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

603A

FROM: Human Resources Department

SUBMITTAL DATE:
June 14, 2010

SUBJECT: Exclusive Care - County of Riverside Health Plan Group Retiree Healthcare Services Agreement Renewal with the City of San Buenaventura (Ventura).

RECOMMENDED MOTION: 1) Ratify and approve the attached County of Riverside Health Plan Group Retiree Healthcare Services Agreement with the City of San Buenaventura (Ventura) from January 1, 2010 through December 31, 2010; 2) authorize the Chairperson to sign four (4) copies of the attached Agreement and; 3) retain one (1) copy of the signed Agreement, returning three (3) copies to Human Resources for distribution.

BACKGROUND: On July 17, 2007, Item 3.36, the Board approved the basic plan design for the Exclusive Care Select Retiree Health Plan that is available to non-Medicare eligible and Medicare eligible retirees and their dependents from the County of Riverside and other participating public entities. The plan has been designed to provide comprehensive health coverage no matter where members need care, locally or nationally.

Barbara A. Olivier
Asst. County Executive Officer/Human Resources Dir.

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

SOURCE OF FUNDS: Health Premiums paid by the City of San Buenaventura

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: NEAL R. KIRNIS DATE 6/21/10

Departmental Concurrence

☒ Policy ☐ Consent
☐ Policy ☐ Consent

Dep't Recomm.:
Per Exec. Ofc.:

Prev. Agn. Ref.: 7/17/07 3.36, 1/29/08 3.33, 1/27/09 3.46 | **District:** ALL | **Agenda Number:** 3.53

ATTACHMENTS FILED WITH THE CLERK OF THE BOARD

BACKGROUND continued:

Eligible County retirees have a choice of County sponsored health plans when making an election. The Exclusive Care Select Retiree Health Plan continues to provide the best value medical coverage to retirees at competitive market rates compared to similarly designed plans.

On January 29, 2008, Item 3.33, the Board approved the Group Retiree Healthcare Services Agreement with the City of Ventura. This Agreement allows the City of Ventura to continue their participation in the Riverside Group Retiree Health Care Plan (Exclusive Care Select Plan).

This agreement was ratified and approved on January 27, 2009, Item 3.46, by the Board of Supervisors for plan year January 1, 2009 through December 31, 2009.

The Human Resources Department has worked with Aon, the County's benefits consultant to develop 2010 premium rates. Aon has actuarially calculated the 2010 rates based on the Plan's design, members demographics, and estimated medical trend rates. Approval of this agreement will allow the continuation of this agreement with the City of Ventura for plan year January 1, 2010 through December 31, 2010.

Late submission of this Form 11 is due to a delay in receiving signed copies resulting from retirement of the City of Ventura employee managing this program.

Agreement No.
2009-080

County of Riverside

EXCLUSIVE CARE HEALTH PLAN

GROUP RETIREE HEALTHCARE SERVICES AGREEMENT

With THE CITY OF SAN BUENAVENTURA

EXCLUSIVE CARE HEALTH PLAN
GROUP RETIREE HEALTHCARE SERVICES AGREEMENT
WITH THE CITY OF SAN BUENVENTURA

County of Riverside, a county and a political subdivision of the State of California, through its self-insured health care plan, "Exclusive Care", and the City of San Buenaventura, a city and a political subdivision of the State of California, hereinafter known as "Group" agree as follows:

RECITAL OF FACTS

Exclusive Care is the Riverside County self-insured health plan which arranges for the provision of medical, hospital, and preventive medical services to persons enrolled as Members on a direct services basis through contracts with associations of licensed physicians, hospitals, and other health care providers, for and on behalf of its individual Members. Group is the eligible Public Entity, as identified herein, which has contracted with Exclusive Care to provide such health care for its eligible Subscribers and their eligible Dependents. In consideration of the application of Group for the benefits provided under this Agreement, and in consideration of the periodic payment of Health Plan Premiums on behalf of Members in advance as they become due, Exclusive Care agrees to arrange or provide medical, surgical, hospital and related health care benefits subject to all terms and conditions of this Group Retiree Healthcare Services Agreement.

1. DEFINITIONS

1.01 Definitions.

(a) Agreement is this Group Retiree Healthcare Services Agreement, including any Attachments and amendments hereto, including the Summary Plan Documents (SPDs) for the Exclusive Care Select Plans.

(b) **COBRA CONTINUATION RIGHTS**

Under the terms of the Consolidated Omnibus Budget Reconciliation Act (COBRA), continued coverage is available to the enrollee, their covered spouse and dependents should they lose coverage under the circumstances described below. Each COBRA-eligible person has a right to make a separate election—choosing or declining COBRA coverage—when there is a qualifying event that causes loss of coverage under the Plan. Exclusive Care shall provide Administrative Services for group as outlined herein in Exhibit 2

(c) Continuation Member is any Subscriber or Dependent who is enrolled and eligible to receive benefits as provided herein under the Continuation of Benefits section.

(d) Co-payments and Coinsurance are fees payable by the Member to a health care provider at the time of provision of services; such fees are in addition to the Health Plan Premiums paid by Group. The amounts of such fees are pursuant to this Agreement and may be a specific dollar amount or a percentage of total fees as specified herein, depending on the type of services provided.

(e) Covered Services are the Medical and Hospital Services arranged or reimbursed for by Exclusive Care as set forth in this Agreement subject to the exclusions and limitations as provided in the Summary Plan Document (SPD).

(f) Group is the eligible Public Entity identified above who has hereby contracted with Exclusive Care to provide health care for its eligible Subscribers and their eligible Dependents in consideration of the Group's periodic payment of Health Plan Premiums on behalf of Members as they become due, and who maintains the eligibility criteria referenced in 9.02.04.

(g) Group Participation is the number of individuals who are enrolled as Subscribers in any Group medical plan expressed as a percentage of the number of employees of the Group who are eligible to enroll as Subscribers in any Group medical plan. Subscribers who are covered under another employer's plan are not considered in the equation.

(h) Group Service Department is the person or persons designated by Exclusive Care to whom oral and written Member complaints may be addressed. The Group Service Department may be contacted by telephone at 1-800-962-1133; by writing to Group Service Department, Exclusive Care P.O. Box 1508, Riverside, CA 92502-1508; or by fax at 951-955-0055

(i) Dependent is any current Spouse, Domestic Partner or unmarried child of Subscriber who is enrolled hereunder and meets all the eligibility requirements set forth in Paragraph 2.03, and for whom applicable Health Plan Premiums are received by Exclusive Care.

