Agreement

Administrative Services Only Agreement

An Independent Member of the Blue Shield Association

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ADMINISTRATIVE SERVICES ONLY AGREEMENT
BETWEEN
BLUE SHIELD OF CALIFORNIA
AND
EL DORADO COUNTY

1. Parties: The parties to this agreement are California Physicians' Service, a California nonprofit corporation doing business as Blue Shield of California (referred to in this agreement as "Blue Shield"), 50 Beale Street, San Francisco, California 94105 and **El Dorado County** (referred to in this agreement as "Contractholder"), a **California** corporation, **330 Fair Lane, Placerville, CA 95667**.

2. Term: The term of this agreement is **July 1, 2009** through **June 30, 2010**.

   a. Renewal. One hundred twenty (120) days before the expiration of the current term of this agreement, or as soon thereafter as necessary data becomes available, Blue Shield will give Contractholder notice of proposed terms and conditions for renewal of this agreement for a subsequent term, including the proposed new administrative service charge. If, prior to the expiration of this agreement, the parties agree on the renewal terms and conditions, this contract will continue for an additional 12-month term as modified by the renewal terms agreed upon, which shall be reflected in an amendment to this agreement. If agreement on renewal terms is not reached, this agreement will terminate at the end of the current term in accordance with the provisions of Section 13 hereof.

3. Purpose:

   a. The purpose of this agreement is to provide risk management and benefit administration services to implement the terms and conditions of the **El Dorado County Medical Plan** (referred to in this agreement as the "Plan"). The Plan is a self-funded employee health benefit Plan sponsored by Contractholder for the benefit of Contractholder's eligible employees and their dependents ("Plan Participants"). Blue Shield provides administrative services only under this agreement and assumes no liability for any benefits payments under the Plan. Contractholder will provide Blue Shield with current written benefit descriptions, terms and conditions of the Plan in force from time to time during the term of this agreement.

   b. This agreement will apply to all claims under the Plan received by Blue Shield during the term of this agreement for services rendered on and after the effective date.

4. Relationship of the Parties: Contractholder is the Plan Sponsor and Plan Administrator. Under this agreement Blue Shield will act as benefits administrator. Blue Shield is an independent contractor and Blue Shield may use employees or other subcontractors to perform Blue Shield's services under this agreement. Blue Shield is only authorized to act on Contractholder's behalf in the administration of benefits under the Plan within the framework of the policies and rules Contractholder has established to the extent stated in this agreement or as otherwise communicated to Blue Shield in writing. Blue Shield will notify Contractholder if Blue Shield believes any action or inaction requested by or on Contractholder's behalf is inconsistent with the Plan and Contractholder will not require that Blue Shield take or withhold such action except upon written direction from Contractholder's properly authorized representative.

5. Service Benefits:

   a. While Blue Shield is acting as benefits administrator, Plan Participants will be entitled to receive service benefits from Blue Shield's physician members and other participating providers of care, services, supplies and equipment. Blue Shield will reimburse Participating Providers for services rendered to Plan Participants in accordance with Blue Shield's participation agreements and review as necessary the amounts allowed Participating Providers for services which are benefits of the Plan. Blue Shield's Participating Providers agree to accept Blue Shield's allowable amount along with applicable deductibles and copayments as payment in full for covered services rendered to Plan Participants.

   b. BlueCard Access Fee. When Plan Participants receive services from participating providers of an out-of-state Blue Cross Blue Shield plan, they will receive the benefit of that plan's participating provider agreements. These Blue Cross Blue Shield plans may charge Blue Shield an access fee for making their contracting provider discounts available to Plan Participants. Effective April 1, 1995, the maximum access fee allowed will be 10% of the discount (savings), up to $2,000 per claim. An access fee may be charged even if the participating provider has not been reimbursed, for example, when a Plan Participant has not satisfied the deductible. Access fees will be included as a claims benefit expense.

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

Liability Calculation Method Per Claim

The calculation of Participant liability on claims for covered health care services incurred outside California, and processed through BlueCard will be based on the negotiated price Blue Shield pays the local Blue Cross and/or Blue Shield plan.

The calculation of Contractholder liability on claims for covered health care services incurred outside California, and processed through BlueCard will be based on the negotiated price Blue Shield pays the local Blue Cross and/or Blue Shield plan.

The methods employed by a local Blue Cross and/or Blue Shield plan to determine a negotiated price will vary among local Blue Cross and/or Blue Shield plans based on the terms of each local Blue Cross and/or Blue Shield plan's provider contracts. The negotiated price paid to a local Blue Cross and/or Blue Shield plan by Blue Shield on a claim for health care services processed through BlueCard may represent:

(i) the actual price paid on the claim by the local Blue Cross and/or Blue Shield plan to the health care provider ("Actual Price"), or

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

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

Local Blue Cross and/or Blue Shield plans using either the Estimated Price or Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over- or underestimation of past prices. However, the amount paid by the Participant is a final price and will not be affected by such prospective adjustment. In addition, the use of a liability calculation method of Estimated Price or Average Price may result in some portion of the amount paid by the Contractholder being held in a variance account by the local Blue Cross and/or Blue Shield plan, pending settlement with its participating providers. Because all amounts paid are final, the funds held in a variance account, if any, do not belong to the Contractholder and are eventually exhausted by provider settlements and through prospective adjustment to the negotiated prices.

