UnitedHealthcare®
A UnitedHealth Group Company

2300 Clayton Road, Suite 1000
Concord, CA 94520

May 25, 2011

Ms. Janet Parnell
Risk Management
County of El Dorado
330 Fair Lane
Placerville, CA 95667

Dear Janet:

This letter confirms that all payments for the UnitedHealthcare for the County of El Dorado should be submitted through Employee Benefits Specialists (EBS). EBS is the administrative intermediary between the UnitedHealthcare Contract Holder (County of El Dorado) and UnitedHealthcare. EBS is responsible for all billing and eligibility functions for the County of El Dorado, and the County of El Dorado agrees to ensure that EBS will submit required documentation and payments to UnitedHealthcare as required by the County of El Dorado's policy with UnitedHealthcare and internal administrative procedures.

Eligibility adjustments reported to UnitedHealthcare after the date the invoice is prepared will be reflected on the subsequent month's invoice from EBS.

Please feel free to let me know if you have any questions.

Sincerely,

Dan Rosenthal
Chief Executive Officer, Northern California
UnitedHealthcare

Signature, Name, Title
County of El Dorado

Signature, Name, Title
County of El Dorado

UHC OF CALIFORNIA dba UNITEDHEALTHCARE OF CALIFORNIA
MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT
COVER SHEET
(This Cover Sheet is an integral part of this Agreement)

GROUP NAME: EL DORADO COUNTY

GROUP CODE: 402750

GROUP COVERAGE EFFECTIVE DATE: July 1, 2011 through December 31, 2011

PLAN CODE: ELS, IBD, BDX, 3RK

PLAN DESCRIPTION: SignatureValue (HMO) $15 / 100% EDC Plan with Infertility Basic Diagnosis & Treatment, UnitedHealthcare of California Behavioral Health / SV&SVA SMI + BH Buy-Up Rider, and Managed Formulary $10 Generic / $20 Brand / $25 Non Formulary $50I Outpatient Prescription Drugs

HEALTH PLAN PREMIUMS:

Employee Only:	$ 613.31
Employee + 1 Dependent:	$1,257.19
Employee + 2 or more Dependents:	$1,778.49

BILLING CODE: 03*
* New adds are charged only if enrolled on or before the 15th of the month. New terminates are charged only if terminated after the 15th of the month.

PREMIUMS DUE ON OR BEFORE (refer to Section 3.06): The 1st of the month of coverage.
ANNUAL COPAY MAXIMUM PER INDIVIDUAL: $2,000.00
ANNUAL COPAY MAXIMUM PER FAMILY: $6,000.00
CONTINUATION OF BENEFITS ELECTIONS: No

ELIGIBILITY:
Group Eligibility
Minimum hours required per week: 32

Dependent Member Eligibility
Dependent children are Eligible through age: 25

Start and End date of coverage: New and rehire employee's coverage starts on the date of hire. Coverage ends on the date of termination of employment.

A new spouse, Domestic Partner or children are eligible as set forth in the UnitedHealthcare of California Evidence of Coverage and Disclosure Form.

ATTACHMENTS: **(The following Attachments are an integral part of this Agreement)**

A - Schedule of Benefits, UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form
I - Basic Infertility Services (Diagnosis & Treatment)
L - UnitedHealthcare of California Behavioral Health
R - Outpatient Prescription Drug Benefit

UHC OF CALIFORNIA dba UNITEDHEALTHCARE OF CALIFORNIA
MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT
COVER SHEET
(This Cover Sheet is an integral part of this Agreement)

GROUP NAME: EL DORADO COUNTY

GROUP CODE: 402751- Early Retiree

GROUP COVERAGE EFFECTIVE DATE: July 1, 2011 through December 31, 2011

PLAN CODE: ELS, IBD, BDX, 3RK

PLAN DESCRIPTION: SignatureValue (HMO) $15 / 100% EDC Plan with Infertility Basic Diagnosis & Treatment, UnitedHealthcare of California Behavioral Health / SV&SVA SMI + BH Buy-Up Rider, and Managed Formulary $10 Generic / $20 Brand / $25 Non Formulary $50I Outpatient Prescription Drugs

HEALTH PLAN PREMIUMS:

Employee Only:	$ 613.31
Employee + 1 Dependent:	$1,257.19
Employee + 2 or more Dependents:	$1,778.49

BILLING CODE: 03*
* New adds are charged only if enrolled on or before the 15th of the month. New terminates are charged only if terminated after the 15th of the month.

PREMIUMS DUE ON OR BEFORE (refer to Section 3.06): The 1st of the month of coverage.
ANNUAL COPAY MAXIMUM PER INDIVIDUAL: $2,000.00
ANNUAL COPAY MAXIMUM PER FAMILY: $6,000.00
CONTINUATION OF BENEFITS ELECTIONS: No

ELIGIBILITY:
Group Eligibility
Minimum hours required per week: N/A

Dependent Member Eligibility
Dependent children are Eligible through age: 25

Start and End date of coverage: Coverage starts on the first of the month after retirement date. Coverage ends on the date of termination of employment.

A new spouse, Domestic Partner or children are eligible as set forth in the UnitedHealthcare of California Evidence of Coverage and Disclosure Form.

ATTACHMENTS: **(The following Attachments are an integral part of this Agreement)**

*	Early Retiree Amendment
A -	Schedule of Benefits, UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form
I -	Basic Infertility Services (Diagnosis & Treatment)
L -	UnitedHealthcare of California Behavioral Health
R -	Outpatient Prescription Drug Benefit

(8-28-02)
Updated 5/1/11 Legal Entity Name Change

UHC OF CALIFORNIA dba UNITEDHEALTHCARE OF CALIFORNIA
MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT
COVER SHEET
(This Cover Sheet is an integral part of this Agreement)

GROUP NAME: EL DORADO COUNTY

GROUP CODE: 521063-AB1401

GROUP COVERAGE EFFECTIVE DATE: July 1, 2011 through December 31, 2011

PLAN CODE: ELU, IBD, BDX, 3RK

PLAN DESCRIPTION: SignatureValue (HMO) $15 / 100% EDC Plan with Infertility Basic Diagnosis & Treatment, UnitedHealthcare of California Behavioral Health / SV&SVA SMI + BH Buy-Up Rider, and Managed Formulary $10 Generic / $20 Brand / $25 Non Formulary $50I Outpatient Prescription Drugs

HEALTH PLAN PREMIUMS:

Employee Only:	$ 674.64
Employee + 1 Dependent:	$1,382.91
Employee + 2 or more Dependents:	$1,956.34

BILLING CODE: 03*
* New adds are charged only if enrolled on or before the 15th of the month. New terminates are charged only if terminated after the 15th of the month.

PREMIUMS DUE ON OR BEFORE (refer to Section 3.06): The 1st of the month of coverage to be paid within 15 days.
ANNUAL COPAY MAXIMUM PER INDIVIDUAL: $2,000.00
ANNUAL COPAY MAXIMUM PER FAMILY: $6,000.00
CONTINUATION OF BENEFITS ELECTIONS: No

ELIGIBILITY:
Group Eligibility
Minimum hours required per week: N/A

Dependent Member Eligibility
Dependent children are Eligible through age: 25

Start and End date of coverage: Cobra

A new spouse, Domestic Partner or children are eligible as set forth in the UnitedHealthcare of California Evidence of Coverage and Disclosure Form.

ATTACHMENTS: **(The following Attachments are an integral part of this Agreement)**

- **A -** Schedule of Benefits, UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form
- **I -** Basic Infertility Services (Diagnosis & Treatment)
- **L -** UnitedHealthcare of California Behavioral Health
- **R -** Outpatient Prescription Drug Benefit

UnitedHealthcare of California

Important Notices under the Patient Protection and Affordable Care Act (PPACA)

IMPORTANT NOTICE: If you have a dependent child whose coverage ended or who was denied coverage (or was not eligible for coverage) because dependent coverage of children was not available up to age 26, you may have the right to enroll that dependent under a special dependent child enrollment period. This right applies as of the first day of the first plan year beginning on or after September 23, 2010 and your employer group must provide you with at least a 30-day enrollment period. If you are adding a dependent child during this special enrollment period and have a choice of coverage options under the plan, you will be allowed to change options. This child special open enrollment may coincide with your annual open enrollment, if you have one. Please contact your employer group or group plan administrator for more information.

