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

612

FROM: Human Resources Department

SUBMITTAL DATE:
August 2, 2011

SUBJECT: 2011 Health Net of California, Inc., Group Services Agreements for the Seniority Plus plans and the Group Medicare Prescription Drug Plan Policy

RECOMMENDED MOTION: That the Board of Supervisors 1) ratify and approve the 2011 Health Net Seniority Plus Group Hospital and Professional Service Agreement, Group Medicare Prescription Drug Plan Policy and Supplement Agreements (Attachments A-C), effective January 1, 2011, to accurately reflect the prescription drug copayments offered to eligible County retirees; 2) ratify and approve the replacement of Health Net Group 69381S (coverage code 1PZD), Group 69381R (coverage code 1Q64), Group N1658R, N5432R (coverage code 1PSW), effective January 1, 2011; 3) ratify and approve the Health Net Group Hospital and Professional Services Agreement and Supplement Agreement (Attachment D), effective January 1, 2011, for retirees who reside in Sutter, California; 4) authorize the Chairperson to sign four (4) copies of the agreements and supplement agreements; and 5) retain one (1) copy of the signed agreements and supplement agreements, and return three (3) copies of the agreements and supplement agreements to Human Resources for distribution.

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

FINANCIAL DATA				
	Current F.Y. Total Cost:	$ 0	In Current Year Budget:	Yes
	Current F.Y. Net County Cost:	$ 0	Budget Adjustment:	No
	Annual Net County Cost:	$ 0	For Fiscal Year:	2010/11

SOURCE OF FUNDS: Retiree Health Insurance Premiums

Positions To Be Deleted Per A-30 ☐

Requires 4/5 Vote ☐

C.E.O. RECOMMENDATION:

APPROVE
BY: Robert Tremaine

County Executive Office Signature

FORM APPROVED COUNTY COUNSEL
BY: TAMMY W. LIEU DATE 8/2/11

Departmental Concurrence

☐ Consent ☒ Policy

☐ Consent ☒ Policy

Dep't Recomm.:

Per Exec. Ofc.:

Prev. Agn. Ref.: 01/25/2011, 3.18 | **District:** All | **Agenda Number:** 3.59

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ATTACHMENTS FILED
WITH THE CLERK OF THE BOARD

BACKGROUND:

On January 25, 2011, Item 3.18, the Board of Supervisors approved the Health Net Seniority Plus and Medicare Coordination of Benefits plans for retirees, effective January 1, 2011. Human Resources has since discovered the Health Net Seniority Plus Group Hospital and Professional Service Agreement and the Medicare Prescription Drug plan were inconsistent with the agreed terms of the retiree prescription drug plan.

In an effort to rectify the error, Health Net assigned new group plan coverage codes to eliminate the 25% co-insurance attached to the prescription drug Tier 4 Injectable Drug and Tier 5 Specialty Drug coverages. The newly assigned group plans replace the prescription drug copayments with flat rates. (Exhibit 1).

The attached agreements listed below are the new Health Net Seniority Plus Group Hospital and Professional Service Agreement and Group Medicare Prescription Drug Plan options for retired members.

- Attachment A:
  Health Net Group Hospital and Professional Service Agreement (Seniority Plus),
  Group#: 69381S, Coverage Code: 1U3I, Plan Code: 3JB Riverside County, and supplement to the Group Hospital and Professional Service Agreement
  Replaces: Group#: 69381S, Coverage Code: 1PZD, Plan Code: 3JB.

- Attachment B:
  Health Net Group Medicare Prescription Drug Plan Policy, Group#: 69381R, Coverage Code: 1U3L, Plan Code: PWE, and supplement to the Group Medicare Prescription Drug Plan Policy
  Replaces: Group#: 69381R, Coverage Code: 1Q64, Plan Code: PCY.

- Attachment C:
  Health Net Group Medicare Prescription Drug Plan Policy,Group#: N1658R, N5432R, Coverage Code: 1U3M, Plan Code: PWF, and supplement to the Group Medicare Prescription Drug Plan Policy
  Replaces: Group#: N1658R, N5432R, Coverage Code: 1PSW, Plan Code: PNF.

In addition, Health Net assigned a new group Seniority Plus Hospital and Professional Service Agreement to reduce disruption of care/services for retirees residing in Sutter, California.

- Attachment D:
  Health Net Group Hospital and Professional Service Agreement (Seniority Plus), Group#: 69381T, Coverage Code: 1UBI, Plan Code: 5SF Sutter, and supplement to the Group Hospital and Professional Service Agreement

There is no direct cost to the County and no change to retiree premium rates for these recommended actions.

Exhibit 1

2011 Health Net of California, Inc.,
Seniority Plus Group Hospital and Professional Service Agreement
and
Group Medicare Prescription Drug Plan Policy

New Prescription Drug Copayment:

Group 69381S, coverage code 1U3I; Group 69381R, coverage code 1U3L;
Group N1658R, N5432R coverage code 1U3M; and Group 69381T, coverage code 1UBI

Drug Tier	Retail Pharmacy (30 day supply)	Retail Pharmacy (90 day supply)	Preferred Mail-Order Pharmacy (90 day supply)	Non-Preferred Mail-Order Pharmacy (90 day supply)	Out of Network Retail Pharmacy (30 day supply)
Tier 1 Preferred Generic Drugs	$10	$30	$20	$30	$10
Tier 2 Preferred Brand Drugs	$25	$75	$50	$75	$25
Tier 3 Non Preferred Drugs	$50	$150	$100	$150	$50
Tier 4 Injectable Drugs	$50	$150	$100	$150	$50
Tier 5 Specialty Drugs	$50	$150	$100	$150	$50

Old Prescription Drug Copayment:

Group 69381S, coverage code 1PZD; Group 69381R, coverage code 1Q64; and Group N1658R, N5432R coverage code 1PSW

Drug Tier	Retail Pharmacy (30 day supply)	Retail Pharmacy (90 day supply)	Preferred Mail-Order Pharmacy (90 day supply)	Non-Preferred Mail-Order Pharmacy (90 day supply)	Out of Network Retail Pharmacy (30 day supply)
Tier 1 Preferred Generic Drugs	$10	$30	$20	$30	$10
Tier 2 Preferred Brand Drugs	$25	$75	$50	$75	$25
Tier 3 Non Preferred Drugs	$50	$150	$100	$150	$50
Tier 4 Injectable Drugs	25%	25%	25%	25%	25%
Tier 5 Specialty Drugs	25%	25%	25%	25%	25%

ATTACHMENT A
Health Net Group Hospital and Professional Service Agreement (Seniority Plus)
Group# 69381S, Coverage Code: 1U3I, Plan Code: 3JB Riverside County of Riverside
and
Supplement to the Group Hospital and Professional Service Agreement

Group Hospital and Professional Service Agreement

Health Net
Seniority Plus

GROUP HOSPITAL AND PROFESSIONAL SERVICE AGREEMENT

ISSUED BY
HEALTH NET

LOS ANGELES, CALIFORNIA

To the extent herein limited and defined, this Agreement provides for comprehensive health services provided through Health Net of California, a federally qualified Health Maintenance Organization and a California Health Care Service Plan, and includes all Medicare Covered Services mandated through a contract between Health Net and the Centers for Medicare & Medicaid Services (CMS).

Upon payment of subscription charges in the amount and manner provided for in this Agreement, Health Net

HEREBY AGREES

to furnish services and benefits as defined in this Agreement to eligible Employees and their eligible Family Members of:

Group Name:	SP: RIVERSIDE COUNTY
Group ID:	69381S
Coverage Code:	1U3I
Plan Code:	3JB

(herein called the "Group")

according to the terms and conditions of this Agreement. Payment of subscription charges by the Group in the amount and manner provided for in the Agreement shall constitute the Group's acceptance of the terms and conditions of the Agreement. This Health Net Group Service Agreement, the "Application for Group Service Agreement," any Health Net Underwriting Assumptions provided to the Group, and the enrollment forms of the Group's eligible employees, and Supplement to Group Hospital and Professional Service Agreement inclusively shall constitute the entire agreement between the parties.

Franklin Tom

Health Net

Steven Sell
President

Franklin Tom

HEALTH NET SENIORITY PLUS (EMPLOYER HMO) GROUP AGREEMENT

Health Net, a Health Care Service Plan licensed by the State of California under the Knox Keene Act, hereby contracts with the Group to provide the Health Net Seniority Plus (Employer HMO) (referred to herein as "Seniority Plus") covered benefits set forth herein and in the attached Evidence of Coverage (hereafter referred to as EOC) to the Members enrolled under this Agreement; subject to the exclusions, limitations, conditions, and other items of this Agreement, including any applicable amendments.

The Members must be entitled to Medicare's Hospital Insurance (Part A) and Supplementary Medical Insurance Plan (Part B) and allow Health Net to provide or arrange for all Part B coverage. CMS will compensate Health Net for each Member who agrees to use Health Net exclusively to obtain Parts A and B Covered Services. If the Member is not entitled to Part A coverage and was a Seniority Plus member prior to 1/1/99, he or she will be required to pay Health Net a subscription charge to obtain coverage of Part A benefits under this EOC. Otherwise, Part A coverage must be arranged through the Member's nearest Medicare office.

The Member agrees to allow Health Net to provide or arrange to provide all Medicare Covered Services through a contracting Physician Group or IPA selected by the Member (except for Emergency, out of area urgently needed services (or, in area under unusual and extraordinary circumstances), or out-of-area Renal Dialysis (kidney)). This Seniority Plus Plan also provides benefits not covered by Medicare under this Agreement and covers Medicare Coinsurance and Copayments. These benefits are provided in return for the payment of subscription charges stated in PART II of this Agreement.

TERM OF AGREEMENT

This Agreement becomes effective on January 1, 2011 at 12:00 a.m. Pacific Time at Los Angeles, California, and will remain in effect for an initial term of twelve consecutive months, subject to the payment of subscription charges as determined by Health Net. Termination or modification shall be effective on the date fixed in the notice. Modification shall not affect the right to benefits provided under this Agreement in connection with any Hospital confinement prior to such date. The Group may terminate this Agreement on 30-days' written notice to Health Net. If this Agreement is terminated by either party, the Medicare Entitled Members will be converted to the Medicare Advantage Seniority Plus Individual Agreement if the Member does not enroll with another Medicare Advantage plan, or submit a request for disenrollment.

Good cause for termination or non-renewal of this Agreement by Health Net shall include:

- Failure of the Group to pay any subscription charges when due,
- Failure of Group to maintain subscription charge contribution requirements as set forth in the application for the Seniority Plus Group Agreement,
- Failure of the Group to maintain at least 15 eligible employees enrolled with Health Net and/or with Health Net Life to be determined annually, 60-days prior to Group's renewal date, with termination effective at the renewal date,
- If Group is enrolled as a guaranteed association, failure of the Group to meet and continue to meet all legal requirements applicable to guaranteed associations; or
- Knowing failure by the Group to abide by and enforce the conditions of enrollment of this Agreement, and any Health Net Underwriting Assumptions provided to the Group
- Termination or not renewing of any other group Agreement in force between the Group and Health Net,
- Fraud or misrepresentation by submission to Health Net by the Group of materially incorrect or incomplete information which is reasonably relied upon by Health Net in issuing or renewing this Agreement and
- A material change in the nature of Group's business. Termination of this Agreement for good cause (other than for non-payment of subscription charges, see PART 2) shall become effective upon 30-days' written notice to the Group.

As with voluntary terminations, if this Group Agreement is terminated for the reasons stated above, then all Medicare Entitled Members who are on said Agreement shall convert to the Medicare Advantage Seniority Plus Individual Agreement.

If this Agreement terminates under its own terms, or is otherwise terminated by either Health Net or the Group, the Group shall promptly mail or hand deliver to each Member covered hereunder a notice of cancellation of this Agreement. The Group shall, upon request by Health Net, provide Health Net with a copy of the notification, a written statement that the notice of cancellation was mailed or hand delivered to each Member and the date of mailing or hand delivery.

SUBSCRIPTION CHARGES

Health Net offers the Members, enrolled under this Agreement, all Medicare benefits through a Medicare Advantage contract between Health Net and the Centers for Medicare & Medicaid Services (CMS). Under the terms of that contract, CMS will pay Health Net a prepaid fee for the Medicare Entitled Members; in return, Health Net has agreed to be the sole provider (with some noted exceptions) of Medicare Services to the Member.

The Group shall pay Health Net monthly subscription charges for benefits, which are not covered by Medicare or for Medicare mandated Coinsurance or Copayments as follows. Such charges shall be calculated by Health Net from current records as to number of Members enrolled. Retroactive payment adjustments will be made in subsequent billings for any additions or deletions of Members not currently reflected in Health Net's records at the time of calculation of subscription charges.

GROUP CHARGES

Monthly Rates for 69381S

Per member: $255.22

The first subscription charges must be paid to Health Net on or before the Effective Date of this Agreement. After that, payment is due on the first of each month while the Agreement is in effect. Group will send payment by wire no later than 45 days of the due date. If payment is not made by the above timeframe, Health Net will send the Group a Prospective Notice of Cancellation 30 business days before any cancellation of coverage. This Prospective Notice of Cancellation will provide the following information (a) that Subscription Charges have not been paid and that the Group Service Agreement will be canceled for non-payment if the required subscription charges are not paid within 30 business days from the date the Prospective Notice of Cancellation was mailed; (b) the specific date and time when coverage for all Members will end if subscription charges are not paid; and (c) how and when the Group can reinstate the Group Service Agreement.

If Health Net does not receive payment of the delinquent subscription charges from the Group within 15 days of the date of mailing of the Prospective Notice of Cancellation, Health Net will cancel the Group Service Agreement retroactively back to 12:00 midnight on the last day of the month for which subscription charges were paid, not to exceed 60 days before the date Health Net mails the Group a Notice Confirming Termination of Coverage. The Notice Confirming Termination of Coverage will provide the Subscriber and the Group with the following information: (1) that the Group Service Agreement has been canceled for non-payment of subscription charges; (2) the specific date and time when your Group coverage ended; (3) to the Group only, how and when coverage may be reinstated; (4) the Health Net telephone number Subscribers can call to obtain additional information, including whether the Group obtained reinstatement of the Group Service Agreement; and (5) an explanation of the Subscriber's options to purchase continuation coverage, (including coverage effective as of the retroactive termination date so the Subscriber can avoid a break in coverage) including (a) the deadline by which the Subscriber must elect to purchase such continuation coverage (which will be 63 days after the date Health Net mails the Subscriber and the Group the Notice Confirming Termination of Coverage); (b) how to obtain the forms necessary to purchase continuation coverage; and (c) referral to Health Net's website for additional information relating to rates and regarding the Subscriber's rights to continuation coverage.

Health Net will allow one reinstatement during any twelve-month period, without a change in subscription charges because of such reinstatement, if the amounts owed are paid within 15 days of the date the Notice of Confirming Termination of Coverage is mailed, including payment of a $100 reinstatement fee. If the Group does not obtain reinstatement of the canceled Group Service Agreement within the required 15 days or if the Group Service Agreement has been previously canceled and reinstated for non-payment of subscription charges within the last twelve months, then Health Net is not required to reinstate the Group Service Agreement, and the Group will need to reapply for coverage. In this case, Health Net may consider the medical conditions of the Group's employees in determining whether to allow enrollment. Amounts received after the termination date will be refunded to the Group by Health Net within 20 business days.

