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

FROM: Human Resources Department

SUBMITTAL DATE: April 4, 2011

SUBJECT: 2011 Medical Plan Contract Renewal with Kaiser Permanente

RECOMMENDED MOTION: That the Board of Supervisors 1) ratify and approve the attached renewal contract effective January 1, 2011 for medical plans offered to eligible County employees and retirees through Kaiser Permanente; 2) authorize the Chairperson to sign four (4) copies of the renewal contract; and 3) retain one (1) copy of the signed renewal contract and return three (3) copies of the renewal contract to Human Resources for distribution.

BACKGROUND: The attached renewal contracts are the official documents confirming the rates and benefits previously approved by the Board of Supervisors on August 10, 2010, Item 3.47. Currently, there are approximately 3,595 active and 860 retired employees enrolled in the Kaiser plan, for a total annual cost of $34,134,618. Kaiser was not prepared to submit their contract to the County of Riverside until this time. Contract terms have been honored since January 1, 2011. There is no direct cost to the County for the recommended action.

Barbara A. Olivier
Asst. County Executive Officer/Human Resources Dir.

FINANCIAL DATA			
Current F.Y. Total Cost:	$ 34,134,618	In Current Year Budget:	Yes
Current F.Y. Net County Cost:	$ 0	Budget Adjustment:	No
Annual Net County Cost:	$ 0	For Fiscal Year:	2010/11

SOURCE OF FUNDS: Employee and Retiree Health Insurance Premiums

Positions To Be Deleted Per A-30 ☐

Requires 4/5 Vote ☐

C.E.O. RECOMMENDATION: APPROVE

BY: Elizabeth J. Olson

County Executive Office Signature

FORM APPROVED COUNTY COUNSEL
BY: TAWNY V. LIEU 4/13/2011 DATE

Departmental Concurrence

☐ Consent ☒ Policy (Dep't Recomm.:)

☐ Consent ☒ Policy (Per Exec. Ofc.:)

MINUTES OF THE BOARD OF SUPERVISORS

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

Ayes: Buster, Tavaglione, Stone, Benoit and Ashley
Nays: None
Absent: None
Date: April 26, 2011
xc: HR

Kecia Harper-Ihem
Clerk of the Board
By: Deputy

Prev. Agn. Ref.: 08/10/2010, Item 3.47 | **District:** All | **Agenda Number:** 3.34

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ATTACHMENTS FILED
WITH THE CLERK OF THE BOARD

Group Service Agreement
Between the County of Riverside and
Kaiser Foundation Health Plan, Inc.
Southern California Region
Plan Year 2011

Purchaser ID: 227016
Contract: 1 Version: 38

Agreement Signature Page

Acceptance of *Agreement*

Group acknowledges acceptance of this *Agreement* by signing the Signature Page and returning it to Health Plan. If Group does not return it to Health Plan, Group will be deemed as having accepted this *Agreement* if Group pays Health Plan any amount toward Premiums.

Group may not change this *Agreement* by adding or deleting words, and any such addition or deletion is void. Health Plan might not respond to any changes or comments submitted on or with this Signature Page. Group may not construe Health Plan's lack of response to any submitted changes or comments to imply acceptance. If Group wishes to change anything in this *Agreement*, Group must contact its Health Plan account manager. Health Plan will issue a new *Agreement* or amendment if Health Plan and Group agree on any changes.

Binding Arbitration

As more fully set forth in the arbitration provision in the applicable *Evidence of Coverage*, disputes between Members, their heirs, or associated parties (on the one hand) and Health Plan, its health care providers, or other associated parties (on the other hand) for alleged violation of any duty arising out of or related to this *Agreement*, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this *Agreement*, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. Members enrolled under this *Agreement* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the applicable *Evidence of Coverage* except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of Small Claims Court
- Claims subject to a Medicare appeals procedure as applicable to Kaiser Permanente Senior Advantage and Medicare Cost Members
- If the Member's Group must comply with the Employee Retirement Income Security Act (ERISA) requirements, the claim is a benefit-related request that constitutes a "benefit claim" in Section 502(a)(1)(B) of ERISA. Note: Benefit claims under this Section of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor regulation prohibiting mandatory binding arbitration of this category of claim (29 CFR 2560.503-1(c)(4)) is modified, amended, repealed, superseded, or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without further notice.

