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 (Medicare COB PPO N5432M).

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

By: _____
Deputy

Date: JUN 03 2014

COUNTY OF RIVERSIDE:

By: _____
Chairman, Board of Supervisors

JUN 03 2014 **JEFF STONE**

Date: _____

Approved as to form:

Pamela J. Walls
County Counsel

By: _____
Deputy County Counsel

CONTRACTOR: Health Net Life Insurance Company; a California Corporation

By: _____

Printed Name: STEVEN 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 N5432M Coverage Code: 27PZ (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 F

Health Net Flex Net Insurance Policy; Group Number: N1658A and Supplement to Health Net PPO Group Insurance Policy

Flex Med
Insurance Policy

Health Net
Life Insurance Company

FLEX NET
INSURANCE 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 the Policy to eligible employees and their eligible Dependents of:

Group Name:	MEDICARE: RIVERSIDE COUNTY
Group ID:	N1658A
Coverage Code:	27Q4
Plan Code:	2TC

(herein called the "Group")

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

HEALTH NET LIFE INSURANCE COMPANY

Steven Sickle
Secretary

Steven Sell
President

A11401 (CA8/13)

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. 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 (see the "Premiums" section regarding termination for non-payment of premium). 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;
- Submission to HNL by the Group of materially incorrect or incomplete information; and
- Termination or not renewing of the HMO Group Agreement in force between the Group and HNL.

Termination of this Policy for good cause for the reasons described in the first three items above shall become effective upon 60 days' written notice to the Group.

Termination of this Policy for good cause because of termination or nonrenewal of the HMO Group Agreement shall become effective upon the earlier of 60 days' written notice to the Group or the Effective Date of termination of such other Group Policy.

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 "Extension of Benefits" sections 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.

SPECIAL ELIGIBILITY RULES

- The Group will have in force with HNL a Group Policy which provides prepaid health care service plan (hereafter referred to as the "HMO plan") benefits to its Employees.
- The Group agrees to maintain consistency between the Covered Person eligibility provisions of this Policy and those of the HMO plan, as may be required by HNL.

- Covered Persons shall be entitled to enroll under this Policy if they meet the eligibility requirements set forth in the "Eligibility, Enrollment and Termination" section of the Flex Net Benefit *Certificate* (made part of this Policy), but only if they are not enrolled under the HMO plan, and either: (1) they are in a defined class as specifically agreed to by the Group and HNL; or (2) their primary residence is outside of Health Net's HMO Service Area.

- If the principal Covered Person is enrolled under this Policy on the basis that his or her primary place of residence is outside Health Net's HMO Service Area, and he or she subsequently establishes his or her primary place of residence within such service area, the principal Covered Person's coverage under this Policy will terminate at the end of the calendar month in which the change in residence occurred, and coverage under the HMO plan will be effective as of the first day of the succeeding calendar month, providing such Covered Person meets the eligibility rules of the HMO plan, and providing that coverage is not terminated prior to the date shown within this provision.

- The principal Covered Persons enrolled under this Policy who are members of the defined class shall be entitled to transfer their enrollment to and from the HMO plan and this Policy, at the time of the Group Open Enrollment Period agreed to by the Group and HNL, providing that such Covered Persons continue to meet the eligibility requirements of the plan he or she is attempting to transfer into, and providing that coverage is not terminated prior to the Effective Date of the Group Open Enrollment Period.

- All principal Covered Persons included within this section shall, at all times, be subject to all other provisions of this Policy, and the Flex Net Benefit *Certificate* made a part of this Policy, in their entirety.

PREMIUMS

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

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 premiums 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 N1658A

Individual Medicare Retiree:	323.80
Retiree and One Family Member:	647.60
Retiree and Two or More Family Members:	323.80

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 length 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 changes to 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 a 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 Flex Net 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 principal Covered Person while this Policy remains in force and effect, and while said principal 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 principal Covered Persons and 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.

Workers' Compensation Insurance
This Policy 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 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. 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 agree-

ment to use and be bound by HNL's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

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

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

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

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

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

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees. 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 employers 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 employers 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 an employer when such requests are consistent with the employer's obligations under the law; and

- Sharing knowledge regarding COBRA and Cal-COBRA with employers 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:

A. 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.

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 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 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 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.

PLAN BENEFITS AND BENEFIT CERTIFICATE

HNL will issue and deliver to each principal Covered Person a Flex Net Benefit *Certificate*, 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 Flex Net *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 *Certificate* are specifically incorporated herein by reference.

IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Health Net Flex Net Insurance Policy (Medicare N1658A).

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 FLEX NET INSURANCE POLICY

BY AND BETWEEN
HEALTH NET LIFE INSURANCE COMPANY
AND
COUNTY OF RIVERSIDE

This Supplement to the Flex Net 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 Flex Net Insurance Policy with Group ID N1658A Coverage Code: 1USN ("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, Health Net shall, at their sole cost, have the right to use counsel of their choice and shall have the right to adjust, settle, or compromise any such action or claim without the prior consent of the Group's Indemnified Parties; provided, however, that any such adjustment, settlement or compromise in no manner whatsoever limits or circumscribes HNL's obligation to indemnify as set forth herein. HNL's obligation to indemnify, defend and hold harmless Group shall be subject to Group having given HNL written notice within a reasonable period of time of the claim or of the commencement of the related action, as the case may be, and information and reasonable assistance, at HNL's expense, for the defense or settlement thereof.

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

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

19. Conflicts. In the event of any conflict between the terms of the Supplement, Policy, the application of the Group, and the enrollment forms of the Group's eligible 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 Flex Net Insurance Policy.