Except as described below, Health Net will not change the subscription charges, applicable Copayments, coinsurance or deductibles for the length of this Agreement, after (1) the Group has delivered notice of acceptance of the Agreement, (2) the start of the Group's Open Enrollment Period or (3) subscription charges for the first month of coverage commencing on the effective date of this Agreement are paid by the Group in the amount and manner provided for in this Agreement.

Health Net may change the subscription charges, applicable Copayments, coinsurance and deductibles under the following circumstances:

- When such changes are authorized or required under this Agreement;
- When agreed to under a preliminary agreement which states that such agreement is subject to execution of a formal agreement between the Group and Health Net; or
- When the terms of this Agreement are altered, in writing, by the consent of both parties.

Any changes to the subscription charges, pursuant to the above stated circumstances, shall be made at renewal with at least a 150-day written notice to the Group prior to the date of such change. Payment of any installment of subscription charges as altered shall constitute acceptance of this change.

If a governmental authority (1) imposes a tax or fee that is computed on subscription charges or (2) requires a change in coverage or administrative practice that increases Health Net's risk, Health Net may amend this Agreement and increase the subscription charges sufficiently to cover the tax, fee, or risk.at renewal of the Agreement, provided that Group receives 150 days written notice and approves of such increase in premiums. If Group approves of the increase in premiums, the effective

date of the increase in premiums shall not be earlier than the date the tax, fee, or required change in coverage or administrative practice is imposed by the governmental authority.

If this Agreement is terminated due to the Group's failure to pay the required subscription charges, then all Medicare Entitled Members shall convert to the Seniority Plus Individual Agreement.

If this Agreement is terminated for any reason, the Group shall be liable for all subscription charges for any time this Agreement is in force during a grace period and any other notice period.

Only Members for whom payment is received by Health Net shall be eligible for services and benefits hereunder and only for the period covered by such payment. If any Member covered hereunder is terminated by Health Net, prepaid subscription charges received on account of the terminated Member or Members applicable to periods after the effective date of termination will be refunded within 30-days and neither Health Net nor any contracting Physician Group has any further liability or responsibility under this Agreement to such terminated Member.

GENERAL PROVISIONS

- FORM OR CONTENT OF AGREEMENT: No agent or employee of Health Net is authorized to change the form or content of this Agreement. Any changes can be made only through an endorsement authorized and signed by an officer of Health Net.
- ENTIRE AGREEMENT: *This Agreement*, the application of the Group, any Health Net Underwriting Assumptions provided to the Group, and the enrollment forms of the Group's eligible employees, and Supplement to Group *Hospital and* Professional Service Agreement,shall constitute the entire Agreement between the parties.".
- CONTINUATION OF MEMBER COVERAGE: Except as otherwise provided herein, Health Net shall not have the right to cancel or terminate any individual Evidence of Coverage issued to any Member while this Agreement remains in force and effect and while said Member remains in an eligible class, as stated in the Evidence of Coverage of the Group, and his or her subscription charges are paid in accordance with the terms of this Agreement.
- CHARTER NOT PART OF AGREEMENT: None of the terms or provisions of the charter, constitution, or by laws of Health Net shall form a part of this Agreement or be used in the defense of any suit hereunder, unless the same is set forth in this Agreement.
- INTERPRETATION OF AGREEMENT: The laws of the United States and the State of California shall be applied to the interpretations of this Agreement.
- RECORDKEEPING: The Group is responsible for keeping records relating to this Agreement. Health Net has the right to inspect and audit those records.
- RELATIONSHIP OF PARTIES: Neither Health Net nor any of its employees or agents are employees or agents of Hospitals of Participating Medical Groups.
- HOLD HARMLESS: Health Net agrees to indemnify and hold harmless Groups and Members for any expense, liability, or claims for eligible services under this Agreement with the exception of any Copayment amounts which may be required as indicated herein.
- NON-DISCRIMINATION: Health Net and Group hereby agree that no person who is otherwise eligible for coverage under this Agreement shall be refused enrollment nor shall their coverage be canceled solely because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or health status.
- MODIFICATIONS TO PLAN AND NOTICE OBLIGATIONS: If the plan is terminated or modified in accordance with the terms and provisions of this Group Service Agreement, including a change or decrease in benefits, Health Net will send notice of such modification or termination to the Group with at least 30 days written notice. Except as required under Section 2 "Subscription Charges" above regarding termination for non-payment, Health Net will not provide notice of such changes to plan Subscribers unless it is required to do so by law. The Group may have obligations under state or federal law to provide notification of these changes to plan Subscribers.
- NOTICE OF CERTAIN EVENTS: *Health Net will give the Group written notice* within a reasonable time of any termination or breach of contract by, or inability to perform of, any participating contracting Provider, if the Group may be materially and adversely affected thereby.

Section-4

COVERAGE FOR DOMESTIC PARTNER

A Member's Domestic Partner is eligible for coverage provided that the partnership meets the Group's domestic partnership eligibility requirements. The Group's eligibility requirements must be compliant with *California law. The Domestic Partner* may enroll on the same basis as the Member in accordance with the terms and conditions of this Agreement that apply generally to the Member under the Plan.

Section-5

COMPLIANCE WITH MEDICARE PART D REGULATIONS IN ADMINISTRATION OF GROUP'S OUTPATIENT PRESCRIPTION DRUG PLAN AS A PART OF THE SENIORITY PLUS PLAN (MA-PD)

A. In accordance with section 1860D-22 ("Part D") of the Social Security Act (the "Act"), Health Net agrees that Group may determine how much of a Member's Part D monthly beneficiary premium it will subsidize, subject to the restrictions set forth below in (1) – (5).

   1. Group can subsidize different amounts for different classes of Members in the Agreement's MA-PD provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried versus hourly). Different classes cannot be based on eligibility for the Low Income Subsidy as defined in 1860D-14 of the Act.
   2. Group cannot vary the premium subsidy for individuals within a given class of Members.
   3. Group cannot charge a Member for prescription drug coverage provided under the Agreement more than the sum of his or her monthly Medicare beneficiary premium attributable to basic prescription drug coverage and 100% of the monthly beneficiary premium attributable to his or her supplemental prescription drug coverage *(if any)*.
   4. For all Members eligible for the Low Income Subsidy, the low income premium subsidy amount will first be used to reduce the portion of the monthly beneficiary premium attributable to basic prescription drug coverage paid by the Member, with any remaining portion of the premium subsidy amount then applied toward the portion of the monthly beneficiary premium attributable to basic prescription drug coverage paid by the Group.
   5. If the low income premium subsidy amount for which a Member is eligible is less than the portion of the monthly beneficiary premium paid by the Member, then the Group shall communicate to the Member the financial consequences for the Member of enrolling in the Group's MA-PD as compared to enrolling in another Part D plan with a monthly beneficiary premium equal to or below the low income premium subsidy amount.

B. When a group utilizes the CMS waiver for enrolling their retirees under a special group enrollment process, Group agrees to notify Members of the Group's intent to enroll them in Health Net's MA-PD and to provide them with all of the information more fully described in the instructions set forth in Chapter 2 of the Medicare Managed Care Manual (Group Enrollment for Employer/Union Sponsored Plans) and as summarized below.

   1. Notify all Members that the Group intends to enroll Members in a MA-PD the Group is offering; and
   2. Inform Members that they may affirmatively opt out of such enrollment; how to accomplish that; and any consequences to Group benefits opting out would bring; and
   3. Provide notice to Members not less than 30 calendar days prior to the effective date of the Members enrollment in the Group sponsored MA-PD; and
   4. Provide Members a summary of benefits offered under the Group sponsored MA-PD, an explanation of how to get *more information about the* MA-PD, and an explanation of how to contact Medicare for information on other Part D options that might be available to the Member; and
   5. Provide required enrollment disclosure information contained within the Centers for Medicare & Medicaid Services (CMS) model enrollment form; and
   6. Provide all the information required for Health Net to submit a complete enrollment request transaction to CMS; and
   7. Provide CMS with any information it has on other insurance coverage for the purpose of coordination of benefits.

C. Group agrees to notify Members of the Group's intent to disenroll Members from the MA-PD and to provide them with all of the information more fully described in the instructions set forth in Chapter 2 of the Medicare Managed Care Manual (Group Enrollment for Employer/Union Sponsored Plans) and as summarized below.

1. Notify all Members that the Group intends to disenroll Members from the Medicare Advantage plan that the Group is offering; and
2. Provide notice to Members not less than 30 calendar days prior to the effective date of the Members disenrollment from the Group sponsored Medicare Advantage plan; and
3. Inform Members how to contact Medicare for information about other Medicare Advantage plan options that might be available to the Member; and
4. Provide all the information required for Health Net to submit a complete disenrollment request transaction to CMS.

BINDING ARBITRATION

Sometimes disputes or disagreements may arise between Group or Members and Health Net regarding the construction, interpretation, performance or breach of this Group *Service Agreement or* regarding other matters relating to or arising out of this Agreement. Health Net uses binding arbitration as the final method for resolving disputes (other than disputes involving Medicare-covered benefits and services), whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved. In addition, disputes with Health Net involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration. **Note that disputes regarding Medicare-covered benefits and services are handled in accordance with Medicare guidelines as discussed in the Evidence of Coverage.**

As a condition to contracting with Health Net, Group and Members agree to submit all disputes they may have with Health Net to final and binding arbitration. Health Net also agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that Group, Members and Health Net are bound to use binding arbitration as the final means of resolving disputes that may arise between them, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to the parties in a court of law will be forfeited by virtue of this agreement to use and be bound by Health Net's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

Health Net's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that the total amount of damages claimed is $200,000 or less, the parties shall, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $200,000. In the event that total amount of damages is over $200,000, the parties shall, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

If the parties fail to reach an agreement during this time frame, then any party may apply to a Court of Competent Jurisdiction for appointment of the arbitrator(s) to hear and decide the matter.

Arbitration can be initiated by submitting a demand for arbitration to Health Net at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

Health Net of California
Attention: Litigation Administrator
PO Box 4504
Woodland Hills, CA 91365-4505

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this Group Service Agreement, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law and stating that the award will be final and binding on all parties except to the extent that state or federal law provide for judicial review of arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees. In *cases of extreme hardship* to a Member, Health Net may assume all or portion of a Member's share of the fees and expenses of the arbitration. Upon written notice by the Member requesting a

hardship application, Health Net will forward the request to an independent professional dispute resolution organization for a determination. Such request for hardship should be submitted to the Litigation Administrator at the address provided above.

Effective July 1, 2002, Members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are not required to submit disputes about certain "adverse benefit determinations" made by Health Net to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by Health Net to deny, reduce, terminate or not pay for all or a part of a benefit. However, you and Health Net may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

Additionally, binding arbitration does not apply to disputes that are subject to the Medicare Appeals process as described in detail in Appendix B and Appendix E of the Evidence of Coverage.

PLAN BENEFITS AND EVIDENCE OF COVERAGE

Health Net will issue and deliver to each Member an Evidence of Coverage (EOC) which will set forth a statement of services and benefits to which Members are entitled and an Identification Card.

The benefits of this plan are set forth commencing on the next page of this Agreement. The language will constitute the EOC.

The parties agree to the terms and conditions of this Agreement, the attached EOC, and all other attachments and exhibits associated with this Agreement.

IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Health Net Group Hospital and Professional Service Agreement.

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

By: _____
Deputy

Date: _____

COUNTY OF RIVERSIDE:

By: _____
Chairman, Board of Supervisors

Date: _____

Approved as to form:

Pamela J. Walls
County Counsel

By: _____
Deputy County Counsel

CONTRACTOR: Health Net Life Insurance Company; a California Corporation

By: Steven Sell

Printed Name: Steven Sell

Title: President

Date: 6-14-11

SUPPLEMENT TO GROUP HOSPITAL AND PROFESSIONAL SERVICE AGREEMENT

BY AND BETWEEN

HEALTH NET OF CALIFORNIA, INC.

AND

COUNTY OF RIVERSIDE

This Supplement to the Group Hospital and Professional Service Agreement ("Supplement") by and between Health Net of California, Inc., a California corporation ("Health Net" or "Contractor"), and County of Riverside, a political subdivision of the State of California ("Group" or "County of Riverside"), becomes effective January 1, 2011 ("Effective Date") at 12:00 a.m. and will remain in effect in for the term of the Group Hospital and Professional Service Agreement.

This Supplement modifies the Group Hospital and Professional Service Agreement with Group ID 69381S Coverage Code: 1U3I ("the Agreement") and does not supersede or modify any terms or provisions of such Agreement, unless specifically stated herein.

NOW, THEREFORE, in consideration of the mutual covenants and promises contained in the Agreement, the Group and Health Net agree to incorporate the following provisions as part of the Agreement:

REQUIRED CONTRACT LANGUAGE

1. Amendments. This Agreement may be modified by Group and Health Net pursuant to mutual written Amendments. Amendments shall require the formal approval of the Board of Supervisors for Group to be effective, except as expressly provided herein.

   Amendments which shall not require the formal approval of the Board of Supervisors to be effective may include, but shall not be limited to amendments of rate adjustment and amendments to the policies and procedures, and/or operations as required by new laws and regulations, or by a court of competent jurisdiction. Such amendments shall be effective upon the date of approval by Group's Assistant CEO/Director of Human Resources.

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

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

If to Group:

County of Riverside, Human Resources
4080 Lemon Street, 7th Floor
Riverside, CA 92501
Attn: Deputy Human Resources Director

If to Contractor:

Health Net of California, Inc.
21281 Burbank Boulevard
Woodland Hills, CA 91367

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

4. Entire Agreement. This Agreement, the application of the Group, any Health Net Underwriting Assumptions provided to the Group, the enrollment forms of the Group's eligible employees, and Supplement to the Agreement contains the entire understanding of Health Net and Group with respect to the subject matter hereof and it incorporates all of the covenants, conditions, promises, and agreements exchanged by the parties hereto with respect to such matter. This Agreement supersedes any and all prior or contemporaneous negotiations, agreements, or communications, whether written or oral, between Health Net and Group with respect to the subject matter of this Agreement.

5. Venue. All actions and proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the state and federal (if permitted by law and a party elects to file an action in federal court) courts located in the County of Riverside, State of California.

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

7. Contractor Responsibility. Health Net shall maintain and provide adequate records and information as reasonably necessary to properly administer the Agreement consistent with state and federal law. Such records shall be retained by Health Net for at least five (5) years from the close of Group's fiscal year in which this Agreement is in effect. This obligation is not terminated upon a termination of the Agreement, whether by rescission or otherwise.

8. Independent Contractor. The relationship between Health Net and Group is an independent contractor relationship. Neither Health Net nor its employee(s) and/or agent(s) shall be considered to be an employee(s), and/or agent(s) of Group. Group nor any employee(s) and/or agent(s) of Group shall be considered to be an employee(s) and/or agent(s) of Health Net. None of the provisions of this

Agreement shall be construed to create a relationship of agency, representation, joint venture, ownership, control or employment between the parties other than that of independent parties contracting for the purposes of effectuating this Agreement.

