EARLY RETIREE REINSURANCE PROGRAM
CALIFORNIA PARTICIPATION AGREEMENT

This Early Retiree Reinsurance Program California Participation Agreement (“Agreement”) is made on the _____ day of ____________, 2010, by and between Health Net of California, Inc., and if applicable, Health Net Life Insurance Company (if and only if and solely to the extent Health Net Life Insurance Company provides Plan Sponsor with insurance products underwritten by Health Net Life Insurance Company), (collectively, “Health Net”) and The City of Redlands on behalf of itself and its health benefit plan (“Plan Sponsor”).

WHEREAS, Plan Sponsor seeks to participate in the Early Retiree Reinsurance Program (the “Program”) authorized by the Patient Protection and Affordable Care Act (the “Act”) and implementing regulations; and

WHEREAS, for purposes of the Program, Health Net is a health insurance issuer for health care coverage benefits for Plan Sponsor’s employees, retirees and their dependents according to that certain agreement (“Group Agreement”) between Health Net and Plan Sponsor for the 12-month period beginning on April 1st of each year for which the Group Agreement is in effect (“Plan Year”); and

WHEREAS, the Program requires Plan Sponsor to have a written agreement with its health insurance issuer in compliance with 45 CFR 149.35(b)(2) that contains certain terms and conditions required for participation in the Program; and

WHEREAS, the parties desire to enter into this written agreement to, among other things, set forth terms and conditions related to participation in the Program including without limitation the disclosure of information, data, documents and records (collectively, “Program Data”) required by the Program as set forth in the statute, implementing regulations at 45 CFR part 149 (“Program Regulations”) and such other guidance (“Program Guidance”) as may be issued by the Secretary of the United States Department of Health and Human Services (“Secretary”) (collectively, “Program Requirements”);

NOW THEREFORE, in exchange for good and valuable consideration the receipt and sufficiency of which is hereby acknowledged, Health Net and Plan Sponsor each agree as follows:

1. Defined Terms. Capitalized terms not specifically defined in this Agreement shall have the meaning ascribed to them in the applicable Program Regulations or Program Guidance.

2. Effective Date. Except as otherwise provided herein, this Agreement shall take effect on the date, if any, that Plan Sponsor becomes certified by the Secretary as required by 45 CFR 149.35(a)(1) for participation in the Program (“Certification”). The data elements Health Net intends to provide as of the date this Agreement is signed are set forth on the attached Exhibit A. The parties agree that if necessary, prior to commencing services under this Agreement, the parties shall negotiate a mutually acceptable written amendment to this Agreement signed by both parties which sets forth additional technical performance specifications regarding the Program Data (“Technical Amendment”).

3. Participation and Certification Responsibilities. Plan Sponsor acknowledges that the Program Data covered by this Agreement is being submitted by or on behalf of Plan Sponsor for purpose of the Plan Sponsor obtaining federal funds under the Program. Plan Sponsor agrees that Plan Sponsor retains sole responsibility for applying to participate in the Program, for obtaining and maintaining Certification to participate in the Program, and for complying with all applicable Program Requirements and all applicable state and federal laws and regulations related to Plan Sponsor’s obligations under this Agreement. Plan Sponsor shall notify Health Net in writing of the date on which Plan Sponsor becomes Certified to participate in the Program.

4. Identification of Early Retirees. Plan Sponsor is responsible for identifying to Health Net, through mechanisms mutually agreed to by the parties, all Early Retirees for whom Plan Sponsor requests that Health Net provide Program Data under this Agreement. Plan Sponsor represents to Health Net that all of the information about Early Retirees provided to Health Net during the term of this Agreement is and shall be true, accurate and complete and that Health Net may rely upon such information in providing Program Data to Plan Sponsor. Health Net shall not be liable for any action taken which is based on inaccurate or incomplete information supplied by Plan Sponsor. Plan Sponsor shall notify Health Net in writing at least thirty (30) days in advance of any change in such information, if possible. However, in no event shall Plan Sponsor provide this information later than thirty (30) days after the effective date if advance notice is not possible. In the event prior notification is not feasible, Health Net may rely on information previously supplied by Plan Sponsor until receipt of notification of any change of such information from Plan Sponsor. Plan Sponsor shall be responsible for any liability arising from the failure to provide Health Net with such notice. Plan Sponsor shall be the sole and final decision-maker regarding identification of Early Retirees.