(j) Domestic Partner is a person who is eligible for domestic partner coverage as a Dependent under Exclusive Care. To be eligible, the Subscriber and Domestic Partner must provide Group with a completed Health Benefit Enrollment form (HBD-12), a copy of the valid Declaration of Domestic Partnership form filed with the California Secretary of State, and a signed Statement of Financial Liability in which each person individually certifies to the following facts:

i. Both persons are at least 18 years of age and are of the same gender; or

ii. Both of the Domestic Partners are over the age of 62 and may be of the same or opposite gender.

iii. Domestic partners are two adults who have chosen to share one another's lives in an intimate and committed relationship or mutual caring.

iv. Both partners have a common residence.

v. Both partners agree to be jointly responsible for each other's basic living expenses incurred during the domestic partnership.

vi. Neither partner is currently married or a member of another domestic partnership.

vii. Neither may be related to the other and are not related by blood closer than would prohibit legal marriage in the State of California such as a parent, brother or sister, half brother or sister, niece, nephew, aunt uncle, grandparent or grandchild. Domestic Partnership does not include roommates, friends or other similar relationship.

(k) Eligible Retiree is a retiree of the Group who meets the Group's eligibility requirements for enrollment in the Exclusive Care Select Plans.

(l) Eligible Dual Coverage is prohibited by Exclusive Care. No individual Member may be covered as both a Subscriber and a Dependent or as the Dependent of two (2) Subscribers under the Health Plan.

(m) Enrollment is the execution of an Exclusive Care Select Plan Enrollment Form by the Subscriber on behalf of the Subscriber and his or her eligible Dependents, and acceptance thereof by Exclusive Care, conditional upon the execution of this Agreement by Group and Exclusive Care and the timely payment of applicable Health Plan Premiums by Group. Exclusive Care will accept enrollment through enrollment forms, and/or electronic submission, provided standard and mutually agreed upon protocols are adhered to.

(n) Exclusive Care Enrollment Packet is the packet of information supplied by the City of San Buenaventura to prospective Members which summarizes this Group Retiree Healthcare Services Agreement and contains the Exclusive Care Enrollment Form, or a non-standard enrollment form approved by Exclusive Care.

(o) Former Spouse for the purpose herein is defined as either an individual who is divorced from an employee or former employee or an individual who was married to an employee or former employee at the time of death of the employee *or former* employee.

(p) Health Plan is the health plan described in this Exclusive Care Group Retiree Healthcare Services Agreement.

(q) Health Plan Premiums are amounts, also referred to as rates, established by Exclusive Care to be paid to Exclusive Care by Group on behalf of Members in consideration of the benefits provided under this Health Plan; such amounts are set forth herein in Exhibit 1.

(r) Medicare Retiree is a Member who is:

i. eligible for Medicare Parts A and B or Part B only; and

ii. no longer eligible for benefits as an active employee or a dependent of an active employee of Group; and

iii. properly enrolled in this Health Plan; and eligible for benefits under this Health Plan pursuant to the requirements set forth herein.

(s) Member is any Subscriber or Dependent who is enrolled in this Health Plan for whom Exclusive Care provides health care services.

(t) Open Enrollment Period is period agreed upon by Exclusive Care and Group during which all Eligible Retirees and their eligible Dependents may enroll in this Health Plan.

(u) Public Entity is the State of California, County, City, City and County, Special district, public authority, commission, public agency, political subdivision of the State of California, or public or municipal corporation of the State.

(v) Qualifying Children, is a child of a lawful spouse or Registered Domestic Partner who is under the age of 23 ("limiting age") and has never been married, may enroll in the Exclusive Care Select Plan if they meet one of the eligibility requirements as set forth below:

i. They must be natural born, legally adopted (i.e. stepchildren), or placed in the home for purposes of foster care of adoption; or

ii. They must be children for whom you, or your lawful spouse or Registered Domestic Partner are appointed as a legal guardian by a court; or

iii. They must be children for whom you or your lawful spouse or Registered Domestic Partner are required to provide health coverage pursuant to a qualified medical child support order ("QMCSO") or who resides with you (general in the absence of the natural or adoptive parent) and who is economically dependent upon you; or

iv. They must be grandchildren who reside with you, generally in the absence of the natural or adoptive parent; and who are economically dependent upon you. A copy of the court ordered custody must be on file.

(w) Service Area is the geographic area in which Exclusive Care is authorized to operate by the California Department of Managed Health Care to offer its Retiree Health Plans to various public entities. The Retiree Health Plans include nationwide provider networks to serve enrolled Retirees wherever they may reside or need services.

(x) Spouse is the Subscriber's legally recognized husband or wife under the laws of the State of California.

(y) Subscriber is the Eligible Retiree who meets the Group's eligibility requirements and is enrolled in the Health Plan for whom the appropriate Health Plan Premium has been received by Exclusive Care, and whose retiree status is the basis for enrollment eligibility.

(z) Summary Plan Document is the booklet that Exclusive Care issues to the Subscriber describing the benefits to which Members are entitled under the Exclusive Care Select Plans.

(aa) Totally Disabled means:

For Subscribers, the persistent inability to reliably engage in any substantially gainful activity by reason of any medically determinable physical or mental impairment resulting from an injury or illness.

For Dependents, the persistent inability to perform activities essential to the daily living of a person of the same age and sex by reason of any medically determinable physical impairment resulting from an injury or illness.

Determination of total disability shall be made by the Member's Primary Care Physician on the basis of a medical examination of the Member and upon concurrence by Exclusive Care's Medical Director. The period of total disability must be expected to extend for at least six (6) months.

A Member Questionnaire for the Disabled Dependent Benefit form (HBD-98) and a Medical Report for the Disabled Dependent Benefit Form (HBD-34) must be approved by Exclusive Care prior to enrollment, and be updated upon request.

2. ELIGIBILITY AND ENROLLMENT

2.01 Enrollment Procedure. Exclusive Care provides Covered Services to Members who meet the eligibility requirements stated in this Agreement and are properly enrolled in the Health Plan pursuant to this Agreement.

2.01.01 Enrollment Election Form. A properly completed enrollment election form provided or approved by the City of San Buenaventura must be submitted to Exclusive Care by Group for each Subscriber, on behalf of the Subscriber and any Dependents. Exclusive Care may, in its discretion and subject to specific protocols, accept enrollment through an electronic submission from Group.