IMPORTANT NOTICE: If coverage or benefits for you or a dependent ended due to reaching a lifetime limit, be advised that a lifetime limit on the dollar value of benefits no longer applies. If you are covered under the plan, you are once again eligible for benefits. Additionally, if you are not enrolled in the plan, but are still eligible for coverage, then you will have a 30 day opportunity to request enrollment. This 30 day enrollment opportunity will begin no later than the first day of the first plan year beginning on or after September 23, 2010. This 30 day enrollment period may coincide with your annual open enrollment, if you have one. Please contact your employer group or group health plan administrator for more information.

UnitedHealthcare of California

Changes in Federal Law that Impact Covered Services

There are changes in Federal law which may impact Covered Services stated in the *Combined Evidence of Coverage and Disclosure Form* and *Schedule of Benefits*. A summary of those changes and the dates the changes are effective appear below.

Patient Protection and Affordable Care Act (PPACA)

Effective for Health Plans that are new or renewing on or after September 23, 2010, the requirements listed below apply. (The *Patient Protection and Affordable Care Act (PPACA)* allows for exceptions to this effective date for collectively bargained groups.)

- If your Health Plan includes lifetime limits, lifetime limits on the dollar amount of essential benefits available to you under the terms of your Health Plan are no longer permitted. Essential benefits include the following:

  Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

- If your Health Plan includes lifetime limits: On or before the first day of the first plan year beginning on or after September 23, 2010, the Enrolling Group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits.

- Essential benefits for plan years beginning prior to January 1, 2014 can only be subject to restricted annual limits. If your Health Plan includes annual limits on essential benefits, restricted annual limits for each person covered under the Health Plan may be no less than the following:

  - For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, $750,000.
  - For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, $1,250,000.
  - For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, $2,000,000.

- If your Health Plan includes any pre-existing condition exclusions, any pre-existing condition exclusions (including denial of benefits or coverage) will not apply to Members under the age of 19.

- Coverage for enrolled Dependent children is no longer dependent upon full-time student or unmarried status or other dependency requirements and will remain in place until the child's 26th birthday. If you have a grandfathered plan, the Employer Group is not required to extend coverage to age 26 if the child is eligible to enroll in an eligible employer-sponsored health plan (as defined by law). Under the *PPACA* a Health Plan generally is "grandfathered" if it was in effect on March 23, 2010 and there are no substantial changes in the benefit design as described in the *Interim Final Rule on Grandfathered Health Plans*.

  On or before the first day of the first plan year beginning on or after September 23, 2010, the Employer Group will provide a 30 day dependent child special open enrollment period for Dependent children who are not currently enrolled under the Health Plan and who have not yet reached the Limiting Age. During this dependent child special open enrollment period, Subscribers who are adding a Dependent child and who have a choice of coverage options will be allowed to change options.

- If your Health Plan includes coverage for enrolled Dependent children beyond the age of 26, which is conditioned upon full-time student status, the following applies:

  Coverage for enrolled Dependent children who are required to maintain full-time student status in order to continue eligibility under the Health Plan is subject to the statute known as *Michelle's Law*. This law amends *ERISA*, the *Public Health Service Act*, and the *Internal Revenue Code* and requires group health plans, which provide coverage for dependent children who are post-secondary school students, to continue such coverage if the student loses the required student status because he or she must take a medically necessary leave of absence from studies due to a serious illness or injury.

- If you do not have a grandfathered plan, Covered Services for preventive care services described below will be paid at 100%, and not subject to any deductible or Copayments:
  - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
  - Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*
  - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration.*
  - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*
- Rescinding coverage under the Health Plan is permitted, with 30 days advance written notice, only in the following circumstances:
  - The individual performs an act, practice or omission that constitutes fraud.
  - The individual makes an intentional misrepresentation of a material fact.
- Other changes provided for under the *PPACA* do not impact your Health Plan because your Health Plan already contains these benefits. These include:
  - Direct access to OB/GYN care without a referral or preauthorization requirement.
  - The ability to designate a pediatrician as a primary care physician.
  - Preauthorization is not required before you receive Covered Services in the emergency department of a hospital.
  - If you seek Emergency Services from non-Participating Providers in the emergency department of a hospital, your cost sharing obligations (Copayments/Coinsurance) will be the same as would be applied to Covered Services received from Participating Providers.

Some Important Information About Appeal and Independent Medical Review (IMR) Rights Under PPACA

If you are enrolled in a non-grandfathered plan with an effective date or plan year anniversary on or after September 23, 2010, the *Patient Protection and Affordable Care Act of 2010 (PPACA)*, as amended, sets forth new and additional internal appeal and Independent Medical Review **(IMR)** rights beyond those that some plans may have previously offered. Also, certain grandfathered plans are complying with the additional internal appeal and **IMR** provisions on a voluntary basis. Please refer to your benefit plan documents, including amendments and notices, or speak with your plan sponsor, regarding the appeal rights available to you under your plan. (Also, please refer to the *Claims and Appeal Notice* section of this document).

- **What if I don't agree with the denial?** You have a right to appeal any decision not to pay for an item or service (in whole or in part).

- **How do I file an appeal?** Follow the instructions set forth in the initial denial notice that you receive from us.

- **What if my situation is urgent?** If your situation meets the definition of urgent under the law, your review will be conducted on an expedited basis. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your doctor, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal, and, if applicable, a simultaneous **IMR** by contacting us at the number listed on the back of your ID card.

- **Who may file an appeal?** You or someone you name to act for you (your authorized representative) may file an appeal.

- **Can I provide additional information about my claim?** Yes, you may supply additional information to us regarding your claim at the address supplied to you in the initial denial notice.

- **Can I request copies of information relevant to my claim?** Yes, you may request copies (free of charge) by contacting us as set forth in the initial denial notice that you receive from us.

- **What happens if I don't agree with the outcome of my appeal?** If you appeal, we will review our decision and provide you with a written determination in accordance with applicable timeframes. If we continue to deny the payment, coverage, or service requested, or you do not receive a timely decision, you may be able to request an **IMR** of your claim by an Independent Medical Review Organization (IRO) who will review the denial and issue a final decision.

  Other resources that may be available to help you: For questions about appeal rights, an adverse benefit determination, or for assistance, you can contact the *Employee Benefits Security Administration* at 1-866-444-EBSA (3272).

Review by the Department of Managed Health Care

The **California Department of Managed Health Care** is responsible for regulating health care service plans. If you have a Grievance against your Health Plan, you should first telephone your **Health Plan at 1-800-624-8822 or 1-800-442-8833 (TDHI)** and use your Health Plan's Grievance process before contacting the department. Utilizing this Grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a Grievance involving an emergency, a Grievance that has not been satisfactorily resolved by your Health Plan, or a Grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a Health Plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219) and a TDHI line (1-877-688-9891)** for the hearing- and speech-impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has Complaint forms, IMR application forms and instructions online.

- **Are verbal interpretations or written translation services available to me during an appeal?** Yes. To get an interpreter or to ask about written information in your language, please call UnitedHealthcare at the number listed on the back of your health plan ID card.

Mental Health/Substance Use Disorder Parity

For Employer Groups with 51 or more employees:

Effective for Health Plans that are new or renewing on or after July 1, 2010, benefits are subject to final regulations supporting the *Mental Health Parity and Addition Equity Act of 2008 (MHPAEA).* Benefits for mental health conditions and/or substance use disorder conditions that are defined as Covered Services under the Health Plan must be treated in the same manner and provided at the same level as Covered Services for the treatment of other sickness or injury.