9. Invalidity and Severability. If any provision of this Agreement is found to be invalid or unenforceable by any court, such provision shall be in effect only to the extent that it is not in contravention of applicable laws without invalidating the remaining provisions hereof.

10. Limitations of Severability. In the event the removal of a provision rendered invalid or unenforceable or declared null and void had the effect of materially altering the obligations of either party in such manner as to cause serious financial hardship to such party, the party so affected shall have the right to terminate this Agreement upon providing thirty (30) days prior written notice to the other party.

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

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

13. Assignment. Neither Party shall, without prior written consent of the other Party, assign any duties or rights under this Agreement. Any assignment in contravention of this paragraph shall constitute a material breach of this Agreement and shall be void.

14. Licenses. Health Net shall maintain any professional licenses required by the laws of the State of California at all times while performing services under this Agreement.

15. Provision of Information. Health Net shall provide Group and/or governmental agencies with such data and other information regarding the rendition of services as may be reasonably requested or as may be otherwise required for compliance with applicable regulatory and disclosure requirements. Health Net shall execute such additional verifications or documents as may be required by law or regulation.

16. Records open for Inspection. All books, records and papers of Health Net or subcontractor of Health Net relating to the performance of this Agreement must be open to inspection and copying during normal business hours by the Group, or state and/or federal regulators. Records shall include, without limitation, Member records (subject to applicable state and federal law governing the confidentiality of medical records), and/or financial records pertaining to the cost of operations and income received for services rendered to Members. Such records shall be made available at all reasonable times upon reasonable request by Group. Health Net or Subcontractor of Health Net shall maintain its books and records in accordance with general standards for books and record keeping.

17. Insurance.

Requirements of Contractor. Without limiting or diminishing Health Net's obligation to indemnify or hold the Group harmless, Health Net shall procure and maintain or cause to be maintained, at its sole cost and expense, the following insurance coverage's during the term of this Agreement.

Workers' Compensation. If Health Net has employees as defined by the State of California, Health Net shall maintain statutory Workers' Compensation Insurance (Coverage A) as prescribed by the laws of the State of California. Policy shall include Employers' Liability (Coverage B) including Occupational Disease with limits not less than $1,000,000 per person per accident. The policy shall be endorsed to waive subrogation in favor of The County of Riverside.

Commercial General Liability. Commercial General Liability insurance coverage, including but not limited to, premises liability, contractual liability, products and completed operations liability, personal and advertising injury and cross liability coverage, covering claims which may arise from or out of Health Net's performance of its obligations hereunder. Policy shall name the County of Riverside, its Agencies, Districts, Special Districts, Court and Departments, their respective directors, officers, Board of Supervisors, employees, elected or appointed officials, agents or representatives as Additional Insured. Policy's limit of liability shall not be less than $1,000,000 per occurrence combined single limit. If such insurance contains a general aggregate limit, it shall apply separately to this agreement or be no less than two (2) times the occurrence limit.

Vehicle Liability. If vehicles or mobile equipment is used in the performance of the obligations under this Agreement, then Health Net shall maintain liability insurance for all owned, non-owned or hired vehicles so used in an amount not less than $1,000,000 per occurrence combined single limit. If such insurance contains a general aggregate limit, it shall apply separately to this agreement or be no less than two (2) times the occurrence limit. Policy shall name the County of Riverside, its Agencies, Districts, Special Districts, Court and Departments, their respective directors, officers, Board of Supervisors, employees, elected or appointed officials, agents or representatives as Additional Insured.

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

General Insurance Provisions - All Lines.

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

2. Health Net's insurance carrier(s) must declare its insurance deductibles or self-insured retentions.

3. Health Net shall cause Health Net's insurance carrier(s) to furnish the County of Riverside with either 1) a properly executed original Certificate(s) of Insurance and copies of Endorsements effecting coverage as required herein. Further, said Certificate(s) and policies of insurance shall contain the covenant of the insurance carrier(s) that endeavor to provide thirty (30) days written notice shall be given to the County of Riverside prior to any material modification, cancellation, expiration or reduction in coverage of such insurance. *Health Net shall not commence operations until the Group has been furnished original Certificate (s) of Insurance and copies of endorsements. An individual authorized by the insurance carrier to do so on its behalf shall sign the original endorsements for each policy and the Certificate of Insurance.*

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

5. The Group's Reserved Rights--Insurance. If, during the term of this Agreement or any extension thereof, there is a material change in the scope of services; or, there is a material change in the equipment to be used in the performance of the scope of work which will add to additional exposures (such as the use of aircraft, watercraft, cranes, etc.); or, the term of this Agreement including any extensions thereof exceeds five (5) years the Group reserves the right to adjust the types of insurance required under this Agreement and the monetary limits of liability for the insurance coverage's currently required herein, if; in the Group Risk Manager's reasonable judgment, the amount or type of insurance carried by Health Net has become inadequate.

6. The insurance requirements contained in this Agreement may be met with a program(s) of self-insurance acceptable to the Group.

18. Hold Harmless/Indemnification.

Health Net shall indemnify and hold harmless Group, its Agencies, Districts, Special Districts and Departments, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives (the "Group's Indemnified Parties") from any liability whatsoever,

including but not limited to, property damage, bodily injury, or death, based or asserted upon any services by Health Net, its directors, officers employees, subcontractors, agents or representatives arising out of or in any way relating to this Agreement. The preceding indemnification provision shall not apply in the event any of the named parties subject to indemnification pursue, alone or in conjunction with other parties, any legal action in court or other jurisdiction against Health Net for any liability whatsoever based upon or asserted upon any services of Health Net, its directors, officers, employees, subcontractors, agents or representatives. Health Net shall defend at its sole expense and pay all costs and fees, including but not limited to, attorney fees, cost of investigation, defense and settlements or awards, on behalf of the Group's Indemnified Parties in any claim or action based upon such liability.

With respect to any action or claim subject to indemnification herein, Health Net shall, at their sole cost, have the right to use counsel of their choice and shall have the right to adjust, settle, or compromise any such action or claim without the prior consent of the Group's Indemnified Parties; provided, however, that any such adjustment, settlement or compromise in no manner whatsoever limits or circumscribes Health Net's obligation to indemnify as set forth herein. Health Net's obligation to indemnify, defend and hold harmless Group shall be subject to Group having given Health Net written notice within a reasonable period of time of the claim or of the commencement of the related action, as the case may be, and information and reasonable assistance, at Health Net's expense, for the defense or settlement thereof.

Health Net's obligations hereunder shall be satisfied when they have provided the Group's Indemnified Parties the appropriate form of dismissal relieving the Group's Indemnified Parties from any liability for the action or claim involved.

The specified insurance limits required in this Agreement shall in no way limit or circumscribe Health Net's obligation to indemnify as set forth herein.

19. Conflicts. In the event of any conflict between the terms of the Supplement, Agreement, the application of the Group, any Health Net Underwriting Assumptions provided to the Group, and the enrollment forms of the Group's eligible employees, such conflict shall be resolved by reference to the document in the following order of priority: the Supplement, then the Agreement, then the application of the Group, then any Health Net Underwriting Assumptions provided to the Group, and then the enrollment forms of the Group's eligible employees. The terms of the above-described document with the higher order of priority shall control with respect to any such conflict.

IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Supplement to the Group Hospital and Professional Service Agreement.

ATTEST:

Clerk of the Board

Kecia Harper-Ihem

By: _____

Deputy

Date: _____

COUNTY OF RIVERSIDE:

By: _____

Chairman, Board of Supervisors

Date: _____

Approved as to form:

Pamela J. Walls

County Counsel

By: _____

Deputy County Counsel

CONTRACTOR: Health Net of California, Inc.,

a California corporation

By: _____

Printed Name: Steven J. Sell

Title: President

Date: 7/27/2011

ATTACHMENT B
Health Net Group Medicare Prescription Drug Plan Policy
Group# 69381R, Coverage Code: 1U3L, Plan Code: PWE
and
Supplement to the Group Medicare Prescription Drug Plan Policy

Group Medicare Prescription Drug Plan Policy

Health Net
Medicare Programs

GROUP MEDICARE PRESCRIPTION DRUG PLAN POLICY

ISSUED BY

HEALTH NET LIFE INSURANCE COMPANY

LOS ANGELES, CALIFORNIA

To the extent herein limited and defined, this Policy provides for a comprehensive prescription drug plans provided through Health Net Life Insurance Company (HNL), and includes Medicare Part D prescription drug coverage mandated through a contract between HNL and the Centers for Medicare & Medicaid Services (CMS).

Upon payment of premiums in the amount and manner provided for in this Policy, Health Net Life Insurance Company.

HEREBY AGREES

to furnish services and benefits as defined in this Policy to eligible Medicare beneficiaries and their eligible Family Member of:

Group Name:	**PDP: RIVERSIDE COUNTY**
Group ID:	**69381R**
Coverage Code:	**1U3L**
Plan Code:	**PWE**

(herein called the "Group")

according to the terms and conditions of this Policy. Payment of premium by the Group in the amount and manner provided for in the Policy shall constitute the Group's acceptance of the terms and conditions of the Policy. This Health Net Life Insurance Company Group Policy, the "Application for Group Service Policy," any Underwriting Assumptions provided to the Group, and the enrollment forms of the Group's eligible Medicare beneficiaries and Supplement Group Medicare Prescription Drug Plan Policy, inclusively s agreement between the parties.

HEALTH NET LIFE INSURANCE COMPANY

Steven Sickle
Secretary

Steven Sell
President

Section-1

TERM OF POLICY

This Policy becomes effective on January 1, 2011 at 12:00 a.m. Pacific Time at Los Angeles, California, and will remain in effect for an initial term of twelve consecutive months, subject to the payment of premiums as determined by HNL. Termination or modification shall be effective on the date fixed in the notice. The Group may terminate this Policy on 30-days' written notice to HNL.

Good cause for termination or non-renewal of this Policy by HNL shall include:

- Failure of the Group to pay any premiums when due;
- Failure of Group to maintain premium contribution requirements as set forth in the application for the Group Policy;
- Failure of the Group to maintain at least 15 eligible employees enrolled with HNL and/or with HNL Life to be determined annually, 60-days prior to Group's renewal date, with termination effective at the renewal date;
- Knowing failure by the Group to abide by and enforce the conditions of enrollment of this Policy, and any Underwriting Assumptions provided to the Group;
- Termination or not renewing of any other group Policy in force between the Group and HNL;
- Fraud or misrepresentation by submission to HNL by the Group of materially incorrect or incomplete information which is reasonably relied upon by HNL in issuing or renewing this Policy; and
- A material change in the nature of Group's business. Termination of this Policy for good cause (other than for non-payment of premiums, see Section 2) shall become effective upon 30-days' written notice to the Group.

As with voluntary terminations, if this Group Policy is terminated for the reasons stated above, then all Medicare Entitled Members who are on said Policy shall convert to the HNL's Medicare Prescription Drug Plan Individual Policy. If this Policy terminates under its own terms, or is otherwise terminated by either HNL or the Group, the Group shall promptly mail or hand deliver to each Member covered hereunder a notice of cancellation of this Policy. The Group shall, upon request by HNL, provide HNL with a copy of the notification, a written statement that the notice of cancellation was mailed or hand delivered to each Member and the date of mailing or hand delivery.

Section-2

PREMIUMS

HNL offers the Members, enrolled under this Policy, Medicare Part D benefits through a contract between HNL and the Centers for Medicare & Medicaid Services (CMS). Under the terms of that contract, CMS will pay HNL a prepaid amount for the Medicare Part D Entitled Members; in return, HNL has agreed to be the sole provider of Prescription Drug benefits to the Member.

The Group shall pay HNL monthly premiums for Prescription Drug benefits as follows. Such charges shall be calculated by HNL from current records as to number of Members enrolled. Retroactive payment adjustments will be made in subsequent billings for any additions or deletions of Members not currently reflected in HNL's records at the time of calculation of premiums.

GROUP CHARGES

Monthly Rates for GROUP #69381R

Per Member: $298.77

The first premiums must be paid to HNL on or before the Effective Date of this Policy. After that, payment is due on the first of each month while the Agreement is in effect. Group will send payment by wire no later than 45 days of the due date. If payment is not made by the timeframe, HNL will send a written notice of termination effective on the last day of the month for which full premiums were paid. If the Group pays the delinquent amount within 30 business days of the date of the notice, this Policy will be reinstated, and the termination notice will be considered canceled.

Except as described below, HNL will not change the premiums, applicable Copayments, coinsurance or Deductibles for the length of this Policy, after (1) the Group has delivered notice of acceptance of the Policy, (2) the start of the Group's Open Enrollment Period or (3) premiums are paid by the Group in the amount and manner provided for in this Policy.

HNL may change the premiums, applicable Copayments, coinsurance and Deductibles under the following circumstances:

- When such changes are authorized or required under this Policy;
- When agreed to under a preliminary agreement which states that such agreement is subject to execution of a formal agreement between the Group and HNL; or
- When the terms of this Policy are altered, in writing, by the consent of both parties.

After this Group Policy has been in effect for at least tweleve consecutive months, any changes to the premiums pursuant to the above stated circumstances, shall be made at renewal with at least a 150-day written notice to the Group prior to the date of such change. Payment of any installment of premiums as altered shall constitute acceptance of this change.

If a governmental authority (1) imposes a tax or fee that is computed on premiums or (2) requires a change in coverage or administrative practice that increases HNL's risk, HNL may amend this Policy and increase the premiums sufficiently to cover the tax, fee, or risk at renewal of the Policy, provided that Group receives 150 days written notice and approves of such increase in premiums. If Group approves of the increase in premiums, the effective date of the increase in premiums shall not be earlier than the date the tax, fee, or required change in coverage or administrative practice is imposed by the governmental authority.

If this Policy is terminated due to the Group's failure to pay the required premiums, then all Medicare Part D Entitled Members shall convert to HNL's Medicare Prescription Drug Plan Individual Policy.

If this Policy is terminated for any reason, the Group shall be liable for all premiums for any time this Policy is in force during a grace period and any other notice period.

Only Members for whom payment is received by HNL shall be eligible for services and benefits hereunder and only for the period covered by such payment. If any Member covered hereunder is terminated by HNL, prepaid premiums received on account of the terminated Member or Members applicable to periods after the effective date of termination will be refunded within 30-days and HNL has any further liability or responsibility under this Policy to such terminated Member.

