33855

RETIREE

GROUP HEALTH SERVICES AGREEMENT

BETWEEN

SCAN HEALTH PLAN

AND

THE CITY OF LONG BEACH

INTRODUCTION

Under this RETIREE GROUP HEALTH SERVICES AGREEMENT, SCAN Health Plan will arrange for the provision of Benefits to **The City of Long Beach** Retirees and their Dependents as Plan Members in accordance with the terms and conditions of this RETIREE GROUP HEALTH SERVICES AGREEMENT, the Plan "Combined Evidence of Coverage and Disclosure Information" and the Plan "Employer Group Application," which are all fully incorporated herein by these references, and together constitute the entire "Agreement" between the parties.

This Agreement is effective January 1, 2014.

IMPORTANT

There is no vested right to receive Benefits under this Agreement. No Member has the right to receive the Benefits of this Agreement for services or supplies furnished following termination of coverage, except as specifically provided herein. Benefits of this Agreement are available only for services and supplies furnished during the term it is in effect and while the Member claiming Benefits is actually covered by this Agreement. Benefits may be modified during the term of this Agreement under the terms set forth herein, or upon renewal. If Benefits are modified, the revised Benefits (including any reduction in Benefits or the elimination of Benefits) apply for services or supplies furnished on or after the effective date of the modification.

ARTICLE I
DEFINITIONS

1.1 Applicable Law - all federal, state and local statutes, rules, regulations, plans, ordinances, policies and ethical standards applicable to the subject matter of this Agreement or the parties' performance of their duties and obligations hereunder, including but not limited to, those promulgated by the federal Department of Health and Human Services ("DHHS"), the federal Centers for Medicare and Medicaid Services ("CMS"), the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the California Department of Managed Health Care (DMHC"), California Department of Health Services ("DHS"), Title 28 of the California Code of Regulations, the California Knox-Keene Health Care Service Plan Act of 1975 and its implementing regulations, and all standards, rules and regulations of all accreditation bodies that have jurisdiction over the subject matter of this Agreement or the parties' performance of their duties hereunder.

1.2 Benefits (Covered Services) - those Services, which a Member is entitled to receive pursuant to the terms of this Agreement.

1.3 Calendar Year - a period beginning at 12:01 a.m. on January 1 and ending at 12:01 a.m. on January I of the next year.

1.4 Combined Evidence of Coverage and Disclosure Information ("EOC") - the contract between a Member and the Plan under which the Member is entitled to receive certain hospital, medical, and other health and/or social services under the Plan Benefits. The EOC is attached to this Agreement and fully incorporated herein.

1.5 Contracted Medical Group/IPA - A group of Physicians organized to provide medical care. The Contracted Medical Group/IPA has an agreement with the Plan to provide medical services to Members.

1.6 Close Relative - the spouse, child, brother, sister or parent of a subscriber or Dependent.

1.7 Contract holder - the Employer entering into this Agreement for the Benefit of its Retirees.

1.8 Copayment - an amount, which a Member is required to pay for certain, Benefits.

1.9 Covered Services (Benefits) - those Services which a Member is entitled to receive pursuant to the terms of this Agreement.

1.10 Dependent -

a. A subscriber's legally married spouse who is not covered for Benefits as a subscriber, is entitled to Benefits under the federal Medicare program, and is eligible to enroll in the Plan.

b. A subscriber's Domestic Partner, with whom the subscriber has filed a "Declaration of Domestic Partnership" with the California Secretary of State pursuant to California Family Code Section 298 and/or files the Employers Affidavit of Domestic Partnership, is entitled to Benefits under the federal Medicare program, and is eligible to enroll in the Plan. Domestic Partners also must meet the Plan's eligibility requirements as defined by the Employer.

1.11 Emergency Services - Inpatient or outpatient covered Services that are 1) Furnished by a provider qualified to furnish emergency services; and 2) Needed to evaluate or stabilize an Emergency Medical Condition.

1.12 Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in; 1) Serious jeopardy to the health of the individual; 2) Serious impairment to bodily functions; or 3) Serious dysfunction of any bodily organ or part.

A psychiatric Emergency Medical Condition is a condition where a layperson with an average knowledge of mental health, feels the absence of immediate psychiatric attention would 1) Place the mental or physical health of either the Member or others in serious jeopardy; 2) Cause serious impairment to bodily or mental functions; 3) Cause serious dysfunction of bodily organs; or 4) Result in serious mental dysfunction.

1.13 Durable Medical Equipment ("DME")- equipment designed for repeated use which is medically necessary to treat an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. DME includes wheelchairs, hospital beds, respirators, and other items that the Plan determines are DME.

1.14 Inpatient - an individual who has been admitted to a hospital or a Skilled Nursing Facility as a registered bed patient and is receiving Services under the direction of a Physician.

1.15 Late Enrollee - an eligible Retiree or Dependent who has declined enrollment in this Plan at the time of the initial enrollment period, and who subsequently requests enrollment in this Plan, provided that the initial enrollment period shall be a period of at least 30 days.