MHPAEA requires that the financial requirements for Copayments and coinsurance for mental health and/or substance use disorder conditions that are defined as Covered Services under the Health Plan must be no more restrictive than those Copayments and coinsurance requirements for substantially all medical/surgical benefits. *MHPAEA* requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and/or substance use disorder benefits that are covered under the Health Plan. Based upon the results of that testing, it is possible that Copayments that apply to mental health conditions or substance use disorder conditions covered under your Health Plan may be reduced.

Changes that result from this requirement affect both preauthorization requirements and exclusions or limitations listed in your *Combined Evidence of Coverage and Disclosure Form*, *Schedule of Benefits* and behavioral health supplement to the *Combined Evidence of Coverage and Disclosure Form* as described below.

Certain exclusions or limitations listed in your *Combined Evidence of Coverage and Disclosure Form* that were specific to covered mental health conditions, but that were not applicable to other sickness or medical conditions, no longer apply.

Preauthorization requirements no longer apply to routine outpatient services provided by a Participating Provider for mental health services or substance use disorders that are Covered Services under the Health Plan, as described in the *Combined Evidence of Coverage and Disclosure Form*, *Schedule of Benefits* and behavioral health supplement to the *Combined Evidence of Coverage and Disclosure Form.*

The following outpatient non-emergency services require preauthorization:

- Intensive outpatient program treatment
- Outpatient electro-convulsive treatment
- Psychological testing
- Extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management

If you fail to obtain preauthorization, services will not be covered. Please refer to your *Combined Evidence of Coverage and Disclosure Form* and behavioral health supplement to the *Combined Evidence of Coverage and Disclosure Form* for further information on how to obtain preauthorization for mental health and substance use disorder benefits covered under your Health Plan.

All other Covered Services under the Health Plan continue to require preauthorization except Emergency Services or Urgently Needed Services as described in Section 3: Emergency and Urgently Needed Services of the *Combined Evidence of Coverage and Disclosure Form.*

Please refer to your *Combined Evidence of Coverage and Disclosure Form* and behavioral health supplement to the *Combined Evidence of Coverage and Disclosure Form* for a description of mental health conditions covered under your Health Plan and any applicable coverage for substance use disorders under your Health Plan.

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, Covered Services are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Covered Services in connection with a mastectomy, Covered Services are also provided for the following Covered Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Services (including Copayments and any annual deductible) are the same as are required for any other Covered Service. Limitations on benefits are the same as for any other Covered Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans ("plans") and health insurance issuers ("issuers") offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier. In any case, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your Combined Evidence of Coverage and Disclosure Form for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Covered Services after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have Covered Services for prescription drug benefits under your Health Plan and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Health Plan, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures. If you pay a Copayment and believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement in accordance with the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-service Requests for Covered Services

Pre-service requests for Covered Services are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Covered Services, and it was submitted properly with all needed information, you will receive written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Covered Services improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Covered Services was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Covered Services will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have Covered Services for prescription drug benefits under the Health Plan and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Covered Services in accordance with the applicable claim filing procedure. When you have filed a request for Covered Services, your request will be treated under the same procedures for pre-service group health plan requests for Covered Services as described in this section.

Urgent Requests for Covered Services that Require Immediate Attention

Urgent requests for Covered Services are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 24 hours after we receive all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within three days.

If you filed an urgent request for Covered Services improperly, we will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the Health Plan provision on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Covered Services as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Covered Services and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally contact our *Customer Service* department before requesting a formal appeal. If the *Customer Service* representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a *Customer Service* representative. If you first informally contact our *Customer Service* department and later wish to request a formal appeal in writing, you should again contact *Customer Service* and request an appeal. If you request a formal appeal, a *Customer Service* representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact our *Customer Service* department immediately.

How to Appeal a Claim Decision

If you disagree with a pre-service request for benefits determination or post-service claim determination or a rescission of coverage determination after following the above steps, you can contact us in writing to formally request an appeal.

Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Covered Services. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Covered Services and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Covered Services as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Covered Services. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent requests for Covered Services, see *Urgent Appeals that Require Immediate Action* below.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision.

Please note that our decision is based only on whether or not Covered Services are available under the Health Plan for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

The following is a general description of certain rights and protections applicable to Employer Groups subject to the Employment Retirement Income Security Act of 1974 (ERISA). Members should contact their Employer Group's benefit administrator to determine whether the Employer Group is subject to ERISA.

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA).*

Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room of the Employee Benefits Security Administration.*

You are entitled to obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description.* The plan administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. The plan sponsor is responsible for providing you notice of your *COBRA* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

You are entitled to a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another group health plan. You should be provided a certificate of creditable coverage, in writing, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect *COBRA* continuation coverage, when your *COBRA* continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. You may request a certificate of creditable coverage by calling the number on the back of your ID card. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA.*

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan

administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the *Employee Benefits Security Administration, U. S. Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor*, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration.*

ERISA Plan Year

If the Employer Group is subject to the *Employee Retirement Income Security Act of 1974 (ERISA)*, we will assume that the Employer Group's *ERISA* plan year is the same as the Employer Group's Health Plan renewal date, and update benefits to comply with Federal law upon renewal.

P.O. Box 30968
Salt Lake City, UT 84130-0968

Customer Service:
800-624-8822
800-442-8833 (TDHI)
www.uhcwest.com

PCA494656-004

Fed Notice
2/11

EARLY RETIREE AMENDMENT TO THE MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT BETWEEN UHC OF CALIFORNIA DOING BUSINESS AS UNITEDHEALTHCARE OF CALIFORNIA ("UNITEDHEALTHCARE") AND EL DORADO COUNTY ("GROUP")

This **EARLY RETIREE AMENDMENT TO THE UNITEDHEALTHCARE OF CALIFORNIA, MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT** (this "Amendment"), dated as of July 1, 2011 is made and entered into by and between UnitedHealthcare of California, a California corporation ("UnitedHealthcare") and El Dorado County ("Group").

NOW THEREFORE, in consideration of the application of Group for the benefits provided under this Agreement, and in consideration of the periodic payment of Health Plan Premiums on behalf of Members in advance as they become due, UnitedHealthcare agrees to arrange for or provide medical, surgical, hospital, and related health care benefits subject to all terms and conditions of this Medical and Hospital Group Subscriber Agreement, including the Cover Sheet and Attachments.

The Group Agreement shall be amended to read as follows:

[1]. SECTION [1.] DEFINITIONS

[1.] DEFINITIONS

1.06 Eligible Employee is deleted in its entirety and replaced with the following:

1.06 Early Retiree is a former Group employee who has met the minimum required Retiree participation conditions as determined by Group, who is not entitled to Medicare Parts A and B, who meets the Subscriber eligibility requirements of the UnitedHealthcare Combined Evidence of Coverage and Disclosure Form, who is enrolled in the UnitedHealthcare Early Retiree Health Plan, and for whom all applicable Health Plan Premiums are received by UnitedHealthcare.

1.16 Subscriber shall be amended to read as follows:

1.16 Subscriber/Eligible Retiree is the individual enrolled in the Health Plan for whom the appropriate Health Plan Premium has been received by UnitedHealthcare, and whose retirement or other status, except for family dependency, is the basis for enrollment eligibility.

2. Effect of this Amendment. The Amendment shall not be further amended, modified or revised and the Agreement shall continue in full force and effect and shall be enforced in accordance with its terms and conditions. **This amendment shall expire on December 31, 2011.**

Amendment to UnitedHealthcare of California Medical and Hospital Group Subscriber Agreement

This **AMENDMENT TO THE UNITEDHEALTHCARE OF CALIFORNIA MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT** (this "Amendment"), dated as of FEBRUARY 1, 20 11, is made pursuant to Section 3.07.02 of the Medical and Hospital Group Subscriber Agreement (the "Agreement"), dated JULY 1, 20 11, between UnitedHealthcare of California, a California corporation ("UnitedHealthcare"), and you ("Group").

