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

662

FROM: Human Resources Department

SUBMITTAL DATE:
May 19, 2014

SUBJECT: Health Net of California, Inc., Medical Plan and Supplemental Agreements and Silver Script Employer Group Waiver Plan Agreements for the 2013 calendar year [District- All] [Total Cost - $0] [SOURCE OF FUNDS - N/A]

RECOMMENDED MOTION: That the Board of Supervisors:

1. Ratify and approve the Medical Plan and Supplemental agreements between Health Net of California, Inc., and the County for the period of January 1, 2013 through December 31, 2013 (Attachments A - I);
2. Ratify and approve the Employer Group Waiver Plan agreements between Silver Script Insurance Company and the County for the period of January 1, 2013 through December 31, 2013 (Attachment J);
3. Authorize the Chairperson to sign four (4) copies of each agreement;
4. Retain one (1) copy of each agreement and return three (3) copies of each agreement to Human Resources for distribution.

Michael T. Stock
Asst. County Executive Officer/
Human Resources Director

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost:	POLICY/CONSENT (per Exec. Office)
COST	$ 0	$ 0	$ 0	$ 0	Consent ☐ Policy ☒
NET COUNTY COST	$ 0	$ 0	$ 0	$ 0	

SOURCE OF FUNDS:

Budget Adjustment: No
For Fiscal Year: 12/13 - 13/14

C.E.O. RECOMMENDATION: **APPROVE**

BY: Samuel Wong 5/26/14
Samuel Wong

County Executive Office Signature

FORM APPROVED COUNTY COUNSEL
BY: NEAL R. KIPNIS DATE 5/21/14

Departmental Concurrence

☐ Positions Added ☐ Change Order ☐ A-30 ☐ 4/5 Vote

MINUTES OF THE BOARD OF SUPERVISORS

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

Ayes: Jeffries, Benoit and Ashley
Nays: None
Absent: Tavaglione
Disqualify: Stone
Date: June 3, 2014
xc: H.R.

Kecia Harper-Ihem
Clerk of the Board
By: Deputy

Prev. Agn. Ref.: 08/20/2013, 3-49 | **District:** All | **Agenda Number:** 3-15

BACKGROUND:

Summary

On August 10, 2010, Item 3.47, the Board of Supervisors approved Health Net of California, Inc. (Health Net) as one of the County's Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO) plans for County active employees and retirees. At that time, Health Net offered the most competitive and cost-efficient plans.

In 2012, Health Net changed its Medicare Prescription Drug Plan (PDP) provider to Silver Script Insurance Company. As a result, the 2013 Agreements (Attachments A-H) were delayed due to the negotiation and clarification of terms in the PDP Agreement and to ensure a Third Party Administrative Agreement between the County and Health Net (Attachment I), along with an Employer Group Waiver Plan Agreement (Attachment J) between the County and Silver Script Insurance Company, was established. These Agreements clarify the responsibilities of Health Net and Silver Script as it relates to the County's Health Net PDP plans.

The 2013 Agreements were recently finalized and reviewed by County Counsel. Agreement terms for active and retiree plans have been honored since January 1, 2013. Human Resources and Health Net are finalizing the terms of the 2014 Agreements.

Impact on Residents and Businesses

There is no direct impact to private residents or private businesses in the County of Riverside.

SUPPLEMENTAL:

Additional Fiscal Information

The 2013 plan rates were previously approved by the Board on July 31, 2012, Item 3-28 for active employees and on September 11, 2012, Item 3-25 for retirees.

The premiums were estimated to cost $38 million in the 2013 calendar year. There is no direct cost to the County for this recommended action. Medical premiums are paid by employees and retirees.

Contract History and Price Reasonableness

Human Resources initially commenced an agreement with Health Net on January 1, 2011. Health Net was selected through a formal request for proposal (RFP) and offered the most competitive rate for the County's health plan designs. Health Net is among the most respected health care companies in California, with an extensive network of physicians, physician groups and affiliates and pharmacies, serving members in California for over 20 years. Health Net continues to provide quality service to County employees and their dependents, offering a two-tier HMO plan and in-network and out-of-network PPO plan. Based on County utilization and claims experience, the plan rates are aligned with the average market trend.

ATTACHMENTS:

A. Health Net Elect Open Access (EOA) Group Hospital and Professional Service Agreement, Group Number: 76617A, E, G, H and Supplement to Group Hospital and Professional Service Agreement;
B. Health Net PPO Group Insurance Policy, Group Number: N5432A, E, G, H, J, K and Supplement to Health Net PPO Group Insurance Policy;
C. Health Net PPO Group Insurance Policy, Group Number: 15834A, E, G, H and Supplement to Health Net PPO Group Insurance Policy;
D. Health Net HMO Medicare Coordination of Benefits (COB) Riverside Group Hospital and Professional Service Agreement, Group Number: 69381M and Supplement to Group Hospital and Professional Service Agreement;

E. Health Net PPO Medicare Coordination of Benefits (COB) Riverside, Group Insurance Policy, Group Number: N5432M and Supplement to Health Net PPO Group Insurance Policy;
F. Health Net Flex Net Insurance Policy; Group Number: N1658A and Supplement to Health Net PPO Group Insurance Policy;
G. Health Net Group Hospital and Professional Service Agreement, Group Number: 69381S and Supplement to Group Hospital and Professional Service Agreement;
H. Health Net Group Hospital and Professional Service Agreement, Group Number: 69381T and Supplement to Group Hospital and Professional Service Agreement;
I. Health Net Life Insurance Administrative Service Agreement;
J. Silver Script Employer Group Waiver Plan Agreement

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ATTACHMENT A

Health Net Elect Open Access (EOA) Group Hospital and Professional Service Agreement, Group Number: 76617A, E, G, H and Supplement to Group Hospital and Professional Service Agreement

JUN 03 2014 3-15

Health Net

ELECT OA

Group Hospital and Professional Service Agreement

GROUP HOSPITAL AND PROFESSIONAL SERVICE AGREEMENT

ISSUED BY
Health Net of California, Inc

LOS ANGELES, CALIFORNIA

To the extent herein limited and defined, this Agreement provides for comprehensive health services provided through Health Net of California, Inc (Health Net), a federally qualified Health Maintenance Organization and a California Health Care Service Plan.

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

HEREBY AGREES

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

Group Name:	RIVERSIDE COUNTY
Group ID:	76617A, E, G, H
Coverage Code:	24RJ
Plan Code:	31C

(herein called "Group")

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

Douglas Schur
Secretary

Steven Sell
President

TERM OF AGREEMENT

This Group Hospital and Professional Service Agreement (hereinafter referred to as "Agreement" or "Group Service Agreement") becomes effective on January 1, 2013 at 12:00 a.m. Pacific Time and will remain in effect for a term of {12-24} consecutive months, subject to the payment of subscription charges as required in "Subscription Charges" section. This Agreement may be terminated by Group with a 30-day written notice to Health Net. Health Net may terminate or not renew this Agreement for good cause as set forth below with a 30-day written notice (see the "Subscription Charges" section regarding termination for nonpayment of subscription charges). If the terms of this Agreement are altered by the consent of both parties, no resulting reduction in coverage will adversely affect a Member who is confined to a Hospital at the time of such change.

Good cause for termination or not renewing this Agreement by Health Net shall include:

- Failure of the Group to pay any subscription charges in accordance with the "Subscription Charges" section;
- Failure of the Group to maintain minimum subscription charge contribution requirements as set forth in the Application for Group Service Agreement;
- Failure of the Group to meet minimum participation requirement(s) as set forth in the new group proposal offer;;
- Failure of the Group to maintain at least 15 eligible employees enrolled with Health Net and/or with Health Net Life Insurance Company, to be determined annually, sixty (60) days prior to Group's renewal date, with termination effective at the renewal date;
- Knowing failure by the Group to abide by and enforce the conditions of enrollment of Subscribers as set forth in "Eligibility, Enrollment and Termination" Section 500 of the *Evidence of Coverage*, the Application for Group Service Agreement and any Health Net Underwriting Assumptions provided to the Group;
- Fraud or misrepresentation by submission to Health Net by the Group of materially incorrect or incomplete information which is reasonably relied upon by Health Net in issuing or renewing this Agreement; or
- A material change in the nature of the Group's business.

Termination of this Agreement for good cause, other than for not paying subscription charges (see "Subscription Charges" section regarding termination for nonpayment of subscription charges), shall become effective with a 30-day written notice to the Group.

If this Agreement terminates under its own terms, or is otherwise terminated by either Health Net or the Group, the Group shall promptly mail or hand deliver to each covered Subscriber, a notice of cancellation of this Agreement. The Group shall, upon request by Health Net, within 30 days of the request, provide Health Net with a copy of the notification, a written statement that the notice of cancellation was mailed or hand delivered to each Subscriber and the date of mailing or hand delivery.

Members who are totally disabled on the date coverage under this Agreement ends, may be eligible for continuation of coverage. See the "Conversion Privilege" and "Extension of Benefits" portions of "Eligibility, Enrollment and Termination," Section 500, in the *Evidence of Coverage* portion of this Agreement.

SUBSCRIPTION CHARGES

The Group shall pay Health Net subscription charges in accordance with the terms set out below.

Such charges shall be calculated by Health Net from current records as to the number of Members enrolled.

Retroactive payment adjustments will be made in subsequent billings for any additions or terminations of Members not currently reflected in Health Net's records at the time of calculation of subscription charges. The Effective Date of the addition or termination will be in accordance with rules established by Health Net for determining Effective Dates of retroactive adjustments, but in no event will the Effective Date be more than 90 days prior to the date of receipt of the written request by Health Net.

In order for a credit of subscription charges to be applied for terminated Members, Health Net must receive notification as soon as possible following the date of the Member's ineligibility, but in no event later than 90 days following such date. Health Net will credit a maximum of 90 days of subscription charges to the Group for ineligible Members.

When a Member is being retroactively terminated, the effective date of retroactive termination cannot be prior to any date on which services or supplies were provided to the Member under this Agreement. In such instances, the date of termination will be the first day of the calendar month following the month in which services or supplies were last provided and any applicable credit of subscription charges will be calculated from that date.

Only Members for whom payment is received by Health Net shall be eligible for services and benefits under this Agreement and only for the period covered by such payment. Upon such termination, prepaid subscription charges received on the account of the terminated Member or Members applicable to periods after the Effective Date of the termination will be credited back to the Group on the next following billing statement and neither Health Net nor any contracting Physician Group will have any further liability or responsibility under this Agreement to such terminated Member. Health Net will credit a maximum of 90 days of subscription charges to the Group for terminated Members.

If the Group seeks to retroactively add Members, enrollment forms must be received by Health Net as soon as possible following the Member's eligibility date, but in no event later than 90 days following such date. Health Net will charge the Group retroactive subscription charges according to the Member's Effective Date, which will be in accordance with rules established by Health Net for determining Effective Dates of retroactive adjustments, but in no event will the Effective Date be more than 90 days prior to when Health Net receives the enrollment or membership change form.

Monthly Rates for 76617A

Individual Employee:	579.77
Employee and One Family Member:	1,159.55
Employee and Two or More Family Members:	1,507.40
J Contract Type:	579.77
K Contract Type:	927.63

Monthly Rates for 76617E

Individual Early Retiree:	887.05
Retiree and One Family Member:	1,774.08
Retiree and Two or More Family Members:	2,306.32
J Contract Type	887.03
K Contract Type	1,419.27

Monthly Rates for 76617G

Individual Employee:	579.77
Employee and One Family Member:	1,159.55
Employee and Two or More Family Members:	1,507.40
J Contract Type:	579.77
K Contract Type:	927.63

Monthly Rates for 76617H

Individual Early Retiree:	887.05
Retiree and One Family Member:	1,774.08
Retiree and Two or More Family Members:	2,306.32
J Contract Type	887.03
K Contract Type	1,419.27

The first subscription charges must be paid to Health Net on or before the Effective Date of this Agreement. After that, payment is due on the first of each month while the Agreement is in effect. Group will send payment by wire no later than 45 days of the due date.

On or before the subscription charges due date each month, Health Net will send the Group a mandatory reminder letter, which explains that there is a 45-day grace period in which to submit delinquent subscription charges before coverage is terminated. The 45-day grace period would start the first day following 45 days of the due date.

If payment is not made within 45 days of the due date, Health Net will send the Group a Prospective Notice of Cancellation with the following information: (a) that subscription charges have not been paid and that the Group Service Agreement will be canceled for non-payment if the required subscription charges are not paid within the 45-day grace period provided; (b) the specific date and time when coverage for all Members will end if subscription charges are not paid; and (c) how and when the Group can reinstate the Group Service Agreement. Health Net will continue the Subscriber's coverage under this plan during the grace period.

If Health Net does not receive payment of the delinquent subscription charges from the Group within the 45-day grace period, the Group Service Agreement will be canceled at the end of the 45-day grace period. Health Net will mail the Group a Notice Confirming Termination of Coverage.

The Notice Confirming Termination of Coverage, will provide the Subscriber and the Group with the following information: (1) that the Group Service Agreement has been canceled for non-payment of subscription charges; (2) the specific date and time when your Group coverage ended; (3) to the Group only, how and when coverage may be reinstated; and (4) the Health Net telephone number Subscribers can call to obtain additional information, including whether the Group obtained reinstatement of the Group Service Agreement.

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

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

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

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

Any change to the subscription charges pursuant to the above stated circumstances, shall be made at renewal with at least a 180-day written notice to the Group prior to the date of such change. Payment of any installment of subscription charges as altered shall constitute acceptance of this change.

If a governmental authority (1) imposes a tax or fee that is computed on subscription charges or (2) requires a change in coverage or administrative practice that increases Health Net's risk, Health Net may amend this Agreement and increase the subscription charges sufficiently to cover the tax, fee, or risk at renewal of this Agreement provided that Group receives at least 180 days advance written notice and approves of such increase in subscription charges. If Group approves of the increase in subscription charges, the effective date of the increase in subscription charges shall not be earlier than the date the tax, fee, or required change in coverage or administrative practice is imposed by the governmental authority.

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

General Provisions

- **FORM OR CONTENT OF AGREEMENT**: No agent or employee of Health Net is authorized to change the form or content of this Agreement. Any changes can be made only through an endorsement authorized and signed by an officer of Health Net.
- **ENTIRE AGREEMENT:** This Agreement, the application of the Group, any Health Net Underwriting Assumptions provided to the Group, the enrollment forms of the Group's eligible employees, and Supplement to Group Hospital and Professional Service Agreement shall constitute the entire Agreement between the parties.
- **CONTINUATION OF SUBSCRIBER COVERAGE**: Except as otherwise provided herein, Health Net shall not have the right to cancel or terminate any individual *Evidence of Coverage* issued to any Subscriber while this Agreement remains in force and effect, while said Subscriber remains in the eligible class of employees of the Group and while his or her subscription charges are paid in accordance with the terms of this Agreement.
- **CHARTER NOT PART OF AGREEMENT**: None of the terms or provisions of the charter, constitution or bylaws of Health Net shall form a part of this Agreement or be used in the defense of any related suit, unless the same is set forth in full in this Agreement.
- **DISTRIBUTION OF NOTICES:** Health Net will send required notices as specified in this Agreement to the Group's address on record. The Group Service Agreement will be posted electronically on Health Net's secure Web site at www.healthnet.com. By registering and logging on to Health Net's Web site, the Group can access, download and print the Group Service Agreement, if it so chooses, or the Group can opt to receive the Group Service Agreement by U.S. mail, in which case Health Net will mail the Group Service Agreement to the Group's address on record with Health Net.
- **INTERPRETATION OF AGREEMENT**: The laws of the State of California shall be applied to interpretations of this Agreement.
- **RECORDKEEPING**: The Group is responsible for keeping records relating to this Agreement. Health Net has the right to inspect and audit those records.
- **RELATIONSHIP OF PARTIES**: Neither Health Net nor any of its employees or agents are employees or agents of Hospitals or the contracting Physician Groups.
- **HOLD HARMLESS**: Health Net agrees to indemnify and hold harmless Group and Members for any expense, liability, or claims for eligible services under this Agreement with the exception of any Copayment amounts which may be required as indicated herein.
- **MEDICAL LOSS RATIO (MLR) REBATES**: In conjunction with the requirements of the federal Affordable Care Act, upon Health Net's request, the Group shall provide the Group's average number of employees employed on business days during the previous Calendar Year, in order for Health Net to accurately categorize the Group, for purposes of determining the appropriate MLR value that is applicable to the Group.
- **MODIFICATIONS TO PLAN AND NOTICE OBLIGATIONS**: If the plan is terminated or modified in accordance with the terms and provisions of this Group Service Agreement, including a change or decrease in benefits. Health Net will send notice of such modification or termination to the Group with at least 60 days written notice. Except as required under the "Subscription Charges" section above regarding termination for nonpayment, Health Net will not provide notice of such changes to plan Subscribers unless it is required to do so

by law. The Group may have obligations under state or federal law to provide notification of these changes to plan Subscribers.