2.01.02 Time of Enrollment. All applications for enrollment shall be submitted by the Eligible Retiree to Group's Designated Department during Open Enrollment Periods, except that prospective Subscribers and their eligible Dependents who were not eligible during the previous Open Enrollment Period may apply for enrollment within sixty (60) days after becoming eligible. Eligible Retirees are covered the first day of the month following the date the Group's Designated Department receives the prospective Member's completed Health Benefit Enrollment Form.

Enrollment elections which are received by the Group within the allotted sixty (60) days shall be subject to rejection by Exclusive Care if received by Exclusive Care ninety (90) days after enrollment as described above. Group shall provide notice to Members of the applicable Open Enrollment Periods.

2.01.03 Off-Cycle Coverage Election. The following off-cycle qualifying events (change in status) will permit an Eligible Retiree off-cycle enrollment:

(a) Change in legal marital status, including marriage, death of spouse, divorce, legal separation and annulment.

(b) Change in number of Dependents, including birth, death, adoption and placement for adoption.

(c) Employment status - any of the following events that change the employment status of the retiree's spouse, the retiree's domestic partner or the retiree's dependent child including:

i. Termination or commencement of employment;

ii. Strike or lockout;

iii. Commencement of or return from an unpaid leave of absence;

iv. Change in work site; or

v. Loss of employment (resulting in loss of other insurance.

(d) Dependent, including Domestic Partner, satisfies or ceases to satisfy eligibility requirements (e.g. attainment of age, student status, or any similar circumstances).

(e) Judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order that requires accident or health coverage for an employee's child).

(f) Entitlement to or loss of Medicare or Medicaid (Medi-Cal).

(g) Addition or elimination of benefit package option providing similar coverage which include voluntary disenrollment by a spouse.

2.02 Subscriber Eligibility. Only the Eligible Retirees (prospective Subscribers) who meet the eligibility requirements stated in this Agreement may be enrolled in the Health Plan. Loss of eligibility shall terminate Subscriber's enrollment in this Health Plan. Subscriber must meet each of the following eligibility requirements:

(a) Be an Eligible Retiree.

(b) Meet all eligibility requirements of Group for enrollment in this Health Plan.

2.03 Dependent Eligibility. The Subscriber's Spouse or Domestic Partner as previously defined and the unmarried dependent children of the Subscriber, Subscriber's Spouse or Domestic Partner who meet the eligibility requirements stated in this Agreement may be enrolled in the Health Plan. Children who are under the limiting age set forth in this Agreement may enroll as Dependents of the Subscriber if the Dependent meets each of the eligibility requirements set forth below.

(a) For purposes of eligibility, children of the Subscriber include:

i. Natural born children, or children placed for the purposes of adoption by or legally adopted children of the Subscriber, Subscriber's Spouse or Domestic Partner (i.e., stepchildren);

ii. Children for whom the Subscriber, Subscriber's Spouse or Domestic Partner has been appointed a legal guardian by a court;

iii. Children for whom the Subscriber, Subscriber's Spouse or Domestic Partner is required to provide health coverage pursuant to a qualified medical child support order;

iv. Grandchildren that reside with the Subscriber, generally in the absence of the natural or adoptive parent, who are economically dependent upon the retiree, and an Affidavit of Eligibility (Form HBD-35) or a copy of the court-ordered custody must be on file.

(b) The following requirement must be met to ensure eligibility:

The Subscriber through whom the Dependent is eligible must be enrolled in the Health Plan.

2.03.01 Coverage for Students and Non-Students. A Dependent unmarried child who is registered on a full-time basis (at least twelve (12) semester units or the equivalent, as determined by Exclusive Care) at a certified educational institution may continue as an eligible Dependent through the end of the month in which they reach the limiting age for full time students, provided proof of such status is submitted timely to Group. Group shall provide such proof timely to Exclusive Care, as may be requested by Exclusive Care.

Dependents who are not full time students as defined above and who reside with the Subscriber may continue as an eligible Dependent through the end of the month in which they reach age 23, provided the Subscriber provides over one-half of the daily support needs of the Dependent. Annual verification is required as determined by Group. In the event of an eligibility issue, Exclusive Care may require from Group supporting documentation of Dependent's residency with Subscriber. Absence of such documentation may result in termination of the Dependent from Exclusive Care.

2.03.02 Commencement of Coverage for Dependents Eligible as a Result of Birth, Legal Guardianship or Adoption. An application to enroll any new Dependent must be made within sixty (60) days of the event which resulted in eligibility.

(a) Coverage for newborn children of Subscriber begins at birth. In order for coverage to continue for more than thirty-one (31) days, an enrollment election for the Dependent must be submitted to Group prior to the expiration of sixty (60) days from birth. If no enrollment form is received within the sixty (60) day enrollment period, Subscriber will be billed for the 31 days of coverage.

(b) Coverage for adopted children is effective the first of the month following the Plan's receipt of an enrollment form for the child. The enrollment form must be accompanied by evidence of eligibility in the form of a written document signed by the appropriate legal authority granting the Subscriber, Subscriber's Spouse or Domestic Partner the legal right to control the health care of the adoptive child.

(c) For children for whom the Subscriber, Subscriber's Spouse or Domestic Partner has been appointed legal guardian by a court, coverage is effective the first of the month following the Plan's receipt of an enrollment form for the child. The enrollment form must be accompanied by evidence that physical custody has been obtained, such as a copy of the court or administrative order. Eligibility for a child for whom Subscriber has been appointed legal guardian ends when the guardianship ends or the child reaches the limiting age.

2.03.03 Coverage for Disabled Dependent Child. Dependent, unmarried children who are incapable of self-sustaining employment by reason of developmental disability, debilitating illness or physical handicap and who are older than the limiting age of 23 may be eligible to enroll or continue enrollment in this Health Plan beyond the limiting age. To be eligible, the dependent child must reside with either the Subscriber or the Subscriber's separated or divorced spouse and must be dependent upon Subscriber for support and maintenance. Group must provide proof of such incapacity and dependency to Exclusive Care within sixty (60) days of the onset of the disability, attainment of the limiting age, or during an Open Enrollment Period on such forms as are approved by Exclusive Care.

Exclusive Care may require ongoing proof of Dependent's incapacity and dependency, but not more frequently than annually following the first two years after the attainment of the limiting age or the onset of the disability. Such proof shall include a written statement by a licensed psychologist, psychiatrist, or other physician to the effect that such Dependent is incapable of self-sustaining employment by reason of developmental disability, debilitating illness or physical handicap.

