retiree's Medicare Part A and B effective dates, Medicare Number, and identification of whether the Retiree has other prescription drug coverage (COB). Contractholder will be responsible for providing this data at least 30 days prior to the effective date of the Retiree's enrollment. Failure to provide required data in a timely manner may result in a delay of a Retiree's effective date with CMS in the Group PDP of up to 45 days.

I. Effect of Delay in Part D Enrollment. In the event of a delay in the Retiree's effective date by CMS for Part D enrollment, for any reason, the Contractholder agrees to pay all dues applicable to the Group PDP, including the portion typically paid by CMS, until such time as CMS confirms the Retiree's effective date and transmits any payments to Blue Shield.

J. Term and Termination.

1. **Term.** This Amendment shall be effective as of January 1, 2010 for a term of one year, subject to the provisions of the Contract, entitled, "Changes: Entire Contract."

2. **Termination of Group PDP Benefits.** Contractholder may cancel this Amendment for Group PDP Benefits at any time by written notice delivered or mailed to Blue Shield, effective on receipt or on such later date as specified in the notice. Upon termination of Group PDP benefits, a Retiree may be eligible for a commercial retiree prescription drug plan if otherwise made available by Contractholder to Retirees not enrolled in Medicare Part D under the Contract.

3. **Termination of Contract.** This Amendment will automatically terminate upon cancellation of the Contract.

PART XI. AMENDMENT FOR MEDICARE PRESCRIPTION DRUG PLAN (PDP) BENEFITS

K. Definitions. For purposes of this Amendment, the following terms have the specified meanings:

1. **"CMS Enrollment and Disenrollment Guidance"** means the guidance published by CMS relating to Part D prescription drug plan enrollment and disenrollment procedures, the full title of which is "PDP Guidance Eligibility, Enrollment and Disenrollment."

2. **"Individual PDP"** means a Medicare Part D prescription drug plan sponsored by Blue Shield that is not a Group PDP.

PART XII. PERFORMANCE GUARANTEES

Blue Shield will be at risk, January 1, 2010, through December 31, 2010, for its performance of certain services provided to the Contractholder. These performance guarantees are contingent upon a minimum enrollment of 1,000 Subscribers at the beginning and end of the contract period. The following Performance Guarantees apply.

A. Performance Guarantees

The Performance Guarantees applicable to the Contract are set forth herein as Attachment 1.

B. Total Amount at Risk

The total amount of premium paid by Contractholder to Blue Shield which is at risk under this Performance Guarantee Addendum is $25,000 – combined for all metrics and all medical plan products.

C. Reporting Frequency and Annual Calculation

Blue Shield will provide Contractholder with reports setting forth the performance of Blue Shield against each of the metric in accordance with the reporting schedule set forth for each metric described in Attachment 1. Reports will be generated within 45 days after the close of each reporting period.

At the close of the contract year, Blue Shield will prepare a single report which sets forth Blue Shield's performance against each of the metrics. In the event Blue Shield has failed to meet any metric, payment by Blue Shield of the applicable performance penalty will be sent to Contractholder within 30 days after the issuance of the annual report.

D. Force Majeure

If Blue Shield's performance under this Agreement is interrupted or delayed by any occurrence not within Blue Shield's control, whether that occurrence is an act of God or public enemy, or whether that occurrence is caused by war, riot, storm, earthquake, or other natural forces, or by a third party(s) not under Blue Shield's control, then Blue Shield will be excused from performance during the occurrence and for whatever period of time after the occurrence is reasonably necessary to remedy the effects thereof.

PART XII. PERFORMANCE GUARANTEES

Blue Shield Service Metric	**Reporting Frequency**	**County of Riverside Performance Guarantees**
Claims turnaround time – percent of clean California claims adjudicated to completion within 14 calendar days	Annual	≥80% Measurement: Client-specific Total Amount at Risk: $5,000
Claims procedural accuracy - This is a measure of California-based claims for Members which are processed by Blue Shield of California and for which the adjudication met Frequency Accuracy, as defined by the Blue Cross/Blue Shied Association's Member Touchpoint Measures program as (# Accurately Paid Claims in Sample)/(Total # of Claims in Sample). Accuracy is defined as proper determination of eligibility, plan benefit(s) and payee. Measurement is based on annual audit conducted by Blue Shield of California's Performance Measurement auditors.	Annual	≥95% Measurement: Client-specific Total Amount at Risk: $5,000
ID Card Release Time/Annual Open Enrollment - The issuance of ID cards is measured by the number of ID cards mailed by such date and postal class in order to be received by members no later than January 1, divided by the total number of newly enrolled members during the open enrollment period. In order to be counted in this measure, receipt of confirmation of eligibility from the County of Riverside must be received no later than 21 business days prior to the contract effective date.	Annual	≥97% Measurement: Client-specific Total Amount at Risk: $5,000
Call Abandonment Rate - This performance standard measures the percentage of calls in which the member opts to speak with a member representative and then hangs up once the transfer to that option is made but prior to speaking with a member service representative.	Quarterly	≤5% Measurement: LTP* Call Center-specific Total Amount at Risk: $5,000
Average Speed to Answer - This is the average of waiting times for all member callers who have requested to speak with a member service representative. This performance measure starts with the caller selecting this option on an automated phone system and ending with the sound of a live voice divided by all the incoming calls answered by the member service representatives. This measurement is based on those callers opting for the first available representative only and is based on a weighting of averages each business day.	Quarterly	≤ 30 seconds Measurement: LTP* Call Center-specific Total Amount at Risk: $5,000