5. Program Data Disclosure. Health Net agrees that it will supply data to Plan Sponsor as necessary for Program Data submission and that, to Health Net's knowledge, such data shall be accurate. The parties acknowledge and agree that Health Net relies on Plan Sponsor's identification of Early Retirees, the data may include claims data submitted by the applicable network providers or other third parties, and Health Net will use reasonable business efforts to verify the integrity of the information from the time of Health Net's receipt of the information. Generally, in providing these services Health Net agrees to use reasonable business efforts, but Health Net shall assume no obligation to modify its systems used otherwise to collect, store and transmit data that becomes used or requested as Program Data. At the request of either party, any Program Requirements published in the Program Regulations or Program Guidance shall be reduced to a mutually agreed upon written instrument signed by the parties hereto and attached as an amendment to this Agreement. Identification of Claims, Incurred Dates, Negotiated Price Concessions (as each of those terms are defined in the Program), and other required elements of Program Data, other than identification of Early Retirees, shall be made based only on information acquired by Health Net in the normal course of conducting business according to the Group Agreement. Health Net makes no representation or warranty regarding the timing or amount of Program reinsurance that may be payable by the government to Plan Sponsor under the Program.

6. Projection Data. Health Net and Plan Sponsor acknowledge that, prior to the effective date of this Agreement, Health Net shall provide Plan Sponsor with Projection Data as necessary for Plan Sponsor's application for the Program as described in 45 CFR 149.40(f)(6). The parties acknowledge and agree that such Projection Data shall be based only on the data in Health Net's possession and control related to the Plan Sponsor.

7. Privacy Laws. The parties acknowledge and agree that the Program Data covered by this Agreement includes protected health information ("PHI") covered by the Privacy Rule, that the Secretary has asserted its authority to authorize disclosure of PHI for Program purposes in accordance with the Privacy Rule in the Program Regulations (see 75 Fed. Reg. 24450 (May 5, 2010) at p. 24454).

a. Privacy Representations and Warranties. Plan Sponsor represents and warrants that it has taken all necessary steps to ensure Plan Sponsor's receipt of Program Data is in full compliance with all applicable privacy requirements under state and federal laws and regulations, including but not limited to the Privacy and Security Rules and, if applicable, that Plan Sponsor's health benefit plan qualifies as and meets the obligations of a Covered Entity under the Privacy and Security Rules (45 CFR 160-164), including without limitation the full implementation of the requirements described in 45 CFR 164.530 and is not operating under the limited compliance requirements of 45 CFR 164.530(k) for fully insured group health plans.

b. Program Data Delivered to Plan Sponsor. Plan Sponsor is hereby specifically directing Health Net to furnish the Program Data to Plan Sponsor. Plan Sponsor hereby certifies that the plan documents for the Group's group health benefit plans (the "Benefit Plans") sponsored by Plan Sponsor have been amended to incorporate the provisions required by Section 504(f) of the Privacy Rule and that Plan Sponsor has issued the certification included herein as Exhibit C, in compliance with Section 504(f) of the Privacy Rule.

c. Program Data Delivered to HHS or to Third Party. Plan Sponsor may direct Health Net to furnish the Program Data directly to HHS or to a third party. Such direction shall not limit the obligations of Plan Sponsor and Plan Sponsor's health benefit plan as described in this Section 7. Plan Sponsor is hereby specifically directing Health Net to furnish the Program Data to HHS.

8. Program Participation Fees. Plan Sponsor shall pay to the government any applicable fees or expenses necessary to apply to or remain Certified in the Program. Plan Sponsor shall pay to Health Net an annual fee to be mutually agreed upon by the parties in an amount based upon, and not to exceed, Health Net's reasonable cost of providing the Program Data submission and related services provided by Health Net under this Agreement. Health Net's liability, if any, to Plan Sponsor arising from Health Net's breach of this Agreement and any amendments hereto shall be limited to amounts paid by Plan Sponsor to Health Net under this Section 8 through the date of such breach.

9. Amendment.

   a. Amendments Due to Law or Regulatory Changes. Health Net may amend this Agreement at any time by giving written notice to Plan Sponsor if Health Net determines, in its sole discretion, that such amendment is required to comply with any law or regulatory requirement.
   b. Amendments Effective on Anniversary Date. Upon 30 days prior written notice to Plan Sponsor, Health Net may amend this Agreement effective on the first day of the next Plan Year.
   c. Acceptance of Amendments. Any amendment to this Agreement proposed by Health Net pursuant to this Section 9 shall be deemed accepted by Plan Sponsor unless Plan Sponsor gives Health Net written notice of non-acceptance within 15 days after the date of Health Net's amendment notice, in which case this Agreement will terminate effective as of the day before the date the amendment would have otherwise gone into effect.

10. Record Retention. Health Net shall maintain copies of the records submitted under the Program on behalf of Plan Sponsor for 6 years after expiration of the Plan Year in which costs were incurred or longer if required by law, and in accordance with the requirements of 45 CFR 149.350. Such records shall be furnished to the Secretary within a reasonably prompt time following the date of the request. Plan Sponsor shall reimburse Health Net for reasonable costs of retrieving and/or copying such data in response to government requests.

11. Government Audits. The parties shall cooperate and comply with government audits under the Program. Plan Sponsor shall reimburse Health Net for its reasonable actual expenses incurred in responding to such audits. Plan Sponsor shall notify Health Net promptly in writing in the event of any audit or inquiry by any state or federal governmental enforcement agency regarding Plan Sponsor's participation in the Program or Health Net's activities in connection therewith.