GENERAL PROVISIONS

- FORM OR CONTENT OF POLICY: No agent or employee of HNL is authorized to change the form or content of this Policy. Any changes can be made only through an endorsement authorized and signed by an officer of HNL.
- ENTIRE POLICY: This Policy, the application of the Group, any HNL Underwriting Assumptions provided to the Group, and the enrollment forms of the Group's eligible Medicare beneficiaries and Supplement Group Medicare Prescription Drug Plan Policy shall constitute the entire Policy between the parties.
- CONTINUATION OF MEMBER COVERAGE: Except as otherwise provided herein, HNL shall not have the right to cancel or terminate any individual Evidence of Coverage issued to any Member while this Policy remains in force and effect and while said Member remains in an eligible class, as stated in the Evidence of Coverage of the Group, and his or her premiums are paid in accordance with the terms of this Policy.
- CHARTER NOT PART OF POLICY: None of the terms or provisions of the charter, constitution, or by laws of HNL shall form a part of this Policy or be used in the defense of any suit hereunder, unless the same is set forth in this Policy.
- INTERPRETATION OF POLICY: The laws of the United States and the State of California shall be applied to the interpretations of this Policy.
- RECORDKEEPING: The Group is responsible for keeping records relating to this Policy. HNL has the right to inspect and audit those records.
- RELATIONSHIP OF PARTIES: Neither HNL nor any of its employees or agents are employees or agents of Hospitals of Participating Medical Groups.
- HOLD HARMLESS: HNL agrees to indemnify and hold harmless Groups and Members for any expense, liability, or claims for eligible services under this Policy with the exception of any Copayment amounts which may be required as indicated herein.
- NON-DISCRIMINATION: HNL and Group hereby agree that no person who is otherwise eligible for coverage under this Policy shall be refused enrollment nor shall their coverage be canceled solely because of *race, color, national origin, ancestry, religion, sex, marital status, sexual orientation,* or health status.
- NOTICE OF CERTAIN EVENTS: HNL will give the Group written notice within a reasonable time if HNL's contract with the Centers of Medicare & Medicaid Services is terminated or if the Group is materially and adversely affected by HNL's exit from a Service Area.

COMPLIANCE WITH MEDICARE PART D REGULATIONS IN ADMINISTRATION OF GROUP'S OUTPATIENT PRESCRIPTION DRUG PLAN (PDP)

In accordance with section 1860D-22 ("Part D") of the Act, HNL agrees that Group may determine how much of a Member's Part D monthly beneficiary premium it will subsidize, subject to the restrictions set forth below in a.–e.

a. Group can subsidize different amounts for different classes of Members in the Policy's PDP provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried versus hourly). Different classes cannot be based on eligibility for the Low Income Subsidy as defined in 1860D-14 of the Act.

b. Group cannot vary the premium subsidy for individuals within a given class of Members.

c. Group cannot charge a Member for prescription drug coverage provided under the Policy more than the sum of his or her monthly Medicare beneficiary premium attributable to basic prescription drug coverage and 100% of the monthly beneficiary premium attributable to his or her supplemental prescription drug coverage (if any).

d. For all Members eligible for the Low Income Subsidy, the low income premium subsidy amount will first be used to reduce the portion of the monthly beneficiary premium attributable to basic prescription drug coverage paid by the Member, with any remaining portion of the premium subsidy amount then applied toward the portion of the monthly beneficiary premium attributable to basic prescription drug coverage paid by the Group.

e. If the low income premium subsidy amount for which a Member is eligible is less than the portion of the monthly beneficiary premium paid by the Member, then the Group shall communicate to the Member the financial consequences for the Member of enrolling in the Group's PDP as compared to enrolling in another Part D plan with a monthly beneficiary premium equal to or below the low income premium subsidy amount.

Group agrees to notify Members of the Group's intent to enroll them in HNL's PDP and to provide them with all of the information more fully described in the instructions set forth in Subchapter 30.1.6 (Group Enrollment for Employer/Union Sponsored PDPs) of the Center for Medicare and Medicaid Services' "PDP Guidance for Eligibility, Enrollment and Disenrollment" finalized August 29, 2005 and as summarized below.

a. Notify all Members that the Group intends to enroll Members in a PDP the Group is offering; and

b. Inform Members that they may affirmatively opt out of such enrollment; how to accomplish that; and any consequences to Group benefits opting out would bring; and

c. Provide notice to Members not less than 30 calendar days prior to the effective date of the Members enrollment in the Group sponsored PDP; and

d. Provide Members a summary of benefits offered under the Group sponsored PDP, an explanation of how to get more information about the PDP, and an explanation of how to contact Medicare for information on other Part D options that might be available to the Member; and

e. Provide required enrollment disclosure information contained within the Centers for Medicare & Medicaid Services (CMS) model enrollment form; and

f. Provide all the information required for HNL to submit a complete enrollment request transaction to CMS; and

g. Provide CMS with any information it has on other insurance coverage for the purpose of coordination of benefits.

Section-5

COVERAGE FOR DOMESTIC PARTNER

A Member's Domestic Partner is eligible for coverage provided that the partnership meets the Group's domestic partnership eligibility requirements. The Group's eligibility requirements must be compliant with California law. The Domestic Partner may enroll on the same basis as the Member in accordance with the terms and conditions of this Agreement that apply generally to the Member under the Plan.

Section-7

BINDING ARBITRATION

Please note that binding arbitration does not apply to disputes that are subject to the Medicare Appeals process as described in detail in Chapter 7 of the Evidence of Coverage.

Sometimes disputes or disagreements may arise between Group or Covered Persons and HNL regarding the construction, interpretation, performance or breach of this Policy, or regarding other matters relating to or arising out of this Policy. HNL uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or

employees, are also involved. In addition, disputes with HNL involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

As a condition to contracting with HNL, Group and Covered Persons agree to submit all disputes they may have with HNL to final and binding arbitration. HNL also agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that Group, Covered Persons and HNL are bound to use binding arbitration as the final means of resolving disputes that may arise between them, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to the parties in a court of law will be forfeited by virtue of this agreement to use and be bound by HNL's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

HNL's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that the total amount of damages claimed is $200,000 or less ($50,000 or less with respect to disputes with HNL involving alleged professional liability or medical malpractice), the parties shall, within 30 days of submission of the demand for arbitration to HNL, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $200,000 or $50,000, whichever is applicable. In the event that total amount of damages is over $200,000 or $50,000, whichever is applicable, the parties shall, within 30 days of submission of the demand for arbitration to HNL, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

If the parties fail to reach an agreement during this time frame, then any party may apply to a Court of Competent Jurisdiction for appointment of the arbitrator(s) to hear and decide the matter.

Arbitration can be initiated by submitting a demand for arbitration to HNL at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

Health Net Life Insurance Company

Attention: Litigation Administrator

PO Box 4504

Woodland Hills, CA 91365-4505

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this Policy, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law, and that award will be final and binding on all parties except to the extent that state or federal law provides for judicial review of arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees.

Effective July 1, 2002, Covered Persons who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are not required to submit disputes about certain "adverse benefit determinations" made by HNL to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by HNL to deny, reduce, terminate or not pay for all or a part of a benefit. However, the Covered Person and HNL may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

PLAN BENEFITS AND EVIDENCE OF COVERAGE

HNL will issue and deliver to each Member an EOC which will set forth a statement of services and benefits to which Members are entitled and an Identification Card.

The benefits of this plan are set forth commencing on the next page of this Policy. The language will constitute the EOC.

The parties agree to the terms and conditions of this Policy, the attached EOC, and all other attachments and exhibits associated with this Policy.

IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Health Net Group Medicare Prescription Drug Plan Policy.

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

By: _____
Deputy

Date: _____

COUNTY OF RIVERSIDE:

By: _____
Chairman, Board of Supervisors

Date: _____

Approved as to form:

Pamela J. Walls
County Counsel

By: _____
Deputy County Counsel

CONTRACTOR: Health Net Life Insurance Company; a California Corporation

By: _____

Printed Name: Steven Sell

Title: President

Date: 6-14-11

SUPPLEMENT TO GROUP MEDICARE PRESCRIPTION DRUG PLAN POLICY

BY AND BETWEEN

HEALTH NET LIFE INSURANCE COMPANY

AND

COUNTY OF RIVERSIDE

This Supplement to the Group Medicare Prescription Drug Plan Policy ("Supplement") by and between Health Net Life Insurance Company, a California corporation ("HNL" or "Contractor"), and County of Riverside, a political subdivision of the State of California ("Group" or "County of Riverside") becomes effective January 1, 2011 ("Effective Date") at 12:00 a.m. and will remain in effect for the term of the Policy.

This Supplement modifies the Group Medicare Prescription Drug Plan Policy with Group ID 69381R, Coverage Code: 1U3L ("the Policy") and does not supersede or modify any terms or provisions of such Policy, unless specifically stated herein.

NOW, THEREFORE, in consideration of the mutual covenants and promises contained in this Supplement, the Group and HNL agree to incorporate the following provisions as part of the Policy:

REQUIRED CONTRACT LANGUAGE

1. Amendments. This Policy may be modified by Group and HNL pursuant to mutual written Amendments. Amendments shall require the formal approval of the Board of Supervisors for Group to be effective, except as expressly provided herein.

   Amendments which shall not require the formal approval of the Board of Supervisors to be effective may include, but shall not be limited to amendments of rate adjustment and amendments to the policies and procedures, and/or operations as required by new laws and regulations, or by a court of competent jurisdiction. Such amendments shall be effective upon the date of approval by Group's Assistant CEO/Director of Human Resources.

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

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

   If to Group:

County of Riverside, Human Resources
4080 Lemon Street, 7th Floor
Riverside, CA 92501
Attn: Deputy Human Resources Director

If to Contractor:

Health Net Life Insurance Company
21281 Burbank Boulevard
Woodland Hills, CA 91367

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

4. EntireAgreement. This Policy, the application of the Group, the enrollment forms of the Group's eligible Medicare beneficiaries, and Supplement to the Policy contains the entire understanding of HNL and Group with respect to the subject matter hereof and it incorporates all of the covenants, conditions, promises, and policy exchanged by the parties hereto with respect to such matter. This Policy supersedes any and all prior or contemporaneous negotiations, policy, or communications, whether written or oral, between HNL and Group with respect to the subject matter of this Policy.

5. Venue. All actions and proceedings arising in connection with this Policy shall be tried and litigated exclusively in the state and federal (if permitted by law and a party elects to file an action in federal court) courts located in the County of Riverside, State of California.

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

7. Contractor Responsibility. HNL shall maintain and provide adequate records and information as reasonably necessary to properly administer the Policy consistent with state and federal law. Such records shall be retained by HNL for at least five (5) years from the close of Group's fiscal year in which this Policy is in effect. This obligation is not terminated upon a termination of the Policy, whether by rescission or otherwise.

8. Independent Contractor. The relationship between HNL and Group is an independent contractor relationship. Neither HNL nor its employee(s) and/or agent(s) shall be considered to be an employee(s), and/or agent(s) of Group. Group nor any employee(s) and/or agent(s) of Group shall be considered to be an employee(s) and/or agent(s) of HNL None of the provisions of this Policy shall be construed to create a relationship of agency, representation, joint venture, ownership, control or employment between the parties other than that of independent parties contracting for the purposes of effectuating this Policy.

9. Invalidity and Severability. If any provision of this Policy is found to be invalid or unenforceable by any court, such provision shall be in effect only to the extent that it is not in contravention of applicable laws without invalidating the remaining provisions hereof.

10. Limitations of Severability. In the event the removal of a provision rendered invalid or unenforceable or declared null and void had the effect of materially altering the obligations of either party in such manner as to cause serious financial hardship to such party, the party so affected shall have the right to terminate this Policy upon providing thirty (30) days prior written notice to the other party.

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

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

13. Assignment. Neither Party shall, without prior written consent of the other Party, assign any duties or rights under this Policy. Any assignment in contravention of this paragraph shall constitute a material breach of this Policy and shall be void.

14. Licenses. HNL shall maintain any professional licenses required by the laws of the State of California at all times while performing services under this Policy.

15. Provision of Information. HNL shall provide Group and/or governmental agencies with such data and other information regarding the rendition of services as may be reasonably requested or as may be otherwise required for compliance with applicable regulatory and disclosure requirements. HNL shall execute such additional verifications or documents as may be required by law or regulation.

16. Records open for Inspection. All books, records and papers of HNL or subcontractor of HNL relating to the performance of this Policy must be open to inspection and copying during normal business hours by the Group, or state and/or federal regulators. Records shall include, without limitation, Member records (subject to applicable state and federal law governing the confidentiality of medical records), and/or financial records pertaining to the cost of operations and income received for services rendered to Members. Such records shall be made available at all reasonable times upon reasonable request by Group. HNL or Subcontractor of HNL shall maintain its books and records in accordance with general standards for books and record keeping.

17. Insurance.

Requirements of Contractor. Without limiting or diminishing HNL's obligation to indemnify or hold the Group harmless, HNL shall procure and maintain or cause to be maintained, at its sole cost and expense, the following insurance coverage's during the term of this Policy.

Workers' Compensation. If HNL has employees as defined by the State of California, HNL shall maintain statutory Workers' Compensation Insurance

(Coverage A) as prescribed by the laws of the State of California. Policy shall include Employers' Liability (Coverage B) including Occupational Disease with limits not less than $1,000,000 per person per accident. The policy shall be endorsed to waive subrogation in favor of The County of Riverside, and, if applicable, to provide a Borrowed Servant/Alternate Employer Endorsement.

Commercial General Liability. Commercial General Liability insurance coverage, including but not limited to, premises liability, contractual liability, products and completed operations liability, personal and advertising injury and cross liability coverage, covering claims which may arise from or out of HNL's performance of its obligations hereunder. Policy shall name the County of Riverside, its Agencies, Districts, Special Districts, Court and Departments, their respective directors, officers, Board of Supervisors, employees, elected or appointed officials, agents or representatives as Additional Insured. Policy's limit of liability shall not be less than $1,000,000 per occurrence combined single limit. If such insurance contains a general aggregate limit, it shall apply separately to this Policy or be no less than two (2) times the occurrence limit.

Vehicle Liability. If vehicles or mobile equipment is used in the performance of the obligations under this Policy, then HNL shall maintain liability insurance for all owned, non-owned or hired vehicles so used in an amount not less than $1,000,000 per occurrence combined single limit. If such insurance contains a general aggregate limit, it shall apply separately to this policy or be no less than two (2) times the occurrence limit. Policy shall name the County of Riverside, its Agencies, Districts, Special Districts, Court and Departments, their respective directors, officers, Board of Supervisors, employees, elected or appointed officials, agents or representatives as Additional Insured.

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

General Insurance Provisions - All Lines.

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

2. HNL's insurance carrier(s) must declare its insurance deductibles or self-insured retentions.

3. HNL shall cause HNL insurance carrier(s) to furnish the County of Riverside with either 1) a properly executed original Certificate(s) of Insurance and copies of Endorsements effecting coverage as required herein. Further, said Certificate(s) and policies of insurance shall contain the covenant of the insurance carrier(s) that endeavor to provide thirty (30) days written notice shall be given to the County of Riverside prior to any material modification, cancellation, expiration or reduction in coverage of such insurance. *HNL shall not commence operations until the Group has been furnished original Certificate (s) of Insurance and copies of endorsements. An individual authorized by the insurance carrier to do so on its behalf shall sign the original endorsements for each policy and the Certificate of Insurance.*

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

5. The Group's Reserved Rights--Insurance. If, during the term of this Policy or any extension thereof, there is a material change in the scope of services; or, there is a material change in the equipment to be used in the performance of the scope of work which will add to additional exposures (such as the use of aircraft, watercraft, cranes, etc.); or, the term of this Policy including any extensions thereof exceeds five (5) years the Group reserves the right to adjust the types of insurance required under this Policy and the monetary limits of liability for the insurance coverage's currently required herein, if; in the Group Risk Manager's reasonable judgment, the amount or type of insurance carried by HNL has become inadequate.