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 YONG

Title: VICE PRESIDENT, SALES + ACCOUNT MANAGEMENT

Date: 5/16/14

ATTACHMENT G

Health Net Group Hospital and Professional Service Agreement, Group Number: 69381S and Supplement to Group Hospital and Professional Service Agreement

Group Hospital and Professional Service Agreement

Health Net
Seniority Plus

GROUP HOSPITAL AND PROFESSIONAL SERVICE AGREEMENT

ISSUED BY
HEALTH NET

LOS ANGELES, CALIFORNIA

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

Upon payment of premiums 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 the Medicare-eligible employees and the Medicare-eligible family members of employees of:

Group Name:	SP: RIVERSIDE COUNTY
Group ID:	69381S
Coverage Code:	1Y3E
Plan Code:	3JB

(herein called the "Group")

according to the terms and conditions of this Agreement. Payment of premiums 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, the enrollment forms of the Group's eligible employees, and Supplement to the Group Hospital and Professional Service Agreement, inclusively shall constitute the entire agreement between the parties.

HEALTH NET

Franklin Tom
Secretary

Steven Sell
President

HEALTH NET SENIORITY PLUS (EMPLOYER HMO) GROUP AGREEMENT

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

The Members must be entitled to Medicare Part A and enrolled in Part B. CMS will compensate Health Net for each Member who agrees to use Health Net exclusively to obtain Parts A and B covered services. If the Member is not entitled to Part A coverage and was a Seniority Plus member prior to 1/1/99, he or she will be required to pay Health Net a premium to obtain coverage of Part A benefits under this EOC. Otherwise, Part A coverage must be arranged through the Member's nearest Medicare office.

The Member agrees to allow Health Net to provide or arrange to provide all Medicare covered services through a contracting Physician Group or IPA selected by the Member (except for Emergency, out of area urgently needed services (or, in area under unusual and extraordinary circumstances), or out-of-area renal dialysis (kidney)). This Seniority Plus Plan also provides benefits not covered by Medicare and covers Medicare coinsurance and copayments. These benefits are provided in return for the payment of premiums stated in Section 2 of this Agreement.

Section-1

TERM OF AGREEMENT

This Agreement becomes effective on January 1, 2013 at 12:00 a.m. Pacific Time at Los Angeles, California, and will remain in effect for an initial term of twelve consecutive months, subject to the payment of premiums as determined by Health Net. Termination or modification shall be effective on the date fixed in the notice. Modification shall not affect the right to benefits provided under this Agreement in connection with any hospital confinement prior to such date. The Group may terminate this Agreement on 30-days' written notice to Health Net; provided, however, notice to Members must also be given in accordance with CMS requirements and in no event less than 21 days prior written notice of disenrollment to each Member. If this Agreement is terminated by either party, the Members will be converted to a Medicare Advantage Seniority Plus individual plan if the Member does not enroll with another Medicare Advantage plan or submit a request for disenrollment.

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

- Failure of the Group to pay any premiums when due,
- Failure of Group to maintain premium contribution requirements as set forth in the application for the Seniority Plus Group Agreement,
- Failure of the Group to maintain at least 15 eligible employees enrolled with Health Net and/or with Health Net Life to be determined annually, 60-days prior to Group's renewal date, with termination effective at the renewal date,
- Knowing failure by the Group to abide by and enforce the conditions of enrollment of this Agreement, and any Health Net Underwriting Assumptions provided to the Group,
- Termination or not renewing of any other group Agreement in force between the Group and Health Net,
- Fraud or misrepresentation by submission to Health Net by the Group of materially incorrect or incomplete information which is reasonably relied upon by Health Net in issuing or renewing this Agreement, and
- A material change in the nature of Group's business.

Termination of this agreement for good cause (other than for non-payment of premiums, see Section 2, "Premiums" regarding termination for nonpayment of premiums), shall become effective upon 30-days' written notice to the Group.

As with voluntary terminations, if this Group Agreement is terminated for the reasons stated above, all Members shall be given the opportunity to enroll as an individual member in a Medicare Advantage Seniority Plus individual plan.

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

Section-2

PREMIUMS

Health Net offers the Members enrolled under this Agreement coverage for all services covered under Medicare Parts A and B through a Medicare Advantage contract between Health Net and CMS. Under the terms of that contract, Health Net has agreed to be the sole provider (with some noted exceptions) of Medicare covered services to the Member.

The Group shall pay Health Net monthly premiums for benefits not covered by Medicare and for Medicare mandated coinsurance or copayments as provided in this Agreement. Such premiums shall be calculated by Health Net from current records as to number of Members enrolled. Retroactive payment adjustments will be made in subsequent billings for any additions or deletions of Members not currently reflected in Health Net's records at the time of calculation of premiums.

GROUP CHARGES

Monthly Rates for 69381S

Per Member: $267.98

The first premiums must be paid to Health Net on or before the Effective Date of this Agreement. After that, payment is due on the first of each month while the Agreement is in effect. Group will send payment by wire no later than 45 days of the due date. If payment is not made by the above timeframe, Health Net will send the Group a Prospective Notice of Cancellation providing a 30-day grace period to submit the delinquent premiums before the Agreement is terminated. This Prospective Notice of Cancellation will include the following information (a) that Premiums have not been paid and that the Group Service Agreement will be canceled for non-payment if the required premiums are not paid within the 30-day grace period; and (b) the specific date and time when coverage for all Members will end if premiums are not paid. Health Net will continue the Subscriber's coverage under this plan during the grace period, that provided, disenrollment of Members shall comply with CMS requirements and in no event occur with less than 21 days prior written notice of disenrollment to each member.

If Health Net does not receive payment of the delinquent premiums from the Group within the 30-day grace period, Health Net will cancel the Group Service Agreement at the end of the 30-day grace period; provided, disenrollment of Members shall comply with CMS requirements and in no event occur with less than 21 days prior written notice of disenrollment to each member. Health Net will mail the Group a Notice Confirming Termination of Coverage.

Except as described below, Health Net will not change the premiums, applicable copayments, coinsurance or deductibles for the length of this Agreement, after (1) the Group has delivered notice of acceptance of the Agreement, (2) the start of the Group's Open Enrollment Period or (3) premiums 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 premiums, applicable copayments, coinsurance and deductibles under the following circumstances:

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

Any changes to the premiums, pursuant to the above state 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 (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 premiums sufficiently to cover the tax, fee, or risk at renewal of the Agreement, 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 the tax, fee, or required change in coverage or administrative practice is imposed by the governmental authority.