2.03.04 Coverage for Dependents as a Result of Court or Administrative Order. A person having custody of the Dependent or a custodial parent who is not a Member may inquire about Dependent coverage, if the Subscriber is required to provide coverage for the Dependent pursuant to a court or administrative order, including a Qualified Medical Child Support Order (QMCSO). Evidence of such order must be submitted at time of enrollment request. Information including, but not limited to, the identification card, the Summary Plan Document (SPD) or other available information including notice of termination will be provided to the custodial parent, legal custodian and/or District Attorney. Coverage will begin on the first of the month following receipt by Exclusive Care of an enrollment form with the court or administrative order attached.

2.04 Commencement of Coverage. The commencement date of coverage under this Health Plan shall be the first of the month following Exclusive Care's receipt of Member's enrollment and verification of Member's eligibility in accordance with the terms of this Agreement unless otherwise provided herein. Exclusive Care's acceptance of Member's enrollment is contingent upon receipt of the applicable Health Plan Premium payment.

2.05 Member's Eligibility Not Affected by Health Status. A Member otherwise eligible and duly enrolled hereunder shall not be terminated from this Health Plan due to the Member's health status or need for health services.

2.06 Exclusive Care's Liability in the Event of Conversion from a Prior Carrier. In the event Exclusive Care replaces a prior carrier of Group's hospital, medical or surgical benefits within sixty (60) days from the date of discontinuance of the prior Group contract, Exclusive Care shall immediately provide coverage to those persons who were validly covered under the previous contract and who are eligible for coverage under this Agreement. Such coverage shall not be limited by any Group requirements for coverage under this Agreement relating to hospital confinement or pregnancy. Notwithstanding the above, Exclusive Care shall not be financially responsible for benefits or services provided to persons who are totally disabled at the date of discontinuance of the prior coverage and entitled to an extension of benefits from the prior carrier under California Health and Safety Code Section 1399.62 or Insurance Code Section 10128.2 to the extent the benefits or services are directly related to any conditions which caused the total disability.

3. GROUP OBLIGATIONS, HEALTH PLAN PREMIUMS, AND NOTICES

3.01 Non-Discrimination. Group shall offer Exclusive Care an opportunity to market this health plan to its retirees and shall offer its retirees an opportunity to enroll in this Health Plan under no less favorable terms or conditions than Group offers enrollment in other health care service plans or retiree health benefit plans.

3.02 Notices to Exclusive Care. Group shall forward to Exclusive Care all completed or amended enrollment forms for each Member within thirty-one (31) days of the Member's initial eligibility. Group acknowledges that any enrollment applications not forwarded to Exclusive Care within ninety (90) days from date of eligibility, as described herein, may be rejected by Exclusive Care. Group further agrees to transmit to Exclusive Care any enrollment eligibility amendments pursuant to the Agreement as described herein.

Group shall forward all notices of termination to Exclusive Care within ninety (90) days after Member loses eligibility or elects to terminate membership under this Agreement. Group shall be responsible for any Member Health Plan Premiums through the last day of the month in which notice of termination is received by Exclusive Care based upon the date notification is received by Exclusive Care.

3.03 Notices to Member. If Group or Exclusive Care terminates this Agreement pursuant to the provisions herein, Group shall promptly notify all Members enrolled through Group of the termination of their coverage in this Health Plan. Group shall provide such notice by delivering to each Subscriber a true, legible copy of the notice of termination at the Subscriber's then current address. Group shall promptly provide Exclusive Care a copy of the notice of termination delivered to each Subscriber along with evidence of the date the notice was provided.

Exclusive Care shall have no responsibility to Members in the event Group fails to provide the notices required herein.

3.04 Payment Due Date. The initial setup fee must be paid by Group to Exclusive Care within thirty (30) days of receipt by Group of a copy of this Agreement signed by duly authorized persons of the respective parties.

Health Plan Premiums are due in full on a monthly basis and must be paid directly by Group to Exclusive Care on or before the last business day of the month in which coverage commences. Exclusive Care reserves the right to assess an administrative fee of two (2) percent of the monthly premium prorated on a thirty (30) day month for each day it is delinquent thereafter. This fee will be assessed solely at Exclusive Care's discretion.

3.05 Modification of Health Plan Premium Rates, Benefits, and/or Term. Benefits and premium rates are guaranteed for a twelve (12) month period as provided herein except for any modification which may be necessary as a result of mandated state or federal benefit changes or other legislative changes that directly impact the cost of providing benefits. Exclusive Care shall provide thirty (30) days written notice mailed postage prepaid to Group of any such modifications. Such modifications shall take effect commencing the first full month following the expiration of the thirty (30) day notice period.

Exclusive Care reserves the right to establish additional premium rates for any Retiree and dependents that Group enrolls or desires to enroll who do not fit into the categories listed in the attached Exhibit 1.

Both parties shall agree to engage in good faith discussions to determine whether the modification of the Covered Services or any other terms of this Agreement is acceptable. If mutually agreed upon modified terms and conditions cannot be reached, either party may terminate this Agreement upon thirty (30) days written notice.

Notwithstanding the above, if the State of California or any other taxing authority imposes upon Exclusive Care a tax or license fee which is levied upon or measured by the monthly amount of Health Plan Premiums or by Exclusive Care's gross receipts or any portions of either, then upon thirty (30) days written notice to Group, Group shall remit to Exclusive Care with the appropriate payment, a pro rata amount sufficient to cover all such taxes and license fees rounded to the nearest cent.

3.06 Payments Made in Error. Member shall reimburse Exclusive Care for any fees paid in error by Exclusive Care for services that were not Covered Services as defined in the Summary Plan Document. Failure to reimburse Exclusive Care, or reach reasonable accommodations with Exclusive Care concerning repayment, within thirty (30) days after Exclusive Care's request for reimbursement shall be grounds for termination of Member's membership pursuant to the provisions herein. The exercise of Exclusive Care's right to terminate this Agreement shall not affect its right to continue enforcement of its right to seek reimbursement from Member.

3.07 Effect of Payment. Except as otherwise provided in this Agreement, only Members for whom Health Plan Premiums are received by Exclusive Care are entitled to health

care benefits as described in this Agreement, and then only for the period for which such payment is received.

4. BENEFITS AND CONDITIONS FOR COVERAGE

4.01 Member Obligations. Member shall complete and submit to Group an enrollment application or other forms or statements as Group may reasonably request. Member agrees to promptly notify Group of any changes in the enrollment information. Member warrants that to the best of his or her knowledge, all information contained in such enrollment election is true and complete, and agrees that all rights to benefits under this Agreement are subject to the condition that all such information is true and complete.