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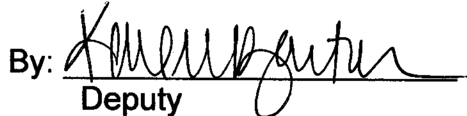
Group Service Agreement
Between the County of Riverside and
Kaiser Foundation Health Plan, Inc.
Southern California Region
Plan Year 2011

Purchaser ID: 227016
Contract: 1 Version: 38

IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this contract renewal as set forth below.

ATTEST:
Clerk of the Board
Kecia Harper-Ihem


By: ______________
Deputy

Date: APR 26 2011

COUNTY OF RIVERSIDE:

By: ______________
Chairman, Board of Supervisors

Date: APR 26 2011

BOB BUSTER

Approved as to form:

Pamela J. Walls
County Counsel

By: ______________
Deputy County Counsel

CONTRACTOR: KAISER FOUNDATION HEALTH PLAN, Inc.

By: ______________

Printed Name: Cynthia Striegel

Title: VP- Strategic Accounts

Date: 3-28-11

APR 26 2011 3.34

Introduction

This Group Agreement (*Agreement*), including the *Evidence of Coverage* (*EOC*) document(s) listed below, the group application that Group submitted to Health Plan, and any amendments to any of them, all of which are incorporated into this *Agreement* by reference, constitute the contract between Kaiser Foundation Health Plan, Inc., (Health Plan) and COUNTY OF RIVERSIDE (Group). In this *Agreement*, some capitalized terms have special meaning; please see the "Definitions" section in the *EOC* document(s) for terms you should know. Pursuant to this *Agreement*, Health Plan will provide covered Services to Members in accord with the following *EOC* document(s):

Product name	Contract option name	*EOC #*
American Specialty Health Plans Chiropractic Plan	Chiropractic For Actives And Retirees Prior 01/01/	1
Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage	Working Aged Risk For Actives	2
Kaiser Permanente Traditional Plan	Traditional HMO For Actives	3
Kaiser Permanente Senior Advantage (HMO) with Part D	Sr Adv Grp HMO SCR For Actives And Retirees Prior	4
Kaiser Permanente Traditional Plan	Traditional HMO For Early And Medicare Retirees	9
Kaiser Permanente Senior Advantage (HMO) with Part D	Sr Adv Grp HMO For Early Retirees After 01/01/2009	10
Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage	Working Aged Risk For Early Retirees After 01/01/2	11
American Specialty Health Plans Chiropractic Plan	Chiropractic For Early Retirees After 01/01/2009	12
Kaiser Permanente Double Covered Plan for Seniors	KPSA/Dbl Cov	13
Kaiser Permanente Senior Advantage (HMO) with Part D	Sr Adv Grp HMO SCR/Dbl Cov	14
American Specialty Health Plans Chiropractic Plan	Chiropractic For Dbl Cov	15

Term of *Agreement* and Renewal

Term of *Agreement*

Unless terminated as set forth in the "Termination of *Agreement*" section, this *Agreement* is effective from January 1, 2011, through December 31, 2011.

Renewal

This *Agreement* does not automatically renew. If Group complies with all of the terms of this *Agreement*, Health Plan will offer to renew the *Agreement*, upon 30 days prior written notice to Group, by doing one of the following:

- Providing Group with a new *Group Agreement* to become effective immediately after termination of this *Agreement*
- Extending the term of this *Agreement* and making other changes pursuant to "Amendments Effective on January 1 (Anniversary Date)" in the "Amendment of *Agreement*" section
- Sending Group a renewal notice, which will include a summary of changes to this *Agreement* that will become effective immediately after termination of this *Agreement*. The new *Group Agreement* will incorporate the changes summarized in the renewal notice. Health Plan will send Group the new Group Agreement after Group confirms it wants to make additional changes or 60 days after Group's Anniversary Date, if Group does not confirm

If Group does not renew the *Agreement*, Group must give Health Plan written notice as described under "Termination on Notice" or "Termination due to Nonacceptance of Amendments" in the "Termination of *Agreement*" section.