Green Initiative. UnitedHealthcare has launched a green initiative which includes efforts to conserve and minimize the use of paper whenever possible. As part of UnitedHealthcare's green initiative, it will provide the UnitedHealthcare Enrollment Packet to Group in electronic form.

Amendment. Pursuant to Section 3.07.02 of the Agreement, Section 2.01.03 of the Agreement is hereby amended by inserting the following sentence as the first sentence of such section:

"UnitedHealthcare shall provide the UnitedHealthcare Enrollment Packet to Group in electronic form and the Plan shall ensure receipt of the packet along with a notification of the right to receive a hard copy of the packet as set forth in SECTION 10 below. If Group does not wish to receive the UnitedHealthcare Enrollment Packet in electronic form, Group may so notify UnitedHealthcare in accordance with Section 8.11 of the Agreement, and thereafter UnitedHealthcare will deliver the UnitedHealthcare Enrollment Packet to Group in paper format. The terms and conditions for Groups who transmit the UnitedHealthcare Enrollment Packet to its employees electronically are in SECTION 3. GROUP OBLIGATIONS, HEALTH PLAN PREMIUMS AND COPAYMENT."

All other provisions of Section 2.01.03 remain unchanged.

The following item is added to SECTION 3. GROUP OBLIGATIONS, HEALTH PLAN PREMIUMS AND COPAYMENT.

3.10 ENROLLMENT PACKETS

1. The following provisions apply to Groups agreeing to receive the Enrollment Packets electronically for distribution to their employees.
   - 1.1 Group agrees to distribute an unmodified, electronic copy of the Enrollment Packet. Group agrees to send the Enrollment Packets to all employees and to use appropriate and necessary means to ensure receipt of the Enrollment Packets;
   - 1.2 Group agrees to protect the confidentiality of the employees' personal information relating to the individual's account or benefits (e.g., incorporating measures designed to preclude unauthorized receipt of, or access to, such information other than the intended individual);
   - 1.3 Group agrees to provide access to computer programs and/or software required to read the Enrollment Packet and access to a printer.
2. Group agrees that it will provide Enrollment Packets in accordance with all applicable state or federal laws. In providing Enrollment Packets in electronic form, Group shall ensure that no modifications to Enrollment Packets will be made which affect the style, format or content of the Enrollment Packets in any manner.
3. Employees receiving the Enrollment Packet electronically will also receive an electronic notification that they may request a hard copy of the packet from the Plan. Group agrees that it will continue to provide Enrollment Packets in paper form to those employees who request a hard copy or do not have access to the electronic Enrollment Packet. Group is responsible to make sure that each employee receives the electronic Enrollment Packet, including providing a hard copy if an undeliverable message is received. UnitedHealthcare shall provide Enrollment Packets in paper form to the Group for distribution to UnitedHealthcare enrollees as they may request.
4. Group agrees that it will make the Enrollment Packet available to employees prior to the Group's renewal or during the entire open enrollment period. UnitedHealthcare agrees to make the Enrollment Packets available to Group as reasonably required by Group. Upon request, Group agrees to provide UnitedHealthcare with confirmation that employees received electronic and/or hard copy of the Enrollment Packet.

The following section is added to the Medical and Hospital Group Subscriber Agreement:

10. UNITEDHEALTHCARE'S OBLIGATIONS

UnitedHealthcare will provide the Agreement to the Group in electronic form through electronic media which may be furnished through the Internet or other electronic communication network. UnitedHealthcare will provide, along with the Agreement, electronic notification of the right to request hard copy. UnitedHealthcare will ensure receipt of the electronic documents through reasonable and necessary measures such as return-receipt or notice of undeliverable electronic mail features, and, in the event the electronic transmission fails, a hard copy of the Agreement will be furnished to the Group.

Effect of this Amendment. Pursuant to Section 3.07.02 of the Agreement, this Amendment shall take effect commencing the first full month following a thirty (30) day period after delivery of this Amendment to Group. The Agreement, as modified by this Amendment, shall continue in full force and effect and shall be enforced in accordance with its terms and conditions.

UnitedHealthcare®

UHC OF CALIFORNIA DOING BUSINESS AS UNITEDHEALTHCARE OF CALIFORNIA ("UNITEDHEALTHCARE")

MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT

Table of Contents

MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT

This Medical and Hospital Group Subscriber Agreement (the "Agreement") is entered into betweenUHC OF CALIFORNIA DOING BUSINESS AS UNITEDHEALTHCARE OF CALIFORNIA, a California corporation, hereinafter called "UnitedHealthcare," and the employer, association or other entity specified as "GROUP" on the Cover Sheet, hereinafter called "Group."

RECITAL OF FACTS

UnitedHealthcare is a health care service plan which arranges for the provision of medical, hospital and preventive medical services to persons enrolled as Members through contracts with associations of licensed physicians, hospitals and other health care providers. Group is an employer, union, trust, organization, or association which desires to provide such health care for its eligible Subscribers and family Dependents. UnitedHealthcare desires to contract with Group to arrange for the provision of such health care services to Subscribers and family Dependents of Group, and Group desires to contract with UnitedHealthcare to arrange for the provision of such services to its Subscribers and family Dependents.

AGREEMENT

NOW THEREFORE, in consideration of the application of Group for the benefits provided under this Agreement, and in consideration of the periodic payment of Health Plan Premiums on behalf of Members in advance as they become due, UnitedHealthcare agrees to arrange for or provide medical, surgical, hospital, and related health care benefits subject to all terms and conditions of this Medical and Hospital Group Subscriber Agreement, including the Cover Sheet and Attachments.

1. DEFINITIONS

1.01 Agreement is this Medical and Hospital Group Subscriber Agreement, including, but not limited to, the Cover Sheet, Attachments and any amendments thereto.

1.02 Combined Evidence of Coverage and Disclosure Form is the document issued to prospective and enrolled Subscribers disclosing and setting forth the benefits and terms and conditions of coverage to which Members of the Health Plan are entitled.

1.03 Copayments are fees payable to a health care provider by the Member at the time of provision of services which are in addition to the Health Plan Premiums paid by the Group. Such fees may be a specific dollar amount or a percentage of total fees as specified herein, depending on the type of services provided.

1.04 Cover Sheet is the Medical and Hospital Group Subscriber Agreement Cover Sheet which is attached to and an integral part of this Agreement.

1.05 Dependent is any spouse, Domestic Partner or unmarried child (including a step-child, adopted child, child(ren) for whom the Subscriber, the Subscriber's spouse or Domestic Partner has assumed permanent guardianship or a child of a Domestic Partner) of a Subscriber who is enrolled hereunder, who meets all the eligibility requirements set forth in the UnitedHealthcare Combined Evidence of Coverage and Disclosure Form attached to this Agreement and for whom applicable Health Plan Premiums are received by UnitedHealthcare.

1.05(a) Domestic Partner is a person who meets the eligibility requirements, as defined by the Group, and the following:

(i) Is eighteen (18) years of age or older;
(ii) Is mentally competent to consent to contract;
(iii) Resides with the Subscriber and intends to do so indefinitely;
(iv) Is jointly responsible with the Subscriber for their common welfare and financial obligations;
(v) Is unmarried; and
(vi) Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the state of residence.

1.06 Eligible Employee is a Group employee who works a fixed number of hours per week as established by the Group, meets any applicable waiting period required by the Group, and meets the following additional criteria:

(a) Is defined as an employee under state and federal law;

(b) Is actively working or is able to return to active work and has certain rights pertaining to leaves of absence if his or her condition improves. Consultants, temporary labor, suppliers or contractors are not Eligible Employees.

1.07 Enrollment is the execution of a UnitedHealthcare Enrollment form, or a non-standard Enrollment form approved by UnitedHealthcare, by the Subscriber on behalf of the Subscriber and his or her Dependents, and acceptance thereof by UnitedHealthcare, conditioned upon the execution of this Agreement by UnitedHealthcare, and either the execution of this Agreement by Group or the timely payment of applicable Health Plan Premiums by Group. In its discretion and subject to specific protocols, UnitedHealthcare may accept Enrollment through an electronic submission from Group.