If this Agreement is terminated due to the Group's failure to pay the required premiums, (1) all Members shall be informed of individual Medicare Advantage plan options available to the Member, including Health Net's Seniority Plus individual plans, and shall convert to a HNL individual Medicare Advantage Plan unless the Member chooses another option; and (2) Member disenrollment shall comply with CMS requirements and in no event occur with less than 21 days prior written notice of disenrollment to each Member.

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

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

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

Section-4

COVERAGE FOR DOMESTIC PARTNER

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

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

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

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

B. When Group utilizes the CMS waiver for enrolling Members under a special group enrollment process, Group agrees to notify Members of the Group's intent to enroll them in Health Net's MA-PD and to provide them with all of the information more fully described in the instructions set forth in Section 40.1.6.1 (Group Enrollment Mechanism) of Chapter 2 (Medicare Advantage Enrollment and Disenrollment) of the Medicare Managed Care Manual and as summarized below.

1. Notify all Members that the Group intends to enroll Members in a MA-PD the Group is offering; and
2. Clearly instruct 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 21 calendar days prior to the effective date of the Members enrollment in the Group sponsored MA-PD; and
4. Provide Members a summary of benefits offered under the Group sponsored MA-PD, an explanation of how to get more information about the MA-PD, and an explanation of how to contact Medicare for information on other Part D options that might be available to the Member; and
5. Provide required enrollment disclosure information contained within the CMS model enrollment form; and
6. Provide all the information required for Health Net to submit a complete enrollment request transaction to CMS; and
7. Provide CMS with any information it has on other insurance coverage for the purpose of coordination of benefits.

C. When Group utilizes the CMS waiver for disenrolling Members Group agrees to notify Members of the Group's intent to disenroll Members from the MA-PD and to provide them with all of the information more fully described in the instructions set forth in Section 50.1.6 (Group Disenrollment for Employer/Union Sponsored Plans) of Chapter 2 of the Medicare Managed Care Manual and as summarized below.

1. Notify all Members that the Group intends to disenroll Members from the Medicare Advantage plan that the Group is offering; and
2. Provide notice to Members not less than 21 calendar days prior to the effective date of the Members disenrollment from the Group sponsored Medicare Advantage plan; and

WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Health Net Medicare Advantage Group Hospital and Professional Service Agreement (69381S Seniority Plus).

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: 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 69381S Coverage Code: 1Y3E (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 H

Health Net Group Hospital and Professional Service Agreement, Group Number: 69381T and Supplement to Group Hospital and Professional Service Agreement

Group Hospital and Professional Service Agreement

Health Net
Seniority Plus

GROUP HOSPITAL AND PROFESSIONAL SERVICE AGREEMENT

ISSUED BY
HEALTH NET

LOS ANGELES, CALIFORNIA

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

Upon payment of premiums 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 the Medicare-eligible employees and the Medicare-eligible family members of employees of:

Group Name:	SP: SUTTER RIVERSIDE COUNTY
Group ID:	69381T
Coverage Code:	1Y3H
Plan Code:	5SF

(herein called the "Group")

according to the terms and conditions of this Agreement. Payment of premiums 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, the enrollment forms of the Group's eligible employees, and Supplement to the Group Hospital and Professional Service Agreement, inclusively shall constitute the entire agreement between the parties.

HEALTH NET

Franklin Tom
Secretary

Steven Sell
President

HEALTH NET SENIORITY PLUS (EMPLOYER HMO) GROUP AGREEMENT

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

The Members must be entitled to Medicare Part A and enrolled in Part B. CMS will compensate Health Net for each Member who agrees to use Health Net exclusively to obtain Parts A and B covered services. If the Member is not entitled to Part A coverage and was a Seniority Plus member prior to 1/1/99, he or she will be required to pay Health Net a premium to obtain coverage of Part A benefits under this EOC. Otherwise, Part A coverage must be arranged through the Member's nearest Medicare office.

The Member agrees to allow Health Net to provide or arrange to provide all Medicare covered services through a contracting Physician Group or IPA selected by the Member (except for Emergency, out of area urgently needed services (or, in area under unusual and extraordinary circumstances), or out-of-area renal dialysis (kidney)). This Seniority Plus Plan also provides benefits not covered by Medicare and covers Medicare coinsurance and copayments. These benefits are provided in return for the payment of premiums stated in Section 2 of this Agreement.

Section-1

TERM OF AGREEMENT

This Agreement becomes effective on January 1, 2013 at 12:00 a.m. Pacific Time at Los Angeles, California, and will remain in effect for an initial term of twelve consecutive months, subject to the payment of premiums as determined by Health Net. Termination or modification shall be effective on the date fixed in the notice. Modification shall not affect the right to benefits provided under this Agreement in connection with any hospital confinement prior to such date. The Group may terminate this Agreement on 30-days' written notice to Health Net; provided, however, notice to Members must also be given in accordance with CMS requirements and in no event less than 21 days prior written notice of disenrollment to each Member. If this Agreement is terminated by either party, the Members will be converted to a Medicare Advantage Seniority Plus individual plan if the Member does not enroll with another Medicare Advantage plan or submit a request for disenrollment.

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

- Failure of the Group to pay any premiums when due,
- Failure of Group to maintain premium contribution requirements as set forth in the application for the Seniority Plus Group Agreement,
- Failure of the Group to maintain at least 15 eligible employees enrolled with Health Net and/or with Health Net Life to be determined annually, 60-days prior to Group's renewal date, with termination effective at the renewal date,
- Knowing failure by the Group to abide by and enforce the conditions of enrollment of this Agreement, and any Health Net Underwriting Assumptions provided to the Group,
- Termination or not renewing of any other group Agreement in force between the Group and Health Net,
- Fraud or misrepresentation by submission to Health Net by the Group of materially incorrect or incomplete information which is reasonably relied upon by Health Net in issuing or renewing this Agreement, and
- A material change in the nature of Group's business.