1.16 Medical Group - an organization of Physicians who are generally located in the same facility and provide Benefits to Members.

1.17 Medically Necessary - medical Services or hospital Services which are determined by the Plan to be:

1.18 Rendered for the treatment or diagnosis of an injury or illness,

1.19 Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards,

1.20 Not furnished primarily for the convenience of the Member, the attending physician, or other Contracted Provider of service, and

1.21 Furnished in the most economically efficient manner, which may be provided safely and effectively to the Member.

1.22 Whether there is "sufficient scientific evidence" shall be determined by the Plan based upon the following: peer-reviewed medical literature; publications, reports, evaluations, and regulations issued by state and federal government agencies, Medicare local carriers, and intermediaries; and such other authoritative medical sources as deemed necessary by the Plan.

1.23 Member – an enrollee, subscriber or Dependent as defined herein.

1.24 Open Enrollment Period - that period of time set forth in the Agreement during which eligible individuals and their Dependents may transfer from another health benefit plan sponsored by the Contract holder to the Plan.

1.25 Personal Care Physician ("PCP") - a general practitioner, board-certified or eligible family practitioner, internist or obstetrician/gynecologist who has contracted with the Plan as a PCP to provide primary care Benefits to Members and to refer, authorize, supervise and coordinate the provision of all Benefits to Members in accordance with this Agreement.

1.26 Physician Group Service Area - a thirty (30) mile linear radius from any Member's assigned PCP office location.

1.27 Physician - an individual licensed and authorized to engage in the practice of medicine (M.D.) or osteopathic medicine (D.O.).

1.28 Plan - SCAN Health Plan

1.29 Plan Hospital - a hospital licensed under Applicable Law and contracting with the Plan to provide Benefits to Members of the Plan.

1.30 Plan Provider - a provider who has a contract with the Plan to provide Plan Benefits to Members.

1.31 Plan Service Area - which geographic area served by the Plan.

1.32 Premium - the monthly pre-payment that is made to the Plan on behalf of each Member.

1.33 Provider - a Medical Group or Independent Practice Association ('IPA") and all associated Physicians, Plan Hospitals and ancillary services providers that contract with the Plan to provide Benefits to Members under this Agreement.

1.34 Retiree(s) - any person who was formerly employed by Contract holder and is, thereby, entitled to Benefits under this Agreement.

1.35 Services - includes Medically Necessary health care services as provided for in the EOC, and Medically Necessary supplies furnished incident to those Services.

1.36 Skilled Nursing Facility - a facility licensed by the California Department of Health Services as a "Skilled Nursing Facility."

1.37 Surviving Spouse/Surviving Domestic Partner – Upon Retiree's death, Retiree's surviving legally married spouse or Domestic Partner as defined in Paragraph 1.10 herein is entitled to Benefits under the federal Medicare program, and is eligible to enroll in the Plan. In the event of Retiree's death, the Retiree's Surviving Spouse/Surviving Domestic Partner shall become the subscriber. Notwithstanding the foregoing or any language to the contrary in this Agreement, in no event shall the future spouse of a Surviving Spouse/Surviving Domestic Partner be considered a Dependent or subscriber."

1.38 Urgently Needed Services - Covered Services provided when the Member needs medical attention right away for an unforeseen illness or injury and it may not be reasonable, given the circumstances, to obtain the medical care from the Member's PCP or Contracted Medical Provider.

ARTICLE II
RETIREE & DEPENDENT ELIGIBILITY

2.1 The following persons are eligible for Benefits under this Agreement:

a. Retirees
b. Dependents as defined herein.
c. Eligible Surviving Spouse/Surviving Domestic Partner as defined herein.

2.2 The date of eligibility for Retirees who declined enrollment in this Plan during the initial enrollment period and later apply for coverage shall be determined as follows:

a. A Late Enrollee who declined enrollment during the initial enrollment period shall be eligible for coverage the earlier of, 12 months from the date of his application for coverage or at the Contractholder's next open enrollment period.

b. A Retiree will not be considered a Late Enrollee if he or his Dependent loses coverage under another employer health benefit plan and shall be eligible for coverage on the date of loss of coverage, provided enrollment is requested within 31 days after termination of that other employer health benefit plan coverage. Retirees will be required to furnish the Plan written proof of the loss of coverage.

c. A Retiree may add newly acquired Dependents as defined herein.

2.3. The date of eligibility for Dependents of Retirees who are enrolled during the initial enrollment period is the latest to occur of the following:

a. The date of eligibility of the subscriber.

b. The date the subscriber acquires a Dependent.

c. The date the Dependent reaches sixty-five (65) years of age.