1.08 Group is the single employer, labor union, trust, organization, or association identified on the Cover Sheet.

1.09 Group Contribution is the amount of the Health Plan Premium applicable to each Subscriber which is paid solely by the Group or employer and which is not paid by the Subscriber either through payroll deduction or otherwise.

1.10 Group Participation is the number of individuals in the Group who are enrolled as Subscribers expressed as a percentage of the number of individuals in the Group who are eligible to enroll as Subscribers.

1.11 Health Plan is the health plan described in this UnitedHealthcare Medical and Hospital Group Subscriber Agreement, Cover Sheet and Attachments, subject to modification pursuant to the terms of this Agreement.

1.12 Health Plan Premiums are amounts established by UnitedHealthcare to be paid to UnitedHealthcare by Group on behalf of Members in consideration of the benefits provided under this Health Plan; such amounts are set forth in the Cover Sheet of this Agreement.

1.13 Member is the Subscriber or any Dependent who is eligible, enrolled and covered by the UnitedHealthcare.

1.14 Open Enrollment Period is the annual period of not less than thirty (30) days agreed upon by UnitedHealthcare and Group, during which all eligible and prospective Group Subscribers and their Eligible Dependents may enroll in this Health Plan.

1.15 UnitedHealthcare Enrollment Packet is the packet of information supplied by UnitedHealthcare to prospective Members which discloses plan policy and procedure and provides information about Plan benefits and exclusions. The UnitedHealthcare Enrollment Packet contains the UnitedHealthcare Enrollment form or a non-standard Enrollment form approved by UnitedHealthcare, and the UnitedHealthcare Combined Evidence of Coverage and Disclosure Form.

1.16 Subscriber is the individual enrolled in the Health Plan for whom the appropriate Health Plan Premium has been received by UnitedHealthcare, and whose employment or other status, except for family dependency, is the basis for enrollment eligibility.

2. ELIGIBILITY AND ENROLLMENT

2.01 Enrollment Procedure

2.01.01 Application Form. A properly completed, signed application for Enrollment on a form provided by UnitedHealthcare, or on a non-standard form approved by UnitedHealthcare, must be submitted to UnitedHealthcare by Group for each eligible and/or prospective Subscriber, on behalf of the eligible and/or prospective Subscriber and any Eligible Dependents. UnitedHealthcare may, in its discretion and subject to specific protocols, accept Enrollment through an electronic submission from Group.

2.01.02 Time of Enrollment. All applications for Enrollment shall be submitted by prospective Subscribers to the Group during Open Enrollment Periods, except that prospective Subscribers and their Eligible Dependents who were not eligible during the previous Open Enrollment Period may apply for Enrollment within thirty-one (31) days after becoming eligible. All applications for Enrollment which are not received by UnitedHealthcare within the thirty-one (31) days from the first day the prospective Subscriber or Dependent becomes eligible shall be subject to rejection by UnitedHealthcare. Prospective Subscribers and their Eligible Dependents may reapply at the next Open Enrollment Period in the event an application was not received by UnitedHealthcare within such thirty-one (31) day period. Group shall provide notice to Members of the applicable Open Enrollment Periods.

2.01.03 Notice and Certification. Group shall provide a written notice and certification, prepared by UnitedHealthcare, as part of the UnitedHealthcare Enrollment Packet to Eligible Employees at the commencement of the initial Open Enrollment Period. The written notice and certification section of the UnitedHealthcare application for Enrollment shall provide notice of the availability of coverage under the Health Plan and indicate that an Eligible Employee's failure to elect coverage, on his or her behalf or on behalf of his or her Eligible Dependents during the initial Open Enrollment Period, permits UnitedHealthcare to exclude coverage for a period of up to twelve (12) months until the Employer's next open enrollment period. Group shall require any Eligible Employee declining coverage under the Health Plan on behalf of himself or herself or any Eligible Dependent, to certify on the written notice and certification prepared by UnitedHealthcare, the reason for declining Enrollment in the Health Plan and that he or she has reviewed the notice and certification and understands the consequences of declining coverage under the Health Plan. Group agrees to submit all completed notices and certifications to UnitedHealthcare for:

a. Each Eligible Employee and/or his or her Eligible Dependents who declined coverage at renewal of this Agreement; and

b. Each Eligible Employee and/or his or her Eligible Dependents who became eligible during the term of this Agreement specified on the Cover Sheet of this Agreement and who have declined coverage.

2.01.04 Late Enrollment. Please refer to the section of this Agreement entitled Combined Evidence of Coverage and Disclosure Form for a complete description of Late Enrollment procedures.

2.02 Commencement of Coverage. The commencement date of coverage under this Health Plan shall be effective in accordance with the terms of the Cover Sheet and this Agreement. UnitedHealthcare's acceptance of each Member's Enrollment is contingent upon receipt of the applicable Health Plan Premium payment.

2.03 UnitedHealthcare's Liability in the Event of Conversion from a Prior Carrier. In the event UnitedHealthcare replaces a prior carrier responsible for the payment of benefits or provision of services under a group contract within a period of sixty (60) days from the date of discontinuation of the prior contract or policy, UnitedHealthcare will immediately cover all employees and dependents who were validly covered under the previous contract or policy at the date of discontinuation, and who are eligible for enrollment under this Agreement, without regard to health status or hospital confinement. Notwithstanding the foregoing, with respect to employees or dependents who were totally disabled on the date of discontinuation of the prior contract or policy, and entitled to an extension of benefits pursuant to Section 1399.62 of the California Health & Safety Code or Section 10128.2 of the California Insurance Code under the prior contract or policy, UnitedHealthcare shall not be financially responsible for any payment of benefits or provision of services directly related to any condition which caused the total disability. In such a situation, the prior carrier shall continue to be financially responsible for all benefits or services directly related to any condition which caused the total disability until such extension of benefits is no longer required under California or federal law.

3. GROUP OBLIGATIONS, HEALTH PLAN PREMIUMS AND COPAYMENTS

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

3.02 Notices to UnitedHealthcare. Group shall forward all completed or amended Enrollment forms for each Member for receipt by UnitedHealthcare within thirty-one (31) days of the Member's initial eligibility. Group acknowledges that any Enrollment applications not received by UnitedHealthcare within such thirty-one (31) day period may be rejected by UnitedHealthcare. Group further agrees to transmit to UnitedHealthcare any Enrollment application amendments pursuant to the Administrative Manual described in Section 8.07 below.

Group shall forward all notices of termination to UnitedHealthcare within thirty-one (31) days after Member loses eligibility or elects to terminate membership under this Agreement. Group agrees to pay any applicable Member Health Plan Premiums through the last day of the month in which notice of termination is received by UnitedHealthcare.

3.03 Notices to Member. If Group or UnitedHealthcare terminates this

Agreement pursuant to Section 7 below, Group shall promptly notify all Members enrolled through Group of the termination of their coverage in this Health Plan. Group shall provide such notice by delivering to each Subscriber a true, legible copy of the notice of termination sent from UnitedHealthcare to Group at the Subscriber's then current address. Group shall promptly provide UnitedHealthcare with a copy of the notice of termination delivered to each Subscriber, along with evidence of the date the notice was provided. In the event that UnitedHealthcare terminates this Agreement for non-payment of Health Plan Premiums, Members will receive notice of termination from UnitedHealthcare.

If, pursuant to Sections 3.07.01 and 3.07.02 below, UnitedHealthcare increases Health Plan Premiums payable by the Subscriber, or if UnitedHealthcare increases Copayments or reduces covered services provided under this Agreement, Group shall promptly notify all Members enrolled through Group of the increase or reduction. In addition, Group shall promptly notify Members enrolled through Group of any other changes in the terms or conditions of this Agreement affecting the Members' benefits or obligations under the Health Plan. Group shall provide such notice by delivering to each Subscriber a true, legible copy of the notice of the Health Plan Premium or Copayment increase or reduction in covered services sent from UnitedHealthcare to Group at the Subscriber's then current address. Group shall promptly provide UnitedHealthcare with a copy of the notice of Health Plan Premium or Copayment increase or reduction in covered services delivered to each Subscriber, along with evidence of the date the notice was provided. UnitedHealthcare shall have no responsibility to Members in the event Group fails to provide the notices required by this Section 3.03.