Termination of this agreement for good cause (other than for non-payment of premiums, see Section 2, "Premiums" regarding termination for nonpayment of premiums), shall become effective upon 30-days' written notice to the Group.

As with voluntary terminations, if this Group Agreement is terminated for the reasons stated above, all Members shall be given the opportunity to enroll as an individual member in a Medicare Advantage Seniority Plus individual plan.

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

Section-2

PREMIUMS

Health Net offers the Members enrolled under this Agreement coverage for all services covered under Medicare Parts A and B through a Medicare Advantage contract between Health Net and CMS. Under the terms of that contract, Health Net has agreed to be the sole provider (with some noted exceptions) of Medicare covered services to the Member.

The Group shall pay Health Net monthly premiums for benefits not covered by Medicare and for Medicare mandated coinsurance or copayments as provided in this Agreement. Such premiums shall be calculated by Health Net from current records as to number of Members enrolled. Retroactive payment adjustments will be made in subsequent billings for any additions or deletions of Members not currently reflected in Health Net's records at the time of calculation of premiums.

GROUP CHARGES

Monthly Rates for 69381T

Per Member: $267.98

The first premiums must be paid to Health Net on or before the Effective Date of this Agreement. After that, payment is due on the first of each month while the Agreement is in effect. Group will send payment by wire no later than 45 days of the due date. If payment is not made by the above timeframe, Health Net will send the Group a Prospective Notice of Cancellation providing a 30-day grace period to submit the delinquent premiums before the Agreement is terminated. This Prospective Notice of Cancellation will include the following information (a) that Premiums have not been paid and that the Group Service Agreement will be canceled for non-payment if the required premiums are not paid within the 30-day grace period; and (b) the specific date and time when coverage for all Members will end if premiums are not paid. Health Net will continue the Subscriber's coverage under this plan during the grace period, that provided, disenrollment of Members shall comply with CMS requirements and in no event occur with less than 21 days prior written notice of disenrollment to each member.

If Health Net does not receive payment of the delinquent premiums from the Group within the 30-day grace period, Health Net will cancel the Group Service Agreement at the end of the 30-day grace period; provided, disenrollment of Members shall comply with CMS requirements and in no event occur with less than 21 days prior written notice of disenrollment to each member. Health Net will mail the Group a Notice Confirming Termination of Coverage.

Except as described below, Health Net will not change the premiums, applicable copayments, coinsurance or deductibles for the length of this Agreement, after (1) the Group has delivered notice of acceptance of the Agreement, (2) the start of the Group's Open Enrollment Period or (3) premiums 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 premiums, applicable copayments, coinsurance and deductibles under the following circumstances:

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

Any changes to the premiums, pursuant to the above state 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 (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 premiums sufficiently to cover the tax, fee, or risk at renewal of the Agreement, 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 the tax, fee, or required change in coverage or administrative practice is imposed by the governmental authority.

If this Agreement is terminated due to the Group's failure to pay the required premiums, (1) all Members shall be informed of individual Medicare Advantage plan options available to the Member, including Health Net's Seniority Plus individual plans, and shall convert to a HNL individual Medicare Advantage Plan unless the Member chooses another option; and (2) Member disenrollment shall comply with CMS requirements and in no event occur with less than 21 days prior written notice of disenrollment to each Member.

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

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

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

Section-4

COVERAGE FOR DOMESTIC PARTNER

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

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

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

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

B. When Group utilizes the CMS waiver for enrolling Members under a special group enrollment process, Group agrees to notify Members of the Group's intent to enroll them in Health Net's MA-PD and to provide them with all of the information more fully described in the instructions set forth in Section 40.1.6.1 (Group Enrollment Mechanism) of Chapter 2 (Medicare Advantage Enrollment and Disenrollment) of the Medicare Managed Care Manual and as summarized below.

1. Notify all Members that the Group intends to enroll Members in a MA-PD the Group is offering; and
2. Clearly instruct 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 21 calendar days prior to the effective date of the Members enrollment in the Group sponsored MA-PD; and
4. Provide Members a summary of benefits offered under the Group sponsored MA-PD, an explanation of how to get more information about the MA-PD, and an explanation of how to contact Medicare for information on other Part D options that might be available to the Member; and
5. Provide required enrollment disclosure information contained within the CMS model enrollment form; and
6. Provide all the information required for Health Net to submit a complete enrollment request transaction to CMS; and
7. Provide CMS with any information it has on other insurance coverage for the purpose of coordination of benefits.

C. When Group utilizes the CMS waiver for disenrolling Members Group agrees to notify Members of the Group's intent to disenroll Members from the MA-PD and to provide them with all of the information more fully described in the instructions set forth in Section 50.1.6 (Group Disenrollment for Employer/Union Sponsored Plans) of Chapter 2 of the Medicare Managed Care Manual and as summarized below.

1. Notify all Members that the Group intends to disenroll Members from the Medicare Advantage plan that the Group is offering; and
2. Provide notice to Members not less than 21 calendar days prior to the effective date of the Members disenrollment from the Group sponsored Medicare Advantage plan; and

3. Inform Members how to contact Medicare for information about other Medicare Advantage plan options that might be available to the Member; and
4. Provide all the information required for Health Net to submit a complete disenrollment request transaction to CMS.

BINDING ARBITRATION

Please note that binding arbitration does not apply to disputes that are subject to the Medicare Appeals process as described in detail in the section titled "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)," of the Evidence of Coverage.

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

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

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

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

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

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

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

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

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

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

PLAN BENEFITS AND EVIDENCE OF COVERAGE

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

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

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

WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Health Net Medicare Advantage Group Hospital and Professional Service Agreement (69381T Seniority Plus).

