APPLICATION IS HEREBY MADE TO
Blue Shield of California
(California Physicians' Service)

FOR A GROUP HEALTH SERVICE CONTRACT

BY: County of San Bernardino
Human Resources Department
Employee Benefits and Services Division
157 West Fifth Street, 1st Floor
San Bernardino, CA 92415-0440

This Contract, number **W0052236-M0022214, M0022215, MM0022216, M0022217, M0022218, M0022219, M0022220 & M0022221**, shall be effective **January 1, 2020 through December 31, 2022** with the option to extend one (1) additional two (2) year term. Monthly Medical Premiums will be negotiated on an annual basis. This Contract has been read and approved, and the terms and conditions are accepted by the County of San Bernardino ("County" or "the County").

The County, on behalf of itself and its Subscribers, hereby expressly acknowledges its understanding that this agreement constitutes a Contract solely between the County and Blue Shield of California (hereafter referred to as "Blue Shield" or "the Plan"), which 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 County 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 County or its Subscribers for any of the Plan's obligations to the County 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.

The County shall sign, date and return this original application page to Blue Shield of California, 50 Beale Street, 18th Floor, San Francisco, California 94105, Attention: Customer Contract Development. The Contract shall be retained by the County. Payment of Medical Premiums and acceptance of Blue Shield's performance hereunder by the County shall be deemed to constitute the County's acceptance of the terms hereof, whether or not this agreement is signed by the County.

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

Dated at _____ (City, State)

this _____ day of _____ 20 ____

_____

(Legal Name of Contractholder)

By _____

Title _____

The County is 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 ADRESS. 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

blue of california

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

GROUP HEALTH SERVICE CONTRACT

SHIELD SIGNATURE HIGH OPTION PLAN

SHIELD SIGNATURE LOW OPTION PLAN

SHIELD SIGNATURE COB HIGH OPTION PLAN

BLUE SHIELD PPO HIGH OPTION PLAN

BLUE SHIELD PPO LOW OPTION PLAN

BLUE SHIELD PPO COB HIGH OPTION PLAN

BLUE SHIELD HYBRID PPO COB PLAN

BLUE SHIELD TRIO HMO LOW OPTION PLAN

between

COUNTY OF SAN BERNARDINO

("The County")

and

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

In consideration of the applications and the timely payment of Medical Premiums, Blue Shield agrees to provide Benefits of this Contract to covered Retirees and their covered Dependents.

This Contract shall be effective as of 12:00 am **January 1, 2020**, for a term of three years with the option to extend one (1) additional two (2) year term, subject to the provisions of the adopted Letter of Agreement (Article A. Term of Agreement).

Jason Bleau
Vice President
Core Accounts
Blue Shield of California

Group Number: **W0052236-M0022214, M0022215, MM0022216, M0022217, M0022218, M0022219, M0022220 & M0022221**

IMPORTANT

No Member has the right to receive the Benefits of this Contract for Services or supplies furnished following termination of coverage. 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 that this Contract, Letter of Agreement and Attachments are in effect and while the individual claiming Benefits is actually covered by this Contract. If Benefits are modified, subject to the terms of the Letter of Agreement Section B.B.2, the revised Benefits (including any reduction in Benefits or the elimination of Benefits) apply for Services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the Benefits of this Contract.

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INTRODUCTION

This Blue Shield of California Medical Plan will provide or arrange for the provision of Services to eligible Retirees and Dependents of the County in accordance with the terms, conditions, limitations, and exclusions of the executed Letter of Agreement, its Attachments, and this Group Health Service Contract.

I. MONTHLY MEDICAL PREMIUMS SCHEDULE

A. Medical Premiums

The Monthly Medical Premiums for the Subscriber and Dependents effective 01/01/20. Rates will be subject to negotiation and will be renewed annually.

Shield Signature High Option	Monthly Rate
Retiree Only (non-Medicare)	$1,044.66
1 dependent (non-Medicare)	2,245.23
2 dependents (non-Medicare)	3,080.78
Shield Signature Low Option	
Retiree Only (non-Medicare)	$ 858.10
1 dependent (non-Medicare)	1,844.22
2 dependents (non-Medicare)	2,530.54
Blue Shield PPO High Option, CA & OOS	
Retiree Only (non-Medicare)	$1,714.18
1 dependent (non-Medicare)	3,474.13
2 dependents (non-Medicare)	5,378.02
Blue Shield PPO Low Option, (CA & OOS)	
Retiree Only (non-Medicare)	$1,341.27
1 dependent (non-Medicare)	2,718.33
2 dependents (non-Medicare)	4,190.41
Blue Shield PPO COB High Option	
Retiree Only (>65 w/Medicare)	$ 787.32
1 dependent (non-Medicare)	1,574.65
2 dependents (non-Medicare)	2,361.98
Blue Shield PPO COB Hybrid	
Retiree Only (>65 w/Medicare)	$ 787.32
1 dependent (non-Medicare)	1,574.65
2 dependents (non-Medicare)	2,361.98
Blue Shield PPO COB Hybrid (Part A only)	
Retiree Only (>65 w/Medicare)	$1,174.59
1 dependent (non-Medicare)	2,349.19
2 dependents (non-Medicare)	3,523.78
Shield Signature COB High Option	
Retiree Only (>65 w/Medicare)	$ 763.86
1 dependent (non-Medicare)	1,527.73
2 dependents (non-Medicare)	2,291.58
Blue Shield Trio HMO Low Option	
Retiree Only (non-Medicare)	$ 783.78
1 dependent (non-Medicare)	1,684.48
2 dependents (non-Medicare)	2,311.35

