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

ITEM: 3.13
(ID # 15629)
MEETING DATE:
Tuesday, July 27, 2021

FROM: HUMAN RESOURCES:

SUBJECT: HUMAN RESOURCES: Ratify and approve the UnitedHealthcare Insurance Company (UHC) Group Policies (PPO), Certificates of Coverage, and Schedules of Benefits with UHC of California for the 2016 – 2019 Calendar Years, All Districts. [Total Cost $0, 100% Employee and Early Retiree Health Insurance Premiums]

RECOMMENDED MOTION: That the Board of Supervisors:

1. Ratify and approve the UnitedHealthcare Insurance Company (UHC) Group Policy (PPO) for County of Riverside (Attachment A), and the UHC Certificate of Coverage including Schedule of Benefits (Attachment B), both with UHC of California, effective January 1, 2016 – December 31, 2016;
2. Ratify and approve the UHC Group Policy (PPO) for County of Riverside (Attachment C), and the UHC Certificate of Coverage including Schedule of Benefits (Attachment D), both with UHC of California, effective January 1, 2017 – December 31, 2017;
3. Ratify and approve the UHC Group Policy (PPO) for County of Riverside (Attachment E), and the UHC Certificate of Coverage including Schedule of Benefits (Attachment F), both with UFC of California, effective January 1, 2018 – December 31, 2018;
4. Ratify and approve the UHC Group Policy (PPO) for County of Riverside (Attachment G), and the UHC Certificate of Coverage including Schedule of Benefits (Attachment H), both with UFC of California, effective January 1, 2019 – December 31, 2019;
5. Authorize the Chair to sign three (3) copies of each Group Policy and Certificate of Coverage; and
6. Retain one (1) copy of each Group Policy and Certificate of Coverage and return two (2) copies of each policy and certificate to Human Resources for distribution.

ACTION: Policy

Brenda Diederichs, Assistant CEO / Human Resources Director 7/7/2021

MINUTES OF THE BOARD OF SUPERVISORS

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

Ayes:	Jeffries, Spiegel, Washington, Perez, and Hewitt
Nays:	None
Absent:	None
Date:	July 27, 2021
xc:	HR

Kecia R. Harper
Clerk of the Board
By: Deputy

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost
COST	$0	$0	$0	$0
NET COUNTY COST	$0	$0	$0	$0

SOURCE OF FUNDS: Retiree Health Insurance Premiums and Departmental Budgets	**Budget Adjustment:** No
	For Fiscal Year: FY 15/16 – FY 19/20

C.E.O. RECOMMENDATION: Approve

BACKGROUND:

Summary

Effective January 1, 2015, the County began offering the UnitedHealthcare (UHC) medical plan to active employees, early retirees, and Medicare eligible retirees. On December 15, 2015, Item 3.24, the Board of Supervisors approved the 2015 Group Policy (PPO) for employees, retirees, and their eligible dependents. Since that time, the Board has also approved UHC plan rates for Calendar Years 2016-2019.

As part of the contract negotiation process, the terms and conditions of the 2016 – 2019 agreements were recently completed. The attached Group Policy (PPO) (Attachments A, C, E and G) confirms the 2016 - 2019, health plan rates and benefit provisions for active employees, early retirees, and Medicare eligible retirees. The prior 2015 group policy was approved by the Board on December 15, 2015, Item 3.24.

Prev. Agn. Ref: 12/15/2015, Item 3.24 District: ALL

Impact on Residents and Businesses

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

SUPPLEMENTAL

Additional Fiscal Information

There is no direct cost to the County for the recommended action. Active employees and early retirees pay health insurance premiums. Medicare eligible retirees pay the full cost of medical premiums for this plan, after receiving a County contribution toward retiree premiums.

Contract History and Price Reasonableness

UHC provides health benefits and services to more than 85 million individuals worldwide.

ATTACHMENTS:

ATTACHMENT A. UnitedHealthcare Insurance Company Group Policy for County of Riverside, Policy Effective Date: January 1, 2016

ATTACHMENT B. UnitedHealthcare Insurance Company Certificate of Coverage, Effective Date: January 1, 2016

ATTACHMENT C. UnitedHealthcare Insurance Company Group Policy for County of Riverside, Policy Effective Date: January 1, 2017

ATTACHMENT D. UnitedHealthcare Insurance Company Certificate of Coverage, Effective Date: January 1, 2017

ATTACHMENT E. UnitedHealthcare Insurance Company Group Policy for County of Riverside, Policy Effective Date: January 1, 2018

ATTACHMENT F. UnitedHealthcare Insurance Company Certificate of Coverage, Effective Date: January 1, 2018

ATTACHMENT G. UnitedHealthcare Insurance Company Group Policy for County of Riverside, Policy Effective Date: January 1, 2019

ATTACHMENT H. UnitedHealthcare Insurance Company Certificate of Coverage, Effective Date: January 1, 2019

Meghan Hahn, Administrative Analyst 7/19/2021

Gregory P. Priamos, Director County Counsel 7/15/2021

UnitedHealthcare Insurance Company

Group Policy

For

County of Riverside

Enrolling Group Number: 902805

Policy Effective Date: January 1, 2016

JUL 27 2021 B13

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

860-702-5000

Regulated by:

California Department of Insurance

Consumer Communication Bureau

300 South Spring Street, South Tower

Los Angeles, CA 90013

1-800-927-HELP (4357)

TDD: 800-482-4833

Group Policy

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

860-702-5000

This Policy is entered into by and between UnitedHealthcare Insurance Company and the "Enrolling Group," as described in Exhibit 1.

When used in this document, the words "we," "us," and "our" are referring to UnitedHealthcare Insurance Company.

Upon our receipt of the Enrolling Group's signed application and payment of the first Policy Charge, this Policy is deemed executed.

We agree to provide Benefits for Covered Health Services set forth in this Policy, including the attached *Certificate(s) of Coverage* and *Schedule(s) of Benefits*, subject to the terms, conditions, exclusions, and limitations of this Policy. The Enrolling Group's application is made a part of this Policy.

This Policy replaces and overrules any previous agreements relating to Benefits for Covered Health Services between the Enrolling Group and us. The terms and conditions of this Policy will in turn be overruled by those of any subsequent agreements relating to Benefits for Covered Health Services between the Enrolling Group and us.

We will not be deemed or construed as an employer or plan administrator for any purpose with respect to the administration or provision of benefits under the Enrolling Group's benefit plan. We are not responsible for fulfilling any duties or obligations of an employer or plan administrator with respect to the Enrolling Group's benefit plan.

This Policy will become effective on the date specified in Exhibit 1 and will be continued in force by the timely payment of the required Policy Charges when due, subject to termination of this Policy as provided in Article 5.

When this Policy is terminated, as described in Article 5, this Policy and all Benefits under this Policy will end at 12:00 midnight on the date of termination.

This Policy is issued as described in Exhibit 1.

Issued By:

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President

Article 1: Glossary of Defined Terms

The terms used in this Policy have the same meanings given to those terms in *Section 9: Defined Terms* of the attached *Certificate(s) of Coverage*.

Coverage Classification - one of the categories of coverage described in Exhibit 2 for rating purposes (for example: Subscriber only, Subscriber and spouse, Subscriber and children, Subscriber and family).

Material Misrepresentation - any oral or written communication or conduct, or combination of communication and conduct, that is untrue and is intended to create a misleading impression in the mind of another person. A misrepresentation is material if a reasonable person would attach importance to it in making a decision or determining a course of action, including but not limited to, the issuance of a policy or coverage under a policy, calculation of rates, or payment of a claim.

Service Area - the State of California or any other geographical area within the state designated in the Policy within which Network provider services are rendered to Covered Persons for Covered Health Services.

Article 2: Benefits

Subscribers and their Enrolled Dependents are entitled to Benefits for Covered Health Services subject to the terms, conditions, limitations and exclusions set forth in the *Certificate(s) of Coverage* and *Schedule(s) of Benefits* attached to this Policy. Each *Certificate of Coverage* and *Schedule of Benefits*, including any Riders and Amendments, describes the Covered Health Services, required Copayments, and the terms, conditions, limitations and exclusions related to coverage.

We pay Benefits for Emergency Health Services that are required to stabilize or initiate treatment in an Emergency as described in the *Certificate of Coverage* and *Schedule of Benefits* to Covered Persons who receive such services outside of the Service Area.

Covered Health Services may be modified by us if required by any change in applicable law or regulation and upon sixty (60) days written notice to Enrolling Group or as soon as reasonably practicable. Such modification shall take effect as required by legal mandate. Our written notice to Enrolling Group shall include the following information: (1) modification to the Covered Health Services, (2) the date the modification shall take effect as required by legal mandate, and (3) the citation to the legal mandate.

Article 3: Premium Rates and Policy Charge

3.1 Premiums

Monthly Premiums payable by or on behalf of Covered Persons are specified in the *Schedule of Premium Rates* in Exhibit 2 of this Policy or in any attached *Notice of Change*.

We reserve the right to change the *Schedule of Premium Rates* as described in Exhibit 1 of this Policy subject to the approval of the Enrolling Group.

3.2 Computation of Policy Charge

The Policy Charge will be calculated based on the number of Subscribers in each Coverage Classification that we show in our records at the time of calculation. The Policy Charge will be calculated using the Premium rates in effect at that time. Exhibit 1 describes the way in which the Policy Charge is calculated.

3.3 Adjustments to the Policy Charge

We may make retroactive adjustments for any additions or terminations of Subscribers or changes in Coverage Classification that are not reflected in our records at the time we calculate the Policy Charge. We will not grant retroactive credit for any change occurring more than 90 days prior to the date we received notification of the change from the Enrolling Group. We also will not grant retroactive credit for any calendar month in which a Subscriber has received Benefits.

The Enrolling Group must notify us in writing or by electronic submission within 90 days of the effective date of enrollments, terminations, or other changes. The Enrolling Group must notify us in writing each month of any change in the Coverage Classification for any Subscriber.

We may modify the Premium at renewal of this Policy provided that Enrolling Group receives 180 days prior written notice and approves of such modification. Premium modification shall take effect at renewal of this Policy.

Notwithstanding the above, if premium taxes, guarantee or uninsured fund assessments, or other governmental charges relating to or calculated in regard to Premium are either imposed or increased, those charges may be added to the Premium provided that Enrolling Group receives at least 90 days prior written notice and approves the increase in Premium. If Enrolling Group declines the increase in Premium, either party may terminate the Policy after at least 60 days prior written notice to the other party.

3.4 Payment of the Policy Charge

The Policy Charge is due in full on a monthly basis by check or electronic transfer and must be paid directly by Enrolling Group to us on or before the last day of the second month after the month for which the Policy Charge applies. For example, the Policy Charge for January is due on or before the last day of March.

All payments shall be made in United States dollars, in immediately available funds, and shall be remitted to us at the address set forth in the Enrolling Group's application, or at such other address as we may from time to time designate in writing. The Enrolling Group agrees not to send us payments marked "paid in full", "without recourse", or similar language. In the event that the Enrolling Group sends such a payment, we may accept it without losing any of our rights under this Policy and the Enrolling Group will remain obligated to pay any and all amounts owed to us.

A late payment charge will be assessed for any Policy Charge not received within the 31 day grace period following the due date. Such late payment charge is five percent (5%) of the monthly Policy Charge prorated on a thirty (30)-day month for each day the payment is delinquent after the end of the grace period. A service charge will be assessed for any non-sufficient-fund check received in payment of the Policy Charge. All Policy Charge payments must be accompanied by supporting documentation that states the names of the Covered Persons for whom payment is being made.

3.5 Grace Period

A grace period of 31 days will be granted for the payment of any Policy Charge not paid when due. During the grace period, this Policy will continue in force. The grace period will not extend beyond the date this Policy terminates.

The Enrolling Group is liable for payment of the Policy Charge during the grace period. If we receive written notice from the Enrolling Group to terminate this Policy during the grace period, we will adjust the

Policy Charge so that it applies only to the number of days this Policy was in force during the grace period.

This Policy terminates as described in Article 5.1 if the grace period expires and the past due Policy Charge remains unpaid.

Article 4: Eligibility and Enrollment

4.1 Eligibility Conditions or Rules

Eligibility conditions or rules for each class are stated in the corresponding Exhibit 2. The eligibility conditions stated in Exhibit 2 are in addition to those specified in *Section 3: When Coverage Begins* of the *Certificate of Coverage*.

4.2 Initial Enrollment Period

Eligible Persons and their Dependents may enroll for coverage under this Policy during the Initial Enrollment Period. The Initial Enrollment Period is determined by the Enrolling Group.

4.3 Open Enrollment Period

An Open Enrollment Period will be provided periodically for each class, as specified in the corresponding Exhibit 2. During an Open Enrollment Period, Eligible Persons and their Eligible Dependents may enroll for coverage under this Policy.

4.4 Effective Date of Coverage

The effective date of coverage for properly enrolled Eligible Persons and their Eligible Dependents is stated in Exhibit 2

4.5 Waiver Form

The Enrolling Group agrees to provide each individual who declines coverage with a form to be signed at the time they are initially eligible to enroll for coverage. The form states that an individual who declines coverage during the Initial Enrollment Period acknowledges that we may, at the time of the individual's later decision to elect coverage, consider the individual a late enrollee.

The Enrolling Group agrees to retain a copy of the individual's signed acknowledgment and forward a copy of the acknowledgment to us when requested.

Article 5: Policy Termination

5.1 Conditions for Termination of the Entire Policy

This Policy and all Benefits for Covered Health Services under this Policy will automatically terminate on the earliest of the dates specified below:

A. On the last day of the grace period if the Policy Charge remains unpaid. The Enrolling Group remains liable for payment of the Policy Charge for the period of time this Policy remained in force during the grace period.

B. On the date specified by the Enrolling Group, after at least 31 days prior written notice to us that this Policy is to be terminated.

C. On the date we specify, after at least 90 days prior written notice to the Enrolling Group, that this Policy is to be terminated due to the Enrolling Group's violation of the participation or contribution rules as shown in Exhibit 1.

D. On the date we specify, after at least 60 days prior written notice to the Enrolling Group, that this Policy is to be terminated because the Enrolling Group performed an act or practice that constituted fraud or made an intentional misrepresentation of a fact that was material to the execution of this Policy or to the provision of coverage under this Policy. In this case, we have the right to rescind this Policy back to either:

- The effective date of this Policy.
- The date of the act or practice, if later.

We will send a notice to the Enrolling Group via certified mail at least 60 days prior to the effective date of the rescission explaining the reason for the rescission and notifying Enrolling Group of its right to appeal as described in Article 5.3. We will not rescind this Policy due to fraud or an intentional misrepresentation of a material fact after twenty-four (24) months from the date of issuance of this Policy.

E. On the date we specify, after at least 90 days prior written notice to the Enrolling Group,that this Policy is to be terminated because we will no longer issue this particular type of group health benefit plan within the applicable market.

F. On the date we specify, after at least 180 days prior written notice to the applicable state authority and to the Enrolling Group, that this Policy is to be terminated because we will no longer issue any employer health benefit plan within the applicable market.

5.2 Payment and Reimbursement Upon Termination

Upon any termination of this Policy, the Enrolling Group is and will remain liable to us for the payment of any and all Premiums which are unpaid at the time of termination, including a pro rata portion of the Policy Charge for any period this Policy was in force during the grace period preceding the termination.

Except in the case of fraud or intentional misrepresentation of a material fact, we will refund the pro rata portion of any and all Policy Charges which have been prepaid by the Enrolling Group to reflect any reduced period of coverage at the time of termination of this Policy. The refund will be reduced by any amount paid for any claims incurred during the period this Policy was in force preceding the termination. Mid-month proration based on the eligibility rules established by the Enrolling Group will be used to refund Policy Charges. Exhibit 1 describes the way in which the Policy Charge is calculated.

5.3 Review by the California Department of Insurance for Improper Cancellation, Rescission or Non-Renewal of Coverage

Enrolling Group may request a review by the California Insurance Commissioner if Enrolling Group believes this Policy or coverage has been or will be wrongly canceled, rescinded or not renewed. Contact the California Insurance Commissioner's Consumer Communications Bureau at 1-800-927-HELP (4357) or TDD 1-800-482-4833 to receive assistance with this process, or submit an inquiry in writing to:

California Department of Insurance

Consumer Communications Bureau

300 S. Spring Street, South Tower

Los Angeles, CA 90013

Or through the website **http://www.insurance.ca.gov**.

Article 6: General Provisions

6.1 Entire Policy

This Policy, including the *Certificate(s) of Coverage*, the *Schedule(s) of Benefits*, the application of the Enrolling Group, and any Amendments, Notices of Change, and Riders, constitute the entire Policy between the parties, and any statement made by the Enrolling Group shall, in absence of fraud, be deemed a representation and not a warranty. No statement made by any Subscriber whose eligibility has been accepted by us shall avoid the insurance or reduce the Benefits under this Policy or be used in defense to a claim hereunder.

6.2 Dispute Resolution and Binding Arbitration Requirement

This Policy requires that disputes be resolved in binding arbitration. The parties are waiving their right to sue in court to resolve a dispute and their right to a jury trial.

No legal proceeding or action may be brought until the parties have attempted, in good faith, to resolve the dispute amongst themselves. In the event the dispute is not resolved within 30 days after one party has received written notice of the dispute from the other party, and either party wishes to pursue the dispute further, , the dispute may be submitted to arbitration as set forth below.

The parties acknowledge that because this Policy affects interstate commerce, the *Federal Arbitration Act* applies. If the Enrolling Group wishes to seek further review of the decision or the complaint or dispute, it must submit the decision, complaint or dispute to binding arbitration pursuant to the rules of the *American Arbitration Association*. This is the only right the Enrolling Group has for further consideration of any dispute that arises out of or is related to this Policy.

Arbitration will take place in Riverside County, California.

The matter must be submitted to binding arbitration within one year of the date notice of the dispute was received. The arbitrators will have no power to award any punitive or exemplary damages or to vary or ignore the provisions of this Policy, and will be bound by federal and/or state law.

6.3 Time Limit on Certain Defenses

After two years from the date of issue of this Policy no misstatements made by the Subscriber in the application for this Policy shall be used to void this Policy or to deny a claim for loss incurred or disability (as defined in this Policy) commencing after the expiration of such two-year period.

No claims for loss incurred or disability (as defined in this Policy) commencing after two years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

6.4 Amendments and Alterations

Amendments to this Policy are effective 31 days after we send written notice to the Enrolling Group. Riders are effective on the date we specify. Except for changes to Exhibit 2, no change will be made to this Policy unless made by an Amendment or a Rider which is signed by one of our authorized executive officers and approved by Enrolling Group, except as provided in Article 2 of this Policy. Changes to Exhibit 2 may be stated in a Notice of Change to Exhibit 2 if approved by both parties. No agent has authority to change this Policy or to waive any of its provisions.