2.4. The date of eligibility for Dependents of Retirees who declined enrollment in this Plan during the initial enrollment period or Dependents who do not request enrollment in this Plan within 31 days of eligibility as provided herein, and later apply for coverage, shall be determined as follows:

a. A Dependent who is a Late Enrollee and who has declined coverage during the initial enrollment period, or Dependents who do not request enrollment within 31 days of eligibility as provided herein, shall be eligible for coverage the earlier of, 12 months from the date of the Late Enrollee's application for coverage or at Contractholder's next open enrollment period.

2.5. Notification of Eligibility Changes. It is the Contractholder's responsibility to notify the Plan within 31 calendar days of all changes in eligibility affecting enrollment in this Plan.

ARTICLE III
EFFECTIVE DATES FOR SUBSCRIBERS AND DEPENDENTS

3.1. Initial enrollment period. Benefits shall become effective when a completed enrollment application indicating the subscriber's and Dependent's choice of PCP is signed before the effective date. Enrollment Applications received later than the first day of eligibility may delay coverage until the first day of the month following the day of receipt.

a. The Benefits of a subscriber and Dependent who enroll on the effective date of this Agreement and who make a written request for enrollment during the initial enrollment period, shall become effective on the date this Agreement becomes effective for the Contractholder.

b. Coverage for an individual who becomes eligible at a time other than during the original effective date of this Agreement (e.g. new spouse or newly transferred Retiree) will become effective on the first day of the month after eligibility was obtained as provided herein.

Newly added Dependents are subject to all other provisions of this Agreement.

3.2. Enrollment and Effective Date of Coverage at a Time Other Than During the Initial Enrollment Period or Open Enrollment Period.

a. The Benefits of a subscriber or Dependent who is not a Late Enrollee shall become effective on the date of loss of coverage under another employer

health benefit plan, provided enrollment is requested within 31 days of the loss of that other employer health benefit plan coverage. The subscriber must furnish written evidence of the loss of coverage.

b. A subscriber requesting reinstatement of his Benefits or Dependent Benefits after they have been discontinued due to voluntary cancellation, would not be eligible for Benefits until the earlier of, 12 months from the date of a request for reinstatement or at the Retiree's former employer's next open enrollment period.

However, the following individuals are not considered Late Enrollees:

a. The Retiree or Dependent was covered under another employer health benefit plan at the time of initial eligibility;

b. The Contractholder offers multiple health benefit plans and the Retiree elects a different plan during an Open Enrollment Period;

c. If a Retiree declines enrollment during the initial enrollment period and subsequently requests enrollment for him and his new Dependent, the Retiree and Dependent coverage will be effective on the first day of the month following receipt of request for enrollment;

d. If the Member is receiving Inpatient care at a non-Plan facility when coverage becomes effective. The Plan will provide Benefits only for as long as the Member's medical condition prevents transfer to a Plan facility in the Member's PCP Service Area, as approved by the Plan. Unauthorized continuing or follow-up care in a non-Plan facility or by non-Plan Providers is not a Covered Service.

3.3. Retroactive Enrollment. The Retiree may choose an effective date of up to three months after the month in which Contractholder receives the signed and completed enrollment election request. However, the effective date may not be earlier than the date that Contractholder receives the signed and completed enrollment election request.

ARTICLE IV
DISCONTINUANCE OF SUBSCRIBER AND/OR DEPENDENT BENEFITS

Except as specifically provided herein, there is no right of either a subscriber or his Dependents to receive Benefits following termination of this Agreement, or any part of it. The Benefits for each cease on the first of the following to occur, with respect to the subscriber and/or Dependent, as applicable:

a. The date of discontinuance of any part of this Agreement providing Benefits;

b. The date of discontinuance of this Agreement;

c. The end of the last period for which the subscriber has made his contribution for Dependent Benefits

d. The date of termination of the subscriber's coverage;

e. The date the Agreement is amended to terminate the eligibility of any class of Retirees of which the subscriber is a member.

f. The last day of the month in which the Dependent ceases to qualify as a Dependent as defined herein, including a spouse following the entry of a final decree of annulment or dissolution of marriage from the subscriber, unless a different date on which the Dependent no longer meets the requirements for eligibility has been agreed to between the Plan and the Contractholder;

g. A subscriber or subscriber's Domestic Partner files with the California Secretary of State a, "Notice of Termination of Domestic Partnership" pursuant to California Family Code Section 298 and/or files the Employers Termination of Domestic Partnership form.

h. Retroactive Disenrollment. The Retiree may choose an effective date of up to three months after the month in which Contractholder receives the signed and completed disenrollment request. However, the effective date may not be earlier than the date that Contractholder receives the signed and completed disenrollment request.

ARTICLE V
PREMIUM RATES ("PREMIUMS")

5.1 Premiums

The Premiums are set forth in EXHIBIT A, "Premium Rates" attached hereto and fully incorporated herein by this reference.