4.02 Benefits. Subject to all terms, conditions, exclusions, and limitations set forth in the Summary Plan Document, all eligible Members, upon receipt by Exclusive Care of all applicable monthly Health Plan Premium payments, shall be entitled to the medical, surgical, hospital and the other services and benefits described in the Exclusive Care Select Plan Summary Plan Documents incorporated herein by reference.

4.03 Identification Cards. Identification cards issued by Exclusive Care to Members are for identification purposes only. Possession of an identification card confers no right to services or other benefits under this Health Plan. Any person receiving benefits or services for which he or she is not entitled shall be charged for the actual cost of such benefits or services. Exclusive Care may immediately terminate any Member's membership if such Member permits the use of his/her identification card by any other person.

4.04 Co-payments and Coinsurance. Co-payments and Coinsurance, when applicable, are an obligation of the Member at the time services are rendered. Failure to pay a Co-payment or Coinsurance may result in termination of Member's coverage under this Health Plan. A schedule of the applicable Co-payments and Coinsurance is set forth in the Summary Plan Document (SPD).

5. LIMITATION ON BENEFITS

5.01 Acts Beyond Exclusive Care's Control. In the event of circumstances not reasonably within the control of Exclusive Care or its contracted providers, such as any major disaster, epidemic, complete or partial destruction of facility, war, riot, or civil insurrection, which results in the unavailability of the facilities or personnel, Exclusive Care and/or its contracted providers shall provide or attempt to arrange for medical and hospital services insofar as practical, according to their best judgment, within the limitation of such facilities and personnel. Neither Exclusive Care nor any of its contracted providers shall have any liability or obligation for delay or failure to provide or arrange for medical and hospital services if such delay or failure is the result of any of the circumstances described above.

5.02 Experimental and Investigational Treatments. This Agreement does not provide any coverage for Experimental or Investigational treatments. Unless otherwise dictated by federal or state law, decisions as to whether a particular treatment is Experimental or Investigational are determined by Exclusive Care's Medical Director or his/her designee

based upon criteria established by Exclusive Care's Physician Review Committee subject to the Limitations and Exclusions set forth in the Schedule of Benefits section of the Summary Plan Document.

6. PARTIES AFFECTED BY THIS AGREEMENT; RELATIONSHIPS BETWEEN PARTIES

6.01 Member Non-Liability. In the event Exclusive Care fails to pay a contracting Provider's charges for Covered Services, neither the Member nor Group shall be liable to the contracting Provider for any sums owed by Exclusive Care.

6.02 Participating Physicians are Independent Contractors. All providers of the Exclusive Care and MultiPlan provider networks are independent contractors.

6.03 Relationship of Parties. Group is not the agent or representative of Exclusive Care, and shall not be liable for any acts or omissions of Exclusive Care, its agents or employees, or Providers, or any other person or organization with which Exclusive Care has made, or hereafter shall make, arrangements for the performance of services under this Health Plan. Member is not the agent or representative of Exclusive Care, and shall not be liable for any acts or omissions of Exclusive Care, its agents or employees.

7. NOTIFICATION TO DEPARTMENT OF MANAGED HEALTH CARE.

7.01 Reviews by Department of Managed Health Care. The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. The Department has a toll-free telephone number **(1-888-HMO-2219)** to receive complaints regarding health plans. The hearing and speech impaired may call the Department's direct toll-free number **(1-877-688-9891)** or the California Relay Service's toll-free telephone numbers **1-800-735-2929 (TTY)** or **1-888-877-5378 (TTY)**. The Department's facsimile number is 1-916-229-4328. The Department's Internet website **(http://www.hmohelp.ca.gov)** has complaint forms and instructions online. If a Member has a grievance against the Exclusive Care Health Plan, the Member should follow the grievance process described in the Summary Plan Documents for the Exclusive Care Select Plans.

8. TERM OF AGREEMENT.

Term. This Agreement is effective from January 1, 2010 through December 31, 2010. This Agreement does not automatically renew.

9. TERMINATION OF GROUP COVERAGE.

9.01 Termination by Group for Convenience. Group may terminate this Agreement by giving a minimum of ninety (90) days written notice of termination to Exclusive Care in person or via First Class Mail. Group termination must always be effective on the first day of the month. Group shall continue to be responsible for collecting and remitting Health

Plan Premiums for all Members enrolled in this Health Plan through Group until the date of termination. In no event shall the Group be liable for any loss of profits resulting from the loss of Group's Members.

9.02 Termination by Exclusive Care.

9.02.01 For Nonpayment of Health Plan Premiums. In the event Group or its designee fails to remit Health Plan Premiums to Exclusive Care in full by the required date, Exclusive Care may terminate this Agreement by giving written notice of termination of this Agreement via First Class Mail to Group. Nonpayment of Health Plan Premiums includes payments returned due to non-sufficient funds (NSF) and post-dated checks. Such notice shall specify that payment of all unpaid Health Plan Premiums must be received by Exclusive Care within fifteen (15) days after the date of receipt of the notice by the Group and that if payment is not received within the fifteen (15) day period, no further notice shall be given and coverage for all Members enrolled in this Health Plan shall terminate effective at the end of the month for which Health Plan Premiums have been actually received by Exclusive Care. Reinstatement of this Agreement may occur, at Exclusive Care's discretion, only by execution of a new Group Retiree Healthcare Services Agreement and by submitting new enrollment eligibility for each Member in accordance with the current eligibility and enrollment requirements. Group shall be liable for any unpaid Health Plan Premiums. Group shall be required to submit a deposit, in the amount of one full month's premium, to Exclusive Care to be held on account. This deposit will be returned to Group upon completion of twelve (12) consecutive months of timely Health Plan Premiums payment, or upon earlier termination of the Agreement, provided that all premium payments have been met at the time of termination. In the event that Group defaults on its premium payments within the first twelve months, Exclusive Care will apply the deposit toward the satisfaction of the premium obligation and will return to Group only that portion of the deposit, if any, that remains after the obligation has been satisfied.

9.02.02 For Breach of Material Term. Exclusive Care may terminate this Agreement if Group materially breaches any material term, covenant or condition of this Agreement and fails to cure such breach within thirty (30) days of receiving written notice of such breach from Exclusive Care. Exclusive Care's written notice of breach shall make specific reference to Group's action causing such breach. If Group fails to cure its breach subject to Exclusive Care's satisfaction within thirty (30) days of receiving notice of the breach from Exclusive Care, Exclusive Care may terminate the Agreement at the end of the thirty (30) day notice period.