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

Return of Overpayments

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

BlueCard Fees and Compensation

The Contractholder understands and agrees (1) to pay certain fees and compensation to Blue Shield of California which we are obligated under BlueCard to pay to the local Blue Cross and/or Blue Shield plan, to the Blue Cross Blue Shield Association, or to the BlueCard vendors, unless our contract obligations to the Contractholder require those fees and compensation to be paid only by Blue Shield of California and (2) that fees and compensation under BlueCard may be revised from time to time without the Contractholder's prior approval in accordance with the standard procedures for revising fees and compensation under BlueCard. Some of these fees and compensation are charged each time a claim is processed through BlueCard and include, but are not limited to, access fees, administrative expense allowance fees, Central Financial Agency Fees, and ITS Transaction Fees. Also, some of these claim-based fees, such as the access fee and the administrative expense allowance fee, may be passed on to the Contractholder as an additional claim liability. Other fees include, but are not limited to, an 800 number fee and a fee for providing PPO provider directories. If you do not have a complete listing, or want an updated listing, of these types of fees or the amount of these fees paid directly by the Contractholder, you should contact Blue Shield of California.

6. <u>Administrative Service Charge</u>:

   a. In consideration of its services under this agreement, Blue Shield shall receive an administrative service charge, exclusive of any brokerage or independent consultant fee, as set forth in Appendix A hereto ("Service Charge"). In the event this agreement is extended beyond its initial term by mutual agreement of the parties, Appendix A will be replaced based on the revised agreed-upon Service Charge.

   b. The Service Charge will be remitted to Blue Shield by Contractholder upon receipt of Blue Shield's monthly invoice, with payment due within 30 days of the invoice date.

   c. If Contractholder proposes a change in services required to administer the Plan and this materially modifies the services Blue Shield has agreed to provide under this agreement, Blue Shield will negotiate with Contractholder in good faith for an equitable adjustment to the Service Charge stated above. Blue Shield will not be required to carry out additional services until the parties have reached agreement on such adjustment.

   d. Blue Shield may adjust the monthly Service Charge at any time during the term of this agreement in the event of an increase or decrease in actual enrollment of 10% or more.

   e. The Service Charge stated above does not contemplate any taxes, fees, other charges or offsets by any state or federal government which may, in the future, be assessed against Blue Shield on the basis of the benefit payments made on Contractholder's behalf under this agreement. In the event Blue Shield becomes liable for any such taxes, fees, other charges or offsets, including amounts assessed against Blue Shield under federal regulation, 42 CFR §411.24 (Medicare Secondary Payer), Contractholder agrees to reimburse Blue Shield for the amount of tax, fee, charge or offset attributable to the benefits paid on Contractholder's behalf. This obligation will survive termination of this agreement.

   f. One hundred twenty (120) days before the expiration of the current term of this agreement, or as soon thereafter as necessary data becomes available, Blue Shield will give Contractholder notice of any change in the Service Charge for renewal of this agreement for a subsequent term pursuant to Section 2 hereof.

7. Contractholder's Responsibilities and Obligations:

a. Authorized Representatives: Contractholder will provide Blue Shield with the names of individuals, together with the scope of their authority, who are authorized to act for Contractholder in connection with this agreement.

b. Plan Documents:

(1) The Plan Sponsor/Plan Administrator is responsible for preparing a written document stating the benefits, terms and conditions of the Plan ("Plan Document") in force from time to time, and preparing and distributing employee booklets/summary Plan descriptions and other communications regarding the Plan to Plan Participants (including COBRA notices)

(2) It is Contractholder's responsibility to provide Blue Shield with advance copies for Blue Shield's review and comment of any proposed or finalized Plan Document, employee booklets, benefit descriptions and administrative procedures insofar as they relate to Blue Shield's administrative services, practices and procedures.

c. Benefit Changes: Contractholder agrees to provide Blue Shield with 90 days written notice prior to any change in the Plan benefits.

d. Eligibility: Contractholder will determine participant eligibility and provide Blue Shield with eligibility records. Blue Shield will be entitled to rely on the eligibility information Contractholder provides and will not maintain or independently verify any portion of the Plan eligibility records. Contractholder will provide Blue Shield with changes in enrollment as soon as practical in the month in which a change in eligibility occurs, but no later than the end of the following month. Changes in eligibility will be effective on the first of the month, whenever possible. Eligibility information will include new Plan Participants and effective dates of coverage, changes in types or levels of coverage for existing Plan Participants and effective dates of termination of coverage.