5.2 When And Where Payable

a. The first month's Premiums must be paid to the Plan by the effective date of this Agreement and subsequent Premiums shall be prepaid in full by the same date of each succeeding month. No Member will be covered under this Agreement until the first month's Premiums payment has been received by the Plan. However there will be a 60 day period for retroactive adjustments for payments or credits.

b. Premiums for Retirees and/or Dependents who become eligible on a date other than the bill date are waived for the month during which eligibility for covered Benefits is attained. Premiums for Retirees and/or Dependents whose eligibility for covered Benefits terminates on a date other than the bill date are due in full for the month during which eligibility is terminated.

c. All Premiums are payable by the Contractholder to the Plan. The payment of any Premiums shall not maintain the Benefits under this Agreement in force beyond the date immediately preceding the next transmittal date.

5.3 The terms of this Agreement or the Premiums payable therefor may be changed from time to time as set forth herein.

5.4 If a state or any other taxing authority imposes upon the Plan a tax or license fee that is levied upon or measured by the base Premiums or by the gross receipts of the Plan, or any portion of either, then the Plan may amend the Agreement to increase the base Premiums by an amount sufficient to cover all such taxes or license fees rounded to the nearest cent. This amendment shall be effective as of the date indicated in the notice which shall not be earlier than the date of the imposition of such tax or license fee, by mailing a postage prepaid notice of the amendment to the Contractholder at its address of record with the Plan at least 60 calendar days before the effective date of the amendment.

5.5 If Benefit amounts are changed due to a change in the terms of this Agreement, or if a tax is levied as described herein, the Premiums charged therefore may be made, or the Premiums credit therefor may be given, as of the effective date of such change.

5.6 A grace period of 30 calendar days will be granted for the payment of Premiums accruing, other than those due on the effective date of this Agreement, during which period this Agreement shall continue in force. The Contract holder shall be liable to the Plan for the payment of all Premiums accruing during the period the Agreement continues in force.

ARTICLE VI
INDEPENDENT CONTRACTORS

Plan Providers are neither agents nor employees of the Plan, but are independent contractors. In no instance shall the Plan be liable for the negligence, wrongful acts or omissions of any person receiving or providing Services, including any Physician, Plan Hospital, or other provider or their employees, subject to the Managed Health Care Insurance Accountability Act of 1999 (California Civil Code Section 3428).

ARTICLE VII
PLAN SERVICE AREA

The Plan Service Area of this Plan is as described in the EOC that the Plan distributes to all Members.

Within the Physician Group Service Area, Members will be entitled to receive all Covered Services specified in the EOC. The Plan will not pay for Covered Services that are not provided by, referred by and authorized by the Member's PCP and/or the Plan, where applicable. The Member will be required to pay for the cost of any services that are not approved by the PCP or the Plan, including services that the Member receives from non-contracting providers, except for Emergency Services or Urgently Needed Services. Procedures for obtaining Emergency Services and Urgently Needed Services are described in the EOC.

ARTICLE VIII
COORDINATION OF BENEFITS

If a Member is covered under one or more other health insurance plans, the Benefits of this Plan will be coordinated with the benefits payable by those other health insurance plans in accordance with the following provisions.

a. Plan is Primary. If a Member possesses health benefits coverage through another policy, which is secondary to the Plan under applicable coordination of Benefits rules, including the Medicare secondary payor program, the Plan will determine its Benefit coverage obligations before the other policy, including applicable Copayments.

b. Plan is Secondary. If a Member possesses health benefits coverage through another policy which is primary to the Plan under applicable coordination of Benefits rules, including the Medicare secondary payor program, or if the Member is entitled to payment under a Workers' Compensation policy, the Plan will determine its Benefit coverage

obligations after the other policy or Workers' Compensation policy, consistent with Applicable Laws and regulations. In such event, the Benefit coverage under the Plan, will not exceed the amount of the out-of-pocket expenses (i.e. coinsurance, Copayments and deductibles) that the Member would incur in the absence of Member's secondary coverage.

ARTICLE IX
DISPUTES BETWEEN THE PLAN AND CONTRACTHOLDER

9.1 Disputes. In the event a dispute arises between Contractholder and the Plan relating to this Agreement, the parties shall meet and negotiate in good faith to resolve the dispute. If the dispute is not resolved after at least sixty (60) calendar days following the date one party sends written notice of the dispute to the other party, any party wishing to pursue the dispute shall submit it to binding arbitration in accordance with the rules of the Comprehensive Rules of JAMS. Administration of the arbitration will be performed by JAMS or other arbitration service as the parties may agree in writing. The parties will endeavor to mutually agree to the appointment of the arbitrator. But if an agreement cannot be reached within thirty (30) days following the date that demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Rules will be used. The arbitration shall be handled by a single arbitrator who has expertise in managed care and particularly in the operations of health maintenance organizations. Discovery in such arbitration proceedings will be in accordance with California Code of Civil Procedure Section 1283.05, as if the subject matter of the arbitration were pending before a superior court in a civil action. Notwithstanding the foregoing, in no event may any arbitration be initiated more than one (1) year following the date the initial written notice of the dispute is sent. Any arbitration proceeding under this Agreement shall be conducted in Los Angeles County, California. The arbitrator shall have no authority to award any punitive or exemplary damages, or to vary or ignore the terms of this Agreement, and shall be bound by controlling law. The losing party shall pay the prevailing party's attorney fees as well as the costs associated with JAMS, unless the arbitrator determines otherwise.

