SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA 649

FROM: Human Resources Department

SUBMITTAL DATE:
February 27, 2013

SUBJECT: 2013 Medical Eye Services Vision Plan Administration Agreement

RECOMMENDED MOTION: That the Board of Supervisors 1) ratify and approve the Medical Eye Services Administration Agreement (Attachment A) and Letter of Understanding (Attachment B), to provide voluntary vision benefits for employees and retirees, effective January 1, 2013 through December 31, 2016; 2) authorize the Chairperson to sign four (4) copies of the attached documents and; 3) retain one (1) copy of the signed documents and return three (3) copies to Human Resources for distribution.

BACKGROUND: On July 31, 2012, Item 3.28, the Board approved the retention of Medical Eye Services (MES) to provide a voluntary vision program to employees covered by the Service Employee's International Union, Laborers International Union of North America, and the Riverside Sheriffs' Association members in the Public Safety Unit.

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

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:	2012/13

SOURCE OF FUNDS: Employee payroll deductions and retiree pension

Positions To Be Deleted Per A-30 ☐

Requires 4/5 Vote ☐

C.E.O. RECOMMENDATION:

APPROVE

BY: Ivan M. Chand 3/4/2013

County Executive Office Signature

FORM APPROVED COUNTY COUNSEL
BY: TAWNY V. LIEU DATE 2/28/13
Departmental Concurrence

☒ Policy ☐ Consent
☐ Policy ☒ Consent

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

MINUTES OF THE BOARD OF SUPERVISORS

On motion of Supervisor Ashley, seconded by Supervisor Stone and duly carried by unanimous vote, IT WAS ORDERED that the above matter is approved as recommended.

Ayes:	Jeffries, Tavaglione, Stone, Benoit and Ashley
Nays:	None
Absent:	None
Date:	March 12, 2013
xc:	H.R.

Kecia Harper-Ihem
Clerk of the Board
By: Deputy

Prev. Agn. Ref.: 7/31/2012, 3.28 | **District:** All | **Agenda Number:** 3-29

ATTACHMENTS FILED WITH THE CLERK OF THE BOARD

G:\EXEC\Form 11\Benefits\2013\2013 Medical Eye Services Vision Plan.docx

Background (continued):

As part of the new agreement, Human Resources was successful in negotiating a 5.3% rate decrease for active employees and a 6.9% rate decrease for retiree rates with a four (4) year rate guarantee for the plan.

Attached is the Administration Agreement (Attachment A) which includes the Group Vision Insurance Policy (Attachment A, Exhibit A) and the Master Application for Group Vision Insurance Policy (Attachment A, Exhibit B). The Administration Agreement along with the group policies renew the terms of the agreement and confirms the rates. The Letter of Understanding (Attachment B) clarifies the terms of the policy and further defines the terms for Spouse, Domestic Partner, Dependent Child(ren) eligiblity and changes to the the general provision in the policy to align with the County's eligibility rules and governing laws.

There is no direct cost to the County for this recommended action. Fees are paid by employee and retiree premiums.

ATTACHMENT A

Vision Benefits Administration Agreement

VISIONBENEFITSADMINISTRATION AGREEMENT
Between County of Riverside and Medical Eye Services, Inc.

This Agreement is entered into effective the 1st day of January, 2013, by and between the County of Riverside, a political subdivision of the State of California, (hereafter "Policyholder"),and Medical Eye Services, Inc., a California corporation, (hereafter "Company").

WHEREAS, Policyholder has contracted with [National Union Fire Insurance Company of Pittsburgh, PA] (hereafter " Underwriter") to underwrite a vision benefit policy (hereinafter "Policy") designed to provide Vision benefits (hereafter "Benefits") to Policyholder's employees and retirees including their eligible dependents; and

WHEREAS, Company offers a variety of administrative services, as a subcontractor of Underwriter related to the operation of certain Vision benefit plans; and

WHEREAS, Policyholder desires to retain Company to provide certain administrative services in connection with the Policy, and Company desires to provide such services, and Policyholder and Company (the "Parties") are entering into this Agreement for that purpose.

NOW THEREFORE, in consideration of their mutual promises and covenants, the parties agree as follows:

1.0 DEFINITIONS As used in this Agreement, the following terms shall have the meaning described below:

1.1 Agreement means this Contract Agreement for the provision of services for the Policy providing Vision administrative services, and all attachments, addendums and amendments hereto.

1.2 Director means the Director of Human Resources for County of Riverside, or his or her designee.

1.3 State means the State of California.

2.0 RESPONSIBILITIES OF POLICYHOLDER

2.1 Enrollment of Participants; Eligibility Lists; Changes in Status. The Policyholder shall submit, to the Company, eligibility information in accordance with the Policy attached hereto as Exhibit A.

2.2 Continuation of Coverage. Policyholder shall, as applicable: (a) determine the occurrence of "qualifying events" as that term is defined for purposes of continuation coverage under "COBRA" or any similar applicable state laws, (b) notify Participants of their continuation coverage rights under such laws, as applicable, and (c) notify Company

of all Participants who have elected continuation coverage, the duration of such coverage and the termination of such coverage.

3.0 COMPANY RESPONSIBILITIES

3.1 Account Administration. Company shall provide administrative services in accordance with the Policy attached hereto as Exhibit A.

3.2 Payment of Claims. Company shall furnish the claims administration services:

(a) Company shall accept claims (each, a "Claim") for benefits under the Policy which are made pursuant to procedures established in connection therewith, and, after due evaluation of each Claim and any other relevant information available to Company, determine the eligibility of the Participant to whom the Services were provided, based on the eligibility information provided by Policyholder.

(b) Company shall maintain a grievance resolution procedure, which shall be made available to a Participant in writing upon request. Company may compromise or adjust any Claim properly submitted under such procedure. If there is a change to a determination of a Claim by virtue of the resolution procedure, Company shall make the necessary changes in its records and comply with the final decision.

3.3 Claim Forms. Subject to the requirements of the Policy and this Agreement, Company shall arrange for the printing and publication of, and maintain a supply of the forms necessary for the administration of the Policy, including without limitation Claim forms, Claim denial forms, and Claim payment forms.

3.4 Records and Information. Company shall maintain and provide records and information necessary to administer the Agreement consistent with all applicable state and federal law and into the future to continue compliance, which laws may change from time to time, during the term of and all extensions of this Agreement. Company shall retain such records for at least seven (7) years from the close of the County'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. It is agreed that the Policyholder is the owner of all records maintained by Company and prior to destruction. Company shall contact Policyholder in writing of the intent to destroy records in sufficient detail to allow Policyholder to agree to their request or to transfer to Policyholder the specified records giving Policyholder sufficient advance notice of not less than sixty (60) days notice of intent to destroy.

3.5 Licenses. Company shall maintain any and all professional licenses required by the laws of the State of California and applicable Federal laws, if any, at all times while performing services on behalf of Policyholder under this Agreement.

3.6 Insurance Requirements. Company shall maintain in full force and effect at its own cost and expense during the term of this agreement and all extensions thereto the following insurance policies:, a policy that provides Professional Liability insurance coverage for Errors and Omissions in limits not less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) aggregate. In addition, the Company will also maintain at its own cost and expense, a Commercial General Liability policy to minimally include contractual liability, personal and advertising injury, employee benefits liability and independent contractors coverage in limits not less than One Million Dollars ($1,000,000) per occurrence, combined single limit and a policy for Workers' Compensation as required by the State of California with one (1) million dollars in limits for Employer Liability. The general liability policy shall provide an additional insured endorsement naming the County of Riverside, its Directors and Officers, board of Supervisors, elected officials, employees, agents and representatives as additional insured's.

In addition to the above insurance coverage's, the Company shall also provide a policy(s) of insurance for: (A) Fiduciary Liability in an amount not less than One Million Dollars ($1,000,000) covering any individual who is construed to be a fiduciary within the meaning of the Employment Retirement Income Security Act of 1974 (ERISA) and all fiduciaries and all persons that handle plan assets, if any, to be bonded as required under the ERISA Act, and; (B) Directors and Officers Liability in an amount not less than One Million Dollars ($1,000,000). The Directors and Officers policy shall have either: 1) an Extended Reporting endorsement (also known as tail coverage); or 2) Prior Dates Coverage for 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 Company has maintained continuous coverage with the same or original insurer. Coverage provided under items 1), 2), or 3) in this paragraph, will continue for a period of not less than five (5) years beyond termination of this agreement.

If Company in any manner handles any monies or any form of money, including but not limited to cash, checks, credit cards, debit card, electronic payments and/or transfers, etc., the Company shall provide and maintain at its own cost and expense during the term of this Agreement and any and all extensions thereto, Crime Insurance for: (A) Employee Dishonesty; (B) Forgery or Alteration; (C) Theft, Disappearance and Destruction, (E) Computer Fraud and any other coverage forms necessary to cover any type of loss arising out of/from this Agreement.

All policies shall provide a covenant of the insurance companies that (30) day's notice of cancellation, material change/modification or reduction in limits shall be given to the County of Riverside. An individual authorized by the insurance carriers to do so on its behalf shall sign the original endorsements and Certificate(s) of Insurance.

Company will provide a Certificate of Insurance as evidence of insurance coverage's prior to the acceptance of this agreement and if requested to do so will provide certified original copies of the policy(s) and all endorsements thereto.

Any insurance carrier providing insurance coverage hereunder shall be admitted to the State of California unless waived, in writing, by County of Riverside's Risk Manager, and such carrier shall have A.M. Best rating of no less than an AVIII.

4.0 ADMINISTRATIVE FEE

4.1 Underwriter shall be entitled to the premiums described in the Master Application for Group Vision Insurance Policy ("Application") attached hereto as Exhibit B. Company as the Third Party Administrator is compensated by the Underwriter and does not retain premiums nor collect compensation from the Policyholder.

5.0 PROPRIETARY RIGHTS

5.1 Proprietary Nature of Information. Policyholder and Company agree to treat all Member patient information provided by Company or Policyholder as confidential. Policyholder and Company shall maintain the confidentiality of all such information and shall make disclosures to third parties only upon the advance written consent of the Member, or when allowed by applicable law. Company shall safeguard the confidentiality of Member health records and treatment in accordance with all applicable state and federal laws, and regulations.

5.2 Use of Trademarks and Copyrights. Policyholder and Company each reserve the right to control the use of its name, symbols, trademarks, or other marks currently existing or later established. However, either party may use the other party's symbol, trademarks, or other marks with the prior written approval of the other party. Policyholder shall be allowed to use the name of Company in its promotional activities and marketing campaign.

5.3 Company Advertising. Prior to listing or otherwise referencing Policyholder in any promotional or advertising brochures, media announcements or other advertising or marketing material, Company shall first obtain the prior written consent of the Director.

6.0 TERM AND TERMINATION

6.1 The term of this Agreement shall become effective on January 1, 2013, for an initial term of two years and shall renew automatically following the initial term for one additional year, unless and until either Party gives the other Party written notice of its desire to terminate this Agreement at least 90 days prior to the end of the initial term or the renewal term then in effect, as applicable. If such notice is so given, this Agreement shall terminate at the end of the then-current term. Notwithstanding the foregoing, under no circumstances shall this Agreement remain in effect past December 31, 2016.

6.2 Causes for Immediate Termination of Agreement by Policyholder. The following shall constitute cause for immediate termination of this Agreement by Policyholder:

i) Breach of Material Term and Failure to Cure – Company's breach of any material term, covenant, or condition and subsequent failure to cure such breach within thirty (30) days following written notice of such breach.
ii) Failure to Provide Services – Failure of Company to provide services in accordance with this Agreement .
iii) Preservation of the Safety, Health and/or Welfare of Members – Determination by Policyholder that Company places the safety, health and/or welfare of Members in danger.
iv) Loss of Licensing – Failure by Company to secure and maintain the necessary governmental licenses, accreditation or certification required for the performance of duties hereunder.
v) Loss of Insurance Coverage – Failure by Company to maintain adequate general and professional liability insurance coverage, as provided herein.
vi) Insolvency of Company – including the filing of bankruptcy of Company.