e. Plan Interpretation: As Plan Sponsor and Plan Administrator, Contractholder retains all final authority and responsibility for the Plan and its operation, including Plan policy, practices and procedures. It will be Contractholder's responsibility to interpret and construe the benefits of the Plan as necessary to assist Blue Shield in the administration of Plan benefits. Blue Shield will refer to Contractholder for consideration and final decision any class of claims which Contractholder specifies or any claim dispute or controversy not resolved through Blue Shield's administrative review procedures.

f. Employee Communications: Contractholder agrees to assist Blue Shield in all reasonable efforts to inform Contractholder's employees about the procedures to be followed to obtain maximum Plan benefits. In this regard Contractholder agrees to provide Blue Shield with advance copies of all employee communications regarding the Plan so that Blue Shield's customer service representatives can respond appropriately to inquiries which may result.

g. Claim Funding: Contractholder will be responsible for funding all claims determined to be payable benefits of the Plan in accordance with the procedures in Appendix B.

h. Stop Loss Coverage:

(1) The County may obtain and keep in effect at all times during the term of this agreement specific stop loss or excess insurance as may be deemed appropriate by the County.

(2) As part of the risk management and claims administration services to be provided by Blue Shield under this Agreement, Blue Shield shall identify and report excess claims to the County's stop loss carrier. Notification of actual or potential excess claims shall first be made to the County via the large claims reports provided to the County on a monthly basis. The same report shall also be sent to the stop loss carrier for its review and reimbursement as may be necessary or appropriate under the terms and conditions of the specific stop-loss coverage. For so long as the County's stop loss carrier is Blue Shield of California Life and Health Insurance Company, Blue Shield shall also make written demands or claims on behalf of the County under the stop loss policy.

8. Blue Shield's Responsibilities and Obligations:

a. Benefit Entitlement Determination: Blue Shield will determine a Plan Participant's entitlement to benefits claimed under the Plan in accordance with the following:

(1) the Plan benefits applicable to each participant, as specified in Contractholder's written Plan Document;

(2) Blue Shield Medical Policy applicable to Blue Shield's standard underwritten business, unless Contractholder advises Blue Shield otherwise in writing. "Medical Policy" refers to those written guidelines adopted by the Blue Shield Medical Policy Committee on Quality and Technology;

(3) benefit cost controls, medical review standards, and other standard practices, policies and procedures used to determine benefits for Blue Shield's standard underwritten PPO benefits, unless Contractholder advises Blue Shield otherwise in writing;

(4) any benefits management provisions (quality and utilization management) applicable to the Plan;

(5) approved Individual Care Management and alternative treatment Plans;

(6) coordination of benefit provisions of the Plan; and

(7) an agreed resolution of disputed claims as provided in the Benefits Disputes or Controversy Section below.

b. Individual Care Management:

(1) Blue Shield is authorized to provide individual care management on behalf of Plan Participants. When appropriate for the most cost-effective use of Plan benefits for catastrophic trauma or terminal illness, Blue Shield may increase the Plan's outpatient benefits in place of inpatient benefits which would otherwise be available under the Plan ("Alternative Benefits"). Alternative Benefits shall not exceed the cost of the total benefits which would otherwise have been payable under the Plan.

(2) Before coverage is extended for Alternative Benefits, Blue Shield must have the patient's and attending provider's agreement on any proposed alternative treatment Plan. Blue Shield will approve any Alternative Benefits for coverage under the Plan for a specific period of time. Coverage for Alternative Benefits will not be provided in a manner which waives Contractholder's right thereafter to administer the Plan strictly in accordance with its express terms.

c. Coordination of Benefits/Third Party Liability: Blue Shield will use Blue Shield's best efforts to coordinate benefits payable under the Plan with other benefit Plans and to identify claims for benefits which may be the liability of a third party. Blue Shield will attempt collection from other benefit Plans and third parties to the extent reasonable under the circumstances.

d. Benefit Disputes or Controversy:

(1) Blue Shield will provide an administrative procedure for the review of denials of benefit claims and advise Plan Participants of the appropriate steps to take if they wish to submit a benefit determination for review. The Plan Participant may submit written issues and comments in support of their appeal which Blue Shield may have reviewed by an appropriate medical review committee.

(2) Blue Shield will advise Contractholder of legal actions taken against either Contractholder or Blue Shield with respect to a claim for benefits under the Plan. Blue Shield agrees to meet and confer on an appropriate course in defense of such action and to cooperate fully with each other; however, neither Contractholder or Blue Shield shall be obligated to conduct or bear the costs of the other's defense, except as may be mutually agreed upon otherwise.

e. Overpayment of Plan Benefits:

(1) If ministerial errors in determining benefits under the Plan are identified (that is, determinations made without the exercise of special discretion or judgment in interpretation of a Plan benefit such as calculation of deductibles), Blue Shield will adjust any underpayments and make diligent efforts to recover any overpayments using the same standard business practices and procedures used to recover overpayments for Blue Shield's underwritten business, including consideration of the cost and probability of successful recovery. In the event Blue Shield discovers fraudulent or criminal acts by healthcare providers or other third parties which result in overpayments, Blue Shield is authorized to enter into a settlement and release of any such claims on the same terms and conditions it settles its own claims with respect to its underwritten business. Blue Shield is authorized, but not required, to commence litigation to recover overpayments.