9.02.03 For Providing Misleading or Fraudulent Information. Exclusive Care may terminate this Agreement upon thirty (30) days written notice to Group if Group knowingly provides materially misleading or fraudulent information to Exclusive Care in any Group questionnaires or is aware that materially misleading or fraudulent information has been provided on membership enrollment forms.

9.02.04 For Ceasing to Meet Group Eligibility Criteria. Exclusive Care may terminate this Agreement if the Group, upon thirty (30) days written notice, fails to meet any of the separate and specific written eligibility criteria agreed on by Exclusive Care and the

Group fails to abide by and enforce any other conditions of Subscriber enrollment set forth herein.

9.02.05 For Changing the Nature of Group's Business. Exclusive Care may terminate Group upon thirty (30) days written notice to Group if Group materially alters the nature of its business. "Materially Alters," means a significant change in the business conducted by Group after the commencement of the Agreement, including, but not limited to, the loss of Public Entity status.

9.02.06 For Insolvency and Bankruptcy. Exclusive Care may terminate Group immediately for insolvency including the Group's filing for bankruptcy.

9.03 Proration of Health Plan Premiums. If Group submits partial month's premium for final coverage month, Exclusive Care shall have the discretion to cancel Group's coverage at the end of the previous month and refund the partial payment or cancel Group's coverage at the end of the final month and pursue collection of the outstanding premium.

9.04 No Cause Termination. Notwithstanding any of the provisions herein, Riverside County, through Exclusive Care, may terminate this Agreement at any time, for no cause, for any reason, at its sole discretion by giving a minimum of ninety (90) days written notice of termination to Group as provided herein.

10. INDEMNIFICATION, ACTS AND OMISSIONS, LIABILITY AND INSURANCE

10.01 Indemnification. Group shall indemnify and hold harmless the County of Riverside its Agencies, Districts, Special Districts and Departments, and their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives and volunteers, from and against any and all claims, demands, actions, damages, expenses, suits, accidents, injuries, liability, or proceedings of any character whatsoever (including without limitation, attorney's fees), brought for, or on account of, or resulting from or arising out of or in connection with, any negligent act, error or omission, wrongful conduct, or other action by Group or any of Group's officers, agents, employees, representatives, volunteers, sub consultants or subcontractors, in connection with or in the performance of this Agreement, except to the extent where such claims, demands, actions, damages, expenses, suits, accidents, injuries, liability or proceedings are caused by any negligent act, error or omission, or wrongful conduct of the services of Exclusive Care, County of Riverside, its Agencies, Districts, Special Districts and Departments, its officers, employees, agents, representatives, volunteers, sub consultants or subcontractors.

The County of Riverside, shall indemnify and hold harmless, The Group, its officers, officials, employees, agents, representatives and volunteers, from and against any and all claims, demands, actions, damages, expenses, suits, accidents, injuries, liability, or proceedings of any character whatsoever (including without limitation, attorney's fees), brought for, or on account of, or resulting from or arising out of or in connection with, any negligent act, error or omission, wrongful conduct, or other action by the services of

Exclusive Care, County of Riverside or any of the County of Riverside's Agencies, Districts, Special Districts and Departments, its, officials, officers, agents, employees, representatives, volunteers, sub consultants or subcontractors in connection with or in the performance of this Agreement, except to the extent where such claims, demands, actions, damages, expenses, suits, accidents, injuries, liability or proceedings are caused by any negligent act, error or omission, or wrongful conduct of the Group, its officers, officials, employees, agents, representatives, volunteers, sub consultants or subcontractors. The words agents, representatives, sub consultants or subcontractors shall not refer to any provider of medical, hospital and/or preventive medical services, which includes, but is not limited to the following: medical provider organization(s): hospital(s), physician(s), medical support organization(s), or ancillary provider(s). It is not the intent of this section for Exclusive Care or the County of Riverside to indemnify the Group for the performance or lack of performance of medical, hospital, and preventive medical services received by the Group or its Members.

With respect to any action or claim subject to indemnification herein by either party, the indemnifying party shall, at their sole cost, have the right to use counsel of their own choice and shall have the right to adjust, settle, or compromise any such action or claim without the prior consent of the other party; provided, however, that any such adjustment, settlement or compromise in no manner whatsoever limits or circumscribes the party's obligation to indemnify the other party as set forth herein. The indemnifying party's obligation to defend, indemnify and hold harmless the other party shall be subject to the indemnified party having given the indemnifying party written notice within a reasonable period of time of the claim or of the commencement of the related action, as the case may be, and information and reasonable assistance, at the indemnifying party's expense, for the defense or settlement thereof. The indemnifying party's obligation hereunder shall be satisfied when they have provided to the indemnified party the appropriate form of dismissal relieving the indemnified party from any liability for the action or claim involved.

10.02 Limited Group Obligation. Notwithstanding any provision to the contrary herein, the provision and funding of benefit payments provided herein is the sole and exclusive responsibility of the County of Riverside through Exclusive Care and is not the direct or indirect responsibility or liability of the Group. Group is not acting in the capacity of an insurer with respect to the plan of medical benefits offered by Exclusive Care. Other than Group's responsibility to collect premiums from Retirees and transmit to Exclusive Care, Group is in no way financially responsible or liable in any respect under this Agreement or otherwise for the payment of benefits under this Agreement except for expenses for enrolled Members where Group has not verified eligibility and cannot provide Exclusive Care proof of eligibility.

11. MISCELLANEOUS PROVISIONS

11.01 Plan Administrator. The Director of Human Resources for Riverside County, or his/her designee, will be the administrator for the Retiree Healthcare Services plans.

11.02 Governing Law. This Agreement is subject to the laws of the State of California and the United States of America, including: the California Health and Safety Code and the regulations promulgated thereunder by the Department of Managed Health Care of

the State of California; the Health Maintenance Organization Act of 1973 and regulations promulgated thereunder by the Department of Health and Human Services of the United States. Any provisions required to be in this Agreement by any of the above acts and regulations shall bind Exclusive Care and Member whether or not expressly provided in this Agreement.

11.03 Use of Name in Promotional/Marketing Materials. Exclusive Care reserves the right to control all use of its name, symbols, trademarks or service marks currently existing or later established. However, either party may use the other party's name, symbols, trademarks or service marks with the prior written or verbal approval of the other party in advertising or other promotional materials relating to this Agreement.

11.04 Assignment. This Agreement and the rights, interests, and benefits hereunder shall not be assigned, transferred, pledged, or hypothecated in any way by either party and shall not be subject to execution, attachment or similar process, nor shall the duties imposed herein be subcontracted or delegated without the approval of the other party.