I. MONTHLY MEDICAL PREMIUMS SCHEDULE

B. When And Where Payable

1. Medical Premiums will be paid by the County on a monthly eligibility basis.

2. Applicable Medical Premiums due are payable by the County to Blue Shield of California.

3. Payments for Retiree Premiums due shall be made via Electronic Funds Transfer (EFT) and/or via check remittance.

C. COBRA

COBRA shall be available to those dependents who experience a qualifying event under the plan. COBRA is the responsibility of and shall be administered by the County, and the premium will be the same as the retiree plan premium, plus the applicable 2% administration fee.

D. Changes to Premium

The County shall remit to Blue Shield the applicable amount(s) specified in Part I. A. ("the Medical Premiums"). 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 Medical Premiums or by the gross receipts of Blue Shield or any portion of either, then Blue Shield may amend the Contract to increase the base Medical Premiums by an amount sufficient to cover all such taxes or license fees rounded to the nearest cent. This amendment shall be executed and effective in accordance with the terms set forth in the Letter of Agreement between the County and Blue Shield, with a minimum notice of at least 90 days before the effective date of the amendment.

If Benefit amounts are changed or if a tax is levied as described in and in accordance with the provisions of the Letter of Agreement Section F.F.3, the Medical Premiums charge therefore may be made, or the Medical Premiums credit therefore may be given, as of the effective date of such change.

E. Premium Delinquency

A grace period of 45 days to pay all delinquent Medical Premiums and avoid cancellation will be granted for the payment of Medical Premiums accruing, other than the initial premiums due on the effective date of this Contract during which period this Contract shall continue in force, but the County shall be liable to Blue Shield for the payment of all Medical Premiums accruing during the period the Contract continues in force during the grace period. Cancellation for non-payment of Medical Premiums shall be in accordance with section VI.B of this contract.

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:

A. Continuation of Coverage (COBRA): A method by which retired employees and/or their eligible Dependents who become Ineligible for group coverage under this Plan may continue their benefit coverage for a limited time pursuant to the terms and conditions in this Contract.

B. Covered Services: The medical services and supplies which are covered under the terms of the Contract, Letter of Agreement and Attachments, and the Evidence of Coverage and Disclosure Form for the applicable Plans.

C. Domestic Partner: A person who, is personally related to the eligible retiree, by a domestic partnership that meet all the following requirements:

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

2. Both persons have filed a Declaration of Domestic Partnership with the California Secretary of State. California state registration is limited to same sex domestic partners and only those opposite sex partners where one partner is at least 62 and eligible for Social Security based on age.

The domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State.

D. Eligibility Date: The date upon which an eligible Retiree's or Eligible Dependent's eligibility for benefits becomes effective under the Contract and Letter of Agreement between the County of San Bernardino and Blue Shield.

E. Eligible Dependent: Any of the dependents of an eligible Retiree who are eligible to enroll for benefits and who meet the conditions of eligibility outlined in Section III of this Contract or as required by legislation.

F. Late Enrollee: an eligible Retiree or dependent who has declined enrollment in this Plan at the time of the initial enrollment period, and who subsequently requests enrollment in this Plan; provided that the initial enrollment period shall be a period of at least 60 days. Please refer to the Evidence of Coverage and Disclosure Form for specific exemption from this status.

G. Medicare Beneficiary: an eligible Subscriber or an enrolled Dependent who is not currently employed by the County and meets the eligibility requirements for retiree coverage as established by the County and who is entitled to Medicare Part A and Part B.

H. Open Enrollment Period: A period of time designated by the County which occurs no less frequent than annually, during which eligible primary enrollees may submit enrollment changes, including changing from one plan to another or adding or deleting dependents.

I. Out-of-Network: Treatment by a Physician who has not signed a Contract with Blue Shield to provide Benefits under the terms of this Contract.

J. Retiree: Each new Retiree entering retirement subsequent to the Effective Date of the Group's initial enrollment period shall be permitted, without proof of insurability, to apply for coverage for himself or herself and eligible Dependents within 60 days of becoming eligible, subject to the enrollment regulations in effect with the Group. Such enrollments, if accepted by Blue Shield of California, become effective when any waiting or probationary period required by the Group is completed. When the Retiree is not subject to a probationary period, the enrollment becomes effective, in accordance with established Group eligibility rules.