(2) If a specifically identified overpayment(s) was (the result of a) fraudulent or criminal, or was caused by Blue Shield's intentional disregard of Blue Shield's obligations under this agreement without Contractholder's direction to do so, then Blue Shield will:

(a) refund to Contractholder any specifically identified unrecovered overpayments made directly to Providers; and

(b) refund to Contractholder any specifically identified unrecovered overpayment made to Plan Participants provided Contractholder has cooperated with Blue Shield's recovery efforts by making at least two written demands for repayment on the Plan Participant.

9. Funding of Benefits: This Plan is a self-funded plan. Contractholder is solely responsible for providing funds for payment of all benefit claims.

   a. Contractholder agrees to fund all benefits Blue Shield determines payable under the Plan during the term of this agreement. This obligation will survive termination or expiration of this agreement for all claims payments issued by Blue Shield on Contractholder's behalf. In regard to the funding of benefits Blue Shield provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. Blue Shield has agreed on banking arrangements or other mechanism for routine funding of benefit payments as described in Appendix B.

   b. If Contractholder makes or withholds employee contributions to coverage under the Plan Contractholder will hold such contribution as a Plan fiduciary, solely for the funding of benefits under the Plan. Blue Shield will refund unclaimed benefits to Contractholder as a Plan fiduciary, for the account of the Plan pursuant to the forfeiture provisions of the Plan.

   c. If Contractholder fails to timely fund benefits as required herein, Blue Shield may cease claims administration and issuance of benefit checks until appropriate funding is provided. Blue Shield will give Contractholder notice of funding deficiencies. If the deficiencies are corrected, Blue Shield will commence claims administration and issuance of benefit checks. If the deficiencies are not corrected, Blue Shield may terminate this agreement pursuant to Section 13a hereof.

   d. In the event Contractholder becomes insolvent, avails itself of the protection of the Federal Bankruptcy Act, or Blue Shield has a reasonable belief that either of these events are imminent, Blue Shield may request adequate assurance from Contractholder of Contractholder's ability to meet its financial obligations to Blue Shield and Blue Shield's participating health care providers. If such assurances are not furnished to Blue Shield within 5 days, or are not satisfactory in Blue Shield's reasonable judgment, Blue Shield may immediately terminate this agreement. Until such assurance is received, Blue Shield will only provide conditional pre-authorization for services under the Plan. Blue Shield will not be required to extend any credit on Contractholder's behalf and will only disburse claims payments following actual receipt of adequate funds to cover such payments. Contractholder agrees to take necessary action to assume or reject this agreement within 30 days from the filing of any action for relief under Chapter 11 of the Federal Bankruptcy Act. Should Contractholder fail to take such action, Blue Shield may, at Blue Shield's discretion, terminate this agreement.

10. Additional Blue Shield Services:

   a. Individual Conversion Plan: Following termination of coverage under the Plan, enrollment in an Individual Conversion Plan then being offered by Blue Shield will be available to Plan Participants who have been covered under Contractholder's Plan for a minimum of 90 days. Enrollment in an Individual Conversion Plan may be subject to a one-time enrollment processing charge. The Individual Conversion Plan coverage must be elected by the eligible Plan Participants within 30 days of termination of coverage. Plan Participants are not eligible for transfer to Blue Shield's Individual Conversion Plan in the event Contractholder replaces Contractholder's Plan with group coverage or an administrative services agreement to which Blue Shield is not a party.

   b. Identification Cards: Blue Shield will prepare and issue paper identification cards for Contractholder's eligible employees. Blue Shield may design a unique identification card for Contractholder's Plan.

   c. Plan Reports: Blue Shield will provide Contractholder with mutually agreed upon Plan management and utilization reports, copies of which shall be attached to this agreement as Appendix C. All reports shall be subject to applicable confidentiality of medical information and privacy laws. Upon request customized or ad hoc client reports may be provided for an additional charge.

   d. 5500 Forms: Contractholder shall be solely responsible for the submission of 5500 Forms. However, Blue Shield shall provide Contractholder with applicable Schedules A or C and such other information in its possession reasonably necessary for Contractholder to submit said forms.

11. General Provisions:

a. COBRA Administration: As Plan Administrator, Contractholder will be responsible for billing and compliance with other administrative requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272 ("COBRA"), as amended, and will notify Blue Shield of qualified beneficiaries eligible to participate under the Plan pursuant to COBRA.

b. Maintenance of Records:

(1) Blue Shield will keep records for each transaction and claimant under the Plan as follows: Blue Shield will keep paper records for the period Blue Shield has determined appropriate for maintenance of claim transactions for Blue Shield's standard underwritten business; computer records on line for 24 months; and microfiche or other format that can be reproduced into hard copy for 7 years.