- **NON-DISCRIMINATION**: Health Net and the Group hereby agree that no person who is otherwise eligible for coverage under this Agreement shall be refused enrollment nor shall their coverage be canceled solely because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status, or physical or mental handicap.
- **NOTICE OF CERTAIN EVENTS**: Health Net will give the Group written notice, within a reasonable time, of any termination or breach of contract, or inability to perform services, by any contracting Physician Group or contracting provider, if the Group may be materially and adversely affected thereby.
- **WORKERS' COMPENSATION INSURANCE:** This Health Net Agreement is not a substitute for and does not affect any requirement for coverage by Workers' Compensation Insurance on behalf of the Group

SUMMARY OF BENEFITS AND COVERAGE (SBC)

Regulations under the federal Patient Protection and Affordable Care Act (SBC Regulations) require that Health Net (a group health insurance issuer) and Group (a group health plan) provide a Summary of Benefits and Coverage (SBC), notice of modification of the SBC, and, upon request, a uniform glossary to Participants and Beneficiaries who are enrolled in the group health plan (Covered Persons) as well as to Participants and Beneficiaries who are eligible for but not enrolled in the group health plan (Eligible Persons). These documents must be available without charge to individuals who enroll or re-enroll in group health coverage during an open enrollment period (including former employees with COBRA continuation coverage) or other than through an open enrollment period (including individuals who are newly eligible for coverage or Special Enrollees).

Group and Health Net, in accordance with the responsibilities assigned to each party as set forth herein below, agree to undertake their respective assignments to satisfy all timing, form and content requirements that pertain to the distribution of SBCs and the uniform glossary to Covered and Eligible Persons. Both Group and Health Net shall cooperate with each other in good faith and to the extent reasonably necessary to ensure that the parties fully comply with requirements of the SBC Regulations.

- **DEFINITIONS**

  This provision defines words that will help you understand this "Summary of Benefits and Coverage (SBC)" section. The terms used within this section have certain meanings that are specific to this section.

  1. "Beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit there under.
  2. "Covered Persons" means Participants and Beneficiaries who are enrolled in the group health plan.
  3. "Eligible Persons" means Participants and Beneficiaries who are eligible for but not enrolled in the group health plan.
  4. "Group" is the business organization (usually an employer or trust) to which Health Net has issued the agreement to provide the benefits to Covered Persons.
  5. "Participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.
  6. "Special Enrollee" means any Participant or Beneficiary who is eligible to enroll as described in the Evidence of Coverage under "Exceptions to Late Enrollment Rules" in "Eligibility, Enrollment and Termination," Section 400.

- **PREPARATION OF SBCs:** Health Net shall prepare and deliver to Group an SBC for each Health Net health benefit plan which Group offers to Covered and Eligible Persons. Health Net shall use reasonable commercial efforts to provide required SBCs to Group before Group's open enrollment process for the next year beginning on or after September 23, 2012 is scheduled to commence. Health Net shall prepare and deliver a modified SBC to Group whenever Health Net determines that material modifications must be made to a previously delivered SBC.

- **DISTRIBUTION OF SBCs:** Group shall provide Covered and Eligible Persons with SBCs in the exact and unmodified form (including appearance and content) in which Health Net provides the SBCs to Group pursuant to the provisions of this section and as described herein below.
- **TIMING:** Group shall provide a SBC to an Eligible or Covered Person:
  1. Upon application for enrollment:
     a. along with any written application materials, or, if the Group does not distribute written application materials for enrollment, then no later than the first date the Eligible or Covered Person is eligible to enroll in coverage for the Participant or any Beneficiaries; and by the first day of coverage, if Health Net provides a modified SBC between the date an Eligible or Covered Person applied for coverage and the first day of coverage; or by the first day of coverage, if Health Net provides a modified SBC between the date an Eligible or Covered Person applied for coverage and the first day of coverage; or
     b. within ninety (90) days following enrollment, if the Eligible or Covered Person is a Special Enrollee.
  2. Upon renewal or reissuance of this Agreement for plan years with open enrollments beginning or after September 23, 2012:
     a. no later than the date on which application materials (including, but not limited to, open enrollment materials) are distributed, if written application (or active election) is required for renewal; or
     b. if renewal is automatic, no later than 30 days prior to the first day of the new plan or policy year. If the Agreement is not issued or renewed before this 30 day period, Group shall provide the SBC as soon as practicable but not later than 7 business days after the Agreement is issued or Health Net receives your Group's written confirmation of its intent to renew the Agreement, whichever is earlier.

     The Group is not required to provide a SBC to a Covered Person automatically upon renewal for benefit packages in which the Covered Person is not enrolled. However, if a Covered Person requests a SBC for a benefit package in which he or she is not enrolled, such SBC must be provided as soon as practicable, but in no event later than 7 business days following receipt of the request.
  3. At any time, upon request for a SBC or summary information about any Health Net health benefit package for which an eligible or Covered Person is eligible. The SBC must be provided as soon as practicable, but within 7 business days following receipt of the request.
- **NUMBER:** A single SBC may be provided to a Participant and any Beneficiaries at the Participant's last known address, unless any Beneficiary is known to reside at a different address. In that case, a separate SBC must be provided to any Beneficiary at his or her last known address.
- **FORM AND MANNER:** Group shall provide the SBC to an Eligible or Covered Person in paper form or, alternatively, electronically (such as by email or an Internet posting) if the followed conditions are met:
  1. SBCs reproduced and distributed in paper form must be in the uniform format provided by Health Net; they must be copied on four, double-sided pages in length and not include print smaller than 12-point font.
  2. SBCs displayed electronically may be on a single webpage, so the viewer can scroll through the information required to be on the SBC without having to advance through pages. However, columns or rows may not be deleted when displaying a complete SBC.
  3. For Covered Persons who are already covered under a benefit package provided under this Agreement, Group may provide the required SBCs electronically if the requirements of the U.S. Department of Labor's regulations at 29 CFR 2520.104b-1 are met. This regulation contains fiduciary disclosure requirements as well as an electronic distribution safe harbor.
  4. For Eligible Persons, Group may provide SBCs electronically if (1) the format is readily accessible (such as in an html, MS Word, or pdf format) and can be electronically retained and printed, (2) paper copies are provided free of charge upon request, and (3) if the electronic form is a Internet posting, the Group timely advises Eligible Persons in paper form (such as a postcard) or by email that the SBCs are available on the Internet, provides the Internet address, and notifies the Eligible Persons that the documents are available in paper form upon request.

Model language for an e-card or postcard in connection with a website posting of a SBC follows:

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is available on the web at: www.healthnet.com. A paper copy is also available, free of charge, by calling 1-800-522-0088 (a toll-free number).

- **NOTICE OF MODIFICATION OF A SBC DURING THE PLAN OR POLICY YEAR:** Upon receipt of timely notice from Health Net of material changes to the contents of an SBC and an updated SBC which reflects such changes, and that occurs other than in connection with a renewal or reissuance of coverage under this Agreement, Group shall provide notice of the material changes to covered persons no later than 60 days prior to the date on which material changes will be come effective. Group shall distribute such notice to Covered and Eligible Persons in the same number, form and manner (so as to comply with the SBC regulations) in which Group provided the original SBC which was subsequently updated.
- **UNIFORM GLOSSARY:** The SBC informs the reader that he or she can view a Glossary of bolded terms used in the SBC at www.cciio.cms.gov or can call Health Net at the number on his or her ID card to request a copy. Health Net shall provide a written copy of the Glossary to a Covered or Eligible Person who requests a written copy within 7 business days after Health Net receives the request.
- **PARTIES TO BEAR THEIR OWN COSTS:** Health Net and Group shall each bear its own costs in connection with the execution of the respective party's responsibilities under this Agreement, as amended, including but not limited to the production, reproduction and distribution of SBCs and the Glossary.
- **ADVICE OF COUNSEL:** Group and Health Net each acknowledge that they have consulted with and have had appropriate advice and legal counsel to determine their responsibilities under the SBC Regulations. Group and Health Net have executed this Agreement, as amended, knowingly and voluntarily.

Binding Arbitration

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

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

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

is over $200,000, the parties shall, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

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

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

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

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

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees. In cases of extreme hardship to a Member, Health Net may assume all or a portion of a Member's share of fees and expenses of the arbitration. Upon written notice by the Member requesting a hardship application, Health Net will forward the request to an independent professional dispute resolution organization for a determination. Such request for hardship should be submitted to the Litigation Administrator at the address provided above.

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

COBRA AND CALIFORNIA-COBRA PROGRAM (CAL-COBRA) CONTINUATION COVERAGE

Health Net recognizes that many Groups must comply with the continuation of Group coverage requirements under federal and California laws and regulations which respectively are commonly referred to as "COBRA" and "Cal-COBRA." Health Net acknowledges that Groups who are so affected cannot discharge their legal responsibilities without Health Net's informed and willing participation in providing the required continuation coverage.

Health Net is, therefore, committed to the following:

A. Maintaining an awareness of the continuation coverage requirements of federal and state laws. This includes federal requirements under the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act, regulations which are issued by the Secretaries of federal agencies and state law requirements under the California COBRA Program (Article 4.5 of the California Health and Safety Code and Article 1.7 of the California Insurance Code).

B. Providing continuation coverage to Plan Members upon the request of a Group when such requests are consistent with the Group's obligations under the law.

C. Sharing knowledge regarding COBRA and Cal-COBRA with Groups as they experience problems, but Health Net will not give legal advice on these matters.

CAL-COBRA OBLIGATIONS

California law requires health plans and insurers to offer individuals who began receiving federal COBRA coverage on or after January 1, 2003 and who have exhausted federal COBRA the opportunity to continue coverage

for a total of 36 months through a combination of COBRA and Cal-COBRA. When such an individual has elected to continue coverage through Cal-COBRA, the Group must do the following:

A **Notify current Cal-COBRA qualified beneficiaries of Group's intent to terminate this Group Service Agreement**. If the Group intends to terminate this Group Service Agreement with Health Net and replace it with coverage through another California HMO or disability (health) insurer, the Group must, at least 30 days prior to the termination, inform all existing Cal-COBRA qualified beneficiaries of this action. The Group must also inform qualified beneficiaries that they have the ability to choose to continue coverage through the new plan for the balance of the period that they could have continued coverage through the Health Net Plan. Health Net will provide the employer the names and last known addresses of enrolled Cal-COBRA qualified beneficiaries.

B **Notify the successor plan of the qualified beneficiaries currently receiving Cal-COBRA coverage.** The Group must notify the successor plan in writing of the qualified beneficiaries currently receiving continuation coverage so that the successor plan, or contracting employer or administrator may provide those qualified beneficiaries with the necessary information to allow the qualified beneficiary to continue coverage through the new plan.

Coverage For Domestic Partners

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

Domestic Partners and their enrolled dependent children are eligible for California COBRA coverage on the same basis as other enrollees. In addition, Health Net will provide federal COBRA-like coverage on the same basis to the Domestic Partner and his or her unmarried dependent children as other COBRA qualified enrollees based on the Group's eligibility rules. Determination of COBRA qualification for Domestic Partners and their children will be based on agreement between Health Net and the Group.

Compliance with Medicare Part D Regulations in Administration of Group's Outpatient Prescription Drug Plan (PDP)

Where Group offers a qualified retiree prescription drug plan, Group and Health Net agree to the requirements set forth in sections A and B below:

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

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

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

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

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

toward the portion of the monthly beneficiary premium attributable to basic prescription drug coverage paid by the Group.

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

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

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

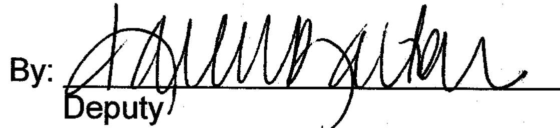
PLAN BENEFITS AND EVIDENCE OF COVERAGE

Health Net will issue and deliver to each Subscriber an *Evidence of Coverage,* electronically by posting it on Health Net's website at www.healthnet.com, if so designated by the Group and elected by the Subscriber (or hard copy by mail to the Subscriber's address on record if so designated by the Group and elected by the Subscriber). The *Evidence of Coverage* sets forth a statement of services and benefits to which the Members are entitled. Health Net will also issue and deliver an Identification Card by mail to the Subscriber's address on record.

The benefits of this Plan are set forth commencing on the next page of this Agreement, the language of which will constitute the *Evidence of Coverage*.

IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Health Net Group Hospital and Professional Service Agreement (Health Net Elect OA 76617A, E, G, H).

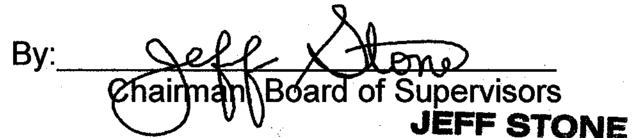
ATTEST:
Clerk of the Board
Kecia Harper-Ihem



By: ______________________
Deputy

Date: JUN 03 2014

COUNTY OF RIVERSIDE:

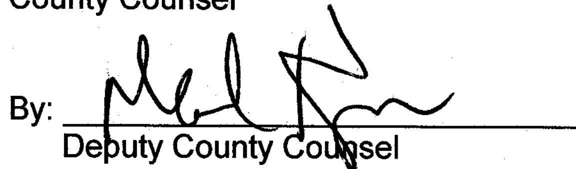


By: ______________________
Chairman, Board of Supervisors
JEFF STONE

Date: JUN 03 2014

Approved as to form:

Pamela J. Walls
County Counsel



By: ______________________
Deputy County Counsel

CONTRACTOR: Health Net of California, Inc.,
a California Corporation

By: ______________________

Printed Name: STEVEN YOUNG

Title: VICE PRESIDENT, SALES + ACCOUNT MANAGEMENT

Date: 5/16/14

SUPPLEMENT TO GROUP HOSPITAL AND PROFESSIONAL SERVICE AGREEMENT

BY AND BETWEEN

HEALTH NET OF CALIFORNIA, INC.

AND

COUNTY OF RIVERSIDE

This Supplement to the Group Hospital and Professional Service Agreement ("Supplement") by and between Health Net of California, Inc., a California corporation ("Health Net" or "Contractor"), and County of Riverside, a political subdivision of the State of California ("Group" or "County of Riverside"), becomes effective January 1, 2013 ("Effective Date") at 12:00 a.m. and will remain in effect for the term of the Group Hospital and Professional Service Agreement.

This Supplement modifies the Group Hospital and Professional Service Agreement with Group ID 76617A, E, G, H Coverage Code: 24RJ (the "Agreement") and does not supersede or modify any terms or provisions of such Agreement, unless specifically stated herein.

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

REQUIRED CONTRACT LANGUAGE

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

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

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

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

If to Group:

County of Riverside, Human Resources
4080 Lemon Street, 1st Floor
Riverside, CA 92501
Attn: Stacey M. Beale, Human Resources Division Manager

If to Contractor:

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

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

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

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

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

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

8. Independent Contractor. The relationship between Health Net and Group is an independent contractor relationship. Neither Health Net nor its employee(s) and/or agent(s) shall be considered to be an employee(s), and/or agent(s) of Group. Group nor any employee(s) and/or agent(s) of Group shall be considered

to be an employee(s) and/or agent(s) of Health Net. None of the provisions of this Agreement shall be construed to create a relationship of agency, representation, joint venture, ownership, control or employment between the parties other than that of independent parties contracting for the purposes of effectuating this Agreement.

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

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

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

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

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

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

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

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

17. Insurance.

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

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

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

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

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

General Insurance Provisions - All Lines.