12. Cost Savings Programs. Plan Sponsor acknowledges that the Program Requirements include an obligation to describe and maintain cost savings programs for benefit plan participants with claims for chronic and high cost conditions, in addition to policies and procedures to protect against fraud, waste and abuse. The parties acknowledge that Health Net has provided Plan Sponsor with a description of such programs operated by Health Net in the attached Exhibit B, and that subject to Section 10 and Section 11 of this Agreement, Health Net agrees to provide the Secretary copies of Health Net's policies and procedures to protect against fraud, waste and abuse within a reasonably prompt time following the date of the request.

13. Term and Termination. This Agreement shall remain in effect until terminated upon the first to occur of any of the following events:
    a. Plan Sponsor for any reasons fails to maintain Certification to participate in the Program or for any reason ceases to participate in the Program;
    b. The Secretary ceases satisfying Plan Sponsor's reimbursement requests under the Program;
    c. The Group Agreement is terminated
    d. Plan Sponsor provides Health Net with written notice of non-acceptance of any amendment within 15 days of the date of Health Net's amendment notice pursuant to Section 9 hereof, in which case this Agreement will terminate the day before the effective date of the amendment;
    e. The parties mutually agree in writing to terminate this Agreement.

Once certified, Plan Sponsor shall notify Health Net immediately in writing if the events in (a) or (b) of this Section 13 occur. In addition, either party may terminate this Agreement for any reason upon sixty (60) days advance written notice or thirty (30) days advance written notice by Health Net in the event Plan Sponsor breaches a material term of this Agreement.

14. Dispute Resolution.

14.1. Initiation: The parties agree to meet and confer within thirty (30) days of a written request by either party in a good faith effort to informally settle any Dispute. The parties each agree and understand that the meet and confer requirements set forth herein may be satisfied only by meeting each of the following requirements: (a) an actual meeting must occur between executive level employees of the parties who have authority to resolve the Dispute and are each prepared to discuss in good faith the Dispute and proposed resolution(s) to the Dispute, and (b) such meeting may take place either in person or on the telephone at a mutually agreeable time, and (c) unless otherwise mutually agreed by the parties, neither party is allowed to have legal counsel present at the meeting or to substitute legal counsel for the executive level employee, and (d) such meeting and all related discussions between the parties shall be treated in the same manner as confidential protected settlement discussions under the State Rules of Civil Procedure.

Confidentiality: All documents created for the purpose of, and exchanged during, the meet and confer process and all meet and confer discussions, negotiations and proceedings shall be treated as compromise and settlement negotiations subject to applicable state law. To the extent the parties produce or exchange any documents, the parties agree that such production or exchange shall not waive the protected nature of those documents and shall not otherwise affect their inadmissibility as evidence in any subsequent proceedings.

14.2. Binding Arbitration. Any dispute arising under or in relation to this Agreement that has not been resolved pursuant to Section 14.1 shall be resolved by binding arbitration described in this Section 14 upon election by either party by notice to the other. .

14.3. Conduct of Arbitration. The arbitration shall be conducted in the county of Los Angeles under the appropriate rules of the AAA or JAMS, as agreed by the parties. Any Arbitrator must be either a judge, or an attorney licensed to practice law in the State of California, who is in good standing with the State Bar, and has at least ten (10) years of experience with the arbitration of health care financial disputes. The parties each understand and agree that the exhaustion of the Meet and Confer Process set forth in Section 14.1 hereof is a condition precedent to binding arbitration under this Section 14.3. The written arbitration demand shall contain a detailed statement of the matter and facts and include copies of all material documents supporting the demand. Arbitration must be initiated within one year after the date the Dispute arose by submitting a written notice to the other party. The parties expressly agree that the deadline to file arbitration set forth above shall not be subject to waiver, tolling, alteration or modification of any

kind or for any reason except for fraud. The failure to initiate arbitration before such deadline shall mean the complaining party shall be barred forever from initiating such proceedings.

All such arbitration proceedings shall be administered by the AAA or JAMS, as agreed by the parties; however, the arbitrator shall be bound by applicable State and federal law, and shall issue a written opinion setting forth findings of fact and conclusions of law. The parties agree that the decision of the arbitrator shall be final and binding as to each of them. Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction. The arbitrator shall have no authority to make material errors of law or to award punitive damages or to add to, modify, or refuse to enforce any agreements between the parties. The arbitrator shall make findings of fact and conclusions of law and shall have no authority to make any award, which could not have been made by a court of law. The party against whom the award is rendered shall pay any monetary award and/or comply with any other order of the arbitrator within sixty (60) days of the entry of judgment on the award. The parties waive their right to a jury or court trial.