6.3 Termination without Cause. After the end of the first term of this Agreement, either party may terminate this Agreement without cause. In the event either party desires to terminate this Agreement without cause, the terminating party shall give the other party at least sixty (60) days written notice of termination.

7.0 MUTUAL INDEMNIFICATION

7.1 Each Party (the "Indemnifying Party") shall indemnify and hold harmless the other Party, its Agencies, Districts, Special Districts and Departments, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives (collectively "Indemnified Party") from any liability whatsoever, based or asserted upon any services of the Indemnifying Party, its officers, employees, subcontractors, agents or representatives arising out of or in any way relating to this Agreement, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever and resulting from any reason whatsoever, or arising from the performance of the Indemnifying Party, its officers, agents employees, subcontractors, agents or representatives from this Agreement. The Indemnifying Party shall defend at its sole expense, all costs and fees, including but not limited to attorney fees, cost of investigation, defense and settlements or awards, of the Indemnified Party in any claim or action based upon such alleged acts or omissions.

With respect to any action or claim subject to indemnification herein by Indemnifying Party, the Indemnifying Party shall, at its sole cost, have the right to use counsel of its own choice and shall have the right to adjust, settle, or compromise any such action or claims without the prior consent of the Indemnified Party; provided, however, that any such adjustment, settlement or compromise in no manner whatsoever limits or circumscribes Indemnifying Party's indemnification of the Indemnified Party as set forth herein. The Indemnified Party's obligation to defend, indemnify and hold

harmless the Indemnifying Party shall be subject to the Indemnifying Party having given the Indemnified Party written notice within a reasonable period of time of the claim or of the commencement of the related action, as the case may be, and information and reasonable assistance, at Indemnifying Party's expense, for the defense or settlement thereof. Indemnifying Party's obligation hereunder shall be satisfied when the Indemnifying Party has provided to the Indemnified Party the appropriate form of dismissal relieving the Indemnified Party from any liability for the action or claim involved.

8.0 MISCELLANEOUS

8.1 Relationship of Parties; Expenses. The relationship between Company and Policyholder is an independent contractor relationship. Neither Company nor its employee(s) and/or agent(s) shall be considered to be an employee(s), and/or agent(s) of Policyholder. Policyholder nor any employee(s) and/or agent(s) of Policyholder shall be considered to be an employee(s) and/or agent(s) of Company. 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. Except as expressly set forth herein, each party shall bear all expenses it may occur in connection with the execution, delivery and performance of this Agreement.

8.2 Legal Requirements. If at any time any federal, state or local law requires agreements of this type to include any provision, which is not already included in this Agreement, the Parties shall amend this Agreement to include such provision promptly following the request of either Party. In addition, if (a) there is (i) any change in any federal, state or local statute, law, regulation, legislation, rule, policy or general instruction or guideline, or (ii) any ruling, judgment, decree or interpretation by any court, agency or other governing body having jurisdiction over either Party (in any such case, for purposes of this section, a "Regulatory Matter"), and (b) such Regulatory Matter materially and adversely affects, or is reasonably likely so to affect, the manner in which either Party is to perform or be compensated for its services under this Agreement or which shall make this Agreement unlawful, the Parties shall immediately use their best efforts to enter into a new arrangement that complies with such Regulatory Matter and approximates as closely as possible the position of the Parties under this Agreement, economically and otherwise, prior to such Regulatory Matter. If the Parties are unable to reach a new agreement within a reasonable period of time following the date upon which such Regulatory Matter arises or it becomes reasonably certain that such Regulatory Matter will arise, then either Party may terminate this Agreement pursuant to Section 6.3 (Termination without Cause). If termination is not feasible, either Party may submit the issue to binding arbitration before the American Arbitration Association ("AAA") in accordance with the AAA's then-current commercial arbitration rules for a single arbitrator. All arbitration hearings shall be held in the State of California. Arbitration proceedings shall be initiated with appropriate written notice to the other Party and to AAA. The decision of the arbitrator shall be final, and judgment on such decision may be entered in any state or federal court of competent jurisdiction within the State of

California. All costs and expenses of arbitration shall be borne by the Parties as determined by the arbitrator.

8.3 No Third Party Benefit. This Agreement is intended for the exclusive benefit of the Parties and their respective successors and assigns, and nothing contained in this Agreement shall be construed as creating any rights or benefits in or to any third party.

8.4 Assignment; Successors. This Agreement shall be binding upon and shall inure to the benefit of all transferees, assigns and successors in interest of any kind of the parties hereto, but no transfer or assignment of any duties or responsibilities of this Agreement may be made without the prior written permission of the other party. Any assignment in contravention of this paragraph shall constitute a material breach of this Agreement and shall be void.

8.5 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 Policyholder:

County of Riverside/Human Resources
Attn: Stacey M. Beale, Human Resources Division Manager
4080 Lemon Street, 7th Floor
Riverside, CA92502-1569

If to Company:

Medical Eye Services, Inc.
Compliance Department
345 Baker Street
Costa Mesa, CA 92626-4518

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.

8.6 Entire Agreement; Modification or Amendment. This Agreement and its attached exhibits represent the full and final understanding of the parties with respect to the subject matter described herein and supersedes any and all prior agreements or understandings, written or oral, express or implied. Policyholder and Company pursuant to mutual written amendments may modify this Agreement. Amendments shall require the formal approval of the Board of Supervisors for County of Riverside to be effective, except as expressly provided herein.

Amendments that shall not require the formal approval of the Board of Supervisors to be effective may include, but shall not be limited to amendments to the policies and procedures, plan documents, 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 Director.

This Agreement contains the entire understanding of Policyholder and Company 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 Company and Policyholder.

8.7 Attachments and Exhibits. Any Attachments or Exhibits attached hereto are incorporated herein by reference and made an integral part of this Agreement.

8.8 Captions. The captions of the various articles and sections of this Agreement are not part of the context of this Agreement, are only labels to assist in locating and reading those sections, and shall be ignored in construing this Agreement.

8.9 Severability. The intention of the Parties is to comply fully with all applicable laws and public policies, and this Agreement shall be construed consistently with all laws and public policies to the extent possible. If and to the extent that any court of competent jurisdiction determines that it is impossible to construe any provision of this Agreement consistently with any law or public policy and consequently holds that provision to be invalid, such holding shall in no way affect the validity of the other provisions of this Agreement, which shall remain in full force and effect. With respect to any provision in this Agreement finally determined by such a court to be invalid or unenforceable, such court shall have jurisdiction to reform this Agreement (consistent with the intent of the Parties) to the extent necessary to make such provision valid and enforceable, and, as reformed, such provision shall be binding on the Parties.

8.10 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.

8.11 Waiver of Breach. Failure of either party hereto to require the performance by the other party hereto of any obligation under this Agreement shall not affect its right subsequently to require performance of that or any other obligation. Any waiver by any party hereto of any breach of any provision of this Agreement shall not be construed as a continuing waiver of any such provision or a waiver of any succeeding breach or modification of any other right under this Agreement.

8.12 Governing Law; Venue. This Agreement shall be governed and construed by the laws of the State of California without regard to its conflict of laws principles. 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.

8.13 Disputes. Policyholder and Company agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement, prior to the filing of a claim under the Government Claims Act (Government Code section 900 et. seq.) and prior to the initiation of any litigation by either party.

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

8.15 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.

8.16 Health Insurance Portability and Accountability Act (HIPAA). The Company in this Agreement is subject to all relevant requirements contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, enacted August 21, 1996, the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009 (HITECH), Public Law 111-5, enacted February 17, 2009, and the laws and regulations promulgated subsequent thereto. The Company hereto agrees to cooperate in accordance with the terms and intent of this Agreement for implementation of relevant law(s) and/or regulation(s) promulgated under HIPAA and HITECH. The Company further agrees that it shall be in compliance, and shall remain in compliance with the requirement of HIPAA, HITECH and the laws and regulations promulgated subsequent hereto, as may be amended from time to time. The parties shall adhere to all terms and conditions as outlined and specified in Exhibit C, Business Associate Agreement, attached hereto and incorporated herein by this reference.

8.17 Force Majeure. Neither party shall be liable to the other party or be deemed to have breached this Agreement for any failure or delay in the performance of all or any part of its obligations under this Agreement if such failure or delay is due to any contingency beyond its reasonable control (a 'force majeure"). Without limiting the generality of the foregoing, such contingency includes, but is not limited to, acts of God, fires, floods, pandemics, storms, earthquakes, riots, boycotts, strikes, lock-outs, acts of terror, wars and war operations, restraints of government, power or communication line failure or other circumstance beyond such party's reasonable control, or by reason of a judgment, ruling or order of any court or agency of competent jurisdiction or change of law or regulation subsequent to the execution of this Agreement. Both parties are obligated to provide reasonable back-up capability to avoid the potential interruptions described above. If a force majeure occurs, the party delayed or unable to perform shall give immediate notice to the other party. Policyholder acknowledges that the foregoing provision does not apply to Policyholder's obligation to make timely payment of any fees

due Company, and that Company shall be entitled to all remedies set forth in this Agreement and those allowed by law for Policyholder's failure to timely pay such fees.

8.18 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.

8.19 Certification of Authority to Execute This Agreement. Company certifies that the individual signing herein has authority to execute this Agreement on behalf of Company, and may legally bind Company to the terms and conditions of this Agreement, and any attachments hereto.

[Remainder of this page was intentionally left blank]

IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Agreement:

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

By: _____
Deputy

Date: MAR 12 2013

COUNTY OF RIVERSIDE:

By: _____
Chairman, Board of Supervisors
JOHN J. BENOIT

Date: MAR 12 2013

Approved as to form:

Pamela J. Walls
County Counsel

By: _____
Deputy County Counsel

MEDICAL EYE SERVICES, INC.

By: _____

Printed Name: Chuck Kupfer

Title: CFO

Date: 12-04-12

MAR 12 2013 3-29

ATTACHMENT A

EXHIBIT A

Group Vision Insurance Policy

A copy of the Underwriter's Group Vision Insurance Policy is attached to this Exhibit A.

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 175 Water Street, 18th Floor, New York, NY 10038
(212) 458-5000
(a capital stock company, herein referred to as the Company)

Policyholder: County of Riverside
Policy Number: VCP 9522302A

GROUP VISION INSURANCE POLICY

This Policy is a legal contract between the Policyholder and the Company. The Company agrees to insure eligible persons of the Policyholder (herein called Insured Person(s)) against loss covered by this Policy subject to its provisions, limitations and exclusions. The persons eligible to be Insured Persons are all persons described in the Classification of Eligible Persons section of the Master Application.

This Policy is issued in consideration of the payment of the required premium when due and the statements set forth in the signed Master Applications, which are attached to and made part of this Policy, and in the individual enrollment forms, if any.

This Policy begins on the Policy Effective Date shown in the Master Application and continues in effect as long as premiums are paid when due, unless otherwise terminated as further provided in this Policy. If this Policy is terminated, insurance ends on the date to w hich premiums have been paid.

This Policy is governed by the laws of the state in which it is delivered.

The President and Secretary of National Union Fire Insurance Com pany of Pittsburgh, Pa. witness this Policy:

President

Secretary

PLEASE READ THIS POLICY CAREFULLY.

Non-Participating Policy

TABLE OF CONTENTS

DEFINITIONS

Copay Amount means an Insured Person's share of costs, paid to the Participating Provider at the time services are rendered. Copay Amounts that apply to the various vision benefits are listed in the Benefit Schedule.

Date of Service - means the calendar date on which a specific service was provided or materials were ordered, which are payable under this Policy.