6.5 Relationship between Parties

The relationships between us and Network providers, and relationships between us and Enrolling Groups, are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees, nor are we or any of our employees an agent or employee of Network providers or Enrolling Groups.

The relationship between a Network provider and any Covered Person is that of provider and patient. The Network provider is solely responsible for the services provided by it to any Covered Person. The relationship between any Enrolling Group and any Covered Person is that of employer and employee, Dependent, or any other category of Covered Person described in the Coverage Classifications specified in this Policy.

The Enrolling Group is solely responsible for enrollment and Coverage Classification changes (including termination of a Covered Person's coverage) and for the timely payment of the Policy Charges.

6.6 Records

The Enrolling Group must furnish us with all information and proofs which we may reasonably require with regard to any matters pertaining to this Policy. We may at any reasonable time inspect:

- All documents furnished to the Enrolling Group by an individual in connection with coverage.
- The Enrolling Group's payroll.
- Any other records pertinent to the coverage under this Policy.

During and after the term of this Policy, we and our related entities may use and transfer de-identified information gathered under this Policy for research and analytic purposes.

6.7 Administrative Services

The services necessary to administer this Policy and the Benefits provided under it will be provided in accordance with our standard administrative procedures or those standard administrative procedures of our designee. If the Enrolling Group requests that administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, the Enrolling Group must pay for such services or reports at the then current charges for such services or reports.

We may offer to provide administrative services to the Enrolling Group for certain wellness programs including, but not limited to, fitness programs, biometric screening programs and wellness coaching programs.

6.8 Governing Law/Venue

This Policy shall be governed by and interpreted in accordance with the laws of the State of California, without regard to applicable conflict of law rules. All actions and proceedings arising from this Policy 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. The applicable provisions of the Government Claims Act (California Government Code Section 900, et seq.) must be followed first for any disputes under this Policy.

6.8 Clerical Error

Clerical error will not deprive any individual of Benefits under this Policy or create a right to Benefits. Failure to report enrollments will not be considered a clerical error and will not result in retroactive

coverage for Eligible Persons. Failure to report the termination of coverage will not continue the coverage for a Covered Person beyond the date it is scheduled to terminate according to the terms of this Policy. Upon discovery of a clerical error, any necessary appropriate adjustment in Premiums will be made. However, we will not grant any such adjustment in Premiums or coverage to the Enrolling Group for more than 90 days of coverage prior to the date we received notification of the clerical error.

6.9 Workers' Compensation Not Affected

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

6.10 Conformity with Law

Any provision of this Policy which, on its effective date, is in conflict with the requirements of State of California or federal statutes or regulations is deemed to be amended to conform to the minimum requirements of those statutes and regulations.

6.11 Notice

When we provide written notice regarding administration of this Policy to an authorized representative of the Enrolling Group, the Enrolling Group is responsible for giving notice to affected Subscribers and their Enrolled Dependents on a timely basis.

Any notice sent to us under this Policy and any notice sent to the Enrolling Group must be addressed as described in Exhibit 1.

6.12 Continuation Coverage

We agree to provide Benefits under this Policy for those Covered Persons who are eligible to continue coverage under federal or state law, as described in *Section 4: When Coverage Ends* of the *Certificate of Coverage*.

Federal Continuation Coverage

We will provide administrative duties with respect to the Enrolling Group's compliance with federal law. The Enrolling Group will provide notification of COBRA continuation rights and we will provide services for billing and collection of Premium.

Extension of Continuation Coverage under State Law (Cal-COBRA) after Exhaustion of Federal COBRA Continuation Coverage

We will provide all administrative duties required by Cal-COBRA, including but not limited to, notifications to affected Covered Persons and billing and collection of Premium.

6.13 Certification of Coverage Forms

As required by the federal *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, we will produce certification of coverage forms for Covered Persons who lose coverage under this Policy. The Enrolling Group agrees to provide us with all necessary eligibility and termination data. Certification of coverage forms will be based on eligibility and termination data that the Enrolling Group provides to our eligibility systems in accordance with our data specifications, and which is available in our eligibility systems as of the date the form is generated. The certification of coverage forms will only include periods of coverage that we administer under this Policy.

6.14 Subscriber's Individual Certificate

We will issue *Certificate(s) of Coverage*, *Schedule(s) of Benefits*, and any attachments to the Enrolling Group for delivery to each covered Subscriber. The *Certificate(s) of Coverage*, *Schedule(s) of Benefits*, and any attachments will show the Benefits and other provisions of this Policy. In addition, each covered Subscriber may have access to his or her *Certificate(s) of Coverage* and *Schedule(s) of Benefits* online at www.myuhc.com.

6.15 System Access

The term "systems" as used in this provision means our systems that we make available to the Enrolling Group to facilitate the transfer of information in connection with this Policy.

System Access

We grant the Enrolling Group the nonexclusive, nontransferable right to access and use the functionalities contained within the systems, under the terms set forth in this Policy. The Enrolling Group agrees that all rights, title and interest in the systems and all rights in patents, copyrights, trademarks and trade secrets encompassed in the systems will remain ours. In order to obtain access to the systems, the Enrolling Group will obtain, and be responsible for maintaining, at no expense to us, the hardware, software and Internet browser requirements we provide to the Enrolling Group, including any amendments to those requirements. The Enrolling Group is responsible for obtaining an internet service provider or other access to the Internet.

The Enrolling Group will not:

- Access systems or use, copy, reproduce, modify, or excerpt any of the systems documentation provided by us in order to access or utilize systems, for purposes other than as expressly permitted under this Policy.
- Share, transfer or lease its right to access and use systems, to any other person or entity which is not a party to this Policy.

The Enrolling Group may designate any third party to access systems on its behalf, provided the third party agrees to these terms and conditions of systems access and the Enrolling Group assumes joint responsibility for such access.

Security Procedures

The Enrolling Group will use commercially reasonable physical and software-based measures, and comply with our security procedures, as may be amended from time to time, to protect the system, its functionalities, and data accessed through systems from any unauthorized access or damage (including damage caused by computer viruses). The Enrolling Group will notify us immediately if any breach of the security procedures, such as unauthorized use, is suspected. If we amend our security procedures that affect the Enrolling Group, we will provide Enrolling Group a 90 day prior written notice which shall include a copy of the amended security procedures.

System Access Termination

We reserve the right to terminate the Enrolling Group's system access:

- On the date the Enrolling Group fails to accept the hardware, software and browser requirements provided by us, including any amendments to the requirements.
- Immediately on the date we reasonably determine that the Enrolling Group has breached, or allowed a breach of, any applicable provision of this Policy. Upon termination of this Policy, the

Enrolling Group agrees to cease all use of systems, and we will deactivate the Enrolling Group's identification numbers and passwords and access to the system.

6.17 Important Notice - Disputes

Should a dispute concerning your coverage arise, contact us first. If the dispute is not resolved, contact the California Department of Insurance.

Call us at the phone number shown on your ID card.

Call the **California Department of Insurance** at:

- **1-800-927-HELP (1-800-927-4357)** in the State of California.
- **213-897-8921** outside of the State of California.

You may write the California Department of Insurance at:

California Department of Insurance

Claims Services Bureau, 11th Floor

300 South Spring Street

Los Angeles, CA 90013

6.18 Notice of Network Provider Termination

We will provide written notice of Network provider termination to the Enrolling Group and to all affected Subscribers and their Enrolled Dependents, within 30 days, if we receive notice that any Network provider in the Service Area terminates or breaches its contract with us, or is unable to perform such contract, if the termination, breach, or inability to perform may materially and adversely affect the Enrolling Group or Covered Persons.

6.19 Liability for Continued Treatment by Terminated Network Provider

If, upon termination of a Network provider's contract as described in Article 6.19, a Covered Person is under the care of a terminated Network provider for one of the medical conditions described in the *Continuity of Care* provision in the *Schedule of Benefits*, we will be liable for continuation of Covered Health Services rendered by the provider until such services are completed, unless reasonable and medically appropriate arrangements for assumption of such Covered Health Services are made by another Network provider. Copayments, deductibles, or other cost sharing components will be the same as the Covered Person would have paid for a Network provider currently contracting with us.

This section does not apply to treatment by a provider or provider group whose contract with us has terminated or not renewed for reasons relating to medical disciplinary cause or reason, fraud or other criminal activity. However, care will be transitioned to a licensed provider who is not subject to medical disciplinary cause or reason, fraud or other criminal activity.

Exhibit 1

1. **Parties**. The parties to this Policy are UnitedHealthcare Insurance Company, a Connecticut corporation, and County of Riverside, a political subdivision of the State of California, the Enrolling Group.

2. **Effective Date of this Policy**. The effective date of this Policy is 12:01 a.m. on January 1, 2016 in the time zone of the Enrolling Group's location.

3. **Place of Issuance**. We are delivering this Policy in the State of California. This Policy is governed by the laws of the State of California.

4. **Premiums**. The *Schedule of Premium Rates* specified in each Exhibit 2 may be modified pursuant to Sections 3.1 and 3.3 of this Policy.

5. **Computation of Policy Charge**. A full calendar month's Premiums will be charged for Covered Persons whose effective date of coverage falls on or before the 15th of that calendar month. No Premiums will be charged for Covered Persons whose effective date of coverage falls after the 15th of that calendar month. A full calendar month's Premiums will be charged for Covered Persons whose coverage is terminated after the 15th of that calendar month. No Premiums will be charged for Covered Persons whose coverage is terminated on or before the 15th of that calendar month.

6. **Payment of the Policy Charge**. The Policy Charge is due and payable to us on a monthly basis on or before the last day of the second month after the month for which the Policy Charge applies. For example, the Policy Charge for January is due on or before the last day of March. A grace period of 31 days will be granted for the payment of any Policy Charge not paid when due.

7. **Minimum Participation Requirement**. The minimum participation requirement for the Enrolling Group is 75% of Eligible Persons excluding spousal waivers but no less than 50% of all Eligible Persons must be enrolled in Enrolling Group's sponsored medical plans.

8. **Minimum Contribution Requirement**. The Minimum Contribution Requirement does not apply.

9. **Notice**. Any notice sent to us under this Policy must be addressed to:

   UnitedHealthcare Insurance Company

   185 Asylum Street

   Hartford, Connecticut 06103-0450

   Any notice sent to the Enrolling Group under this Policy must be addressed to:

   County of Riverside, Human Resources Benefits Division

   P.O. Box 1569

   Riverside, California 92502-1569

   Attn: Stacey M. Beale, Human Resources Division Manager

   Notice sent to us or Enrolling Group by registered or certified mail, return receipt requested, U.S. Postal Service Express Mail, or overnight carrier is deemed given on the date of delivery. If sent by regular mail, the notice is deemed given five (5) business days after its deposit in the United States mail, postage prepaid.

10. 902805: Enrolling Group Number

Exhibit 2 Class 1

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description**.

   All Employees enrolled in UnitedHealthcare Select Plan PVI.

2. **Eligibility**. The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      None

   B. Other:

      Retired Employees under 65 years of age. As required by federal law, for policies that are new or renewing on or after January 1, 2014, the waiting period limitation cannot be greater than 90 days as described in item 4 below.

3. **Open Enrollment Period**. An Open Enrollment Period will be provided by the Enrolling Group during which Eligible Persons and their Eligible Dependents may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2016.

   For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first of the month following receipt of enrollment election form submitted to Enrolling Group.

5.. **Schedule of Premium Rates**.

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2016 is shown below:

Coverage Classification	Monthly Premium
EPO COB (Medicare A&B) + Dependents (> 65) Retiree Only	$638.68
EPO COB (Medicare A&B) + Dependents (> 65) Retiree plus One Dependent	$1,277.36
EPO COB (Medicare A&B) + Dependents (> 65) Retiree plus Family	$1,722.11
EPO COB + HMO (For EPO COB) Retiree plus Spouse (1 Medicare)	$1,028.37
EPO COB + HMO (For EPO COB) Retiree plus Family (1 Medicare)	$1,744.48
EPO COB + HMO (For EPO COB) Retiree plus Family (2 Medicare)	$716.11

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2.*

Exhibit 2 Class 2

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description**.

   All Employees enrolled in UnitedHealthcare Select Plus Plan PR3 (Option 1).

2. **Eligibility**. The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      None

   B. Other:

      Retired Employees under 65 years of age. As required by federal law, for policies that are new or renewing on or after January 1, 2014, the waiting period limitation cannot be greater than 90 days as described in item 4 below.

3. **Open Enrollment Period**. An Open Enrollment Period will be provided by the Enrolling Group during which Eligible Persons and their Eligible Dependents may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2016.

   For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first of the month following receipt of enrollment election form submitted to Enrolling Group.

5. **Schedule of Premium Rates**.

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2016 is shown below:

Coverage Classification	**Monthly Premium**
PPO (Non-Blythe) - Active/COBRA Employee Only	$1,052.50
PPO (Non-Blythe) - Active/COBRA Employee plus One Dependent	$2,092.32
PPO (Non-Blythe) - Active/COBRA Employee plus Family	$2,716.50
PPO (Non-Blythe) - AB1401 Employee Only	$1,157.75
PPO (Non-Blythe) - AB1401 Employee plus One Dependent	$2,301.55
PPO (Non-Blythe) - AB1401 Employee plus Family	$2,988.15
PPO (Non-Blythe) - ERET Employee Only	$1,481.92
PPO (Non-Blythe) - ERET Employee plus One Dependent	$2,845.55

PPO (Non-Blythe) - ERET Employee plus Family	$3,824.84
PPO - Out of Area Dependents (Students) with HMO Subscriber	$0.00

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2*.

Exhibit 2 Class 3

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description**.

   All Employees enrolled in UnitedHealthcare Select Plus Plan PR3 (Option 2).

2. **Eligibility**. The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      None

   B. Other:

      Retired Employees under 65 years of age. As required by federal law, for policies that are new or renewing on or after January 1, 2014, the waiting period limitation cannot be greater than 90 days as described in item 4 below.

3. **Open Enrollment Period**. An Open Enrollment Period will be provided by the Enrolling Group during which Eligible Persons and their Eligible Dependents may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2016.

   For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first of the month following receipt of enrollment election form submitted to Enrolling Group.

5. **Schedule of Premium Rates**.

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2016 is shown below:

Coverage Classification	**Monthly Premium**
PPO COB (Blythe and Non-Blythe) (Medicare A&B) Retiree Only (> 65)	$896.85
PPO COB (Blythe and Non-Blythe) (Medicare A&B) Retiree plus One Dependent (> 65)	$1,793.70
PPO COB (Blythe and Non-Blythe) (Medicare A&B) Retiree plus Family (> 65)	$2,418.22
PPO (Blythe and Non-Blythe) (For PPO COB) Retiree plus One Dependent (1 Medicare)	$1,481.92
PPO (Blythe and Non-Blythe) (For PPO COB) Retiree plus Family (1 Medicare)	$2,513.85

PPO (Blythe and Non-Blythe) (For PPO COB) Retiree plus Family (2 Medicare) $1,031.93

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2*.

Exhibit 2 Class 4

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description**.

   All Employees enrolled in UnitedHealthcare Non-Differential PPO Plan PUZ.

2. **Eligibility**. The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      None

   B. Other:

      Retired Employees under 65 years of age. As required by federal law, for policies that are new or renewing on or after January 1, 2014, the waiting period limitation cannot be greater than 90 days as described in item 4 below.

3. **Open Enrollment Period**. An Open Enrollment Period will be provided by the Enrolling Group during which Eligible Persons and their Eligible Dependents may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2016.

   For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first of the month following receipt of enrollment election form submitted to Enrolling Group.

5. **Schedule of Premium Rates**.

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2016 is shown below:

Coverage Classification	**Monthly Premium**
Non-Diff PPO COB (Medicare A&B)	$959.56
Non-Diff PPO COB (Medicare A&B) Retiree plus One Dependent (>65)	$1,919.12
Non-Diff PPO COB (Medicare A&B) Retiree plus Family (>65)	$2,587.31
Non-Diff PPO COB (Medicare A&B) Retiree plus One Dependent (1 Medicare)	$1,585.54
Non-Diff PPO COB (Medicare A&B) Retiree plus Family (1 Medicare)	$2,689.63
Non-Diff PPO COB (Medicare A&B) Retiree plus Family (2 Medicare)	$1,104.09

   Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2*.

Exhibit 3 - Miscellaneous Provisions

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 and 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 1067.02(b)(2)(C).

OTICES

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	California Department of Insurance
Guarantee Association	Consumer Communications Bureau
P.O. Box 16860	300 South Spring Street
Beverly Hills, CA 90209-3319	Los Angeles, CA 90013
(323) 782-0182	(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.

Enrolling Group Location Requirement Policy Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to include a location requirement for the Enrolling Group.

The following provision is added to the Policy in *Exhibit 1*:

Enrolling Group Location Requirement. This Policy is only approved for sale if the Enrolling Group's principal business address is located within the area set forth in our rate filings. For purposes of this provision, principal business address means the physical location of the Enrolling Group's business.

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President

California Life and Health Insurance Guaranty Association Act Summary Document and Disclaimer

Residents of California who purchase life and health insurance and annuities should know that the insurance companies licensed in this state to write these types of insurance are members of the California Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of this Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided through the Guaranty Association is not unlimited, as noted below, and is not a substitute for consumers' care in selecting insurers.

The Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in California. You should not rely on coverage by the Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

Policyholders with additional questions should first contact their insurer or agent or may then contact:

California Life and Health Insurance Guaranty Association

PO Box 17319

Beverly Hills, CA 90209-3319

California Department of Insurance

Consumer Service Division

300 S. Spring St.

Los Angeles, CA 90013

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

Coverage

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

Exclusions from Coverage

However, persons holding such policies are not protected by this Guaranty Association if:

- Their insurer was not authorized to do business in this state when it issued the policy or contract;

- Their policy was issued by a health care service plan (HMO), Blue Cross, Blue Shield, 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;
- They are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.

The Guaranty Association also does not provide coverage for:

- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which guarantee rights to group contract holders, not individuals;
- Employer and association plans, to the extent they are self-funded or uninsured;
- Synthetic guaranteed interest contracts;
- 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 a variable contract sold by prospectus;
- Any policy of reinsurance unless an assumption certificate was issued;
- Interest rate yields that exceed an average rate;
- Any portion of a contract that provides dividends or experience rating credits.