11.05 Invalidity and Severability. If any provision of this Agreement is found to be invalid or unenforceable by any court, such provision shall not affect the enforceability and validity of the balance of this Agreement. In the event the removal of a provision rendered invalid or unenforceable or declared null and void had the effect of materially altering the obligations of either party in such manner as to cause serious financial hardship to such party, the party so affected shall have the right to terminate this Agreement upon providing thirty (30) days prior written notice to the other party.

11.06 Confidentiality. Exclusive Care agrees to maintain and preserve the confidentiality of any and all medical records of Member. Group shall ensure that on enrollment Member authorizes the release of information and access to any and all of Member's medical records for purposes of utilization review, a quality review, processing of any claim, financial audit, coordination of benefits, or for any other purpose reasonably related to the provision of benefits under this Agreement to Exclusive Care, its agents and employees, Member's Primary Care Physician, and appropriate governmental agencies. Exclusive Care shall not release any information to Group which would directly or indirectly indicate to Group that a Member is receiving or has received Covered Services, unless authorized to do so by the Member.

11.07 Amendments. This Agreement may be modified by Exclusive Care and the Group pursuant to mutual written Amendments. Amendments shall require the formal approval of the Board of Supervisors for Riverside County to be effective, except as expressly provided herein.

Amendments which shall not require the formal approval of the Board of Supervisors for Riverside County to be effective may include, but shall not be limited to amendments of the Summary Plan Document, rate adjustment and amendments to the policies and procedures, and/or operations of Exclusive Care 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 Director of Human Resources of Riverside County.

11.08 Attachments. All Attachments attached hereto or referenced herein are hereby incorporated into and made an integral part of this Agreement.

11.09 Use of Gender. The use of masculine gender in this Agreement includes the feminine gender and the singular includes the plural.

11.10 Waiver of Default. The waiver by either party of any one or more defaults by either Exclusive Care or Group, or Member of the Group, 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 Agreement.

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

If to Exclusive Care:
Exclusive Care
County of Riverside
P.O. Box 1508
Riverside, CA 92502-1508
Attn: Plan Administrator

If to Group:
Human Resources, Benefits Division
City of San Buenaventura
P.O. Box 99
Ventura, CA 93002-0099

All notices shall be deemed given on the date of delivery if delivered personally or on the third business day after such notice is deposited in the United States mail, addressed and sent as provided above.

11.12 Entire Agreement. This Agreement contains the entire understanding of Group and Exclusive Care with respect to the subject matter hereof and it incorporates all of the covenants, conditions, promises, and Agreements exchanged by the parties hereto with respect to such matter. This Agreement supersedes any and all prior or contemporaneous negotiations, Agreements, or communications, whether written or oral, between Group and Exclusive Care with respect to the subject matter of this Agreement.

11.13 Venue. All actions and proceedings arising in connection with this Agreement 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.

11.14 Government Claims Act. The provisions of the Government Claims Act (Government Code section 900 et. seq.) must be followed first for any disputes arising under this Agreement.

11.15 Group Responsibility. Group shall maintain and provide adequate records and information as reasonably necessary to Exclusive Care so that Exclusive Care may properly administer the health plan consistent with state and federal law. Such records

shall be retained by Group for at least eight (8) calendar years after the effective date of termination of this Agreement. This obligation is not terminated upon a termination of the Agreement, whether by rescission or otherwise.

11.16 Independent Contractor. The relationship between Group and Exclusive Care is an independent contractor relationship. Neither Group nor its employee(s) and/or agent(s) shall be considered to be an employee(s), and/or agent(s) of Exclusive Care. Neither Exclusive Care nor any employee(s) and/or agent(s) of Exclusive Care shall be considered to be an employee(s) and/or agent(s) of Group. None of the provisions of this Agreement 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 contracting for the purposes of effectuating this Agreement.

11.17 Dissemination of Information. Group agrees that Exclusive Care may use Group's name, address, and telephone number in any informational material routinely distributed to Members and for other purposes related to the administration and marketing of Exclusive Care or as a reference to potential clients.

11.18 Group Advertising. Prior to listing or otherwise referencing Exclusive Care or Group in any promotional or advertising brochures, media announcements or other advertising or marketing material, the applicable party shall first obtain the prior written consent of the other party.

11.19 Use of Names and Trademarks. Exclusive Care and Group each reserve the right to control the use of its name, symbols, trademarks, or other marks currently existing or later established. However, either party may use the other party's symbol, trademarks, or other marks with the prior written approval of the other party. Exclusive Care shall be allowed to use the name of Group in its promotional activities and marketing campaign as described herein.

11.20 Captions. Captions in this Agreement are descriptive only and do not affect the intent or interpretation of the Agreement.

11.21 Attorneys Fees. If any action at law or in equity is necessary to enforce the terms of this Agreement, the prevailing party shall be entitled to reasonable attorney's fees and reasonable costs, in addition to any other relief to which such party may be entitled.

11.22 Time is of the Essence. Time shall be of the essence of each and every term, obligation, and condition of this Agreement.

11.23 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 Agreement.

11.24 Certification Of Authority To Execute This Agreement. Group certifies that the individual signing herein has authority to execute this Agreement on behalf of Group, and may legally bind Group to the terms and conditions of this Agreement, and any

attachments hereto. County of Riverside certifies that the individual signing herein has authority to execute this Agreement on behalf of the County and its Exclusive Care Health Plan, and may legally bind County to the terms and conditions of this Agreement, and any attachments hereto.

IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Group Retiree Healthcare Services Agreement for Riverside County's Exclusive Care Health Plan.