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: 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 69381T Coverage Code: 1Y3H (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:

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 I
Health Net Life Insurance Administrative Service Agreement

ADMINISTRATIVE SERVICE AGREEMENT

This Administrative Service Agreement is made and entered into as of this 1st day of January, 2013 (the "Effective Date"), by and between the County of Riverside, a political subdivision of the State of California (the "County"), and Health Net Life Insurance Company, a California corporation ("Health Net"), and referred to collectively as the "Parties" (the "Agreement").

1.0 **Purpose of Contract**

1.1 The County is an employer that offers an "employer-sponsored group prescription drug plan" within the meaning of 42 C.F.R § 423.454 to its Part D eligible beneficiaries ("Retirees"). County is purchasing from SilverScript Insurance Company ("SilverScript"), an Employer Group Waiver Plan pursuant to Title I of the Medicare Prescription Drug Improvement and Modernization Act of 2003 and its implementing regulations at 42 C.F.R. Part 423 (the "Plan") for its Retirees. Health Net and County desire that Health Net perform certain services for the County with respect to the Plan as described in this Agreement.

2.0 **Services**

2.1 Health Net agrees to perform the services set out in Appendix A attached hereto and made part hereof (the "Services") in accordance with the provisions of this Agreement.

2.2 County agrees to provide Health Net with the premium payments, data and other information and other services set out in this Agreement and Appendix A, each within time frames necessary and appropriate to enable Health Net to perform its Services for County hereunder.

2.3 The Services to be provided by Health Net shall be limited to ministerial functions for the County within a framework of policies, interpretations, rules, practices and procedures reasonably established by the County and communicated to Health Net. Health Net shall not have discretionary authority or control with respect to management of the Plan nor shall Health Net exercise and discretionary authority or control with respect to management or disposition of the assets of the Plan.

3.0 **Records and Documents**

3.1 All books, records, forms, lists of names, plates, seals, passbooks, journal ledgers and all other recorded information and documents held by Health Net for the performance of Services that are the Confidential Information of the County remain the property of the County.

3.2 All County Confidential Information and data stored on computer media and in the custody of Health Net pertaining to the Services is and shall remain the property of the County. In the event of termination of this Agreement, Health Net will assist the County or their designees in identifying, understanding and decoding said information.

3.3 All Confidential Information of Health Net and its systems or programs used by or developed by Health Net shall remain the property of Health Net. All books, records, forms, lists of names, plates, seals, passbooks, journal, ledgers and all other recorded information and documents of Health Net not related to the Services shall remain the property of Health Net.

3.4 Health Net will send to the County or their designees, at County's expense, to a location to be designated by the County, all records and documents which are the property of the County upon termination of the Services of Health Net.

4.0 **Insurance**

4.1 Insurance

Without limiting or diminishing Health Net's obligation to indemnify and hold the County 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.

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

b. Commercial General Liability: Health Net shall maintain Commercial General Liability insurance coverage, including but not limited to, premises liability, contractual liability, personal and advertising injury covering claims which may arise from or out of Health Net performance of its obligations hereunder, in an amount not less than $1,000,000 per occurrence combined single limit. Policy shall be endorsed to the County as an Additional Insured. 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.

c. Vehicle Liability: If Health Net's vehicle or mobile equipment are 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, and Departments, their respective directors, officers, Board of Supervisors, employees, elected or appointed officials, agents or representatives as Additional Insureds. This coverage may be included in the Commercial General Liability policy.

d. Professional Liability: Health Net shall maintain Professional Liability Insurance providing coverage for performance of work included within this Agreement, with a limit of liability of not less than $1,000,000 per occurrence and $1,000,000 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.

e. Commercial Crime Policy: Health Net shall maintain a Commercial Crime Policy including, but not limited to, coverage under; Forms 'A' – Employee Dishonesty, 'B' – Forgery or Alteration, 'F' – Computer Fraud and 'G' – Extortion, covering all Directors, Officers, employees, agents and representatives of the Health Net who may be involved in any way with, including but not limited to, the direction, handling, depositing, payment or other function that involves County funds associated with the performance of this Agreement. Health Net shall maintain a limit of liability of not less than an amount per loss equal to, or greater than, the maximum amount of County money that may be in trust or managed by the Health Net at any one time. The Health Net shall show County that such coverage is currently in force and has been in force from the beginning of this Agreement and will remain in force or at least three (3) years subsequent to the termination of this Agreement. If this coverage is written on a "Claims-Made" basis the Health Net will provide either 1) an Extended Reporting Endorsement (also know as Tail Coverage); or, 2) Prior Dates Coverage from a 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. Such extended coverage shall be maintained for a period of three (3) years or until that time when all monies have been reconciled and the County has agreed in writing that all financial issues have been completed and the Health Net no longer has directional control of any County assets held in the Trust under the Plan.

f. General Insurance Provisions – All lines:

1) Any insurance carrier providing insurance coverage hereunder shall be admitted to 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 County Risk Manager.

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

3) Health Net shall cause its insurance carrier(s) to furnish the County of Riverside with either 1) a properly executed original Certificate(s) of Insurance and original copies of Endorsements effecting coverage as required herein, and 2) if requested to do so orally in writing by the County Risk Manager, shall allow County to review. Further, said Certificate(s) and policies of insurance shall contain the covenant of the insurance carrier(s) to 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. In the event of a material modification, cancellation, expiration, or reduction in coverage, this Agreement shall terminate forthwith, unless the County of Riverside receives prior to such effective date, another properly executed original Certificate of Insurance and original copies of endorsements, including all endorsements and attachments thereto evidencing coverage's set forth herein and the insurance required herein is in full force and effect. Health Net shall not commence operations until the Sponsor has been furnished original Certificate(s) of Insurance in this Section. 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 County's insurance and/or deductibles and/or self-insured retention's or self-insured programs shall not be construed as contributory.