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

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

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

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

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

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

18. Hold Harmless/Indemnification.

Health Net shall indemnify and hold harmless Group, its Agencies, Districts, Special Districts and Departments, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and

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

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

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

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

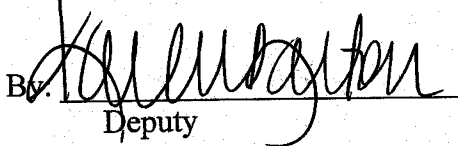
19. Conflicts. In the event of any conflict between the terms of the Supplement, Agreement, the application of the Group, any Health Net Underwriting Assumptions provided to the Group, and the enrollment forms of the Group's eligible employees, such conflict shall be resolved by reference to the document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

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

ATTEST:

Clerk of the Board

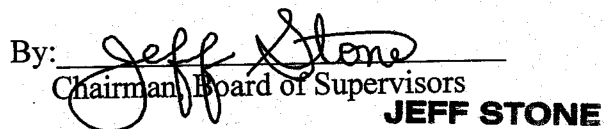
Kecia Harper-Ihem



By: ______________________
Deputy

Date: JUN 03 2014

COUNTY OF RIVERSIDE:



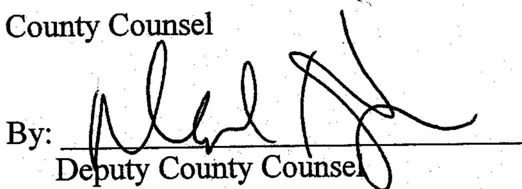
By: ______________________
Chairman, Board of Supervisors
JEFF STONE

Date: JUN 03 2014

Approved as to form:

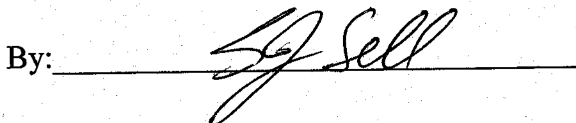
Pamela J. Walls

County Counsel



By: ______________________
Deputy County Counsel

CONTRACTOR: Health Net of California, Inc., a California Corporation



By: ______________________

Printed Name: Steven J. Sell

Title: President

Date: 5-13-14

ATTACHMENT B

Health Net PPO Group Insurance Policy, Group Number: N5432A, E, G, H, J, K and Supplement to Health Net PPO Group Insurance Policy

PPO Group Policy

HEALTH NET PPO GROUP INSURANCE POLICY
(the Policy)

ISSUED BY

HEALTH NET LIFE INSURANCE COMPANY (HNL)

LOS ANGELES, CALIFORNIA

Health Net Life Insurance Company agrees to provide the benefits of the Policy, as herein limited and defined, for enrolled Covered Persons of the Group. These benefits are subject to all the terms and conditions of this Policy.

Upon payment of premium charges in the amount and manner provided in this Policy. Health Net Life Insurance Company

HEREBY AGREES

to provide benefits as defined in this Policy to eligible employees and their eligible Dependents of:

Group Name:	RIVERSIDE COUNTY
Group ID:	N5432A, E, G, H, J, K
Coverage Code:	24RM
Plan Code:	31H

(herein called the "Group")

according to the terms and conditions of this Policy. Payment of premium by the Group in the amount and manner provided for in the Policy shall constitute the Group's acceptance of the terms and conditions of the Policy. This Health Net Life Insurance Company Policy, the "Application for Group Policy" the enrollment forms of the Group's eligible employees, and Supplement to Health Net PPO Group Insurance Policy,, inclusively shall constitute the entire agreement between the parties.

HEALTH NET LIFE INSURANCE COMPANY

Steven Sickle
Secretary

Steven Sell
President

PPO846LRG(1/13)

NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities
  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of April 1, 2011, is $470,125. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927- 4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

Term Of Policy

This Group Hospital and Professional Service Policy (hereinafter referred to as "Policy" or "Group Service Agreement")becomes effective on January 1, 2013 at 12:00 a.m. Pacific Time, and will remain in effect for a term of 12 consecutive months, subject to the payment of premiums as required in the "Premiums" section below. This Policy may be terminated by the Group with a 30 day written notice to HNL. HNL may terminate or not renew this Policy for good cause as set forth below with a 30 day written notice. If the terms of this Policy are altered by the consent of both parties, no resulting reduction in coverage will adversely affect a Covered Person who is confined to a Hospital at the time of such change.

Good cause for termination or not renewing of this Policy by HNL shall include:

- Failure of the Group to pay any premiums in accordance with the "Subscription Charges" section;
- Failure of the Group to meet minimum participation and the Group contribution requirement at the time of renewal; and
- Submission to HNL by the Group of materially incorrect or incomplete information.

Termination of this Policy for good cause for the reasons described above shall become effective upon 30 days' written notice to the Group.

Covered Persons who are totally disabled on the date coverage under this Policy ends may be eligible for continuation of coverage. See the "Conversion Coverage" and the "Extension of Benefits" portions of the "Eligibility, Enrollment and Termination" section in the *Certificate* portion of this Policy.

If HNL decides to discontinue offering a particular medical benefit plan in the group market in California, HNL will:

- Provide notice to the Commissioner of Insurance of California and each affected Group of its intention to discontinue offering the particular medical benefit plan in California;
- Provide such notice at least 90 days prior to discontinuance of the particular Comprehensive Medical Benefit plan; and
- Offer to each affected group whose coverage is being discontinued, the option of replacing the discontinued plan with any other Group plan currently being offered by HNL in California, for which the Group is eligible.

Premiums

The Group shall pay HNL monthly premiums in accordance with the terms set out below.

Charges shall be calculated by HNL from current records as to the number of Covered Persons enrolled.

Retroactive payment adjustments will be made in subsequent billing statements for any additions or terminations of Covered Persons not currently reflected in HNL's records at the time of calculation of premiums. The Effective Date of the addition or termination will be in accordance with rules established by HNL for determining Effective Dates of retroactive adjustments, but in no event will the Effective Date be more than 90 days prior to the date of receipt of the written request by HNL.

In order for a credit of premiums to be applied for terminated Covered Persons, HNL must receive notification as soon as possible following the date of the Covered Person's ineligibility, but in no event later than 90 days following such date. HNL will credit a maximum of 90 days of premium to the Group for ineligible Covered Persons.

Only Covered Persons for whom payment is received by HNL shall be eligible for services and benefits hereunder and only for the period covered by such payment. Upon such termination, prepaid premiums received on account of the terminated Covered Person or Covered Persons applicable to periods after the Effective Date of the termination will be credited back to the Group on the next following billing statement, and HNL shall not have any further liability or responsibility under this Policy to such terminated Covered Person. HNL will credit a maximum of 90 days of premium to the Group for terminated Covered Persons.

In the foregoing instances where a Covered Person is being retroactively terminated, the Effective Date of retroactive termination cannot be prior to any date on which services or supplies were provided to the Covered Person under this Policy. In such instances, the date of termination will be the first day of the calendar month following the

month in which services or supplies were provided, and any applicable credit of premium will be calculated from that date.

If the Group seeks to retroactively add Covered Persons, enrollment forms must be received by HNL as soon as possible following the Covered Person's eligibility date, but in no event later than 90 days following such date. HNL will charge the Group retroactive premium(s) according to the Covered Person's Effective Date, which will be in accordance with rules established by HNL for determining Effective Dates of retroactive adjustments, but in no event will the Effective Date be more than 90 days prior to when HNL receives the enrollment or membership change form.

Monthly Rates for N5432A

Individual Employee:	909.61
Employee and One Family Member:	1,819.24
Employee and Two or More Family Members:	2,365.00
J Contract Type:	909.61
K Contract Type:	1,455.39

Monthly Rates for N5432E

Individual Early Retiree:	1,220.50
Retiree and One Family Member:	2,221.30
Retiree and Two or More Family Members:	3,185.50
J Contract Type	1,000.80
K Contract Type	1,965.00

Monthly Rates for N5432G

Individual Employee:	909.61
Employee and One Family Member:	1,819.24
Employee and Two or More Family Members:	2,365.00
J Contract Type:	909.61
K Contract Type:	1,455.39

Monthly Rates for N5432H

Individual Early Retiree:	1,220.50
Retiree and One Family Member:	2,221.30
Retiree and Two or More Family Members:	3,185.50
J Contract Type	1,000.80
K Contract Type	1,965.00

Monthly Rates for N5432J

Individual Employee:	579.77
Employee and One Family Member:	1,159.55
Employee and Two or More Family Members:	1,507.40
J Contract Type:	579.77
K Contract Type:	927.63

Monthly Rates for N5432K

Individual Early Retiree:	887.05
Retiree and One Family Member:	1,774.08

Retiree and Two or More Family Members:	2,306.32
J Contract Type	887.03
K Contract Type	1,419.27

The first premiums must be paid to HNL on or before the Effective Date of this Policy. After that, payment is due on the first of each month while the Policy is in effect. Group will send payment by wire no later than 45 days of the due date.On or before the subscription charges due date each month, Health Net will send the Group a mandatory reminder letter, which explains that there is a 30-day grace period in which to submit delinquent subscription charges before coverage is terminated. The 30-day grace period would start the first day following 45 days of the due date.

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

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

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

Any change to the premiums pursuant to the above stated circumstances, shall be made at renewal with at least a 180-day written notice to the Group prior to the date of such change. Payment of any installment of premiums as altered shall constitute acceptance of this change.

If a governmental authority (a) imposes a tax or fee that is computed on premiums or (b) requires a change in coverage or administrative practice that increases HNL's risk, HNL may amend this Policy and increase the premium sufficiently to cover the tax, fee, or risk, at renewal of the Policy, provided that Group receives 180 days written notice and approves of such increase in premiums. If Group approves of the increase in premiums, the effective date of the increase in premiums shall not be earlier than the date that the tax, fee, or required change in coverage or administrative practice is imposed by the governmental authority.

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

GENERAL PROVISIONS

Form or Content of Policy

No agent or employee of HNL is authorized to change the form or content of this Policy. Any changes can be made only through an endorsement authorized and signed by an officer of HNL.

Entire Agreement

This Policy, the application of the Group, the enrollment forms of the Group's eligible employees shall and Supplement to Health Net PPO Group Insurance Policy constitute the entire agreement between the parties.

Grace Period

A grace period of 45 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force (subject to the right of the insurer to cancel in accordance with the cancellation provision hereof).

Continuation of Coverage for Covered Persons

Except as otherwise provided herein, HNL shall not have the right to cancel or terminate any individual *Certificate* issued to any Covered Person while this Policy remains in force and effect, and while said Covered Person remains in the eligible class of Employees of the Group and his or her premiums are paid in accordance with the terms of this Policy.

Charter Not Part of Policy

None of the terms or provisions of the charter, constitution or bylaws of HNL shall form a part of this Policy or be used in the defense of any suit hereunder, unless the same is set forth in full in this Policy.

Distribution of Notices

HNL will send required notices as specified in this Policy to the Group's address on record. The Policy will be posted electronically on HNL's secure Web site at www.healthnet.com. By registering and logging on to HNL's Web site, the Group can access, download and print the Policy, if it so chooses, or the Group can opt to receive the Policy by U.S. mail, in which case HNL will mail the Policy to the Group's address on record with HNL.

Enrollment Regulations

This Policy may be terminated by HNL if at any time the number of Covered Persons does not meet the enrollment regulations of HNL.

Regulation and Interpretation of Policy

This Policy is issued with and is governed by the State of California. The regulations and laws of California shall be applied to interpretations of this Policy.

Recordkeeping

The Group is responsible for keeping records relating to this Policy. HNL has the right to inspect and audit those records.

Nondiscrimination

HNL and the Group hereby agree that no person who is otherwise eligible for coverage under this Policy shall be refused enrollment nor shall his or her coverage be canceled solely because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status, or physical or mental handicap.

Notice of Cancellation

If this Policy terminates for any reason, HNL will send the notice of cancellation to the Group. The notice of cancellation will include information on conversion coverage for Covered Persons. The Group shall promptly mail a copy of the notice to each Covered Person and provide HNL proof of such mailing, including the date thereof.

Medical Loss Ratio (MLR) Rebates

In conjunction with the requirements of the federal Affordable Care Act, upon HNL's request, the Group shall provide the Group's average number of employees employed on business days during the previous Calendar Year, in order for HNL to accurately categorize the Group, for purposes of determining the appropriate MLR value that is applicable to the Group.

Misstatement of Age

If the age of the Covered Person has been misstated, all amounts payable under this Policy shall be such as the premium paid would have been purchased at the correct age.

Modifications to Plan and Notice Obligations

If the plan is modified in accordance with the terms and provisions of this Group Policy, HNL will send notice of such modification to the holder of the Group Policy with at least 60 days written notice. HNL will not provide notice of such changes to Covered Persons of this plan unless it is required to do so by law. The Group may have obligations under state or federal law to provide notification of these changes to the Covered Persons under this plan.

Modifications to Preferred Provider Organization Network and Notice Obligations

HNL will send written notice to the holder of the Group Policy within a reasonable period of time, of any termination, permanent breach of contract or permanent inability to perform of any Preferred Provider, if that termination, breach or inability materially and adversely affects the holder of the Group Policy or Covered Persons of this plan. In such circumstances, the Group must provide the substance of such notice of the termination, breach or inability to perform, to the principal Covered Persons covered under this plan, not later than 30 days after the receipt of such notice from HNL.

Worker's Compensation Insurance

This Health Net PPO Policy is not a substitute for and does not affect any requirement for coverage by worker's compensation insurance on behalf of Group.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

Regulations under the federal Patient Protection and Affordable Care Act (SBC Regulations) require that HNL (a group health insurance issuer) and Group (a group health plan) provide a Summary of Benefits and Coverage (SBC), notice of modification of the SBC, and, upon request, a uniform glossary to Participants and Beneficiaries who are enrolled in the group health plan (Covered Persons) as well as to Participants and Beneficiaries who are eligible for but not enrolled in the group health plan (Eligible Persons). These documents must be available without charge to individuals who enroll or re-enroll in group health coverage during an open enrollment period (including former employees with COBRA continuation coverage) or other than through an open enrollment period (including individuals who are newly eligible for coverage or Special Enrollees).

Group and HNL, in accordance with the responsibilities assigned to each party as set forth herein below, agree to undertake their respective assignments to satisfy all timing, form and content requirements that pertain to the distribution of SBCs and the uniform glossary to Covered and Eligible Persons. Both Group and HNL shall cooperate with each other in good faith and to the extent reasonably necessary to ensure that the parties fully comply with requirements of the SBC Regulations.

- **DEFINITIONS**

  This provision defines words that will help understand this "Summary of Benefits and Coverage (SBC)" section. The terms used within this section have certain meanings that are specific to this section.

  1. "Beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.
  2. "Covered Persons" means Participants and Beneficiaries who are enrolled in the group health plan.
  3. "Eligible Persons" means Participants and Beneficiaries who are eligible for but not enrolled in the group health plan.
  4. "Group" is the business organization (usually an employer or trust) to which HNL has issued the agreement to provide the benefits to Covered Persons.
  5. "Participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.
  6. "Special Enrollee" means any Participant or Beneficiary who is eligible to enroll as described in the *Certificate* under "Exceptions to Late Enrollment Rule" in the "Eligibility, Enrollment and Termination" section.

- **PREPARATION OF SBCs:** HNL shall prepare and timely deliver to Group an SBC for each HNL health benefit plan which Group offers to Covered and Eligible Persons, as required by SBC Regulations. In addition, HNL shall provide required SBCs to Group at least 30 days prior to the first day of Group's open enrollment process for health coverage for the next plan year. HNL shall prepare and deliver a modified SBC to Group whenever HNL determines that material modifications must be made to a previously delivered SBC.

- **DISTRIBUTION OF SBCs**: Group shall provide Covered and Eligible Persons with SBCs in the exact and unmodified form (including appearance and content) in which HNL provides the SBCs to Group pursuant to the provisions of this section and as described herein below.

- **TIMING:** Group shall provide a SBC to an Eligible or Covered Person:
  1. Upon application for enrollment:
     a. along with any written application materials, or, if the Group does not distribute written application materials for enrollment, then no later than the first date the Eligible or Covered Person is eligible to enroll in coverage for the Participant or any Beneficiaries; and by the first day of coverage, if HNL provides a modified SBC between the date an Eligible or Covered Person applied for coverage and the first day of coverage; or by the first day of coverage, if HNL provides a modified SBC between the date an Eligible or Covered Person applied for coverage and the first day of coverage; or
     b. within ninety (90) days following enrollment, if the Eligible or Covered Person is a Special Enrollee.
  2. Upon renewal or reissuance of this Agreement for plan years with open enrollments beginning or after September 23, 2012:
     a. no later than the date on which application materials (including, but not limited to, open enrollment materials) are distributed, if written application (or active election) is required for renewal; or
     b. if renewal is automatic, no later than 30 days prior to the first day of the new plan or policy year. If the Agreement is not issued or renewed before this 30 day period, Group shall provide the SBC as soon as practicable but not later than 7 business days after the Agreement is issued or HNL receives Group's written confirmation of its intent to renew the Agreement, whichever is earlier.