K. Plan: The County's Blue Shield Plans (as applicable) that are described in this Contract, Letter of Agreement and Attachments.

L. Premium (Dues): The agreed upon amount paid for medical insurance coverage, as specified in Contract for the duration of the term as listed in the Letter of Agreement between the County and Blue Shield.

III. ELIGIBILITY, ENROLLMENT, AND CANCELLATION OF ENROLLMENT

A. Retiree 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 Retirees who enroll during the initial enrollment period shall be determined as follows:

   a. Each such individual that holds "Retiree" status as indicated by the County on the effective date of this Contract is eligible on the effective date of this Contract.

   b. New Retirees shall become eligible for coverage as established by the County of San Bernardino.

2. Family Status Changes (FSC): The County agrees to offer Medical Benefits coverage to all eligible Retirees during the initial enrollment period, at the time of a qualifying event, and during the annual Open Enrollment period. Coverage effective dates for Family Status changes are subject to the County of San Bernardino eligibility and enrollment rules. Retro-enrollment shall not exceed 90 days.

   If an eligible Retiree becomes deceased, his or her eligible dependents may continue to participate in the Plan as long as they pay the cost of the premiums when due.

3. Open Enrollment: A period of time designated by the County which occurs no less frequent than annually, during which a Retiree may transfer enrollment for himself or his dependent(s) from another group medical plan sponsored by the County to the medical Plan covered by this Contract. A Retiree may also add or remove dependents during the annual open enrollment period of each year. The effective date of Benefits for such Retiree and dependent(s) shall be the first day of each subsequent Plan Year. Submission of evidence of acceptability is not required when application is made during this open enrollment period except as provided by applicable state and federal law.

4. The County shall make all reasonable efforts to timely report any additions or terminations of Retirees or dependents so that retroactive Medical Premiums adjustments are avoided and claims are not paid for ineligible individuals. However, if it has been determined that an administrative error has been made in the processing of eligibility for a Retiree or dependent, Blue Shield will accept the retroactive changes subject to the following limitations:

   a. Blue Shield will accept enrollment of the Retiree or dependent retroactively for a maximum of 90 days, as long as Medical Premiums are received from the County for the entire retroactive enrollment period. If a Retiree or dependent is retroactively enrolled pursuant to this, and the Retiree or dependent received covered medical care Services during that retroactive period, Blue Shield will reimburse the Retiree for payments made for covered Services received in accordance with the rules of the Evidence of Coverage and Disclosure Form, minus the Member's Copayments as stated in the Evidence of Coverage and Disclosure Form;

   b. Blue Shield will accept termination/disenrollment of the Retiree or dependent retroactive for a maximum of 90 days and will refund appropriate Medical Premiums paid for the retroactive termination period. In such case, Blue Shield reserves the right to request refund from the Retiree for any payments made for services rendered during the retroactive termination period. In making a request for retroactive termination or disenrollment, the County shall comply with all applicable state and federal law, including, but not limited to, the Patient Protection & Affordable Care Act and any related regulations.

III. ELIGIBILITY, ENROLLMENT, AND CANCELLATION OF ENROLLMENT

B. 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, the Letter of Agreement, and all applicable Amendments and/or Attachments:

1. The Benefits of a Member shall cease on the first day of the month following the month in which the Subscriber ceases to be a member of a class eligible for coverage, unless a different date on which the Subscriber no longer meets the requirements for eligibility has been agreed to between Blue Shield and the County.
2. With respect to a newborn child or a child placed for adoption, coverage will cease on the 60th day at 11:59 p.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 the County prior to the 60th day following the effective date of coverage.
3. The subscriber and all his or her dependent(s) will become ineligible for coverage at the same time if the subscriber loses eligibility except where as required by law.

IV. GROUP RENEWAL ADVANCE PROVISIONS

A. Advance Notification of Intent to Renew the Group Health Service Contract

The term of this contract is for a three (3) year period with an option to extend for one (1) additional two (2) year term. The County shall notify Blue Shield of its intent to exercise the one-year extensions of this Group Health Service Contract at least 90 days prior to the proposed effective date of the renewal. However, this renewal advance notification is distinct from, and does not alter the notification periods specified in this contract, the Letter of Agreement, and applicable amendments and attachments.

B. Renewal of the Group Health Service Contract

Blue Shield will renew this Group Health Service Contract at the option of the County except in the following instances:

1. the County fails to pay the required medical Premiums as specified under Article I. Monthly Medical Premiums Schedule;
2. the County commits fraud or other intentional misrepresentation of material fact;
3. the County fails to comply with an imposed legislative amendment;
4. Blue Shield ceases to offer a plan type purchased by the County;
5. Blue Shield ceases to offer Medical benefit plans in the state (withdrawal of all products).