The parties recognize and agree that theirs is an ongoing business relationship, which may lead to sensitive issues with respect to the exchange of information related to any Dispute. The parties agree, therefore, to enter into such protective orders (including without limitation creating a category of discovery documents "for attorney's eyes only" to the extent feasible given the nature of the evidence and the Dispute). All discovery information shall be used solely and exclusively for arbitration of the Dispute between the parties and may not be used for any other purpose. After the arbitration award becomes final, each party shall return or destroy all documents obtained from the other party during the course of the arbitration that are subject to a protective order, and within thirty (30) days of such date shall provide to the other party an officer's certificate signed under penalty of perjury indicating that all such information has been returned or destroyed.

In all cases submitted to arbitration, the parties agree to share equally the administrative fee as well as the arbitrator's fee, if any, unless otherwise assessed by the arbitrator. The administrative fees shall be advanced by the initiating party subject to final apportionment by the arbitrator in this award. The parties agree that the content and decision of any arbitration proceeding shall be confidential unless disclosure is required by applicable State or federal statutes or regulations.

15. Miscellaneous

15.1. Headings. The headings used in this Agreement are for convenience only and shall not affect the interpretation of this Agreement.

15.2. Assignment. Health Net may assign this Agreement. Plan Sponsor may not assign this Agreement or any of the rights, interests, claims for money due, benefits, or obligations under this Agreement without Health Net's prior written consent. This Agreement shall be binding on the successors and permitted assignees of Health Net and Plan Sponsor.

15.3. Governing Law. Except as preempted by federal law, this Agreement will be governed in accord with California law and any provision that is required to be in this Agreement by state or federal law shall bind Plan Sponsor and Health Net whether or not set forth in this Agreement.

15.4. Waiver. Health Net's failure to enforce any provision of this Agreement will not constitute a waiver of that or any other provision, or impair Health Net's right thereafter to require Plan Sponsor's strict performance of any provision.

15.5. Notices. Notices must be sent to the addresses referenced in the Group Agreement.

15.6. Counterparts. This Agreement may be executed in multiple counterparts, each of which shall be deemed an original, and counterpart signature pages may be assembled to form a single original document.

15.7. Integration. This Agreement sets forth the entire understanding of the parties relating to the transactions it contemplates, and supersedes all prior understandings relating to them, whether written or oral. There are no obligations, commitments, representations or warranties relating to them except those expressly set forth in this Agreement.

15.8. Waiver/Modification/Amendment. No amendment of, supplement to or waiver of any obligations under this Agreement will be enforceable or admissible unless set forth in a writing signed by the party against which enforcement or admission is sought. No delay or failure to require performance of any provision of this Agreement shall constitute a waiver of that provision as to that or any other instance. Any waiver granted shall apply solely to the specific instance expressly stated.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first written above.

HEALTH NET OF CALIFORNIA, INC.	**[NAME OF PLAN SPONSOR]**
By: ____________________________ Authorized officer signature	By: ____________________________ Authorized officer signature
________________________________ Printed name	________________________________ Printed name
________________________________ Title	________________________________ Title
Date: ___________________________	Date: ___________________________

If and only if and solely to the extent Health Net Life Insurance Company ("HNL") provides insurance products to Plan Sponsor underwritten by HNL:

HEALTH NET LIFE INSURANCE COMPANY

By: ____________________________

____
Printed Name

Date: ___________________________

EXHIBIT A
DATA ELEMENTS

Two Data Sets will be Sent:
#1 - Projection: May provide 2-year projections as described in Program Requirements
#2 - Monthly Transmission: To be sent to meet HHS requirements

Data to be Transmitted	Source
Encrypted Member ID (Health Net ID)	Direct from source system
First Name	Direct from source system
Middle Initial	Direct from source system
Last name	Direct from source system
Date of Birth/Year of Birth	Direct from source system
Member Type (Employee, Spouse, Dependent)	Direct from source system
Group Suffix	Direct from source system
Medical Plan Code (benefit option)	Direct from source system
Service/Incurred Date	Direct from source system
Paid Date	Direct from source system
Service Provider	Direct from source system
Claim Type (e.g., Medical, MHN-provided Mental Health, Rx, Capitation*)	Direct from source system
Benefit Provided (e.g., Inpatient, Outpatient, Physician, Rx, MHN-provided Mental Health services)	Direct from source system
Paid Amount (Net of price concessions, rebates**)	Direct from source system
Member required payment (deductible, copay, coinsurance required by the benefit plan)	Direct from source system

* Capitation will be based on the average capitation per member per month
** Information to be provided when it becomes available

Sample Report to be provided:

C:\Early Retiree Subsidy Reportv3.xls

EXHIBIT B
DESCRIPTION OF COST SAVINGS PROGRAMS AND FRAUD, WASTE AND ABUSE PROGRAMS

The following describes Health Net's Medical Management programs and procedures that have generated or have the potential to generate cost savings for plan participants with claims for chronic and high cost conditions.