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

4.2 **Indemnification**

a) Health Net shall defend, indemnify and hold harmless County, its subsidiaries and affiliates and each of their respective Board of Supervisors, officers, directors, and employees (the "County Parties") from and against any and all claims, liabilities, demands, damages, losses, costs or expenses of any kind, including, without limitation, reasonable attorneys' fees and expenses ("Losses") incurred by any County Parties arising out of or relating to Health Net's negligence or breach of its Services set forth in this Agreement, except to the extent such Losses are caused by the negligence or willful misconduct of any County Parties, or breach of this Agreement by County.

b). County Indemnification. County shall defend, indemnify and hold harmless Health Net, its subsidiaries and affiliates and each of their respective officers, directors, and employees (the "Health Net Parties") from and against any and all Losses incurred by any Health Net Parties arising out of or relating to County's negligence or breach of their obligations or warranties set forth in this Agreement, except to the extent such Losses are caused by the negligence or willful misconduct of any Health Net Parties or breach of this Agreement by Health Net.

c) Notice of Claim. The party seeking indemnification shall notify the other party in writing within thirty (30) days of the assertion of any claim or the commencement of any action or proceeding for which indemnity may be sought under this Agreement. Failure to notify the other party shall not result in the waiver of indemnity rights with respect to such claim, suit, action or proceeding unless such failure materially prejudices the ability of the indemnifying party to defend such claim, suit, action or proceeding. The parties shall cooperate with each other in the defense and settlement of any such claim, action or proceeding.

4.3 Limitations. Except as otherwise expressly set forth in this Agreement, neither Party makes any additional representations or warranties, including, without limitation, warranties of merchantability or fitness for a particular purpose. In no event shall either party be liable to the other party for any indirect, special or consequential damages or lost profits, arising out of or related to performance of this Agreement or a breach of this Agreement, even if advised of the possibility of such damages or lost profits.

5.0 Contract Duration and Fees

5.1 Unless terminated earlier as provided in Article 6.0, this Agreement shall be for an initial term of one year beginning with the effective date of the Plan, and shall renew upon renewal of the Plan.

5.2 Each party shall bear their own costs and expenses with respect to their respective performance under this Agreement.

6.0 Termination Provision

6.1 Either party may terminate this Agreement at anytime without cause upon sixty (60) days written notice served upon the other party. Notwithstanding the foregoing, this Agreement shall terminate upon termination or expiration of the Plan.

6.2 If, for any reason, this Agreement is terminated prior to full completion of Services, Health Net agrees to furnish to County within thirty (30) days following

termination of this Agreement, all documents related to the Services that remain unperformed as County may reasonably request in writing.

6.3 Either party may terminate this Agreement in the event of a material breach by the other party upon written notice to the other party unless the breach is cured within thirty (30) days of the termination notice.

7.0 Assignment and Delegation

7.1 No contract or agreement shall be made by Health Net with any party for the furnishing of any of the Services described herein, and in Attachment A hereto. This Agreement may not be assigned by, either in whole or in part, by either party without prior written consent of the other party, and with respect to the County, as approved and authorized by the Board of Supervisors of County. This provision shall not require the approval of contracts or agreements for the employment between County and personnel that have been specifically named in this Agreement on behalf of the County. The parties expressly recognize that County personnel, including the Chief Executive Officer of County are without authorization to either change or waive any requirements of this Agreement.

8.0 Alteration and/or Amendment

8.1 No alteration, amendment, or variation of the terms of this Agreement shall be valid unless made in writing and signed by the parties hereto, and no oral understanding or agreement not incorporated herein, shall be binding on any of the parties hereto. Only the Board of Supervisors of County may authorize any alteration or revision of this Agreement on behalf of County. The parties expressly recognize that County personnel, including the Chief Executive Officer of County are without authorization to either change or waive any requirements of this Agreement.

9.0 Nondiscrimination

9.1 This Agreement is subject to the affirmative action and nondiscrimination requirements of Executive Order 11246 as amended, Section 503 of the Rehabilitation Act of 1973, and Section 402 of the Vietnam Era Veterans' Readjustment Assistance Act of 1974, and with all rules, regulations, pertaining thereto, which are incorporated herein by specific reference.

10.0 Conflict of Interest

10.1 Health Net shall have no interest, and shall not acquire any interest, direct or indirect, which will conflict in any manner or degree with the performance of Services required under this Agreement.

11.0 Confidentiality

11.1 Neither Health Net, County, nor any of a Party's respective officers, employees, advisors, agents or representatives shall disclose or make use of any Confidential Information except as permitted under this Agreement without the prior written consent of the non-disclosing party, which consent may, inter alia, be conditioned upon the execution of a confidentiality agreement prior to any disclosure to a third party. Each Party will disclose Confidential Information of the other Party only to its officers, employees, advisors, agents or representatives, (collectively "Authorized Representatives") who have a need to know the Confidential Information in order to accomplish the purpose of this Agreement and who (A) have been informed of the confidential and proprietary nature of the Confidential Information, and (B) have agreed not to disclose it to others and to treat it in accordance with the requirements of this Section. Each Party shall advise its Authorized Representatives of the confidentiality provisions set forth in this Agreement.

11.2. The foregoing shall not apply to such Confidential Information to the extent: (A) the information is or becomes generally available or known to the public through no fault of the receiving party; (B) the information was already known by or available to the receiving party prior to the disclosure by the other party on a non-confidential basis; (C) the information is subsequently disclosed to the receiving party by a third party who is not under any obligation of confidentiality to the party who disclosed the information; (D) the information has already been or is hereafter independently acquired or developed by the receiving party without violating any confidentiality agreement or other similar obligation; (E) the information is required to be disclosed pursuant to a court order; or (F) the information is required to be disclosed by County in accordance with the California Public Records Act (Government Code section 6250 et seq.) and/or Brown Act (Government Code section 54950 et seq.) and is not subject to an applicable exemption under such Acts as determined by County. If either Party is required to disclose the Confidential Information of the other party as part of a judicial process, government investigation, legal proceeding, or other similar process, such Party, if it is reasonably possible to do so, shall give such prior written notice to the other Party to allow the other Party to seek an appropriate protective order or modification of any disclosure.