9.2 Alternative Dispute Settlement Techniques. Should the parties, prior to submitting a dispute to arbitration, desire to utilize other impartial dispute settlement techniques such as mediation or fact-finding, a joint request for such services may be made to JAMS, or the parties may initiate such other procedures as they may mutually agree upon at such time.

9.3 Limitation on Initiation of Arbitration. Nothing contained herein is intended to create (nor shall it be construed to create) any right of any Member to independently initiate the arbitration procedure established herein. This limitation shall not prevent the Plan from initiating such procedures as the representative of its Members, or Contractholder from initiating such procedures on behalf of Members,

provided that in any such case the Plan or Contractholder shall be considered the initiating party for the purposes hereof. In no event shall this section govern direct actions, third party actions, indemnification actions, or any other actions arising out of a professional malpractice claim.

9.4 Notice. Contract holder and Plan agree to provide timely written notice as specified herein, to each other in the event of a dispute which is potentially arbitrable, or in the event either party becomes aware of facts or circumstances which indicate a reasonable possibility of litigation with any third party or entity and are relevant to any rights, obligations, or other responsibilities or duties provided under this Agreement.

9.5 Injunctive Relief. Notwithstanding anything herein to the contrary, Plan shall have the right to apply for and obtain a temporary restraining order or other temporary, interim or permanent injunctive or equitable relief from a court of competent jurisdiction in order to enforce the provisions of any part of this Agreement as may be necessary to protect its rights.

ARTICLE X
MEMBER GRIEVANCE AND APPEALS PROCEDURES

10.1 Administration. The Plan shall be responsible for establishing and administering the Appeal and Grievance Procedures as described in the EOC.

10.2 Participation by Contractholder. Contractholder agrees to cooperate fully, participate in, and provide assistance and information to the Plan as may be necessary or helpful to the Plan in administering such Appeal and Grievance Procedures, including participation in any independent external review of coverage decisions.

10.3 Binding Arbitration. In the event any grievance or appeal of a Member cannot be settled through the grievance mechanism described herein, such matter may be submitted to binding arbitration in accordance with the terms of the EOC. In such event, Contractholder shall cooperate and, when necessary, participate, in any arbitration proceedings arising therefrom, subject to either party's right to seek judicial review thereof in accordance with the terms of the EOC.

10.4 Appeals. Appeals of claims denials and/or referral for service denials by Members shall be resolved according to the appeals and reconsideration procedures established by CMS as outlined in the EOC or in applicable CMS regulations, policies, or letters or instructions, which documents shall supersede the provisions outlined in the EOC.

ARTICLE XI
CANCELLATION

11.1 Cancellation of the Agreement

a. The Contractholder may cancel this Agreement at any time by providing one hundred twenty (120) days' prior written notice to the Plan. If the Agreement is cancelled on or after the 15th of the month, the Contractholder is liable for a full month's payment of Premiums. If the Agreement is cancelled prior to the 15th of the month, then Premiums payment will be waived and refunded to the group. In the event of such cancellation by either the Plan or the Contractholder, the Contractholder shall promptly pay any earned Premiums which have not previously been paid, and the Plan shall within 30 days (a) return to the Contractholder the amount of prepaid Premiums, if any, that the Plan determines will not have been earned as of such cancellation date; and (b) be responsible for Benefits for which charges were incurred prior to such cancellation date.

11.2 The Plan may cancel this Agreement for:

a. Failure of the Contractholder to pay any Premiums in accordance with the conditions of this Agreement;

b. Failure of the Contractholder to abide by and enforce the conditions of enrollment as set forth in this Agreement and in the, "Employer Group Application;"

c. A material change in the nature of the Contractholder's business, such as a bankruptcy or failure to maintain reasonable financial stability, a change in ownership, or a change in the Contractholder- Retiree relationship.

d. At any time by providing the Contractholder one hundred twenty (120) days' prior written notice.

11.3 Notification Of Cancellation To Subscribers. If this Agreement is rescinded, or cancelled by either party, the Contractholder shall be responsible for providing written notification of rescission or cancellation to the subscriber. The Contract holder shall promptly mail a legible, true copy of the Plan's notice of the rescission or cancellation to each subscriber at the subscriber's current address and shall promptly provide proof of such mailing and the date thereof to the Plan.

11.4 Cancellation Of Individual Members For Cause. The Plan may terminate coverage of a Member and his/her Dependent(s) for cause immediately upon notice to the Member for any of the reasons set forth in the EOC.