     The Group is not required to provide a SBC to a Covered Person automatically upon renewal for benefit packages in which the Covered Person is not enrolled. However, if a Covered Person requests a SBC for a benefit package in which he or she is not enrolled, such SBC must be provided as soon as practicable, but in no event later than 7 business days following receipt of the request.
  3. At any time, upon request for a SBC or summary information about any HNL health benefit package for which an eligible or Covered Person is eligible. The SBC must be provided as soon as practicable, but within 7 business days following receipt of the request.
- **NUMBER:** A single SBC may be provided to a Participant and any Beneficiaries at the Participant's last known address, unless any Beneficiary is known to reside at a different address. In that case, a separate SBC must be provided to any Beneficiary at his or her last known address.
- **FORM AND MANNER:** Group shall provide the SBC to an Eligible or Covered Person in paper form or, alternatively, electronically (such as by email or an Internet posting) if the followed conditions are met:
  1. SBCs reproduced and distributed in paper form must be in the uniform format provided by HNL; they must be copied on four, double-sided pages in length and not include print smaller than 12-point font.
  2. SBCs displayed electronically may be on a single webpage, so the viewer can scroll through the information required to be on the SBC without having to advance through pages. However, columns or rows may not be deleted when displaying a complete SBC.
  3. For Covered Persons who are already covered under a benefit package provided under this Agreement, Group may provide the required SBCs electronically if the requirements of the U.S. Department of Labor's regulations at 29 CFR 2520.104b-1 are met. This regulation contains fiduciary disclosure requirements as well as an electronic distribution safe harbor.
  4. For Eligible Persons, Group may provide SBCs electronically if (1) the format is readily accessible (such as in an html, MS Word, or pdf format) and can be electronically retained and printed, (2) paper copies are provided free of charge upon request, and (3) if the electronic form is an Internet posting, the Group timely advises Eligible Persons in paper form (such as a postcard) or by email that the SBCs are available on the Internet, provides the Internet address, and notifies the Eligible Persons that the documents are available in paper form upon request.

Model language for an e-card or postcard in connection with a website posting of a SBC follows:

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is available on the web at: www.healthnet.com. A paper copy is also available, free of charge, by calling 1-800-676-6976 (a toll free number).

- **NOTICE OF MODIFICATION OF A SBC DURING THE PLAN OR POLICY YEAR:** Upon receipt of timely notice from HNL of material changes to the contents of an SBC and an updated SBC which reflects such changes, and that occurs other than in connection with a renewal or reissuance of coverage under this Agreement, Group shall provide notice of the material changes to covered persons no later than 60 days prior to the date on which material changes will become effective. Health Net shall provide the modified SBC to Group no later than 90 days prior to the effective date of the material changes to the contents of the SBC. Group shall distribute such notice to Covered and Eligible Persons in the same number, form and manner (so as to comply with the SBC regulations) in which Group provided the original SBC which was subsequently updated.
- **UNIFORM GLOSSARY:** The SBC informs the reader that he or she can view a Glossary of bolded terms used in the SBC at www.cciio.cms.gov or can call HNL at the number on his or her ID card to request a copy. HNL shall provide a written copy of the Glossary to a Covered or Eligible Person who requests a written copy within 7 business days after HNL receives the request.
- **PARTIES TO BEAR THEIR OWN COSTS:** HNL and Group shall each bear its own costs in connection with the execution of the respective party's responsibilities under this Agreement, as amended, including but not limited to the production, reproduction and distribution of SBCs and the Glossary.
- **ADVICE OF COUNSEL:** Group and HNL each acknowledge that they have consulted with and have had appropriate advice and legal counsel to determine their responsibilities under the SBC Regulations. Group and HNL have executed this Agreement, as amended, knowingly and voluntarily.

BINDING ARBITRATION

Sometimes disputes or disagreements may arise between HNL and the Group or Covered Persons regarding the construction, interpretation, performance or breach of this Policy, or regarding other matters relating to or arising out of this Policy. HNL uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved. In addition, disputes with HNL involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

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

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

total amount of damages is over $200,000 or $50,000, whichever is applicable, the parties shall, within 30 days of submission of the demand for arbitration to HNL, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

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

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

Health Net Life Insurance Company
Attention: Litigation Administrator
PO Box 4504
Woodland Hills, CA 91365-4505

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

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees. In cases of extreme hardship to a Covered Person, HNL may assume all or portion of a Covered Person's share of the fees and expenses of the arbitration. Upon written notice by the Covered Person requesting a hardship application, HNL will forward the request to an independent professional dispute resolution organization for a determination. Such request for hardship should be submitted to the Litigation Administrator at the address provided above.

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

COBRA AND CALIFORNIA-COBRA PROGRAM (CAL-COBRA) CONTINUATION COVERAGE

HNL recognizes that many Groups must comply with the continuation of group coverage requirements under federal and California laws and regulations, which respectively are commonly referred to as "COBRA" and "Cal-COBRA." HNL acknowledges that Groups who are so affected cannot discharge their legal responsibilities without HNL's informed and willing participation in providing the required continuation coverage.

HNL is, therefore, committed to the following:

- Maintaining an awareness of the continuation coverage requirements of federal and state laws. This includes federal requirements under the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act, regulations which are issued by the Secretaries of federal agencies and state law requirements under the California COBRA Program (Article 4.5 of the California Health and Safety Code and Article 1.7 of the California Insurance Code);
- Providing continuation coverage to plan Covered Persons upon the request of a Group when such requests are consistent with the Group's obligations under the law; and
- Sharing knowledge regarding COBRA and Cal-COBRA with Groups as they experience problems, but HNL will not give legal advice on these matters.

CAL-COBRA OBLIGATIONS

California law requires health plans and insurers to offer individuals who began receiving federal COBRA coverage on or after January 1, 2003 and who have exhausted federal COBRA the opportunity to continue coverage for a total of 36 months through a combination of COBRA and Cal-COBRA. When such an individual has elected to continue coverage through Cal-COBRA, the Group must do the following:

- Notify current Cal-COBRA qualified beneficiaries of Group's intent to terminate this Policy. If the Group intends to terminate this Policy with HNL and replace it with coverage through another California HMO or disability (health) insurer, the Group must, at least 30 days prior to the termination, inform all existing Cal-COBRA qualified beneficiaries of this action. The Group must also inform qualified beneficiaries that they have the ability to choose to continue coverage through the new plan for the balance of the period that they could have continued coverage through the HNL Plan. HNL will provide the employer the names and last known addresses of enrolled Cal-COBRA qualified beneficiaries.
- Notify the successor plan of the qualified beneficiaries currently receiving Cal-COBRA coverage. The Group must notify the successor plan in writing of the qualified beneficiaries currently receiving continuation coverage so that the successor plan, or contracting employer or administrator may provide those qualified beneficiaries with the necessary information to allow the qualified beneficiary to continue coverage through the new plan.

PLAN BENEFITS AND BENEFIT CERTIFICATE

HNL will issue and deliver to each principal Covered Person a Health Net PPO *Certificate of Insurance*, electronically by posting it on HNL's website at www.healthnet.com, if so designated by the Group and elected by the Covered Person (or hard copy by mail to the Covered Person's address on record if so designated by the Group and elected by the Covered Person). The Health Net PPO *Certificate of Insurance* sets forth a statement of benefits to which the Covered Persons are entitled. HNL will also issue and deliver an identification card by mail to the Covered Person's address on record.

The benefits of this plan and the language of the Health Net PPO *Certificate of Insurance* are specifically incorporated herein by reference.

COVERAGE FOR DOMESTIC PARTNERS

A principal Covered Person's Domestic Partner is eligible for coverage provided that the partnership meets the Group's domestic partnership eligibility requirements. The Group's eligibility requirements must be compliant with California law. The Domestic Partner and the dependent children of the Domestic Partner may enroll on the same basis as a principal Covered Person's spouse and his or her children in accordance with the terms and conditions of this Policy that apply generally to the spouse of a principal Covered Person under this Plan.

Domestic Partners and their enrolled dependent children are eligible for California COBRA coverage on the same basis as other enrollees based on the Group's eligibility rule. Determination of COBRA qualification for Domestic Partners and their children will be based on agreement between HNL and the Group. In addition, HNL agrees to provide federal COBRA-like coverage on the same basis to the Domestic Partner and his or her unmarried dependent children as other COBRA qualified enrollees.

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

Where Group offers a qualified retiree prescription drug plan, Group and HNL agree to the requirements set forth in sections A and B below:

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

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

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

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

IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Health Net PPO Group Insurance Policy (N5432A, E, G, H, J, K).

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

By: ____________________
Deputy

Date: JUN 03 2014

COUNTY OF RIVERSIDE:

By: ____________________
Chairman, Board of Supervisors **JEFF STONE**

Date: JUN 03 2014

Approved as to form:

Pamela J. Walls
County Counsel

By: ____________________
Deputy County Counsel

CONTRACTOR: Health Net Life Insurance Company; a California Corporation

By: ____________________

Printed Name: STEVEN YOUNG

Title: VICE PRESIDENT, SALES + ACCT MANAGEMENT

Date: 5/16/14

SUPPLEMENT TO HEALTH NET PPO GROUP INSURANCE POLICY

BY AND BETWEEN

HEALTH NET LIFE INSURANCE COMPANY

AND

COUNTY OF RIVERSIDE

This Supplement to the Health Net PPO Group Insurance Policy ("Supplement") by and between Health Net Life Insurance Company, a California corporation ("HNL" or "Contractor"), and County of Riverside, a political subdivision of the State of California ("Group" or "County of Riverside") becomes effective January 1, 2013 ("Effective Date") at 12:00 a.m. and will remain in effect for the term of the Policy.

This Supplement modifies the Health Net PPO Group Insurance Policy with Group ID N5432A, E, G, H, J, K Coverage Code: 24RM (the "Policy") and does not supersede or modify any terms or provisions of such Policy, unless specifically stated herein.

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

REQUIRED CONTRACT LANGUAGE

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

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

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

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

   If to Group:

County of Riverside, Human Resources
4080 Lemon Street, 1st Floor
Riverside, CA 92501

Attn: Stacey M. Beale, Human Resources Division Manager

If to Contractor:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17. Insurance.

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

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

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

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

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

General Insurance Provisions - All Lines.

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

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

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

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

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

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

18. Hold Harmless/Indemnification.

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

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

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

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

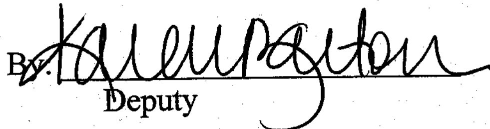
19. Conflicts. In the event of any conflict between the terms of the Supplement, Policy, the application of the Group, and the enrollment forms of the Group's eligible employees, such conflict shall be resolved by reference to the document in the following order of priority: the Supplement, then the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

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

ATTEST:

Clerk of the Board

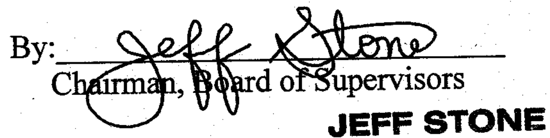
Kecia Harper-Ihem



By: ______________________
Deputy

Date: JUN 03 2014

COUNTY OF RIVERSIDE:



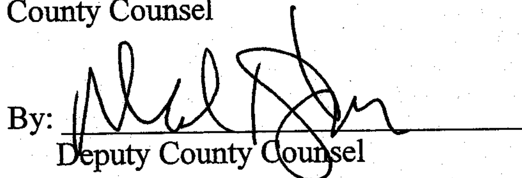
By: ______________________
Chairman, Board of Supervisors
JEFF STONE

Date: JUN 03 2014

Approved as to form:

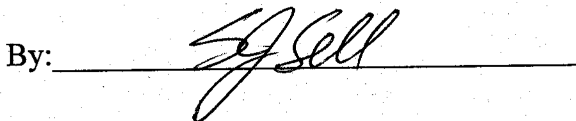
Pamela J. Walls

County Counsel



By: ______________________
Deputy County Counsel

CONTRACTOR: Health Net of California, Inc., a California Corporation



By: ______________________

Printed Name: Steven J. Sell

Title: President

Date: 5-13-14

ATTACHMENT C

Health Net PPO Group Insurance Policy, Group Number: 15834A, E, G, H and Supplement to Health Net PPO Group Insurance Policy

PPO Group Policy

HEALTH NET PPO GROUP INSURANCE POLICY
(the Policy)

ISSUED BY

HEALTH NET LIFE INSURANCE COMPANY (HNL)

LOS ANGELES, CALIFORNIA

Health Net Life Insurance Company agrees to provide the benefits of the Policy, as herein limited and defined, for enrolled Covered Persons of the Group. These benefits are subject to all the terms and conditions of this Policy.

Upon payment of premium charges in the amount and manner provided in this Policy. Health Net Life Insurance Company

HEREBY AGREES

to provide benefits as defined in this Policy to eligible employees and their eligible Dependents of:

Group Name:	OOS: RIVERSIDE COUNTY
Group ID:	15834A, E, G, H
Coverage Code:	24ST
Plan Code:	31H

(herein called the "Group")

according to the terms and conditions of this Policy. Payment of premium by the Group in the amount and manner provided for in the Policy shall constitute the Group's acceptance of the terms and conditions of the Policy. This Health Net Life Insurance Company Policy, the "Application for Group Policy" the enrollment forms of the Group's eligible employees and Supplement to Health Net PPO Group Insurance Policy, inclusively shall constitute the entire agreement between the parties.

HEALTH NET LIFE INSURANCE COMPANY

Steven Sickle
Secretary

Steven Sell
President

NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities
  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of April 1, 2011, is $470,125. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927- 4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

TERM OF POLICY

This Group Hospital and Professional Service Policy (hereinafter referred to as "Policy" or "Group Service Policy") becomes effective on January 1, 2013 at 12:00 a.m. Pacific Time, and will remain in effect for a term of 12 consecutive months, subject to the payment of premiums as required in the "Premiums" section below. This Policy may be terminated by the Group with a 30 day written notice to HNL. HNL may terminate or not renew this Policy for good cause as set forth below with a 30 day written notice. If the terms of this Policy are altered by the consent of both parties, no resulting reduction in coverage will adversely affect a Covered Person who is confined to a Hospital at the time of such change.

Good cause for termination or not renewing of this Policy by HNL shall include:

- Failure of the Group to pay any premiums when due in accordance with the "Subscription Charges" section;
- Failure of the Group to meet minimum participation and the Group contribution requirement at the time of renewal; and
- Submission to HNL by the Group of materially incorrect or incomplete information.

Termination of this Policy for good cause for the reasons described above shall become effective upon 30 days' written notice to the Group.

Covered Persons who are totally disabled on the date coverage under this Policy ends may be eligible for continuation of coverage. See the "Conversion Coverage" and the "Extension of Benefits" portions of the "Eligibility, Enrollment and Termination" section in the *Certificate* portion of this Policy.

If HNL decides to discontinue offering a particular medical benefit plan in the group market in California, HNL will:

- Provide notice to the Commissioner of Insurance of California and each affected Group of its intention to discontinue offering the particular medical benefit plan in California;
- Provide such notice at least 90 days prior to discontinuance of the particular Comprehensive Medical Benefit plan; and
- Offer to each affected group whose coverage is being discontinued, the option of replacing the discontinued plan with any other Group plan currently being offered by HNL in California, for which the Group is eligible.

PREMIUMS

The Group shall pay HNL monthly premiums in accordance with the terms set out below.

Charges shall be calculated by HNL from current records as to the number of Covered Persons enrolled.

Retroactive payment adjustments will be made in subsequent billing statements for any additions or terminations of Covered Persons not currently reflected in HNL's records at the time of calculation of premiums. The Effective Date of the addition or termination will be in accordance with rules established by HNL for determining Effective Dates of retroactive adjustments, but in no event will the Effective Date be more than 90 days prior to the date of receipt of the written request by HNL.

In order for a credit of premiums to be applied for terminated Covered Persons, HNL must receive notification as soon as possible following the date of the Covered Person's ineligibility, but in no event later than 90 days following such date. HNL will credit a maximum of 90 days of premium to the Group for ineligible Covered Persons.

Only Covered Persons for whom payment is received by HNL shall be eligible for services and benefits hereunder and only for the period covered by such payment. Upon such termination, prepaid premiums received on account of the terminated Covered Person or Covered Persons applicable to periods after the effective date of the termination will be credited back to the Group on the next following billing statement, and HNL shall not have any further liability or responsibility under this Policy to such terminated Covered Person. HNL will credit a maximum of 90 days of premium to the Group for terminated Covered Persons.