Limits on Amount of Coverage

The Act limits the Guaranty Association to pay benefits as follows:

- Life and Annuity Benefits
- 80% of what the life insurance company would owe under a life policy or annuity contract up to:
  - $100,000 in cash surrender values,
  - $100,000 in present value of annuities, or
  - $250,000 in life insurance death benefits.
- A maximum of $250,000 for any one insured life no matter how many policies and contracts there were with the same company, even if the policies provided different types of coverages.

Health Benefits

A maximum of $200,000 of the contractual obligations that the health insurance company would owe were it not insolvent. The maximum may increase or decrease annually based upon changes in the health care cost component of the consumer price index.

Premium Surcharge

Member insurers are required to recoup assessments paid to the Guaranty Association by way of a surcharge on premiums charged for health insurance policies to which the Act applies.

UnitedHealthcare Insurance Company
Group Policy
For
County of Riverside
Enrolling Group Number: 902805
Policy Effective Date: January 1, 2016

IN WITNESS WHEREOF, the parties hereto have caused their duly authorized representatives to execute the Group Policy with an effective date of January 1, 2016.

ATTEST:
Clerk of the Board
Kecia Harper

By: _____
Deputy

Date: JUL 27 2021

COUNTY OF RIVERSIDE

By: Karen S. Spiegel
Karen Spiegel, Chairwoman,
Board of Supervisors

Date: JUL 27 2021

Approved as to form:

Gregory P. Priamos
County Counsel

By: _____
Deputy County Counsel
LISA SANCHEZ

CONTRACTOR: UHC OF CALIFORNIA
dba UNITEDHEALTHCARE OF CALIFORNIA,
a California corporation

By: _____

Printed Name: Robert C. Falkenberg

Title: CEO, UHC of CA

Date: 04/05/2021

UnitedHealthcare Insurance Company

Group Policy

For

County of Riverside

Enrolling Group Number: 902805

Policy Effective Date: January 1, 2017

JUL 27 2021 3.13

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

860-702-5000

Regulated by:

California Department of Insurance

Consumer Communication Bureau

300 South Spring Street, South Tower

Los Angeles, CA 90013

1-800-927-HELP (4357)

TDD: 800-482-4833

Group Policy

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

860-702-5000

This Policy is entered into by and between UnitedHealthcare Insurance Company and the "Enrolling Group," as described in Exhibit 1.

When used in this document, the words "we," "us," and "our" are referring to UnitedHealthcare Insurance Company.

Upon our receipt of the Enrolling Group's signed application and payment of the first Policy Charge, this Policy is deemed executed.

We agree to provide Benefits for Covered Health Services set forth in this Policy, including the attached *Certificate(s) of Coverage* and *Schedule(s) of Benefits*, subject to the terms, conditions, exclusions, and limitations of this Policy. The Enrolling Group's application is made a part of this Policy.

This Policy replaces and overrules any previous agreements relating to Benefits for Covered Health Services between the Enrolling Group and us. The terms and conditions of this Policy will in turn be overruled by those of any subsequent agreements relating to Benefits for Covered Health Services between the Enrolling Group and us.

We will not be deemed or construed as an employer or plan administrator for any purpose with respect to the administration or provision of benefits under the Enrolling Group's benefit plan. We are not responsible for fulfilling any duties or obligations of an employer or plan administrator with respect to the Enrolling Group's benefit plan.

This Policy will become effective on the date specified in Exhibit 1 and will be continued in force by the timely payment of the required Policy Charges when due, subject to termination of this Policy as provided in Article 5.

When this Policy is terminated, as described in Article 5, this Policy and all Benefits under this Policy will end at 12:00 midnight on the date of termination.

This Policy is issued as described in Exhibit 1.

Issued By:

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President

Article 1: Glossary of Defined Terms

The terms used in this Policy have the same meanings given to those terms in *Section 9: Defined Terms* of the attached *Certificate(s) of Coverage*.

Coverage Classification - one of the categories of coverage described in Exhibit 2 for rating purposes (for example: Subscriber only, Subscriber and spouse, Subscriber and children, Subscriber and family).

Material Misrepresentation - any oral or written communication or conduct, or combination of communication and conduct, that is untrue and is intended to create a misleading impression in the mind of another person. A misrepresentation is material if a reasonable person would attach importance to it in making a decision or determining a course of action, including but not limited to, the issuance of a policy or coverage under a policy, calculation of rates, or payment of a claim.

Service Area - the State of California or any other geographical area within the state designated in the Policy within which Network provider services are rendered to Covered Persons for Covered Health Services.

Article 2: Benefits

Subscribers and their Enrolled Dependents are entitled to Benefits for Covered Health Services subject to the terms, conditions, limitations and exclusions set forth in the *Certificate(s) of Coverage* and *Schedule(s) of Benefits* attached to this Policy. Each *Certificate of Coverage* and *Schedule of Benefits*, including any Riders and Amendments, describes the Covered Health Services, required Copayments, and the terms, conditions, limitations and exclusions related to coverage.

We pay Benefits for Emergency Health Services that are required to stabilize or initiate treatment in an Emergency as described in the *Certificate of Coverage* and *Schedule of Benefits* to Covered Persons who receive such services outside of the Service Area.

Article 3: Premium Rates and Policy Charge

3.1 Premiums

Monthly Premiums payable by or on behalf of Covered Persons are specified in the *Schedule of Premium Rates* in Exhibit 2 of this Policy or in any attached *Notice of Change*.

We reserve the right to change the *Schedule of Premium Rates* as described in Exhibit 1 of this Policy. We also reserve the right to change the *Schedule of Premium Rates* at any time if the *Schedule of Premium Rates* was based upon a Material Misrepresentation that resulted in the Premium rates being lower than they would have been if the Material Misrepresentation had not been made. We reserve the right to change the *Schedule of Premium Rates* for this reason retroactive to the effective date of the *Schedule of Premium Rates* that was based on the Material Misrepresentation.

3.2 Computation of Policy Charge

The Policy Charge will be calculated based on the number of Subscribers in each Coverage Classification that we show in our records at the time of calculation. The Policy Charge will be calculated using the Premium rates in effect at that time. Exhibit 1 describes the way in which the Policy Charge is calculated.

3.3 Adjustments to the Policy Charge

We may make retroactive adjustments for any additions or terminations of Subscribers or changes in Coverage Classification that are not reflected in our records at the time we calculate the Policy Charge. We will not grant retroactive credit for any change occurring more than 90 days prior to the date we

received notification of the change from the Enrolling Group. We also will not grant retroactive credit for any calendar month in which a Subscriber has received Benefits.

The Enrolling Group must notify us in writing within 60 days of the effective date of enrollments, terminations, or other changes. The Enrolling Group must notify us in writing each month of any change in the Coverage Classification for any Subscriber.

If premium taxes, guarantee or uninsured fund assessments, or other governmental charges relating to or calculated in regard to Premium are either imposed or increased, those charges will automatically be added to the Premium. In addition, any change in law or regulation that significantly affects our cost of operation will result in an increase in Premium in an amount we determine.

3.4 Payment of the Policy Charge

The Policy Charge is payable to us in advance by the Enrolling Group as described under "Payment of the Policy Charge" in Exhibit 1. The first Policy Charge is due and payable on or before the effective date of this Policy. Subsequent Policy Charges are due and payable no later than the first day of each payment period specified in item 6 of Exhibit 1, while this Policy is in force.

All payments shall be made in United States dollars, in immediately available funds, and shall be remitted to us at the address set forth in the Enrolling Group's application, or at such other address as we may from time to time designate in writing. The Enrolling Group agrees not to send us payments marked "paid in full", "without recourse", or similar language. In the event that the Enrolling Group sends such a payment, we may accept it without losing any of our rights under this Policy and the Enrolling Group will remain obligated to pay any and all amounts owed to us.

A late payment charge will be assessed for any Policy Charge not received within 10 calendar days following the due date. A service charge will be assessed for any non-sufficient-fund check received in payment of the Policy Charge. All Policy Charge payments must be accompanied by supporting documentation that states the names of the Covered Persons for whom payment is being made.

The Enrolling Group must reimburse us for attorney's fees and any other costs related to collecting delinquent Policy Charges.

3.5 Grace Period

A grace period of 90 days will be granted for the payment of any Policy Charge not paid when due. During the grace period, this Policy will continue in force. The grace period will not extend beyond the date this Policy terminates.

The Enrolling Group is liable for payment of the Policy Charge during the grace period. If we receive written notice from the Enrolling Group to terminate this Policy during the grace period, we will adjust the Policy Charge so that it applies only to the number of days this Policy was in force during the grace period.

This Policy terminates as described in Article 5.1 if the grace period expires and the past due Policy Charge remains unpaid.

Article 4: Eligibility and Enrollment

4.1 Eligibility Conditions or Rules

Eligibility conditions or rules for each class are stated in the corresponding Exhibit 2. The eligibility conditions stated in Exhibit 2 are in addition to those specified in *Section 3: When Coverage Begins* of the *Certificate of Coverage*.

4.2 Initial Enrollment Period

Eligible Persons and their Dependents may enroll for coverage under this Policy during the Initial Enrollment Period. The Initial Enrollment Period is determined by the Enrolling Group.

4.3 Open Enrollment Period

An Open Enrollment Period will be provided periodically for each class, as specified in the corresponding Exhibit 2. During an Open Enrollment Period, Eligible Persons may enroll for coverage under this Policy.

4.4 Effective Date of Coverage

The effective date of coverage for properly enrolled Eligible Persons and their Dependents is stated in Exhibit 2.

4.5 Waiver Form

The Enrolling Group agrees to provide each individual who declines coverage with a form to be signed at the time they are initially eligible to enroll for coverage. The form states that an individual who declines coverage during the Initial Enrollment Period acknowledges that we may, at the time of the individual's later decision to elect coverage, consider the individual a late enrollee.

The Enrolling Group agrees to retain a copy of the individual's signed acknowledgment and forward a copy of the acknowledgment to us when requested.

Article 5: Policy Termination

5.1 Conditions for Termination of the Entire Policy

This Policy and all Benefits for Covered Health Services under this Policy will automatically terminate on the earliest of the dates specified below:

A. On the last day of the grace period if the Policy Charge remains unpaid. The Enrolling Group remains liable for payment of the Policy Charge for the period of time this Policy remained in force during the grace period.

B. On the date specified by the Enrolling Group, after at least 31 days prior written notice to us that this Policy is to be terminated.

C. On the date we specify, after at least 31 days prior written notice to the Enrolling Group, that this Policy is to be terminated due to the Enrolling Group's violation of the participation or contribution rules as shown in Exhibit 1.

D. On the date we specify, after at least 31 days prior written notice to the Enrolling Group, that this Policy is to be terminated because the Enrolling Group performed an act or practice that constituted fraud or made an intentional misrepresentation of a fact that was material to the execution of this Policy or to the provision of coverage under this Policy. In this case, we have the right to rescind this Policy back to either:

   - The effective date of this Policy.
   - The date of the act or practice, if later.

   We will send a notice to the Enrolling Group via certified mail at least 30 days prior to the effective date of the rescission explaining the reason for the rescission and notifying them of their right to appeal as described in Article 5.3. We will not rescind this Policy due to fraud or an intentional

misrepresentation of a material fact after twenty-four (24) months from the date of issuance of this Policy.

E. On the date we specify, after at least 90 days prior written notice to the Enrolling Group, that this Policy is to be terminated because we will no longer issue this particular type of group health benefit plan within the applicable market.

F. On the date we specify, after at least 180 days prior written notice to the applicable state authority and to the Enrolling Group, that this Policy is to be terminated because we will no longer issue any employer health benefit plan within the applicable market.

5.2 Payment and Reimbursement Upon Termination

Upon any termination of this Policy, the Enrolling Group is and will remain liable to us for the payment of any and all Premiums which are unpaid at the time of termination, including a pro rata portion of the Policy Charge for any period this Policy was in force during the grace period preceding the termination.

Except in the case of fraud or intentional misrepresentation of a material fact, we will refund the pro rata portion of any and all Policy Charges which have been prepaid by the Enrolling Group to reflect any reduced period of coverage at the time of termination of this Policy. The refund will be reduced by any amount paid for any claims incurred during the period this Policy was in force preceding the termination. Mid-month proration based on the eligibility rules established by the Enrolling Group will be used to refund Policy Charges. Exhibit 1 describes the way in which the Policy Charge is calculated.

5.3 Review by the California Department of Insurance for Improper Cancellation, Rescission or Non-Renewal of Coverage

You may request a review by the California Insurance Commissioner if you believe your Policy or coverage has been or will be wrongly canceled, rescinded or not renewed. Contact the California Insurance Commissioner's Consumer Communications Bureau at **1-800-927-HELP (4357)** or **TDD 1-800-482-4833** to receive assistance with this process, or submit an inquiry in writing to:

California Department of Insurance

Consumer Communications Bureau

300 S. Spring Street, South Tower

Los Angeles, CA 90013

Or through the website **http://www.insurance.ca.gov**.

Article 6: General Provisions

6.1 Entire Policy

This Policy, including the *Certificate(s) of Coverage*, the *Schedule(s) of Benefits*, the application of the Enrolling Group, and any Amendments, Notices of Change, and Riders, constitute the entire Policy between the parties, and any statement made by the Enrolling Group shall, in absence of fraud, be deemed a representation and not a warranty. No statement made by any Subscriber whose eligibility has been accepted by us shall avoid the insurance or reduce the Benefits under this Policy or be used in defense to a claim hereunder.

6.2 Dispute Resolution and Binding Arbitration Requirement

This Policy requires that disputes be resolved in binding arbitration. You are waiving your right to sue UnitedHealthcare Insurance Company in court to resolve a dispute. You are waiving your right to a jury trial.

No legal proceeding or action may be brought until the parties have attempted, in good faith, to resolve the dispute amongst themselves. In the event the dispute is not resolved within 30 days after one party has received written notice of the dispute from the other party, and either party wishes to pursue the dispute further, this applies to disputes of any kind whatsoever, including, but not limited to, claims for medical malpractice (that is, as to whether any medical services rendered under Policy were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), the dispute may be submitted to arbitration as set forth below.

The parties acknowledge that because this Policy affects interstate commerce, the *Federal Arbitration Act* applies. If the Enrolling Group wishes to seek further review of the decision or the complaint or dispute, it must submit the decision, complaint or dispute to binding arbitration pursuant to the rules of the *American Arbitration Association*. This is the only right the Enrolling Group has for further consideration of any dispute that arises out of or is related to this Policy.

If a claim for medical malpractice seeks total damages of $50,000 or less, the claim or dispute shall provide for selection by the parties of a single neutral arbitrator who shall have no jurisdiction to award more than $50,000. If the parties are unable to agree on the selection of a single arbitrator, the following method shall be utilized:

- If the arbitration agreement provides a method of appointing an arbitrator, that method shall be followed.
- If the arbitration agreement does not provide a method for appointing an arbitrator, the parties to the agreement who seek arbitration and against whom is sought may agree on a method of appointing an arbitrator and that method shall be followed.
- In the absence of an agreed method, or if the agreed method fails for any reason cannot be followed, or when an arbitrator appointed fails to act and his or her successor has not been appointed, the court, on petition of a party to the arbitration agreement, shall appoint the arbitrator. When petition is made to the court to appoint a neutral arbitrator, the court shall nominate five persons from lists of persons supplied jointly by the parties to the arbitration or obtained from a governmental agency concerned with arbitration or private disinterested association concerned with arbitration. The parties to the agreement who seek arbitration and against whom arbitration is sought may within five days of receipt of notice of the nominees from the court jointly select the arbitrator whether or not the arbitrator is among the nominees. If the parties fail to select an arbitrator within the five-day period, the court shall appoint the arbitrator from the nominees.

Arbitration will take place in Orange County, California.

The matter must be submitted to binding arbitration within one year of the date notice of the dispute was received. The arbitrators will have no power to award any punitive or exemplary damages or to vary or ignore the provisions of this Policy, and will be bound by federal and/or state law.

6.3 Amendments and Alterations

Amendments based on changes to state or federal mandates to this Policy are effective 31 days after we send written notice to the Enrolling Group. Other than changes to Exhibit 2, no change will be made to this Policy unless made by an Amendment to incorporate federal or state mandates which is signed by one of our authorized executive officers. No agent has authority to change this Policy or to waive any of its provisions.

6.4 Relationship between Parties

The relationships between us and Network providers, and relationships between us and Enrolling Groups, are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees, nor are we or any of our employees an agent or employee of Network providers or Enrolling Groups.

The relationship between a Network provider and any Covered Person is that of provider and patient. The Network provider is solely responsible for the services provided by it to any Covered Person. The relationship between any Enrolling Group and any Covered Person is that of employer and employee, Dependent, or any other category of Covered Person described in the Coverage Classifications specified in this Policy.

The Enrolling Group is solely responsible for enrollment and Coverage Classification changes (including termination of a Covered Person's coverage) and for the timely payment of the Policy Charges.

6.5 Records

The Enrolling Group must furnish us with all information and proofs which we may reasonably require with regard to any matters pertaining to this Policy. We may at any reasonable time inspect:

- All documents furnished to the Enrolling Group by an individual in connection with coverage.
- The Enrolling Group's payroll.
- Any other records pertinent to the coverage under this Policy.

By accepting Benefits under this Policy, each Covered Person authorizes and directs any person or institution that has provided services to him or her, to furnish us or our designees any and all information and records or copies of records relating to the health care services provided to the Covered Person. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form.

We agree that such information and records will be considered confidential. We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy including records necessary for appropriate medical review and quality assessment or as we are required by law or regulation.

During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy for research and analytic purposes.

6.6 Administrative Services

The services necessary to administer this Policy and the Benefits provided under it will be provided in accordance with our standard administrative procedures or those standard administrative procedures of our designee. If the Enrolling Group requests that administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, the Enrolling Group must pay for such services or reports at the then current charges for such services or reports.

We may offer to provide administrative services to the Enrolling Group for certain wellness programs including, but not limited to, fitness programs, biometric screening programs and wellness coaching programs.

6.7 Employee Retirement Income Security Act (ERISA)

When this Policy is purchased by the Enrolling Group to provide benefits under a welfare plan governed by the federal *Employee Retirement Income Security Act* 29 U.S.C., 1001 et seq., we will not be named

as, and will not be, the plan administrator or the named fiduciary of the welfare plan, as those terms are used in ERISA.

6.8 Examination of Covered Persons

In the event of a question or dispute concerning Benefits for Covered Health Services, we may reasonably require that a Network Physician, acceptable to us, examine the Covered Person at our expense.