(2) Blue Shield will not be required to release individually identifiable medical information regarding Plan Participants without Contractholder's warranty that Contractholder has established procedures which ensure appropriate safeguards against unauthorized disclosure or use of such information and that the information will be used solely for the purposes allowed in the California Confidentiality of Medical Information Act, the California Insurance Information and Privacy Protection Act and the US Public Health Service Act and other applicable privacy laws.

(3) If this agreement is terminated Blue Shield will provide Contractholder with records Blue Shield has which are reasonably required for subsequent administration of the Plan in Blue Shield's standard format for maintenance of records. Notwithstanding the foregoing, Contractholder understands and accepts that Blue Shield's provider allowances and negotiated prices are confidential trade secret information which will not be released upon termination of this agreement.

c. Audit:

(1) During the term of this agreement Contractholder may inspect and audit benefit payment records relevant to Blue Shield's services under this agreement with 60 days prior written notice and request for such records. Any examination of individual benefit payment records will be carried out in a manner agreed to by the parties and designed to protect the confidentiality of individual medical information.

(2) Benefit payment audits may be conducted by Contractholder's audit staff or by an independent contractor employed at Contractholder's expense who may be either a Certified Public Accountant or otherwise professionally qualified to perform such auditing services. Blue Shield is not required to allow access for the purpose of an audit to any individual Blue Shield reasonably believes is likely to misuse or misappropriate information which may be available in the course of an audit as a result of a conflict of interest or otherwise or any independent consultant whose compensation for performing such an audit is contingent on or otherwise wholly or partially based on the audit findings.

(3) For the purpose of comment on operational performance, sampling Plans, selection techniques and other audit protocols will be based on generally accepted audit standards selected to achieve verifiable, statistically valid results.

(4) In the event Contractholder seeks to conduct more than 1 audit in any 12-month period, Contractholder agrees to reimburse Blue Shield the reasonable value of staff time and expenses incurred by Blue Shield to comply with such additional audit.

(5) Contractholder will provide Blue Shield with a copy of any audit report.

d. Stipulations Regarding Caremark:

(1) Contractholder has entered into an agreement with Caremark, 18054 Virginia Drive, Los Gatos, California 95030, pursuant to which Caremark will provide preservice benefit determination, certification and utilization review services with respect to outpatient prescription drug Plan benefits. During the continuance of its agreement, Caremark shall receive, process, determine and make disbursement on all outpatient prescription drug claims in accordance with its own review and medical policy determination.

(2) Caremark will be responsible for review of inquiries and appeals of all outpatient prescription drug claims.

(3) Blue Shield shall allow Caremark access to Blue Shield's documents and records as Blue Shield deems appropriate with regard to Caremark's obligations under its agreement with Contractholder.

(4) It is understood that Blue Shield makes no representation of any kind as to the appropriateness of Caremark's medical policy determination. It is further understood that failure on the part of Blue Shield to complain of any action on the part of Caremark shall not constitute a waiver by Blue Shield of any of its rights under this agreement.

(5) Contractholder shall indemnify and hold Blue Shield harmless from and against all loss, damages, injury, liability, penalties and claims thereof, including reasonable attorneys' fees and other costs of litigation resulting directly or indirectly from (1) any benefit determination, modification, or reimbursement which is based on a Caremark review or (2) the release of any medical records or information which Blue Shield may be required to provide to Caremark.

12. <u>Indemnification Agreements</u>:

a. In performing services under this agreement, Blue Shield shall act with reasonable and ordinary care for a prudent benefits administrator acting under the circumstances then prevailing.

b. Blue Shield agrees to indemnify and hold Contractholder, Contractholder's officers and employees harmless for any claims, lawsuits, settlements, judgments, costs, penalties and expenses, including reasonable attorneys' fees, in proportion to and to the extent caused by the negligence or willful misconduct of Blue Shield's employees in the performance or non-performance of Blue Shield's obligations under this agreement. Notwithstanding the preceding indemnification, the Overpayment of Plan Benefits Section above sets forth the exclusive remedy for ministerial errors in benefit determinations.

c. Contractholder agrees to indemnify and hold Blue Shield, Blue Shield's officers, and employees harmless for any claims, lawsuits, settlements, judgments, costs, penalties, and expenses, including reasonable attorneys' fees, in proportion to and to the extent caused by the negligence or willful misconduct of Contractholder's employees in the performance or non-performance of Contractholder's obligations under this agreement.

d. If the indemnifying party fails to assume the defense of a claim subject to indemnification, the party claiming indemnification may assume defense of the claim with the right to defend, settle or compromise the claim in its sole discretion, at the sole expense and liability of the indemnifying party. If a dispute arises between the parties as to whether a claim is subject to indemnification under this section, it must be settled pursuant to the Dispute Resolution provisions below.