11.3. Any unauthorized disclosure or use of Confidential Information with any consulting agents, advisors, brokers, or any other third party, other than Authorized Representatives as permitted under Section 11.1 above, would cause Health Net or County immediate and irreparable injury or loss that may not be adequately compensated with money damages. Accordingly, if either Party fails to comply with this Section 11, the other Party will be entitled to seek specific performance including immediate issuance of a temporary restraining order or preliminary injunction enforcing this Agreement, to judgment for losses caused by the breach, and to any other remedies provided by law.

11.4 For purposes of this Agreement, the term "Confidential Information" includes, but is not limited to, any information of either County or Health Net (whether oral, written, visual or fixed in any tangible medium of expression) relating to either party's services, operations, systems, programs, inventions, techniques, suppliers, customers and prospective customers, contractors, costs and pricing data, trade secrets, know-how, processes, plans, designs and other information of or relating to either party's business. "Confidential Information" does not include: Protected Health Information, the use and disclosure of which is governed by the Business Associate Agreement attached hereto as Exhibit B.

12.0 **Notices**

12.1 All correspondence and notices required or contemplated by this Agreement shall be delivered to the respective parties at the addresses set forth below and are deemed submitted one (1) day after deposit to the United States Postal Services or a private courier if delivered by U.S. Postal Services express mail or overnight courier that guarantees next day delivery, or five (5) business days after their deposit in the United States mail, postage prepaid:

To the County of Riverside:
County of Riverside
Human Resources
4080 Lemon St., 1st Floor
Riverside, CA 92501
Attn: Stacey Beale, HR Division Manager

To Health Net:

Health Net, Inc.

21650 Oxnard Street

Woodland Hills, CA 91367

Attn:General Counsel

Cc: Health Net, Inc.

650 East Hospitality Lane, Suite 200

San Bernardino, CA 92408

Attn: Cathleen Bryant, Senior Account Manager

Any notice, demand or other communication given in a manner prescribed in this Section 12 shall be deemed to have been delivered on receipt.

13.0 **Licenses**

13.1 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.

14.0 **Work Product**

14.1 All reports, findings, data or documents developed by Health Net as part of the Services performed for County under this Agreement becomes the property of County, and shall be transmitted to County at the termination of this Agreement, if so requested by County in writing. Notwithstanding anything to the contrary contained in this Agreement, Health Net shall retain ownership of all of its Confidential Information and any intellectual property contained in any reports, findings, data or documents developed by Health Net under this Agreement.

15.0 **Severability**

15.1 In the event any provision in this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions will nevertheless continue in full force without being impaired or invalidated in any way.

16.0 **Waiver**

16.1 Any waiver by either party of any breach of any one or more of the terms of this Agreement shall not be construed to be a waiver of any subsequent or other breach of the same term or of any other term herein.

17.0 **Governing Law**

17.1 The applicable provisions of the Government Claims Act (Government Code Section 900, et seq.) must be followed first for any disputes under this Agreement.

17.2 This Agreement shall be governed by and interpreted in accordance with the laws of the State of California, without regard to applicable conflict of law rules.

17.3 All actions and proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the state or 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.

18.0 **Compliance with HIPAA and HITECH**

18.1 The Parties to this Agreement are subject to all relevant requirements contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191, enacted August 21, 1996, the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009 ("HITECH"), Public Law 111-5, enacted February 17, 2009, and the laws and regulations promulgated subsequent thereto. The Parties shall adhere to all terms and conditions as outlined and specified in Attachment B – Business Associate Agreement (BAA), attached hereto and by this reference incorporated herein. The Parties agree to cooperate in accordance with the terms and intent of this Agreement and the BAA for implementation of relevant laws and/or regulations promulgated under HIPAA and HITECH, as may be amended from time to time.

19.0 **Miscellaneous**

19.1 This Agreement, including attachments and the appendix, which are hereby incorporated in this Agreement, supersedes any and all other agreements, promises, negotiations or representations, either oral or written, between the parties with respect to the subject matter and period governed by this Agreement and no other agreement, statement or promise relating to this Agreement shall be binding or valid.

19.2 Health Net certifies that the individual signing below has authority to execute this Agreement on behalf of Health Net, and may legally bind Health Net to the terms and conditions of this Agreement, and any attachments hereto.

[SIGNATURES ON FOLLOWING PAGE]

IN WITNESS WHEROF, the parties hereto have caused their duly appointed representatives to execute this 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

Health Net Life Insurance Company

By: _____

Printed Name: STEVEN J. SELL

Title: PRESIDENT

Date: 5-7-14

APPENDIX "A" TO ADMINISTRATIVE SERVICES AGREEMENT

Appendix "A"

Health Net's Roles and Responsibilities

Enrollment

a) Health Net will provide to SilverScript on behalf of County, in a written or electronic format acceptable to SilverScript, all information required by SilverScript to group enroll each County retiree in the Plan and to collect premiums from County and remit to SilverScript (the "Enrollment Information"). The Enrollment Information shall include, at a minimum, County's tax identification number and each County Retiree's name, mailing address, Health Information Claim Number or HICN, date of birth, effective date of coverage, signature/application date, and any other information or elements as requested by SilverScript as required to enable SilverScript to submit a complete enrollment request to CMS for County retirees. County will provide Health Net with the Enrollment Information to submit to SilverScript.

b) Upon receipt from SilverScript a County retiree list containing enrollment effective dates and a record of which County retirees CMS has notified SilverScript are eligible for low income subsidy ("LIS"), Health Net will do the following:

1. If SilverScript requests missing Enrollment Information, Health Net will request from County and County shall provide to Health Net the missing Enrollment Information;
2. Health Net will continue to provide all missing Enrollment Information to SilverScript until it is deemed sufficient by SilverScript.
3. County agrees to identify and provide missing enrollment information to Health Net and acknowledges that SilverScript will not submit an enrollment request to CMS and cannot ensure a particular effective date unless and until all Enrollment Information has been provided to, and deemed sufficient, by SilverScript.