6.9 Clerical Error

Clerical error will not deprive any individual of Benefits under this Policy or create a right to Benefits. Failure to report enrollments will not be considered a clerical error and will not result in retroactive coverage for Eligible Persons. Failure to report the termination of coverage will not continue the coverage for a Covered Person beyond the date it is scheduled to terminate according to the terms of this Policy. Upon discovery of a clerical error, any necessary appropriate adjustment in Premiums will be made. However, we will not grant any such adjustment in Premiums or coverage to the Enrolling Group for more than 60 days of coverage prior to the date we received notification of the clerical error.

6.10 Workers' Compensation Not Affected

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

6.11 Conformity with Law

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is deemed to be amended to conform to the minimum requirements of those statutes and regulations.

6.12 Notice

When we provide written notice regarding administration of this Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to Covered Persons on a timely basis.

Any notice sent to us under this Policy and any notice sent to the Enrolling Group must be addressed as described in Exhibit 1.

6.13 Continuation Coverage

We agree to provide Benefits under this Policy for those Covered Persons who are eligible to continue coverage under federal or state law, as described in *Section 4: When Coverage Ends* of the *Certificate of Coverage*.

Federal Continuation Coverage

We will not provide any administrative duties with respect to the Enrolling Group's compliance with federal law. All duties of the plan sponsor or plan administrator required by federal law remain the sole responsibility of the Enrolling Group, including but not limited to notification of COBRA continuation rights and billing and collection of Premium.

Extension of Continuation Coverage under State Law (Cal-COBRA) after Exhaustion of Federal COBRA Continuation Coverage

We will provide all administrative duties required by Cal-COBRA, including but not limited to, notifications to affected Covered Persons and billing and collection of Premium.

6.14 Certification of Coverage Forms

As required by the federal *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, we will produce certification of coverage forms for Covered Persons who lose coverage under this Policy. The Enrolling Group agrees to provide us with all necessary eligibility and termination data. Certification of coverage forms will be based on eligibility and termination data that the Enrolling Group provides to our eligibility systems in accordance with our data specifications, and which is available in our eligibility systems as of the date the form is generated. The certification of coverage forms will only include periods of coverage that we administer under this Policy.

6.15 Subscriber's Individual Certificate

We will issue *Certificate(s) of Coverage*, *Schedule(s) of Benefits*, and any attachments to the Enrolling Group for delivery to each covered Subscriber. The *Certificate(s) of Coverage*, *Schedule(s) of Benefits*, and any attachments will show the Benefits and other provisions of this Policy. In addition, you may have access to your *Certificate(s) of Coverage* and *Schedule(s) of Benefits* online at www.myuhc.com.

6.16 Summary of Benefits and Coverage

We will provide a *Summary of Benefits and Coverage* (*"SBC"*), as required by the *Affordable Care Act* and associated regulations (*"ACA"*), to the Enrolling Group for each benefit plan purchased by the Enrolling Group. The Enrolling Group shall be responsible for delivering the *SBC* to all Covered Persons and to other persons eligible for coverage in the manner and at the times required by the *ACA*, unless we notify the Enrolling Group that we will deliver the *SBC* to Covered Persons and other persons eligible for coverage.

6.17 System Access

The term "systems" as used in this provision means our systems that we make available to the Enrolling Group to facilitate the transfer of information in connection with this Policy.

System Access

We grant the Enrolling Group the nonexclusive, nontransferable right to access and use the functionalities contained within the systems, under the terms set forth in this Policy. The Enrolling Group agrees that all rights, title and interest in the systems and all rights in patents, copyrights, trademarks and trade secrets encompassed in the systems will remain ours. In order to obtain access to the systems, the Enrolling Group will obtain, and be responsible for maintaining, at no expense to us, the hardware, software and Internet browser requirements we provide to the Enrolling Group, including any amendments to those requirements. The Enrolling Group is responsible for obtaining an internet service provider or other access to the Internet.

The Enrolling Group will not:

- Access systems or use, copy, reproduce, modify, or excerpt any of the systems documentation provided by us in order to access or utilize systems, for purposes other than as expressly permitted under this Policy.
- Share, transfer or lease its right to access and use systems, to any other person or entity which is not a party to this Policy.

The Enrolling Group may designate any third party to access systems on its behalf, provided the third party agrees to these terms and conditions of systems access and the Enrolling Group assumes joint responsibility for such access.

Security Procedures

The Enrolling Group will use commercially reasonable physical and software-based measures, and comply with our security procedures, as may be amended from time to time, to protect the system, its functionalities, and data accessed through systems from any unauthorized access or damage (including damage caused by computer viruses). The Enrolling Group will notify us immediately if any breach of the security procedures, such as unauthorized use, is suspected.

System Access Termination

We reserve the right to terminate the Enrolling Group's system access:

- On the date the Enrolling Group fails to accept the hardware, software and browser requirements provided by us, including any amendments to the requirements.
- Immediately on the date we reasonably determine that the Enrolling Group has breached, or allowed a breach of, any applicable provision of this Policy. Upon termination of this Policy, the Enrolling Group agrees to cease all use of systems, and we will deactivate the Enrolling Group's identification numbers and passwords and access to the system.

6.18 Important Notice - Disputes

Should a dispute concerning your coverage arise, contact us first. If the dispute is not resolved, contact the California Department of Insurance.

Call us at the phone number shown on your ID card.

Call the **California Department of Insurance** at:

- **1-800-927-HELP (1-800-927-4357)** in the State of California.
- **213-897-8921** outside of the State of California.

You may write the California Department of Insurance at:

California Department of Insurance

Claims Services Bureau, 11th Floor

300 South Spring Street

Los Angeles, CA 90013

6.19 Notice of Network Provider Termination

We will provide written notice to the Enrolling Group, within a reasonable period of time, if we receive notice that any Network provider in the Service Area terminates or breaches its contract with us, or is unable to perform such contract, if the termination, breach, or inability to perform may materially and adversely affect the Enrolling Group or Covered Persons.

When we provide such written notice of Network provider termination to the Enrolling Group, the Enrolling Group is responsible for distributing the substance of the notice to all affected Subscribers and their Enrolled Dependents no later than 30 days after its receipt.

6.20 Liability for Continued Treatment by Terminated Network Provider

If, upon termination of a Network provider's contract as described in Article 6.19, a Covered Person is under the care of a terminated Network provider for one of the medical conditions described in the *Continuity of Care* provision in the *Schedule of Benefits*, we will be liable for continuation of Covered Health Services rendered by the provider until such services are completed, unless reasonable and medically appropriate arrangements for assumption of such Covered Health Services are made by another Network provider. Copayments, deductibles, or other cost sharing components will be the same as the Covered Person would have paid for a Network provider currently contracting with us.

This section does not apply to treatment by a provider or provider group whose contract with us has terminated or not renewed for reasons relating to medical disciplinary cause or reason, fraud or other criminal activity.

Exhibit 1

1. **Parties**. The parties to this Policy are UnitedHealthcare Insurance Company and County of Riverside, the Enrolling Group.

2. **Effective Date of this Policy**. The effective date of this Policy is 12:01 a.m. on January 1, 2017 in the time zone of the Enrolling Group's location.

3. **Place of Issuance**. We are delivering this Policy in the State of California. This Policy is governed by ERISA. To the extent that state law applies, the laws of the State of California are the laws that govern this Policy.

4. **Premiums**. We reserve the right to change the *Schedule of Premium Rates* specified in each Exhibit 2, after a 45-day prior written notice at any time.

5. **Computation of Policy Charge**. A full calendar month's Premiums will be charged for Covered Persons whose effective date of coverage falls on or before the 15th of that calendar month. No Premiums will be charged for Covered Persons whose effective date of coverage falls after the 15th of that calendar month. A full calendar month's Premiums will be charged for Covered Persons whose coverage is terminated after the 15th of that calendar month. No Premiums will be charged for Covered Persons whose coverage is terminated on or before the 15th of that calendar month.

6. **Payment of the Policy Charge**. The Policy Charge is payable to us in advance by the Enrolling Group on a monthly basis.

7. **Minimum Participation Requirement**. The minimum participation requirement for the Enrolling Group is 17% of Eligible Persons excluding spousal waivers but no less than 50% of all Eligible Persons must be enrolled for coverage under this Policy.

8. **Minimum Contribution Requirement**. The Minimum Contribution Requirement does not apply.

9. **Notice**. Any notice sent to us under this Policy must be addressed to:

   UnitedHealthcare Insurance Company

   185 Asylum Street

   Hartford, Connecticut 06103-0450

   Any notice sent to the Enrolling Group under this Policy must be addressed to:

   County of Riverside

   4080 Lemon Street

   Riverside, California 92501

10. 902805: Enrolling Group Number

Exhibit 2 Class 1

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description**.

   All Employees enrolled in UnitedHealthcare Select Plan AKMS.

2. **Eligibility**. The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      None

   B. Other:

      Retired Employees under 65 years of age

   Important Note Regarding Waiting or Probationary Period: Any required waiting or probationary period for newly Eligible Persons will not exceed 90 days. A waiting or probationary period may only be a condition of employment if applied equally to all Eligible Persons and Dependents and if consistent with the *Patient Protection and Affordable Care Act*. A waiting or probationary period may not be based on health status.

3. **Open Enrollment Period**. An Open Enrollment Period of at least 30 days will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2017.

   For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first day of the month following the date the Eligible Person joins the Enrolling Group. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates**.

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2017 is shown below:

Coverage Classification	Monthly Premium
EPO COB (Medi A&B) + Dependents (> 65) Employee Only	$722.28
EPO COB (Medi A&B) + Dependents (> 65) Employee plus One Dependent	$1,444.56
EPO COB (Medi A&B) + Dependents (> 65) Employee plus Family	$1,947.53
EPO COB (Medi A&B) - RS1M Employee Only	$1,162.98
EPO COB (Medi A&B) - RS1M Employee plus One Dependent	$1,162.98
EPO COB (Medi A&B) - RS1M Employee plus Family	$1,162.98
EPO COB (Medi A&B) - RSD1M Employee Only	$1,972.83
EPO COB (Medi A&B) - RSD1M Employee plus One Dependent	$1,972.83

EPO COB (Medi A&B) - RSD1M Employee plus Family $1,972.83

EPO COB (Medi A&B) - RSD2M Employee Only $809.85

EPO COB (Medi A&B) - RSD2M Employee plus One Dependent $809.85

EPO COB (Medi A&B) - RSD2M Employee plus Family $809.85

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2*.

Exhibit 2 Class 2

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description**.

   All Employees enrolled in UnitedHealthcare Select Plus Plan AKLV (Option 1).

2. **Eligibility**. The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      None

   B. Other:

      Retired Employees under 65 years of age

   Important Note Regarding Waiting or Probationary Period: Any required waiting or probationary period for newly Eligible Persons will not exceed 90 days. A waiting or probationary period may only be a condition of employment if applied equally to all Eligible Persons and Dependents and if consistent with the *Patient Protection and Affordable Care Act*. A waiting or probationary period may not be based on health status.

3. **Open Enrollment Period**. An Open Enrollment Period of at least 30 days will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2017.

   For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first day of the month following the date the Eligible Person joins the Enrolling Group. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates**.

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2017 is shown below:

Coverage Classification	**Monthly Premium**
Non-Blythe S+ Option #1 - Active Employee Only	$1,190.27
Non-Blythe S+ Option #1 - Active Employee plus One Dependent	$2,366.20
Non-Blythe S+ Option #1 - Active Employee plus Family	$3,072.08
Non-Blythe S+ Option #1 - COBRA Employee Only	$1,190.27
Non-Blythe S+ Option #1 - COBRA Employee plus One Dependent	$2,366.20
Non-Blythe S+ Option #1 - COBRA Employee plus Family	$3,072.08
Non-Blythe S+ Option #1 - AB1401 Employee Only	$ 1,309.30
Non-Blythe S+ Option #1 - AB1401 Employee plus One Dependent	$ 2,602.82

Non-Blythe S+ Option #1 - AB1401 Employee plus Family $3,379.29

Non-Blythe S+ Option #1 - ERET Employee Only $1,675.90

Non-Blythe S+ Option #1 - ERET Employee plus One Dependent $3,218.03

Non-Blythe S+ Option #1 - ERET Employee plus Family $4,325.50

Out of Area Dependent (Students) - Active Employee Only $0.02

Out of Area Dependent (Students) - Active Employee plus One Dependent $0.02

Out of Area Dependent (Students) - Active Employee plus Family $0.02

Blythe Only (Follow HMO Increase) - Active Employee Only $703.06

Blythe Only (Follow HMO Increase) - Active Employee plus One Dependent $1,397.66

Blythe Only (Follow HMO Increase) - Active Employee plus Family $1,814.64

Blythe Only (Follow HMO Increase) - COBRA Employee Only $703.06

Blythe Only (Follow HMO Increase) - COBRA Employee plus One Dependent $1,397.66

Blythe Only (Follow HMO Increase) - COBRA Employee plus Family $1,814.64

Blythe Only (Follow HMO Increase) - AB1401 Employee Only $773.37

Blythe Only (Follow HMO Increase) - AB1401 Employee plus One Dependent $1,537.43

Blythe Only (Follow HMO Increase) - AB1401 Employee plus Family $1,996.10

Blythe Only (Follow HMO Increase) - ERET Employee Only $1,084.93

Blythe Only (Follow HMO Increase) - ERET Employee plus One Dependent $2,156.78

Blythe Only (Follow HMO Increase) - ERET Employee plus Family $2,800.20

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2*.

Exhibit 2 Class 3

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description**.

   All Employees enrolled in UnitedHealthcare Select Plus Plan AKLV (Option 2).

2. **Eligibility**. The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      None

   B. Other:

      Retired Employees under 65 years of age

   Important Note Regarding Waiting or Probationary Period: Any required waiting or probationary period for newly Eligible Persons will not exceed 90 days. A waiting or probationary period may only be a condition of employment if applied equally to all Eligible Persons and Dependents and if consistent with the *Patient Protection and Affordable Care Act*. A waiting or probationary period may not be based on health status.

3. **Open Enrollment Period**. An Open Enrollment Period of at least 30 days will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2017.

   For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first day of the month following the date the Eligible Person joins the Enrolling Group. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates**.

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2017 is shown below:

Coverage Classification	**Monthly Premium**
Non-Blythe&Blythe S+ Opt#2 - COB Medi A&B - Active Employee Only	$1,014.25
Non-Blythe&Blythe S+ Opt#2 - COB Medi A&B - Active Employee plus One Dependent	$2,028.50
Non-Blythe&Blythe S+ Opt#2 - COB Medi A&B- Active Employee plus Family	$2,734.77
Non-Blythe&Blythe S+ Opt#2 Medi A&B- RS1M Employee Only	$1,675.91
Non-Blythe&Blythe S+ Opt#2 Medi A&B- RS1M Employee plus One Dependent	$1,675.91
Non-Blythe&Blythe S+ Opt#2 Medi A&B- RS1M Employee plus Family	$1,675.91
Non-Blythe&Blythe S+ Opt#2 Medi A&B - RSD1M Employee Only	$2,842.92
Non-Blythe&Blythe S+ Opt#2 Medi A&B - RSD1M Employee plus One Dependent	$2,842.92

Non-Blythe&Blythe S+ Opt#2 Medi A&B - RSD1M Employee plus Family $2,842.92

Non-Blythe&Blythe S+ Opt#2 Medi A&B - RSD2MEmployee Only $1,167.01

Non-Blythe&Blythe S+ Opt#2 Medi A&B - RSD2M Employee plus One Dependent $1,167.01

Non-Blythe&Blythe S+ Opt#2 Medi A&B - RSD2M Employee plus Family $1,167.01

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2.*

Exhibit 2 Class 4

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description**.

   All Employees enrolled in UnitedHealthcare Non-Differential PPO PUZ.

2. **Eligibility**. The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      None

   B. Other:

      Retired Employees under 65 years of age

   Important Note Regarding Waiting or Probationary Period: Any required waiting or probationary period for newly Eligible Persons will not exceed 90 days. A waiting or probationary period may only be a condition of employment if applied equally to all Eligible Persons and Dependents and if consistent with the *Patient Protection and Affordable Care Act.* A waiting or probationary period may not be based on health status.

3. **Open Enrollment Period**. An Open Enrollment Period of at least 30 days will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2017.

   For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first day of the month following the date the Eligible Person joins the Enrolling Group. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates**.

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2017 is shown below:

Coverage Classification	Monthly Premium
Non Diff "Flex Net" - COB Medi A&B Employee Only	$1,085.17
Non Diff "Flex Net" - COB Medi A&B Employee plus One Dependent	$2,170.34
Non Diff "Flex Net" - COB Medi A&B Employee plus Family	$2,926.00
Non Diff "Flex Net" COB Medi A&B- RS1M Employee Only	$1,793.09
Non Diff "Flex Net" COB Medi A&B- RS1M Employee plus One Dependent	$1,793.09
Non Diff "Flex Net" COB Medi A&B- RS1M Employee plus Family	$1,793.09
Non Diff "Flex Net" COB Medi A&B - RSD1M Employee Only	$3,041.72
Non Diff "Flex Net" COB Medi A&B - RSD1M Employee plus One Dependent	$3,041.72

Non Diff "Flex Net" COB Medi A&B - RSD1M Employee plus Family $3,041.72

Non Diff "Flex Net" COB Medi A&B - RSD2M Employee Only $1,248.63

Non Diff "Flex Net" COB Medi A&B - RSD2M Employee plus One Dependent $1,248.63

Non Diff "Flex Net" COB Medi A&B - RSD2M Employee plus Family $1,248.63

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2*.

Exhibit 3 - Miscellaneous Provisions

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 and 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	California Department of Insurance
Guarantee Association	Consumer Communications Bureau
P.O. Box 16860	300 South Spring Street
Beverly Hills, CA 90209-3319	Los Angeles, CA 90013
(323) 782-0182	(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.

Exhibit 3

Wellness Program Stipend

The Enrolling Group is eligible for a wellness stipend up to $100,000 during the Policy year for the purpose of establishing, implementing and maintaining a wellness program that increases awareness of health risks and supports behavior change.

The Enrolling Group will collaborate with our representatives to define and plan bona-fide, HIPAA compliant wellness services and program strategies:

- Awareness and Education activities may include, but are not limited to biometric screenings and health kiosks.
- Behavioral Change activities may include, but are not limited to health and wellness educational programs such as smoking cessation and Weight Watchers.
- Environmental Change activities may include but are not limited to activities such as onsite exercise classes and/or equipment.
- Incentives which encourage or reward participation in wellness programs.

The Enrolling Group will maintain and provide documentation to us of program costs and related expenditures.

Enrolling Group Location Requirement Policy Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to include a location requirement for the Enrolling Group.