Insured - means a person: (1) who is a member of an eligible class of persons as described in the Classification of Eligible Persons section of the Master Application; (2) who has enrolled for coverage under this Policy, if required; (3) for whom premium has been paid; and (4) while covered under this Policy. However, an Insured does not include any person covered under this Policy solely as an Insured Dependent as defined in the Family Coverage Rider.

Immediate Family Member - means a person who is related to the Insured Person in any of the following ways: Spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild).

Insured Person - means an Insured or an Insured Dependent as defined in the Family Coverage Rider.

Non-Participating Provider - means an Ophthalmologist, Optician or Optometrist who has not entered into a contract with the Vision Benefit Manager.

Ophthalmologist - means a person who is licensed by the state in which he or she practices as a Doctor of Medicine or Osteopathy and is qualified to practice within the medical specialty of ophthalmology, who is not: (1) the Insured Person; (2) an Immediate Family Member; or (3) retained by the Policyholder.

Optically Necessary/Optical Necessity - means a prescription or a change of prescription is required to correct visual function.

Optician - means a person or business licensed by the state in which services are rendered to manufacture, grind and/or dispense lenses and frames prescribed by either an Optometrist or an Ophthalmologist, who is not: (1) the Insured Person; (2) an Immediate Family Member; or (3) retained by the Policyholder.

Optometrist - means a person licensed to practice optometry as defined by the laws of the state in which his or her services are rendered, who is not: (1) the Insured Person; (2) an Immediate Family Member; or (3) retained by the Policyholder.

Participating Ophthalmologist - means an Ophthalmologist who is a Participating Provider.

Participating Optician - means an Optician who is a Participating Provider.

Participating Optometrist - means an Optometrist who is a Participating Provider.

Participating Provider - means an Ophthalmologist, Optician or Optometrist who has elected to enter into a contract with the Vision Benefit Manager and who is listed in the Participating Provider Directory.

Standard Lenses - means lenses up to 61 mm manufactured from glass or plastic, which are optically clear; standard multifocal lenses include segments through flat top 35 for plastic bifocal and lenticular lenses, glass trifocals through flat top 28 and plastic trifocals through flat top 35.

Sub-Normal Visual Aids - means devices (optical and non-optical) to assist individuals who are partially sighted.

Vision Benefit Manager - means the entity which will provide complete service and facilities for the writing and servicing of this Policy as agreed to in a contract betw een the Vision Benefit Manager and the Company.

Vision Examination - means an examination of principal vision functions. A Vision Examination includes but is not limited to, case history, examination for pathology or anomalies, job visual analysis, refraction, visual field testing and tonometry, if indicated. The exam will be consistent with the community standards, rules and regulations of the jurisdiction in which the provider practic e is located.

POLICY EFFECTIVE AND TERMINATION DATES

Effective Date. This Policy begins on the Policy Effective Date shown in the Master Application at 12:01 AM Standard Time at the address of the Policyholder where this Policy is delivered.

Termination Date The Company may terminate this Policy at any time by written notice delivered to the Policyholder, or mailed to its last address as shown on the records for the Company, stating when, not less than 90 days thereafter, such termination shall be effective. However, except for nonpayment of the required premium of the failure to meet the required underwriting standards, the Company will not terminate this Policy prior to the first anniversary date of the Effective Date of this Policy. The Policyholder may terminate this Policy at any time by written notice delivered or mailed to the Company, effective upon receipt or upon such later date as may be specified in the notice. This Policy terminates automatically on the earlier of: 1) the Policy Termination Date shown in the Master Application; or 2) the premium due date if premiums are not paid when due. In the event of such termination by either the Company or the Policyholder, the Company shall promptly return on a prorata basis the unearned premium which has not been paid. Termination takes effect at 12:01 AM Standard Time at the Policyholder's address on the date of such termination.

Such termination shall be without prejudice to any claim originating prior to the effective date of such termination.

INSURED'S EFFECTIVE AND TERMINATION DATES

Effective Date. An Insured's coverage under this Policy begins on the latest of: (1) the Policy Effective Date; (2) the date the first premium for the Insured's coverage is paid in accordance with the Premiums section of the Master Application; (3) if individual enrollment is required, the date written enrollment is received by the Policyholder; (4) the date the person becomes a member of an eligible class of persons as described in the Classification of Eligible Persons section of the Master Application; or (5) the Coverage Effective Date described in the Master Application.

Termination Date. An Insured's coverage under this Policy ends on the earliest of: (1) the date this Policy is terminated; (2) the premium due date if premiums are not paid when due, subject to the Grace Period provision; (3) the premium due date coincident with or next following the date the Insured requests, in writing, that his or her coverage be terminated; or (4) the date the Insured ceases to be a member of any eligible class(es) of persons as described in the Classification of Eligible Persons section of the Master Application.

If the Insured voluntarily elects to terminate coverage, the Insured will not be eligible to re-enroll for 12 months from the next Policy anniversary date.

Termination of coverage will not affect a claim for a covered loss that occurred while the Insured's coverage was in force under this Policy.

PREMIUM

Premiums. Premiums are payable to the Company at the rates and in the manner described in the Premiums section of the Master Application. The Company may change the required premiums due on any premium due date on or after the second Policy anniversary date, as measured annually from the Policy Effective Date by giving the Policyholder at least 180 days advance written notice. The Company may also change the required premiums at any time when any coverage change affecting premiums is made in this Policy.

Grace Period. A Grace Period of 61 days will be provided for the payment of any premium due after the first. This Policy will not be terminated for nonpayment of premium during the Grace Period if the Policyholder pays all premiums due by the last day of the Grace Period. This Policy will terminate on the last day of the period for which all premiums have been paid if the Policyholder fails to pay all premiums due by the last day of the Grace Period.

If the Company expressly agrees to accept late payment of a premium without terminating this Policy, the Company does so in accordance with the Noncompliance with Policy Requirements provision of the General Provisions section. In such case, the Policyholder will be liable to the Company for any unpaid premiums for the time this Policy is in force, plus all costs and expenses (including, but not limited to, reasonable attorney fees, collection fees and court costs) incurred by the Company in the collection of all overdue amounts.

No grace period will be provided if the Company receives notice to terminate this Policy prior to a premium due date.

VISION BENEFITS

The amount of Vision Benefits payable hereunder and the manner of payment is determined by whether the Insured Person utilizes the services of a Participating Provider or a non-Participating Provider.

The Insured will receive a program identification card or cards for use while covered under this Policy. The Policyholder shall submit, to the Vision Benefit Manager, on a monthly basis, a list of all Insured Persons. When the Insured Person incurs the services of a Participating Provider, such Insured Person may be required to present the Insured's program identification card to the Participating Provider. The Participating Provider may: (1) verify eligibility; and (2) notify the Insured Person of any out-of-pocket expenses.

If the Insured Person incurs the services of a non-Participating Provider, such Insured Person will be required to pay the full cost of such services at the time of the purchase.

Vision Examination Benefit. If an Insured Person incurs expenses for a Vision Examination, the Company will pay such expenses up to the applicable Vision Examination Maximum Benefit shown in the Master Application, subject to the Exclusions, provided: (1) such expenses were incurred while the Insured Person was covered under this Policy; and (2) the Insured Person has paid any applicable Copay, as shown in the Master Application. Benefits will be payable at the Vision Examination Benefit Frequency shown in the Master Application.

Standard Eyeglass Lenses Benefit. If an Insured Person incurs expenses for Standard Lenses, the Company will pay such expenses up to the Standard Eyeglass Lenses Maximum Benefit shown in the Master Application subject to the Exclusions, provided: (1) such expenses were incurred while the Insured Person was covered under this Policy; and (2) the Insured Person has paid any applicable Copay, as shown in the Master Application. Benefits will be payable at the Standard Eyeglass Lenses Benefit Frequency shown in the Master Application.

Eyeglass Frame Benefit. If an Insured Person incurs expenses for eyeglass frames, the Company will pay such expenses up to the applicable Eyeglass Frame Maximum Benefit shown in the Master Application, subject to the Exclusions, provided: (1) such expenses were incurred while the Insured Person was covered under this Policy; and (2) the Insured Person has paid any applicable Copay, as shown in the Master

Application. Benefits will be payable at the Eyeglass Frame Benefit Frequency shown in the Master Application.

Contact Lenses Benefit. If an Insured Person incurs expenses for contact lenses, the Company will pay such expenses up to the applicable Contact Lenses Maximum Benefit shown in the Master Application, subject to the Exclusions, provided: (1) such expenses were incurred while the Insured Person was covered for the applicable optical correction type under this Policy; and (2) the Insured Person has paid any applicable Copay, as shown in the Master Application.

Medically Necessary Contact Lenses Benefit. If an Insured Person incurs expenses for Medically Necessary contact lenses, the Company will pay such expenses up to the applicable Medically Necessary Contact Lenses Maximum Benefit shown in the Master Application, subject to the Exclusions, provided: (1) such expenses were incurred while the Insured Person was covered for the applicable optical correction type under this Policy; and (2) the Insured Person has paid any applicable Copay, as shown in the Master Application and (3) the contact lenses are determined to be Medically Necessary upon preapproval. Upon approval of the request by the Vision Benefit Manager, benefits shall be payable at the Medically Necessary Contact Lenses Benefit Frequency shown in the Master Application.

Medically Necessary/Medical Necessity means: (1) vision is not correctable to better than 20/70 in the better eye by conventional lenses; (2) contact lenses are required following cataract surgery; or (3) contact lenses are necessitated as a result of anisometropia or certain conditions of keratoconus. The Participating or non-Participating Provider of such services, must make a request, in writing, to the Vision Benefit Manager stating that contact lenses are necessary to achieve the best possible correction for the Insured Person.

LIMITATIONS

If the Contact Lenses Benefit is payable in lieu of the Standard Eyeglass Lenses Benefit and the Eyeglass Frame Benefit, an Insured Person shall be eligible to receive benefits under the Standard Eyeglass Lenses Benefit or the Eyeglass Frame Benefit only after the Contact Lenses Benefit Frequency has ended.

If the Standard Eyeglass Lenses Benefit and the Eyeglass Frame Benefit is payable in lieu of the Contact Lenses Benefit, an Insured Person shall be eligible to receive benefits under the Contact Lenses Benefit only after the Standard Eyeglass Lenses Benefit and the Eyeglass Frame Benefit Frequency has ended.

EXCLUSIONS

Benefits will not be payable under this Policy for expenses incurred for:

1. professional services and/or materials in connection with:
   a. plano (non-prescription) lenses;
   b. Sub-normal Visual Aids;
   c. blended bifocals, no line, or progressive addition lenses;
   d. compensated or special multi-focal lenses;
   e. anti-reflective, scratch, UV400, or any coating of lamination applied to lenses;
   f. tints other than solid;
   g. orthoptics, vision training and developmental vision procedures;
   h. polycarbonate lenses
   i contact lens insurance or care kits
   k services that are experimental or investigational in nature;

2. broken, lost or stolen lenses, contact lenses or frames;

3. medical or surgical treatment of the eye, unless such treatment is performed during a Vision Examination, subject to the applicable Vision Examination Maximum Benefit shown in the Master Application;

4. services or materials which are payable under any Workers' Compensation Act or similar law or any public program other than Medicaid;

5. services or materials rendered by a provider other than an Ophthalmologist, Optometrist, or Optician acting within the scope of his or her license; or by an Immediate Family Member;

6 any additional service required outside basic vision analyses for contact lenses, except fitting fees;

7 vision examination for vision materials that may be required as a condition of employment, including but not limited to industrial or safety glasses;

8 services rendered after the date an Insured Person ceases to be covered under this Policy, except when vision materials ordered before coverage ended are delivered and the services rendered to the Insured Person within 31 days from the date of such order; and

9. services rendered or materials ordered before the date coverage began under this Policy.

Regardless of Optical Necessity or Medical Necessity, benefits are not available more frequently than that which is specified in the Master Application.