3.04 Indemnification. Group agrees to indemnify, defend and hold UnitedHealthcare harmless and accept all legal and financial responsibility for any liability arising out of Group's failure to perform its obligations as set forth in this Section 3.

3.05 Rates (Prepayment Fees). The Health Plan Premium rates are set forth in the Health Plan Premiums section of the Cover Sheet and supplemental Health Plan Premium notices.

3.06 Due Date. Health Plan Premiums are due in full on a monthly basis by check or electronic transfer and must be paid directly by Group to UnitedHealthcare on or before the last business day of the month prior to the month for which the premium applies. Failure to provide payment on or before the due date may result in termination of Group, as set forth in Section 7.02.01 below. UnitedHealthcare reserves the right to assess an administrative fee of five percent (5%) of the monthly premium prorated on a thirty (30)-day month for each day it is delinquent thereafter. This fee will be assessed solely at UnitedHealthcare's discretion. In the event that deposit of payments not made in a timely manner are received by UnitedHealthcare after termination of Group, the depositing or applying of such funds does not constitute acceptance, and such funds shall be refunded by UnitedHealthcare within twenty (20) business days of receipt if UnitedHealthcare, in its sole discretion, does not reinstate Group.

3.07 Modification of Rates and Benefits.

3.07.01 Modification of Health Plan Premium Rates. The Health Plan Premium rates set forth on the Cover Sheet and the UnitedHealthcare Enrollment Packet may be modified by UnitedHealthcare in its sole discretion upon thirty (30) days prior written notice mailed postage prepaid to Group. Any such modification shall take effect commencing the first full month following the expiration of the thirty (30)-day notice period.

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

3.07.02 Modification of Benefits or Terms. The covered services set forth in the Combined Evidence of Coverage and Disclosure Form, the Schedule of Benefits, and the Schedule of Supplemental Benefits in the UnitedHealthcare Enrollment Packet, as well as other terms of this Agreement, may be modified by UnitedHealthcare in its sole discretion upon thirty (30) days written notice mailed postage prepaid to Group. Any such modification shall take effect commencing the first full month following the expiration of the thirty (30)-day notice period.

3.08 Effect of Payment. Except as otherwise provided in this Agreement, only Members for whom Health Plan Premiums are received by UnitedHealthcare are entitled to health care benefits as described in this Agreement, and then only for the period for which such payment is received. Group agrees to pay premium to UnitedHealthcare for the first month of coverage for newborn or adopted children who become eligible as provided in the Combined Evidence of Coverage and Disclosure Form section of this Agreement.

3.09 Continuation of Benefits and Conversion Coverage.

3.09.01 Federal Continuation Coverage. With the exception of Domestic Partners and their Dependents, Group shall operate in accordance with the provision of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended ("COBRA"), and the regulations promulgated thereunder (the "COBRA Regulations"). Accordingly, Group shall establish reasonable procedures for members to notify Group of certain qualifying events, as required by the COBRA Regulations, and shall be solely responsible for receiving such notices from Members. Group shall provide affected Members with written notice of available continuation coverage as required by and in accordance with COBRA and amendments thereto. Group shall be solely responsible for collecting Health Plan Premiums from Members who elect to continue benefits under COBRA and shall transmit such Health Plan Premiums to UnitedHealthcare along with the Group's Health Plan Premiums otherwise due under this Agreement. Group shall

maintain accurate records regarding Health Plan Premiums for Members who elect to continue benefits, including qualifying events, terminating events, and other information necessary to administer this continuation of benefits. The obligations to be performed by Group under this Subsection may be performed directly by Group, or wholly or in part through a subsidiary or affiliate of Group, or on behalf of Group by a third party, including but not limited to a COBRA coverage administrator; provided that Group will remain liable to UnitedHealthcare for satisfaction of the obligations to be performed by Group under this Subsection. UnitedHealthcare is not responsible for the acts or omissions of Group or designee and shall be held harmless for any failure by Group to fulfill its obligations, including but not limited to failure to provide proper notice or failure to forward premium payments to UnitedHealthcare within applicable statutory time frames. Please refer to the Combined Evidence of Coverage and Disclosure form, which sets forth the terms and conditions under which COBRA will be provided to Members.

3.09.02 Notice of Individual Conversion Rights. Within fifteen (15) days after a Member's coverage terminates, Group shall notify the Subscriber on behalf of the Subscriber and his or her Dependents or, if no Subscriber is available, any terminated Dependent, including a Domestic Partner and his or her Dependents of the availability, terms, and individual conversion rights as set forth in the Combined Evidence of Coverage and Disclosure Form.

3.09.03 Uniformed Services Employment and Reemployment Rights Act. Continuation coverage under this Health Plan shall be available to Members through Group under the Uniform Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"). The continuation coverage under this section shall be equal to, and subject to the same limitations as, the benefits provided to other Members regularly enrolled in this Health Plan and shall be made available to eligible Members absent from employment by reason of service in the United States uniformed services. Such coverage, including but not limited to, the maximum 24-month period, will be provided to Members who meet the USERRA requirements. USERRA benefits run concurrently with any benefits that may be available through COBRA. Group is responsible for notifying affected Members of available USERRA continuation coverage and notifying UnitedHealthcare of Members who elect to continue coverage under USERRA. Group is responsible for billing and collecting Health Plan Premiums and maintaining accurate records regarding Health Plan Premiums, qualifying events, terminating events, and any other information that may be necessary for UnitedHealthcare to administer this continuation benefit.

4. BENEFITS AND CONDITIONS FOR COVERAGE

The attached UnitedHealthcare Combined Evidence of Coverage and Disclosure Form, Schedule of Benefits, and additional related attachments included at the end of this Agreement, are an integral part of this Agreement, and include a complete description of the Benefits and Conditions of Coverage of this Health Plan.

5. PARTIES AFFECTED BY THIS AGREEMENT; RELATIONSHIPS BETWEEN PARTIES

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

5.02 Compliance with the Health Insurance Portability and Accountability Act of 1996. UnitedHealthcare agrees to furnish written certification of prior creditable coverage ("Certificates") to all eligible Members, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). UnitedHealthcare and Group acknowledge that UnitedHealthcare's agreement to issue Certificates to all eligible Members relieves Group of its obligation under HIPAA to furnish Certificates. Group acknowledges that UnitedHealthcare must rely completely on eligibility information and data (including, but not limited to, Member's name and current address) furnished by Group in issuing Certificates to Members. Group agrees to notify UnitedHealthcare of all terminations within thirty (30) days of the termination, and to provide UnitedHealthcare with eligibility information and data within thirty (30) days of its receipt or change. Group agrees to indemnify, defend and hold UnitedHealthcare harmless and accept all legal, financial and regulatory responsibility for any liability arising out of UnitedHealthcare's furnishing Certificates to eligible members under HIPAA.

6. TERM OF AGREEMENT; RENEWAL PROVISIONS

6.01 Term; Automatic Renewal. The term of this Agreement shall be one (1) year, commencing on the Group Coverage Effective Date set out in the Cover Sheet, unless otherwise indicated on the Cover Sheet or unless this Agreement is terminated as provided herein. This Agreement shall automatically renew for a one (1) year term on each anniversary of the date of commencement of this Agreement or as indicated on the Cover Sheet, unless terminated as provided herein. Renewal of this Agreement shall be subject to modification of rates and benefits pursuant to Section 3.07.

7. TERMINATION

7.01 Termination by Group. Group may terminate this Agreement by giving a minimum of thirty (30) days written notice of termination to UnitedHealthcare. Group termination must always be effective on the first day of the month. Group shall continue to be liable for Health Plan Premiums for all Members enrolled in this Health Plan

through Group until the date of termination.