Amendment of *Agreement*

Amendments Effective on January 1 (Anniversary Date)

Upon 30 days prior written notice to Group, Health Plan may extend the term of this *Agreement* and make other changes by amending this *Agreement* effective January 1 (the Anniversary Date).

Amendments Related to Government Approval

If Health Plan notified Group that Health Plan had not received all necessary governmental approvals related to this *Agreement*, Health Plan may amend this *Agreement* by giving written notice to Group after receiving all necessary governmental approvals. Any such government-approved provisions go into effect on January 1, 2011 (unless the government requires a later effective date).

Amendment Due to Medicare Changes

Health Plan contracts on a calendar year basis with the Centers for Medicare & Medicaid Services (CMS) to offer Kaiser Permanente Senior Advantage. Health Plan may amend this *Agreement* to change any Kaiser Permanente Senior Advantage *EOCs* and Premiums effective January 1, 2012 (unless the federal government requires or allows a different effective date). The amendment may include an increase or decrease in Premiums and benefits (including Member Cost Sharing and any Medicare Part D coverage level thresholds). Health Plan will give Group written notice of any such amendment.

In addition, Health Plan may amend this *Agreement* at any time by giving written notice to Group, in order to increase any benefits of any Medicare product approved by the Centers for Medicare & Medicaid Services (CMS).

Amendment Due to Tax or Other Charges

If a government agency or other taxing authority imposes or increases a tax or other charge (other than a tax on or measured by net income) upon Health Plan or Plan Providers (or any of their activities), then upon 30 days prior written notice, Health Plan may increase Group's Premiums to include Group's share of the new or increased tax or charge. Group's share will be determined by dividing the number of Members enrolled through Group by the total number of members enrolled in the Southern California Region.

Other Amendments

Health Plan may amend this *Agreement* at any time by giving written notice to Group, in order to address any law or regulatory requirement, which may include an increase in Premiums to reflect an increase in costs to Health Plan or Plan Providers (Health Plan will give Group 30 days prior written notice of any increase in Premiums or reduction in benefits).

Acceptance of Amendments

All amendments are deemed accepted by Group unless Group gives Health Plan written notice of nonacceptance within 15 days after the date of Health Plan's amendment notice, in which case this *Agreement* will terminate pursuant to "Termination due to Nonacceptance of Amendments" in the "Termination of *Agreement*" section.

Termination of *Agreement*

This *Agreement* will terminate under any of the conditions listed below. All rights to benefits under this *Agreement* end on the termination date, except as expressly provided in the "Termination of Membership" or "Continuation of Membership"

sections of an *Evidence of Coverage*. The termination date is the first day when this *Agreement* is no longer in effect (for example, if the termination date is January 1, 2012, the last minute this *Agreement* was in effect was at 11:59 p.m. on December 31, 2011).

If Health Plan terminates this *Agreement*, Health Plan will give Group written notice. Within five business days of receipt, Group will mail to each Subscriber a legible copy of the notice and will give Health Plan proof of that mailing and of the date thereof.

Termination on Notice

Group may terminate this *Agreement* effective January 1 (the Anniversary Date) by giving at least 15 days prior written notice to Health Plan and remitting all amounts payable relating to this *Agreement*, including Premiums, for the period prior to the termination date.

Termination Due to Nonacceptance of Amendments

All amendments are deemed accepted by Group unless Group gives Health Plan written notice of nonacceptance within 15 days after the date of Health Plan's amendment notice and remits all amounts payable related to this *Agreement*, including Premiums, for the period prior to the amendment effective date. This *Agreement* will terminate the day before the effective date of the amendment.

Termination for Nonpayment

If Group fails to make any past-due payment within 15 days after Health Plan's initial written notice to Group of the amount payable, Health Plan may terminate this *Agreement* immediately by giving written notice to Group, and Group is liable for all unpaid Premiums up to the termination date.

Termination for Fraud or Intentionally Furnishing Incorrect or Incomplete Information

Health Plan may terminate this *Agreement* upon 15 days prior written notice to Group, if Group commits fraud or intentionally furnishes incorrect or incomplete material information to Health Plan.