ARTICLE XII
HIPAA COMPLIANCE

Contractholder shall comply with all applicable requirements of HIPPA, including regulations promulgated and in full force and effect thereunder, upon the compliance dates set forth in rules and regulations promulgated pursuant to HIPAA. For purposes of this Agreement, HIPAA rules, regulations and/or requirements include, but are not limited to, all rules and regulations promulgated by the Department of Health and Human Services, or any office, administration or division thereof, pursuant to HIPAA.

ARTICLE XIII
HIPAA BUSINESS ASSOCIATE AGREEMENT

13.1 Plan and Contractholder are parties to this Agreement pursuant to which Contractholder does business with the Plan, and in connection therewith, uses or discloses Protected Health Information ("PHI") that is subject to protection under HIPAA, and certain regulations found at 45 CFR Parts 160 through 164 ("HIPAA Regulations").

13.2 Plan is a Covered Entity as that term is defined in the HIPAA Regulations. Contractholder creates or receives PHI from or on behalf of the Plan and is, therefore, a Business Associate, as defined in the HIPAA Regulations. Pursuant to the HIPAA Regulations, Contractholder, as a Business Associate of the Plan, must agree in writing to certain mandatory provisions regarding the use and disclosure of PHI. The purpose of this Section is to satisfy the Business Associate contract requirements as set forth at § 164.504(e) of the HIPAA Regulations, as they may be amended from time-to-time.

13.3 Except as otherwise limited in this Agreement, Contractholder shall use and disclose PHI solely to provide the services, or perform the functions described in the Agreement, provided that such use or disclosure would not violate the HIPAA Regulations if so used or disclosed by the Plan. Contractholder may use or disclose PHI for the proper management and administration of Contractholder or to provide data aggregation services to the Plan.

13.4 In connection with its use and disclosure of PHI, Contractholder shall:

a. not use or disclose PHI other than as permitted or required by this Agreement or as required by law.

b. use reasonable and appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement.

c. mitigate, to the extent practicable, any harmful effect that is known to Contractholder of a use or disclosure of PHI by Contractholder in violation of the requirements of this Agreement.

d. report to the Plan any use or disclosure of the PHI not provided for by this Agreement of which Contractholder becomes aware.

e. require contractors, subcontractors, and/or agents to whom Contractholder provides PHI created or received by Contractholder on behalf of the Plan to agree to the same restrictions and conditions that apply to Contractholder with respect to such PHI under this Agreement.

f. provide access, at the request of the Plan, within 10 business days, to PHI in a Designated Record Set, as defined in the HIPAA Regulations to the Plan in order to meet the requirements under § 164.524 of the HIPAA Regulations. If the Plan and Contractholder mutually agree, Contractholder may provide such access directly to Member, provided that such access is provided to the Member in the time-frames set forth in § 164.524 of the HIPAA Regulations.

g. make any amendment(s) to PHI in a Designated Record Set that the Plan directs or agrees to pursuant to § 164.526 of the HIPAA Regulations at the request of the Plan within 10 business days.

h. make internal practices, books, and records, including, but not limited to, policies and procedures, relating to the use and disclosure of PHI created or received by Contractholder on behalf of the Plan available to the Secretary of DHHS ("Secretary"), and to the Plan, if requested, in a time and manner designated by the Secretary, for purposes of the Secretary determining the Plan's compliance with the HIPAA Regulations.

i. maintain for a period of six (6) years an accounting of all disclosures of PHI that are required to be maintained under § 164.528 of the HIPAA Regulations. Such accounting will include the date of the disclosure, the name of the recipient, a description of PHI disclosed and the purpose of the disclosure.

j. provide to the Plan within 10 business days, information collected in accordance with this Section, to permit the Plan to respond to a request by a Member for an accounting of disclosures of PHI in

accordance with § 164.528 of the HIPAA Regulations. If the Plan and Contractholder mutually agree, Contractholder may provide such accounting directly to Member, provided that such accounting is provided to the Member within the time-frames set forth in § 164.528 of the HIPAA Regulations.

k. make reasonable efforts to implement any restriction of the use or disclosure of PHI that the Plan has agreed to under this Agreement.

13.5 The Plan shall:

a. provide Contractholder with the notice of privacy practices that the Plan furnishes to Members in accordance with § 164.520 of the HIPAA Regulations.

b. promptly notify Contractholder of any changes in, or revocation of, permission by Member to use or disclose PHI, to the extent that such changes may affect Contractholder's use or disclosure of PHI.

c. Promptly notify Contractholder of any restriction to the use or disclosure of PHI that the Plan has agreed to in accordance with §164.522 of the HIPAA Regulations, to the extent that such restriction may affect Contractholder's use or disclosure of PHI.

d. Not request Contractholder to use or disclose PHI in any manner that would not be permissible under the HIPAA Regulations if so used or disclosed by the Plan, unless such use or disclosure is necessary for the purposes of data aggregation or management and administrative activities of Contractholder under the Agreement.

e. pay Contractholder per the terms otherwise set forth in this Agreement for all records and documents that Contractholder is obligated to provide to the Plan under the terms of this Agreement.