c) Health Net will provide SilverScript, on a monthly basis, distinct and separate enrollment files for (i) additions, (ii) changes, and (iii) deletions to Enrollment Information as provided to Health Net by County.

d) Health Net will follow all applicable CMS Requirements regarding group enrollment and disenrollment processes in Chapter 3 of CMS' Prescription Drug Benefit Manual ("Part D Manual") and the CMS Enrollment Guidance including the requirements in Section 4.0 and as applicable in Section 50.6.1 of the Part D Manual. Health Net will comply with the notice and other requirements of Section 50.6 of the Part D Manual and agrees to provide notice from County to SilverScript within ten (10) business days, of the ineligibility of any County retiree to participate in the Plan and all information necessary for SilverScript to submit a complete disenrollment request to CMS. County shall provide Health Net with the information required to perform the Services in this Section (d).

e) As received from the County, Health Net will forward to SilverScript disenrollment requests, each Monday and Thursday for those County retirees deemed by the County to be eligible to request disenrollment and shall include with such request, the County's determination of the Client Retiree's eligibility to disenroll from the Plan so that SilverScript has the information necessary to determine whether the County retiree qualifies for a Special Enrollment Period Employer Group Plan ("SEP EGHP") under Section 30.3.8 of the CMS Enrollment Guidance.

f) **Premium Invoices**

- Health Net, on behalf of SilverScript, will invoice the County each month for the Plan Premiums due for County retirees enrolled in the Plan for the coming month and County agrees to pay such amounts to Health Net by the 45th day of the month following the month the invoice was received. Health Net will remit the same to SilverScript as received from the County.

Exhibit B

HIPAA Business Associate Agreement
Addendum to Contract
Between the County of Riverside and Health Net of California, Inc.

This HIPAA Business Associate Agreement (the "Addendum") supplements, and is made part of the **Administrative Service Agreement** (the "Underlying Agreement") between the County of Riverside ("County") and **Health Net Life Insurance Company** ("Contractor") and shall be effective as of the date the Underlying Agreement is approved by both Parties (the "Effective Date").

RECITALS

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

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

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

WHEREAS, to the extent County discloses PHI and/or ePHI to Contractor or Contractor creates, receives, maintains, transmits, or has access to PHI and/or ePHI of County, Contractor is a business associate, as defined in the Privacy Rule; and,

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

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

WHEREAS, the parties intend to enter into this Addendum to address the requirements and obligations set forth in the Privacy Rule, Security Rule, HITECH and HIPAA as they apply

to Contractor as a business associate of County, including the establishment of permitted and required uses and disclosures of PHI and/or ePHI created or received by Contractor during the course of performing functions, services and activities on behalf of County, and appropriate limitations and conditions on such uses and disclosures;

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

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

   A. "Breach" when used in connection with PHI means the acquisition, access, use or disclosure of PHI in a manner not permitted under subpart E of the Privacy Rule which compromises the security or privacy of the PHI, and shall have the meaning given such term in 45 CFR §164.402.

      (1) Except as provided below in Paragraph (2) of this definition, acquisition, access, use, or disclosure of PHI in a manner not permitted by subpart E of the Privacy Rule is presumed to be a breach unless Contractor demonstrates that there is a low probability that the PHI has been compromised based on a risk assessment of at least the following four factors:

         (a) The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;

         (b) The unauthorized person who used the PHI or to whom the disclosure was made;

         (c) Whether the PHI was actually acquired or viewed; and

         (d) The extent to which the risk to the PHI has been mitigated.

      (2) Breach excludes:

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

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

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

B. "Business associate" has the meaning given such term in 45 CFR §164.501, including but not limited to a subcontractor that creates, receives, maintains, transmits or accesses PHI on behalf of the business associate.

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

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

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

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

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

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

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

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

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

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

M. "Secretary" means the Secretary of the U.S. Department of Health and Human Services ("HHS").

N. "Security incident" as defined in 45 CFR §164.304 means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

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

P. "Subcontractor" as defined in 45 CFR §160.103 means a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate.

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

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

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

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

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

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

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

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

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

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

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

(4) De-identify all PHI and/or ePHI of County received by Contractor under this Addendum provided that the de-identification conforms to the requirements of the

Privacy Rule and/or Security Rule and does not preclude timely payment and/or claims processing and receipt.

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

3. **Prohibited Uses and Disclosures.**

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

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

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

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

(1) Not to use or disclose PHI for fundraising , unless pursuant to the Underlying Agreement and only if permitted by and in compliance with the requirements of 45 CFR §164.514(f) or 45 CFR §164.508;

(2) Not to use or disclose PHI for marketing, as defined in 45 CFR §164.501, unless pursuant to the Underlying Agreement and only if permitted by and in compliance with the requirements of 45 CFR §164.508(a)(3);

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

(4) Not to receive, directly or indirectly, remuneration in exchange for PHI, or engage in any act that would constitute a sale of PHI, as defined in 45 CFR §164.502(a)(5)(ii), unless permitted by the Underlying Agreement and in compliance with the requirements of a valid authorization under 45 CFR §164.508(a)(4). This prohibition shall not apply to payment by County to Contractor for services provided pursuant to the Underlying Agreement.

4. **Obligations of County.**

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

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

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

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

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

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

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

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

   C. Use appropriate safeguards and comply, where applicable, with the Security Rule with respect to ePHI, to prevent use or disclosure of PHI and/or ePHI other than as provided for by this Addendum.

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

   E. Report to County any use or disclosure of PHI and/or ePHI not provided for by this Addendum or otherwise in violation of HITECH, HIPAA, the Privacy Rule, and/or Security Rule of which Contractor becomes aware, including breaches of unsecured PHI as required by 45 CFR §164.410.