Termination for Violation of Contribution or Participation Requirements

Health Plan may terminate this *Agreement* upon 15 days prior written notice to Group, if Group fails to comply with Health Plan's participation or contribution requirements (including those discussed in the "Contribution and Participation Requirements" section).

Termination for Discontinuance of a Product or all Products within a Market

Health Plan may terminate a particular product or all products offered in a small or large group market as permitted or required by law. If Health Plan discontinues offering a particular product in a market, Health Plan may terminate this *Agreement* with respect to that product upon 90 days prior written notice to Group. Health Plan will offer Group another product that it makes available to groups in the small or large group market, as applicable. If Health Plan discontinues offering all products to groups in a small or large group market, as applicable, Health Plan may terminate this *Agreement* upon 180 days prior written notice to Group and Health Plan will not offer any other product to Group. A "product" is a combination of benefits and services that is defined by a distinct *Evidence of Coverage*.

Contribution and Participation Requirements

No change in Group's contribution or participation requirements listed below is effective for purposes of this *Agreement* unless Health Plan consents in writing. As a condition to consenting to Group's revised contribution and participation requirements, Health Plan may require Group to agree to amend the Premiums, benefits, or other provisions of this *Agreement.*

Group must:

- Contribute to all health care coverage available through Group on a basis that does not financially discriminate against Health Plan or against people who choose to enroll in Health Plan
- For each Family, Group's contribution must be an amount that is at least 50 percent of the Premiums required for a single Subscriber for the coverage in which the Subscriber is enrolled
- Ensure that:
  - all employees enrolled in Health Plan work at least 20 hours per week unless Health Plan agrees otherwise in writing
  - all employees enrolled in Health Plan are covered by workers' compensation or the employer's liability benefits, unless not required by law to be covered
  - at least 75 percent of eligible employees are covered by a group health care plan
  - all Subscribers live or work inside the Service Area applicable to their coverage when they enroll (except that Group must ensure that Subscribers live inside the Service Area applicable to their coverage when they enroll if Group chooses not to have a "live or work" eligibility rule, and that Kaiser Permanente Senior Advantage Members live inside the Service Area applicable to their coverage when they enroll in Senior Advantage and thereafter)
  - at least one employee, proprietor, or partner who lives or works inside the Service Area is eligible to enroll as a Subscriber
  - the number of Subscribers enrolled under this *Agreement* does not fall below the greater of five employees or five percent of the total number of eligible employees
  - the ratio between the number of Subscribers and the total number of people who are eligible to enroll as Subscribers will not drop by 20 percent or more. For the purpose of computing this percentage requirement, Group may include subscribers and those eligible to enroll as subscribers under all other agreements between Group and Health Plan and all other Regions
- Hold an annual open enrollment period during which all eligible people may enroll in Health Plan or in any other health care plan available through Group. Also, Group must not hold open enrollment for 2012 until Group receives its 2012 group agreement Premium and coverage information from Health Plan. If Group holds the open enrollment without receiving 2012 group agreement Premium and coverage information, Health Plan may change Premiums and coverage (including benefits and Cost Sharing) when it offers to renew Group's *Agreement* as described under "Renewal" in the "Term of *Agreement* and Renewal" section
- Meet all applicable legal and contractual requirements, such as:
  - distribute the *Disclosure Form* or the Summary of Group Plan Provisions, as applicable, to Subscribers and potential Subscribers and the *Evidence of Coverage* to Subscribers in accord with applicable laws, including the Medicare-as-Secondary-Payer laws
  - adhere to all requirements set forth in the applicable *Evidence of Coverage*
  - obtain Health Plan's prior written approval of any Group eligibility requirements that are not stated in the applicable *Evidence of Coverage*
  - use Member enrollment application forms that are provided or approved by Health Plan as described under "Enrollment Application Requirements" in the "Miscellaneous Provisions" section
  - For any coverage identified in an *EOC* as a "grandfathered health plan" under the Patient Protection and Affordable Care Act, immediately inform Health Plan if this coverage does not meet (or no longer meets) the requirements for grandfathered status
  - comply with CMS requirements governing enrollment in, and disenrollment from, Kaiser Permanente Senior Advantage