V. INTER-PLAN ARRANGEMENTS (BLUECARD® PROGRAM AND OTHERS)

A. Out-of Area Services

Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as Inter-Plan Arrangements. Whenever a Member accesses Covered Services outside of California, the claim for those services may be processed through one of these Inter-Plan Arrangements and presented to Blue Shield for payment in accordance with the Blue Cross Blue Shield Association rules and procedures then in effect. The Inter-Plan Arrangements available to Members under this agreement are described generally below.

When Members access Covered Services outside of California, within the BlueCard Service Area, they may obtain care from participating health care providers that have a contractual agreement with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (Host Blue). In some instances, Members may obtain care from health care providers in the Host Blue geographic area that do not have a contractual agreement with the Host Blue (non-participating providers). Blue Shield's payment practices in both instances are described below.

B. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this arrangement, when Members access Covered Services within the geographic area served by a Host Blue, Blue Shield will remain responsible for fulfilling our contractual obligations. However, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating health care providers.

The financial terms of the BlueCard Program are described generally below.

C. Liability Calculation Method Per Claim

Calculation of Member liability on claims for Covered Services processed through the BlueCard Program, if not a flat dollar copayment, will be based on the lower of the participating provider's billed charges for Covered Services or the negotiated price made available to Blue Shield by the Host Blue. The negotiated price may represent one of the following:

(i) an actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases, or

(ii) an estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced, or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

(iii) an average price. An average price is a percentage of billed charges for Covered Services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its health care providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual price, estimated price, or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., a prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the BlueCard Program requires that the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by Blue Shield in determining the County's Premiums.

V. INTER-PLAN ARRANGEMENTS (BLUECARD® PROGRAM AND OTHERS)

D. Inter-Plan Arrangements: Federal/State Taxes/Surcharges/Fees

In some instances, federal or state laws or regulations may impose a surcharge, tax, or other fee that applies to insured accounts. If applicable, Blue Shield will include any such surcharge, tax, or other fee in determining the County's premiums.

E. Special Cases: Value-Based Programs

Blue Shield has included a factor for bulk distributions from Host Blues in the premium for Value-Based Programs when applicable under this agreement.

F. Non-Participating Providers Outside of California

When Covered Services, other than Emergency Services, are received from non-participating providers outside of California, but within the BlueCard Service Area, the amount(s) a Member pays for such services will generally be based on the Host Blue's non-participating provider local payment, the Allowable Amount Blue Shield pays a Non-Participating provider in California if the Host Blue has no non-participating provider allowance, or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the non-participating provider bills and the payment Blue Shield will make for the Covered Services as set forth in this paragraph.

Claims for covered Emergency Services are paid based on the Allowable Amount as defined in the EOC.

G. Blue Shield Global Core

If Members are outside the BlueCard Service Area, they may be able to take advantage of Blue Shield Global Core when accessing Out-of-Area Covered Health Care Services. Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard Service Area. Although Blue Shield Global Core assists Members with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a Host Blue plan. As such, when Members receive care from providers outside the BlueCard Service Area, Members will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services. Details for Blue Shield Global Core claim submission are provided in the *Inter-Plan Arrangements* section of the EOC.

VI. CANCELLATION/REINSTATEMENT/GRACE PERIOD

A. Cancellation Without Cause

The County 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 Medical Premiums

Blue Shield may cancel this Contract for non-payment of Medical Premiums. Blue Shield will, if Medical Premiums are not received when due, and the 45 day grace period has been exhausted, provide a 30 day notice of intent to cancel coverage to the County. The County will be liable for all Medical Premiums accrued while this Contract, Letter of Agreement and Attachments and any Amendments continue in force including those accrued during the 45 day grace period and subsequent 30 day notice of intent to cancel period. A new application for coverage will be required by the County and a new Contract will be issued only upon demonstration that the County meets all underwriting requirements at the time of application.

C. Cancellation/Rescission for Fraud, Intentional Misrepresentations of Material Fact or Failure to Provide Records

Upon 45 days written notice, Blue Shield may cancel or rescind this Contract for fraud or intentional misrepresentation of material fact by the County. This Contract may also be cancelled for failure to provide Blue Shield with records and information in accordance with state and federal law. A rescission voids the Contract retroactively as if it was never effective; Blue Shield will provide 45 days written notice prior to any rescission.

As it applies to coverage of Retirees and/or dependents, Retiree coverage provided under this contract may be cancelled for fraud or intentional misrepresentation of material fact by the Retiree, dependent, or (by way of power of attorney) their representative. Blue Shield shall notify the County of any such cancellation fifteen (15) days prior to the effective date such cancellation.

D. Grace Period

The County shall be entitled to a grace period of 45 days for payment of Medical Premiums. If during a Medical Premiums 45 day grace period written notice is given by the County to Blue Shield that the Contract or (subject to the consent of Blue Shield) any part of the Contract is to be discontinued, in accordance with applicable requirements specified by the Letter of Agreement, before the expiration date of the grace period, the Contract or applicable section shall be discontinued as of the date specified by the County or the date of receipt of such written notice by Blue Shield, whichever is the later date, and the County shall be liable to Blue Shield for applicable monthly premiums. If discontinuance of coverage occurs then Medical Premiums payment will be waived and refunded to the group for the applicable monthly period.