6. The insurance requirements contained in this Policy may be met with a program(s) of self-insurance acceptable to the Group.

18. Hold Harmless/Indemnification.

HNL shall indemnify and hold harmless Group, its Agencies, Districts, Special Districts and Departments, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives (the "Group's Indemnified Parties") from any liability whatsoever, including but not limited to, property damage, bodily injury, or death, based or asserted upon any services by HNL, its directors, officers employees, subcontractors, agents or representatives arising out of or in any way relating to this Policy. The preceding indemnification provision shall not apply in the event any of the named parties subject to indemnification pursue, alone or in conjunction with other parties, any legal action in court or other jurisdiction against HNL for any liability whatsoever based upon or asserted upon any services of HNL, its directors, officers, employees, subcontractors, agents or representatives. HNL shall defend at its sole expense and pay all costs and fees, including but not limited to, attorney fees, cost of investigation, defense and settlements or awards, on behalf of the Group's Indemnified Parties in any claim or action based upon such liability.

With respect to any action or claim subject to indemnification herein, Health Net shall, at their sole cost, have the right to use counsel of their choice and shall have the right to adjust, settle, or compromise any such action or claim without the prior consent of the Group's Indemnified Parties; provided, however, that any such adjustment, settlement or compromise in no manner whatsoever limits or circumscribes HNL's obligation to indemnify as set forth herein. HNL's obligation to indemnify, defend and hold harmless Group shall be subject to Group having given HNL written notice within a reasonable period of time of the claim or of the commencement of the related action, as the case may be, and information and reasonable assistance, at HNL's expense, for the defense or settlement thereof.

HNL's obligations hereunder shall be satisfied when they have provided the Group's Indemnified Parties the appropriate form of dismissal relieving the Group's Indemnified Parties from any liability for the action or claim involved.

The specified insurance limits required in this Policy shall in no way limit or circumscribe HNL's obligation to indemnify as set forth herein.

19. Conflicts. In the event of any conflict between the terms of the Supplement, Policy, the application of the Group, and the enrollment forms of the Group's eligible Medicare beneficiaries, such conflict shall be resolved by reference to the document in the following order of priority: the Supplement, then the Policy, then the application of the Group, and then the enrollment forms of the Group's eligible Medicare beneficiaries. The terms of the above-described document with the higher order of priority shall control with respect to any such conflict.

IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Supplement to Group Medicare Prescription Drug Plan Policy.

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

By: _____
Deputy

Date: _____

COUNTY OF RIVERSIDE:

By: _____
Chairman, Board of Supervisors

Date: _____

Approved as to form:
Pamela J. Walls
County Counsel

By: _____
Deputy County Counsel

CONTRACTOR: Health Net Life Insurance Company, a California Corporation

By: _____

Printed Name: Steven J. Sell

Title: President

Date: 7/27/2011

ATTACHMENT C
Health Net Group Medicare Prescription Drug Plan Policy
Group# N1658R, N5432R, Coverage Code: 1U3M, Plan Code: PWF
and
Supplement to the Group Medicare Prescription Drug Plan Policy

Group Medicare Prescription Drug Plan Policy

Health Net
Medicare Programs

GROUP MEDICARE PRESCRIPTION DRUG PLAN POLICY

ISSUED BY

HEALTH NET LIFE INSURANCE COMPANY

LOS ANGELES, CALIFORNIA

To the extent herein limited and defined, this Policy provides for a comprehensive prescription drug plans provided through Health Net Life Insurance Company (HNL), and includes Medicare Part D prescription drug coverage mandated through a contract between HNL and the Centers for Medicare & Medicaid Services (CMS).

Upon payment of premiums in the amount and manner provided for in this Policy, Health Net Life Insurance Company.

HEREBY AGREES

to furnish services and benefits as defined in this Policy to eligible Medicare beneficiaries and their eligible Family Member of:

Group Name:	**PDP: RIVERSIDE COUNTY**
Group ID:	**N1658R, N5432R**
Coverage Code:	**1U3M**
Plan Code:	**PWF**

(herein called the "Group")

according to the terms and conditions of this Policy. Payment of premium by the Group in the amount and manner provided for in the Policy shall constitute the Group's acceptance of the terms and conditions of the Policy. This Health Net Life Insurance Company Group Policy, the "Application for Group Service Policy," any Underwriting Assumptions provided to the Group, and the enrollment forms of the Group's eligible Medicare beneficiaries, and Supplement to Group Medicare Prescription Drug Plan Policy, inclusively shall constitute the entire agreement between the parties.

HEALTH NET LIFE INSURANCE COMPANY

Steven Sickle
Secretary

President

TERM OF POLICY

This Policy becomes effective on January 1, 2011 at 12:00 a.m. Pacific Time at Los Angeles, California, and will remain in effect for an initial term of twelve consecutive months, subject to the payment of premiums as determined by HNL. Termination or modification shall be effective on the date fixed in the notice. The Group may terminate this Policy on 30-days' written notice to HNL.

Good cause for termination or non-renewal of this Policy by HNL shall include:

- Failure of the Group to pay any premiums when due;
- Failure of Group to maintain premium contribution requirements as set forth in the application for the Group Policy;
- Failure of the Group to maintain at least 15 eligible employees enrolled with HNL and/or with HNL Life to be determined annually, 60-days prior to Group's renewal date, with termination effective at the renewal date;
- Knowing failure by the Group to abide by and enforce the conditions of enrollment of this Policy, and any Underwriting Assumptions provided to the Group;
- Termination or not renewing of any other group Policy in force between the Group and HNL;
- Fraud or misrepresentation by submission to HNL by the Group of materially incorrect or incomplete information which is reasonably relied upon by HNL in issuing or renewing this Policy; and
- A material change in the nature of Group's business. Termination of this Policy for good cause (other than for non-payment of premiums, see Section 2) shall become effective upon 30-days' written notice to the Group.

As with voluntary terminations, if this Group Policy is terminated for the reasons stated above, then all Medicare Entitled Members who are on said Policy shall convert to the HNL's Medicare Prescription Drug Plan Individual Policy. If this Policy terminates under its own terms, or is otherwise terminated by either HNL or the Group, the Group shall promptly mail or hand deliver to each Member covered hereunder a notice of cancellation of this Policy. The Group shall, upon request by HNL, provide HNL with a copy of the notification, a written statement that the notice of cancellation was mailed or hand delivered to each Member and the date of mailing or hand delivery.

PREMIUMS

HNL offers the Members, enrolled under this Policy, Medicare Part D benefits through a contract between HNL and the Centers for Medicare & Medicaid Services (CMS). Under the terms of that contract, CMS will pay HNL a prepaid amount for the Medicare Part D Entitled Members; in return, HNL has agreed to be the sole provider of Prescription Drug benefits to the Member.

The Group shall pay HNL monthly premiums for Prescription Drug benefits as follows. Such charges shall be calculated by HNL from current records as to number of Members enrolled. Retroactive payment adjustments will be made in subsequent billings for any additions or deletions of Members not currently reflected in HNL's records at the time of calculation of premiums.

GROUP CHARGES

Monthly Rates for GROUP N1658R

Per Member: $471.74

Monthly Rates for GROUP N5432R

Per Member: $442.85

The first premiums must be paid to HNL on or before the Effective Date of this Policy. After that, payment is due on the first of each month while the Policy is in effect. If payment is not made by the due date or within the 45 day grace period, HNL will send a written notice of termination effective on the last day of the month for which full premiums were paid. If the Group pays the delinquent amount within 15 days of the date of the notice, this Policy will be reinstated, and the termination notice will be considered canceled.

Except as described below, HNL will not change the premiums, applicable Copayments, coinsurance or Deductibles for the length of this Policy, after (1) the Group has delivered notice of acceptance of the Policy, (2) the start of the Group's Open Enrollment Period or (3) premiums are paid by the Group in the amount and manner provided for in this Policy.

HNL may change the premiums, applicable Copayments, coinsurance and Deductibles under the following circumstances:

- When such changes are authorized or required under this Policy;
- When agreed to under a preliminary agreement which states that such agreement is subject to execution of a formal agreement between the Group and HNL; or
- When the terms of this Policy are altered, in writing, by the consent of both parties.

Any changes to the premiums, pursuant to the above stated circumstances, shall be made at renewal with at least a 150-day written notice to the Group prior to the date of such change. Payment of any installment of premiums as altered shall constitute acceptance of this change.

If a governmental authority (1) imposes a tax or fee that is computed on premiums or (2) requires a change in coverage or administrative practice that increases HNL's risk, HNL may amend this Policy and increase the premiums sufficiently to cover the tax, fee, or risk at renewal of the Policy, provided that Group receives 150 days written notice and approves of such increase in premiums. If Group approves of the increase in premiums, the effective date of the increase in premiums shall not be earlier than the date the tax, fee, or required change in coverage or administrative practice is imposed by the governmental authority.

If this Policy is terminated due to the Group's failure to pay the required premiums, then all Medicare Part D Entitled Members shall convert to HNL's Medicare Prescription Drug Plan Individual Policy.

If this Policy is terminated for any reason, the Group shall be liable for all premiums for any time this Policy is in force during a grace period and any other notice period.

Only Members for whom payment is received by HNL shall be eligible for services and benefits hereunder and only for the period covered by such payment. If any Member covered hereunder is terminated by HNL, prepaid premiums received on account of the terminated Member or Members applicable to periods after the effective date of termination will be refunded within 30-days and HNL has any further liability or responsibility under this Policy to such terminated Member.

GENERAL PROVISIONS

- FORM OR CONTENT OF POLICY: No agent or employee of HNL is authorized to change the form or content of this Policy. Any changes can be made only through an endorsement authorized and signed by an officer of HNL.
- ENTIRE POLICY: This Policy, the application of the Group, any HNL Underwriting Assumptions provided to the Group, and the enrollment forms of the Group's eligible Medicare beneficiaries, and Supplement to Group Medicare Prescription Drug Plan Policy, shall constitute the entire Policy between the parties.
- CONTINUATION OF MEMBER COVERAGE: Except as otherwise provided herein, HNL shall not have the right to cancel or terminate any individual Evidence of Coverage issued to any Member while this Policy remains in force and effect and while said Member remains in an eligible class, as stated in the Evidence of Coverage of the Group, and his or her premiums are paid in accordance with the terms of this Policy.
- CHARTER NOT PART OF POLICY: None of the terms or provisions of the charter, constitution, or by laws of HNL shall form a part of this Policy or be used in the defense of any suit hereunder, unless the same is set forth in this Policy.
- INTERPRETATION OF POLICY: The laws of the United States and the State of California shall be applied to the interpretations of this Policy.
- RECORDKEEPING: The Group is responsible for keeping records relating to this Policy. HNL has the right to inspect and audit those records.
- RELATIONSHIP OF PARTIES: Neither HNL nor any of its employees or agents are employees or agents of Hospitals of Participating Medical Groups.
- HOLD HARMLESS: HNL agrees to indemnify and hold harmless Groups and Members for any expense, liability, or claims for eligible services under this Policy with the exception of any Copayment amounts which may be required as indicated herein.
- NON-DISCRIMINATION: HNL and Group hereby agree that no person who is otherwise eligible for coverage under this Policy shall be refused enrollment nor shall their coverage be canceled solely because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or health status.
- NOTICE OF CERTAIN EVENTS: HNL will give the Group written notice within a reasonable time if HNL's contract with the Centers of Medicare & Medicaid Services is terminated or if the Group is materially and adversely affected by HNL's exit from a Service Area.

COMPLIANCE WITH MEDICARE PART D REGULATIONS IN ADMINISTRATION OF GROUP'S OUTPATIENT PRESCRIPTION DRUG PLAN (PDP)

In accordance with section 1860D-22 ("Part D") of the Act, HNL agrees that Group may determine how much of a Member's Part D monthly beneficiary premium it will subsidize, subject to the restrictions set forth below in a.–e.

a. Group can subsidize different amounts for different classes of Members in the Policy's PDP provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried versus hourly). Different classes cannot be based on eligibility for the Low Income Subsidy as defined in 1860D-14 of the Act.

b. Group cannot vary the premium subsidy for individuals within a given class of Members.

c. Group cannot charge a Member for prescription drug coverage provided under the Policy more than the sum of his or her monthly Medicare beneficiary premium attributable to basic prescription drug coverage and 100% of the monthly beneficiary premium attributable to his or her supplemental prescription drug coverage (if any).

d. For all Members eligible for the Low Income Subsidy, the low income premium subsidy amount will first be used to reduce the portion of the monthly beneficiary premium attributable to basic prescription drug coverage paid by the Member, with any remaining portion of the premium subsidy amount then applied toward the portion of the monthly beneficiary premium attributable to basic prescription drug coverage paid by the Group.

e. If the low income premium subsidy amount for which a Member is eligible is less than the portion of the monthly beneficiary premium paid by the Member, then the Group shall communicate to the Member the financial consequences for the Member of enrolling in the Group's PDP as compared to enrolling in another Part D plan with a monthly beneficiary premium equal to or below the low income premium subsidy amount.

Group agrees to notify Members of the Group's intent to enroll them in HNL's PDP and to provide them with all of the information more fully described in the instructions set forth in Subchapter 30.1.6 (Group Enrollment for Employer/Union Sponsored PDPs) of the Center for Medicare and Medicaid Services' "PDP Guidance for Eligibility, Enrollment and Disenrollment" finalized August 29, 2005 and as summarized below.

a. Notify all Members that the Group intends to enroll Members in a PDP the Group is offering; and

b. Inform Members that they may affirmatively opt out of such enrollment; how to accomplish that; and any consequences to Group benefits opting out would bring; and

c. Provide notice to Members not less than 30 calendar days prior to the effective date of the Members enrollment in the Group sponsored PDP; and

d. Provide Members a summary of benefits offered under the Group sponsored PDP, an explanation of how to get more information about the PDP, and an explanation of how to contact Medicare for information on other Part D options that might be available to the Member; and

e. Provide required enrollment disclosure information contained within the Centers for Medicare & Medicaid Services (CMS) model enrollment form; and

f. Provide all the information required for HNL to submit a complete enrollment request transaction to CMS; and

g. Provide CMS with any information it has on other insurance coverage for the purpose of coordination of benefits.

Section-5

COVERAGE FOR DOMESTIC PARTNER

A Member's Domestic Partner is eligible for coverage provided that the partnership meets the Group's domestic partnership eligibility requirements. The Group's eligibility requirements must be compliant with California law. The Domestic Partner may enroll on the same basis as the Member in accordance with the terms and conditions of this Agreement that apply generally to the Member under the Plan.

Section-7

BINDING ARBITRATION

Please note that binding arbitration does not apply to disputes that are subject to the Medicare Appeals process as described in detail in Chapter 7 of the Evidence of Coverage.