13. <u>Termination</u>:

a. This agreement may be terminated:

(1) on the date of discontinuance of the Plan;

(2) with 5 days prior written notice for failure to provide sufficient funds for claim payments as required under this agreement unless such funds are paid in full before such date;

(3) with 30 days prior written notice for breach of any other material obligation under this agreement (including timely payment of Service Charges) provided such breach has not been cured within the 30-day period; or

(4) on any date mutually agreed upon between the parties.

b. Services under this agreement apply only to benefits administered or claims Blue Shield actually receives during the term of this agreement. Following termination Blue Shield will complete the processing of all claims in Blue Shield's possession on the date of termination and prepare benefit payments to the extent of benefit funds Contractholder has provided. Blue Shield will also complete the processing of recoveries and adjustments of erroneous payments.

c. With the exception of termination for non-payment, Blue Shield is willing to administer claims incurred during the term of this agreement but received after termination ("Run-out Claims") subject to mutual agreement as to the services to be performed and the applicable Service Charge.

14. <u>Insurance:</u>

a. Blue Shield shall maintain and upon request provide evidence of the following insurance coverage satisfactory to the County Risk Manager:

(1) Worker's Compensation and Employer's Liability Insurance providing full statutory coverage as required under the laws of the State of California.

(2) Comprehensive General Liability Coverage of not less than One Million Dollars ($1,000,000) combined single limit bodily injury and property damage per occurrence.

(3) Comprehensive Automobile Liability Insurance on owned, hired or leased vehicles used in connection with Blue Shield's business of not less than Five Hundred Thousand Dollars ($500,000) combined single limit bodily injury and property damage per occurrence.

(4) Professional Liability (Errors and Omissions) Coverage of not less than One Million Dollars ($1,000,000) combined single limit per occurrence.

b. Premiums and deductibles under the above coverage shall be the responsibility of Blue Shield and the insurance carriers shall not have recourse against the County, its officers and employees for payment of any premium or assessments. The County, its officers and employees shall be included as additional insured under b. and c. above, except with regard to occurrences that result from their own negligence. If the County or its officers and employees have other insurance against a loss covered by the above policies, such other insurance shall be excess insurance only. Blue Shield shall advise its insurance carriers to provide the County 30 days prior notice to any cancellation or material change in the above policies. Failure to maintain or otherwise comply with the insurance coverage required by this section shall constitute a material breach of this Agreement.

15. Interpretation and Applicable Law: The subject headings and sections used in this agreement are for reference and convenience only and are not to be used for the interpretation of this agreement. The parties have negotiated this agreement at arm's length and it is not to be construed against either of the parties. Except to the extent governed by ERISA, this agreement will be governed by the laws of the State of California.

16. Amendments: This agreement constitutes the entire agreement between the parties concerning the matters discussed herein. This agreement may only be amended by the parties written mutual agreement.

17. Assignment: Assignment of this agreement by either of the parties will only be valid with the written consent of the other.

18. Third Party Beneficiaries: This is an agreement for "Administrative Services Only" and is for the sole and exclusive benefit of the parties. It is not intended and does not confer any benefits on third parties, with the exception of Blue Shield's participating providers who are intended beneficiaries of the Contractholder's obligation to fund all claims incurred under the Plan.

19. Dispute Resolution:

a. Neither party shall bring a lawsuit or other proceeding of any character in any court to settle any dispute arising out of or relating to this agreement except to compel mediation or arbitration or to enforce the settlement or judgment resulting from such proceeding. If a dispute or controversy arises between the parties out of or relating to this agreement, the parties agree to submit the dispute to mediation with a neutral third party mediator in accordance with the Mediation Rules of the American Arbitration Association. Either party may initiate mediation proceedings by advising the other in writing setting forth the nature of the dispute. The mediation provisions of this agreement may be enforced by any court of competent jurisdiction in the same manner as a petition for arbitration.

b. If mediation fails to resolve the dispute, upon written demand by either party, the dispute or controversy must be settled by arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association and judgment upon the award rendered by the Arbitrator(s) may be entered by any court having jurisdiction. The arbitrators will have no authority to award punitive damages or any other damages not measured by the prevailing party's actual damages, and may not, in any event, make any ruling, finding or award that does not conform to the terms and conditions of this agreement.

20. Waivers: Failure by either of the parties to enforce any term of this agreement is not to be construed as a waiver.

21. Association Disclosure: The Contractholder, on behalf of itself and its Participants, hereby expressly acknowledges its understanding that this agreement constitutes a contract solely between the Contractholder and Blue Shield, that Blue Shield 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 Blue Shield to use the Blue Shield Service Mark in the State of California, and that Blue Shield is not contracting as the agent of the Association. The Contractholder further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than Blue Shield and that no person, entity or organization other than Blue

Shield shall be held accountable or liable to the Contractholder or its Participants for any of Blue Shield's obligations created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of Blue Shield, other than those obligations created under other provisions of this agreement.

21. Notices: All notices and other communications under this agreement will be in writing and will be deemed to have been duly given when delivered by U.S. Mail, postage prepaid, by certified mail, return receipt requested, and addressed as follows:

If to Contractholder:	If to Blue Shield:
El Dorado County 330 Fair Lane Placerville, CA 95667 Attn: Health Benefits Manager	Blue Shield of California 50 Beale Street San Francisco, CA 94105 Attn: Paul Markovich Senior Vice President Commercial Business Unit

or, at such other place as either of the parties, from time to time, designates by written notice to the other.