- Meet all Health Plan requirements set forth in the "Rate Assumptions and Requirements" section of the *Rate Proposal* document
- Offer enrollment in Health Plan to all eligible people on conditions no less favorable than those for any other health care plan available through Group
- Permit Health Plan to examine Group's records with respect to contribution and participation requirements, eligibility, and payments under this *Agreement*

Miscellaneous Provisions

Assignment

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

Attorney Fees and Costs

If Health Plan or Group institutes legal action against the other to collect any sums owed under this *Agreement*, the party that substantially prevails will be reimbursed for its reasonable litigation expenses, including attorneys' fees, by the other party.

Confidential Information about Health Plan or its Affiliates

For the purposes of this "Confidential Information about Health Plan or its Affiliates" section, "Confidential Information" means any oral, written, or electronic information concerning Health Plan or its affiliates, if the information either is marked "confidential" or is by its nature proprietary or non-public, except that it does not include any of the following:

- Information that is or becomes available to the public other than as a result of disclosure by Group or its employees, advisors, or representatives
- Information that was available to Group or within its knowledge before Health Plan disclosed it to Group
- Information that becomes available to Group from a source other than Health Plan, but only if that source is not bound by a confidentiality agreement with Health Plan

If Group receives any Confidential Information, it will use that information only to evaluate Health Plan and actual or proposed group agreements with Health Plan. Group will ensure that the information is not disclosed to anyone other than a limited number of Group's employees and advisors, and only to the extent necessary in connection with the evaluation of Health Plan and actual or proposed group agreements with Health Plan. Group will inform any such employees and advisors that the information is confidential and that they must treat it confidentially.

Upon Health Plan's request Group will promptly return to Health Plan all Confidential Information, and will destroy any other copies and any notes or other Group documents about the information.

If Group is requested or required (by oral questions, interrogatories, request for information or documents, subpoena, civil investigative demand, or similar process) to disclose any Confidential Information, Group will give Health Plan prompt notice of the request or requirement, and Group will cooperate with Health Plan in seeking to legally avoid the disclosure. If, in the absence of a protective order, Group is legally compelled, in the opinion of its counsel, to disclose any of the information, Health Plan either will seek and obtain appropriate protective orders against the disclosure or will be deemed to waive Group's compliance with the provisions of this "Confidential Information about Health Plan or its Affiliates" section to the extent necessary to satisfy the request or requirement.

Group understands (and will inform any employees and advisors who receive Confidential Information) that United States securities laws prohibit anyone who has material non-public information about a company from buying or selling that company's securities in reliance upon that information or from communicating the information to any other person or entity under circumstances in which it is reasonably foreseeable that the person or entity is likely to buy or sell that company's securities in reliance upon the information. Group agrees that it and its affiliates, associates, employees, agents, and advisors will not rely on any Confidential Information in directly or indirectly buying or selling any Health Plan securities.

Monetary damages would not be a sufficient remedy for any breach or threatened breach of this "Confidential Information about Health Plan or its Affiliates" section. Health Plan will be entitled to equitable relief by way of injunction or specific performance if Group or any of its officers, directors, employees, attorneys, accountants, agents, advisors, or representatives breach, or threaten to breach, any of the provisions of this "Confidential Information about Health Plan or its Affiliates" section.

Group's obligations under this "Confidential Information about Health Plan or its Affiliates" section will continue indefinitely and will survive the termination or expiration of this *Agreement*.

Contract Providers

Health Plan will give Group written notice within a reasonable time of any termination or breach of contract by, or inability to perform of, any health care provider that contracts with Health Plan if Group may be materially and adversely affected thereby.

Delegation of Claims Review

Group delegates to Health Plan the discretion to determine whether a Member is entitled to benefits under this *Agreement*. In making these determinations, Health Plan has discretionary authority to review claims in accord with the procedures contained in this *Agreement* and to construe this *Agreement* to determine whether the Member is entitled to benefits. If coverage under an *EOC* is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), Health Plan is a "named claims fiduciary" to review claims under that *EOC*.