In the foregoing instances where a Covered Person is being retroactively terminated, the effective date of retroactive termination cannot be prior to any date on which services or supplies were provided to the Covered Person under

this Policy. In such instances, the date of termination will be the first day of the calendar month following the month in which services or supplies were provided, and any applicable credit of premium will be calculated from that date.

If the Group seeks to retroactively add Covered Persons, enrollment forms must be received by HNL as soon as possible following the Covered Person's eligibility date, but in no event later than 90 days following such date. HNL will charge the Group retroactive premium(s) according to the Covered Person's Effective Date, which will be in accordance with rules established by HNL for determining Effective Dates of retroactive adjustments, but in no event will the Effective Date be more than 90 days prior to when HNL receives the enrollment or membership change form.

Monthly Rates for 15834A

Individual Employee:	1,162.86
Employee and One Family Member:	2,116.39
Employee and Two or More Family Members:	3,035.07
J Contract Type:	953.53
K Contract Type:	1,872.21

Monthly Rates for 15834E

Individual Early Retiree:	1,162.86
Retiree and One Family Member:	2,116.39
Retiree and Two or More Family Members:	3,035.07
J Contract Type	953.53
K Contract Type	1,872.21

Monthly Rates for 15834G

Individual Employee:	579.77
Employee and One Family Member:	1,159.55
Employee and Two or More Family Members:	1,507.40
J Contract Type:	579.77
K Contract Type:	927.63

Monthly Rates for 15834H

Individual Employee:	909.61
Employee and One Family Member:	1,819.24
Employee and Two or More Family Members:	2,365.00
J Contract Type:	909.61
K Contract Type:	1,455.39

The first premiums must be paid to HNL on or before the Effective Date of this Policy. After that, payment is due on the first of each month while the Policy is in effect. Group will send payment by wire no later than 45 days of the due date.

On or before the subscription charges due date each month, Health Net will send the Group a mandatory reminder letter, which explains that there is a 30-day grace period in which to submit delinquent subscription charges before coverage is terminated. The 30-day grace period would start the first day following 45 days of the due date.

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

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

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

Any change to the premiums pursuant to the above stated circumstances shall be made at renewal with at least a 180-day written notice to the Group prior to the date of such change. Payment of any installment of premiums as altered shall constitute acceptance of this change.

If a governmental authority (a) imposes a tax or fee that is computed on premiums or (b) requires a change in coverage or administrative practice that increases HNL's risk, HNL may amend this Policy and increase the premium sufficiently to cover the tax, fee, or risk at renewal of the Policy provided that Group receives at least 180 days advance written notice and approves of such increases in premiums. If Group approves of the increase in premiums, the effective date of the increase in premiums date shall not be earlier than the date that the tax, fee, or required change in coverage or administrative practice is imposed by the governmental authority.

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

GENERAL PROVISIONS

Form or Content of Policy

No agent or employee of HNL is authorized to change the form or content of this Policy. Any changes can be made only through an endorsement authorized and signed by an officer of HNL.

Entire Agreement

This Policy, the application of the Group and the enrollment forms of the Group's eligible employees and Supplement to Health Net PPO Group Insurance Policy shall constitute the entire agreement between the parties.

Grace Period

A grace period of 45 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force (subject to the right of the insurer to cancel in accordance with the cancellation provision hereof).

Continuation of Coverage for Covered Persons

Except as otherwise provided herein, HNL shall not have the right to cancel or terminate any individual *Certificate* issued to any Covered Person while this Policy remains in force and effect, and while said Covered Person remains in the eligible class of Employees of the Group and his or her premiums are paid in accordance with the terms of this Policy.

Charter Not Part of Policy

None of the terms or provisions of the charter, constitution or bylaws of HNL shall form a part of this Policy or be used in the defense of any suit hereunder, unless the same is set forth in full in this Policy.

Distribution of Notices

HNL will send required notices as specified in this Policy to the Group's address on record. The Policy will be posted electronically on HNL's secure Web site at www.healthnet.com. By registering and logging on to HNL's Web site, the Group can access, download and print the Policy, if it so chooses, or the Group can opt to receive the Policy by U.S. mail, in which case HNL will mail the Policy to the Group's address on record with HNL.

Enrollment Regulations
This Policy may be terminated by HNL if at any time the number of Covered Persons does not meet the enrollment regulations of HNL.

Regulation and Interpretation of Policy
This Policy is issued with and is governed by the State of California. The regulations and laws of California shall be applied to interpretations of this Policy.

Recordkeeping
The Group is responsible for keeping records relating to this Policy. HNL has the right to inspect and audit those records.

Nondiscrimination
HNL and the Group hereby agree that no person who is otherwise eligible for coverage under this Policy shall be refused enrollment nor shall his or her coverage be canceled solely because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status, or physical or mental handicap.

Notice of Cancellation
If this Policy terminates for any reason, HNL will send the notice of cancellation to the Group, providing a 30-day grace period to submit the delinquent subscription charges before the Agreement is terminated, The notice of cancellation will include information on conversion coverage for Covered Persons. The Group shall promptly mail a copy of the notice to each Covered Person and provide HNL proof of such mailing, including the date thereof.

Medical Loss Ratio (MLR) Rebates
In conjunction with the requirements of the federal Affordable Care Act, upon HNL's request, the Group shall provide the Group's average number of employees employed on business days during the previous Calendar Year, in order for HNL to accurately categorize the Group, for purposes of determining the appropriate MLR value that is applicable to the Group.

Misstatement of Age
If the age of the Covered Person has been misstated, all amounts payable under this Policy shall be such as the premium paid would have been purchased at the correct age.

Modifications to Plan and Notice Obligations
If the plan is modified in accordance with the terms and provisions of this Group Policy, HNL will send notice of such modification to the holder of the Group Policy with at least 60 days written notice. HNL will not provide notice of such changes to Covered Persons of this plan unless it is required to do so by law. The Group may have obligations under state or federal law to provide notification of these changes to the Covered Persons under this plan.

Modifications to Preferred Provider Organization Network and Notice Obligations
HNL will send written notice to the holder of the Group Policy within a reasonable period of time, of any termination, permanent breach of contract or permanent inability to perform of any Preferred Provider, if that termination, breach or inability materially and adversely affects the holder of the Group Policy or Covered Persons of this plan. In such circumstances, the Group must provide the substance of such notice of the termination, breach or inability to perform, to the principal Covered Persons covered under this plan, not later than 30 days after the receipt of such notice from HNL.

Worker's Compensation Insurance
This Health Net PPO Policy is not a substitute for and does not affect any requirement for coverage by worker's compensation insurance on behalf of Group.

SUMMARY OF BENEFITS AND COVERAGE (SBC)
Regulations under the federal Patient Protection and Affordable Care Act (SBC Regulations) require that HNL (a group health insurance issuer) and Group (a group health plan) provide a Summary of Benefits and Coverage

(SBC), notice of modification of the SBC, and, upon request, a uniform glossary to Participants and Beneficiaries who are enrolled in the group health plan (Covered Persons) as well as to Participants and Beneficiaries who are eligible for but not enrolled in the group health plan (Eligible Persons). These documents must be available without charge to individuals who enroll or re-enroll in group health coverage during an open enrollment period (including former employees with COBRA continuation coverage) or other than through an open enrollment period (including individuals who are newly eligible for coverage or Special Enrollees).

Group and HNL, in accordance with the responsibilities assigned to each party as set forth herein below, agree to undertake their respective assignments to satisfy all timing, form and content requirements that pertain to the distribution of SBCs and the uniform glossary to Covered and Eligible Persons. Both Group and HNL shall cooperate with each other in good faith and to the extent reasonably necessary to ensure that the parties fully comply with requirements of the SBC Regulations.

- **DEFINITIONS**

  This provision defines words that will help understand this "Summary of Benefits and Coverage (SBC)" section. The terms used within this section have certain meanings that are specific to this section.

  1. "Beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.
  2. "Covered Persons" means Participants and Beneficiaries who are enrolled in the group health plan.
  3. "Eligible Persons" means Participants and Beneficiaries who are eligible for but not enrolled in the group health plan.
  4. "Group" is the business organization (usually an employer or trust) to which HNL has issued the agreement to provide the benefits to Covered Persons.
  5. "Participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.
  6. "Special Enrollee" means any Participant or Beneficiary who is eligible to enroll as described in the *Certficiate* under "Exceptions to Late Enrollment Rule" in the "Eligibility, Enrollment and Termination" section.

- **PREPARATION OF SBCs:** HNL shall prepare and timely deliver to Group an SBC for each HNL health benefit plan which Group offers to Covered and Eligible Persons, as required by SBC Regulations. In addition,. HNL shall provide required SBCs to Group at least 30 days prior to the first day of Group's open enrollment process for health coverage for the next plan year. HNL shall prepare and deliver a modified SBC to Group whenever HNL determines that material modifications must be made to a previously delivered SBC.
- **DISTRIBUTION OF SBCs**: Group shall provide Covered and Eligible Persons with SBCs in the exact and unmodified form (including appearance and content) in which HNL provides the SBCs to Group pursuant to the provisions of this section and as described herein below.
- **TIMING:** Group shall provide a SBC to an Eligible or Covered Person:

  1. Upon application for enrollment:

     a. along with any written application materials, or, if the Group does not distribute written application materials for enrollment, then no later than the first date the Eligible or Covered Person is eligible to enroll in coverage for the Participant or any Beneficiaries; and by the first day of coverage, if HNL provides a modified SBC between the date an Eligible or Covered Person applied for coverage and the first day of coverage; or by the first day of coverage, if HNL provides a modified SBC between the date an Eligible or Covered Person applied for coverage and the first day of coverage; or

     b. within ninety (90) days following enrollment, if the Eligible or Covered Person is a Special Enrollee.

  2. Upon renewal or reissuance of this Agreement for plan years with open enrollments beginning or after September 23, 2012:

a. no later than the date on which application materials (including, but not limited to, open enrollment materials) are distributed, if written application (or active election) is required for renewal; or

b. if renewal is automatic, no later than 30 days prior to the first day of the new plan or policy year. If the Agreement is not issued or renewed before this 30 day period, Group shall provide the SBC as soon as practicable but not later than 7 business days after the Agreement is issued or HNL receives Group's written confirmation of its intent to renew the Agreement, whichever is earlier.

The Group is not required to provide a SBC to a Covered Person automatically upon renewal for benefit packages in which the Covered Person is not enrolled. However, if a Covered Person requests a SBC for a benefit package in which he or she is not enrolled, such SBC must be provided as soon as practicable, but in no event later than 7 business days following receipt of the request.

3. At any time, upon request for a SBC or summary information about any HNL health benefit package for which an eligible or Covered Person is eligible. The SBC must be provided as soon as practicable, but within 7 business days following receipt of the request.

- **NUMBER:** A single SBC may be provided to a Participant and any Beneficiaries at the Participant's last known address, unless any Beneficiary is known to reside at a different address. In that case, a separate SBC must be provided to any Beneficiary at his or her last known address.
- **FORM AND MANNER:** Group shall provide the SBC to an Eligible or Covered Person in paper form or, alternatively, electronically (such as by email or an Internet posting) if the followed conditions are met:

1. SBCs reproduced and distributed in paper form must be in the uniform format provided by HNL; they must be copied on four, double-sided pages in length and not include print smaller than 12-point font.
2. SBCs displayed electronically may be on a single webpage, so the viewer can scroll through the information required to be on the SBC without having to advance through pages. However, columns or rows may not be deleted when displaying a complete SBC.
3. For Covered Persons who are already covered under a benefit package provided under this Agreement, Group may provide the required SBCs electronically if the requirements of the U.S. Department of Labor's regulations at 29 CFR 2520.104b-1 are met. This regulation contains fiduciary disclosure requirements as well as an electronic distribution safe harbor.
4. For Eligible Persons, Group may provide SBCs electronically if (1) the format is readily accessible (such as in an html, MS Word, or pdf format) and can be electronically retained and printed, (2) paper copies are provided free of charge upon request, and (3) if the electronic form is a Internet posting, the Group timely advises Eligible Persons in paper form (such as a postcard) or by email that the SBCs are available on the Internet, provides the Internet address, and notifies the Eligible Persons that the documents are available in paper form upon request.

Model language for an e-card or postcard in connection with a website posting of a SBC follows:

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is available on the web at: www.healthnet.com. A paper copy is also available, free of charge, by calling 1-800-676-6976 (a toll free number).

- **NOTICE OF MODIFICATION OF A SBC DURING THE PLAN OR POLICY YEAR:** Upon receipt of timely notice from HNL of material changes to the contents of an SBC and an updated SBC which reflects such changes, and that occurs other than in connection with a renewal or reissuance of coverage under this

Agreement, Group shall provide notice of the material changes to covered persons no later than 60 days prior to the date on which material changes will become effective. Health Net shall provide the modified SBC to Group no later than 90 days prior to the effective date of the material changes to the contents of the SBC Group shall distribute such notice to Covered and Eligible Persons in the same number, form and manner (so as to comply with the SBC regulations) in which Group provided the original SBC which was subsequently updated.

- **UNIFORM GLOSSARY:** The SBC informs the reader that he or she can view a Glossary of bolded terms used in the SBC at www.cciio.cms.gov or can call HNL at the number on his or her ID card to request a copy. HNL shall provide a written copy of the Glossary to a Covered or Eligible Person who requests a written copy within 7 business days after HNL receives the request.
- **PARTIES TO BEAR THEIR OWN COSTS:** HNL and Group shall each bear its own costs in connection with the execution of the respective party's responsibilities under this Agreement, as amended, including but not limited to the production, reproduction and distribution of SBCs and the Glossary.
- **ADVICE OF COUNSEL:** Group and HNL each acknowledge that they have consulted with and have had appropriate advice and legal counsel to determine their responsibilities under the SBC Regulations. Group and HNL have executed this Agreement, as amended, knowingly and voluntarily.

BINDING ARBITRATION

Sometimes disputes or disagreements may arise between HNL and the Group or Covered Persons regarding the construction, interpretation, performance or breach of this Policy, or regarding other matters relating to or arising out of this Policy. HNL uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved. In addition, disputes with HNL involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

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

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

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

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

Health Net Life Insurance Company
Attention: Litigation Administrator
PO Box 4504
Woodland Hills, CA 91365-4505

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

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees. In cases of extreme hardship to a Covered Person, HNL may assume all or portion of a Covered Person's share of the fees and expenses of the arbitration. Upon written notice by the Covered Person requesting a hardship application, HNL will forward the request to an independent professional dispute resolution organization for a determination. Such request for hardship should be submitted to the Litigation Administrator at the address provided above.

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

COBRA and California-COBRA Program (Cal-COBRA) Continuation Coverage

HNL recognizes that many Groups must comply with the continuation of group coverage requirements under federal and California laws and regulations, which respectively are commonly referred to as "COBRA" and "Cal-COBRA." HNL acknowledges that Groups who are so affected cannot discharge their legal responsibilities without HNL's informed and willing participation in providing the required continuation coverage.

HNL is, therefore, committed to the following:

- Maintaining an awareness of the continuation coverage requirements of federal and state laws. This includes federal requirements under the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act, regulations which are issued by the Secretaries of federal agencies and state law requirements under the California COBRA Program (Article 4.5 of the California Health and Safety Code and Article 1.7 of the California Insurance Code);
- Providing continuation coverage to plan Covered Persons upon the request of a Group when such requests are consistent with the Group's obligations under the law; and
- Sharing knowledge regarding COBRA and Cal-COBRA with Groups as they experience problems, but HNL will not give legal advice on these matters.

Cal-COBRA Obligations

California law requires health plans and insurers to offer individuals who began receiving federal COBRA coverage on or after January 1, 2003 and who have exhausted federal COBRA the opportunity to continue coverage for a total of 36 months through a combination of COBRA and Cal-COBRA. When such an individual has elected to continue coverage through Cal-COBRA, the Group must do the following:

- Notify current Cal-COBRA qualified beneficiaries of Group's intent to terminate this Policy. If the Group intends to terminate this Policy with HNL and replace it with coverage through another California HMO or dis-

ability (health) insurer, the Group must, at least 30 days prior to the termination, inform all existing Cal-COBRA qualified beneficiaries of this action. The Group must also inform qualified beneficiaries that they have the ability to choose to continue coverage through the new plan for the balance of the period that they could have continued coverage through the HNL Plan. HNL will provide the employer the names and last known addresses of enrolled Cal-COBRA qualified beneficiaries.

- Notify the successor plan of the qualified beneficiaries currently receiving Cal-COBRA coverage. The Group must notify the successor plan in writing of the qualified beneficiaries currently receiving continuation coverage so that the successor plan, or contracting employer or administrator may provide those qualified beneficiaries with the necessary information to allow the qualified beneficiary to continue coverage through the new plan.