7.02 Termination by UnitedHealthcare.

7.02.01 For Nonpayment of Health Plan Premiums. UnitedHealthcare may terminate this Agreement in the event Group or its designee fails to remit Health Plan Premiums in full by the required date to UnitedHealthcare by giving written notice of termination of this Agreement via first class mail to Group. Nonpayment of Health Plan Premiums includes but is not limited to, payments returned due to non-sufficient funds (NSF) and post-dated checks. Such notice shall specify that payment of all unpaid Health Plan Premiums must be received by UnitedHealthcare within fifteen (15) days of the date of issuance of the notice, and that if payment is not received within the fifteen (15) day period, no further notice shall be given, and coverage for all Members enrolled in this Health Plan shall automatically be terminated effective at the end of the month for which Health Plan Premiums have been actually received by UnitedHealthcare, subject to compliance with notice requirements. After the initial issuance of the notice to Group, UnitedHealthcare will send a HIPAA Certificate of Creditable Coverage to the Subscribers, notifying the Subscriber's that their health care coverage and their Dependent's health care coverage under this Plan has terminated effective the first of the month for which Health Plan Premiums were not received. Subscribers and eligible Dependents will be able to elect either UnitedHealthcare's Individual Conversion Plan or HIPAA Guaranteed Issue product effective the first of the month in which the Member loses coverage.

7.02.01.01 Reinstatement Following Non-Payment of Premium. Notwithstanding Section 7.02.01, receipt by UnitedHealthcare of all Health Plan Premium payments then due and owing on or before the succeeding Health Plan Premium payment due date will reinstate this Agreement as though it had never been terminated. However, UnitedHealthcare may, in its discretion, elect not to reinstate this Agreement in any of the following circumstances: (1) the notice of termination states that, if Health Plan Premium payment is not received within fifteen (15) days of issuance of the notice of termination, a new application is required and identifies conditions under which a new agreement will be issued or this Agreement reinstated; (2) if payment of Health Plan Premiums is received by UnitedHealthcare more than fifteen (15) days after the issuance of notice of termination, and the Plan refunds such payment within twenty (20) business days of receipt; or, (3) if payment of Health Plan Premiums is received more than fifteen (15) days after issuance of the notice of termination, and UnitedHealthcare issues to Group, within twenty (20) business days of receipt of such Health Plan Premiums, a new Agreement accompanied by written notice stating clearly those respects in which the new Agreement differs from this Agreement in benefits, coverage or otherwise. In the event UnitedHealthcare receives untimely payments after Group has been terminated, the deposit or application of such funds by UnitedHealthcare does not constitute acceptance of such funds or reinstate group, and such funds may be refunded by UnitedHealthcare at its sole discretion.

7.02.02 Termination for Breach of Material Term. UnitedHealthcare may

terminate this Agreement if Group breaches any material term, covenant or condition of this Agreement and fails to cure such breach within thirty (30) days after UnitedHealthcare sends written notice of such breach. For purposes of this Section 7.02.02, material terms of this Agreement specifically include, but are not limited to, Sections 3.01 and 8.03. UnitedHealthcare's written notice of breach shall make specific reference to Group's action causing such breach. If Group fails to cure its breach subject to UnitedHealthcare's satisfaction within thirty (30) days after UnitedHealthcare sends notice of the breach, UnitedHealthcare may terminate this Agreement at the end of the thirty (30)-day notice period.

7.02.03 For Providing Misleading or Fraudulent Information. UnitedHealthcare may terminate this Agreement thirty (30) days after UnitedHealthcare sends written notice to Group if Group provides materially misleading or fraudulent information to UnitedHealthcare in any Group questionnaires or is aware that materially misleading or fraudulent information has been provided on membership Enrollment forms.

7.02.04 For Ceasing to Meet Group Eligibility Criteria. UnitedHealthcare may terminate Group upon thirty (30) days written notice to Group if Group fails to meet any of the following Group eligibility requirements:

(a) Group fails to maintain active Group Participation percentage of seventy-five percent (75%);

(b) For Subscribers without Dependents, Group fails to maintain a Group Contribution equal to seventy-five percent (75%) of the Health Plan Premium;

(c) For Subscribers with Dependents, Group fails to maintain a Group Contribution equal to the dollar amount of the Group Contribution for Subscribers without Dependents;

(d) Group fails to abide by and enforce the conditions of Subscriber Enrollment set forth in this Agreement.

7.02.05 For Changing the Nature of Group's Business. UnitedHealthcare may terminate Group thirty (30) days after UnitedHealthcare sends written notice to Group if Group materially alters the nature of its business. "Materially Alters," for the purposes of this Section 7.02.05, means a significant change in the business conducted by Group after the commencement of this Agreement.

7.02.06 For Loss of Group's Office Location within Geographic Area of Licensure. UnitedHealthcare may terminate Group if Group no longer maintains an office location within the area in which UnitedHealthcare is licensed as a health care service plan. UnitedHealthcare shall provide Group with thirty (30) days written notice prior to such termination. Group must notify UnitedHealthcare of changes of the Group's office location provided on the Group application within (30) thirty days of the change.

7.03 Return of Prepayment Premium Fees Following Termination. In the event of termination by either UnitedHealthcare (except in the case of fraud or deception in the use of UnitedHealthcare services or facilities, or knowingly permitting such fraud or deception by another) or Group, UnitedHealthcare will, within thirty (30) days, return to Group the pro-rata portion of money paid to UnitedHealthcare which corresponds to any unexpired period for which payment has been received, together with amounts due on claims, if any, less any amounts due to UnitedHealthcare.

8. MISCELLANEOUS PROVISIONS

8.01 Governing Law. This Agreement is subject to the laws of the State of California and the United States of America, including the Knox-Keene Health Care Service Plan Act of 1974, as amended, (codified at Chapter 2.2 of Division 2 of the California Health and Safety Code), and the regulations promulgated thereunder by the California Department of Managed Health Care (codified at Chapter 1 of Division 1 of Title 28 of the California Code of Regulations); the Health Maintenance Organization Act of 1973, as amended, (codified at Subchapter XI of Chapter 6A of Title 42 of the United States Code), and the regulations promulgated thereunder by the Center for Medicare and Medicaid Services (codified at Part 417 of Chapter IV of Title 42 of the Code of Federal Regulations); and, the Employee Retirement Income Security Act of 1974, as amended, (codified at Chapter 18 of Title 29 of the United States Code, and the regulations promulgated thereunder by the United States Department of Labor (codified at Chapter XXV of Title 29 of the Code of Federal Regulations), and the Health Insurance Portability and Accountability Act of 1996, Public law 104-1910 (codified at Section 8.1, title II subtitle F section 261-264). Any provisions required to be in this Agreement by any of the above laws and regulations shall bind UnitedHealthcare, Group and Member whether or not expressly provided in this Agreement.

8.02 UnitedHealthcare Names, Logos and Service Marks. UnitedHealthcare reserves the right to control all use of its name, product names, symbols, logos, trademarks, and service marks currently existing or later established. Group shall not use UnitedHealthcare's name, product names, symbols, logos, trademarks, or service marks without obtaining the prior written approval of UnitedHealthcare.

8.03 Assignment. This Agreement and the rights, interests and benefits hereunder shall not be assigned, transferred, pledged, or hypothecated in any way by either party and shall not be subject to execution, attachment or similar process, nor shall the duties imposed herein be subcontracted or delegated without the approval of the other party. Notwithstanding the above, if UnitedHealthcare assigns, sells or otherwise transfers substantially all of its assets and business to another corporation, firm or person, with or without recourse, this Agreement will continue in full force and effect as if such corporation, firm or person were a party to this Agreement, provided such corporation, firm or person continues to provide prepaid health services.

8.04 Validity. The unenforceability or invalidity of any part of this Agreement shall not affect the enforceability and validity of the balance of this Agreement.