Enrollment Application Requirements

Group must use enrollment application forms that are provided by Health Plan. If Group wants to use a different form or system for enrolling Members, Group must obtain Health Plan's approval of the form or system. Other forms and systems include a "universal" enrollment application form, interactive voice recording (IVR) enrollment system, or intranet online enrollment system. All forms and systems must meet Health Plan requirements for enrolling Members, including disclosure of binding arbitration in accord with Section 1363.1 of the California Health and Safety Code and other applicable law. Group's Health Plan account manager can provide Group with Health Plan's current requirements for enrollment application forms and systems.

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 Group and Health Plan whether or not set forth in this *Agreement*.

Group Delegation to Health Plan of Clerical COBRA Functions

Group hereby delegates to Health Plan the following clerical COBRA functions:

- Billing and collecting COBRA Premiums under this *Agreement*. Group authorizes Health Plan to include in COBRA Premiums the COBRA administrative charge listed under "Calculating Monthly Premiums" in the "Premiums" section. The total COBRA Premiums will not exceed the maximum permitted by COBRA law
- Terminating the memberships of Group's COBRA Members for nonpayment of COBRA Premiums, or for expiration of the expected time limit that Group specified for the Member's COBRA coverage

Group retains all other COBRA responsibilities, such as notifying qualified beneficiaries of COBRA rights and processing COBRA elections. In addition, it is understood that Group relies on its own sources (for example, Group's legal counsel) for information about Group's responsibilities under COBRA law. Health Plan is not responsible for advising Group about Group's responsibilities. Health Plan is not a named fiduciary for purposes of administration of COBRA coverage.

When a COBRA qualified beneficiary makes a COBRA election and enrolls through Group in Health Plan, Group will notify Health Plan of the enrollment, the COBRA qualifying event (for example, termination of employment), and the expected time limit for the COBRA membership (for example, 36 months for a Spouse if the COBRA qualifying event is divorce). Health Plan will then bill and collect Premiums from the appropriate Member for the Family's COBRA Members.

Group will notify Health Plan when a Member's COBRA membership terminates (except for terminations that Health Plan initiates) or changes status (for example, if a Subscriber requests any membership change or there is a disability determination that makes a COBRA Member eligible for the disability extension of COBRA eligibility).

Health Plan will send Group a monthly report of the membership status of COBRA Members. This report will include the names and the current billing addresses (according to Health Plan's records) of all COBRA Members. The report will also list the following:

- Members whose COBRA Premiums are delinquent. Unless Group notifies Health Plan that Group does not want Health Plan to terminate the membership of one or more of these Members, Health Plan will terminate the membership of these Members for nonpayment if Health Plan does not receive payment by the due date specified in Health Plan's notice to the Member
- Members whose membership Health Plan has terminated for nonpayment or for expiration of the expected time limit that Group specified for the Member's COBRA coverage

Group will notify Health Plan immediately if one of the following occurs:

- Group disagrees with a Member's COBRA expiration date listed on the report
- The report lists a COBRA Member whose Premiums are delinquent or whose membership has been terminated for nonpayment, and Group does not want that Member's membership terminated for nonpayment

Note: Nothing in this "Group Delegation to Health Plan of Clerical COBRA Functions" section is intended to prohibit Health Plan from terminating memberships without Group's consent in accord with the *EOC*, for example, in the case of termination for cause.

Member Information

Group will inform Subscribers of eligibility requirements for Members and when coverage becomes effective and terminates.

When Health Plan notifies Group about changes to this *Agreement* or provides Group other information that affects Members, Group will disseminate the information to Subscribers by the next regular communication to them, but in no event later than 30 days after Group receives the information.

No Waiver

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

Notices

Notices must be sent to the addresses listed below. Health Plan or Group may change its addresses for notices by giving written notice to the other. All notices are deemed given when delivered in person or deposited in a U.S. Postal Service receptacle for the collection of U.S. mail.

Notices from Health Plan to Group will be sent to:

BARBARA OLIVIER, ASSISTANT HUMAN RESOURES DIREC
COUNTY OF RIVERSIDE
PO BOX 1569
RIVERSIDE, CA 92502-1569

If Group has chosen to receive group agreements electronically through Health Plan's website at **kp.org/yourcontract**, Health Plan will send a notice to Group at the address listed above when a group agreement has been posted to that website.