13.6 Upon the Plan's knowledge of a material breach of the terms of this Section by Contractholder, the Plan shall, in accordance with the notification requirement and cure period set forth in the Agreement, provide an opportunity for Contractholder to cure the breach or end the violation. The Plan may terminate the Agreement if Contractholder does not cure the breach or end the violation within the cure period set forth in the Agreement.

13.7 Upon the expiration or earlier termination of the Agreement, for any reason, Contractholder shall return or destroy all PHI received from the Plan, or created or received by Contractholder on behalf of the Plan that Contractholder still maintains and retain no copies of such PHI, provided that if such return or destruction of PHI is

infeasible, Contractholder shall provide to the Plan notification of the conditions that make return or destruction infeasible and shall extend the protections of this Section to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Contractholder maintains such PHI.

13.8 The parties agree to take such action to amend this Agreement from time-to-time as is necessary for the Plan to comply with the requirements of HIPAA and the HIPAA Regulations.

13.9 The respective rights and obligations of Contractholder under this Section of this Agreement shall survive the termination of the Agreement.

13.10 Any ambiguity in this Section shall be resolved to permit the Plan to comply with the requirements HIPAA and the HIPAA Regulations.

ARTICLE XIV
Term and Termination

The term of this Agreement shall be one year commencing on the date indicated in the "INTRODUCTION" section above, of this Agreement, and shall automatically renew for one-year periods, unless this Agreement is terminated as provided in **ARTICLE XI CANCELLATION** herein. Wherever this Agreement provides for a date of commencement or termination of any part or all of this Agreement, commencement or termination shall be effective as of 12:01 A.M. Pacific Standard Time of that date.

ARTICLE XV
GENERAL PROVISIONS

15.1 Use Of Masculine Pronoun

Whenever a masculine pronoun is used in this Agreement, it shall include the feminine gender unless the context clearly indicates otherwise.

15.2 Business Interruption-Cause Beyond Control of Contractholder or the Plan

In the event the operations of Contractholder or the Plan or any substantial portion thereof, are interrupted by war, fire, insurrection, labor problems, riots, the elements, earthquakes, acts of God, or, without limiting the foregoing, any other cause beyond the control of Contractholder or the Plan, the provisions of this Agreement (or such portions hereof as Contractholder or the Plan is thereby rendered incapable of performing) shall be suspended for the duration of such interruption

15.3 Applicability of State and Federal Laws and Regulations. This Agreement shall be governed and construed in accordance with Applicable Law as defined herein. Contractholder acknowledges that the Plan is subject to Applicable Law, and any provision required to be in this Agreement, whether or not set forth herein, shall be incorporated into this Agreement and shall bind both parties hereto. Any provision of this Agreement which is in conflict with, or does not conform to Applicable Law as applied to the Plan shall be amended automatically to conform to the requirements of such Applicable Law.

15.4 Severability. In the event any provision of this Agreement is or becomes invalid or unenforceable by Act of Congress, statute passed by the California Legislature, local ordinance, or any regulation duly promulgated by officers of the United States or of the State of California acting in accordance with law, or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof, shall remain in full force and effect.

15.5 Limitation. In the event any change or changes required because of changes in Applicable Law, have the effect of materially altering the obligations of either party in such manner as to cause such party to act in violation of its corporate Articles of Incorporation or Bylaws (or similar organizational documents or agreements), the parties shall make all reasonable efforts to negotiate amendments to this Agreement which shall abrogate the effect of such statute, regulation, or judicial decision and to take such other available steps as shall avoid, to the extent possible under the circumstances, interruption of the delivery of services, or interference with the business activities of the other party. In the event the parties cannot reach mutual agreement on any amendments, the affected party shall have the right to terminate this Agreement upon sixty (60) days' prior written notice to the other party.

15.6 Provision for Amendment. This Agreement may be amended as follows:

The Plan and Contractholder may amend this Agreement by mutual written agreement, provided that no such amendment, unless otherwise provided by law, shall affect the rights or duties of Members as provided under the EOC or conflict with Applicable Law. This Agreement shall be amended automatically as necessary for the Plan to comply with all Applicable Law or regulatory policies. The Plan has the right, in its sole discretion and without Contractholder approval to modify or amend any Plan Benefits and/or EOC effective January 1 of each year and/or subject to appropriate regulatory requirements. In the event there are material changes in the Plan Benefits and/or EOC that have a material, adverse financial impact upon Contractholder, as reasonably demonstrated by Contractholder to the Plan, the parties shall meet in good faith to, if possible, negotiate a reasonable amendment to the compensation terms of this Agreement to address the impact.

15.7 Procedure for Amendment. In the event either party wishes to amend the terms of this Agreement, that party shall notify the other in writing of desired

changes, together with a statement of the reason(s) for such changes. The parties shall then meet in good faith to reach an agreement on the terms of the amendment. Upon agreement, an appropriate amendment shall be drafted, executed by both parties, and attached to and incorporated into this Agreement.