Sometimes disputes or disagreements may arise between Group or Covered Persons and HNL regarding the construction, interpretation, performance or breach of this Policy, or regarding other matters relating to or arising out of this Policy. HNL uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or

employees, are also involved. In addition, disputes with HNL involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

As a condition to contracting with HNL, Group and Covered Persons agree to submit all disputes they may have with HNL to final and binding arbitration. HNL also agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that Group, Covered Persons and HNL are bound to use binding arbitration as the final means of resolving disputes that may arise between them, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to the parties in a court of law will be forfeited by virtue of this agreement to use and be bound by HNL's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

HNL's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that the total amount of damages claimed is $200,000 or less ($50,000 or less with respect to disputes with HNL involving alleged professional liability or medical malpractice), the parties shall, within 30 days of submission of the demand for arbitration to HNL, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $200,000 or $50,000, whichever is applicable. In the event that total amount of damages is over $200,000 or $50,000, whichever is applicable, the parties shall, within 30 days of submission of the demand for arbitration to HNL, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

If the parties fail to reach an agreement during this time frame, then any party may apply to a Court of Competent Jurisdiction for appointment of the arbitrator(s) to hear and decide the matter.

Arbitration can be initiated by submitting a demand for arbitration to HNL at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

Health Net Life Insurance Company

Attention: Litigation Administrator

PO Box 4504

Woodland Hills, CA 91365-4505

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this Policy, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law, and that award will be final and binding on all parties except to the extent that state or federal law provides for judicial review of arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees.

Effective July 1, 2002, Covered Persons who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are not required to submit disputes about certain "adverse benefit determinations" made by HNL to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by HNL to deny, reduce, terminate or not pay for all or a part of a benefit. However, the Covered Person and HNL may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

PLAN BENEFITS AND EVIDENCE OF COVERAGE

HNL will issue and deliver to each Member an EOC which will set forth a statement of services and benefits to which Members are entitled and an Identification Card.

The benefits of this plan are set forth commencing on the next page of this Policy. The language will constitute the EOC.

The parties agree to the terms and conditions of this Policy, the attached EOC, and all other attachments and exhibits associated with this Policy.

IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Health Net Group Medicare Prescription Drug Plan Policy.

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

By: _____
Deputy

Date: _____

COUNTY OF RIVERSIDE:

By: _____
Chairman, Board of Supervisors

Date: _____

Approved as to form:

Pamela J. Walls
County Counsel

By: _____
Deputy County Counsel

CONTRACTOR: Health Net Life Insurance Company; a California Corporation

By: _____

Printed Name: Steven Sell

Title: President

Date: 6-14-11

SUPPLEMENT TO GROUP MEDICARE PRESCRIPTION DRUG PLAN POLICY

BY AND BETWEEN

HEALTH NET LIFE INSURANCE COMPANY

AND

COUNTY OF RIVERSIDE

This Supplement to the Group Medicare Prescription Drug Plan Policy ("Supplement") by and between Health Net Life Insurance Company, a California corporation ("HNL" or "Contractor"), and County of Riverside, a political subdivision of the State of California ("Group" or "County of Riverside") becomes effective January 1, 2011 ("Effective Date") at 12:00 a.m. and will remain in effect for the term of the Policy.

This Supplement modifies the Group Medicare Prescription Drug Plan Policy with Group ID N1658R, N5432R Coverage Code 1U3M ("the Policy") and does not supersede or modify any terms or provisions of such Policy, unless specifically stated herein.

NOW, THEREFORE, in consideration of the mutual covenants and promises contained in this Supplement, the Group and HNL agree to incorporate the following provisions as part of the Policy:

REQUIRED CONTRACT LANGUAGE

1. Amendments. This Policy may be modified by Group and HNL pursuant to mutual written Amendments. Amendments shall require the formal approval of the Board of Supervisors for Group to be effective, except as expressly provided herein.

   Amendments which shall not require the formal approval of the Board of Supervisors to be effective may include, but shall not be limited to amendments of rate adjustment and amendments to the policies and procedures, and/or operations as required by new laws and regulations, or by a court of competent jurisdiction. Such amendments shall be effective upon the date of approval by Group's Assistant CEO/Director of Human Resources.

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

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

If to Group:

County of Riverside, Human Resources
4080 Lemon Street, 7th Floor
Riverside, CA 92501
Attn: Deputy Human Resources Director

If to Contractor:

Health Net Life Insurance Company
21281 Burbank Boulevard
Woodland Hills, CA 91367

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

4. Entire Agreement. This Policy, the application of the Group, any HNL Underwriting Assumptions provided to Group, the enrollment forms of the Group's eligible Medicare beneficiaries, and Supplement to the Policy contains the entire understanding of HNL and Group with respect to the subject matter hereof and it incorporates all of the covenants, conditions, promises, and policy exchanged by the parties hereto with respect to such matter. This Policy supersedes any and all prior or contemporaneous negotiations, policy, or communications, whether written or oral, between HNL and Group with respect to the subject matter of this Policy.

5. Venue. All actions and proceedings arising in connection with this Policy shall be tried and litigated exclusively in the state and federal (if permitted by law and a party elects to file an action in federal court) courts located in the County of Riverside, State of California.

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

7. Contractor Responsibility. HNL shall maintain and provide adequate records and information as reasonably necessary to properly administer the Policy consistent with state and federal law. Such records shall be retained by HNL for at least five (5) years from the close of Group's fiscal year in which this Policy is in effect. This obligation is not terminated upon a termination of the Policy, whether by rescission or otherwise.

8. Independent Contractor. The relationship between HNL and Group is an independent contractor relationship. Neither HNL nor its employee(s) and/or agent(s) shall be considered to be an employee(s), and/or agent(s) of Group. Group nor any employee(s) and/or agent(s) of Group shall be considered to be an employee(s) and/or agent(s) of HNL None of the provisions of this Policy shall be construed to create a relationship of agency, representation, joint venture,

ownership, control or employment between the parties other than that of independent parties contracting for the purposes of effectuating this Policy.

9. Invalidity and Severability. If any provision of this Policy is found to be invalid or unenforceable by any court, such provision shall be in effect only to the extent that it is not in contravention of applicable laws without invalidating the remaining provisions hereof.

10. Limitations of Severability. In the event the removal of a provision rendered invalid or unenforceable or declared null and void had the effect of materially altering the obligations of either party in such manner as to cause serious financial hardship to such party, the party so affected shall have the right to terminate this Policy upon providing thirty (30) days prior written notice to the other party.

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

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

13. Assignment. Neither Party shall, without prior written consent of the other Party, assign any duties or rights under this Policy. Any assignment in contravention of this paragraph shall constitute a material breach of this Policy and shall be void.

14. Licenses. HNL shall maintain any professional licenses required by the laws of the State of California at all times while performing services under this Policy.

15. Provision of Information. HNL shall provide Group and/or governmental agencies with such data and other information regarding the rendition of services as may be reasonably requested or as may be otherwise required for compliance with applicable regulatory and disclosure requirements. HNL shall execute such additional verifications or documents as may be required by law or regulation.

16. Records open for Inspection. All books, records and papers of HNL or subcontractor of HNL relating to the performance of this Policy must be open to inspection and copying during normal business hours by the Group, or state and/or federal regulators. Records shall include, without limitation, Member records (subject to applicable state and federal law governing the confidentiality of medical records), and/or financial records pertaining to the cost of operations and income received for services rendered to Members. Such records shall be made available at all reasonable times upon reasonable request by Group. HNL or Subcontractor of HNL shall maintain its books and records in accordance with general standards for books and record keeping.

17. Insurance.

Requirements of Contractor. Without limiting or diminishing HNL's obligation to indemnify or hold the Group harmless, HNL shall procure and maintain or cause to be maintained, at its sole cost and expense, the following insurance coverage's during the term of this Policy.

Workers' Compensation. If HNL has employees as defined by the State of California, HNL shall maintain statutory Workers' Compensation Insurance (Coverage A) as prescribed by the laws of the State of California. Policy shall include Employers' Liability (Coverage B) including Occupational Disease with limits not less than $1,000,000 per person per accident. The policy shall be endorsed to waive subrogation in favor of The County of Riverside, and, if applicable, to provide a Borrowed Servant/Alternate Employer Endorsement.

Commercial General Liability. Commercial General Liability insurance coverage, including but not limited to, premises liability, contractual liability, products and completed operations liability, personal and advertising injury and cross liability coverage, covering claims which may arise from or out of HNL's performance of its obligations hereunder. Policy shall name the County of Riverside, its Agencies, Districts, Special Districts, Court and Departments, their respective directors, officers, Board of Supervisors, employees, elected or appointed officials, agents or representatives as Additional Insured. Policy's limit of liability shall not be less than $1,000,000 per occurrence combined single limit. If such insurance contains a general aggregate limit, it shall apply separately to this Policy or be no less than two (2) times the occurrence limit.

Vehicle Liability. If vehicles or mobile equipment is used in the performance of the obligations under this Policy, then HNL shall maintain liability insurance for all owned, non-owned or hired vehicles so used in an amount not less than $1,000,000 per occurrence combined single limit. If such insurance contains a general aggregate limit, it shall apply separately to this policy or be no less than two (2) times the occurrence limit. Policy shall name the County of Riverside, its Agencies, Districts, Special Districts, Court and Departments, their respective directors, officers, Board of Supervisors, employees, elected or appointed officials, agents or representatives as Additional Insured.

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

General Insurance Provisions - All Lines.

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

2. HNL's insurance carrier(s) must declare its insurance deductibles or self-insured retentions.

3. HNL shall cause HNL insurance carrier(s) to furnish the County of Riverside with either 1) a properly executed original Certificate(s) of Insurance and copies of Endorsements effecting coverage as required herein. Further, said Certificate(s) and policies of insurance shall contain the covenant of the insurance carrier(s) that endeavor to provide thirty (30) days written notice shall be given to the County of Riverside prior to any material modification, cancellation, expiration or reduction in coverage of such insurance. *HNL shall not commence operations until the Group has been furnished original Certificate (s) of Insurance and copies of endorsements. An individual authorized by the insurance carrier to do so on its behalf shall sign the original endorsements for each policy and the Certificate of Insurance.*

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

5. The Group's Reserved Rights--Insurance. If, during the term of this Policy or any extension thereof, there is a material change in the scope of services; or, there is a material change in the equipment to be used in the performance of the scope of work which will add to additional exposures (such as the use of aircraft, watercraft, cranes, etc.); or, the term of this Policy including any extensions thereof exceeds five (5) years the Group reserves the right to adjust the types of insurance required under this Policy and the monetary limits of liability for the insurance coverage's currently required herein, if; in the Group Risk Manager's reasonable judgment, the amount or type of insurance carried by HNL has become inadequate.

6. The insurance requirements contained in this Policy may be met with a program(s) of self-insurance acceptable to the Group.

18. Hold Harmless/Indemnification.

HNL shall indemnify and hold harmless Group, its Agencies, Districts, Special Districts and Departments, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives (the "Group's Indemnified Parties") from any liability whatsoever, including but not limited to, property damage, bodily injury, or death, based or asserted upon any services by HNL, its directors, officers employees, subcontractors, agents or representatives arising out of or in any way relating to this Policy. The preceding indemnification provision shall not apply in the event any of the named parties subject to indemnification pursue, alone or in conjunction with other parties, any legal action in court or other jurisdiction against HNL for any liability whatsoever based upon or asserted upon any services of HNL, its directors, officers, employees, subcontractors, agents or representatives. HNL shall defend at its sole expense and pay all costs and fees, including but not limited to, attorney fees, cost of investigation, defense and settlements or awards, on behalf of the Group's Indemnified Parties in any claim or action based upon such liability.

With respect to any action or claim subject to indemnification herein, Health Net shall, at their sole cost, have the right to use counsel of their choice and shall have the right to adjust, settle, or compromise any such action or claim without the prior consent of the Group's Indemnified Parties; provided, however, that any such adjustment, settlement or compromise in no manner whatsoever limits or circumscribes HNL's obligation to indemnify as set forth herein. HNL's obligation to indemnify, defend and hold harmless Group shall be subject to Group having given HNL written notice within a reasonable period of time of the claim or of the commencement of the related action, as the case may be, and information and reasonable assistance, at HNL's expense, for the defense or settlement thereof.

HNL's obligations hereunder shall be satisfied when they have provided the Group's Indemnified Parties the appropriate form of dismissal relieving the Group's Indemnified Parties from any liability for the action or claim involved.

The specified insurance limits required in this Policy shall in no way limit or circumscribe HNL's obligation to indemnify as set forth herein.

19. Conflicts. In the event of any conflict between the terms of the Supplement, Policy, the application of the Group, any HNL Underwriting Assumptions provided to the Group, and the enrollment forms of the Group's eligible Medicare beneficiaries, such conflict shall be resolved by reference to the document in the following order of priority: the Supplement, then the Policy, then the application of the Group, then any HNL Underwriting Assumptions provided to the Group, and then the enrollment forms of the Group's eligible Medicare beneficiaries. The terms of the above-described document with the higher order of priority shall control with respect to any such conflict.

IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Supplement to Group Medicare Prescription Drug Plan Policy.

ATTEST:

Clerk of the Board

Kecia Harper-Ihem

By: _____

Deputy

Date: _____

COUNTY OF RIVERSIDE:

By: _____

Chairman, Board of Supervisors

Date: _____

Approved as to form:

Pamela J. Walls

County Counsel

By: _____

Deputy County Counsel

CONTRACTOR: Health Net Life Insurance Company, a California Corporation

By: SJ Sell

Printed Name: Steven J. Sell

Title: President

Date: 7/27/2011

ATTACHMENT D
Health Net Group Hospital and Professional Service Agreement (Seniority Plus)
Group# 69381T, Coverage Code: 1UBI, Plan Code: 5SF Sutter
and
Supplement to the Group Hospital and Professional Service Agreement

Group Hospital and Professional Service Agreement

Health Net
Seniority Plus

GROUP HOSPITAL AND PROFESSIONAL SERVICE AGREEMENT

ISSUED BY
HEALTH NET

LOS ANGELES, CALIFORNIA

To the extent herein limited and defined, this Agreement provides for comprehensive health services provided through Health Net of California, a federally qualified Health Maintenance Organization and a California Health Care Service Plan, and includes all Medicare Covered Services mandated through a contract between Health Net and the Centers for Medicare & Medicaid Services (CMS).

Upon payment of subscription charges in the amount and manner provided for in this Agreement, Health Net

HEREBY AGREES

to furnish services and benefits as defined in this Agreement to eligible Employees and their eligible Family Members of:

Group Name:	SP: SUTTER RIVERSIDE COUNTY
Group ID:	69381T
Coverage Code:	1UBI
Plan Code:	5SF

(herein called the "Group")

according to the terms and conditions of this Agreement. Payment of subscription charges by the Group in the amount and manner provided for in the Agreement shall constitute the Group's acceptance of the terms and conditions of the Agreement. This Health Net Group Service Agreement, the "Application for Group Service Agreement," any Health Net Underwriting Assumptions provided to the Group, and the enrollment forms of the Group's eligible employees, and Supplement to Group Hospital and Professional Service Agreement inclusively shall constitute the entire agreement between the parties.