Note: When Health Plan sends Group a new (renewed) *Agreement*, Health Plan will enclose a summary of changes that discusses the changes Health Plan has made to the *Group Agreement*. Groups that want information about changes before receiving the *Agreement* may request advance information from Group's Health Plan account manager. Also, if Group designates a third party in writing (for example, "Broker of Record" statements), Health Plan may send the advance information to the third party rather than to Group (unless Group requests a copy too).

Notices from Group to Health Plan must be sent to:

Kaiser Permanente
1950 Franklin Street
Oakland, CA 94612
Attn: Jerry Fleming, Senior Vice President and Health Plan Manager

Reporting Membership Changes and Retroactivity

Group must report membership changes (including sending appropriate membership forms) within the time limit for retroactive changes and in accord with any applicable "rescission" provisions of the Patient Protection and Affordable Care Act and regulations. Except for Senior Advantage membership terminations discussed below, the time limit for retroactive membership changes is the calendar month when Health Plan's California Service Center receives Group's notification of the change plus the previous 2 months.

In accord with the Centers for Medicare & Medicaid Services (CMS) requirements, Senior Advantage members must receive 21 days prior written notice before their membership terminates. This means that Group may not retroactively terminate Senior Advantage membership. In addition, Group must give Health Plan's California Service Center 30 days prior written notice of Senior Advantage involuntary membership terminations. The effective date of membership termination is determined by the date when Group gives notice to the Service Center. The membership termination date is the first of the month following 30 days after the date when Health Plan's California Service Center receives a Senior Advantage membership termination notice unless Group specifies a later termination date. For example, if Health Plan's California Service Center receives a termination notice on March 5 for a Senior Advantage Member, the earliest termination date is May 1 and Group is required to pay applicable Premiums for the months of March and April. Note: If Health Plan's California Service Center receives a disenrollment notice from CMS or the Member, the effective date of membership termination will be in accord with that notice and CMS requirements.

Health Plan's *Administrative Handbook* includes the details about how to report membership changes. Group's Health Plan account manager can provide Group with an *Administrative Handbook* if Group does not have one.

Social Security and Tax Identification Numbers

Within 60 days after Health Plan sends Group a written request, Group will send Health Plan a list of all Members covered under this Agreement, along with the following:

- The Social Security number of the Member
- The tax identification number of the employer of the Subscriber in the Member's Family
- Any other information that Health Plan is required by law to collect

Premiums

Only Members for whom Health Plan (or its designee) has received the appropriate Premium payment listed below are entitled to coverage under this *Agreement*, and then only for the period for which Health Plan (or its designee) has received appropriate payment. Group is responsible for paying Premiums, except that Members who have Cal-COBRA coverage under an EOC that is included in this Agreement are responsible for paying Premiums for Cal-COBRA coverage.

Due Date and Payment of Premiums

The payment due date for each enrollment unit associated with Group will be reflected on the monthly membership invoice if applicable to Group (if not applicable, then as specified in writing by Health Plan). If Group does not pay Full Premiums by the first of the coverage month, the Premiums may include an additional administrative charge upon renewal. "Full Premiums" means 100 percent of monthly Premiums for each enrolled Member, as set forth under "Calculating Monthly Premiums" in this "Premiums" section.

New Members

Premiums are payable for a new Member for the entire month when the Member's coverage effective date is any day during that month.

Note: Membership begins at the beginning (12:00 a.m.) of the effective date of coverage.

Member Termination

Premiums are payable for the entire month for a Member whose last day of coverage is any day during that month.

In accord with the Centers for Medicare & Medicaid Services (CMS) requirements, the effective date of Senior Advantage involuntary membership termination is the first of the month following 30 days after the date when Health Plan's California Service Center receives a Senior Advantage membership termination notice unless Group specifies a later termination date. For example, if Health Plan's California Service Center receives a termination notice on March 5 for a Senior Advantage Member, the earliest termination date is May 1 and Group is required to pay applicable Premiums for the months of March and April. Note: If Health Plan's California Service Center receives a disenrollment notice from CMS or the Member, the effective date of membership termination will be in accord with that notice and CMS requirements.