E. Payment or Refund of Medical Premiums Upon Cancellation

In the event of cancellation, by either the County or Blue Shield, the County shall promptly pay any Medical Premiums which have not previously been paid but that are due. Blue Shield shall within 30 days of cancellation (1) return to the County the amount of prepaid Medical Premiums, if any, that Blue Shield and the County mutually determines were not due 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.

VI. CANCELLATION/REINSTATEMENT/GRACE PERIOD

F. Termination of Benefits

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

In the event this Contract is cancelled for any reason, including but not limited to for non-payment of Medical Premiums, no further Benefits will be provided after cancellation unless the Member 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.

G. Notice Confirming Termination of Coverage

If this Contract is rescinded, or cancelled by either party, the County shall notify the Subscribers.

If rescinded or cancelled by Blue Shield, Blue Shield shall have the option, in addition to the County notification, to distribute to Subscribers such notices that are required by either 1) internal Blue Shield protocols and procedures or 2) applicable state and federal law. These notices shall be subject to review by the County prior to distribution.

VII. GENERAL PROVISIONS

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

A. 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.

B. Choice of Providers – Retiree HMO Plans

1. Shield Signature HMO: The Plan has established a network of primary care and specialty Physicians, Hospitals, Participating Hospice Agencies, and Non-Physician Medical Care Practitioners to provide Covered Services to Members. To receive Level I Benefits, a Member must obtain or receive approval for all Covered Services from his Primary Care Physician or the MHSA. Each Member must select a Primary Care Physician from the list of Primary Care 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 Primary Care 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 Primary Care Physicians, Plan Hospitals and Participating Hospice Agencies in the Primary Care Physician Service Area. Members should contact Member Services for information on Plan Non-Physician Medical Care Practitioners in their Primary Care Physician Service Area.

2. Shield Signature HMO: The Member may obtain office visit and specified medical Services as detailed in the Shield Signature HMO Plan's Evidence of Coverage and Disclosure Form from any Provider under Level II of the Shield Signature HMO Plan without consulting his Primary Care Physician. If the Provider under Level II of the Shield Signature HMO Plan refers a Member to a hospital or other inpatient facility, such inpatient services are not covered under this Contract. The Member must obtain or receive approval for all inpatient facility Covered Services from the Level I Shield Signature HMO Primary Care Physician or the MHSA and specialty Physicians, Hospitals, Participating Hospice Agencies, and Non-Physician Medical Care Practitioners. However, the Member will be responsible for applicable deductibles, Copayments and non-covered charges, and for non-Plan Providers all charges above the Allowable Amount, as stated elsewhere in this Contract.

3. Trio HMO: 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 Primary Care Physician. Each Subscriber must select a Primary Care Physician for himself and each of his Dependents from the list of Primary Care Physicians in the Trio HMO Health Plan Physician and Hospital Directory. Members enrolled in this Trio HMO Health Plan may only obtain Covered Services from Primary Care Physicians and Medical Group/IPAs designated as Plan Providers in the Blue Shield Trio HMO Health Plan Physician and Hospital Directory, except for Emergency Services or Urgent Services when the Member is out of the Service Area. The Physician and Hospital Directory applicable to this Plan will be given to Members at the time of enrollment. A Member's Primary Care 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 a Plan Hospitals.

VII. GENERAL PROVISIONS

C. Choice of Providers – Retiree PPO Plans

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

P.O. Box 7168
San Francisco, CA 94120

or

P.O. Box 92945
Los Angeles, CA 90009

In the event that the inability to perform of a Participating Provider, the breach of the Contract to furnish Services by a Participating Provider, or the termination of a Participating Provider's Contract with Blue Shield may materially and adversely affect the County, Blue Shield will, within fifteen (15) days, advise the County in writing of such inability to perform, breach, or termination.

D. Choice of Providers – Medicare

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. Each Member must select a Primary Care Physician from the list of Primary Care Physicians in the Provider Directory. The Provider Directory will be given to Members at the time of enrollment. A Member's Primary Care 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 Provider Directory includes the location and phone numbers of all Primary Care Physicians, and plan hospitals in the Service Area. Members should contact Member Services for information on plan non-physician health care practitioners in the Service Area.

Network Provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**network providers**" when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

E. Changes: Entire Contract

Any statement made by the County or by any Member shall, in the absence of fraud, be deemed a representation and not a warranty.

The terms of this Contract shall be subject to the conditions set forth in the section "Agreement Amendments" (Section B.B.2) of the executed Letter of Agreement (LOA) between the County of San Bernardino and Blue Shield.

Notice of changes in benefits, and any documents that may be delivered to the County or the County's representative for the purpose of informing members of the details of their coverage under this Contract, will be distributed by the County or its representative immediately upon receipt but in no event later than 60 days after receipt of such material.