In witness of this agreement El Dorado County and California Physicians' Service will have this agreement signed in duplicate by their respective officers properly authorized to act on their behalf. Payment of administrative service fees by and acceptance of Blue Shield's performance hereunder by Contractholder shall be deemed to constitute the Contractholder's acceptance of the terms hereof, whether or not this agreement is signed by the Contractholder.

CALIFORNIA PHYSICIANS' SERVICE **d.b.a. BLUE SHIELD OF CALIFORNIA**	**EL DORADO COUNTY**
By: [signature]	**By:** ______________
Title: VP/GM	**Title:** ______________
Date: 7/30/09	**Date:** ______________

Appendix A - Administrative Service Charge and Other Miscellaneous Terms

1. Monthly Administrative Service Charge:

Quoted charge pepm for non-Medicare Participants	$44.92
Quoted charge pepm for Medicare Participants	$47.48

2. Stop Loss Coverage:

Specific stop loss at	$175,000 per Plan Participant

Appendix B - Funding of Benefit Payments

1. Funding Method - Automated Clearing House - Blue Shield Originator:

   a. Blue Shield has established an account with Bank of America (Account # 1499-9-05524) which can receive electronic fund transfers via automated clearing house (ACH) transactions.

   b. Contractholder will establish an account with a bank acceptable to Blue Shield which: (i) can transmit ACH-enabled payments, and, (ii) operates in accordance with the NACHA operating rules as they currently exist and as modified in the future.

   c. Contractholder will provide its bank with the appropriate authorization which permits Blue Shield to initiate transfer electronically of benefit claims amounts from Contractholder's account and into Blue Shield's bank account, following notice from Blue Shield to Contractholder of the amount to be transferred electronically.

   d. Blue Shield will notify Contractholder of the dollar amount of benefit claims which have been paid and/or finalized and then will initiate the electronic transfer of this amount from Contractholder's account to Blue Shield's account by an ACH transaction. When Contractholder is notified before 11:30 a.m. (Pacific time), the transaction will be initiated on the same day. If the notification is received after 11:30 a.m. (Pacific time), the transaction will be initiated on the next working day. Blue Shield will follow the initial notification with written confirmation by mail.

2. Late Payment Fee: If Contractholder fails to provide funds to Blue Shield in accordance with this schedule, Blue Shield may, at Blue Shield's sole discretion, issue benefit payments and charge Contractholder a fee calculated as the amount of the late reimbursement multiplied by the Bank of America prime rate plus 1% multiplied by the number of late days divided by 365. The remedy set forth herein is in addition to Blue Shield's rights as set forth in Section 9c hereof and any other remedies available at law.

3. Escheatment: Blue Shield will prepare in Blue Shield's standard format summaries of checks (including the amounts thereof) drawn, but not presented for payment and/or funded, including any special reports of uncashed checks required to comply with applicable forfeiture provisions of the Plan or abandoned property laws.

Appendix C - Plan Reports

1. Blue Shield will make the necessary reports to the United States Internal Revenue Service and State Franchise Tax Board as to benefit payments to providers of service as required by law.

2. Blue Shield will provide Contractholder with the following Plan Reports and the semi-annual Membership Reports:

   Monthly

   a. Large Claims Report
   b. Detailed Claims Report
   c. Membership
   d. Age Distribution
   e. Claims Lag Report
   f. Group Paid Claims Experience Report

   Annually

   Key Indicators Report and its respective data components as listed below:

   a. Membership
   b. Utilization:
      (1) Facility Inpatient
      (2) Professional Inpatient
      (3) Facility Outpatient
      (4) Professional Outpatient
      (5) Other Goods and Services
   c. Paid Claims Dollars:
      (1) Facility Inpatient
      (2) Professional Inpatient
      (3) Facility Outpatient
      (4) Professional Outpatient
      (5) Other Goods and Services
   d. Network Utilization and Costs
   e. Major Diagnostic Categories
      (1) Inpatient Cases
      (2) Outpatient Cases
   f. Top Inpatient Facilities
   g. Network Savings and Cost Containment Features

3. Customized or ad hoc client reports may be provided upon request for additional charge.

Appendix D – Business Associate Addendum

This Addendum effective July 1, 2007 is entered into by El Dorado County ("Covered Entity"), and the party executing this Addendum, Blue Shield of California ("Business Associate"), which party for the purpose of this Agreement is a Business Associate (as defined herein) of Covered Entity. This Addendum to the underlying Agreement ("Agreement") is drafted in accordance with Covered Entity's obligations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the applicable requirements of the HIPAA's implementing regulations issued by the U.S. Department of Health and Human Services, 45 C.F.R. Parts 160-64 ("HIPAA Regulations") to ensure the integrity and confidentiality of individually identifiable protected health information ("PHI") that a business associate may create for or receive from the Covered Entity.

A. **Definitions.** Unless otherwise provided in this Amendment, capitalized terms have the same meaning as set forth in the HIPAA Regulations.