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

By _____
Deputy
Date_____

COUNTY OF RIVERSIDE:

By_____
Chairman, Board of Supervisors
Date_____

Approved as to form and content:
Pamela J. Walls
County Counsel

By: _____
Deputy County Counsel

By_____

Barbara Olivier, Asst. CEO/HR Director

GROUP: City of San Buenaventura (Ventura)

By: Rick Cole

Printed Name: Rick Cole

Title: City Manager

Date: 12/24/09

APPROVED AS TO FORM:
ARIEL PIERRE CALONNE, CITY ATTORNEY

By: _____
SONIA HEHIR
ASSISTANT CITY ATTORNEY

EXHIBIT 1: MONTHLY PREMIUM RATES for EXCLUSIVE CARE SELECT PLANS

Exclusive Care Select Medical Plan 2010 Plan Rates	
	Effective 1-1-10
Exclusive Care Select Early Retiree Plan	
Retiree Only (< 65, no MC)	$650.53
Retiree + 1 (all < 65, no MC)	$1,181.88
Retiree + 2 (all < 65, no MC)	$1,701.09
Exclusive Care Select Medicare Coordination Plan	
RETIREE ONLY	
Retiree > 65 with MC parts A & B	$486.40
Retiree > 65 with MC part B only	$719.46
RETIREE W/1 DEPENDENT	
One > 65 with MC parts A & B	$1,136.93
One > 65 with MC part B only	$1,369.99
Two > 65 with MC parts A & B	$972.81
Two > 65 with MC part B only	$1,438.93
RETIREE W/2 DEPENDENTS	
One > 65 with MC parts A & B	$1,787.46
One > 65 with MC part B only	$2,020.52
Two > 65 with MC parts A & B	$1,492.02
Two > 65 with MC part B only	$1,958.14
Three > 65 with MC parts A & B	$1,459.21
Three > 65 with MC part B only	$2,158.39
Exclusive Care Select Post 65 Retiree Plan	
Retiree Only (> 65, no MC)	$991.92
Retiree + 1 (all > 65, no MC)	$1,804.49
Retiree + 2 (> 65, no MC)	$2,616.10
Exclusive Care Select Medicare Supplemental Plan	
Retiree Only (> 65 with MC parts A &B)	$269.20
Retiree + 1 (> 65 with MC parts A &B)	$538.38
Retiree & Spouse, one with Medicare parts A & B	$919.73
Retiree & Family, one with Medicare parts A & B	$1,451.08
Retiree & Family, two with Medicare parts A & B	$1,188.91

EXHIBIT 2

CONTRACTOR HOLDER NOTIFICATION REQUIREMENTS

The City of San Buenaventura, hereafter referred to as Contractholder, has various notification requirements under this Group Health Service Contract. The Contractholder's notification requirements are listed 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 Contractor nor does it absolve the Contractholder from any obligations specified elsewhere under this Group Health Service Contract.

A. Initial Enrollment

The Contractholder agrees to offer health benefits coverage to all eligible Retirees during the initial enrollment period.

B. Notification of Cancellation to Subscribers

If this Contract is rescinded, or canceled by the Contractholder, the Contractholder shall notify the Subscribers of said cancellation. If rescinded or canceled by Exclusive Care, Exclusive Care shall promptly mail a copy of Exclusive Care's notice of rescission or cancellation to each Subscriber and provide Contractholder proof of such mailing and the date thereof. Exclusive Care is solely responsible for notifying each Subscriber 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 of the Evidence of Coverage and Disclosure Form)

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. Contractholder, subject to the California Continuation Benefits Replacement Act (Cal-COBRA), is responsible for notifying Exclusive Care 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 Exclusive Care of any "qualifying" event as prescribed under the federal regulations as prescribed by COBRA or under state mandated benefits under AB528, such as, but not limited to the Subscriber's death, termination or reduction of

hours of employment, or of the Subscriber's Medicare entitlement, or the Contractholder's filing for reorganization under Title XI, United States Code.

3. Duration and Extension of Continuation of Group Coverage:
   Exclusive Care is responsible for notifying COBRA enrollees of rights with respect to continuation of coverage under AB528 (Cal-COBRA) within the prescribed timetable under the law.

The following provisions are applicable 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 Exclusive Care COBRA Administrator. (See the Amendment for COBRA Administrative Services, if applicable)

The Contractholder retains responsibility for the following COBRA administrative 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 Exclusive Care.

2. Contractholder will promptly provide Exclusive Care with any enrollment forms returned by the Subscribers and/or Dependents and with copies of any other written communications with enrollees regarding COBRA rights or election of COBRA coverage.

D. Individual Conversion Plan

Exclusive Care is solely responsible for notifying Employees of the availability, terms and conditions of the Individual Conversion Plan within the timeframe as prescribed under the applicable laws and regulations. (See the Individual Conversion Plan section of the Evidence of Coverage and Disclosure Form.)

EXHIBIT 2

COBRA ADMINISTRATIVE SERVICES

This exhibit is to be made part of the Contractholder's current Exclusive Care 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, Exclusive Care, and the Subscriber, in the event that federal continuation of coverage requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, applies 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 Exclusive Care 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:

    i. 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 Exclusive Care.

    ii. Contractholder will promptly provide Exclusive Care with any enrollment forms returned to it by Subscribers and/or Dependents 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 Exclusive Care in Section B of this Amendment.

B. Exclusive Care

1. Exclusive Care 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 and Cal-COBRA administration obligations except as set forth in this Section B.

2. To the extent required by COBRA and Cal-COBRA, and upon timely receipt of dues and proper enrollment forms, Exclusive Care will continue the group coverage to qualified beneficiaries effective on the date that the subscriber(s) coverage under this plan would otherwise terminate due to the occurrence of a qualifying event, and will continue for up to the applicable period, provided that coverage is timely elected, and dues are timely paid.

3. Dues for the subscriber(s) coverage shall be 102 percent of the applicable group retiree rates if the member is a COBRA enrollee, or 110 percent of the applicable group retiree rates if the Subscriber is a Cal-COBRA enrollee, except for the subscriber(s) who is eligible to continue group coverage to 29 months because of a Social Security disability determination, in which case, the dues for months 19 through 29 shall be 150 percent of the applicable groups retiree rates. For COBRA enrollees who are eligible to extend group coverage under COBRA to 29 months because of Social Security disability determination, dues for Cal-COBRA coverage shall be 110 percent of the applicable group dues rate for months 30-36.

4. If the Contractholder or any Subscriber or Dependant fails to meet its obligation under the Contract and COBRA, Exclusive Care 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.

5. With the exception of those obligations retained by the Contractholder in Section A hereof, Exclusive Care agrees to be solely responsible for providing 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 per B (3) above

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

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 records, provide as reasonable disaster recovery program, and provide reasonable access to the records by the Cardholder, 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. Provide the Contractholder a list of current COBRA Qualified Beneficiaries and their current mailing address annually at Open enrollment.

6. Exclusive Care is not responsible for notifying Subscribers or Dependants or any other parties entitled to notice regarding COBRA continuation rights, or for providing them with enrollment forms.

7. Exclusive Care is not responsible for determining whether a participant's 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.

8. Exclusive Care agrees to assume responsibility if a violation of COBRA occurs due to Exclusive Care's failure to perform the obligations specified in Part X.

C. Amendment

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

Except as amended herein, all terms and conditions of the City of San Buenaventura's Contract remain in full force and effect.