Utilization Management Coordinators process requests and electronically forward the record to a prior authorization nurse if clinical review is required. The prior authorization nurse evaluates the request utilizing Health Net National Medical Policies and InterQual®, Health Net's primary source for clinical criteria for medical necessity and levels of care. If criteria are met, authorization is approved. Approval notifications are sent to members and requesting practitioners/providers**.**

If criteria are not met and additional clinical information is required, the practitioner/provider will be contacted and the member notified of the need for additional information. When additional information is received and criteria are still not met, the request will be referred to a Health Net Medical Director for review. Upon completion of the review by the Medical Director, approved requests follow the above process and denied requests result in denial letters to be distributed to members and practitioners/providers according to Health Net Policy and Procedures.

LARGE-CASE MANAGEMENT SERVICES

Health Net and its delegates provide Case Management services to deliver individualized assistance to members experiencing complex, acute or catastrophic illnesses or with exceptional needs in all lines of business. The focus is on early identification of high-risk members and application of a systematic approach to coordination of care to increase satisfaction, to arrange medically appropriate care and to improve the health, functional status and quality of life of Health Net members.

There is no cost threshold that triggers Health Net's case management intervention. Health Net's predictive modeling identifies members who are at high risk for ongoing utilization, hospital admission or readmission. Health Net provides case management based on the member's identified needs and situation, regardless of cost.

Referrals for case management services are obtained from sources such as a predictive modeling strategy (evaluating utilization, pharmacy, lab and encounter data), customer service, contracted vendors, members, family members, providers, claims, concurrent review, sales and other Health Net departments.

Examples of members appropriate for referral for case management include:

- Lack of established or ineffective treatment plan
- Potential or identified compromised patient safety
- New permanent or temporary alteration of functional status
- High cost injuries or illnesses
- History of non adherence to treatment, medications or multiple missed appointments
- Over, under or inappropriate utilization of services
- Delayed discharge from the appropriate level of care

- Lack of family or social support
- Lack of financial resources to meet health needs
- Actual or potential exhaustion of benefits
- Lack of education of disease course or process
- High Risk pregnancy
- Transplant evaluation and surgery
- Pain Management
- Continuity of care assistance
- Post discharge follow up
- NICU discharge
- Post Bariatric surgery with complications
- Hospice-pending or actual
- Avoidable inpatient admissions/readmissions

Goals of the case management programs are to:

- Consistently perform the activities of assessment, planning, facilitation and advocacy for members throughout the continuum of care, in accordance with accreditation standards and standards of practice.
- Collaborate and communicate with the member/family, the physician and other health care providers in the development and implementation of a care plan that is driven by the member's goals for health improvement.
- Accomplish the goals in the individual member's care plan.
- Provide members and their families with the information and education that promotes self-care management.
- Assist in optimizing use of available benefits.
- Improve member and provider satisfaction.
- Promote effective utilization and monitoring of health care resources while ensuring that services are coordinated and appropriate for the member.
- Provide members with tools to empower members to achieve optimal health, independence and functioning in the most proactive and effective way.

Research shows that goals mutually developed with members positively influence case management outcomes.

COMPLEX CASE MANAGEMENT

Health Net and its delegates make available Complex Case Management services to all members. The goal of the complex case management program is that members with complex conditions receive support and assistance with coordination of care and access to any needed services. There is no cost threshold that triggers Health Net's complex case management intervention.

Members are initially identified for participation in the program using data stratification that includes:

- Claims and encounter data
- Hospital discharge data
- Pharmacy and lab data
- Health information lines
- Any of the Health Net Disease Management programs
- The concurrent review and discharge planning process
- A member request for case management
- A practitioner request for case management

Members are screened telephonically by a registered nurse and invited to participate in complex case management if they meet established screening criteria. Members are also afforded the opportunity to decline participation in the program.

The Health Net complex case management program includes an initial assessment of the use of evidence based care plans and algorithms, documentation of member resources, barriers, goals, progress and ongoing evaluation of member needs with adjustments of interventions as needed.

Health Net's shared-risk medical groups generally are directed by Health Net to use Health Net's vendor for complex-care management. Dual-risk medical groups are encouraged to use this vendor, but may manage complex care directly or through a vendor of their choosing.

Each year the program is evaluated for it effectiveness using both established metrics and documented measures of member satisfaction.

CHRONIC POPULATION DISEASE MANAGEMENT

Members face a wide variety of health care issues and concerns. Health Net knows that members need support that extends beyond any single chronic condition to other conditions, decisions, and lifestyle risks. The key to Health Net's Decision Power^{SM} program is to engage members in better managing their overall health, not just any one of their conditions. Decision Power Health Coaches support members across a broad spectrum of conditions and needs. Essentially, Health Coaches coach people, not their diseases. This "whole person" approach allows our Health Coaches to support a greater number of members across a wider range of conditions and issues.

Decision Power Health Coaches apply stage-of-change methods and motivational interviewing to assess opportunities for behavior change to improve lifestyle management and modify risk behaviors. Health Coaches are equipped to offer the right level of support and provide non-judgmental coaching intended to move members along stages of change toward the adoption of a healthier lifestyle. They help members recognize and minimize barriers to behavior change and resolve feelings of ambivalence while increasing motivation.