CLAIMS PROVISIONS

Proof of Claim. Proof of claim for expenses incurred for charges made by a non-Participating Provider, for benefits payable under this Policy, must be furnished to the Vision Benefit Manager within 90 days after the Date of Service. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. Proof of Claim for charges made by a Participating Provider, for benefits payable under this Policy, will be made by the Participating Provider on the Insured Person's behalf.

Payment of Claims. Payment for charges made by a Participating Provider, which are payable under this Policy, will be made directly to the Participating Provider. Payment for expenses incurred by the Insured Person for charges made by a non-Participating Provider, which are payable under this Policy, will be made to the Insured Person.

Filing a Claim. If the Insured Person incurs expenses for benefits payable under this Policy from a Participating Provider, payments will be made in accordance with the Benefit Schedule. The Insured Person will pay any applicable Copay, as shown in the Master Application and any non-covered charges.

If the Insured Person incurs expenses for benefits payable under this Policy from a non-Participating Provider, he or she will be required to pay the full cost at the time of the purchase. The Insured Person must submit a Proof of Claim consisting of: (1) and itemized receipt from the non-Participating Provider; (2) the Date of Service; (3) the name of the non-Participating Provider; (4) the charges incurred from such non-Participating Provider; and (5) the name of the Insured Person on whose behalf the charges were incurred to the Vision Benefit Manager at Medical Eye Services, P.O. Box 25209, Santa Ana, CA 92799-5209 in order to be reimbursed for the amount payable under this Policy. The receipt should also include the Policyholder's name and the Policy number.

Any payment the Vision Benefit Manager makes in good faith fully discharges the Company's liability to the extent of the payment made.

Time of Payment of Claims. Benefits payable under this Policy will be paid as they accrue immediately upon the Vision Benefit Manager's receipt of due written proof of the claim.

GENERAL PROVISIONS

Entire Contract; Changes. This Policy, the Master Application, and any attached Riders, Endorsements and Amendments constitute the entire contract between the parties, and any statement made by the Policyholder or any Insured Person shall, in the absences of fraud, be deemed a representation and not a warranty. No such statement shall be used in defense to a claim hereunder unless it is contained in a written application..

No change in this Policy shall be valid unless approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or waive any of its provisions.

Time Limit on Certain Defenses. After three years from the date of issue of this Policy, no misstatement of the Policyholder, except a fraudulent misstatement, made in its application shall be used to void the Policy. After three years from the effective date of the coverage with respect to which any claim is made, no misstatement of any Insured Person eligible for coverage under the Policy, except a fraudulent misstatement, made in an application under the Policy shall be used to deny a claim for loss incurred commencing after expiration of such three years.

Certificates of Insurance. The Company will provide certificates of insurance or description of coverage for delivery to each Insured describing the coverage provided, any limitations, reductions, and exclusions applicable to the coverage, and to whom benefits will be paid.

Legal Actions. No action at law or in equity may be brought to recover on this Policy prior to the expiration of 60 days after written proof of claim has been furnished in accordance with the requirements of this Policy. No such action may be brought after the expiration of three years after the time written proof of claim, extending from the Date of Service, is required to be furnished.

Misstatement of Age. If premiums for the Insured Person are based on age and the Insured Person's age has been misstated, there will be a fair adjustment of premiums based on the true age. If the benefits for which the Insured Person is insured are based on age and the Insured Person's age has been misstated, there will be an adjustment of benefits based on the true age. The Company may require satisfactory proof of age before paying any claim.

Conformity With State Statutes. Any provision of this Policy which, on its effective date, is in conflict with the statutes of the state in which this Policy is delivered is hereby amended to conform to the minimum requirements of those statutes.

Noncompliance with Policy Requirements. Any express waiver by the Company of any requirements of this Policy will not constitute a continuing waiver of such requirements. Any failure by the Company to insist upon compliance with any Policy provision will not operate as a waiver or amendment of that provision.

Workers' Compensation. This Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.

Clerical Error. Clerical error, whether by the Policyholder or the Company, will not void the insurance of any Insured Person if that insurance would otherwise have been in effect nor extend the insurance of any Insured Person if that insurance would otherwise have ended or been reduced as provided in this Policy.

Records. The Company has the right to inspect at any reasonable time, any records of the Policyholder that may have a bearing on this insurance.

Assignment. This Policy is non-assignable. An Insured may not assign any of his or her rights, privileges or benefits under this Policy.

New Entrants. This Policy will allow from time to time, that new eligible Insured Persons of the Policyholder be added to the class(es) of Insured Persons originally insured under this Policy.

Non-Participating. The Policyholder does not participate in the Company's surplus earnings.

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 175 Water Street, 18th Floor, New York, NY 10038
(212) 458-5000
(a capital stock company, herein referred to as the Company)

Policyholder: County of Riverside
Policy Number: VCP 9522302A

FAMILY COVERAGE RIDER

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy's Master Application. It is subject to all of the provisions, limitations and exclusions of the Policy except as they are specifically modified by this Rider

Insured Dependent's Effective Date. An Insured Dependent's coverage under the Policy begins on the latest of: (1) the date the Insured's coverage under the Policy begins (or the date this Rider becomes effective, if later); (2) the date the first premium for the Insured Dependent's coverage is paid when due; (3) if individual enrollment is required, the date the Insured enrolls the dependent for Family Coverage except if the Insured does not enroll within 60 days after the date the dependent becomes eligible, the Insured must wait until the next open enrollment period of the Policyholder to enroll the dependent; (4) the date the person becomes a member of any eligible class of persons as described in the Classification of Eligible Persons section of the Master Application; or (5) the Coverage Effective Date described in the Master Application.

If a husband and wife are both eligible to enroll for coverage under the Policy, one, but not both, may purchase Family Coverage. The other spouse may elect single coverage only.

Insured Dependent's Termination Date. An Insured Dependent's coverage under the Policy ends on the earliest of: (1) the date the Insured's coverage under the Policy ends; (2) the premium due date if premiums for the Insured Dependent are not paid when due; (3) the date the Insured requests, in writing, that coverage for the Insured Dependent be terminated; or (4) the date the Insured Dependent ceases to be a member of any eligible class of persons as described in the Classification of Eligible Persons section of the Master Application.

Insured Dependent's Beneficiary. The Insured Dependent's beneficiary is the Insured.

Insured Dependent Child - means the Insured's Eligible Dependent Child as described in the Classification of Eligible Persons section of the Master Application: (1) whom the Insured has elected to cover under the Policy; (2) for whom premium has been paid; and (3) while covered under the Policy.

Insured Dependent - means an Insured Spouse or an Insured Dependent Child.

Insured Spouse - means the Insured's Eligible Spouse as described in the Classification of Eligible Persons section of the Master Application: (1) whom the Insured has elected to cover under the Policy; (2) for whom premium has been paid; and (3) while covered under the Policy.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this Rider:

President

Secretary

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 175 Water Street, 18th Floor, New York, NY 10038
(212) 458-5000
(a capital stock company, herein referred to as the Company)

Policyholder: County of Riverside
Policy Number: VCP 9522302A
Effective Date of this Endorsement: January 1, 2013

AMENDED DEFINITION ENDORSEMENT

This Endorsement is attached to and made part of the Policy or Certificate as of the Effective Date shown above. It is subject to all of the provisions, limitations and exclusions of the Policy except as specifically modified herein.

In the **Vision Benefits** section, the definition of Medically Necessary/Medical Necessity under the Medically Necessary Contact Lenses Benefit is hereby deleted and replaced with the following:

> **Medically Necessary/Medical Necessity** means that Contact Lenses are necessary or required as a result of or following: (1) a diagnosis that vision is not correctable to better than 20/40 for certain conditions of keratoconus and anisometropia by conventional lenses; (2) cataract surgery; (3) a diagnosis of myopia of greater than 12 diopters; (4) a diagnosis of hyperopia of greater than 7 diopters; or (5) a diagnosis of astigmatism of 5 diopters or more. The Participating or non-Participating Provider of such services must make a request, in writing, to the Vision Benefit Manager stating that special contact lenses are necessary to achieve the best possible correction.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this Endorsement:

President

Secretary

AIG AIG Domestic Accident & Health Division

Privacy Notice

Administrative Offices
600 King Street, Wilmington, DE 19801

Our Customers' Privacy Is Important to Us

We are committed to providing individuals covered by our accident and health insurance policies (our "Customers") with top-notch products backed by top-quality customer service. While information is fundamental to our ability to do this, we recognize the great importance of keeping our Customers' non-public personal information secure. Accordingly, we, the Domestic Accident & Health Division of the AIG Companies[SM] listed below, have established practices and procedures with respect to the collection and sharing of our current and former Customers' non-public personal financial and health information ("Customer Information").

Information Collection

We may collect information about our Customers from enrollment forms, applications, transactions, and other interactions with us or our affiliates, as well as from credit reporting agencies and other third parties. We will collect and disclose this information only in accordance with applicable laws or regulations or in response to our Customer's request for a product or service from us. The information we gather helps us identify who our Customers are, manage our relationship with them, and develop products and services that meet their needs.

Information Sharing

We may share Customer Information with third parties under the following circumstances:

- **Affiliates:** We may share Customer Information with our affiliates. These affiliates may include providers of financial services such as other insurance companies, banks, securities broker-dealers, and insurance agents and agencies. They may also include affiliated non-financial entities such as marketing companies, e-commerce service providers, and companies providing administrative services.

  We will not share our Customer's non-public personal *financial* information with our affiliates, other than transaction or experience-related information, without first providing our Customer an opportunity to direct that such information not be shared. Furthermore, we will not share our Customer's non-public personal *health* information with affiliates except as directed or authorized by our Customer.

- **Non-Affiliates:** We may also share Customer Information with non-affiliated companies for administrative purposes, the purposes of risk management, underwriting, to detect and prevent fraud, as directed or authorized by our Customer, or as otherwise permitted or required by law.

  From time to time, we may also enter into joint marketing and/or service agreements to share Customer non-public personal *financial* information with non-affiliated third parties as permitted by law. These third parties may include providers of financial products or services such as insurance companies, financial institutions, and securities firms.

The types of information we may share in these circumstances include identifying information (e.g., name or address), application information (e.g., income or assets), transactional information (e.g., premium history), and/or information received from a consumer reporting agency (e.g., credit history). Because we do not share Customer Information in any other way, there is no need for an opt-out process in our privacy procedures.

Information Protection

We maintain physical, electronic, and procedural safeguards designed to protect Customer Information and permit only authorized insurance agents, administrators, and employees who are trained in the proper handling of Customer Information, to have access to that information.

We expect any non-affiliated third party that serves our Customers on our behalf to adhere to our privacy policy. Those third parties are legally bound to use our Customers' Information only for the purposes for which it was provided, and to not disclose it or use it in any way. These third parties are also subject to and governed by federal and state privacy laws and regulations, and we are not responsible for their misuse of information.

To help prevent unwarranted disclosure of your non-public personal information and secure it from theft, we utilize secure computer networks and restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you.

Maintaining Accurate Information

We also maintain procedures to ensure that the information we collect is accurate, up-to-date, and as complete as possible. If you believe the information we have about you in our records or files is incomplete or inaccurate, you may request that we make additions or corrections, or if it is feasible, that we delete this information from our files. You may make this request in writing to (include your name, address and policy number):

Chief Privacy Officer
AIG - Domestic Brokerage Group
175 Water Street, 3rd Floor
New York, NY 10038
E-Mail: DBG.Privacy@AIG.com

Special notice for policyholders who reside in any of the following states: Arizona, California, Connecticut, Georgia, Illinois, Kansas, Maine, Massachusetts, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, Virginia or Wisconsin: You can obtain access to any non-public personal information we have about you if you properly identify yourself and submit a written request to us at the address above describing the information you want to review (include your name, address and policy number). Once we have received your request, and if the information is reasonably locatable and retrievable, we will, within 30 business days, take the following actions:

- Inform you of the nature and substance of the recorded information;
- Allow you to see and copy, in person, such recorded personal information; or
- Send you a copy of the recorded personal information by mail (we may charge you a reasonable fee to cover the cost of this service).