**Blue Shield of California's Labor, Trust and Public Sector dedicated Member Service's 800-number.*

EVIDENCE OF COVERAGE AND DISCLOSURE FORM

An Evidence of Coverage and Disclosure Form booklet and any applicable Supplements will be issued by Blue Shield for all Subscribers covered under this Group Health Service Contract. The following pages contain the exact provisions of this Evidence of Coverage and Disclosure Form and any applicable Supplements and are incorporated into and made a part of this Contract.

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

Blue Shield Group Health Service Contract
Addendum #1
Healthy Lifestyle Rewards

The Group Health Service Contract dated January 1, 2010, effective January 1, 2010, between California Physicians' Service, Inc., dba Blue Shield of California ("Blue Shield") and the County of Riverside, State of California, a public entity, ("County") (hereinafter the "County Contract") is hereby amended as of January 1, 2010, as follows.

RECITALS

A. The County and Blue Shield are parties to certain Group Health Service Contracts effective January 1, 2010, ("County Contracts") under which Blue Shield provides health plan coverage for enrolled employees, retirees and dependents of the County (hereinafter "BSC Members") as defined in the Contracts.

B. In conjunction with the County Contracts, Blue Shield has also agreed to make its Healthy Lifestyle Rewards program, including the Health Coach component (collectively "HLR"), available to BSC Members.

C. Rewards earned under the HLR program are payable only to the BSC Subscriber. All eligible dependents of Subscribers are able to participate in HLR program, but are not eligible for Rewards payment.

I. DEFINITIONS

1.1 **BSC Member** – An eligible employee, retiree or dependent of the County enrolled on a Blue Shield health plan under the County Contracts.

1.2 **BSC Subscriber** – An employee or retiree of the County who elects coverage with Blue Shield under the County Contracts.

1.3 **County Contract(s)** – The Group Health Services Contracts in effect between the County and Blue Shield.

1.4 **HLR Program** – The Healthy Lifestyle Rewards Program, an online program that supports, motivates, and ultimately rewards individuals in order to create healthy, more active lifestyles. The Health Coach portion of the program is a telephonic support service made available to Members with certain identified health risks.

1.5 **Reward** – The incentive payment earned by a BSC Subscriber for completing a health risk (wellness) assessment and for participating in the HLR Program for the predetermined number of weeks. BSC Subscribers can earn Rewards without participating tin the Health Coach portion of the program.

II.TERM & TERMINATION

2.1 The term of this Agreement shall be for twelve (12) months, beginning on the effective date set forth above. The Agreement shall end on December 31, 2010, unless otherwise extended or renewed by mutual written agreement of the parties hereto and approved by County of Riverside, Board of Supervisors.

2.2 This Agreement will automatically terminate upon the termination of all County Contracts, whether or not prior to the end of the Agreement term specific in Section 2.1 hereof.

III. PROGRAM TO BE PROVIDED

3.1 Blue Shield will make the HLR Program described in Exhibit 1. hereto available to the BSC Members.

3.2 The HLR Program will be available to BSC Members for a total of approximately 52 weeks beginning on or about January 1, 2010 and ending on or about December 31, 2010.

3.3 BSC Members who have questions or need assistance will be supported through the electronic on-line support program; responses to questions or problems presented will be provided within three (3) business days.

3.4 Blue Shield will track participation of all BSC Members in the HLR Program and administer payment to BSC Subscribers of Rewards earned in accordance with the program description.

3.5 In order to implement and promote the HLR Program to BSC Members, Blue Shield will provide the County with a promotional campaign that may consist of: (a) 1 or 2 direct mail postcards for the County to mail , (b) a suggested reminder calendar with HTML postcards and templated E-Mail text, and, (c) proposed text and layout (in .pdf format) of posters and flyers.

3.6 Blue Shield will provide the County with the reports set forth in Exhibit 2. attached hereto.

IV. COST

4.1 There is no additional cost to the County for the HLR program or the HLR Rewards. The costs of administration of the HLR Program and the HLR Rewards are included in the Dues paid by the County under the County Contract.

4.2 The Rewards will be paid by Blue Shield to BSC Subscribers as described in Exhibit 1.

Except as amended herein, all terms and conditions of the County Contract remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Agreement.