Franklin Tom

Health Net

Steven Sell
President

Franklin Tom

HEALTH NET

HEALTH NET SENIORITY PLUS (EMPLOYER HMO) GROUP AGREEMENT

Health Net, a Health Care Service Plan licensed by the State of California under the Knox Keene Act, hereby contracts with the Group to provide the Health Net Seniority Plus (Employer HMO) (referred to herein as "Seniority Plus") covered benefits set forth herein and in the attached Evidence of Coverage (hereafter referred to as EOC) to the Members enrolled under this Agreement; subject to the exclusions, limitations, conditions, and other items of this Agreement, including any applicable amendments.

The Members must be entitled to Medicare's Hospital Insurance (Part A) and Supplementary Medical Insurance Plan (Part B) and allow Health Net to provide or arrange for all Part B coverage. CMS will compensate Health Net for each Member who agrees to use Health Net exclusively to obtain Parts A and B Covered Services. If the Member is not entitled to Part A coverage and was a Seniority Plus member prior to 1/1/99, he or she will be required to pay Health Net a subscription charge to obtain coverage of Part A benefits under this EOC. Otherwise, Part A coverage must be arranged through the Member's nearest Medicare office.

The Member agrees to allow Health Net to provide or arrange to provide all Medicare Covered Services through a contracting Physician Group or IPA selected by the Member (except for Emergency, out of area urgently needed services (or, in area under unusual and extraordinary circumstances), or out-of-area Renal Dialysis (kidney)). This Seniority Plus Plan also provides benefits not covered by Medicare under this Agreement and covers Medicare Coinsurance and Copayments. These benefits are provided in return for the payment of subscription charges stated in PART II of this Agreement.

TERM OF AGREEMENT

This Agreement becomes effective on January 1, 2011 at 12:00 a.m. Pacific Time at Los Angeles, California, and will remain in effect for an initial term of twelve consecutive months, subject to the payment of subscription charges as determined by Health Net. Termination or modification shall be effective on the date fixed in the notice. Modification shall not affect the right to benefits provided under this Agreement in connection with any Hospital confinement prior to such date. The Group may terminate this Agreement on 30-days' written notice to Health Net. If this Agreement is terminated by either party, the Medicare Entitled Members will be converted to the Medicare Advantage Seniority Plus Individual Agreement if the Member does not enroll with another Medicare Advantage plan, or submit a request for disenrollment.

Good cause for termination or non-renewal of this Agreement by Health Net shall include:

- Failure of the Group to pay any subscription charges when due,
- Failure of Group to maintain subscription charge contribution requirements as set forth in the application for the Seniority Plus Group Agreement,
- Failure of the Group to maintain at least 15 eligible employees enrolled with Health Net and/or with Health Net Life to be determined annually, 60-days prior to Group's renewal date, with termination effective at the renewal date,
- If Group is enrolled as a guaranteed association, failure of the Group to meet and continue to meet all legal requirements applicable to guaranteed associations; or
- Knowing failure by the Group to abide by and enforce the conditions of enrollment of this Agreement, and any Health Net Underwriting Assumptions provided to the Group
- Termination or not renewing of any other group Agreement in force between the Group and Health Net,
- Fraud or misrepresentation by submission to Health Net by the Group of materially incorrect or incomplete information which is reasonably relied upon by Health Net in issuing or renewing this Agreement and
- A material change in the nature of Group's business. Termination of this Agreement for good cause (other than for non-payment of subscription charges, see PART 2) shall become effective upon 30-days' written notice to the Group.

As with voluntary terminations, if this Group Agreement is terminated for the reasons stated above, then all Medicare Entitled Members who are on said Agreement shall convert to the Medicare Advantage Seniority Plus Individual Agreement.

If this Agreement terminates under its own terms, or is otherwise terminated by either Health Net or the Group, the Group shall promptly mail or hand deliver to each Member covered hereunder a notice of cancellation of this Agreement. The Group shall, upon request by Health Net, provide Health Net with a copy of the notification, a written statement that the notice of cancellation was mailed or hand delivered to each Member and the date of mailing or hand delivery.

SUBSCRIPTION CHARGES

Health Net offers the Members, enrolled under this Agreement, all Medicare benefits through a Medicare Advantage contract between Health Net and the Centers for Medicare & Medicaid Services (CMS). Under the terms of that contract, CMS will pay Health Net a prepaid fee for the Medicare Entitled Members; in return, Health Net has agreed to be the sole provider (with some noted exceptions) of Medicare Services to the Member.

The Group shall pay Health Net monthly subscription charges for benefits, which are not covered by Medicare or for Medicare mandated Coinsurance or Copayments as follows. Such charges shall be calculated by Health Net from current records as to number of Members enrolled. Retroactive payment adjustments will be made in subsequent billings for any additions or deletions of Members not currently reflected in Health Net's records at the time of calculation of subscription charges.

GROUP CHARGES

Monthly Rates for 69381T

Per member: $255.22

The first subscription charges must be paid to Health Net on or before the Effective Date of this Agreement. After that, payment is due on the first of each month while the Agreement is in effect. Group will send payment by wire no later than 45 days of the due date. If payment is not made by the above timeframe, Health Net will send the Group a Prospective Notice of Cancellation 30 business days before any cancellation of coverage. This Prospective Notice of Cancellation will provide the following information (a) that Subscription Charges have not been paid and that the Group Service Agreement will be canceled for non-payment if the required subscription charges are not paid within 30 business days from the date the Prospective Notice of Cancellation was mailed; (b) the specific date and time when coverage for all Members will end if subscription charges are not paid; and (c) how and when the Group can reinstate the Group Service Agreement.

If Health Net does not receive payment of the delinquent subscription charges from the Group within 15 days of the date of mailing of the Prospective Notice of Cancellation, Health Net will cancel the Group Service Agreement retroactively back to 12:00 midnight on the last day of the month for which subscription charges were paid, not to exceed 60 days before the date Health Net mails the Group a Notice Confirming Termination of Coverage. The Notice Confirming Termination of Coverage will provide the Subscriber and the Group with the following information: (1) that the Group Service Agreement has been canceled for non-payment of subscription charges; (2) the specific date and time when your Group coverage ended; (3) to the Group only, how and when coverage may be reinstated; (4) the Health Net telephone number Subscribers can call to obtain additional information, including whether the Group obtained reinstatement of the Group Service Agreement; and (5) an explanation of the Subscriber's options to purchase continuation coverage, (including coverage effective as of the retroactive termination date so the Subscriber can avoid a break in coverage) including (a) the deadline by which the Subscriber must elect to purchase such continuation coverage (which will be 63 days after the date Health Net mails the Subscriber and the Group the Notice Confirming Termination of Coverage); (b) how to obtain the forms necessary to purchase continuation coverage; and (c) referral to Health Net's website for additional information relating to rates and regarding the Subscriber's rights to continuation coverage.

Health Net will allow one reinstatement during any twelve-month period, without a change in subscription charges because of such reinstatement, if the amounts owed are paid within 15 days of the date the Notice of Confirming Termination of Coverage is mailed, including payment of a $100 reinstatement fee. If the Group does not obtain reinstatement of the canceled Group Service Agreement within the required 15 days or if the Group Service Agreement has been previously canceled and reinstated for non-payment of subscription charges within the last twelve months, then Health Net is not required to reinstate the Group Service Agreement, and the Group will need to reapply for coverage. In this case, Health Net may consider the medical conditions of the Group's employees in determining whether to allow enrollment. Amounts received after the termination date will be refunded to the Group by Health Net within 20 business days.

Except as described below, Health Net will not change the subscription charges, applicable Copayments, coinsurance or deductibles for the length of this Agreement, after (1) the Group has delivered notice of acceptance of the Agreement, (2) the start of the Group's Open Enrollment Period or (3) subscription charges for the first month of coverage commencing on the effective date of this Agreement are paid by the Group in the amount and manner provided for in this Agreement.

Health Net may change the subscription charges, applicable Copayments, coinsurance and deductibles under the following circumstances:

- When such changes are authorized or required under this Agreement;
- When agreed to under a preliminary agreement which states that such agreement is subject to execution of a formal agreement between the Group and Health Net; or
- When the terms of this Agreement are altered, in writing, by the consent of both parties.

Any changes to the subscription charges, pursuant to the above stated circumstances, shall be made at renewal with at least a 150-day written notice to the Group prior to the date of such change. Payment of any installment of subscription charges as altered shall constitute acceptance of this change.

If a governmental authority (1) imposes a tax or fee that is computed on subscription charges or (2) requires a change in coverage or administrative practice that increases Health Net's risk, Health Net may amend this Agreement and increase the subscription charges sufficiently to cover the tax, fee, or risk.at renewal of the Agreement, provided that Group receives 150 days written notice and approves of such increase in premiums. If Group approves of the increase in premiums, the effective

date of the increase in premiums shall not be earlier than the date the tax, fee, or required change in coverage or administrative practice is imposed by the governmental authority.

If this Agreement is terminated due to the Group's failure to pay the required subscription charges, then all Medicare Entitled Members shall convert to the Seniority Plus Individual Agreement.

If this Agreement is terminated for any reason, the Group shall be liable for all subscription charges for any time this Agreement is in force during a grace period and any other notice period.

Only Members for whom payment is received by Health Net shall be eligible for services and benefits hereunder and only for the period covered by such payment. If any Member covered hereunder is terminated by Health Net, prepaid subscription charges received on account of the terminated Member or Members applicable to periods after the effective date of termination will be refunded within 30-days and neither Health Net nor any contracting Physician Group has any further liability or responsibility under this Agreement to such terminated Member.

GENERAL PROVISIONS

- FORM OR CONTENT OF AGREEMENT: No agent or employee of Health Net is authorized to change the form or content of this Agreement. Any changes can be made only through an endorsement authorized and signed by an officer of Health Net.
- ENTIRE AGREEMENT: This Agreement, the application of the Group, any Health Net Underwriting Assumptions provided to the Group, and the enrollment forms of the Group's eligible employees, and Supplement to Group Hospital and Professional Service Agreement,shall constitute the entire Agreement between the parties.".
- CONTINUATION OF MEMBER COVERAGE: Except as otherwise provided herein, Health Net shall not have the right to cancel or terminate any individual Evidence of Coverage issued to any Member while this Agreement remains in force and effect and while said Member remains in an eligible class, as stated in the Evidence of Coverage of the Group, and his or her subscription charges are paid in accordance with the terms of this Agreement.
- CHARTER NOT PART OF AGREEMENT: None of the terms or provisions of the charter, constitution, or by laws of Health Net shall form a part of this Agreement or be used in the defense of any suit hereunder, unless the same is set forth in this Agreement.
- INTERPRETATION OF AGREEMENT: The laws of the United States and the State of California shall be applied to the interpretations of this Agreement.
- RECORDKEEPING: The Group is responsible for keeping records relating to this Agreement. Health Net has the right to inspect and audit those records.
- RELATIONSHIP OF PARTIES: Neither Health Net nor any of its employees or agents are employees or agents of Hospitals of Participating Medical Groups.
- HOLD HARMLESS: Health Net agrees to indemnify and hold harmless Groups and Members for any expense, liability, or claims for eligible services under this Agreement with the exception of any Copayment amounts which may be required as indicated herein.
- NON-DISCRIMINATION: Health Net and Group hereby agree that no person who is otherwise eligible for coverage under this Agreement shall be refused enrollment nor shall their coverage be canceled solely because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or health status.
- MODIFICATIONS TO PLAN AND NOTICE OBLIGATIONS: If the plan is terminated or modified in accordance with the terms and provisions of this Group Service Agreement, including a change or decrease in benefits, Health Net will send notice of such modification or termination to the Group with at least 30 days written notice. Except as required under Section 2 "Subscription Charges" above regarding termination for non-payment, Health Net will not provide notice of such changes to plan Subscribers unless it is required to do so by law. The Group may have obligations under state or federal law to provide notification of these changes to plan Subscribers.
- NOTICE OF CERTAIN EVENTS: Health Net will give the Group written notice within a reasonable time of any termination or breach of contract by, or inability to perform of, any participating contracting Provider, if the Group may be materially and adversely affected thereby.

Section-4

COVERAGE FOR DOMESTIC PARTNER

A Member's Domestic Partner is eligible for coverage provided that the partnership meets the Group's domestic partnership eligibility requirements. The Group's eligibility requirements must be compliant with California law. The Domestic Partner may enroll on the same basis as the Member in accordance with the terms and conditions of this Agreement that apply generally to the Member under the Plan.

Section-5

COMPLIANCE WITH MEDICARE PART D REGULATIONS IN ADMINISTRATION OF GROUP'S OUTPATIENT PRESCRIPTION DRUG PLAN AS A PART OF THE SENIORITY PLUS PLAN (MA-PD)

A. In accordance with section 1860D-22 ("Part D") of the Social Security Act (the "Act"), Health Net agrees that Group may determine how much of a Member's Part D monthly beneficiary premium it will subsidize, subject to the restrictions set forth below in (1) – (5).

1. Group can subsidize different amounts for different classes of Members in the Agreement's MA-PD provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried versus hourly). Different classes cannot be based on eligibility for the Low Income Subsidy as defined in 1860D-14 of the Act.
2. Group cannot vary the premium subsidy for individuals within a given class of Members.
3. Group cannot charge a Member for prescription drug coverage provided under the Agreement more than the sum of his or her monthly Medicare beneficiary premium attributable to basic prescription drug coverage and 100% of the monthly beneficiary premium attributable to his or her supplemental prescription drug coverage (if any).
4. For all Members eligible for the Low Income Subsidy, the low income premium subsidy amount will first be used to reduce the portion of the monthly beneficiary premium attributable to basic prescription drug coverage paid by the Member, with any remaining portion of the premium subsidy amount then applied toward the portion of the monthly beneficiary premium attributable to basic prescription drug coverage paid by the Group.
5. If the low income premium subsidy amount for which a Member is eligible is less than the portion of the monthly beneficiary premium paid by the Member, then the Group shall communicate to the Member the financial consequences for the Member of enrolling in the Group's MA-PD as compared to enrolling in another Part D plan with a monthly beneficiary premium equal to or below the low income premium subsidy amount.

B. When a group utilizes the CMS waiver for enrolling their retirees under a special group enrollment process, Group agrees to notify Members of the Group's intent to enroll them in Health Net's MA-PD and to provide them with all of the information more fully described in the instructions set forth in Chapter 2 of the Medicare Managed Care Manual (Group Enrollment for Employer/Union Sponsored Plans) and as summarized below.

1. Notify all Members that the Group intends to enroll Members in a MA-PD the Group is offering; and
2. Inform Members that they may affirmatively opt out of such enrollment; how to accomplish that; and any consequences to Group benefits opting out would bring; and
3. Provide notice to Members not less than 30 calendar days prior to the effective date of the Members enrollment in the Group sponsored MA-PD; and
4. Provide Members a summary of benefits offered under the Group sponsored MA-PD, an explanation of how to get more information about the MA-PD, and an explanation of how to contact Medicare for information on other Part D options that might be available to the Member; and
5. Provide required enrollment disclosure information contained within the Centers for Medicare & Medicaid Services (CMS) model enrollment form; and
6. Provide all the information required for Health Net to submit a complete enrollment request transaction to CMS; and
7. Provide CMS with any information it has on other insurance coverage for the purpose of coordination of benefits.