The following provision is added to the Policy in *Exhibit 1*:

Enrolling Group Location Requirement. This Policy is only approved for sale if the Enrolling Group's principal business address is located within the area set forth in our rate filings. For purposes of this provision, principal business address means the physical location of the Enrolling Group's business.

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President

UnitedHealthcare Insurance Company
Group Policy
For
County of Riverside
Enrolling Group Number: 902805
Policy Effective Date: January 1, 2017

IN WITNESS WHEREOF, the parties hereto have caused their duly authorized representatives to execute the Group Policy with an effective date of January 1, 2017.

ATTEST:
Clerk of the Board
Kecia Harper

By: _____
Deputy

Date: JUL 27 2021

COUNTY OF RIVERSIDE

By: Karen S. Spiegel
Karen Spiegel, Chairwoman,
Board of Supervisors

Date: JUL 27 2021

Approved as to form:

Gregory P. Priamos
County Counsel

By: _____
Deputy County Counsel
LISA SANCHEZ

CONTRACTOR: UHC OF CALIFORNIA
dba UNITEDHEALTHCARE OF CALIFORNIA,
a California corporation

By: _____

Printed Name: Robert C. Falkenberg

Title: CEO, UHC of CA

Date: 04/05/2021

UnitedHealthcare Insurance Company

Group Policy

For

County of Riverside

Enrolling Group Number: 902805

Policy Effective Date: January 1, 2018

JUL 27 2021 3.13

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

860-702-5000

Regulated by:

California Department of Insurance

Consumer Communication Bureau

300 South Spring Street, South Tower

Los Angeles, CA 90013

1-800-927-HELP (4357)

TDD: 800-482-4833

Group Policy

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

860-702-5000

This Policy is entered into by and between UnitedHealthcare Insurance Company and the "Enrolling Group," as described in Exhibit 1.

When used in this document, the words "we," "us," and "our" are referring to UnitedHealthcare Insurance Company.

Upon our receipt of the Enrolling Group's signed application and payment of the first Policy Charge, this Policy is deemed executed.

We agree to provide Benefits for Covered Health Services set forth in this Policy, including the attached *Certificate(s) of Coverage* and *Schedule(s) of Benefits*, subject to the terms, conditions, exclusions, and limitations of this Policy. The Enrolling Group's application is made a part of this Policy.

This Policy replaces and overrules any previous agreements relating to Benefits for Covered Health Services between the Enrolling Group and us. The terms and conditions of this Policy will in turn be overruled by those of any subsequent agreements relating to Benefits for Covered Health Services between the Enrolling Group and us.

We will not be deemed or construed as an employer or plan administrator for any purpose with respect to the administration or provision of benefits under the Enrolling Group's benefit plan. We are not responsible for fulfilling any duties or obligations of an employer or plan administrator with respect to the Enrolling Group's benefit plan.

This Policy will become effective on the date specified in Exhibit 1 and will be continued in force by the timely payment of the required Policy Charges when due, subject to termination of this Policy as provided in Article 5.

When this Policy is terminated, as described in Article 5, this Policy and all Benefits under this Policy will end at 12:00 midnight on the date of termination.

This Policy is issued as described in Exhibit 1.

Issued By:

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President

Article 1: Glossary of Defined Terms

The terms used in this Policy have the same meanings given to those terms in *Section 9: Defined Terms* of the attached *Certificate(s) of Coverage*.

Coverage Classification - one of the categories of coverage described in Exhibit 2 for rating purposes (for example: Subscriber only, Subscriber and spouse, Subscriber and children, Subscriber and family).

Material Misrepresentation - any oral or written communication or conduct, or combination of communication and conduct, that is untrue and is intended to create a misleading impression in the mind of another person. A misrepresentation is material if a reasonable person would attach importance to it in making a decision or determining a course of action, including but not limited to, the issuance of a policy or coverage under a policy, calculation of rates, or payment of a claim.

Service Area - the State of California or any other geographical area within the state designated in the Policy within which Network provider services are rendered to Covered Persons for Covered Health Services.

Article 2: Benefits

Subscribers and their Enrolled Dependents are entitled to Benefits for Covered Health Services subject to the terms, conditions, limitations and exclusions set forth in the *Certificate(s) of Coverage* and *Schedule(s) of Benefits* attached to this Policy. Each *Certificate of Coverage* and *Schedule of Benefits*, including any Riders and Amendments, describes the Covered Health Services, required Copayments, and the terms, conditions, limitations and exclusions related to coverage.

We pay Benefits for Emergency Health Services that are required to stabilize or initiate treatment in an Emergency as described in the *Certificate of Coverage* and *Schedule of Benefits* to Covered Persons who receive such services outside of the Service Area.

Article 3: Premium Rates and Policy Charge

3.1 Premiums

Monthly Premiums payable by or on behalf of Covered Persons are specified in the *Schedule of Premium Rates* in Exhibit 2 of this Policy or in any attached *Notice of Change*.

We reserve the right to change the *Schedule of Premium Rates* as described in Exhibit 1 of this Policy. We also reserve the right to change the *Schedule of Premium Rates* at any time if the *Schedule of Premium Rates* was based upon a Material Misrepresentation that resulted in the Premium rates being lower than they would have been if the Material Misrepresentation had not been made. We reserve the right to change the *Schedule of Premium Rates* for this reason retroactive to the effective date of the *Schedule of Premium Rates* that was based on the Material Misrepresentation.

3.2 Computation of Policy Charge

The Policy Charge will be calculated based on the number of Subscribers in each Coverage Classification that we show in our records at the time of calculation. The Policy Charge will be calculated using the Premium rates in effect at that time. Exhibit 1 describes the way in which the Policy Charge is calculated.

3.3 Adjustments to the Policy Charge

We may make retroactive adjustments for any additions or terminations of Subscribers or changes in Coverage Classification that are not reflected in our records at the time we calculate the Policy Charge. We will not grant retroactive credit for any change occurring more than 90 days prior to the date we

received notification of the change from the Enrolling Group. We also will not grant retroactive credit for any calendar month in which a Subscriber has received Benefits.

The Enrolling Group must notify us in writing within 60 days of the effective date of enrollments, terminations, or other changes. The Enrolling Group must notify us in writing each month of any change in the Coverage Classification for any Subscriber.

If premium taxes, guarantee or uninsured fund assessments, or other governmental charges relating to or calculated in regard to Premium are either imposed or increased, those charges will automatically be added to the Premium. In addition, any change in law or regulation that significantly affects our cost of operation will result in an increase in Premium in an amount we determine.

3.4 Payment of the Policy Charge

The Policy Charge is payable to us in advance by the Enrolling Group as described under "Payment of the Policy Charge" in Exhibit 1. The first Policy Charge is due and payable on or before the effective date of this Policy. Subsequent Policy Charges are due and payable no later than the first day of each payment period specified in item 6 of Exhibit 1, while this Policy is in force.

All payments shall be made in United States dollars, in immediately available funds, and shall be remitted to us at the address set forth in the Enrolling Group's application, or at such other address as we may from time to time designate in writing. The Enrolling Group agrees not to send us payments marked "paid in full", "without recourse", or similar language. In the event that the Enrolling Group sends such a payment, we may accept it without losing any of our rights under this Policy and the Enrolling Group will remain obligated to pay any and all amounts owed to us.

A late payment charge will be assessed for any Policy Charge not received within 10 calendar days following the due date. A service charge will be assessed for any non-sufficient-fund check received in payment of the Policy Charge. All Policy Charge payments must be accompanied by supporting documentation that states the names of the Covered Persons for whom payment is being made.

The Enrolling Group must reimburse us for attorney's fees and any other costs related to collecting delinquent Policy Charges.

3.5 Grace Period

A grace period of 90 days will be granted for the payment of any Policy Charge not paid when due. During the grace period, this Policy will continue in force. The grace period will not extend beyond the date this Policy terminates.

The Enrolling Group is liable for payment of the Policy Charge during the grace period. If we receive written notice from the Enrolling Group to terminate this Policy during the grace period, we will adjust the Policy Charge so that it applies only to the number of days this Policy was in force during the grace period.

This Policy terminates as described in Article 5.1 if the grace period expires and the past due Policy Charge remains unpaid.

Article 4: Eligibility and Enrollment

4.1 Eligibility Conditions or Rules

Eligibility conditions or rules for each class are stated in the corresponding Exhibit 2. The eligibility conditions stated in Exhibit 2 are in addition to those specified in *Section 3: When Coverage Begins* of the *Certificate of Coverage*.

4.2 Initial Enrollment Period

Eligible Persons and their Dependents may enroll for coverage under this Policy during the Initial Enrollment Period. The Initial Enrollment Period is determined by the Enrolling Group.

4.3 Open Enrollment Period

An Open Enrollment Period will be provided periodically for each class, as specified in the corresponding Exhibit 2. During an Open Enrollment Period, Eligible Persons may enroll for coverage under this Policy.

4.4 Effective Date of Coverage

The effective date of coverage for properly enrolled Eligible Persons and their Dependents is stated in Exhibit 2.

4.5 Waiver Form

The Enrolling Group agrees to provide each individual who declines coverage with a form to be signed at the time they are initially eligible to enroll for coverage. The form states that an individual who declines coverage during the Initial Enrollment Period acknowledges that we may, at the time of the individual's later decision to elect coverage, consider the individual a late enrollee.

The Enrolling Group agrees to retain a copy of the individual's signed acknowledgment and forward a copy of the acknowledgment to us when requested.

Article 5: Policy Termination

5.1 Conditions for Termination of the Entire Policy

This Policy and all Benefits for Covered Health Services under this Policy will automatically terminate on the earliest of the dates specified below:

A. On the last day of the grace period if the Policy Charge remains unpaid. The Enrolling Group remains liable for payment of the Policy Charge for the period of time this Policy remained in force during the grace period.

B. On the date specified by the Enrolling Group, after at least 31 days prior written notice to us that this Policy is to be terminated.

C. On the date we specify, after at least 31 days prior written notice to the Enrolling Group, that this Policy is to be terminated due to the Enrolling Group's violation of the participation and contribution rules as shown in Exhibit 1.

D. On the date we specify, after at least 31 days prior written notice to the Enrolling Group, that this Policy is to be terminated because the Enrolling Group performed an act or practice that constituted fraud or made an intentional misrepresentation of a fact that was material to the execution of this Policy or to the provision of coverage under this Policy. In this case, we have the right to rescind this Policy back to either:

   - The effective date of this Policy.
   - The date of the act or practice, if later.

   We will send a notice to the Enrolling Group via certified mail at least 30 days prior to the effective date of the rescission explaining the reason for the rescission and notifying them of their right to appeal as described in Article 5.3. We will not rescind this Policy due to fraud or an intentional

misrepresentation of a material fact after twenty-four (24) months from the date of issuance of this Policy.

E. On the date we specify, after at least 90 days prior written notice to the Enrolling Group, that this Policy is to be terminated because we will no longer issue this particular type of group health benefit plan within the applicable market.

F. On the date we specify, after at least 180 days prior written notice to the applicable state authority and to the Enrolling Group, that this Policy is to be terminated because we will no longer issue any employer health benefit plan within the applicable market.

5.2 Payment and Reimbursement Upon Termination

Upon any termination of this Policy, the Enrolling Group is and will remain liable to us for the payment of any and all Premiums which are unpaid at the time of termination, including a pro rata portion of the Policy Charge for any period this Policy was in force during the grace period preceding the termination.

Except in the case of fraud or intentional misrepresentation of a material fact, we will refund the pro rata portion of any and all Policy Charges which have been prepaid by the Enrolling Group to reflect any reduced period of coverage at the time of termination of this Policy. The refund will be reduced by any amount paid for any claims incurred during the period this Policy was in force preceding the termination. Mid-month proration based on the eligibility rules established by the Enrolling Group will be used to refund Policy Charges. Exhibit 1 describes the way in which the Policy Charge is calculated.

5.3 Review by the California Department of Insurance for Improper Cancellation, Rescission or Non-Renewal of Coverage

You may request a review by the California Insurance Commissioner if you believe your Policy or coverage has been or will be wrongly canceled, rescinded or not renewed. Contact the California Insurance Commissioner's Consumer Communications Bureau at **1-800-927-HELP (4357)** or **TDD 1-800-482-4833** to receive assistance with this process, or submit an inquiry in writing to:

California Department of Insurance

Consumer Communications Bureau

300 S. Spring Street, South Tower

Los Angeles, CA 90013

Or through the website **http://www.insurance.ca.gov**.

Article 6: General Provisions

6.1 Entire Policy

This Policy, including the *Certificate(s) of Coverage*, the *Schedule(s) of Benefits*, the application of the Enrolling Group, and any Amendments, Notices of Change, and Riders, constitute the entire Policy between the parties, and any statement made by the Enrolling Group shall, in absence of fraud, be deemed a representation and not a warranty. No statement made by any Subscriber whose eligibility has been accepted by us shall avoid the insurance or reduce the Benefits under this Policy or be used in defense to a claim hereunder.

6.2 Dispute Resolution and Binding Arbitration Requirement

This Policy requires that disputes be resolved in binding arbitration. You are waiving your right to sue UnitedHealthcare Insurance Company in court to resolve a dispute. You are waiving your right to a jury trial.

No legal proceeding or action may be brought until the parties have attempted, in good faith, to resolve the dispute amongst themselves. In the event the dispute is not resolved within 30 days after one party has received written notice of the dispute from the other party, and either party wishes to pursue the dispute further, this applies to disputes of any kind whatsoever, including, but not limited to, claims for medical malpractice (that is, as to whether any medical services rendered under Policy were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), the dispute may be submitted to arbitration as set forth below.

The parties acknowledge that because this Policy affects interstate commerce, the *Federal Arbitration Act* applies. If the Enrolling Group wishes to seek further review of the decision or the complaint or dispute, it must submit the decision, complaint or dispute to binding arbitration pursuant to the rules of the *American Arbitration Association*. This is the only right the Enrolling Group has for further consideration of any dispute that arises out of or is related to this Policy.

If a claim for medical malpractice seeks total damages of $50,000 or less, the claim or dispute shall provide for selection by the parties of a single neutral arbitrator who shall have no jurisdiction to award more than $50,000. If the parties are unable to agree on the selection of a single arbitrator, the following method shall be utilized:

- If the arbitration agreement provides a method of appointing an arbitrator, that method shall be followed.
- If the arbitration agreement does not provide a method for appointing an arbitrator, the parties to the agreement who seek arbitration and against whom is sought may agree on a method of appointing an arbitrator and that method shall be followed.
- In the absence of an agreed method, or if the agreed method fails for any reason cannot be followed, or when an arbitrator appointed fails to act and his or her successor has not been appointed, the court, on petition of a party to the arbitration agreement, shall appoint the arbitrator. When petition is made to the court to appoint a neutral arbitrator, the court shall nominate five persons from lists of persons supplied jointly by the parties to the arbitration or obtained from a governmental agency concerned with arbitration or private disinterested association concerned with arbitration. The parties to the agreement who seek arbitration and against whom arbitration is sought may within five days of receipt of notice of the nominees from the court jointly select the arbitrator whether or not the arbitrator is among the nominees. If the parties fail to select an arbitrator within the five-day period, the court shall appoint the arbitrator from the nominees.

Arbitration will take place in Orange County, California.

The matter must be submitted to binding arbitration within one year of the date notice of the dispute was received. The arbitrators will have no power to award any punitive or exemplary damages or to vary or ignore the provisions of this Policy, and will be bound by federal and/or state law.

6.3 Amendments and Alterations

Amendments based on changes to state or federal mandates to this Policy are effective 31 days after we send written notice to the Enrolling Group. Other than changes to Exhibit 2, no change will be made to this Policy unless made by an Amendment to incorporate federal or state mandates which is signed by one of our authorized executive officers. No agent has authority to change this Policy or to waive any of its provisions.

6.4 Relationship between Parties

The relationships between us and Network providers, and relationships between us and Enrolling Groups, are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees, nor are we or any of our employees an agent or employee of Network providers or Enrolling Groups.

The relationship between a Network provider and any Covered Person is that of provider and patient. The Network provider is solely responsible for the services provided by it to any Covered Person. The relationship between any Enrolling Group and any Covered Person is that of employer and employee, Dependent, or any other category of Covered Person described in the Coverage Classifications specified in this Policy.

The Enrolling Group is solely responsible for enrollment and Coverage Classification changes (including termination of a Covered Person's coverage) and for the timely payment of the Policy Charges.

6.5 Records

The Enrolling Group must furnish us with all information and proofs which we may reasonably require with regard to any matters pertaining to this Policy. We may at any reasonable time inspect:

- All documents furnished to the Enrolling Group by an individual in connection with coverage.
- The Enrolling Group's payroll.
- Any other records pertinent to the coverage under this Policy.

By accepting Benefits under this Policy, each Covered Person authorizes and directs any person or institution that has provided services to him or her, to furnish us or our designees any and all information and records or copies of records relating to the health care services provided to the Covered Person. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form.

We agree that such information and records will be considered confidential. We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy including records necessary for appropriate medical review and quality assessment or as we are required by law or regulation.

During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy for research and analytic purposes.

6.6 Administrative Services

The services necessary to administer this Policy and the Benefits provided under it will be provided in accordance with our standard administrative procedures or those standard administrative procedures of our designee. If the Enrolling Group requests that administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, the Enrolling Group must pay for such services or reports at the then current charges for such services or reports.

We may offer to provide administrative services to the Enrolling Group for certain wellness programs including, but not limited to, fitness programs, biometric screening programs and wellness coaching programs.

6.7 Employee Retirement Income Security Act (ERISA)

When this Policy is purchased by the Enrolling Group to provide benefits under a welfare plan governed by the federal *Employee Retirement Income Security Act* 29 U.S.C., 1001 et seq., we will not be named

as, and will not be, the plan administrator or the named fiduciary of the welfare plan, as those terms are used in ERISA.

6.8 Examination of Covered Persons

In the event of a question or dispute concerning Benefits for Covered Health Services, we may reasonably require that a Network Physician, acceptable to us, examine the Covered Person at our expense.

6.9 Clerical Error

Clerical error will not deprive any individual of Benefits under this Policy or create a right to Benefits. Failure to report enrollments will not be considered a clerical error and will not result in retroactive coverage for Eligible Persons. Failure to report the termination of coverage will not continue the coverage for a Covered Person beyond the date it is scheduled to terminate according to the terms of this Policy. Upon discovery of a clerical error, any necessary appropriate adjustment in Premiums will be made. However, we will not grant any such adjustment in Premiums or coverage to the Enrolling Group for more than 90 days of coverage prior to the date we received notification of the clerical error.