We will also tell you at this time the identity, if recorded, of persons to whom we have disclosed the non-public personal information within the preceding two years.

If you ask us to correct, amend or delete any information about you, we will, within 30 business days, either correct, amend or delete the non-public personal information in dispute or notify you of our refusal to take such action along with the reasons for our decision. If we make the correction, amendment or deletion you've requested, we will also notify you along with any person you designate who has received the information about you within the preceding two years, together with any insurance support organization(s) which provided us with the disputed information.

If we refuse to make the requested correction, amendment or deletion, you are permitted to file a concise statement setting forth what you think is the correct, relevant or fair information along with a statement of the reasons why you disagree with our refusal to correct, amend or delete the information subject to dispute. We will file your statement with the disputed personal information and make any person who reviews your file aware of your statement. We will also furnish your statement to any person who has received personal information from us within the two preceding years and any insurance support organization whose primary source of personal information is an insurer.

Important Information Concerning the Applicability and Future Changes to this Privacy Policy

This privacy policy applies, with respect to non-public personal financial information, to products or services provided primarily for personal, family, or household purposes in the United States by the AIG Companies listed below, and it applies to all non-public personal health information these Companies may have. Although we may change this policy at any time, please rest assured that you will be notified of any changes as required by law.

Our Customers Can Depend on Us

We are committed to maintaining our trusted relationship with our Customers. We consider it our privilege to serve our Customers' insurance and financial needs and we value the trust they have placed in us. Our Customers' privacy is a top priority with us and thus we will continue to monitor our privacy practices in order to protect and respect that privacy and will comply with state privacy laws that require more restrictive practices than those set out in this notice.

ATTACHMENT A

EXHIBIT B

Master Application for Group Vision Insurance Policy

A copy of the Underwriter's Master Application for Group Vision Insurance Policy is attached to this Exhibit B.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ENDORSEMENT # 1

This endorsement, effective 12:01 A.M. at January 1, 2013 forms a part of Policy No. VCP 9522302A issued to County of Riverside by National Union Fire Insurance Company of Pittsburgh, PA

COVERAGE TERRITORY ENDORSEMENT

This endorsement modifies insurance provided under the following:

Payment of loss under this policy shall only be made in full compliance with all United States of America economic or trade sanction laws or regulations, including, but not limited to, sanctions, laws and regulations administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC").

President

Secretary

IMPORTANT NOTICE TO OUR CUSTOMERS REGARDING THE OFFICE OF FOREIGN ASSETS CONTROL

Your rights as a policyholder and payments to you, any insured, additional insured, loss payee, mortgagee, or claimant, for loss under this policy may be affected by the administration and enforcement of U.S. economic embargoes and trade sanctions by the OFFICE OF FOREIGN ASSETS CONTROL ("OFAC").

WHAT IS OFAC?

OFAC is an office of the Department of the Treasury and acts under presidential wartime and national emergency powers, as well as authority granted by specific legislation, to impose controls on transactions and freeze foreign assets under U.S. jurisdiction. OFAC administers and enforces economic embargoes and trade sanctions primarily against:

- Targeted foreign countries and their agents
- Terrorism sponsoring agencies and organizations
- International narcotics traffickers

PROHIBITED ACTIVITY

- OFAC enforces certain embargoes and sanctions against certain designated countries. No U.S. business or person may enter into certain transactions in or connected to such designated "sanctioned" countries.
- OFAC maintains a directory known as the "Specially Designated Nationals and Blocked Persons" ("SDNBP") list. No U.S. business or person may transact business with any person or entity named on the SDNBP list.

Additional and more in-depth information on OFAC is available at the following website: http://www.ustreas.gov/offices/eotffc/ofac.

OBLIGATIONS PLACES ON US BY OFAC

If we determine that you or any insured, additional insured, loss payee, mortgagee, or claimant are on the SDNBP list or are connected to a sanctioned country as described in the regulations enforced by OFAC, we must block or "freeze" property and payment of any funds transfers or transactions and report all blocks to OFAC within ten (10) days.

POTENTIAL ACTIONS BY US

1. We may immediately cancel your coverage effective on the day that we determine that we have transacted business with an individual or entity associated with your policy on the SDNBP list or connected to a sanctioned country as described in the regulations enforced by OFAC.
2. If we cancel your coverage, you will not receive a return premium unless approved by OFAC. All funds will be placed in an interest bearing blocked account established on the books of a U.S. financial institution.
3. We will not pay a claim, accept premium or exchange monies or assets of any kind to or with individuals, entities or companies (including a bank) on the SDNBP list or connected to a sanctioned country as described in the regulations enforced by OFAC. And, we will not defend or provide any other benefits under your policy to individuals, entities or companies on the SDNBP list or connected to a sanctioned country as described in the regulations enforced by OFAC.

YOUR RIGHTS AS A POLICYHOLDER

If funds are blocked or frozen by us in conjunction with the OFFICE OF FOREIGN ASSETS CONTROL, you may complete an "APPLICATION FOR THE RELEASE OF BLOCKED FUNDS" and apply for a specific license to request their release. Forms are available for download at the OFAC website. See http://www.ustreas.gov/offices/eotffc/ofac/legal/forms/license.pdf.

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 175 Water Street, 18th Floor, New York, NY 10038
(212) 458-5000
(a capital stock company, herein referred to as the Company)

MASTER APPLICATION FOR GROUP VISION INSURANCE POLICY

Application is hereby made for a plan of vision insurance based on the following statements and representations:

1. **Identification of Policyholder:**

   Name of Policyholder: County of Riverside
   Address of Policyholder: 4080 Lemon Street, Riverside, CA 92502
   Type of Business or Purpose of Organization: Government
   Policy Number: VCP 9522302A

2. **Identification of Vision Benefit Manager:**

   Name of Vision Benefit Manager: Medical Eye Services
   Address of Plan Administrator: P.O. Box 25209, Santa Ana, CA 92799-5209

3. **Classification of Eligible Persons:**

Class	Description of Class
I	All Eligible Regular and Part-Time Employees of the Policyholder under 110 years of age working 20 or more hours of paid service bi-weekly, enrolled in coverage.
II	All Eligible Retirees of the Policyholder under 110 years of age enrolled in coverage.
III	All Eligible Spouses under 110 years of age of Class I ,and II Insureds, enrolled in coverage
IV	All Eligible Dependent Children of Class I, and II Insureds, enrolled in coverage.

Eligible Spouse - as used above, means the Insured's legal spouse or Domestic Partner.

Domestic Partner – as used above, means an opposite or a same sex partner who has met all of the following requirements for at least 12 months: (1) resides with the Insured; (2) shares financial assets and obligations with the Insured; (3) is not related by blood to the Insured to a degree of closeness that would prohibit a legal marriage; (4) is at least the age of consent in the state in which they reside; and (5) neither the Insured or Domestic Partner is married to anyone else, nor has any other Domestic Partner. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

Eligible Dependent Children - as used above, means the Insured's unmarried children, including natural children from the moment of birth, step, foster or adopted children from the moment of placement in the home of the Insured, under age 26.

Any unmarried Eligible Dependent Children of the Insured covered under the Policy before reaching the age limit specified above, who are incapable of self-sustaining employment by reason of mental or physical incapacity, and who are primarily dependent on the Insured for support and maintenance, may continue to be eligible under the Policy beyond that age limit for as long as the Policy is in force, but only if the Insured and they remain continuously covered under the Policy. The Company may request that the Insured submit satisfactory proof of the Eligible Dependent Child(ren)'s incapacity and dependency to the Company within 31 days after the Eligible Dependent Child(ren) reach the age limit specified above. If the Insured fails to furnish the requested proof within 31 days, coverage for the Eligible Dependent Child(ren) will not be extended past the age limit. If coverage is extended, the Company may request that the Insured submit satisfactory proof of the Eligible Dependent Child(ren)'s continued incapacity and dependency to the Company once every two years after the initial request. If the Insured fails to furnish the requested proof within 31 days of the request, coverage for the Eligible Dependent Child(ren) will terminate at the end of that 31-day period.

Continuation of Eligibility. If premium payments are continued on a basis that precludes individual selection, an Insured under 110 years of age who ceases to be a member of any eligible class of persons as described above may still be regarded as in an eligible class of persons as follows: (1) if the Insured is on temporary lay-off or leave of absence (other than an authorized family or medical leave), for the full period of the lay-off or leave, but not for more than three months in a row; or (2) if the Insured is absent from work due to an authorized family or medical leave, for the full period of the leave, but not for more than three months in a row unless a longer period is agreed to by the Company and the Policyholder.

4. **Policy Coverage:**

A. **Benefit Schedule:**

Plan 1: Exam and Eyewear (Employee Plan)

Vision Examination Benefit	X Provided	Not Provided
Benefit Copay Amount		
Participating Provider	$0	
Non-Participating Provider	$0	
Maximum Benefit		
Participating Provider	100%	
Non-Participating Provider	$50 Optometrist / $60 Opthalmalogist	
Benefit Frequency	Once every 12 months from the Date of Service	

Standard Eyeglass Lenses Benefit X Provided _____Not Provided

Benefit Copay Amount
Participating Provider $0
Non-Participating Provider $0

Maximum Benefit
Single Vision
Participating Provider 100%
Non-Participating Provider $43
Bifocal
Participating Provider 100%
Non-Participating Provider $60
Trifocal
Participating Provider 100%
Non-Participating Provider $75
Lenticular
Participating Provider 100%
Non-Participating Provider $120 Monofocal; $200.00 Multifocal

Benefit Frequency Once every 12 months from the Date of Service

Eyeglass Frame Benefit X Provided _____Not Provided

Benefit Copay Amount
Participating Provider $0
Non-Participating Provider $0

Maximum Benefit
Participating Provider $75
Non-Participating Provider $40

Benefit Frequency Once every 12 months from the Date of Service

A) Contact Lenses Benefit X Provided _____Not Provided

Benefit Copay Amount
Participating Provider $0
Non-Participating Provider $0

In lieu of Standard Eyeglass Lenses and Eyeglass Frames Benefit X Yes ____No

Maximum Benefit
Standard Correction

Participating Provider $100
Non-Participating Provider $100

Benefit Frequency Once every 12 months from the Date of Service

B) Medically Necessary Contact Lenses Benefit*

Benefit Copay Amount	
Participating Provider	$0
Non-Participating Provider	$0
Maximum Benefit	
Participating Provider	100%
Non-Participating Provider	$250
Benefit Frequency	Once every 12 months from the Date of Service

***Pre-approval from the Vision Benefit Manager is required.**

Plan 2: Eyewear Only (Employee Plan)

Standard Eyeglass Lenses Benefit X Provided _____Not Provided

Benefit Copay Amount	
Participating Provider	$0
Non-Participating Provider	$0
Maximum Benefit	
Single Vision	
Participating Provider	100%
Non-Participating Provider	$43
Bifocal	
Participating Provider	100%
Non-Participating Provider	$60
Trifocal	
Participating Provider	100%
Non-Participating Provider	$75
Lenticular	
Participating Provider	100%
Non-Participating Provider	$120 Monofocal; $200.00 Multifocal
Benefit Frequency	Once every 12 months from the Date of Service

Eyeglass Frame Benefit X Provided _____Not Provided

Benefit Copay Amount	
Participating Provider	$0
Non-Participating Provider	$0
Maximum Benefit	
Participating Provider	$75
Non-Participating Provider	$40
Benefit Frequency	Once every 12 months from the Date of Service

A) Contact Lenses Benefit __X__Provided _____Not Provided

Benefit Copay Amount	
Participating Provider	$0
Non-Participating Provider	$0

In lieu of Standard Eyeglass Lenses and Eyeglass Frames Benefit __X__Yes ____No

Maximum Benefit	
Standard Correction	
Participating Provider	$100
Non-Participating Provider	$100
Benefit Frequency	Once every 12 months from the Date of Service