15.8 Approval of DMHC/DHS/CMS. All amendments, including but not limited to renewals of this Agreement, and any proposed amendments governing premiums, Covered Services, or the term hereof, shall be submitted to applicable/appropriate regulatory agencies for prior approval at least thirty (30) days before their effective date. No such amendment between Contractholder and the Plan shall be effective unless the appropriate approval from the regulatory agencies have been obtained.

15.9 Notice. Written notice required under this Agreement shall be delivered personally, or sent by United States registered certified mail or express mail, postage prepaid and return receipt requested, and shall be deemed given when so delivered by hand or if mailed, on the date of delivery shown on the receipt and addressed or delivered to each of the parties at the following address (or such other address as may hereafter be designated by a party by written notice thereof to the other party):

Plan:	SCAN Health Plan Attn: Gil Miller Sr. Vice President National Sales 3800 Kilroy Airport Way, Suite 100 Long Beach, California 90801-5616
With a copy to:	SCAN Health Plan Attn: General Counsel 3800 Kilroy Airport Way Suite 100 Long Beach, CA 90801- 5616
Contract-holder:	The City of Long Beach 333 West Ocean Blvd Long Beach, CA 90802

15.10 Records and Information To Be Furnished. The Contractholder shall furnish the Plan such information as the Plan may require to enable it to administer this

Plan, to determine the Premiums and to enable it to perform its obligations under the Agreement. All of the Contractholder's records that relate to eligibility and Benefits of this Plan shall be made available for inspection by the Plan when and so often as reasonably required.

15.11 Non-Assignability.

a. By Contractholder - this Agreement is not assignable by the Contractholder without the written consent of the Plan.

b. By a Member - the coverage and any Benefits of this Agreement are not assignable by any Member without the written consent of the Plan.

15.12 Limitation of Liability. Members shall not be responsible to Plan Providers for payment for Services to the extent they are a Benefit of this Plan. When Covered Services are rendered by a Plan Provider, the Member is responsible only for the applicable Copayments, and for non-benefit items. Members are responsible for the full charges for any non-covered services they obtain.

15.13 Payment of Providers. The Plan generally Contracts with groups of Physicians to provide Services to Members. A fixed, monthly fee is generally paid to the groups of Physicians for each Member whose PCP is in the group. This payment system, capitation, includes incentives to the group of Physicians to manage all Services provided to Members in an appropriate manner consistent with this Agreement. Members may request additional information about this payment system by contacting the Plan's Member Services Department or the Member's Plan Provider.

15.14 Plan Interpretation. The Plan shall have the power and discretionary authority to construe and interpret the provisions of this Agreement, to determine the Benefits of this Agreement and determine eligibility to receive Benefits under this Agreement. The Plan shall exercise this authority for the benefit of all Members entitled to receive Benefits under this Agreement.

15.15 Conditions Precedent To The Effectiveness Of This Agreement.

a. Service Delivery System Completion. This Agreement is contingent upon execution of contracts by the Plan with hospitals, physicians, and ancillary service providers who collectively constitute the Plan-Contracted Network. The Plan shall pursue these agreements in good faith, but does not covenant that such agreements can be reached.

b. Governmental Approval. This Agreement is contingent upon the Plan receiving approval from the appropriate local, state, and federal governmental or

quasi-governmental agencies, which have regulatory or quasi-regulatory powers over the Plan or its programs. Such agencies include, but are not limited to DMHC, DHS, CMS and any other relevant state, federal and local agencies. Additionally, this Agreement is contingent upon approval by DMHC in writing, or by operation of law.

15.16 Contract holder Notice Obligations. It is Contract holder's obligation to advise enrollees and/or their dependents of any rights they may have under the Employee Retirement Income Security Act of 1974 ("ERISA"), the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), and Cal-COBRA, to the extent applicable.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized representatives as of the effective date.

Executed at Long Beach, California

SCAN HEALTH PLAN

By _____

Name Chris Wing

Title Chief Executive Officer

Date 4-13-15

THE CITY OF LONG BEACH

By _____ Assistant City Manager

Name Patrick H. West

Title City Manager

Date 5/11/15

Tax ID [redacted]

EXECUTED PURSUANT TO SECTION 301 OF THE CITY CHARTER.

APPROVED AS TO FORM

5/5/2015

CHARLES PARKIN, City Attorney

By _____

LINDA T. VU

DEPUTY CITY ATTORNEY

SCAN HEALTH PLAN

By _____

Name William H. Roth

Title President

Date 4-13-15

EXHIBIT A

The City of Long Beach

Group Rates

Effective: January 1, 2014 – December 31, 2014

Group #119

Retiree	$331.56
Retiree + 1	$663.12
Retiree + 2	$994.68

Eligible retirees must have Medicare Parts A and B.