PLAN BENEFITS AND BENEFIT CERTIFICATE

HNL will issue and deliver to each principal Covered Person a Health Net PPO *Certificate of Insurance*, electronically by posting it on HNL's website at www.healthnet.com, if so designated by the Group and elected by the Covered Person (or hard copy by mail to the Covered Person's address on record if so designated by the Group and elected by the Covered Person). The Health Net PPO *Certificate of Insurance* sets forth a statement of benefits to which the Covered Persons are entitled. HNL will also issue and deliver an identification card by mail to the Covered Person's address on record.

The benefits of this plan and the language of the Health Net PPO *Certificate of Insurance* are specifically incorporated herein by reference.

COVERAGE FOR DOMESTIC PARTNERS

A principal Covered Person's Domestic Partner is eligible for coverage provided that the partnership meets the Group's domestic partnership eligibility requirements. The Group's eligibility requirements must be compliant with California law. The Domestic Partner and the dependent children of the Domestic Partner may enroll on the same basis as a principal Covered Person's spouse and his or her children in accordance with the terms and conditions of this Policy that apply generally to the spouse of a principal Covered Person under this Plan.

Domestic Partners and their enrolled dependent children are eligible for California COBRA coverage on the same basis as other enrollees based on the Group's eligibility rule. Determination of COBRA qualification for Domestic Partners and their children will be based on agreement between HNL and the Group. In addition, HNL agrees to provide federal COBRA-like coverage on the same basis to the Domestic Partner and his or her unmarried dependent children as other COBRA qualified enrollees.

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

Where Group offers a qualified retiree prescription drug plan, Group and HNL agree to the requirements set forth in sections A and B below:

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

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

   2. Group cannot vary the premium subsidy for individuals within a given class of Covered Persons.

   3. Group cannot charge a Covered Person for prescription drug coverage provided under the Policy more than the sum of his or her monthly Medicare beneficiary premium attributable to basic prescrip-

tion drug coverage and 100% of the monthly beneficiary premium attributable to his or her supplemental prescription drug coverage (if any).

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

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

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

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

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

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

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

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

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

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

IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Health Net PPO Group Insurance Policy (OOS 15834 A, E, G, H).

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

By: ______________________
Deputy

Date: JUN 03 2014

COUNTY OF RIVERSIDE:

By: ______________________
Chairman, Board of Supervisors
JEFF STONE

Date: JUN 03 2014

Approved as to form:

Pamela J. Walls
County Counsel

By: ______________________
Deputy County Counsel

CONTRACTOR: Health Net Life Insurance Company; a California Corporation

By: ______________________

Printed Name: STEVEN YOUNG

Title: VICE PRESIDENT, SALES & ACCOUNT MANAGEMENT

Date: 5/16/14

SUPPLEMENT TO HEALTH NET PPO GROUP INSURANCE POLICY

BY AND BETWEEN

HEALTH NET LIFE INSURANCE COMPANY

AND

COUNTY OF RIVERSIDE

This Supplement to the Health Net PPO Group Insurance Policy ("Supplement") by and between Health Net Life Insurance Company, a California corporation ("HNL" or "Contractor"), and County of Riverside, a political subdivision of the State of California ("Group" or "County of Riverside") becomes effective January 1, 2013 ("Effective Date") at 12:00 a.m. and will remain in effect for the term of the Policy.

This Supplement modifies the Health Net PPO Group Insurance Policy with Group ID 15834A, E, G, H Coverage Code:24ST (the "Policy") and does not supersede or modify any terms or provisions of such Policy, unless specifically stated herein.

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

REQUIRED CONTRACT LANGUAGE

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

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

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

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

If to Group:

County of Riverside, Human Resources
4080 Lemon Street, 1st Floor
Riverside, CA 92501
Attn: Stacey M. Beale, Human Resources Division Manager

If to Contractor:

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

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

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

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

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

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

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

General Insurance Provisions - All Lines.

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

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

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

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

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

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

18. Hold Harmless/Indemnification.

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

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

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

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

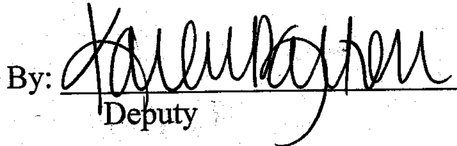
19. Conflicts. In the event of any conflict between the terms of the Supplement, Policy, the application of the Group, and the enrollment forms of the Group's eligible employees, such conflict shall be resolved by reference to the document in the following order of priority: the Supplement, then the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

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

ATTEST:

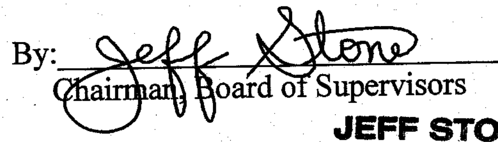
Clerk of the Board

Kecia Harper-Ihem

By: 
Deputy

Date: JUN 03 2014

COUNTY OF RIVERSIDE:

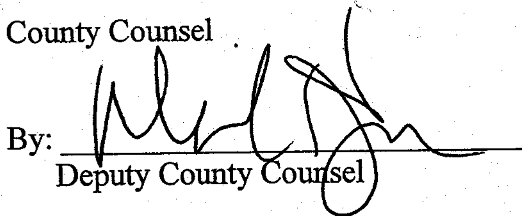
By: 
Chairman, Board of Supervisors
JEFF STONE

Date: JUN 03 2014

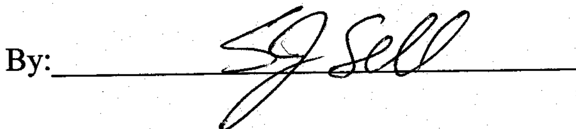
Approved as to form:

Pamela J. Walls

County Counsel

By: 
Deputy County Counsel

CONTRACTOR: Health Net of California, Inc., a California Corporation

By: 

Printed Name: Steven J. Sell

Title: President

Date: 5-13-14

ATTACHMENT D

Health Net HMO Medicare Coordination of Benefits (COB) Riverside Group Hospital and Professional Service Agreement, Group Number: 69381M and Supplement to Group Hospital and Professional Service Agreement

Group Hospital and Professional Service Agreement

GROUP HOSPITAL AND PROFESSIONAL SERVICE AGREEMENT

ISSUED BY

HEALTH NET OF CALIFORNIA, INC.

LOS ANGELES, CALIFORNIA

To the extent herein limited and defined, this Agreement provides for comprehensive health services provided through Health Net of California, Inc. (Health Net), a federally qualified Health Maintenance Organization and a California Health Care Service Plan.

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

HEREBY AGREES

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

Group Name:	MEDICARE: RIVERSIDE COUNTY
Group ID:	69381M
Coverage Code:	27Q0
Plan Code:	31E

(herein called the "Group")

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

Douglas Schur
Secretary

Steven Sell
President

HEALTH NET

TERM OF AGREEMENT

This Group Hospital and Professional Service Agreement (hereinafter referred to as "Agreement" or "Group Service Agreement") becomes effective on January 1, 2013 at 12:00 a.m., Pacific Time and will remain in effect for a term of twelve consecutive months, subject to the payment of subscription charges as required in Section 2. This Agreement may be terminated by the Group with a 30-day written notice to Health Net. Health Net may terminate or not renew this Agreement for good cause as set forth below with a 30-day written notice (see Section 2 regarding termination for nonpayment of subscription charges). If the terms of this Agreement are altered by the consent of both parties, no resulting reduction in coverage will adversely affect a Member who is confined to a Hospital at the time of such change.

Good cause for termination or not renewing this Agreement by Health Net shall include:

- Failure of the Group to pay any subscription charges in accordance with the "Subscription Charges" section;
- Failure of the Group to maintain minimum subscription charge contribution requirements as set forth in the Application for Group Service Agreement;
- Failure of the Group to maintain at least 15 eligible employees enrolled with Health Net or with Health Net Life to be determined annually, 60 days prior to Group's renewal date, with termination effective at the renewal date;
- Knowing failure by the Group to abide by and enforce the conditions of enrollment of Subscribers as set forth in the Eligibility, Enrollment and Termination Section of the *Evidence of Coverage,* the Application for Group Service Agreement and any Health Net Underwriting Assumptions provided to the Group;
- Fraud or misrepresentation by submission to Health Net by the Group of materially incorrect or incomplete information which is reasonably relied upon by Health Net in issuing or renewing this Agreement; or
- A material change in the nature of the Group's business.

Termination of this Agreement for good cause, other than for not paying subscription charges (see Section 2, "Subscription Charges" regarding termination for nonpayment of subscription charges), shall become effective with a 30-day written notice to the Group.

If this Agreement terminates under its own terms or is otherwise terminated by either Health Net or the Group, the Group shall promptly mail or hand deliver to each covered Subscriber, a notice of cancellation of this Agreement. The Group shall, upon request by Health Net, within 30 days of the request, provide Health Net with a copy of the notification, a written statement that the notice of cancellation was mailed or hand delivered to each Subscriber and the date of mailing or hand delivery.

Members who are totally disabled on the date coverage under this Agreement ends, may be eligible for continuation of coverage. See the "Conversion Privilege" and "Extension of Benefits" sections in the *Evidence of Coverage* portion of this Agreement.

Section-2

SUBSCRIPTION CHARGES

The Group shall pay Health Net subscription charges as follows.

Such charges shall be calculated by Health Net from current records as to the number of Members enrolled.

Retroactive payment adjustments will be made in subsequent billings for any additions or terminations of Members not currently reflected in Health Net's records at the time of calculation of subscription charges. The Effective Date of the addition or termination will be in accordance with rules established by Health Net for determining Effective Dates of retroactive adjustments, but in no event will the Effective Date be more than 90 days prior to the date of receipt of the written request by Health Net.

In order for a credit of subscription charges to be applied for terminated Members, Health Net must receive notification as soon as possible following the date of the Member's ineligibility, but in no event later than 90 days following such date. Health Net will credit a maximum of 90 days of subscription charges to the Group for ineligible Members.

When a Member is being retroactively terminated, the effective date of retroactive termination cannot be prior to any date on which services or supplies were provided to the Member under this Agreement. In such instances, the date of termination will be the first day of the calendar month following the month in which services or supplies were last provided and any applicable credit of subscription charges will be calculated from that date.

Only Members for whom payment is received by Health Net shall be eligible for services and benefits under this Agreement and only for the period covered by such payment. Upon such termination, prepaid subscription charges received on the account of the terminated Member or Members applicable to periods after the Effective Date of the termination will be credited back to the Group on the next following billing statement, and neither Health Net nor any contracting Physician Group will have any further liability or responsibility under this Agreement to such terminated Member. Health Net will credit a maximum of 90 days of subscription charges to the Group for terminated Members.

If the Group seeks to retroactively add Members, enrollment forms must be received by Health Net as soon as possible following the Member's eligibility date, but in no event later than 90 days following such date. Health Net will charge the Group retroactive subscription charges according to the Member's Effective Date, which will be in accordance with rules established by Health Net for determining Effective Dates of retroactive adjustments, but in no event will the Effective Date be more than 90 days prior to when Health Net receives the enrollment or membership change form.

MONTHLY CHARGES

Monthly Rates for 69381M

Individual Medicare Retiree:	223.19
Retiree and One Family Member:	446.36
J Contract Type:	223.19

The first subscription charges must be paid to Health Net on or before the Effective Date of this Agreement. After that, payment is due on the first of each month while the Agreement is in effect. Group will send payment by wire no later than 45 days of the due date.

On or before the subscription charges due date each month, Health Net will send the Group a mandatory reminder letter, which explains that there is a 30-business day grace period in which to submit delinquent subscription charges before coverage is terminated. The 30-business day grace period provided would start the first day 45 days of the due date.

If payment is not made within 45 days of the due date, Health Net will send the Group a Prospective Notice of Cancellation, providing a 30-day grace period to submit the delinquent subscription charges before the Agreement is terminated, with the following information: (a) that Subscription Charges have not been paid and that the Group Service Agreement will be canceled for non-payment if the required subscription charges are not paid within the 30-day grace period provided; (b) the specific date and time when coverage for all Members will end if subscription charges are not paid; and (c) how and when the Group can reinstate the Group Service Agreement. Health Net will continue the Subscriber's coverage under this plan during the grace period.

If Health Net does not receive payment of the delinquent subscription charges from the Group within the 30-business day grace period, the Group Service Agreement will be canceled at the end of the 30-business day grace period. Health Net will mail the Group a Notice Confirming Termination of Coverage.

The Notice Confirming Termination of Coverage, will provide the Subscriber and the Group with the following information: (1) that the Group Service Agreement has been canceled for non-payment of subscription charges; (2) the specific date and time when your Group coverage ended; (3) to the Group only, how and when coverage

may be reinstated; and (4) the Health Net telephone number Subscribers can call to obtain additional information, including whether the Group obtained reinstatement of the Group Service Agreement.

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

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

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

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

Any changes to the subscription charges, pursuant to the above circumstances, shall be made at renewal with at least a 180-day written notice to the Group prior to the date of such change. Payment of any installment of subscription charges as altered shall constitute acceptance of this change.

If a governmental authority (1) imposes a tax or fee that is computed on subscription charges or (2) requires a change in coverage or administrative practice that increases Health Net's risk, Health Net may amend this Agreement and increase the subscription charges sufficiently to cover the tax, fee or risk. risk at renewal provided that Group receives at least 180 days advance written notice and approves of such increase in subscription charges. If Group approves of the increase in subscription charges, the effective date of the increase in subscription charges shall not be earlier than the date the tax, fee or required change in coverage or administrative practice is imposed by the governmental authority.

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

Section-3

GENERAL PROVISIONS

- **FORM OR CONTENT OF AGREEMENT**: No agent or employee of Health Net is authorized to change the form or content of this Agreement. Any changes can be made only through an endorsement authorized and signed by an officer of Health Net.
- **ENTIRE AGREEMENT**: This Agreement, the application of the Group, any Health Net Underwriting Assumptions provided to the Group, the enrollment forms of the Group's eligible employees and Supplement to Group Hospital and Professional Service Agreement shall constitute the entire Agreement between the parties.
- **CONTINUATION OF SUBSCRIBER COVERAGE**: Except as otherwise provided herein, Health Net shall not have the right to cancel or terminate any individual *Evidence of Coverage* issued to any Subscriber while this Agreement remains in force and effect, while said Subscriber remains in the eligible class of employees of the Group, and while his or her subscription charges are paid in accordance with the terms of this Agreement.
- **CHARTER NOT PART OF AGREEMENT**: None of the terms or provisions of the charter, constitution or bylaws of Health Net shall form a part of this Agreement or be used in the defense of any related suit, unless the same is set forth in full in this Agreement.

- **DISTRIBUTION OF NOTICES:** Health Net will send required notices as specified in this Agreement to the Group's address on record. The Group Service Agreement will be posted electronically on Health Net's secure Web site at www.healthnet.com. By registering and logging on to Health Net's Web site, the Group can access, download and print the Group Service Agreement, if it so chooses, or the Group can opt to receive the Group Service Agreement by U.S. mail, in which case Health Net will mail the Group Service Agreement to the Group's address on record with Health Net.
- **INTERPRETATION OF AGREEMENT**: The laws of the State of California shall be applied to interpretations of this Agreement.
- **RECORDKEEPING**: The Group is responsible for keeping records relating to this Agreement. Health Net has the right to inspect and audit those records.
- **RELATIONSHIP OF PARTIES**: Neither Health Net nor any of its employees are employees or agents of Hospitals or the contracting Physician Groups.
- **HOLD HARMLESS**: Health Net agrees to indemnify and hold harmless Group and Members for any expense, liability or claims for eligible services under this Agreement with the exception of any Copayment amounts which may be required as indicated herein.
- **MEDICAL LOSS RATIO (MLR) REBATES:** In conjunction with the requirements of the federal Affordable Care Act, upon Health Net's request, the Group shall provide the Group's average number of employees employed on business days during the previous Calendar Year, in order for Health Net to accurately categorize the Group, for purposes of determining the appropriate MLR value that is applicable to the Group.
- **MODIFICATIONS TO PLAN AND NOTICE OBLIGATIONS**: If the plan is terminated or modified in accordance with the terms and provisions of this Group Service Agreement, including a change or decrease in benefits. Health Net will send notice of such modification or termination to the Group with at least 60 days written notice. Except as required under Section 2 "Subscription Charges" above regarding termination for non-payment, Health Net will not provide notice of such changes to plan Subscribers unless it is required to do so by law. The Group may have obligations under state or federal law to provide notification of these changes to plan Subscribers.
- **NON-DISCRIMINATION**: Health Net and the Group hereby agree that no person who is otherwise eligible for coverage under this Agreement shall be refused enrollment nor shall their coverage be canceled solely because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status or physical or mental handicap.
- **NOTICE OF CERTAIN EVENTS**: Health Net will give the Group written notice, within a reasonable time, of any termination or breach of contract, or inability to perform services, by any contracting Physician Group or contracting provider, if the Group may be materially and adversely affected thereby.
- **WORKERS' COMPENSATION INSURANCE**: This Health Net Agreement is not a substitute for and does not affect any requirement for coverage by Workers' Compensation Insurance on behalf of the Group.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

Regulations under the federal Patient Protection and Affordable Care Act (SBC Regulations) require that Health Net (a group health insurance issuer) and Group (a group health plan) provide a Summary of Benefits and Coverage (SBC), notice of modification of the SBC, and, upon request, a uniform glossary to Participants and Beneficiaries who are enrolled in the group health plan (Covered Persons) as well as to Participants and Beneficiaries who are eligible for but not enrolled in the group health plan (Eligible Persons). These documents must be available without charge to individuals who enroll or re-enroll in group health coverage during an open enrollment period (including former employees with COBRA continuation coverage) or other than through an open enrollment period (including individuals who are newly eligible for coverage or Special Enrollees).