B) Medically Necessary Contact Lenses Benefit*

Benefit Copay Amount	
Participating Provider	$0
Non-Participating Provider	$0
Maximum Benefit	
Participating Provider	100%
Non-Participating Provider	$250
Benefit Frequency	Once every 12 months from the Date of Service

***Pre-approval from the Vision Benefit Manager is required.**

Plan 3: Exam and Eyewear (Retiree Plan)

Vision Examination Benefit X Provided ____ Not Provided

Benefit Copay Amount	
Participating Provider	$0
Non-Participating Provider	$0
Maximum Benefit	
Participating Provider	100%
Non-Participating Provider	$50 Optometrist / $60 Opthalmalogist
Benefit Frequency	Once every 12 months from the Date of Service

Standard Eyeglass Lenses Benefit	X Provided	_____Not Provided
Benefit Copay Amount		
Participating Provider	$0	
Non-Participating Provider	$0	
Maximum Benefit		
Single Vision		
Participating Provider	100%	
Non-Participating Provider	$43	
Bifocal		
Participating Provider	100%	
Non-Participating Provider	$60	
Trifocal		
Participating Provider	100%	
Non-Participating Provider	$75	
Lenticular		
Participating Provider	100%	
Non-Participating Provider	$120 Monofocal; $200.00 Multifocal	
Benefit Frequency	Once every 12 months from the Date of Service	
Eyeglass Frame Benefit	X Provided	_____Not Provided
Benefit Copay Amount		
Participating Provider	$0	
Non-Participating Provider	$0	
Maximum Benefit		
Participating Provider	$120	
Non-Participating Provider	$72	
Benefit Frequency	Once every 12 months from the Date of Service	
A) Contact Lenses Benefit	X Provided	_____Not Provided
Benefit Copay Amount		
Participating Provider	$0	
Non-Participating Provider	$0	

In lieu of Standard Eyeglass Lenses and Eyeglass Frames Benefit X Yes ____No

Maximum Benefit	
Standard Correction	
Participating Provider	$105
Non-Participating Provider	$105

Benefit Frequency Once every 12 months from the Date of Service

B) Medically Necessary Contact Lenses Benefit*

Benefit Copay Amount	
Participating Provider	$0
Non-Participating Provider	$0
Maximum Benefit	
Participating Provider	100%
Non-Participating Provider	$250

Benefit Frequency Once every 12 months from the Date of Service

***Pre-approval from the Vision Benefit Manager is required.**

B. The following Riders are attached to and made part of the Policy as of the Policy Effective Date. Each Rider is subject to all provisions, limitations and exclusions of the Policy that are not specifically modified by the Rider.

CLASS(ES) I, II, III, & IV

FORM NO.	DESCRIPTION
C22441DBG	Family Coverage
C30532DBG	Amended Definition Endorsement

5. **Premiums:**

It is hereby agreed and understood that the prem ium rate is as follows for each class described above:

Plan 1: Exam and Eyewear (Employee Plan)

Employee Only Coverage:	$8.55 per Person per Month
Employee + Spouse Coverage:	$12.92 per Person per Month
Employee + Spouse + Dependent Chi ld(ren):	$17.48 per Person per Month

Plan 2: Eyewear Only (Employee Plan)

Employee Only Coverage:	$7.22 per Person per Month
Employee + Spouse Coverage:	$11.50 per Person per Month
Employee + Spouse + Dependent Chi ld(ren):	$15.87 per Person per Month

Plan 3: Exam and Eyewear (Retiree Plan)

Retiree Only Coverage:	$10.17 per Person per Month
Retiree + Spouse Coverage:	$19.48 per Person per Month
Retire + Spouse + Dependent Child(ren):	$25.84 per Person per Month

Such premiums are due and payable in the following manner: monthly

6. **Coverage Effective Date:**

Subject to the Policy provisions regarding the effective date of coverage for individuals, insurance will become effective as to each eligible person for whom enrollment has been received by the Policyholder, if applicable, and for whom premium has been paid on the following date: (a) the Policy Effective Date or (b) the first date of the month following enrollment.

A change in coverage due to a change in the eligible person's election of benefits will become effective on the latest of the following dates: (1) if individual enrollment for the change is required, the date the written enrollment form requesting the change is received by the Policyholder; (2) if the change requires a change in premium, the date the first changed premium is paid when due. A change in coverage applies only with respect to losses that occur on or after the effective date of the change.

7. **Policy Effective Date:** January 1, 2013

8. **Policy Termination Date:** January 1, 2017

Signed for the Policyholder

JOHN J. BENOIT

Title **CHAIRMAN, BOARD OF SUPERVISORS**

3/12/13

Date

ATTEST:
KECIA HARPER-IHEM, Clerk
By
DEPUTY

Signed by Licensed Resident Agent
(Where Required by Law)

ATTACHMENT A

EXHIBIT C

HIPAA Business Associate Agreement

EXHIBIT C

HIPAA Business Associate Agreement
Between the County of Riverside and Medical Eye Services, Inc.

This HIPAA Business Associate Agreement (the "Addendum") supplements, and is made part of the Vision Plan Administration Agreement (the "Underlying Agreement") between the County of Riverside ("County") and Medical Eye Services, Inc. ("Contractor") and shall be effective as of the date the Underlying Agreement is approved by both Parties (the "Effective Date").

RECITALS

WHEREAS, County and Contractor entered into the Underlying Agreement pursuant to which the Contractor provides services to County, and in conjunction with the provision of such services certain protected health information ("PHI") and/or certain electronic protected health information ("ePHI") may be created by or made available to Contractor for the purposes of carrying out its obligations under the Underlying Agreement; and,

WHEREAS, the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191 enacted August 21, 1996, and the Health Information Technology for Economic and Clinical Health Act ("HITECH") of the American Recovery and Reinvestment Act of 2009, Public Law 111-5 enacted February 17, 2009, and the laws and regulations promulgated subsequent thereto, as may be amended from time to time, are applicable to the protection of any use or disclosure of PHI and/or ePHI pursuant to the Underlying Agreement; and,

WHEREAS, County is a covered entity, as defined in the Privacy Rule; and,

WHEREAS, Contractor when a creator or recipient of, or when they have access to, PHI and/or ePHI of County, is a business associate as defined in the Privacy Rule; and,

WHEREAS, pursuant to 42 USC §17931 and §17934, certain provisions of the Security Rule and Privacy Rule apply to a business associate of a covered entity in the same manner that they apply to the covered entity, the additional security and privacy requirements of HITECH are applicable to business associates and must be incorporated into the business associate agreement, and a business associate is liable for civil and criminal penalties for failure to comply with these security and/or privacy provisions; and,

WHEREAS, the parties mutually agree that any use or disclosure of PHI and/or ePHI must be in compliance with the Privacy Rule, Security Rule, HIPAA, HITECH and any other applicable law; and,

WHEREAS, the parties intend to enter into this Addendum to address the requirements and obligations set forth in the Privacy Rule, Security Rule, HITECH and HIPAA as they apply to Contractor as a business associate of County, including the establishment of permitted and required uses and disclosures of PHI and/or ePHI created or received by Contractor during the course of performing services on behalf of County, and appropriate limitations and conditions on such uses and disclosures;

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

1. **Definitions.** Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in HITECH, HIPAA, Security Rule and/or Privacy Rule, as may be amended from time to time.

   A. "Breach" when used in connection with PHI means the acquisition, access, use or disclosure of PHI in a manner not permitted by the Privacy Rule which compromises the security or privacy of the PHI, and shall have the meaning given such term in 45 CFR §164.402. For purposes of this definition, "compromises the security or privacy of PHI" means poses a significant risk of financial, reputational, or other harm to the individual, unless a use or disclosure of PHI does not include the identifiers listed at 45 CFR §164.514(e)(2), date of birth and zip code. Breach excludes:

      (1) Any unintentional acquisition, access or use of PHI by a workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under subpart E of the Privacy Rule.

      (2) Any inadvertent disclosure by a person who is authorized to access PHI at a covered entity or business associate to another person authorized to access PHI at the same covered entity, business associate, or organized health care arrangement in which County participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted by subpart E of the Privacy Rule.

      (3) A disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

   B. "Data aggregation" has meaning given such term in 45 CFR §164.501.

   C. "Designated record set" as defined in 45 CFR §164.501 means a group of records maintained by or for a covered entity that may include: the medical records and billing records about individuals maintained by or for a covered health care provider; the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or, used, in whole or in part, by or for the covered entity to make decisions about individuals.

   D. "Electronic protected health information" ("ePHI") as defined in 45 CFR §160.103 means protected health information transmitted by or maintained in electronic media.

   E. "Electronic health record" means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff, and shall have the meaning given such term in 42 USC §17921(5).

   F. "Health care operations" has the meaning given such term in 45 CFR §164.501.

G. "Individual" as defined in 45 CFR §160.103 means the person who is the subject of protected health information.

H. "Person" as defined in 45 CFR §160.103 means a natural person, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private.

I. "Privacy Rule" means the HIPAA regulations codified at 45 CFR Parts 160 and 164, Subparts A and E.

J. "Protected health information" ("PHI") has the meaning given such term in 45 CFR §160.103, which includes ePHI.

K. "Required by law" has the meaning given such term in 45 CFR §164.103.

L. "Secretary" means the Secretary of the Department of Health and Human Services ("HHS").

M. "Security Rule" means the HIPAA Regulations codified at 45 CFR Parts 160 and 164, Subparts A and C.

N. "Unsecured protected health information" and "unsecured PHI" as defined in 45 CFR §164.402 means PHI not rendered unusable, unreadable, or indecipherable to unauthorized individuals through use of a technology or methodology specified by the Secretary in the guidance issued under 42 USC §17932(h)(2) on the HHS web site.

2. **Scope of Use and Disclosure by Contractor of County's PHI and/or ePHI.**

A. Except as otherwise provided in this Addendum, Contractor may use, disclose, or access PHI and/or ePHI as necessary to perform any and all obligations of Contractor under the Underlying Agreement or to perform functions, activities or services for, or on behalf of, County as specified in this Addendum, if such use or disclosure does not violate HIPAA, HITECH, the Privacy Rule and/or Security Rule.

B. Unless otherwise limited herein, in addition to any other uses and/or disclosures permitted or authorized by this Addendum or required by law, in accordance with 45 CFR §164.504(e)(2), Contractor may:

(1) Use PHI and/or ePHI if necessary for Contractor's proper management and administration and to carry out its legal responsibilities; and,

(2) Disclose PHI and/or ePHI for the purpose of Contractor's proper management and administration or to carry out its legal responsibilities, only if:

(a) The disclosure is required by law; or,

(b) Contractor obtains reasonable assurances, in writing, from the person to whom Contractor will disclose such PHI and/or ePHI that the person will:

(i) Hold such PHI and/or ePHI in confidence and use or further disclose it only for the purpose for which Contractor disclosed it to the person, or as required by law; and,

(ii) Notify Contractor of any instances of which it becomes aware in which the confidentiality of the information has been breached; and,

(3) Use PHI to provide data aggregation services relating to the health care operations of County pursuant to the Underlying Agreement or as requested by County; and,

(4) De-identify all PHI and/or ePHI of County received by Contractor under this Addendum provided that the de-identification conforms to the requirements of the Privacy Rule and/or Security Rule and does not preclude timely payment and/or claims processing and receipt.

C. Notwithstanding the foregoing, in any instance where applicable state and/or federal laws and/or regulations are more stringent in their requirements than the provisions of HIPAA, including, but not limited to, prohibiting disclosure of mental health and/or substance abuse records, the applicable state and/or federal laws and/or regulations shall control the disclosure of records.

3. **Prohibited Uses and Disclosures.**

A. Contractor may neither use, disclose, nor access PHI and/or ePHI in a manner not authorized by the Underlying Agreement or this Addendum without patient authorization or de-identification of the PHI and/or ePHI and as authorized in writing from County.