VII. GENERAL PROVISIONS

F. 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, if applicable, the 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 County and Blue Shield whether or not such provision is actually included in this Contract.

G. Legal Process

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

H. 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 12:00 a.m. Pacific Time of the commencement date and as of 11:59 p.m. Pacific Time of the termination date.

I. Records and Information to be Furnished

The County shall furnish Blue Shield with such information as Blue Shield may require to enable it to administer this Plan, to determine the Medical Premiums, to collect payment from CMS for Services rendered to qualified Medicare Beneficiaries 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, County identification number and County size.

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 County 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 County 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 County, the Plan may provide aggregate, encrypted, or encoded data regarding Subscribers and Dependents to the County, unless such data would explicitly or implicitly identify specific Subscribers or Dependents. To the extent the County receives, maintains, or transmits personal or health information of Subscribers or Dependents electronically, the County 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.

VII. GENERAL PROVISIONS

L. Termination of a Blue Shield of California Shield Plan Provider Contract

1. Blue Shield shall provide written notice to the County within fifteen (15) days of any termination or breach of Contract of a Blue Shield of California Provider if such termination or breach may materially affect the County or its Subscribers.

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

M. Special Cases: Value-Based Programs

Enrollees may access covered services from providers that participate in a Blue Shield Value-Based Program. Blue Shield Value-Based Programs include, but are not limited to, Accountable Care Organizations, Episode Based Payments, Patient Centered Medical Homes and Shared Savings arrangements.

Blue Shield has included any associated costs in the Premium for Blue Shield Value-Based Programs when applicable under this agreement.

VIII. CONTRACTHOLDER RESPONSIBILITY FOR DISTRIBUTION AND NOTIFICATION REQUIREMENTS

There are various distribution of notices and Member materials and other notification requirements under this Group Health Service Contract. Some of the major distribution and notification requirements are summarized below; however, this is a summary only and not to be construed as an all-inclusive list.

A. Initial Enrollment

The County agrees to offer Medical Benefits coverage to all eligible Retirees during the initial enrollment period. The County shall be responsible for determining (and maintaining) eligibility for participation under this Group Health Service Contract, Letter of Agreement, Amendments and Attachments. Blue Shield shall rely on the most current information provided by the County for providing services pursuant to this contract, Letter of Agreement, Amendments and Attachments and provisions contained therein.

B. Distribution of Summary of Benefits and Coverage (SBC)

A summary of benefits and coverage (SBC) will be issued by the Plan for all eligible Retirees and Dependents. The County is solely responsible for the timely distribution of a complete SBC for each benefit plan offered. The County will distribute the SBCs free of charge to Members and prospective Members as required by applicable federal law and regulations.

The County shall distribute the SBCs in a manner which complies with applicable federal law and regulations. If the County does not distribute paper SBCs, then the County will ensure that any alternative or electronic distribution method used complies with applicable federal requirements.

If a material modification is made to the County's group health plan that impacts the SBC, other than at the time of renewal, then notice of the material change, as provided by Blue Shield, will be distributed by the County to the Subscriber and any Dependents no later than 60 days prior to the date on which the modification will become effective. The notice shall be distributed in a manner that complies with applicable federal requirements.

In the event that the County fails to distribute SBCs to Members or prospective Members as required herein, Blue Shield will, after notice to the County, distribute SBCs as necessary to comply with applicable federal statutes and regulations. In such case, the County agrees to reimburse Blue Shield for the reasonable costs incurred by Blue Shield to generate and distribute the SBCs.

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

Membership cards will be issued by Blue Shield 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 be sent Subscribers.

Blue Shield will make available to the County an electronic version of the Evidence of Coverage and Disclosure Form applicable to the Contract, adopted Agreement(s) and amendments (as applicable) via the Blue Shield employer website. The County shall make available the Evidence of Coverage and Disclosure Form to Subscribers by one of the following methods: (1) post the electronic Evidence of Coverage and Disclosure Form in a read-only format on the intranet site which is accessed by Retirees of the County, (2) Emailing the EOC/DF directly to Subscribers, or, (3) providing Subscribers with instructions from Blue Shield about how to electronically retrieve the EOC/DF from the County of San Bernardino website. Once the Evidence of Coverage and Disclosure Form has been adopted, the County is not authorized to modify or alter in any way the text or the formatting of the electronic Evidence of Coverage and Disclosure Form file. Blue Shield assumes no responsibility for any changes in text or formatting that may occur in the Evidence of Coverage and Disclosure Form after it is provided to the County.

If the County posts the electronic Evidence of Coverage and Disclosure Form on its internet site, it shall do so in such a way so as to permit Retirees of the County to download and print a complete and accurate copy of the Evidence of Coverage and Disclosure Form. Blue Shield will, via annual postcard mailing, notify Retirees enrolled in the plan(s) that the Evidence of Coverage and Disclosure Form for their plan is available to review, download

and print from the County's internet site and will provide enrollees with reasonable and appropriate instructions by which to access and print the document from the internet site.