C. Group agrees to notify Members of the Group's intent to disenroll Members from the MA-PD and to provide them with all of the information more fully described in the instructions set forth in Chapter 2 of the Medicare Managed Care Manual (Group Enrollment for Employer/Union Sponsored Plans) and as summarized below.

1. Notify all Members that the Group intends to disenroll Members from the Medicare Advantage plan that the Group is offering; and
2. Provide notice to Members not less than 30 calendar days prior to the effective date of the Members disenrollment from the Group sponsored Medicare Advantage plan; and
3. Inform Members how to contact Medicare for information about other Medicare Advantage plan options that might be available to the Member; and
4. Provide all the information required for Health Net to submit a complete disenrollment request transaction to CMS.

BINDING ARBITRATION

Sometimes disputes or disagreements may arise between Group or Members and Health Net regarding the construction, interpretation, performance or breach of this Group Service Agreement or regarding other matters relating to or arising out of this Agreement. Health Net uses binding arbitration as the final method for resolving disputes (other than disputes involving Medicare-covered benefits and services), whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved. In addition, disputes with Health Net involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration. **Note that disputes regarding Medicare-covered benefits and services are handled in accordance with Medicare guidelines as discussed in the Evidence of Coverage.**

As a condition to contracting with Health Net, Group and Members agree to submit all disputes they may have with Health Net to final and binding arbitration. Health Net also agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that Group, Members and Health Net are bound to use binding arbitration as the final means of resolving disputes that may arise between them, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to the parties in a court of law will be forfeited by virtue of this agreement to use and be bound by Health Net's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

Health Net's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that the total amount of damages claimed is $200,000 or less, the parties shall, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $200,000. In the event that total amount of damages is over $200,000, the parties shall, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

If the parties fail to reach an agreement during this time frame, then any party may apply to a Court of Competent Jurisdiction for appointment of the arbitrator(s) to hear and decide the matter.

Arbitration can be initiated by submitting a demand for arbitration to Health Net at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

Health Net of California
Attention: Litigation Administrator
PO Box 4504
Woodland Hills, CA 91365-4505

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this Group Service Agreement, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law and stating that the award will be final and binding on all parties except to the extent that state or federal law provide for judicial review of arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees. In cases of extreme hardship to a Member, Health Net may assume all or portion of a Member's share of the fees and expenses of the arbitration. Upon written notice by the Member requesting a

hardship application, Health Net will forward the request to an independent professional dispute resolution organization for a determination. Such request for hardship should be submitted to the Litigation Administrator at the address provided above.

Effective July 1, 2002, Members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are not required to submit disputes about certain "adverse benefit determinations" made by Health Net to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by Health Net to deny, reduce, terminate or not pay for all or a part of a benefit. However, you and Health Net may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

Additionally, binding arbitration does not apply to disputes that are subject to the Medicare Appeals process as described in detail in Appendix B and Appendix E of the Evidence of Coverage.

PLAN BENEFITS AND EVIDENCE OF COVERAGE

Health Net will issue and deliver to each Member an Evidence of Coverage (EOC) which will set forth a statement of services and benefits to which Members are entitled and an Identification Card.

The benefits of this plan are set forth commencing on the next page of this Agreement. The language will constitute the EOC.

The parties agree to the terms and conditions of this Agreement, the attached EOC, and all other attachments and exhibits associated with this Agreement.

IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Health Net Group Hospital and Professional Service Agreement.

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

By: _____
Deputy

Date: _____

COUNTY OF RIVERSIDE:

By: _____
Chairman, Board of Supervisors

Date: _____

Approved as to form:

Pamela J. Walls
County Counsel

By: _____
Deputy County Counsel

CONTRACTOR: Health Net Life Insurance Company; a California Corporation

By: Steven Sell

Printed Name: Steven Sell

Title: President

Date: 6-14-11

SUPPLEMENT TO GROUP HOSPITAL AND PROFESSIONAL SERVICE AGREEMENT

BY AND BETWEEN

HEALTH NET OF CALIFORNIA, INC.

AND

COUNTY OF RIVERSIDE

This Supplement to the Group Hospital and Professional Service Agreement ("Supplement") by and between Health Net of California, Inc., a California corporation ("Health Net" or "Contractor"), and County of Riverside, a political subdivision of the State of California ("Group" or "County of Riverside"), becomes effective January 1, 2011 ("Effective Date") at 12:00 a.m. and will remain in effect in for the term of the Group Hospital and Professional Service Agreement.

This Supplement modifies the Group Hospital and Professional Service Agreement with Group ID 69381T Coverage Code: 1UBI ("the Agreement") and does not supersede or modify any terms or provisions of such Agreement, unless specifically stated herein.

NOW, THEREFORE, in consideration of the mutual covenants and promises contained in the Agreement, the Group and Health Net agree to incorporate the following provisions as part of the Agreement:

REQUIRED CONTRACT LANGUAGE

1. Amendments. This Agreement may be modified by Group and Health Net pursuant to mutual written Amendments. Amendments shall require the formal approval of the Board of Supervisors for Group to be effective, except as expressly provided herein.

   Amendments which shall not require the formal approval of the Board of Supervisors to be effective may include, but shall not be limited to amendments of rate adjustment and amendments to the policies and procedures, and/or operations as required by new laws and regulations, or by a court of competent jurisdiction. Such amendments shall be effective upon the date of approval by Group's Assistant CEO/Director of Human Resources.

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

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

If to Group:

County of Riverside, Human Resources
4080 Lemon Street, 7th Floor
Riverside, CA 92501
Attn: Deputy Human Resources Director

If to Contractor:

Health Net of California, Inc.
21281 Burbank Boulevard
Woodland Hills, CA 91367

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

4. Entire Agreement. This Agreement, the application of the Group, any Health Net Underwriting Assumptions provided to the Group, the enrollment forms of the Group's eligible employees, and Supplement to the Agreement contains the entire understanding of Health Net and Group with respect to the subject matter hereof and it incorporates all of the covenants, conditions, promises, and agreements exchanged by the parties hereto with respect to such matter. This Agreement supersedes any and all prior or contemporaneous negotiations, agreements, or communications, whether written or oral, between Health Net and Group with respect to the subject matter of this Agreement.

5. Venue. All actions and proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the state and federal (if permitted by law and a party elects to file an action in federal court) courts located in the County of Riverside, State of California.

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

7. Contractor Responsibility. Health Net shall maintain and provide adequate records and information as reasonably necessary to properly administer the Agreement consistent with state and federal law. Such records shall be retained by Health Net for at least five (5) years from the close of Group's fiscal year in which this Agreement is in effect. This obligation is not terminated upon a termination of the Agreement, whether by rescission or otherwise.

8. Independent Contractor. The relationship between Health Net and Group is an independent contractor relationship. Neither Health Net nor its employee(s) and/or agent(s) shall be considered to be an employee(s), and/or agent(s) of Group. Group nor any employee(s) and/or agent(s) of Group shall be considered to be an employee(s) and/or agent(s) of Health Net. None of the provisions of this

Agreement shall be construed to create a relationship of agency, representation, joint venture, ownership, control or employment between the parties other than that of independent parties contracting for the purposes of effectuating this Agreement.

9. Invalidity and Severability. If any provision of this Agreement is found to be invalid or unenforceable by any court, such provision shall be in effect only to the extent that it is not in contravention of applicable laws without invalidating the remaining provisions hereof.

10. Limitations of Severability. In the event the removal of a provision rendered invalid or unenforceable or declared null and void had the effect of materially altering the obligations of either party in such manner as to cause serious financial hardship to such party, the party so affected shall have the right to terminate this Agreement upon providing thirty (30) days prior written notice to the other party.

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

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

13. Assignment. Neither Party shall, without prior written consent of the other Party, assign any duties or rights under this Agreement. Any assignment in contravention of this paragraph shall constitute a material breach of this Agreement and shall be void.

14. Licenses. Health Net shall maintain any professional licenses required by the laws of the State of California at all times while performing services under this Agreement.

15. Provision of Information. Health Net shall provide Group and/or governmental agencies with such data and other information regarding the rendition of services as may be reasonably requested or as may be otherwise required for compliance with applicable regulatory and disclosure requirements. Health Net shall execute such additional verifications or documents as may be required by law or regulation.

16. Records open for Inspection. All books, records and papers of Health Net or subcontractor of Health Net relating to the performance of this Agreement must be open to inspection and copying during normal business hours by the Group, or state and/or federal regulators. Records shall include, without limitation, Member records (subject to applicable state and federal law governing the confidentiality of medical records), and/or financial records pertaining to the cost of operations and income received for services rendered to Members. Such records shall be made available at all reasonable times upon reasonable request by Group. Health Net or Subcontractor of Health Net shall maintain its books and records in accordance with general standards for books and record keeping.

17. Insurance.

Requirements of Contractor. Without limiting or diminishing Health Net's obligation to indemnify or hold the Group harmless, Health Net shall procure and maintain or cause to be maintained, at its sole cost and expense, the following insurance coverage's during the term of this Agreement.

Workers' Compensation. If Health Net has employees as defined by the State of California, Health Net shall maintain statutory Workers' Compensation Insurance (Coverage A) as prescribed by the laws of the State of California. Policy shall include Employers' Liability (Coverage B) including Occupational Disease with limits not less than $1,000,000 per person per accident. The policy shall be endorsed to waive subrogation in favor of The County of Riverside.

Commercial General Liability. Commercial General Liability insurance coverage, including but not limited to, premises liability, contractual liability, products and completed operations liability, personal and advertising injury and cross liability coverage, covering claims which may arise from or out of Health Net's performance of its obligations hereunder. Policy shall name the County of Riverside, its Agencies, Districts, Special Districts, Court and Departments, their respective directors, officers, Board of Supervisors, employees, elected or appointed officials, agents or representatives as Additional Insured. Policy's limit of liability shall not be less than $1,000,000 per occurrence combined single limit. If such insurance contains a general aggregate limit, it shall apply separately to this agreement or be no less than two (2) times the occurrence limit.

Vehicle Liability. If vehicles or mobile equipment is used in the performance of the obligations under this Agreement, then Health Net shall maintain liability insurance for all owned, non-owned or hired vehicles so used in an amount not less than $1,000,000 per occurrence combined single limit. If such insurance contains a general aggregate limit, it shall apply separately to this agreement or be no less than two (2) times the occurrence limit. Policy shall name the County of Riverside, its Agencies, Districts, Special Districts, Court and Departments, their respective directors, officers, Board of Supervisors, employees, elected or appointed officials, agents or representatives as Additional Insured.

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

General Insurance Provisions - All Lines.

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

2. Health Net's insurance carrier(s) must declare its insurance deductibles or self-insured retentions.

3. Health Net shall cause Health Net's insurance carrier(s) to furnish the County of Riverside with either 1) a properly executed original Certificate(s) of Insurance and copies of Endorsements effecting coverage as required herein. Further, said Certificate(s) and policies of insurance shall contain the covenant of the insurance carrier(s) that endeavor to provide thirty (30) days written notice shall be given to the County of Riverside prior to any material modification, cancellation, expiration or reduction in coverage of such insurance. *Health Net shall not commence operations until the Group has been furnished original Certificate (s) of Insurance and copies of endorsements. An individual authorized by the insurance carrier to do so on its behalf shall sign the original endorsements for each policy and the Certificate of Insurance.*

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

5. The Group's Reserved Rights--Insurance. If, during the term of this Agreement or any extension thereof, there is a material change in the scope of services; or, there is a material change in the equipment to be used in the performance of the scope of work which will add to additional exposures (such as the use of aircraft, watercraft, cranes, etc.); or, the term of this Agreement including any extensions thereof exceeds five (5) years the Group reserves the right to adjust the types of insurance required under this Agreement and the monetary limits of liability for the insurance coverage's currently required herein, if; in the Group Risk Manager's reasonable judgment, the amount or type of insurance carried by Health Net has become inadequate.

6. The insurance requirements contained in this Agreement may be met with a program(s) of self-insurance acceptable to the Group.

18. Hold Harmless/Indemnification.

Health Net shall indemnify and hold harmless Group, its Agencies, Districts, Special Districts and Departments, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives (the "Group's Indemnified Parties") from any liability whatsoever,

including but not limited to, property damage, bodily injury, or death, based or asserted upon any services by Health Net, its directors, officers employees, subcontractors, agents or representatives arising out of or in any way relating to this Agreement. The preceding indemnification provision shall not apply in the event any of the named parties subject to indemnification pursue, alone or in conjunction with other parties, any legal action in court or other jurisdiction against Health Net for any liability whatsoever based upon or asserted upon any services of Health Net, its directors, officers, employees, subcontractors, agents or representatives. Health Net shall defend at its sole expense and pay all costs and fees, including but not limited to, attorney fees, cost of investigation, defense and settlements or awards, on behalf of the Group's Indemnified Parties in any claim or action based upon such liability.

With respect to any action or claim subject to indemnification herein, Health Net shall, at their sole cost, have the right to use counsel of their choice and shall have the right to adjust, settle, or compromise any such action or claim without the prior consent of the Group's Indemnified Parties; provided, however, that any such adjustment, settlement or compromise in no manner whatsoever limits or circumscribes Health Net's obligation to indemnify as set forth herein. Health Net's obligation to indemnify, defend and hold harmless Group shall be subject to Group having given Health Net written notice within a reasonable period of time of the claim or of the commencement of the related action, as the case may be, and information and reasonable assistance, at Health Net's expense, for the defense or settlement thereof.

Health Net's obligations hereunder shall be satisfied when they have provided the Group's Indemnified Parties the appropriate form of dismissal relieving the Group's Indemnified Parties from any liability for the action or claim involved.

The specified insurance limits required in this Agreement shall in no way limit or circumscribe Health Net's obligation to indemnify as set forth herein.

19. Conflicts. In the event of any conflict between the terms of the Supplement, Agreement, the application of the Group, any Health Net Underwriting Assumptions provided to the Group, and the enrollment forms of the Group's eligible employees, such conflict shall be resolved by reference to the document in the following order of priority: the Supplement, then the Agreement, then the application of the Group, then any Health Net Underwriting Assumptions provided to the Group, and then the enrollment forms of the Group's eligible employees. The terms of the above-described document with the higher order of priority shall control with respect to any such conflict.

IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Supplement to the Group Hospital and Professional Service Agreement.

ATTEST:

Clerk of the Board

Kecia Harper-Ihem

By: _____

Deputy

Date: _____

COUNTY OF RIVERSIDE:

By: _____

Chairman, Board of Supervisors

Date: _____

Approved as to form:

Pamela J. Walls

County Counsel

By: _____

Deputy County Counsel

CONTRACTOR: Health Net of California, Inc.,

a California corporation

By: _____

Printed Name: Steven J. Sell

Title: President

Date: 7/27/2011