B. Contractor may neither use, disclose, nor access PHI and/or ePHI it receives from County or from another business associate of County, except as permitted or required by this Addendum, or as required by law.

C. Contractor agrees not to make any disclosure of PHI and/or ePHI that County would be prohibited from making.

D. Contractor shall not use or disclose PHI for any purpose prohibited by the Privacy Rule, Security Rule, HIPAA and/or HITECH, including, but not limited to 42 USC §§17935 and 17936. Contractor agrees:

(1) Not to use or disclose PHI for fundraising or marketing purposes, unless pursuant to the Underlying Agreement and as permitted by and consistent with the requirements of 42 USC §17936;

(2) Not to disclose PHI, except as otherwise required by law, to a health plan for purposes of carrying out payment or health care operations, if the individual has requested this restriction pursuant to 42 USC §17935(a) and 45 CFR §164.522, and has paid out of pocket in full for the health care item or service to which the PHI solely relates; and,

(3) Not to receive, directly or indirectly, remuneration in exchange for PHI, unless permitted by 42 USC §17935(d)(2) and with the prior written consent of County. This prohibition shall not apply to payment by County to Contractor for services provided pursuant to the Underlying Agreement.

4. **Obligations of County.**

A. County agrees to make its best efforts to notify Contractor promptly in writing of any restrictions on the use or disclosure of PHI and/or ePHI agreed to by County that may affect Contractor's ability to perform its obligations under the Underlying Agreement, or this Addendum.

B. County agrees to make its best efforts to promptly notify Contractor in writing of any changes in, or revocation of, permission by any individual to use or disclose PHI and/or ePHI, if such changes or revocation may affect Contractor's ability to perform its obligations under the Underlying Agreement, or this Addendum.

C. County agrees to make its best efforts to promptly notify Contractor in writing of any known limitation(s) in its notice of privacy practices to the extent that such limitation may affect Contractor's use or disclosure of PHI and/or ePHI.

D. County agrees not to request Contractor to use or disclose PHI and/or ePHI in any manner that would not be permissible under HITECH, HIPAA, the Privacy Rule, and/or Security Rule.

E. County agrees to obtain any authorizations necessary for the use or disclosure of PHI and/or ePHI, so that Contractor can perform its obligations under this Addendum and/or Underlying Agreement.

5. **Obligations of Contractor.** In connection with the use or disclosure of PHI and/or ePHI, Contractor agrees to:

A. Use or disclose PHI only if such use or disclosure complies with each applicable requirement of 45 CFR §164.504(e). Contractor shall also comply with the additional privacy requirements that are applicable to covered entities in HITECH, as may be amended from time to time.

B. Not use or further disclose PHI and/or ePHI other than as permitted or required by this Addendum or as required by law. Contractor shall promptly notify County if Contractor is required by law to disclose PHI and/or ePHI.

C. Use appropriate safeguards to prevent use or disclosure of PHI and/or ePHI other than as provided for by this Addendum.

D. Mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of PHI and/or ePHI by Contractor in violation of this Addendum.

E. Report to County any use or disclosure of PHI and/or ePHI not provided for by this Addendum or otherwise in violation of HITECH, HIPAA, the Privacy Rule, and/or Security Rule of which Contractor becomes aware.

F. Require any subcontractors or agents to whom Contractor provides PHI and/or ePHI to agree to the same restrictions and conditions that apply to Contractor with respect to such PHI and/or ePHI, including the restrictions and conditions pursuant to this Addendum.

G. Make available to County or the Secretary, in the time and manner designated by County or Secretary, Contractor's internal practices, books and records relating to the use, disclosure and privacy protection of PHI received from County, or created or received by Contractor on behalf of County, for purposes of determining, investigating or auditing Contractor's and/or County's compliance with the Privacy Rule.

H. Request, use or disclose only the minimum amount of PHI necessary to accomplish the intended purpose of the request, use or disclosure in accordance with 42 USC §17935(b) and 45 CFR §164.502(b)(1).

I. Comply with requirements of satisfactory assurances under 45 CFR §164.512 relating to notice or qualified protective order in response to a third party's subpoena, discovery request, or other lawful process for the disclosure of PHI, which Contractor shall promptly notify County upon Contractor's receipt of such request from a third party.

J. Not require an individual to provide patient authorization for use or disclosure of PHI as a condition for treatment, payment, enrollment in any health plan (including the health plan administered by County), or eligibility of benefits, unless otherwise excepted under 45 CFR §164.508(b)(4) and authorized in writing by County.

K. Use appropriate administrative, technical and physical safeguards to prevent inappropriate use, disclosure, or access of PHI and/or ePHI.

L. Obtain and maintain knowledge of applicable laws and regulations related to HIPAA and HITECH, as may be amended from time to time.

6. **Access to PHI, Amendment and Disclosure Accounting.** Contractor agrees to:

A. **Access to PHI and electronic health record.** Provide access to PHI in a designated record set to County or an individual as directed by County, within five (5) days of request from County, to satisfy the requirements of 45 CFR §164.524. If Contractor uses or maintains electronic health records, Contractor shall, at the request of County, provide electronic health records in electronic format to enable County to fulfill its obligations under 42 USC §17935(e).

B. **Amendment of PHI.** Make PHI available for amendment and incorporate amendments to PHI in a designated record set County directs or agrees to at the request of an individual, within fifteen (15) days of receiving a written request from County, in accordance with 45 CFR §164.526.

C. **Accounting of disclosures of PHI and electronic health record.** Assist County to fulfill its obligations to provide accounting of disclosures of PHI under 45 CFR §164.528 and, where applicable, electronic health records under 42 USC §17935(c) if Contractor uses or maintains electronic health records. Contractor shall:

(1) Document such disclosures of PHI and/or electronic health records, and information related to such disclosures, as would be required for County to respond to a request by an individual for an accounting of disclosures of PHI and/or electronic health record in accordance with 45 CFR §164.528.

(2) Within fifteen (15) days of receiving a written request from County, provide to County or any individual as directed by County information collected in accordance with this section to permit County to respond to a request by an individual for an accounting of disclosures of PHI and/or electronic health record.

(3) Make available for County information required by this section for six (6) years preceding the individual's request for accounting of disclosures of PHI, and for three (3) years preceding the individual's request for accounting of disclosures of electronic health record.

7. **Security of ePHI.** In the event Contractor needs to create, receive, or have access to County ePHI, in accordance with 42 USC §17931 and 45 CFR §§164.314(a)(2)(i), and 164.306, Contractor shall:

A. Implement the administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI that Contractor creates, receives, maintains, or transmits on behalf of County as required by the Security Rule, including without limitations, each of the requirements of the Security Rule at 45 CFR §§164.308, 164.310, and 164.312;

B. Comply with each of the requirements of 45 CFR §164.316 relating to the implementation of policies, procedures and documentation requirements with respect to ePHI;

C. Protect against any reasonably anticipated threats or hazards to the security or integrity of ePHI;

D. Protect against any reasonably anticipated uses or disclosures of ePHI that are not permitted or required under the Privacy Rule;

E. Ensure compliance by Contractor's workforce;

F. Ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable appropriate safeguards to protect it;

G. Report to County any security incident of which Contractor becomes aware; and,

H. Comply with any additional security requirements that are applicable to covered entities in Title 42 (Public Health and Welfare) of the United States Code, as may be amended from time to time, including but not limited to HITECH.

8. **Breach of Unsecured PHI.** In the case of breach of unsecured PHI, Contractor shall comply with the applicable provisions of 42 USC §17932 and 45 CFR Part 164, Subpart D, including but not limited to 45 CFR §164.410.

A. **Discovery and notification.** Following the discovery of a breach of unsecured PHI, Contractor shall notify County in writing of such breach without unreasonable delay and in no case later than 60 calendar days after discovery of a breach, except as provided in 45 CFR §164.412.

(1) **Breaches treated as discovered.** A breach is treated as discovered by Contractor as of the first day on which such breach is known to Contractor or, by exercising reasonable diligence, would have been known to Contractor, which includes any person, other than the person committing the breach, who is an employee, officer, or other agent of Contractor (determined in accordance with the federal common law of agency).

(2) **Content of notification.** The written notification to County relating to breach of unsecured PHI shall include, to the extent possible, the following information if known (or can be reasonably obtained) by Contractor:

(a) The identification of each individual whose unsecured PHI has been, or is reasonably believed by Contractor to have been accessed, acquired, used or disclosed during the breach;

(b) A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;

(c) A description of the types of unsecured PHI involved in the breach, such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved;

(d) Any steps individuals should take to protect themselves from potential harm resulting from the breach;

(e) A brief description of what Contractor is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches; and,

(f) Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, web site, or postal address.

B. **Cooperation.** With respect to any breach of unsecured PHI reported by Contractor, Contractor shall cooperate with County and shall provide County with any information requested by County to enable County to fulfill in a timely manner its own reporting and notification obligations, including but not limited to providing notice to individuals, media outlets and the Secretary in accordance with 42 USC §17932 and 45 CFR §§ 164.404, 164.406 and 164.408.

C. **Breach log.** To the extent breach of unsecured PHI involves less than 500 individuals, Contractor shall maintain a log or other documentation of such breaches and provide such log or other documentation on an annual basis to County not later than fifteen (15) days after the end of each calendar year for submission to the Secretary.

D. **Delay of notification authorized by law enforcement.** If Contractor delays notification of breach of unsecured PHI pursuant to a law enforcement official's statement that required notification, notice or posting would impede a criminal investigation or cause damage to national security, Contractor shall maintain documentation sufficient to demonstrate its compliance with the requirements of 45 CFR §164.412.

E. **Payment of costs.** With respect to any breach of unsecured PHI caused solely by the Contractor's failure to comply with one or more of its obligations under this Addendum and/or

the provisions of HITECH, HIPAA, the Privacy Rule or the Security Rule, Contractor agrees to pay any and all costs associated with providing all legally required notifications to individuals, media outlets, and the Secretary. This provision shall not be construed to limit or diminish Contractor's obligations to indemnify, defend and hold harmless County under Section 9 of this Addendum.

F. **Documentation.** Pursuant to 45 CFR §164.414(b), in the event Contractor's use or disclosure of PHI and/or ePHI violates the Privacy Rule, Contractor shall maintain documentation sufficient to demonstrate that all notifications were made by Contractor as required by 45 CFR Part 164, Subpart D, or that such use or disclosure did not constitute a breach.

9. **Hold Harmless/Indemnification.**

A. Contractor agrees to indemnify and hold harmless County, all Agencies, Districts, Special Districts and Departments of County, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives from any liability whatsoever, based or asserted upon any services of Contractor, its officers, employees, subcontractors, agents or representatives arising out of or in any way relating to this Addendum, including but not limited to property damage, bodily injury, death, or any other element of any kind or nature whatsoever arising from the performance of Contractor, its officers, agents, employees, subcontractors, agents or representatives from this Addendum. Contractor shall defend, at its sole expense, all costs and fees, including but not limited to attorney fees, cost of investigation, defense and settlements or awards, of County, all Agencies, Districts, Special Districts and Departments of County, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents or representatives in any claim or action based upon such alleged acts or omissions.

B. With respect to any action or claim subject to indemnification herein by Contractor, Contractor shall, at their sole cost, have the right to use counsel of their choice, subject to the approval of County, which shall not be unreasonably withheld, and shall have the right to adjust, settle, or compromise any such action or claim without the prior consent of County; provided, however, that any such adjustment, settlement or compromise in no manner whatsoever limits or circumscribes Contractor's indemnification to County as set forth herein. Contractor's obligation to defend, indemnify and hold harmless County shall be subject to County having given Contractor 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 Contractor's expense, for the defense or settlement thereof. Contractor's obligation hereunder shall be satisfied when Contractor has provided to County the appropriate form of dismissal relieving County from any liability for the action or claim involved.