Blue Shield will also, via annual postcard mailing, notify Retirees that printed hard copies of the Evidence of Coverage and Disclosure Form are available and will be promptly provided to Retirees by Blue Shield upon request.

Blue Shield will also provide the County with printed Evidence of Coverage and Disclosure Form booklets in an amount not to exceed 10% of the total Subscriber count at no additional charge. If Blue Shield receives inquiries from enrollees in the County's plan regarding obtaining a copy of the Evidence of Coverage and Disclosure Form, Blue Shield will, first refer the enrollee to the County's website and direct them that a copy of the Evidence of Coverage and Disclosure Form is available electronically and a copy can be downloaded from the website. If the enrollee still wishes to receive a hard copy Evidence of Coverage and Disclosure Form, Blue Shield will then mail one out to the mailing address on file for the enrollee at no charge to the County or to the enrollee.

In the event Blue Shield reasonably concludes that the County is either using the electronic Evidence of Coverage and Disclosure Form in a manner not permitted by this Agreement or is not providing Subscribers with access to the Evidence of Coverage and Disclosure Form in accordance herewith, Blue Shield will provide written notice to the County of such conclusion. This notice shall contain the reasons, data, and/or other relevant evidence that supports Blue Shield's position. Upon acknowledged receipt of such written notice, Blue Shield will allow a 30 day period for the County to respond or to cure any such identified deficiencies. Blue Shield will then notify the County should there be a need for Blue Shield to print copies of the Evidence of Coverage and Disclosure Form, and with the County's cooperation, ensure that printed copies of the Evidence of Coverage and Disclosure Form are timely provided to all Retirees of the County enrolled with Blue Shield. County agrees to reimburse Blue Shield for the reasonable cost of printing and delivering the Evidence of Coverage and Disclosure Form documents.

D. Notification of Cancellation to Subscribers

If this Contract is rescinded, or cancelled by either party, the County shall notify the Subscribers.

If rescinded or cancelled by Blue Shield, Blue Shield shall have the option, in addition to the County notification, to distribute to subscribers such notices that are required by either 1) internal Blue Shield protocols and procedures or 2) applicable state and federal law. These notices shall be subject to review by the County prior to distribution.

E. Notice of CMS Creditable Coverage

Blue Shield shall be responsible for assisting and/or providing any and all such necessary information to the County that will enable it to meet its Centers for Medicare & Medicaid Services (CMS) disclosure of creditable coverage reporting requirements.

F. Notice of HIPAA Creditable Coverage

Notices of creditable coverage shall be furnished:

1. By the County upon request.
2. By Blue Shield in accordance with federal and state regulations.

G. COBRA and Cal-COBRA

The following provisions are applicable only when the County is subject to Title X. of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended or the California Continuation Benefits Replacement Act (Cal-COBRA). See the Continuation of Group Coverage and Extension of Benefits sections of the Evidence of Coverage and Disclosure Form.

1. COBRA

Blue Shield has no responsibility, on any level, for the County's COBRA administration obligations.

VIII. CONTRACTHOLDER RESPONSIBILITY FOR DISTRIBUTION AND NOTIFICATION REQUIREMENTS

To the extent required by COBRA, and upon timely receipt of premiums 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.

Blue Shield will not be responsible for determining whether a Subscriber or Dependent is eligible to receive continuation coverage; such determination is based on the requirements of COBRA and the procedures established by the County and/or its COBRA administrator.

If the County 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.

The County is solely responsible for all aspects of the administration of COBRA and any amendments with respect to the group health coverage provided by this Contract. The obligations of the County, in the event that federal continuation of coverage requirements of COBRA apply to the County, include the following:

a. The County or its COBRA administrator 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.

b. The County or its COBRA administrator will establish procedures to verify eligibility for COBRA coverage and receive COBRA election forms from Qualified Beneficiaries.

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

d. The County or its COBRA administrator will establish applicable COBRA rates may be annually and determine the applicable premium amount for qualified COBRA beneficiaries in accordance with its Contract with Blue Shield, adding the 2% administrative fee permitted by COBRA.

e. The County or its COBRA administrator will bill and collect premiums from COBRA Qualified Beneficiaries, and provide timely notification of nonpayment of COBRA continuation coverage premiums, per the terms of the Contract and COBRA.

f. The County or its COBRA administrator will remit premiums to Blue Shield on behalf of the COBRA qualified beneficiary until Blue Shield receives notice from the County that such beneficiary is no longer entitled to COBRA coverage.

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

h. The County or its COBRA administrator will 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.

i. The County agrees to assume responsibility for any and all COBRA violations resulting from the failure of the County or its COBRA administrator to perform its COBRA administration responsibilities.

VIII. CONTRACTHOLDER RESPONSIBILITY FOR DISTRIBUTION AND NOTIFICATION REQUIREMENTS

2. Cal-COBRA

NOTE: Blue Shield and the County understand and agree that the following provision is not applicable to and non-enforceable in whole or in part by either party at any time during the term of this contract but is required as a standard provision of this contract.