6.10 Workers' Compensation Not Affected

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

6.11 Conformity with Law

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is deemed to be amended to conform to the minimum requirements of those statutes and regulations.

6.12 Notice

When we provide written notice regarding administration of this Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to Covered Persons on a timely basis.

Any notice sent to us under this Policy and any notice sent to the Enrolling Group must be addressed as described in Exhibit 1.

6.13 Continuation Coverage

We agree to provide Benefits under this Policy for those Covered Persons who are eligible to continue coverage under federal or state law, as described in *Section 4: When Coverage Ends* of the *Certificate of Coverage*.

Federal Continuation Coverage

We will not provide any administrative duties with respect to the Enrolling Group's compliance with federal law. All duties of the plan sponsor or plan administrator required by federal law remain the sole responsibility of the Enrolling Group, including but not limited to notification of COBRA continuation rights and billing and collection of Premium.

Extension of Continuation Coverage under State Law (Cal-COBRA) after Exhaustion of Federal COBRA Continuation Coverage

We will provide all administrative duties required by Cal-COBRA, including but not limited to, notifications to affected Covered Persons and billing and collection of Premium.

6.14 Certification of Coverage Forms

As required by the federal *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, we will produce certification of coverage forms for Covered Persons who lose coverage under this Policy. The Enrolling Group agrees to provide us with all necessary eligibility and termination data. Certification of coverage forms will be based on eligibility and termination data that the Enrolling Group provides to our eligibility systems in accordance with our data specifications, and which is available in our eligibility systems as of the date the form is generated. The certification of coverage forms will only include periods of coverage that we administer under this Policy.

6.15 Subscriber's Individual Certificate

We will issue *Certificate(s) of Coverage*, *Schedule(s) of Benefits*, and any attachments to the Enrolling Group for delivery to each covered Subscriber. The *Certificate(s) of Coverage*, *Schedule(s) of Benefits*, and any attachments will show the Benefits and other provisions of this Policy. In addition, you may have access to your *Certificate(s) of Coverage* and *Schedule(s) of Benefits* online at www.myuhc.com.

6.16 Summary of Benefits and Coverage

We will provide a *Summary of Benefits and Coverage* (*"SBC"*), as required by the *Affordable Care Act* and associated regulations (*"ACA"*), to the Enrolling Group for each benefit plan purchased by the Enrolling Group. The Enrolling Group shall be responsible for delivering the *SBC* to all Covered Persons and to other persons eligible for coverage in the manner and at the times required by the *ACA*, unless we notify the Enrolling Group that we will deliver the *SBC* to Covered Persons and other persons eligible for coverage.

6.17 System Access

The term "systems" as used in this provision means our systems that we make available to the Enrolling Group to facilitate the transfer of information in connection with this Policy.

System Access

We grant the Enrolling Group the nonexclusive, nontransferable right to access and use the functionalities contained within the systems, under the terms set forth in this Policy. The Enrolling Group agrees that all rights, title and interest in the systems and all rights in patents, copyrights, trademarks and trade secrets encompassed in the systems will remain ours. In order to obtain access to the systems, the Enrolling Group will obtain, and be responsible for maintaining, at no expense to us, the hardware, software and Internet browser requirements we provide to the Enrolling Group, including any amendments to those requirements. The Enrolling Group is responsible for obtaining an internet service provider or other access to the Internet.

The Enrolling Group will not:

- Access systems or use, copy, reproduce, modify, or excerpt any of the systems documentation provided by us in order to access or utilize systems, for purposes other than as expressly permitted under this Policy.
- Share, transfer or lease its right to access and use systems, to any other person or entity which is not a party to this Policy.

The Enrolling Group may designate any third party to access systems on its behalf, provided the third party agrees to these terms and conditions of systems access and the Enrolling Group assumes joint responsibility for such access.

Security Procedures

The Enrolling Group will use commercially reasonable physical and software-based measures, and comply with our security procedures, as may be amended from time to time, to protect the system, its functionalities, and data accessed through systems from any unauthorized access or damage (including damage caused by computer viruses). The Enrolling Group will notify us immediately if any breach of the security procedures, such as unauthorized use, is suspected.

System Access Termination

We reserve the right to terminate the Enrolling Group's system access:

- On the date the Enrolling Group fails to accept the hardware, software and browser requirements provided by us, including any amendments to the requirements.
- Immediately on the date we reasonably determine that the Enrolling Group has breached, or allowed a breach of, any applicable provision of this Policy. Upon termination of this Policy, the Enrolling Group agrees to cease all use of systems, and we will deactivate the Enrolling Group's identification numbers and passwords and access to the system.

6.18 Important Notice - Disputes

Should a dispute concerning your coverage arise, contact us first. If the dispute is not resolved, contact the California Department of Insurance.

Call us at the phone number shown on your ID card.

Call the **California Department of Insurance** at:

- **1-800-927-HELP (1-800-927-4357)** in the State of California.
- **213-897-8921** outside of the State of California.

You may write the California Department of Insurance at:

California Department of Insurance

Claims Services Bureau, 11th Floor

300 South Spring Street

Los Angeles, CA 90013

6.19 Notice of Network Provider Termination

We will provide written notice to the Enrolling Group, within a reasonable period of time, if we receive notice that any Network provider in the Service Area terminates or breaches its contract with us, or is unable to perform such contract, if the termination, breach, or inability to perform may materially and adversely affect the Enrolling Group or Covered Persons.

When we provide such written notice of Network provider termination to the Enrolling Group, the Enrolling Group is responsible for distributing the substance of the notice to all affected Subscribers and their Enrolled Dependents no later than 30 days after its receipt.

6.20 Liability for Continued Treatment by Terminated Network Provider

If, upon termination of a Network provider's contract as described in Article 6.19, a Covered Person is under the care of a terminated Network provider for one of the medical conditions described in the *Continuity of Care* provision in the *Schedule of Benefits*, we will be liable for continuation of Covered Health Services rendered by the provider until such services are completed, unless reasonable and medically appropriate arrangements for assumption of such Covered Health Services are made by another Network provider. Copayments, deductibles, or other cost sharing components will be the same as the Covered Person would have paid for a Network provider currently contracting with us.

This section does not apply to treatment by a provider or provider group whose contract with us has terminated or not renewed for reasons relating to medical disciplinary cause or reason, fraud or other criminal activity.

Exhibit 1

1. **Parties**. The parties to this Policy are UnitedHealthcare Insurance Company and County of Riverside, the Enrolling Group.

2. **Effective Date of this Policy**. The effective date of this Policy is 12:01 a.m. on January 1, 2018 in the time zone of the Enrolling Group's location.

3. **Place of Issuance**. We are delivering this Policy in the State of California. This Policy is governed by ERISA. To the extent that state law applies, the laws of the State of California are the laws that govern this Policy.

4. **Premiums**. We reserve the right to change the *Schedule of Premium Rates* specified in each Exhibit 2, after a 45-day prior written notice at any time.

5. **Computation of Policy Charge**. A full calendar month's Premiums will be charged for Covered Persons whose effective date of coverage falls on or before the 15th of that calendar month. No Premiums will be charged for Covered Persons whose effective date of coverage falls after the 15th of that calendar month. A full calendar month's Premiums will be charged for Covered Persons whose coverage is terminated after the 15th of that calendar month. No Premiums will be charged for Covered Persons whose coverage is terminated on or before the 15th of that calendar month.

6. **Payment of the Policy Charge**. The Policy Charge is payable to us in advance by the Enrolling Group on a monthly basis.

7. **Minimum Participation Requirement**. The minimum participation requirement for the Enrolling Group is 75% of Eligible Persons excluding spousal waivers but no less than 50% of all Eligible Persons must be enrolled for coverage under this Policy.

8. **Minimum Contribution Requirement**. The Enrolling Group must maintain a minimum contribution requirement of 50% of the Premium for each Eligible Person.

9. **Notice**. Any notice sent to us under this Policy must be addressed to:

   UnitedHealthcare Insurance Company

   185 Asylum Street

   Hartford, Connecticut 06103-0450

   Any notice sent to the Enrolling Group under this Policy must be addressed to:

   County of Riverside

   4080 Lemon Street

   Riverside, California 92501

10. 902805: Enrolling Group Number

Exhibit 2 Class 1

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description**.

   All Employees enrolled in UnitedHealthcare Choice Plan AKMS.

2. **Eligibility**. The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      None

   B. Other:

      Retired Employees under 65 years of age

   Important Note Regarding Waiting or Probationary Period: Any required waiting or probationary period for newly Eligible Persons will not exceed 90 days. A waiting or probationary period may only be a condition of employment if applied equally to all Eligible Persons and Dependents and if consistent with the *Patient Protection and Affordable Care Act*. A waiting or probationary period may not be based on health status.

3. **Open Enrollment Period**. An Open Enrollment Period of at least 30 days will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2018.

   For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first day of the month following the date the Eligible Person joins the Enrolling Group. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates**.

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2018 is shown below:

Coverage Classification	Monthly Premium
EPO COB (Medi A&B) + Dependents (> 65) Employee Only	$878.33
EPO COB (Medi A&B) + Dependents (> 65) Employee plus One Dependent	$1,756.66
EPO COB (Medi A&B) + Dependents (> 65) Employee plus Family	$2,368.30
EPO COB (Medi A&B) - RS1M Employee Only	$1,414.24
EPO COB (Medi A&B) - RS1M Employee plus One Dependent	$1,414.24
EPO COB (Medi A&B) - RS1M Employee plus Family	$1,414.24
EPO COB (Medi A&B) - RSD1M Employee Only	$2,399.08
EPO COB (Medi A&B) - RSD1M Employee plus One Dependent	$2,399.08
EPO COB (Medi A&B) - RSD1M Employee plus Family	$2,399.08

EPO COB (Medi A&B) - RSD2M Employee Only $984.84

EPO COB (Medi A&B) - RSD2M Employee plus One Dependent $984.84

EPO COB (Medi A&B) - RSD2M Employee plus Family $984.84

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2.*

Exhibit 2 Class 2

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description**.

   All Employees enrolled in UnitedHealthcare Choice Plus Plan AKLV (Option 1).

2. **Eligibility**. The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      None

   B. Other:

      Retired Employees under 65 years of age

   Important Note Regarding Waiting or Probationary Period: Any required waiting or probationary period for newly Eligible Persons will not exceed 90 days. A waiting or probationary period may only be a condition of employment if applied equally to all Eligible Persons and Dependents and if consistent with the *Patient Protection and Affordable Care Act*. A waiting or probationary period may not be based on health status.

3. **Open Enrollment Period**. An Open Enrollment Period of at least 30 days will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2018.

   For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first day of the month following the date the Eligible Person joins the Enrolling Group. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates**.

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2018 is shown below:

Coverage Classification	Monthly Premium
Non-Blythe S+ Option #1 - Active Employee Only	$1,447.43
Non-Blythe S+ Option #1 - Active Employee plus One Dependent	$2,877.42
Non-Blythe S+ Option #1 - Active Employee plus Family	$3,735.81
Non-Blythe S+ Option #1 - COBRA Employee Only	$1,447.43
Non-Blythe S+ Option #1 - COBRA Employee plus One Dependent	$2,877.42
Non-Blythe S+ Option #1 - COBRA Employee plus Family	$3,735.81
Non-Blythe S+ Option #1 - AB1401 Employee Only	$1,592.17
Non-Blythe S+ Option #1 - AB1401 Employee plus One Dependent	$3,165.16
Non-Blythe S+ Option #1 - AB1401 Employee plus Family	$4,109.39

Non-Blythe S+ Option #1 - ERET Employee Only$2,037.98

Non-Blythe S+ Option #1 - ERET Employee plus One Dependent $3,913.29

Non-Blythe S+ Option #1 - ERET Employee plus Family $5,260.03

Out of Area Dependent (Students) - Employee Only $0.02

Out of Area Dependent (Students) - Employee plus One Dependent $0.02

Out of Area Dependent (Students) - Employee plus Family $0.02

Blythe Only (Follow HMO Increase) - Active Employee Only $818.25

Blythe Only (Follow HMO Increase) - Active Employee plus One Dependent $1,668.90

Blythe Only (Follow HMO Increase) - Active Employee plus Family $2,166.79

Blythe Only (Follow HMO Increase) - COBRA Employee Only $818.25

Blythe Only (Follow HMO Increase) - COBRA Employee plus One Dependent $1,668.90

Blythe Only (Follow HMO Increase) - COBRA Employee plus Family $2,166.79

Blythe Only (Follow HMO Increase) - AB1401 Employee Only $900.08

Blythe Only (Follow HMO Increase) - AB1401 Employee plus One Dependent $1,835.79

Blythe Only (Follow HMO Increase) - AB1401 Employee plus Family $2,383.46

Blythe Only (Follow HMO Increase) - ERET Employee Only $1,280.21

Blythe Only (Follow HMO Increase) - ERET Employee plus One Dependent $2,545.00

Blythe Only (Follow HMO Increase) - ERET Employee plus Family $3,304.24

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2.*

Exhibit 2 Class 3

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description.**

   All Employees enrolled in UnitedHealthcare Choice Plus Plan AKLV (Option 2).

2. **Eligibility**. The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      None

   B. Other:

      Retired Employees under 65 years of age

   Important Note Regarding Waiting or Probationary Period: Any required waiting or probationary period for newly Eligible Persons will not exceed 90 days. A waiting or probationary period may only be a condition of employment if applied equally to all Eligible Persons and Dependents and if consistent with the *Patient Protection and Affordable Care Act*. A waiting or probationary period may not be based on health status.

3. **Open Enrollment Period**. An Open Enrollment Period of at least 30 days will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2018.

   For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first day of the month following the date the Eligible Person joins the Enrolling Group. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates**.

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2018 is shown below:

Coverage Classification	Monthly Premium
Non-Blythe&Blythe S+ Opt#2 - COB Medi A&B Employee Only	$1,233.38
Non-Blythe&Blythe S+ Opt#2 - COB Medi A&B Employee plus One Dependent	$2,466.76
Non-Blythe&Blythe S+ Opt#2 - COB Medi A&B Employee plus Family	$3,325.62
Non-Blythe&Blythe S+ Opt#2 Medi A&B- RS1M Employee Only	$2,037.99
Non-Blythe&Blythe S+ Opt#2 Medi A&B- RS1M Employee plus One Dependent	$2,037.99
Non-Blythe&Blythe S+ Opt#2 Medi A&B- RS1M Employee plus Family	$2,037.99
Non-Blythe&Blythe S+ Opt#2 Medi A&B - RSD1M Employee Only	$3,457.13
Non-Blythe&Blythe S+ Opt#2 Medi A&B - RSD1M Employee plus One Dependent	$3,457.13
Non-Blythe&Blythe S+ Opt#2 Medi A&B - RSD1M Employee plus Family	$3,457.13

Non-Blythe&Blythe S+ Opt#2 Medi A&B - RSD2M Employee Only $1,419.14

Non-Blythe&Blythe S+ Opt#2 Medi A&B - RSD2M Employee plus One Dependent $1,419.14

Non-Blythe&Blythe S+ Opt#2 Medi A&B - RSD2M Employee plus Family $1,419.14

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2.*

Exhibit 2 Class 4

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description**.

   All Employees enrolled in UnitedHealthcare Non-Differential PPO Plan PUZ.

2. **Eligibility**. The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      None

   B. Other:

      Retired Employees under 65 years of age

   Important Note Regarding Waiting or Probationary Period: Any required waiting or probationary period for newly Eligible Persons will not exceed 90 days. A waiting or probationary period may only be a condition of employment if applied equally to all Eligible Persons and Dependents and if consistent with the *Patient Protection and Affordable Care Act*. A waiting or probationary period may not be based on health status.

3. **Open Enrollment Period**. An Open Enrollment Period of at least 30 days will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2018.

   For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first day of the month following the date the Eligible Person joins the Enrolling Group. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates**.

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2018 is shown below:

Coverage Classification	Monthly Premium
Non Diff "Flex Net" - COB Medi A&B Employee Only	$1,319.62
Non Diff "Flex Net" - COB Medi A&B Employee plus One Dependent	$2,639.24
Non Diff "Flex Net" - COB Medi A&B Employee plus Family	$3,558.16
Non Diff "Flex Net" COB Medi A&B- RS1M Employee Only	$2,180.49
Non Diff "Flex Net" COB Medi A&B- RS1M Employee plus One Dependent	$2,180.49
Non Diff "Flex Net" COB Medi A&B- RS1M Employee plus Family	$2,180.49
Non Diff "Flex Net" COB Medi A&B - RSD1M Employee Only	$3,698.87
Non Diff "Flex Net" COB Medi A&B - RSD1M Employee plus One Dependent	$3,698.87
Non Diff "Flex Net" COB Medi A&B - RSD1M Employee plus Family	$3,698.87

Non Diff "Flex Net" COB Medi A&B - RSD2M Employee Only $1,518.38

Non Diff "Flex Net" COB Medi A&B - RSD2M Employee plus One Dependent $1,518.38

Non Diff "Flex Net" COB Medi A&B - RSD2M Employee plus Family $1,518.38

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2.*

Exhibit 3 - Miscellaneous Provisions

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 and 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	California Department of Insurance
Guarantee Association	Consumer Communications Bureau
P.O. Box 16860	300 South Spring Street
Beverly Hills, CA 90209-3319	Los Angeles, CA 90013
(323) 782-0182	(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.

Exhibit 4

Wellness Program Stipend

The Enrolling Group is eligible for a wellness stipend up to $100,000 during the Policy year for the purpose of establishing, implementing and maintaining a wellness program that increases awareness of health risks and supports behavior change.

The Enrolling Group will collaborate with our representatives to define and plan bona-fide, HIPAA compliant wellness services and program strategies:

- Awareness and Education activities may include, but are not limited to biometric screenings and health kiosks.
- Behavioral Change activities may include, but are not limited to health and wellness educational programs such as smoking cessation and Weight Watchers.
- Environmental Change activities may include but are not limited to activities such as onsite exercise classes and/or equipment.
- Incentives which encourage or reward participation in wellness programs.

The Enrolling Group will maintain and provide documentation to us of program costs and related expenditures.

Enrolling Group Location Requirement Policy Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to include a location requirement for the Enrolling Group.

The following provision is added to the Policy in *Exhibit 1*:

Enrolling Group Location Requirement. This Policy is only approved for sale if the Enrolling Group's principal business address is located within the area set forth in our rate filings. For purposes of this provision, principal business address means the physical location of the Enrolling Group's business.

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President

UnitedHealthcare Insurance Company
Group Policy
For
County of Riverside
Enrolling Group Number: 902805
Policy Effective Date: January 1, 2018

IN WITNESS WHEREOF, the parties hereto have caused their duly authorized representatives to execute the Group Policy with an effective date of January 1, 2018.