Using a variety of proprietary tools and systems, Health Coaches help individuals address knowledge gaps and set goals and action plans not only for their own lifestyle risks or concerns, but also for those of their families. Health Coaches share evidence-based information and help the member learn to recognize and honor his or her own values and preferences in taking care of his or her own health.

CHRONIC POPULATION IDENTIFICATION/STRATIFICATION AND SUPPORT

Health Net members who may benefit from Health Coaching are identified and stratified, through four core components: Data Analytics (medical inpatient/outpatient and pharmacy claims), Member Outreach, Health Coaching, and Provider Engagement (encounter data).

Claims data are loaded monthly into a database; predictive modeling methodology is applied to identify and stratify members according to risk. All newly identified chronic members are sent a welcome packet that contains detailed information about their condition and are invited to call a Health Coach for additional information.

Members are re-stratified monthly and can move up and down the risk scale based on the data loaded into the system each month. The highest risk members are stratified for outbound

Health Coaching calls. Members who fall below the highest risk level may be loaded for an AutoDialog™ call if they meet the predictive modeling criteria for this intervention. The AutoDialog™ (IVR) call will provide education about their condition and the opportunity to transfer to a Health Coach. To ensure member privacy, those who are targeted for AutoDialog™ calls are identified as a targeted member before the message is delivered.

Health Net's Care Management programs, Disease Management, Preference-Sensitive Condition support and Wellness programs are included for all members. There is no cost sharing with the member for any of these services.

Chronic Condition support targets members who have one or more major chronic medical conditions, such as:

- Coronary heart disease,
- Diabetes,
- Heart failure,
- Asthma, and
- Chronic obstructive pulmonary disease.

Using our whole-person approach, Health Net also supports the co morbid conditions frequently associated with these conditions, including but not limited to

- Chronic pain,
- Obesity,
- Depression, and
- Hypertension.

Preference-Sensitive Condition support extends to conditions for which either medical evidence supports multiple acceptable treatment options or there is inadequate medical evidence about the treatment choices. Examples of preference-sensitive care include choosing between treatments like mastectomy or lumpectomy in early-stage breast cancer; surgery or conservative treatment for patients with back pain due to disc disease; and invasive cardiac surgery or medical management for chest pain due to CHD. These are treatment choices that should depend on an informed individual making a decision with her physician that is based on the best clinical evidence and her own values.

Decision Power is specifically and uniquely designed to support members with comorbidities. In fact, Health Coaches expect that members will have a variety of health concerns; one of their primary goals is to help each member identify and manage the controllable aspects of his or her conditions. Our primary Health Coach model meets the coordination needs of members with multiple comorbidities and offers favorable cost and savings economics. For members with multiple comorbid conditions, Health Coaches use our proprietary Chronic Condition Guide to identify high priority issues; Health Coaches can also call on clinical specialists when complex issues surface.

The SMART™ Registry – Chronic Management Provider Coordination

Health Net and Decision Power's approach is to support the physician-patient relationship. Most Disease Management Programs focus either on the physician or the member. Health Net and Decision Power do both. Decision Power coordinates closely with physicians,

especially as part of the chronic illness management portion of our program. The program also features the SMART™ Registry.

The SMART™ Registry is a proprietary tool that provides physicians with actionable clinical information at the point of care to help them deliver high-quality, evidence-based care for their patients. Each physician is provided a list of members identified in the various chronic disease populations.

This list includes the key clinical parameters tracked for each member and identifies for each member the significant gaps in care. The SMART™ Registry also includes reports at an individual patient level that can be included in the chart. These enable a much more focused visit, eliminating the need for a search through voluminous paper records for key data and can serve to guide treatment plans focused on closing gaps in care.

MEMBER EDUCATION

Frequency and Types of Support and Outreach:
Symptom management support extends to issues and needs for members who have minor symptoms, questions, or concerns, like earaches, bee stings, and diaper rash. Even though these may be “simple” issues, Health Coaches use motivational interviewing on every call, and take every opportunity to educate callers, reinforce self-reliance, and remind them of their access to existing resources.

- All commercial members receive an invitation to call Decision Power,
- Ongoing outreach mailings and telephone campaigns are targeted to identified members,
- Ongoing Physician-referral campaigns,
- Internal referral training for customer service, case management etc, is refreshed quarterly,
- Active employer participation and promotion of the program.

Health Net sends quarterly newsletters that advise members of available services and reminders, along with recent and noteworthy health information. All members, regardless of group definitions, also may receive personal emails and other health reminders or information of their choosing at www.healthnet.com.

Health Net employs wellness-related outreach efforts including IVR calls, direct mail and outbound calls. Decision Power uses Health Coach referrals and case findings. Health Coaches use every interaction as a means of identifying lifestyle issues. For example, on a hay fever symptom call, a Health Coach may learn that the individual has an unhealthy body mass index (BMI), and can refer the member to both general weight management support, as well as the intensive weight management program, as appropriate.