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

COUNTY OF RIVERSIDE:

By: _____
Deputy

By: _____
Chairman, Board of Supervisors

Date: _____

Date: _____

Approved as to form and content:

Pamela J. Walls
County Counsel

By: _____
Deputy County Counsel

California Physicians' Service, dba Blue Shield of California

David S. Joyner, Senior Vice President
Large Group and Specialty Benefits
Blue Shield of California

EXHIBIT 1 – Program Overview

About the program

Healthy Lifestyle Rewards is an online program that supports, motivates, and ultimately rewards individuals in order to create healthy, more active lifestyles. Health Coach is a telephonic program whereby moderate to high risk individuals receive a series of calls from professionally trained health coaches, intended to provide support, focus and accountability for making lifestyle changes that will reduce their identified health risks.

Key components of this program include:

- Initial health risk appraisal (wellness assessment), and ongoing (self-reported) measurement of behavior
- Interactive, online coaching: such as nutrition planning, health education materials; exercise tracking tools; weight loss, diet and stress reduction strategies; weekly e-mails; progress tracking; calculators and quizzes
- A series of outbound phone calls from trained health coaches (usually ranging from 4-12 per year, depending on risk) and unlimited inbound calling access.
- Rewards are offered to BSC Subscribers based upon completion of the wellness assessment as well as on their reports of the healthy activities of their choosing. Individuals do what works for them.
- Rewards are redeemed by a vendor under contract with Blue Shield of California. Participants may redeem their rewards for cash , delivered via debit card, as they have earned sufficient credit. Completion of the wellness assessment is worth $25. Eligible participants may also earn $50 for every 12 weeks of activity tracked online with an annual maximum of $150. Total maximum rewards redeemed by a participant will not exceed $175.

How the program works

BSC Members will access Healthy Lifestyle Rewards through a custom, co-branded web site landing page. The program is intended to reduce modifiable risk factors that contribute to chronic disease by focusing on healthy eating, tobacco abstinence, stress management and physical activity. Individuals can select from five different programs, each lasting approximately 10 weeks. These Lifestyle Improvement Programs offer focused, actionable content as well as interactive and tailored tools (such as recipes, exercise logs, walking trackers) that allow the user to find practical, easy strategies that lead to long term success.

To begin the program, individuals must register and complete a health risk assessment that establishes a baseline snapshot of health risks and helps the individual see where lifestyle improvements may be in order. The individual then selects any course of action that appeals to them and begins participation. Weekly email reminders provide prompts to help keep participants on target.

- To qualify for rewards, BSC Subscribers must log on and track activity at least once a week for 12 weeks. The weeks need not be consecutive. Individuals will be able to earn credit every week by logging on and using trackers, journals, and health information to help them

meet their goals. Simply logging in and tracking one's activities shouldn't take more than 5-10 minutes per week although some individuals may choose to spend more time exploring the interactive tools and information. The website includes a rewards summary that allows participants to monitor their progress.

- To qualify for the $25 wellness assessment reward, a participant must complete and submit a wellness assessment during the length of the program.
- Rewards are processed by a vendor under contract with Blue Shield of California. Participants may redeem their rewards for cash as soon as they have earned sufficient credit. Completion of the wellness assessment is worth $25. Eligible participants may also earn $50 for every 12 weeks of activity tracked online with an annual maximum of $150. Total maximum rewards redeemed by a participant will not exceed $175.

If the individual indicates moderate to high risks through their wellness assessment, he/she will be told he/she qualifies for health coaching at their end of their assessment and that a coach will be contacting him/her. Participation in the Health Coach program is completely voluntary and does not impact the Subscriber's entitlement to receive HLR Rewards. Once enrolled in the coaching program the individual receives:

- Welcome letter explaining the program, how it works and the inbound phone number.
- A series of 4-12 personalized phone calls with a trained health coach over a 12 month period.
- Two health guides of their choosing mailed to them.
- Unlimited inbound calling access.

EXHIBIT 2 – Reports

Metric	Frequency	Measures
HLR Enrollment	▪ Monthly	▪ Adoption rate
HRA Completion	▪ Monthly	▪ Adoption rate
Health Risk Assessment aggregate results and program usage	▪ Quarterly ▪ Sent 30 days after close of quarter	▪ Program adoption and site use ▪ Population profile - program interest areas ▪ Self-reported health risks ▪
Health Coach	▪ Quarterly ▪ Sent 30 days after close of quarter	▪ Adoption rate ▪ Total calls made ▪ Targeted risks ▪ Satisfaction
Health Risk Assessment - aggregate results	▪ Annually ▪ Sent 30 days after close of program	▪ Self reported chronic disease stratification ▪ Health risk prevalence ▪ Readiness to change within risk categories

NOTE: All reporting will be aggregated or anonymized to protect the confidential and personal health information of the individuals participating in the HLR Program. The County understands and agrees that Blue Shield will not provide County with any information on BSC Members participating in the HLR that is individually identifiable or would otherwise violate state or federal relating to the confidentiality of personal and health information.