C. The specified insurance limits required in the Underlying Agreement of this Addendum shall in no way limit or circumscribe Contractor's obligations to indemnify and hold harmless County herein from third party claims arising from issues of this Addendum.

D. In the event there is conflict between this clause and California Civil Code §2782, this clause shall be interpreted to comply with Civil Code §2782. Such interpretation shall not relieve the Contractor from indemnifying County to the fullest extent allowed by law.

E. In the event there is a conflict between this indemnification clause and an indemnification clause contained in the Underlying Agreement of this Addendum, this indemnification shall only apply to the subject issues included within this Addendum.

10. **Term.** This Addendum shall commence upon the Effective Date and shall terminate when all PHI and/or ePHI provided by County to Contractor, or created or received by Contractor on behalf of County, is destroyed or returned to County, or, if it is infeasible to return or destroy PHI and/ePHI, protections are extended to such information, in accordance with section 11.B of this Addendum.

11. **Termination.**

A. **Termination for Breach of Contract.** A breach of any provision of this Addendum by either party shall constitute a material breach of the Underlying Agreement and will provide grounds for terminating this Addendum and the Underlying Agreement with or without an opportunity to cure the breach, notwithstanding any provision in the Underlying Agreement to the contrary. Either party, upon written notice to the other party describing the breach, may take any of the following actions:

(1) Terminate the Underlying Agreement and this Addendum, effective immediately, if the other party breaches a material provision of this Addendum.

(2) Provide the other party with an opportunity to cure the alleged material breach and in the event the other party fails to cure the breach to the satisfaction of the non-breaching party in a timely manner, the non-breaching party has the right to immediately terminate the Underlying Agreement and this Addendum.

(3) If termination of the Underlying Agreement is not feasible, the non-breaching party may report the problem to the Secretary, and upon the non-breaching party's request, the breaching party at its own expense shall implement a plan to cure the breach and report regularly on its compliance with such plan to the non-breaching party.

B. **Effect of Termination.**

(1) Upon termination of this Addendum, for any reason, Contractor shall return or destroy all PHI and/or ePHI received from County, or created or received by the Contractor on behalf of County, and, in the event of destruction, Contractor shall certify such destruction, in writing, to County. This provision shall apply to all PHI and/or ePHI which are in the possession of subcontractors or agents of Contractor. Contractor shall retain no copies of PHI and/or ePHI, except as provided below in paragraph (2) of this section.

(2) In the event that Contractor determines that returning or destroying the PHI and/or ePHI is not feasible, Contractor shall provide written notification to County of the conditions that make such return or destruction not feasible. Upon determination by Contractor that return or destruction of PHI and/or ePHI is not feasible, Contractor shall extend the protections of this Addendum to such PHI and/or ePHI and limit further uses and disclosures of such PHI and/or ePHI to those purposes which make the return or destruction not feasible, for so long as Contractor maintains such PHI and/or ePHI.

12. **General Provisions.**

A. **Retention Period.** Whenever Contractor is required to document or maintain documentation pursuant to the terms of this Addendum, Contractor shall retain such documentation for 6 years from the date of its creation or as otherwise prescribed by law, whichever is later.

B. **Amendment.** The parties agree to take such action as is necessary to amend this Addendum from time to time as is necessary for County to comply with HITECH, the Privacy Rule, Security Rule, and HIPAA generally.

C. **Survival.** The obligations of Contractor under Sections 3, 5, 6, 7, 8, 9, 11.B and 12.A of this Addendum shall survive the termination or expiration of this Addendum.

D. **Regulatory and Statutory References.** A reference in this Addendum to a section in HITECH, HIPAA, the Privacy Rule and/or Security Rule means the section(s) as in effect or as amended.

E. **Conflicts.** The provisions of this Addendum shall prevail over any provisions in the Underlying Agreement that conflict or appear inconsistent with any provision in this Addendum.

F. **Interpretation of Addendum.**

(1) This Addendum shall be construed to be part of the Underlying Agreement as one document. The purpose is to supplement the Underlying Agreement to include the requirements of the Privacy Rule, Security Rule, HIPAA and HITECH.

(2) Any ambiguity between this Addendum and the Underlying Agreement shall be resolved to permit County to comply with the Privacy Rule, Security Rule, HIPAA and HITECH generally.

G. **Notices to County.** All notifications required to be given by Contractor pursuant to the terms of this Addendum shall be in writing and delivered to the County by either registered or certified mail return receipt requested or guaranteed overnight mail with tracing capability at the address listed below, or at such other address as County may hereafter designate. All notices provided by Contractor pursuant to this Section shall be deemed given or made when received by County.

Name: Barbara A. Olivier

Title: Assistant CEO/Human Resources Director

Address: 4080 Lemon St. 7th floor

Riverside, CA 92502

ATTACHMENT B

Letter of Understanding

LETTER OF UNDERSTANDING
CONCERNING THE GROUP VISION INSURANCE POLICY

This **Letter of Understanding** is made by and between the County of Riverside, a political subdivision of the State of California ("Policyholder"), and National Union Fire Insurance Company of Pittsburgh, PA., a Pennsylvania corporation ("Company"), and referred to collectively as the "Parties."

WHEREAS, the Company has issued the Group Vision Insurance Policy Number VCP 9522302A (the "Policy") with an effective date of January 1, 2013 to the Policyholder; and,

WHEREAS, the Policyholder desires to modify certain provisions in the Policy and the Master Application, as described herein, for the Policy ("Master Application") and the Company is willing to make the appropriate filings with the California Department of Insurance ("CDOI");

WHEREAS, Company shall issue the Policy in its currently approved form upon the renewal date of January 1, 2013, and Company will not make any modification to the language of the forms until the changes described in this LOU are approved by the CDOI.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, the Policyholder and Company agree as follows:

1. Defined Terms. Unless otherwise defined herein, the capitalized terms used herein shall have the same meaning set forth in the Policy and Master Application.

2. Definition of Eligible Spouse Proposed Modification in the Master Application

The Parties agree that the Company will modify the definition of "Eligible Spouse" in Paragraph 3 (Classification of Eligible Persons) of the Master Application form as follows and will incorporate the definition in the Definitions section of the Policy and file the Master Application form and the Policy form with the CDOI:

> "**Eligible Spouse** – means the Insured's legal spouse or Domestic Partner. If legal spouse, a copy of the marriage certificate must be provided to the Company."

3. Definition of Domestic Partner Proposed Modification in the Master Application

The Parties agree that the Company will modify the definition of "Domestic Partner" in Paragraph 3 (Classification of Eligible Persons) of the Master Application form as follows and will incorporate the definition in the Definitions section of the Policy and file the Master Application form and the Policy form with the CDOI:

> "**Domestic Partner**– means [an opposite] [or] [a same] sex partner who has met all of the requirements of the California Family Code Section 297 and filed a Declaration of Domestic Partnership with the Secretary of State. The Insured must provide a copy of the Declaration of Domestic Partnership registered with the California Secretary of State and their partner's social security number."

4. Definition of Eligible Dependent Children Proposed Modification in the Master Application

The Parties agree that the Company will modify the definition of "Eligible Dependent Children" in Paragraph 3 (Classification of Eligible Persons) of the Master Application as follows and will incorporate the definition in the Definitions section of the Policy and file the Master Application form and the Policy form with the CDOI:

> "**Eligible Dependent Children** – means Your unmarried and married children, including natural children from the moment of birth, step, children of registered Domestic Partner or adopted children [from the moment of placement in Your home], under age [26].
>
> Any of Your unmarried and married Eligible Dependent Children covered under the Policy before reaching the age limit specified above, who are incapable of self-sustaining employment by reason of mental or physical incapacity, and who are primarily dependent on You for support and maintenance, may continue to be eligible under the Policy beyond that age limit for as long as the Policy is in force, but only if You and they remain continuously covered under the Policy. The Company may request that You submit satisfactory proof of the Eligible Dependent Child(ren)'s incapacity and dependency to the Company within 31 days after the Eligible Dependent Child(ren) reach the age limited specified above. If You fail to furnish the requested proof within 31 days of the Eligible Dependent Child(ren) reaching the age limit, coverage for the Eligible Dependent Child(ren) will not be extended past the age limit. The Company may request that You submit satisfactory proof of the Eligible Dependent Child(ren)'s continued incapacity and dependency to the Company once every two years after the initial request. If You fail to furnish the requested proof within 31 days of the request, coverage for the Eligible Dependent Child(ren) will terminate at the end of that 31-day period."

5. Entire Contract; Changes

The Parties agree that Company will modify the first sentence of the second paragraph of the "Entire Contract; Changes" provision in the "General Provisions" section of the Policy as follows and file the Policy form with the CDOI:

> "No change in this Policy or the Master Application shall be valid unless: (1) approved in writing by the Policyholder; and (2) approved by an executive officer of the Company and unless such approval be endorsed thereon or attached hereto."

6. Approval by Department of Insurance

a. Company agrees that it will make the appropriate filings with the CDOI to modify the Policy and the Master Application in a manner that is consistent with the provisions of this Letter of Understanding within the Policy to the extent such modifications are approved

by the CDOI. The Company agrees to make the filings on or before March 1, 2013 and shall be in a form which is appropriate under the requirements of the CDOI.

b. Prior to making the appropriate filings with the CDOI as set forth in Section 6.a. above, Company shall provide the Policyholder a draft of the modified forms for review and approval.

c. Upon receipt of the CDOI's determinations regarding the Company's filings to amend the Policy, Company shall promptly provide written notice of such determinations to the Policyholder.

d. In the event the CDOI does not approve Company's filings, Company agrees to make reasonable efforts to work with the CDOI to secure approval from the CDOI. Failure of the Company to secure approval of the Company's filings will have no effect on the terms and conditions of the Policy as issued to the Policyholder.

7. Notice to Parties. All notices and other communications required to be given under this Letter of Understanding shall be in writing and either delivered personally or by express delivery or United States mail at the address set forth below or such other address as the Parties may hereafter designate, and shall be deemed to be delivered on receipt:

The County of Riverside
Attn: Stacey Beale
4080 Lemon St., 1st Floor
Riverside, CA 92501

AIG Benefit Solutions
Attn: Joseph Weiss
1 World Financial Center
200 Liberty Street – 14th Floor
New York, NY 10281

8. Certification of Authority to Execute This Letter of Understanding. Company and Policyholder certify that the individual signing below has the authority to execute this Letter of Understanding, respectively, on behalf of Company and Policyholder, and may legally bind Company and Policyholder to the terms and conditions of this Letter of Understanding.

9. Effective Date. This Letter of Understanding is made effective as of January 1, 2013 ("Effective Date").

10. Termination. This Letter of Understanding shall automatically terminate on the date the Policy terminates or the date of the CDOI's approval or disapproval of Company's filings to pursuant, this Letter of Understanding, whichever occurs first.

11. Severability. In the event any provision contained in this Letter of Understanding is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions will nevertheless continue in full force and effect without being impaired or invalidated in any way.

12. Governing Law; Venue. This Letter of Understanding shall be governed and construed by the laws of the State of California without regard to conflict of laws principles. All actions and proceedings arising in connection with this Letter of Understanding 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.

IN WITNESS WHEREOF, the Parties hereto have caused their duly appointed representatives to execute this Letter of Understanding Concerning the Group Vision Insurance Policy as set forth below.

National Union Fire Insurance Company of Pittsburgh, PA., a Pennsylvania corporation

By: _____

Printed Name: M. STEVENSON

Title: ATTY IN FACT

Date: 2/20/13

COUNTY OF RIVERSIDE

By: _____

Printed Name: **JOHN J. BENOIT**

Title: **CHAIRMAN, BOARD OF SUPERVISORS**

Date: MAR 12 2013

ATTEST:
KECIA HARPER-IHEM, Clerk
By _____
DEPUTY

MAR 12 2013 3-29