Onsite Health Fairs and Biometric Screenings - Health Net can enhance onsite health events with biometric screenings. These services, available for an additional fee, can be arranged through our preferred provider or another third-party vendor. Biometric screenings provide an opportunity for identifying individuals with high blood pressure, BMI, cholesterol, etc. We integrate data from screenings into our identification and outreach efforts, and can refer those individuals to our telephonic lifestyle programs, as appropriate.

Additionally, providers, health plan case managers, customer service personnel, or other partner resources can be a rich source of referrals to Health Net’s Wellness Programs.

All Health Net members also receive an annual NCQA Immunization reminder mailing. This mailing includes reminders for men, women, teenagers and children.

Adult commercial HMO, POS and Medicare Advantage members identified with a new antidepressant prescription receive a series of three educational mailings over a 12-week period to inform them about depression. The content of the educational mailings includes the following:

- Explanation of depression and skills for dealing with depression
- Appointment reminders for office visits with the member's provider and/or behavioral health practitioners and providers (members are recommended to have at least three follow-up visits in the first 12 weeks after beginning antidepressant medication)
- Encouragement to continue the prescription antidepressant medication through completion, usually at least six months (four to five months after complete remission of symptoms)
- Information and resources about depression on the Health Net member portal at www.healthnet.com
- Information on how to opt out of the program

HEALTH NET WELLNESS – LIFESTYLE PROGRAMS

Lifestyle risk and wellness support provides support to members facing lifestyle issues—such as weight loss, smoking cessation, and stress management—by leveraging motivational interviewing and the Decision Power behavior change Health Coaching model and online tools.

Health Net's Decision Power program combines advanced analytics, sophisticated engagement methods, and effective behavior change techniques. Decision Power includes programs and educational materials on topics most affecting members including but not limited to:

- Tobacco cessation
- Weight loss and weight management
- Cardio-metabolic risk management
- Stress management
- Diet and nutrition
- Exercise and fitness
- Preventive health screenings
- Flu vaccinations
- Sleep

Decision Power Wellness Program goals are to help our members with existing medical conditions optimize their health and functional capacity. To attain significant value for both members and employer groups, our programs focus on:

- Getting ahead of the medical cost curve by encouraging prevention behaviors
- Maximizing productivity and reducing absenteeism by teaching healthy practices
- Improving total population health by coaching members at all health risk levels and health states
- Creating a healthy work culture by offering personal programs that are reinforced at the corporate level

Health Net achieves these goals through a dynamic and engaging wellness offering that supports individuals through our proven whole-person, total-population approach. Decision Power:

- Uses lifestyle-based proprietary analytics to identify at-risk individuals
- Engages members through innovative outreach strategies
- Provides members with education and support through greater access to specialty coaches, online resources, print materials, and onsite programs

For identification and stratification the Decision Power model uses Health Risk Questionnaire (HRQ) data as well as proprietary lifestyle-based predictive models including the Wellness Segmenter and CommunityGrid™. These models are able to identify individuals who are likely to be smoking, obese, at cardio-metabolic risk, and/or have overall high lifestyle risk, in the absence of HRQ data. Data sources for the models include medical claims, pharmacy data, lab data and demographic data from eligibility files. We drive our outreach efforts based on HRQ and/or these predictive models.

Health Net also offers, Health Net's Decision Power℠ Healthy Discounts – members save with discounts on weight loss solutions with Jenny Craig® and Weight Watchers®, and on other health and wellness products and services.

The following describes Health Net's policies and procedures in place to protect against fraud, waste and abuse under the plan

Claims Fraud, Waste and Abuse

Except as otherwise noted below, Health Net's formal policies and procedures documentation on this topic will be provided to HHS upon request. Health Net's claims processing systems serve as the front line in combating inappropriately billed claims. Each claim is subject to a variety of edits that:

- Verify data accuracy,
- Verify billed services are covered under the member's plan,
- Identify recovery opportunities,
- Process claims according to contractual arrangements with providers, and
- Discover any other suspect issues.

After a claim is processed, analytical data mining is used by Health Net's Special Investigations Unit (SIU) to identify claims patterns, possible payment errors, utilization trends and other indicators of potential Fraud, Waste and Abuse (FWA), as well as investigating cases upon identification of potential FWA by quantifying the potential exposure.

Data analysis assists in the detection and prevention of fraud, waste and abuse by comparing claims information and other related data to help identify any potential errors in billing and/or fraud indicators found in the data by procedure/prescription claim submitted.

Data mining can be used to identify norms, abnormalities, and individual variables that describe statistically significant time-series trends. Examples of such statistically significant time-series trends over a period and in comparison to relative time periods are:

- Standard deviations from the mean;
- Percent above the mean or median,
- Percent increase in charges,

- Number of visits/services from one period to another.

Data analysis typically provides an overarching view of what is occurring and can help identify trends and assist in the development of an efficient investigative process. The SIU also utilizes a program named STARS™ to manually conduct analytical data mining, which also includes the STARSentinel™ program to provide automated analytical data mining that is based on over 400 fraud rules that are commonly attributable to fraud, waste and abuse.