Group and Health Net, in accordance with the responsibilities assigned to each party as set forth herein below, agree to undertake their respective assignments to satisfy all timing, form and content requirements that pertain to the distribution of SBCs and the uniform glossary to Covered and Eligible Persons. Both Group and Health Net shall cooperate with each other in good faith and to the extent reasonably necessary to ensure that the parties fully comply with requirements of the SBC Regulations.

- **DEFINITIONS**

  This provision defines words that will help understand this "Summary of Benefits and Coverage (SBC)" section. The terms used within this section have certain meanings that are specific to this section.

  1. "Beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.
  2. "Covered Persons" means Participants and Beneficiaries who are enrolled in the group health plan.
  3. "Eligible Persons" means Participants and Beneficiaries who are eligible for but not enrolled in the group health plan.
  4. "Group" is the business organization (usually an employer or trust) to which Health Net has issued the agreement to provide the benefits to Covered Persons.
  5. "Participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.
  6. "Special Enrollee" means any Participant or Beneficiary who is eligible to enroll as described in the *Evidence of Coverage* under "Exceptions to Late Enrollment Rule" in the "Eligibility, Enrollment and Termination" section.

- **PREPARATION OF SBCs:** Health Net shall prepare and timely deliver to Group an SBC for each Health Net health benefit plan which Group offers to Covered and Eligible Persons, as required by SBC Regulations. In addition, Health Net shall provide required SBCs to Group at least 30 days prior to the first day of Group's open enrollment process for health coverage for the next plan year. Health Net shall prepare and deliver a modified SBC to Group whenever Health Net determines that material modifications must be made to a previously delivered SBC.

- **DISTRIBUTION OF SBCs:** Group shall provide Covered and Eligible Persons with SBCs in the exact and unmodified form (including appearance and content) in which Health Net provides the SBCs to Group pursuant to the provisions of this section and as described herein below.

- **TIMING:** Group shall provide a SBC to an Eligible or Covered Person:

  1. Upon application for enrollment:

     a. along with any written application materials, or, if the Group does not distribute written application materials for enrollment, then no later than the first date the Eligible or Covered Person is eligible to enroll in coverage for the participant or any beneficiaries; and by the first day of coverage, if Health Net provides a modified SBC between the date an Eligible or Covered Person applied for coverage and the first day of coverage; or by the first day of coverage, if Health Net provides a modified SBC between the date an Eligible or Covered Person applied for coverage and the first day of coverage; or

     b. within ninety (90) days following enrollment, if the Eligible or Covered Person is a special enrollee.

  2. Upon renewal or reissuance of this Agreement for plan years with open enrollments beginning or after September 23, 2012:

     a. no later than the date on which application materials (including, but not limited to, open enrollment materials) are distributed, if written application (or active election) is required for renewal; or

     b. if renewal is automatic, no later than 30 days prior to the first day of the new plan or policy year. If the Agreement is not issued or renewed before this 30 day period, Group shall provide the SBC as soon as practicable but not later than 7 business days after the Agreement is issued or Health Net receives Group's written confirmation of its intent to renew the Agreement, whichever is earlier.

     The Group is not required to provide a SBC to a Covered Person automatically upon renewal for benefit packages in which the Covered Person is not enrolled. However, if a Covered Person requests a SBC for a benefit package in which he or she is not enrolled, such SBC must be provided as soon as practicable, but in no event later than 7 business days following receipt of the request.

3. At any time, upon request for a SBC or summary information about any Health Net health benefit package for which an eligible or Covered Person is eligible. The SBC must be provided as soon as practicable, but within 7 business days following receipt of the request.

- **NUMBER:** A single SBC may be provided to a participant and any beneficiaries at the participant's last known address, unless any beneficiary is known to reside at a different address. In that case, a separate SBC must be provided to any beneficiary at his or her last known address.
- **FORM AND MANNER:** Group shall provide the SBC to an Eligible or Covered Person in paper form or, alternatively, electronically (such as by email or an Internet posting) if the followed conditions are met:
  1. SBCs reproduced and distributed in paper form must be in the uniform format provided by Health Net; they must be copied on four, double-sided pages in length and not include print smaller than 12-point font.
  2. SBCs displayed electronically may be on a single webpage, so the viewer can scroll through the information required to be on the SBC without having to advance through pages. However, columns or rows may not be deleted when displaying a complete SBC.
  3. For Covered Persons who are already covered under a benefit package provided under this Agreement, Group may provide the required SBCs electronically if the requirements of the U.S. Department of Labor's regulations at 29 CFR 2520.104b-1 are met. This regulation contains fiduciary disclosure requirements as well as an electronic distribution safe harbor.
  4. For Eligible Persons, Group may provide SBCs electronically if (1) the format is readily accessible (such as in an html, MS Word, or pdf format) and can be electronically retained and printed, (2) paper copies are provided free of charge upon request, and (3) if the electronic form is an Internet posting, the Group timely advises Eligible Persons in paper form (such as a postcard) or by email that the SBCs are available on the Internet, provides the Internet address, and notifies the Eligible Persons that the documents are available in paper form upon request.

Model language for an e-card or postcard in connection with a website posting of a SBC follows:

Availability of Summary Health Information
As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in case of illness or injury. Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options. The SBC is available on the web at: www.healthnet.com. A paper copy is also available, free of charge, by calling 1-800-522-0088 (a toll-free number).

- **NOTICE OF MODIFICATION OF A SBC DURING THE PLAN OR POLICY YEAR:** Upon receipt of timely notice from Health Net of material changes to the contents of an SBC and an updated SBC which reflects such changes, and that occurs other than in connection with a renewal or reissuance of coverage under this Agreement, Group shall provide notice of the material changes to covered persons no later than 60 days prior to the date on which material changes will become effective. Health Net shall provide the modified SBC to Group no later than 90 days prior to the effective date of the material changes to the contents of the SBC. Group shall distribute such notice to covered and eligible persons in the same number, form and manner (so as to comply with the SBC regulations) in which Group provided the original SBC which was subsequently updated.
- **UNIFORM GLOSSARY:** The SBC informs the reader that he or she can view a Glossary of bolded terms used in the SBC at www.cciio.cms.gov or can call Health Net at the number on his or her ID card to request a copy. Health Net shall provide a written copy of the Glossary to a Covered or Eligible Person who requests a written copy within 7 business days after Health Net receives the request.

- **PARTIES TO BEAR THEIR OWN COSTS:** Health Net and Group shall each bear its own costs in connection with the execution of the respective party's responsibilities under this Agreement, as amended, including but not limited to the production, reproduction and distribution of SBCs and the Glossary.
- **ADVICE OF COUNSEL:** Group and Health Net each acknowledge that they have consulted with and have had appropriate advice and legal counsel to determine their responsibilities under the SBC Regulations. Group and Health Net have executed this Agreement, as amended, knowingly and voluntarily.

BINDING ARBITRATION

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

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

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

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

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

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

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

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

dispute resolution organization for a determination. Such request for hardship should be submitted to the Litigation Administrator at the address provided above.

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

Section-5

COBRA AND CALIFORNIA-COBRA PROGRAM (CAL-COBRA) CONTINUATION COVERAGE

Health Net recognizes that many Groups must comply with the continuation of group coverage requirements under federal and California laws and regulations, which respectively are commonly referred to as "COBRA" and "Cal-COBRA." Health Net acknowledges that Groups who are so affected cannot discharge their legal responsibilities without Health Net's informed and willing participation in providing the required continuation coverage.

Health Net is, therefore, committed to the following:

A. Maintaining an awareness of the continuation coverage requirements of federal and state laws. This includes federal requirements under the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act, regulations which are issued by the Secretaries of federal agencies and state law requirements under the California COBRA Program (Article 4.5 of the California Health and Safety Code and Article 1.7 of the California Insurance Code).

B. Providing continuation coverage to Plan Members upon the request of a Group when such requests are consistent with the Group's obligations under the law.

C. Sharing knowledge regarding COBRA and Cal-COBRA with Groups as they experience problems, but Health Net will not give legal advice on these matters.

Section-6

CAL-COBRA OBLIGATIONS

California law requires health plans and insurers to offer individuals who began receiving federal COBRA coverage on or after January 1, 2003 and who have exhausted federal COBRA the opportunity to continue coverage for a total of 36 months through a combination of COBRA and Cal-COBRA. When such an individual has elected to continue coverage through Cal-COBRA, the Group must do the following:

A. Notify current Cal-COBRA qualified beneficiaries of Group's intent to terminate this Group Service Agreement. If the Group intends to terminate this Group Service Agreement with Health Net and replace it with coverage through another California HMO or disability (health) insurer, the Group must, at least 30 days prior to the termination, inform all existing Cal-COBRA qualified beneficiaries of this action. The Group must also inform qualified beneficiaries that they have the ability to choose to continue coverage through the new plan for the balance of the period that they could have continued coverage through the Health Net Plan. Health Net will provide the employer the names and last known addresses of enrolled Cal-COBRA qualified beneficiaries.

B. Notify the successor plan of the qualified beneficiaries currently receiving Cal-COBRA coverage. The Group must notify the successor plan in writing of the qualified beneficiaries currently receiving continuation coverage so that the successor plan, or contracting employer or administrator may provide those qualified beneficiaries with the necessary information to allow the qualified beneficiary to continue coverage through the new plan.

COVERAGE FOR DOMESTIC PARTNERS

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

Domestic Partners and their enrolled dependent children are eligible for California COBRA coverage on the same basis as other enrollees. In addition, Health Net will provide federal COBRA-like coverage on the same basis to the Domestic Partner and his or her unmarried dependent children as other COBRA qualified enrollees based on the Group's eligibility rules. Determination of COBRA qualification for Domestic Partners and their children will be based on agreements between Health Net and the Group.

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

Where Group offers a qualified retiree prescription drug plan, Group and Health Net agree to the requirements set forth in sections A and B below:

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

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

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

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

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

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

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

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

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

Section 9

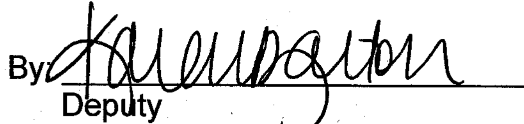
PLAN BENEFITS AND EVIDENCE OF COVERAGE

Health Net will issue and deliver to each Subscriber an *Evidence of Coverage,* electronically by posting it on Health Net's website at www.healthnet.com, if so designated by the Group and elected by the Subscriber (or hard copy by mail to the Subscriber's address on record if so designated by the Group and elected by the Subscriber). The *Evidence of Coverage* sets forth a statement of services and benefits to which the Members are entitled. Health Net will also issue and deliver an Identification Card by mail to the Subscriber's address on record.

The benefits of this plan are set forth commencing on the next page of this Agreement, the language of which will constitute the *Evidence of Coverage*.

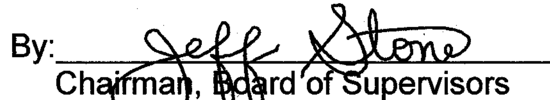
IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Health Net Group Hospital and Professional Service Agreement (Medicare HMO COB 69381M).

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

By: 
Deputy

Date: JUN 03 2014

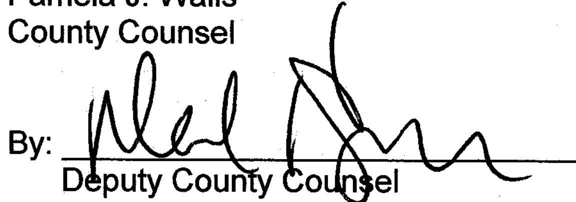
COUNTY OF RIVERSIDE:

By: 
Chairman, Board of Supervisors
JEFF STONE

Date: JUN 03 2014

Approved as to form:

Pamela J. Walls
County Counsel

By: 
Deputy County Counsel

CONTRACTOR: Health Net of California, Inc., a California Corporation

By:

Printed Name: STEVEN YOUNG

Title: VICE PRESIDENT, SALES + ACCOUNT MANAGEMENT

Date: 5/16/14

SUPPLEMENT TO GROUP HOSPITAL AND PROFESSIONAL SERVICE AGREEMENT

BY AND BETWEEN

HEALTH NET OF CALIFORNIA, INC.

AND

COUNTY OF RIVERSIDE

This Supplement to the Group Hospital and Professional Service Agreement ("Supplement") by and between Health Net of California, Inc., a California corporation ("Health Net" or "Contractor"), and County of Riverside, a political subdivision of the State of California ("Group" or "County of Riverside"), becomes effective January 1, 2013 ("Effective Date") at 12:00 a.m. and will remain in effect for the term of the Group Hospital and Professional Service Agreement.

This Supplement modifies the Group Hospital and Professional Service Agreement with Group 69381M Coverage Code: 27Q0 (the "Agreement") and does not supersede or modify any terms or provisions of such Agreement, unless specifically stated herein.

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

REQUIRED CONTRACT LANGUAGE

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

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

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

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

If to Group:

County of Riverside, Human Resources
4080 Lemon Street, 1st Floor
Riverside, CA 92501
Attn: Stacey M. Beale, Human Resources Division Manager

If to Contractor:

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

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

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

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

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

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

8. Independent Contractor. The relationship between Health Net and Group is an independent contractor relationship. Neither Health Net nor its employee(s) and/or agent(s) shall be considered to be an employee(s), and/or agent(s) of Group. Group nor any employee(s) and/or agent(s) of Group shall be considered

to be an employee(s) and/or agent(s) of Health Net. None of the provisions of this Agreement shall be construed to create a relationship of agency, representation, joint venture, ownership, control or employment between the parties other than that of independent parties contracting for the purposes of effectuating this Agreement.

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

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

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

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

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

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

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

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

17. Insurance.

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

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

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

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

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

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

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

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

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

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

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

ATTEST:

Clerk of the Board

Kecia Harper-Ihem

By: ______________________
Deputy

Date: JUN 03 2014

COUNTY OF RIVERSIDE:

By: ______________________
Chairman, Board of Supervisors
JEFF STONE

Date: JUN 03 2014

Approved as to form:

Pamela J. Walls

County Counsel

By: ______________________
Deputy County Counsel

CONTRACTOR: Health Net of California, Inc., a California Corporation

By: ______________________

Printed Name: Steven J. Sell

Title: President

Date: 5-13-14

ATTACHMENT E

Health Net PPO Medicare Coordination of Benefits (COB) Riverside, Group Insurance Policy, Group Number: N5432M and Supplement to Health Net PPO Group Insurance Policy

PPO Group Policy

HEALTH NET PPO GROUP INSURANCE POLICY
(the Policy)

ISSUED BY

HEALTH NET LIFE INSURANCE COMPANY
(HNL)

LOS ANGELES, CALIFORNIA

Health Net Life Insurance Company agrees to provide the benefits of the Policy, as herein limited and defined, for enrolled Covered Persons of the Group. These benefits are subject to all the terms and conditions of this Policy.