ATTEST:
Clerk of the Board
Kecia Harper

By: _____
Deputy

Date: JUL 27 2021

COUNTY OF RIVERSIDE

By: Karen S. Spiegel
Karen Spiegel, Chairwoman,
Board of Supervisors

Date: JUL 27 2021

Approved as to form:

Gregory P. Priamos
County Counsel

By: _____
Deputy County Counsel
LISA SANCHEZ

CONTRACTOR: UHC OF CALIFORNIA
dba UNITEDHEALTHCARE OF CALIFORNIA,
a California corporation

By: _____

Printed Name: Robert C. Falkenberg

Title: CEO, UHC of CA

Date: 04/05/2021

UnitedHealthcare Insurance Company

Group Policy

For

County of Riverside

Enrolling Group Number: 902805

Policy Effective Date: January 1, 2019

JUL 27 2021 3.13

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

860-702-5000

Regulated by:

California Department of Insurance

Consumer Communication Bureau

300 South Spring Street, South Tower

Los Angeles, CA 90013

1-800-927-HELP (4357)

TDD: 800-482-4833

Group Policy

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

860-702-5000

This Policy is entered into by and between UnitedHealthcare Insurance Company and the "Enrolling Group," as described in Exhibit 1.

When used in this document, the words "we," "us," and "our" are referring to UnitedHealthcare Insurance Company.

Upon our receipt of the Enrolling Group's signed application and payment of the first Policy Charge, this Policy is deemed executed.

We agree to provide Benefits for Covered Health Services set forth in this Policy, including the attached *Certificate(s) of Coverage* and *Schedule(s) of Benefits*, subject to the terms, conditions, exclusions, and limitations of this Policy. The Enrolling Group's application is made a part of this Policy.

This Policy replaces and overrules any previous agreements relating to Benefits for Covered Health Services between the Enrolling Group and us. The terms and conditions of this Policy will in turn be overruled by those of any subsequent agreements relating to Benefits for Covered Health Services between the Enrolling Group and us.

We will not be deemed or construed as an employer or plan administrator for any purpose with respect to the administration or provision of benefits under the Enrolling Group's benefit plan. We are not responsible for fulfilling any duties or obligations of an employer or plan administrator with respect to the Enrolling Group's benefit plan.

This Policy will become effective on the date specified in Exhibit 1 and will be continued in force by the timely payment of the required Policy Charges when due, subject to termination of this Policy as provided in Article 5.

When this Policy is terminated, as described in Article 5, this Policy and all Benefits under this Policy will end at 12:00 midnight on the date of termination.

This Policy is issued as described in Exhibit 1.

Issued By:

UNITEDHEALTHCARE INSURANCE COMPANY

William J Golden, President

Article 1: Glossary of Defined Terms

The terms used in this Policy have the same meanings given to those terms in *Section 9: Defined Terms* of the attached *Certificate(s) of Coverage*.

Coverage Classification - one of the categories of coverage described in Exhibit 2 for rating purposes (for example: Subscriber only, Subscriber and spouse, Subscriber and children, Subscriber and family).

Material Misrepresentation - any oral or written communication or conduct, or combination of communication and conduct, that is untrue and is intended to create a misleading impression in the mind of another person. A misrepresentation is material if a reasonable person would attach importance to it in making a decision or determining a course of action, including but not limited to, the issuance of a policy or coverage under a policy, calculation of rates, or payment of a claim.

Service Area - the State of California or any other geographical area within the state designated in the Policy within which Network provider services are rendered to Covered Persons for Covered Health Services.

Article 2: Benefits

Subscribers and their Enrolled Dependents are entitled to Benefits for Covered Health Services subject to the terms, conditions, limitations and exclusions set forth in the *Certificate(s) of Coverage* and *Schedule(s) of Benefits* attached to this Policy. Each *Certificate of Coverage* and *Schedule of Benefits*, including any Riders and Amendments, describes the Covered Health Services, required Copayments, and the terms, conditions, limitations and exclusions related to coverage.

We pay Benefits for Emergency Health Services that are required to stabilize or initiate treatment in an Emergency as described in the *Certificate of Coverage* and *Schedule of Benefits* to Covered Persons who receive such services outside of the Service Area.

Article 3: Premium Rates and Policy Charge

3.1 Premiums

Monthly Premiums payable by or on behalf of Covered Persons are specified in the *Schedule of Premium Rates* in Exhibit 2 of this Policy or in any attached *Notice of Change*.

We reserve the right to change the *Schedule of Premium Rates* as described in Exhibit 1 of this Policy. We also reserve the right to change the *Schedule of Premium Rates* at any time if the *Schedule of Premium Rates* was based upon a Material Misrepresentation that resulted in the Premium rates being lower than they would have been if the Material Misrepresentation had not been made. We reserve the right to change the *Schedule of Premium Rates* for this reason retroactive to the effective date of the *Schedule of Premium Rates* that was based on the Material Misrepresentation.

3.2 Computation of Policy Charge

The Policy Charge will be calculated based on the number of Subscribers in each Coverage Classification that we show in our records at the time of calculation. The Policy Charge will be calculated using the Premium rates in effect at that time. Exhibit 1 describes the way in which the Policy Charge is calculated.

3.3 Adjustments to the Policy Charge

We may make retroactive adjustments for any additions or terminations of Subscribers or changes in Coverage Classification that are not reflected in our records at the time we calculate the Policy Charge. We will not grant retroactive credit for any change occurring more than 90 days prior to the date we

received notification of the change from the Enrolling Group. We also will not grant retroactive credit for any calendar month in which a Subscriber has received Benefits.

The Enrolling Group must notify us in writing within 60 days of the effective date of enrollments, terminations, or other changes. The Enrolling Group must notify us in writing each month of any change in the Coverage Classification for any Subscriber.

If premium taxes, guarantee or uninsured fund assessments, or other governmental charges relating to or calculated in regard to Premium are either imposed or increased, those charges will automatically be added to the Premium. In addition, any change in law or regulation that significantly affects our cost of operation will result in an increase in Premium in an amount we determine.

3.4 Payment of the Policy Charge

The Policy Charge is payable to us in advance by the Enrolling Group as described under "Payment of the Policy Charge" in Exhibit 1. The first Policy Charge is due and payable on or before the effective date of this Policy. Subsequent Policy Charges are due and payable no later than the first day of each payment period specified in item 6 of Exhibit 1, while this Policy is in force.

All payments shall be made in United States dollars, in immediately available funds, and shall be remitted to us at the address set forth in the Enrolling Group's application, or at such other address as we may from time to time designate in writing. The Enrolling Group agrees not to send us payments marked "paid in full", "without recourse", or similar language. In the event that the Enrolling Group sends such a payment, we may accept it without losing any of our rights under this Policy and the Enrolling Group will remain obligated to pay any and all amounts owed to us.

A late payment charge will be assessed for any Policy Charge not received within 10 calendar days following the due date. A service charge will be assessed for any non-sufficient-fund check received in payment of the Policy Charge. All Policy Charge payments must be accompanied by supporting documentation that states the names of the Covered Persons for whom payment is being made.

The Enrolling Group must reimburse us for attorney's fees and any other costs related to collecting delinquent Policy Charges.

3.5 Grace Period

A grace period of 90 days will be granted for the payment of any Policy Charge not paid when due. During the grace period, this Policy will continue in force. The grace period will not extend beyond the date this Policy terminates.

The Enrolling Group is liable for payment of the Policy Charge during the grace period. If we receive written notice from the Enrolling Group to terminate this Policy during the grace period, we will adjust the Policy Charge so that it applies only to the number of days this Policy was in force during the grace period.

This Policy terminates as described in Article 5.1 if the grace period expires and the past due Policy Charge remains unpaid.

Article 4: Eligibility and Enrollment

4.1 Eligibility Conditions or Rules

Eligibility conditions or rules for each class are stated in the corresponding Exhibit 2. The eligibility conditions stated in Exhibit 2 are in addition to those specified in *Section 3: When Coverage Begins* of the *Certificate of Coverage*.

4.2 Initial Enrollment Period

Eligible Persons and their Dependents may enroll for coverage under this Policy during the Initial Enrollment Period. The Initial Enrollment Period is determined by the Enrolling Group.

4.3 Open Enrollment Period

An Open Enrollment Period will be provided periodically for each class, as specified in the corresponding Exhibit 2. During an Open Enrollment Period, Eligible Persons may enroll for coverage under this Policy.

4.4 Effective Date of Coverage

The effective date of coverage for properly enrolled Eligible Persons and their Dependents is stated in Exhibit 2.

4.5 Waiver Form

The Enrolling Group agrees to provide each individual who declines coverage with a form to be signed at the time they are initially eligible to enroll for coverage. The form states that an individual who declines coverage during the Initial Enrollment Period acknowledges that we may, at the time of the individual's later decision to elect coverage, consider the individual a late enrollee.

The Enrolling Group agrees to retain a copy of the individual's signed acknowledgment and forward a copy of the acknowledgment to us when requested.

Article 5: Policy Termination

5.1 Conditions for Termination of the Entire Policy

This Policy and all Benefits for Covered Health Services under this Policy will automatically terminate on the earliest of the dates specified below:

A. On the last day of the grace period if the Policy Charge remains unpaid. The Enrolling Group remains liable for payment of the Policy Charge for the period of time this Policy remained in force during the grace period.

B. On the date specified by the Enrolling Group, after at least 31 days prior written notice to us that this Policy is to be terminated.

C. On the date we specify, after at least 31 days prior written notice to the Enrolling Group, that this Policy is to be terminated due to the Enrolling Group's violation of the participation or contribution rules as shown in Exhibit 1.

D. On the date we specify, after at least 31 days prior written notice to the Enrolling Group, that this Policy is to be terminated because the Enrolling Group performed an act or practice that constituted fraud or made an intentional misrepresentation of a fact that was material to the execution of this Policy or to the provision of coverage under this Policy. In this case, we have the right to rescind this Policy back to either:

   - The effective date of this Policy.
   - The date of the act or practice, if later.

   We will send a notice to the Enrolling Group via certified mail at least 30 days prior to the effective date of the rescission explaining the reason for the rescission and notifying them of their right to appeal as described in Article 5.3. We will not rescind this Policy due to fraud or an intentional

misrepresentation of a material fact after twenty-four (24) months from the date of issuance of this Policy.

E. On the date we specify, after at least 90 days prior written notice to the Enrolling Group, that this Policy is to be terminated because we will no longer issue this particular type of group health benefit plan within the applicable market.

F. On the date we specify, after at least 180 days prior written notice to the applicable state authority and to the Enrolling Group, that this Policy is to be terminated because we will no longer issue any employer health benefit plan within the applicable market.

5.2 Payment and Reimbursement Upon Termination

Upon any termination of this Policy, the Enrolling Group is and will remain liable to us for the payment of any and all Premiums which are unpaid at the time of termination, including a pro rata portion of the Policy Charge for any period this Policy was in force during the grace period preceding the termination.

Except in the case of fraud or intentional misrepresentation of a material fact, we will refund the pro rata portion of any and all Policy Charges which have been prepaid by the Enrolling Group to reflect any reduced period of coverage at the time of termination of this Policy. The refund will be reduced by any amount paid for any claims incurred during the period this Policy was in force preceding the termination. Mid-month proration based on the eligibility rules established by the Enrolling Group will be used to refund Policy Charges. Exhibit 1 describes the way in which the Policy Charge is calculated.

5.3 Review by the California Department of Insurance for Improper Cancellation, Rescission or Non-Renewal of Coverage

You may request a review by the California Insurance Commissioner if you believe your Policy or coverage has been or will be wrongly canceled, rescinded or not renewed. Contact the California Insurance Commissioner's Consumer Communications Bureau at **1-800-927-HELP (4357)** or **TDD 1-800-482-4833** to receive assistance with this process, or submit an inquiry in writing to:

California Department of Insurance

Consumer Communications Bureau

300 S. Spring Street, South Tower

Los Angeles, CA 90013

Or through the website **http://www.insurance.ca.gov**.

Article 6: General Provisions

6.1 Entire Policy

This Policy, including the *Certificate(s) of Coverage*, the *Schedule(s) of Benefits*, the application of the Enrolling Group, and any Amendments, Notices of Change, and Riders, constitute the entire Policy between the parties, and any statement made by the Enrolling Group shall, in absence of fraud, be deemed a representation and not a warranty. No statement made by any Subscriber whose eligibility has been accepted by us shall avoid the insurance or reduce the Benefits under this Policy or be used in defense to a claim hereunder.

6.2 Dispute Resolution and Binding Arbitration Requirement

This Policy requires that disputes be resolved in binding arbitration. You are waiving your right to sue UnitedHealthcare Insurance Company in court to resolve a dispute. You are waiving your right to a jury trial.

No legal proceeding or action may be brought until the parties have attempted, in good faith, to resolve the dispute amongst themselves. In the event the dispute is not resolved within 30 days after one party has received written notice of the dispute from the other party, and either party wishes to pursue the dispute further, this applies to disputes of any kind whatsoever, including, but not limited to, claims for medical malpractice (that is, as to whether any medical services rendered under Policy were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), the dispute may be submitted to arbitration as set forth below.

The parties acknowledge that because this Policy affects interstate commerce, the *Federal Arbitration Act* applies. If the Enrolling Group wishes to seek further review of the decision or the complaint or dispute, it must submit the decision, complaint or dispute to binding arbitration pursuant to the rules of the *American Arbitration Association*. This is the only right the Enrolling Group has for further consideration of any dispute that arises out of or is related to this Policy.

If a claim for medical malpractice seeks total damages of $50,000 or less, the claim or dispute shall provide for selection by the parties of a single neutral arbitrator who shall have no jurisdiction to award more than $50,000. If the parties are unable to agree on the selection of a single arbitrator, the following method shall be utilized:

- If the arbitration agreement provides a method of appointing an arbitrator, that method shall be followed.
- If the arbitration agreement does not provide a method for appointing an arbitrator, the parties to the agreement who seek arbitration and against whom is sought may agree on a method of appointing an arbitrator and that method shall be followed.
- In the absence of an agreed method, or if the agreed method fails for any reason cannot be followed, or when an arbitrator appointed fails to act and his or her successor has not been appointed, the court, on petition of a party to the arbitration agreement, shall appoint the arbitrator. When petition is made to the court to appoint a neutral arbitrator, the court shall nominate five persons from lists of persons supplied jointly by the parties to the arbitration or obtained from a governmental agency concerned with arbitration or private disinterested association concerned with arbitration. The parties to the agreement who seek arbitration and against whom arbitration is sought may within five days of receipt of notice of the nominees from the court jointly select the arbitrator whether or not the arbitrator is among the nominees. If the parties fail to select an arbitrator within the five-day period, the court shall appoint the arbitrator from the nominees.

Arbitration will take place in Orange County, California.

The matter must be submitted to binding arbitration within one year of the date notice of the dispute was received. The arbitrators will have no power to award any punitive or exemplary damages or to vary or ignore the provisions of this Policy, and will be bound by federal and/or state law.

6.3 Amendments and Alterations

Amendments based on changes to state or federal mandates to this Policy are effective 31 days after we send written notice to the Enrolling Group. Other than changes to Exhibit 2, no change will be made to this Policy unless made by an Amendment to incorporate federal or state mandates which is signed by one of our authorized executive officers. No agent has authority to change this Policy or to waive any of its provisions.

6.4 Relationship between Parties

The relationships between us and Network providers, and relationships between us and Enrolling Groups, are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees, nor are we or any of our employees an agent or employee of Network providers or Enrolling Groups.

The relationship between a Network provider and any Covered Person is that of provider and patient. The Network provider is solely responsible for the services provided by it to any Covered Person. The relationship between any Enrolling Group and any Covered Person is that of employer and employee, Dependent, or any other category of Covered Person described in the Coverage Classifications specified in this Policy.

The Enrolling Group is solely responsible for enrollment and Coverage Classification changes (including termination of a Covered Person's coverage) and for the timely payment of the Policy Charges.

6.5 Records

The Enrolling Group must furnish us with all information and proofs which we may reasonably require with regard to any matters pertaining to this Policy. We may at any reasonable time inspect:

- All documents furnished to the Enrolling Group by an individual in connection with coverage.
- The Enrolling Group's payroll.
- Any other records pertinent to the coverage under this Policy.

By accepting Benefits under this Policy, each Covered Person authorizes and directs any person or institution that has provided services to him or her, to furnish us or our designees any and all information and records or copies of records relating to the health care services provided to the Covered Person. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form.

We agree that such information and records will be considered confidential. We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy including records necessary for appropriate medical review and quality assessment or as we are required by law or regulation.

During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy for research and analytic purposes.

6.6 Administrative Services

The services necessary to administer this Policy and the Benefits provided under it will be provided in accordance with our standard administrative procedures or those standard administrative procedures of our designee. If the Enrolling Group requests that administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, the Enrolling Group must pay for such services or reports at the then current charges for such services or reports.

We may offer to provide administrative services to the Enrolling Group for certain wellness programs including, but not limited to, fitness programs, biometric screening programs and wellness coaching programs.

6.7 Employee Retirement Income Security Act (ERISA)

When this Policy is purchased by the Enrolling Group to provide benefits under a welfare plan governed by the federal *Employee Retirement Income Security Act* 29 U.S.C., 1001 et seq., we will not be named

as, and will not be, the plan administrator or the named fiduciary of the welfare plan, as those terms are used in ERISA.

6.8 Examination of Covered Persons

In the event of a question or dispute concerning Benefits for Covered Health Services, we may reasonably require that a Network Physician, acceptable to us, examine the Covered Person at our expense.

6.9 Clerical Error

Clerical error will not deprive any individual of Benefits under this Policy or create a right to Benefits. Failure to report enrollments will not be considered a clerical error and will not result in retroactive coverage for Eligible Persons. Failure to report the termination of coverage will not continue the coverage for a Covered Person beyond the date it is scheduled to terminate according to the terms of this Policy. Upon discovery of a clerical error, any necessary appropriate adjustment in Premiums will be made. However, we will not grant any such adjustment in Premiums or coverage to the Enrolling Group for more than 90 days of coverage prior to the date we received notification of the clerical error.

6.10 Workers' Compensation Not Affected

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

6.11 Conformity with Law

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is deemed to be amended to conform to the minimum requirements of those statutes and regulations.

6.12 Notice

When we provide written notice regarding administration of this Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to Covered Persons on a timely basis.

Any notice sent to us under this Policy and any notice sent to the Enrolling Group must be addressed as described in Exhibit 1.