Should the County be subject to the California Continuation Benefits Replacement Act (Cal-COBRA) the County is responsible for notifying Blue Shield in writing within 30 days when the County 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.

Should the County be subject to the California Continuation Benefits Replacement Act (Cal-COBRA) the County will be responsible for notifying Blue Shield in writing of the subscriber's eligibility within 30 days of the qualifying event of the conversion to Cal-COBRA.

IX. ACCESS TO REPORTS SECTION L

Access to Reports

A. Blue Shield agrees to provide the County with access to Health Data & Management Solution's ("HDMS") application Custom Reports Now ("CRN"), in order for the County to comply with its responsibilities as plan sponsor, as that term is defined in the Health Insurance Portability and Accountability Act, as amended ("HIPAA") at 45 CFR § 164.103.

B. Blue Shield and the County agree that CRN contains Confidential Information, as defined herein. Confidential Information shall mean the confidential and proprietary information of Blue Shield available through CRN, including but not limited to proprietary systems, financial data and provider information including aggregated provider payment rates as well as aggregated and statistically de-identified claims, records and medical information of Members. The parties hereto stipulate that, as between them, the same are important, material and confidential. Confidential Information shall not include information which: (i) is already known by the County; (ii) becomes publicly known through no act or fault of the County; (iii) is received by the County from a third party without a restriction on disclosure or use; (iv) is independently developed by the County without reference to the Confidential Information provided by Blue Shield.

C. Blue Shield represents that it has obtained statistical certification that the reports available through CRN do not contain any Protected Health Information ("PHI") as that term is defined at 45 CFR § 160.103.

D. The County hereby agrees that: (a) Unauthorized access to CRN or unauthorized use of the Confidential Information contained therein may cause irreparable harm, loss, damage to Blue Shield; and (b) that it has been and will be conferred a benefit as a result of its knowledge of and access to the CRN; and (c) that it has agreed to the provisions contained in this Amendment.

E. The County shall require that any Retirees, agents, or independent contractors retained by the County that have access to CRN shall each comply with the requirements set forth in this Contract and with all applicable state and federal law.

F. The County hereby agrees that it shall not disclose or communicate to any person, firm, or corporation, any Confidential Information, without the written consent of Blue Shield. In addition, the County agrees to undertake the following obligations with respect to the Confidential Information.

   a. The County agrees not to attempt re-identification of Subscribers or their Dependents (collectively"Members") based upon the Confidential Information provided through the CRN; and

   b. The County agrees to restrict the use, locations, storage and access to Confidential Information through CRN; and

   c. The County agrees to return or destroy any Confidential Information obtained through CRN upon termination of the Group Contract; and

   d. The County agrees not to link any other data elements in its possession with the Confidential Information available through CRN without a statistician's certification that the data remains statistically de-identified pursuant to 45 CFR § 164.514; and

   e. The County agrees to implement and maintain appropriate data security and privacy procedures with associated physical, technical and administrative safeguards as needed to assure that the Confidential Information is accessed only by personnel authorized to do so and will remain de-identified; and ensure that all personnel authorized to access the data are trained on proper protocols for protecting the data in accordance with: 1) the terms of the HDMS data licensing agreement and 2) the conditions contained herein relative to the statistical deidentification requirements of the HIPAA.

G. The County agrees to allow access to CRN and use the Confidential Information solely in its capacity as plan sponsor for payment and administrative activities as plan sponsor.

IX. ACCESS TO REPORTS SECTION L

H. The County agrees to retain all Confidential Information in strict confidence and not to use or disclose the same except as otherwise provided or permitted in this Contract.

I. The County agrees to limit the individuals who are authorized to have access to CRN to those who have a reasonable need to do so. On an annual basis, the County must provide the names and titles of those individuals authorized to access CRN. The County must notify Blue Shield within thirty (30) days of any changes to those authorized to access CRN.

J. The County acknowledges and agrees that, in the event of any breach of this Contract by the County, Blue Shield may immediately block further access by the County to CRN and may terminate this Amendment immediately. These remedies shall be in addition to and not in limitation of any other rights or remedies to which Blue Shield is or may be entitled.

K. In the event of a breach of the terms of this Contract by the County, its Retirees, agents or independent contractors, the County agrees to indemnify, defend and hold Blue Shield harmless from and against any claims, causes of action or costs, arising out of the indemnifying parties breach of its obligations hereunder.

L. The restrictions and obligations of the parties as contained in this Part, Sections A-H and Section K, shall survive the expiration, termination or cancellation of the Group Contract, and shall continue in full force and effect indefinitely.

X. 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 included as part of this Contract.

The County and Blue Shield both mutually agree that no changes shall be made to the Evidence of Coverage and Disclosure Form unless they have been subject to the terms of the conditions set forth in the section “Agreement Amendments” (Section B.B.2) of the executed Letter of Agreement (LOA) between the County of San Bernardino and Blue Shield.

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.