8.05 Confidentiality. UnitedHealthcare agrees to maintain and preserve the confidentiality of any and all medical records of Member in accordance with all applicable state and federal laws. However, Member authorizes the release of information and access to any and all of Member's medical records for purposes of utilization review, quality review, processing of any claim, financial audit, coordination of benefits, or for any other purpose reasonably related to the provision of benefits under this Agreement to UnitedHealthcare, its agents and employees, Member's participating medical group, and appropriate governmental agencies. UnitedHealthcare shall not release any information to Group which would directly or indirectly indicate to the Group that a Member is receiving or has received covered services, unless authorized to do so by the Member.

8.06 Amendments. This Agreement may be modified by UnitedHealthcare as set forth in Section 3.07, above, or it may be amended upon the mutual written consent of the parties.

8.07 Group Use of Administrative Manual. Group agrees to comply with and conform to policies and procedures in the Administrative Manual provided by UnitedHealthcare. UnitedHealthcare agrees to provide thirty (30) days notice to Group of any changes in the Administrative Manual. In the event of conflict between this Agreement and the Administrative Manual, the terms of this Agreement shall prevail.

8.08 Attachments. The Cover Sheet and Attachments to this Agreement, and all terms and conditions set forth therein, as they are from time-to-time amended by parties, are incorporated by reference herein and made an integral part of this Agreement.

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

8.10 Waiver of Default. The waiver by UnitedHealthcare of any one or more defaults by Group or Member shall not be construed as a waiver of any other or future defaults under the same or different terms, conditions or covenants contained in this Agreement.

8.11 Notices. Any notice required or permitted under this Agreement shall be in writing and either delivered personally or by regular, registered, or certified mail, U.S. Postal Service Express Mail, or overnight courier, postage prepaid, or by facsimile transmission at the addresses set forth below:

If to UnitedHealthcare: UnitedHealthcare of California
Attention: President
P.O. Box 6006
Cypress, California 90630-0006

If to Group or Member, at Group's or Member's last address known to UnitedHealthcare.

Any notice sent by registered or certified mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. If sent by regular mail, the notice shall be deemed given forty-eight (48) hours after the notice is addressed and mailed with postage prepaid. Notices delivered by U.S. Postal Service Express mail or overnight courier that guarantees next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the United State Postal Service or courier. If any notice is transmitted by facsimile transmission or similar means, the notice shall be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail.

8.12 Acceptance of Agreement. Group may accept this Agreement either by execution of the Agreement or by making its initial payment to UnitedHealthcare of Health Plan Premiums on or before the due date specified on the Cover Sheet. Member accepts the terms, conditions and provisions of this Agreement upon completion and execution of the Enrollment form. Acceptance by any of these methods shall render all terms and provisions of this Agreement binding on UnitedHealthcare, Group and Members.

8.13 Entire Agreement. This Agreement, including all exhibits, attachments and amendments, contains the entire understanding of Group and UnitedHealthcare with respect to the subject matter hereof and it incorporates all of the covenants, conditions, promises, and agreements exchanged by the parties hereto with respect to such matter. This Agreement supersedes any and all prior or contemporaneous negotiations, agreements, representations, or communications, whether written or oral, between Group and UnitedHealthcare with respect to the subject matter of this Agreement.

8.14 Contracting Provider Termination. UnitedHealthcare will provide written notice to Group within a reasonable time if it receives notice that any contracting provider terminates or breaches its contract with UnitedHealthcare, or is unable to perform such contract, if the termination, breach, or inability to perform may materially and adversely affect Group.

8.15 Headings. The headings of the various sections of this Agreement are inserted merely for the purpose of convenience and do not expressly, or by implication, limit or define or extend the specific terms of the section so designated.

8.16 No Third Party Beneficiaries. Except as otherwise expressly indicated in this Agreement, this Agreement shall not create any rights in any third parties who have not entered into this Agreement, nor shall this Agreement entitle any such third party to enforce any rights or obligations that may be possessed by such third party.

9. ARBITRATION

9.01 Disputes Between Group and UnitedHealthcare. All disputes between Group and UnitedHealthcare shall be resolved by binding arbitration before JAMS, a non-judicial arbitration and mediation service. If the amount at issue is less than $200,000, then the arbitrator will have no jurisdiction to award more than $200,000. The JAMS Comprehensive Arbitration Rules and Procedures ("Rules") in effect at the time a demand for arbitration is made will be applied to the arbitration. The parties will seek to mutually agree on the appointment of an arbitrator; however, if an agreement cannot be reached within thirty (30) days following the date demanding arbitration, the parties will use the arbitrator appointment procedures in the Rules. Arbitration hearings will be held at the neutral administrator's offices in Orange County, California or at another location agreed upon in writing by the parties. Civil discovery may be taken in such arbitration as provided by California law and civil procedure. The arbitrator(s) selected will have the power to control the timing, scope and manner of the taking of discovery and will have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California. This includes, but is not limited to, the imposition of sanctions. The arbitrator(s) will have the power to grant all remedies provided by California law. The arbitrator(s) will prepare in writing an award that includes the legal and factual reasons for the decision. The parties will divide equally the fees and expenses of the arbitrator(s) and the neutral administrator. The arbitrator(s) will not have the power to commit errors of law or legal reasoning, and the award may be vacated or corrected pursuant to California law. The Federal Arbitration Act, 9 U.S.C. §§ 1-16, will also apply to the arbitration.

9.02 Disputes Between Member and UnitedHealthcare.

9.02.01 Member Appeals and Grievances. The attached UnitedHealthcare Combined Evidence of Coverage and Disclosure Form includes a complete description of the UnitedHealthcare appeals and grievance procedures and dispute resolution processes for Members.

9.02.02 Binding Arbitration. Any and all disputes of any kind whatsoever, including, but not limited to, claims for medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered) between Member (including any heirs, successors, or assigns of Member) and UnitedHealthcare except for claims subject to ERISA shall be submitted to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Member and UnitedHealthcare are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and are instead accepting the use of binding arbitration by a single arbitrator in accordance with the Comprehensive Rules of JAMS, and administration of the arbitration shall be performed by JAMS or such other arbitration service as the parties may agree in writing. The parties will endeavor to

mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) days following the date demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Rules will be utilized.

Arbitration hearings shall be held in Orange County, California or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration as provided by California law and the Code of Civil Procedure. The arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies provided by California law. The parties shall divide equally the expenses of JAMS and the arbitrator. In cases of extreme hardship, UnitedHealthcare may assume all or part of the Member's share of the fees and expenses of JAMS and the arbitrator, provided the Member submits a hardship application to JAMS. The approval or denial of the hardship application will be determined solely by JAMS.

The arbitrator shall prepare in writing an award that includes the legal and factual reasons for the decision. The Federal Arbitration Act, 9 U.S.C. §§ 1-16, shall also apply to the arbitration.

9.03 Mandatory Arbitration. Group, Member and UnitedHealthcare agree and understand that any and all disputes, including claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), except for claims subject to ERISA, shall be determined by submission to binding arbitration in accordance with the terms of this Agreement. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Group, Member, and UnitedHealthcare are giving up the constitutional right to have any such dispute decided in a court of law before a jury, and instead is accepting the use of binding arbitration.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement in _____, California, on _____, 20___.

GROUP: _____

BY: _____

NAME: _____

TITLE: _____

DATE: _____

UNITEDHEALTHCARE OF CALIFORNIA

BY: _____

NAME: Steven H. Nelson

TITLE: CEO, West Region

DATE: _____

Administrator: The County Officer or employee with responsibility for administering this Agreement is Janet Parnell, Principal Risk Management Analyst, Human Resources, Risk Management Division, or successor.

Entire Agreement: This document and the documents referred to herein or exhibits hereto are the entire Agreement between the parties and they incorporate or supersede all prior written or oral Agreements or understandings.

Requesting Contract Administrator Concurrence:

By: _____ Dated: 5/26/2011

Janet Parnell
Principal Risk Management Analyst
Human Resources Department, Risk Management Division

Requesting Department Head Concurrence:

By: _____ Dated: 5/26/11

Allyn Buzomi
Director
Human Resources Department