Upon payment of premium charges in the amount and manner provided in this Policy. Health Net Life Insurance Company

HEREBY AGREES

to provide benefits as defined in this Policy to eligible employees and their eligible Dependents of:

Group Name:	MEDICARE: RIVERSIDE COUNTY
Group ID:	N5432M
Coverage Code:	27PZ
Plan Code:	31G

(herein called the "Group")

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

HEALTH NET LIFE INSURANCE COMPANY

Steven Sickle
Secretary

Steven Sell
President

PPO846LRG(1/13)

NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  - 80% of death benefits but not to exceed $300,000
  - 80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities
  - 80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of April 1, 2011, is $470,125. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance Guarantee Association
P.O Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927- 4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

TERM OF POLICY

This Group Hospital and Professional Service Policy becomes effective on January 1, 2013 at 12:00 a.m. Pacific Time, and will remain in effect for a term of 12 consecutive months, subject to the payment of premiums as required in the "Premiums" section below. This Policy may be terminated by the Group with a 30 day written notice to HNL. HNL may terminate or not renew this Policy for good cause as set forth below with a 30 day written notice. If the terms of this Policy are altered by the consent of both parties, no resulting reduction in coverage will adversely affect a Covered Person who is confined to a Hospital at the time of such change.

Good cause for termination or not renewing of this Policy by HNL shall include:

- Failure of the Group to pay any premiums in accordance with the "Subscription Charges" section;;
- Failure of the Group to meet minimum participation and the Group contribution requirement at the time of renewal; and
- Submission to HNL by the Group of materially incorrect or incomplete information.

Termination of this Policy for good cause for the reasons described above shall become effective upon 30 days' written notice to the Group.

Covered Persons who are totally disabled on the date coverage under this Policy ends may be eligible for continuation of coverage. See the "Conversion Coverage" and the "Extension of Benefits" portions of the "Eligibility, Enrollment and Termination" section in the *Certificate* portion of this Policy.

If HNL decides to discontinue offering a particular medical benefit plan in the group market in California, HNL will:

- Provide notice to the Commissioner of Insurance of California and each affected Group of its intention to discontinue offering the particular medical benefit plan in California;
- Provide such notice at least 90 days prior to discontinuance of the particular Comprehensive Medical Benefit plan; and
- Offer to each affected group whose coverage is being discontinued, the option of replacing the discontinued plan with any other Group plan currently being offered by HNL in California, for which the Group is eligible.

PREMIUMS

The Group shall pay HNL monthly premiums in accordance with the terms set out below.

Charges shall be calculated by HNL from current records as to the number of Covered Persons enrolled.

Retroactive payment adjustments will be made in subsequent billing statements for any additions or terminations of Covered Persons not currently reflected in HNL's records at the time of calculation of premiums. The effective date of the addition or termination will be in accordance with rules established by HNL for determining effective dates of retroactive adjustments, but in no event will the effective date be more than 90 days prior to the date of receipt of the written request by HNL.

In order for a credit of premiums to be applied for terminated Covered Persons, HNL must receive notification as soon as possible following the date of the Covered Person's ineligibility, but in no event later than 90 days following such date. HNL will credit a maximum of 90 days of premium to the Group for ineligible Covered Persons.

Only Covered Persons for whom payment is received by HNL shall be eligible for services and benefits hereunder and only for the period covered by such payment. Upon such termination, prepaid premiums received on account of the terminated Covered Person or Covered Persons applicable to periods after the effective date of the termination will be credited back to the Group on the next following billing statement, and HNL shall not have any further liability or responsibility under this Policy to such terminated Covered Person. HNL will credit a maximum of 90 days of premium to the Group for terminated Covered Persons.

In the foregoing instances where a Covered Person is being retroactively terminated, the effective date of retroactive termination cannot be prior to any date on which services or supplies were provided to the Covered Person under this Policy. In such instances, the date of termination will be the first day of the calendar month following the month in which services or supplies were provided, and any applicable credit of premium will be calculated from that date.

If the Group seeks to retroactively add Covered Persons, enrollment forms must be received by HNL as soon as possible following the Covered Person's eligibility date, but in no event later than 90 days following such date. HNL will charge the Group retroactive premium(s) according to the Covered Person's Effective Date, which will be in accordance with rules established by HNL for determining effective dates of retroactive adjustments, but in no event will the effective date be more than 90 days prior to when HNL receives the enrollment or membership change form.

Monthly Rates for N5432M

Individual Medicare Retiree:	301.13
Retiree and One Family Member:	602.27
Retiree with Spouse and Child(ren):	301.13

The first premiums must be paid to HNL on or before the effective date of this Policy. After that, payment is due on the first of each month while the Policy is in effect. Group will send payment by wire no later than 45 days of the due date.

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

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

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

Any change to the premiums pursuant to the above stated circumstances, shall be made at renewal with at least a 180-day written notice to the Group prior to the date of such change. Payment of any installment of premiums as altered shall constitute acceptance of this change.

If a governmental authority (a) imposes a tax or fee that is computed on premiums or (b) requires a change in coverage or administrative practice that increases HNL's risk, HNL may amend this Policy and increase the premium sufficiently to cover the tax, fee, or risk at renewal of the Policy provided that Group receives at least 180 days advance written notice and approves of such increase in premiums. If Group approves of the increase in premiums, the effective date of the increase in premiums shall not be earlier than the date that the tax, fee, or required change in coverage or administrative practice is imposed by the governmental authority.

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

GENERAL PROVISIONS

Form or Content of Policy

No agent or employee of HNL is authorized to change the form or content of this Policy. Any changes can be made only through an endorsement authorized and signed by an officer of HNL.

Entire Agreement

This Policy, the application of the Group, the enrollment forms of the Group's eligible employees and Supplement to Health Net PPO Group Insurance Policy shall constitute the entire agreement between the parties.

Grace Period
A grace period of 45 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force (subject to the right of the insurer to cancel in accordance with the cancellation provision hereof).

Continuation of Coverage for Covered Persons
Except as otherwise provided herein, HNL shall not have the right to cancel or terminate any individual *Certificate* issued to any Covered Person while this Policy remains in force and effect, and while said Covered Person remains in the eligible class of Employees of the Group and his or her premiums are paid in accordance with the terms of this Policy.

Charter Not Part of Policy
None of the terms or provisions of the charter, constitution or bylaws of HNL shall form a part of this Policy or be used in the defense of any suit hereunder, unless the same is set forth in full in this Policy.

Distribution of Notices
HNL will send required notices as specified in this Policy to the Group's address on record. The Policy will be posted electronically on HNL's secure Web site at www.healthnet.com. By registering and logging on to HNL's Web site, the Group can access, download and print the Policy, if it so chooses, or the Group can opt to receive the Policy by U.S. mail, in which case HNL will mail the Policy to the Group's address on record with HNL.

Enrollment Regulations
This Policy may be terminated by HNL if at any time the number of Covered Persons does not meet the enrollment regulations of HNL.

Regulation and Interpretation of Policy
This Policy is issued with and is governed by the State of California. The regulations and laws of California shall be applied to interpretations of this Policy.

Recordkeeping
The Group is responsible for keeping records relating to this Policy. HNL has the right to inspect and audit those records.

Nondiscrimination
HNL and the Group hereby agree that no person who is otherwise eligible for coverage under this Policy shall be refused enrollment nor shall his or her coverage be canceled solely because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status, or physical or mental handicap.

Notice of Cancellation
If this Policy terminates for any reason, HNL will send the notice of cancellation to the Group. The notice of cancellation will include information on conversion coverage for Covered Persons. The Group shall promptly mail a copy of the notice to each Covered Person and provide HNL proof of such mailing, including the date thereof.

Medical Loss Ratio (MLR) Rebates
In conjunction with the requirements of the federal Affordable Care Act, upon HNL's request, the Group shall provide the Group's average number of employees employed on business days during the previous Calendar Year, in order for HNL to accurately categorize the Group, for purposes of determining the appropriate MLR value that is applicable to the Group.

Misstatement of Age
If the age of the Covered Person has been misstated, all amounts payable under this Policy shall be such as the premium paid would have been purchased at the correct age.

Modifications to Plan and Notice Obligations

If the plan is modified in accordance with the terms and provisions of this Group Policy, HNL will send notice of such modification to the holder of the Group Policy with at least 60 days written notice. HNL will not provide notice of such changes to Covered Persons of this plan unless it is required to do so by law. The Group may have obligations under state or federal law to provide notification of these changes to the Covered Persons under this plan.

Modifications to Preferred Provider Organization Network and Notice Obligations

HNL will send written notice to the holder of the Group Policy within a reasonable period of time, of any termination, permanent breach of contract or permanent inability to perform of any Preferred Provider, if that termination, breach or inability materially and adversely affects the holder of the Group Policy or Covered Persons of this plan. In such circumstances, the Group must provide the substance of such notice of the termination, breach or inability to perform, to the principal Covered Persons covered under this plan, not later than 30 days after the receipt of such notice from HNL.

Worker's Compensation Insurance

This Health Net PPO Policy is not a substitute for and does not affect any requirement for coverage by worker's compensation insurance on behalf of Group.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

Regulations under the federal Patient Protection and Affordable Care Act (SBC Regulations) require that HNL (a group health insurance issuer) and Group (a group health plan) provide a Summary of Benefits and Coverage (SBC), notice of modification of the SBC, and, upon request, a uniform glossary to Participants and Beneficiaries who are enrolled in the group health plan (Covered Persons) as well as to Participants and Beneficiaries who are eligible for but not enrolled in the group health plan (Eligible Persons). These documents must be available without charge to individuals who enroll or re-enroll in group health coverage during an open enrollment period (including former employees with COBRA continuation coverage) or other than through an open enrollment period (including individuals who are newly eligible for coverage or Special Enrollees).

Group and HNL, in accordance with the responsibilities assigned to each party as set forth herein below, agree to undertake their respective assignments to satisfy all timing, form and content requirements that pertain to the distribution of SBCs and the uniform glossary to Covered and Eligible Persons. Both Group and HNL shall cooperate with each other in good faith and to the extent reasonably necessary to ensure that the parties fully comply with requirements of the SBC Regulations.

- **DEFINITIONS**

  This provision defines words that will help understand this "Summary of Benefits and Coverage (SBC)" section. The terms used within this section have certain meanings that are specific to this section.

  1. "Beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.
  2. "Covered Persons" means Participants and Beneficiaries who are enrolled in the group health plan.
  3. "Eligible Persons" means Participants and Beneficiaries who are eligible for but not enrolled in the group health plan.
  4. "Group" is the business organization (usually an employer or trust) to which HNL has issued the agreement to provide the benefits to Covered Persons.
  5. "Participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.
  6. "Special Enrollee" means any Participant or Beneficiary who is eligible to enroll as described in the *Certficiate* under "Exceptions to Late Enrollment Rule" in the "Eligibility, Enrollment and Termination" section.

- **PREPARATION OF SBCs:** HNL shall prepare and timely deliver to Group an SBC for each HNL health benefit plan which Group offers to Covered and Eligible Persons, as required by SBC Regulations. In addition, HNL shall provide required SBCs to Group at least 30 days prior to the first day of Group's open enrollment process for health coverage for the next plan year . HNL shall prepare and deliver a modified SBC to Group whenever HNL determines that material modifications must be made to a previously delivered SBC.
- **DISTRIBUTION OF SBCs**: Group shall provide Covered and Eligible Persons with SBCs in the exact and unmodified form (including appearance and content) in which HNL provides the SBCs to Group pursuant to the provisions of this section and as described herein below.
- **TIMING:** Group shall provide a SBC to an Eligible or Covered Person:
  1. Upon application for enrollment:
     a. along with any written application materials, or, if the Group does not distribute written application materials for enrollment, then no later than the first date the Eligible or Covered Person is eligible to enroll in coverage for the Participant or any Beneficiaries; and by the first day of coverage, if HNL provides a modified SBC between the date an Eligible or Covered Person applied for coverage and the first day of coverage; or by the first day of coverage, if HNL provides a modified SBC between the date an Eligible or Covered Person applied for coverage and the first day of coverage; or

     b. within ninety (90) days following enrollment, if the Eligible or Covered Person is a Special Enrollee.
  2. Upon renewal or reissuance of this Agreement for plan years with open enrollments beginning or after September 23, 2012:
     a. no later than the date on which application materials (including, but not limited to, open enrollment materials) are distributed, if written application (or active election) is required for renewal; or

     b. if renewal is automatic, no later than 30 days prior to the first day of the new plan or policy year. If the Agreement is not issued or renewed before this 30 day period, Group shall provide the SBC as soon as practicable but not later than 7 business days after the Agreement is issued or HNL receives Group's written confirmation of its intent to renew the Agreement, whichever is earlier.

     The Group is not required to provide a SBC to a Covered Person automatically upon renewal for benefit packages in which the Covered Person is not enrolled. However, if a Covered Person requests a SBC for a benefit package in which he or she is not enrolled, such SBC must be provided as soon as practicable, but in no event later than 7 business days following receipt of the request.
  3. At any time, upon request for a SBC or summary information about any HNL health benefit package for which an eligible or Covered Person is eligible. The SBC must be provided as soon as practicable, but within 7 business days following receipt of the request.
- **NUMBER:** A single SBC may be provided to a Participant and any Beneficiaries at the Participant's last known address, unless any Beneficiary is known to reside at a different address. In that case, a separate SBC must be provided to any Beneficiary at his or her last known address.
- **FORM AND MANNER:** Group shall provide the SBC to an Eligible or Covered Person in paper form or, alternatively, electronically (such as by email or an Internet posting) if the followed conditions are met:
  1. SBCs reproduced and distributed in paper form must be in the uniform format provided by HNL; they must be copied on four, double-sided pages in length and not include print smaller than 12-point font.
  2. SBCs displayed electronically may be on a single webpage, so the viewer can scroll through the information required to be on the SBC without having to advance through pages. However, columns or rows may not be deleted when displaying a complete SBC.
  3. For Covered Persons who are already covered under a benefit package provided under this Agreement, Group may provide the required SBCs electronically if the requirements of the U.S. Department of Labor's regulations at 29 CFR 2520.104b-1 are met. This regulation contains fiduciary disclosure requirements as well as an electronic distribution safe harbor.
  4. For Eligible Persons, Group may provide SBCs electronically if (1) the format is readily accessible (such as in an html, MS Word, or pdf format) and can be electronically retained and printed, (2) paper copies

are provided free of charge upon request, and (3) if the electronic form is an Internet posting, the Group timely advises Eligible Persons in paper form (such as a postcard) or by email that the SBCs are available on the Internet, provides the Internet address, and notifies the Eligible Persons that the documents are available in paper form upon request.

Model language for an e-card or postcard in connection with a website posting of a SBC follows:

> Availability of Summary Health Information
>
> As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in case of illness or injury.
>
> Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.
>
> The SBC is available on the web at: www.healthnet.com. A paper copy is also available, free of charge, by calling 1-800-676-6976 (a toll free number).

- **NOTICE OF MODIFICATION OF A SBC DURING THE PLAN OR POLICY YEAR:** Upon receipt of timely notice from HNL of material changes to the contents of an SBC and an updated SBC which reflects such changes, and that occurs other than in connection with a renewal or reissuance of coverage under this Agreement, Group shall provide notice of the material changes to covered persons no later than 60 days prior to the date on which material changes will become effective. Health Net shall provide the modified SBC to Group no later than 90 days prior to the effective date of the material changes to the contents of the SBC. Group shall distribute such notice to Covered and Eligible Persons in the same number, form and manner (so as to comply with the SBC regulations) in which Group provided the original SBC which was subsequently updated.
- **UNIFORM GLOSSARY:** The SBC informs the reader that he or she can view a Glossary of bolded terms used in the SBC at www.cciio.cms.gov or can call HNL at the number on his or her ID card to request a copy. HNL shall provide a written copy of the Glossary to a Covered or Eligible Person who requests a written copy within 7 business days after HNL receives the request.
- **PARTIES TO BEAR THEIR OWN COSTS:** HNL and Group shall each bear its own costs in connection with the execution of the respective party's responsibilities under this Agreement, as amended, including but not limited to the production, reproduction and distribution of SBCs and the Glossary.
- **ADVICE OF COUNSEL:** Group and HNL each acknowledge that they have consulted with and have had appropriate advice and legal counsel to determine their responsibilities under the SBC Regulations. Group and HNL have executed this Agreement, as amended, knowingly and voluntarily.

BINDING ARBITRATION

Sometimes disputes or disagreements may arise between HNL and the Group or Covered Persons regarding the construction, interpretation, performance or breach of this Policy, or regarding other matters relating to or arising out of this Policy. HNL uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved. In addition, disputes with HNL involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

As a condition to contracting with HNL, Group and Covered Persons agree to submit all disputes they may have with HNL to final and binding arbitration. HNL also agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that Group, Covered Persons and HNL are bound to use binding arbitration as the final means of resolving disputes that may arise between them, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to the parties in a