Eligibility and Enrollment Fraud, Waste and Abuse

Health Net's Special Investigations Unit (SIU) uses the Evidence of Coverage (EOC) or the contract (ASO, large group, government contract, etc.) as the primary tool for investigating enrollment (or any type of member eligibility) fraud. These documents define the majority of the SIU's capabilities for these areas. The SIU Department's Policies and Procedures outlines the methods of how all investigations are to be handled. This document is proprietary and confidential, and cannot be released without a signed Non-Disclosure Agreement**.**

Important Note:
The information provided regarding State and federal laws and regulations, including, but not limited to the Patient Protection and Affordable Care Act (PPACA), is based upon the latest information available to Health Net as of the date this document was written. Health Net's responses are non-exhaustive, subject to further revision and clarification based upon the issuance of interpretive regulations and other guidance by the government, and are provided for information purposes only. Please note that Health Net is unable to provide legal, tax, or legislative implementation advice and recommends that our clients consult their professional legal, tax and legislative implementation advisors in evaluating the requirements of these laws and regulations and their impact on our clients' group health plans.

Health Net looks forward and remains committed to working with our clients, consultants, brokers and vendors to provide health plan benefit structures that comply with all applicable state and federal laws and regulations, including, but not limited to the Patient Protection and Affordable Care Act.

EXHIBIT C

PLAN SPONSOR CERTIFICATION

1. In General. The undersigned certifies that the plan documents for the group health plans (the "Plans") sponsored by ________________________ been amended to incorporate the provisions required by Section 504(f) of the regulations implementing the standards protecting the privacy of individually identifiable health information, 45 CFR Part 164 (the "Privacy Rule"), which were promulgated under the authority of the Health Insurance Portability and Accountability Act of 1996, Pub.L. 104-191 ("HIPAA"). Furthermore, the Plan Sponsor agrees:

(a) not to use or further disclose individually identifiable health information created in connection with the Plans except as required by law or for the Plans' administrative purposes as described in the Plans' documents, as they are amended from time to time;

(b) to arrange for any of its agents or subcontractors that receive Protected Health Information (within the meaning of the Privacy Rule) to use and disclose Protected Health Information consistent with section 1(a) of this Certification;

(c) not to use or disclose the Protected Health Information for employment related actions or in connection with benefits or benefit plans outside the scope of what Plan Sponsor has, for Privacy Rule purposes, deemed its health care component;

(d) to report to the Plans any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures for the Plans' administrative purposes as described in the Plans' documents, as they are amended from time to time, that it becomes aware of;

(e) to make available any Protected Health Information in any "designated record set" (as such term is defined in the Privacy Rule) related to the Plans' participants or beneficiaries that it has control of in accordance with Section 524 of the Privacy Rule;

(f) to make available for amendment or amend, to the extent required by Section 526 of the Privacy Rule, the Protected Health Information in a designated record set which is related to the Plans' participants or beneficiaries;

(g) to make information available the information required for an accounting of Protected Health Information disclosures related to the Plans' participants or beneficiaries in response to such person's exercise of their rights under such section;

(h) to make its internal practices, books and records relating to the use and disclosure of Protected Health Information received available to the Secretary of the Department of Health and Human Services to assist the Secretary in determining the Plans or the Plans' health insurance issuer's compliance with the Privacy Rule;

(i) where feasible to return or destroy any Protected Health Information received when such Protected Health Information is no longer needed by the Plan Sponsor for the purpose which permitted the disclosure and, where such return or destruction of Protected Health Information is not feasible, to limit its future use of the Protected Health Information to the situations that make the return or destruction of the Protected Health Information not feasible; and

(j) to limit access of its employees to the Plans' Protected Health Information (other than as subjects of the Protected Health Information or subscribers to the coverage), except where such employees are in job classifications which have been designated in the Plans' documents as assisting in the Plans' administration and thus engaging in the use or disclosure of Protected Health Information for treatment, payment and health care operations purposes.

2. Interpretation. The terms and conditions of this Certification shall be construed in light of any applicable interpretation of and/or guidance on the HIPAA Privacy Rule issued by HHS or the Office of Civil Rights from time to time.

3. Third Party Beneficiaries. Nothing in this Certification shall be construed to create any third party beneficiary rights in any person, including any participant or beneficiary of the Plans.

4. Authority. The execution, delivery and performance of this Certification by the Plan Sponsor is within its corporate powers, and not in contravention of its articles of incorporation, bylaws or any amendments thereto and have been duly authorized by all appropriate corporate action. The person executing on behalf of the Plan Sponsor has the requisite power and authority to make this Certification on the Plan Sponsor's behalf.

IN WITNESS WHEREOF, the Plan Sponsor has caused this certification to be executed as of the date and year set forth below.

________________________:

By: ___________________________
Title: ___________________________
Date: ___________________________