B. **Obligations of Business Associate.** Business Associate is permitted or required to use or disclose PHI it creates for or receives from Covered Entity only as follows:

1. Not use or disclose PHI other than as permitted or required by the Agreement or as required by law.
2. Use reasonable and appropriate safeguards to try to prevent use or disclosure of the PHI other than as provided for by the Agreement.
3. Mitigate, to the extent practicable, harmful effects that are known to Business Associate of a use or disclosure of PHI by the Business Associate in violation of the requirements of this Amendment.
4. Report to Covered Entity any use or disclosure of the PHI not provided for by this Amendment or as allowed by law of which Business Associate becomes aware.
5. Require contractors, subcontractors, and/or agents to whom the Business Associate provides PHI (that was created by or received from the Covered Entity) to agree to substantially the same conditions that apply to the Business Associate with respect to such PHI under this Amendment.
6. Provide access to the Covered Entity's PHI within a Designated Record Set in response to the Covered Entity's written request within thirty (30) calendar days after receiving such written request, pursuant to §164.524 of the HIPAA Regulations.
7. Make amendment(s) to the Covered Entity's PHI in a Designated Record Set that the Covered Entity and Business Associate agree to, pursuant to §164.526 of the HIPAA Regulations, within thirty (30) calendar days.
8. Make internal practices, books, and records, including, but not limited to, policies and procedures, relating to the use and disclosure of PHI created or received by Business Associate on behalf of Covered Entity available to the U.S. Department of Health and Human Services ("DHHS"), if requested, in a time and manner designated by DHHS, for purposes of DHHS determining Covered Entity's compliance with the HIPAA Regulations.
9. For a period of six (6) years from the termination date of the Agreement, maintain an accounting of all disclosures of PHI that are required to be maintained under § 164.528 of the HIPAA Regulations. Such accounting will include the date of the disclosure, the name of the recipient, a description of PHI disclosed and the purpose of the disclosure.
10. Provide information collected in accordance with Section B.9 of this Amendment to Covered Entity within thirty (30) calendar days of receipt of a written request from Covered Entity, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with §164.528 of the HIPAA Regulations.
11. Make reasonable efforts to implement additional restrictions on the use or disclosure of Covered Entity's PHI, as reasonably requested by the Covered Entity, in accordance with §164.522 of the HIPAA Regulations.

C. **Obligations of Covered Entity.** Covered Entity shall:

1. Advise Business Associate of any specific limitations in Covered Entity's Notice of Privacy Practices, to the extent that such limitations may affect Business Associate's use or disclosure of Covered Entity's PHI.
2. Promptly notify Business Associate of any changes in, or revocation of, permission by Individuals to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of Covered Entity's PHI.
3. Promptly notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with §164.522 of the HIPAA Regulations, to the extent that such restriction may affect Business Associate's use or disclosure of Covered Entity's PHI.
4. Not request that Business Associate use or disclose PHI in any manner that would be impermissible under the HIPAA Regulations if so used or disclosed by Covered Entity.

D. **Termination for Breach**. As required by the HIPAA Regulations, Covered Entity may, in addition to other available remedies, terminate the Agreement if Business Associate has materially breached any provision(s) of the Agreement and has failed to cure or take any actions to cure such material breach within thirty (30) calendar days of written notification of such material breach. Covered Entity shall exercise this right to terminate the Agreement by providing Business Associate written notice of termination, which shall include the reason for the termination.

1. Upon the expiration or earlier termination of the Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity that Business Associate still maintains; provided that if such return or destruction of PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible and shall extend the protections of this Amendment to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

E. **Indemnification**. Covered Entity shall indemnify and hold harmless Business Associate and Business Associate's affiliates, subsidiaries, officers, directors, employees and agents from and against any claim, cause of action, liability, damage, cost or expense, including attorneys' fees and court or proceeding costs, arising out of or in connection with any non-permitted or violating use or disclosure of PHI or other breach of this Addendum by Business Associate or any Business Associate subcontractor, agent, representative, person or entity. This section shall survive the termination of the Agreement.

F. **Survival**. The respective rights and obligations of this amendment shall survive the termination of the Agreement.

G. **Conflicts**. The terms and conditions of this Addendum shall prevail in the event this Addendum conflicts with any provision of the Agreement.

H. **Privacy and Security Contact Information**.

1. Blue Shield of California
a) Sharon A. Anolik, Esq., Privacy Official
PO Box 272540
Chico, CA 95927-2540
Phone: 888-266-8080
Fax: 800-201-9020
Email: blueshieldca_privacy@blueshieldca.com

b) Errol Oliver, Director of IT Security
50 Beale Street
San Francisco, CA 94105
Phone: 415-229-5870
Email: riskmanagement@blueshieldca.com

2. Covered Entity
   a) Contact name: ______________________________
Contact title: ______________________________
Contact address: ______________________________
Contact city, state, zip: ______________________________
Contact phone number: ______________________________
Contact email address: ______________________________