6.13 Continuation Coverage

We agree to provide Benefits under this Policy for those Covered Persons who are eligible to continue coverage under federal or state law, as described in *Section 4: When Coverage Ends* of the *Certificate of Coverage*.

Federal Continuation Coverage

We will not provide any administrative duties with respect to the Enrolling Group's compliance with federal law. All duties of the plan sponsor or plan administrator required by federal law remain the sole responsibility of the Enrolling Group, including but not limited to notification of COBRA continuation rights and billing and collection of Premium.

Extension of Continuation Coverage under State Law (Cal-COBRA) after Exhaustion of Federal COBRA Continuation Coverage

We will provide all administrative duties required by Cal-COBRA, including but not limited to, notifications to affected Covered Persons and billing and collection of Premium.

6.14 Certification of Coverage Forms

As required by the federal *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, we will produce certification of coverage forms for Covered Persons who lose coverage under this Policy. The Enrolling Group agrees to provide us with all necessary eligibility and termination data. Certification of coverage forms will be based on eligibility and termination data that the Enrolling Group provides to our eligibility systems in accordance with our data specifications, and which is available in our eligibility systems as of the date the form is generated. The certification of coverage forms will only include periods of coverage that we administer under this Policy.

6.15 Subscriber's Individual Certificate

We will issue *Certificate(s) of Coverage*, *Schedule(s) of Benefits*, and any attachments to the Enrolling Group for delivery to each covered Subscriber. The *Certificate(s) of Coverage*, *Schedule(s) of Benefits*, and any attachments will show the Benefits and other provisions of this Policy. In addition, you may have access to your *Certificate(s) of Coverage* and *Schedule(s) of Benefits* online at www.myuhc.com.

6.16 Summary of Benefits and Coverage

We will provide a *Summary of Benefits and Coverage* (*"SBC"*), as required by the *Affordable Care Act* and associated regulations (*"ACA"*), to the Enrolling Group for each benefit plan purchased by the Enrolling Group. The Enrolling Group shall be responsible for delivering the *SBC* to all Covered Persons and to other persons eligible for coverage in the manner and at the times required by the *ACA*, unless we notify the Enrolling Group that we will deliver the *SBC* to Covered Persons and other persons eligible for coverage.

6.17 System Access

The term "systems" as used in this provision means our systems that we make available to the Enrolling Group to facilitate the transfer of information in connection with this Policy.

System Access

We grant the Enrolling Group the nonexclusive, nontransferable right to access and use the functionalities contained within the systems, under the terms set forth in this Policy. The Enrolling Group agrees that all rights, title and interest in the systems and all rights in patents, copyrights, trademarks and trade secrets encompassed in the systems will remain ours. In order to obtain access to the systems, the Enrolling Group will obtain, and be responsible for maintaining, at no expense to us, the hardware, software and Internet browser requirements we provide to the Enrolling Group, including any amendments to those requirements. The Enrolling Group is responsible for obtaining an internet service provider or other access to the Internet.

The Enrolling Group will not:

- Access systems or use, copy, reproduce, modify, or excerpt any of the systems documentation provided by us in order to access or utilize systems, for purposes other than as expressly permitted under this Policy.
- Share, transfer or lease its right to access and use systems, to any other person or entity which is not a party to this Policy.

The Enrolling Group may designate any third party to access systems on its behalf, provided the third party agrees to these terms and conditions of systems access and the Enrolling Group assumes joint responsibility for such access.

Security Procedures

The Enrolling Group will use commercially reasonable physical and software-based measures, and comply with our security procedures, as may be amended from time to time, to protect the system, its functionalities, and data accessed through systems from any unauthorized access or damage (including damage caused by computer viruses). The Enrolling Group will notify us immediately if any breach of the security procedures, such as unauthorized use, is suspected.

System Access Termination

We reserve the right to terminate the Enrolling Group's system access:

- On the date the Enrolling Group fails to accept the hardware, software and browser requirements provided by us, including any amendments to the requirements.
- Immediately on the date we reasonably determine that the Enrolling Group has breached, or allowed a breach of, any applicable provision of this Policy. Upon termination of this Policy, the Enrolling Group agrees to cease all use of systems, and we will deactivate the Enrolling Group's identification numbers and passwords and access to the system.

6.18 Important Notice - Disputes

Should a dispute concerning your coverage arise, contact us first. If the dispute is not resolved, contact the California Department of Insurance.

Call us at the phone number shown on your ID card.

Call the **California Department of Insurance** at:

- **1-800-927-HELP (1-800-927-4357)** in the State of California.
- **213-897-8921** outside of the State of California.

You may write the California Department of Insurance at:

California Department of Insurance

Claims Services Bureau, 11th Floor

300 South Spring Street

Los Angeles, CA 90013

6.19 Notice of Network Provider Termination

We will provide written notice to the Enrolling Group, within a reasonable period of time, if we receive notice that any Network provider in the Service Area terminates or breaches its contract with us, or is unable to perform such contract, if the termination, breach, or inability to perform may materially and adversely affect the Enrolling Group or Covered Persons.

When we provide such written notice of Network provider termination to the Enrolling Group, the Enrolling Group is responsible for distributing the substance of the notice to all affected Subscribers and their Enrolled Dependents no later than 30 days after its receipt.

6.20 Liability for Continued Treatment by Terminated Network Provider

If, upon termination of a Network provider's contract as described in Article 6.19, a Covered Person is under the care of a terminated Network provider for one of the medical conditions described in the *Continuity of Care* provision in the *Schedule of Benefits*, we will be liable for continuation of Covered Health Services rendered by the provider until such services are completed, unless reasonable and medically appropriate arrangements for assumption of such Covered Health Services are made by another Network provider. Copayments, deductibles, or other cost sharing components will be the same as the Covered Person would have paid for a Network provider currently contracting with us.

This section does not apply to treatment by a provider or provider group whose contract with us has terminated or not renewed for reasons relating to medical disciplinary cause or reason, fraud or other criminal activity.

Exhibit 1

1. **Parties**. The parties to this Policy are UnitedHealthcare Insurance Company and County of Riverside, the Enrolling Group.

2. **Effective Date of this Policy**. The effective date of this Policy is 12:01 a.m. on January 1, 2019 in the time zone of the Enrolling Group's location.

3. **Place of Issuance**. We are delivering this Policy in the State of California. This Policy is governed by ERISA. To the extent that state law applies, the laws of the State of California are the laws that govern this Policy.

4. **Premiums**. We reserve the right to change the *Schedule of Premium Rates* specified in each Exhibit 2, after a 45-day prior written notice at any time.

5. **Computation of Policy Charge**. A full calendar month's Premiums will be charged for Covered Persons whose effective date of coverage falls on or before the 15th of that calendar month. No Premiums will be charged for Covered Persons whose effective date of coverage falls after the 15th of that calendar month. A full calendar month's Premiums will be charged for Covered Persons whose coverage is terminated after the 15th of that calendar month. No Premiums will be charged for Covered Persons whose coverage is terminated on or before the 15th of that calendar month.

6. **Payment of the Policy Charge**. The Policy Charge is payable to us in advance by the Enrolling Group on a monthly basis.

7. **Minimum Participation Requirement**. The minimum participation requirement for the Enrolling Group is 75% of Eligible Persons excluding spousal waivers but no less than 50% of all Eligible Persons must be enrolled for coverage under this Policy.

8. **Minimum Contribution Requirement**. The Minimum Contribution Requirement does not apply.

9. **Notice**. Any notice sent to us under this Policy must be addressed to:

   UnitedHealthcare Insurance Company

   185 Asylum Street

   Hartford, Connecticut 06103-0450

   Any notice sent to the Enrolling Group under this Policy must be addressed to:

   County of Riverside

   4080 Lemon Street

   Riverside, California 92501

10. 902805: Enrolling Group Number

Exhibit 2 Class 1

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description**.

   All Employees enrolled in UnitedHealthcare Choice Plan AKMS.

2. **Eligibility**. The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      None

   B. Other:

      Retired Employees under 65 years of age

   Important Note Regarding Waiting or Probationary Period: Any required waiting or probationary period for newly Eligible Persons will not exceed 90 days. A waiting or probationary period may only be a condition of employment if applied equally to all Eligible Persons and Dependents and if consistent with the *Patient Protection and Affordable Care Act*. A waiting or probationary period may not be based on health status.

3. **Open Enrollment Period**. An Open Enrollment Period of at least 30 days will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2019.

   For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first day of the month following the date the Eligible Person joins the Enrolling Group. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates**.

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2019 is shown below:

Coverage Classification	**Monthly Premium**
EPO COB (Medi A&B) Employee Only	$1,093.52
EPO COB (Medi A&B) Employee plus One Dependent	$2,187.04
EPO COB (Medi A&B) Employee plus Family	$2,948.53
EPO COB (Medi A&B) - RS1M Employee Only	$1,760.73
EPO COB (Medi A&B) - RS1M Employee plus One Dependent	$1,760.73
EPO COB (Medi A&B) - RS1M Employee plus Family	$1,760.73
EPO COB (Medi A&B) - RSD1M Employee Only	$2,986.85
EPO COB (Medi A&B) - RSD1M Employee plus One Dependent	$2,986.85
EPO COB (Medi A&B) - RSD1M Employee plus Family	$2,986.85

EPO COB (Medi A&B) - RSD2M Employee Only	$1,226.12
EPO COB (Medi A&B) - RSD2M Employee plus One Dependent	$1,226.12
EPO COB (Medi A&B) - RSD2M Employee plus Family	$1,226.12

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2.*

Exhibit 2 Class 2

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description**.

   All Employees enrolled in UnitedHealthcare Choice Plus Plan AKLV (Option 1).

2. **Eligibility**. The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      None

   B. Other:

      Retired Employees under 65 years of age

   Important Note Regarding Waiting or Probationary Period: Any required waiting or probationary period for newly Eligible Persons will not exceed 90 days. A waiting or probationary period may only be a condition of employment if applied equally to all Eligible Persons and Dependents and if consistent with the *Patient Protection and Affordable Care Act.* A waiting or probationary period may not be based on health status.

3. **Open Enrollment Period**. An Open Enrollment Period of at least 30 days will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2019.

   For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first day of the month following the date the Eligible Person joins the Enrolling Group. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates**.

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2019 is shown below:

Coverage Classification	Monthly Premium
Non-Blythe S+ Option #1 - Active/COBRA Employee Only	$1,802.05
Non-Blythe S+ Option #1 - Active/COBRA Employee plus One Dependent	$3,582.39
Non-Blythe S+ Option #1 - Active/COBRA Employee plus Family	$4,651.08
Non-Blythe S+ Option #1 - Early Retirees Employee Only	$2,537.29
Non-Blythe S+ Option #1 - Early Retirees Employee plus One Dependent	$4,872.05
Non-Blythe S+ Option #1 - Early Retirees Employee plus Family	$6,548.74
Non-Blythe S+ Option #1 - AB1401 Employee Only	$1,982.26
Non-Blythe S+ Option #1 - AB1401 Employee plus One Dependent	$3,940.63
Non-Blythe S+ Option #1 - AB1401 Employee plus Family	$5,116.19

Out of Area Dependent (Students) - Employee Only	$0.02
Out of Area Dependent (Students) - Employee plus One Dependent	$0.02
Out of Area Dependent (Students) - Employee plus Family	$0.02
Blythe Only (Follow HMO) - Active/COBRA Employee Only	$801.89
Blythe Only (Follow HMO) - Active/COBRA Employee plus One Dependent	$1,635.52
Blythe Only (Follow HMO) - Active/COBRA Employee plus Family	$2,123.45
Blythe Only (Follow HMO) - AB1401 Employee Only	$882.08
Blythe Only (Follow HMO) - AB1401 Employee plus One Dependent	$1,799.07
Blythe Only (Follow HMO) - AB1401 Employee plus Family	$2,335.80
Blythe Only (Follow HMO) - Early Retirees Employee Only	$1,254.61
Blythe Only (Follow HMO) - Early Retirees Employee plus One Dependent	$2,494.10
Blythe Only (Follow HMO) - Early Retirees Employee plus Family	$3,238.16

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2*.

Exhibit 2 Class 3

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description**.

   All Employees enrolled in UnitedHealthcare Choice Plus Plan AKLV (Option 2).

2. **Eligibility**. The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      None

   B. Other:

      Retired Employees under 65 years of age

   Important Note Regarding Waiting or Probationary Period: Any required waiting or probationary period for newly Eligible Persons will not exceed 90 days. A waiting or probationary period may only be a condition of employment if applied equally to all Eligible Persons and Dependents and if consistent with the *Patient Protection and Affordable Care Act*. A waiting or probationary period may not be based on health status.

3. **Open Enrollment Period**. An Open Enrollment Period of at least 30 days will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2019.

   For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first day of the month following the date the Eligible Person joins the Enrolling Group. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates**.

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2019 is shown below:

Coverage Classification	Monthly Premium
Non-Blythe&Blythe S+ Opt#2 - COB Medi A&B Employee Only	$1,535.56
Non-Blythe&Blythe S+ Opt#2 - COB Medi A&B Employee plus One Dependent	$3,071.12
Non-Blythe&Blythe S+ Opt#2 - COB Medi A&B Employee plus Family	$4,140.40
Non-Blythe&Blythe S+ Opt#2 Medi A&B- RS1M Employee Only	$2,537.30
Non-Blythe&Blythe S+ Opt#2 Medi A&B- RS1M Employee plus One Dependent	$2,537.30
Non-Blythe&Blythe S+ Opt#2 Medi A&B- RS1M Employee plus Family	$2,537.30
Non-Blythe&Blythe S+ Opt#2 Medi A&B - RSD1M Employee Only	$4,304.13
Non-Blythe&Blythe S+ Opt#2 Medi A&B - RSD1M Employee plus One Dependent	$4,304.13
Non-Blythe&Blythe S+ Opt#2 Medi A&B - RSD1M Employee plus Family	$4,304.13

Non-Blythe&Blythe S+ Opt#2 Medi A&B - RSD2M Employee Only	$1,766.83
Non-Blythe&Blythe S+ Opt#2 Medi A&B - RSD2M Employee plus One Dependent	$1,766.83
Non-Blythe&Blythe S+ Opt#2 Medi A&B - RSD2M Employee plus Family	$1,766.83

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2*.

Exhibit 2 Class 4

The provisions included in this Exhibit are applicable only to the class of Eligible Persons described below.

1. **Class Description**.

   All Employees enrolled in UnitedHealthcare Non-Differential PPO Plan PUZ.

2. **Eligibility**. The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage* applicable to this class:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      None

   B. Other:

      Retired Employees under 65 years of age

   Important Note Regarding Waiting or Probationary Period: Any required waiting or probationary period for newly Eligible Persons will not exceed 90 days. A waiting or probationary period may only be a condition of employment if applied equally to all Eligible Persons and Dependents and if consistent with the *Patient Protection and Affordable Care Act*. A waiting or probationary period may not be based on health status.

3. **Open Enrollment Period**. An Open Enrollment Period of at least 30 days will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is January 1, 2019.

   For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first day of the month following the date the Eligible Person joins the Enrolling Group. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates**.

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of January 1, 2019 is shown below:

Coverage Classification	Monthly Premium
Non Diff "Flex Net" - COB Medi A&B Employee Only	$1,642.93
Non Diff "Flex Net" - COB Medi A&B Employee plus One Dependent	$3,285.85
Non Diff "Flex Net" - COB Medi A&B Employee plus Family	$4,429.91
Non Diff "Flex Net" COB Medi A&B- RS1M Employee Only	$2,714.71
Non Diff "Flex Net" COB Medi A&B- RS1M Employee plus One Dependent	$2,714.71
Non Diff "Flex Net" COB Medi A&B- RS1M Employee plus Family	$2,714.71
Non Diff "Flex Net" COB Medi A&B - RSD1M Employee Only	$4,605.10
Non Diff "Flex Net" COB Medi A&B - RSD1M Employee plus One Dependent	$4,605.10
Non Diff "Flex Net" COB Medi A&B - RSD1M Employee plus Family	$4,605.10

Non Diff "Flex Net" COB Medi A&B - RSD2M Employee Only	$1,890.39
Non Diff "Flex Net" COB Medi A&B - RSD2M Employee plus One Dependent	$1,890.39
Non Diff "Flex Net" COB Medi A&B - RSD2M Employee plus Family	$1,890.39

Changes to this *Schedule of Premium Rates* and/or subsequent *Schedules of Premium Rates* will be attached to this Policy by means of a *Notice of Change to Exhibit 2.*

Exhibit 3 - Miscellaneous Provisions

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 and 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.

Exhibit 4

Wellness Program Stipend

The Enrolling Group is eligible for a wellness stipend up to $100,000 during the Calendar year for the purpose of establishing, implementing and maintaining a wellness program that increases awareness of health risks and supports behavior change.

The Enrolling Group will collaborate with our representatives to define and plan bona-fide, HIPAA compliant wellness services and program strategies:

- Awareness and Education activities may include, but are not limited to biometric screenings and health kiosks.
- Behavioral Change activities may include, but are not limited to health and wellness educational programs such as smoking cessation and Weight Watchers.
- Environmental Change activities may include but are not limited to activities such as onsite exercise classes and/or equipment.
- Incentives which encourage or reward participation in wellness programs.

The Enrolling Group will maintain and provide documentation to us of program costs and related expenditures.

Enrolling Group Location Requirement Policy Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to include a location requirement for the Enrolling Group.

The following provision is added to the Policy in *Exhibit 1*:

Enrolling Group Location Requirement. This Policy is only approved for sale if the Enrolling Group's principal business address is located within the area set forth in our rate filings. For purposes of this provision, principal business address means the physical location of the Enrolling Group's business.

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President

UnitedHealthcare Insurance Company
Group Policy
For
County of Riverside
Enrolling Group Number: 902805
Policy Effective Date: January 1, 2019

IN WITNESS WHEREOF, the parties hereto have caused their duly authorized representatives to execute the Group Policy with an effective date of January 1, 2019.

ATTEST:
Clerk of the Board
Kecia Harper

By: _____
Deputy

Date: JUL 27 2021

COUNTY OF RIVERSIDE

By: Karen S. Spiegel
Karen Spiegel, Chairwoman,
Board of Supervisors

Date: JUL 27 2021

Approved as to form:

Gregory P. Priamos
County Counsel

By: _____
Deputy County Counsel
LISA SANCHEZ

CONTRACTOR: UHC OF CALIFORNIA
dba UNITEDHEALTHCARE OF CALIFORNIA,
a California corporation

By: _____

Printed Name: Robert C. Falkenberg

Title: CEO, UHC of CA

Date: 04/05/2021