Note: The membership termination date is the first day a Member is not covered (for example, if the termination date is January 1, 2012, the last minute of coverage was at 11:59 p.m. on December 31, 2011).

Medicare

Medicare as primary coverage

For Members who are (or the subscriber in the family is) retired, age 65 or over, and eligible for Medicare as primary coverage, Premiums are based on the assumption that Health Plan or its designee will receive Medicare payments for Medicare-covered services provided to Members whose Medicare coverage is primary. If a Member age 65 or over is (or becomes) eligible for Medicare as primary coverage and is not for any reason enrolled through Group under an *EOC* that requires Members to have Medicare (including inability to enroll under that *EOC* because he or she does not meet the plan's eligibility requirements, the plan is not available through Group, or the plan is closed to enrollment), Group must pay the Premiums listed below for the *EOC* under which the Member is enrolled that apply to Members age 65 or over who are not enrolled through Group under one of our Medicare plans. The following plans require Members to have Medicare:

- Kaiser Permanente Senior Advantage
- Double Covered Plan for Seniors

If a Member age 65 or over who is eligible for Medicare as primary coverage and enrolled under an *EOC* that requires Members to have Medicare is no longer eligible for that plan, Health Plan may transfer the Member's membership to one of Group's plans that does not require Members to have Medicare, and Group must pay the Premiums listed below for the *EOC* under which the Member is enrolled that apply to Members age 65 or over who are not enrolled through Group under one of our Medicare plans.

Medicare as secondary coverage

Medicare is the primary coverage except when federal law requires that Group's health care coverage be primary and Medicare coverage be secondary. Members entitled to Medicare when Medicare is secondary by law, are subject to the same Premiums and receive the same benefits as Members who are under age 65 not eligible for Medicare. In addition, any such Members for whom Medicare is secondary and who meet the Kaiser Permanente Senior Advantage eligibility requirements, may also enroll in the Kaiser Permanente Senior Advantage plan applicable when Medicare is secondary under this *Agreement*. These Members receive the benefits and coverage described in both the *EOC* for the non-Medicare plan (the plan that does not require Members to have Medicare) and the Senior Advantage *EOC* applicable when Medicare is secondary.

Subscriber Contributions for Medicare Part C and Part D Coverage

Medicare Part C coverage

This "Medicare Part C coverage" section applies to Group's Kaiser Permanente Senior Advantage coverage. Group's Senior Advantage Premiums include the Medicare Part C premium for coverage of items and services covered under Parts A and B of Medicare, and supplemental benefits. Group may determine how much it will require Subscribers to contribute toward the Medicare Part C premium for each Senior Advantage Member in the Subscriber's Family, subject to the following restrictions:

- If Group requires different contribution amounts for different classes of Senior Advantage Members for the Medicare Part C premium, then Group agrees to the following:
  - any such differences in classes of Members are reasonable and based on objective business criteria, such as years of service, business location, and job category
  - Group will not require different Subscriber contributions toward the Medicare Part C premium for Members within the same class
- Group will not require Subscribers to pay a contribution for Medicare Part C coverage for a Senior Advantage Member that exceeds the Medicare Part C Premium for items and services covered under Parts A and B of Medicare, and supplemental benefits. Health Plan will pass through monthly payments received from CMS (the monthly payments described in 42 C.F.R. 422.304(a)) to reduce the amount the Member contributes toward the Medicare Part C premium

Medicare Part D coverage

This "Medicare Part D coverage" section applies only to Group's Kaiser Permanente Senior Advantage coverage that includes Medicare Part D prescription drug coverage. Group's Senior Advantage Premiums include the Medicare Part D

premium. Group may determine how much it will require Subscribers to contribute toward the Medicare Part D premium for each Senior Advantage Member in the Subscriber's Family, subject to the following restrictions:

- If Group requires different contribution amounts for different classes of Senior Advantage Members for the Medicare Part D premium, then Group agrees to the following:
  - any such differences in classes of Members are reasonable and based on objective business criteria, such as years of service, business location, and job category, and are not based on eligibility for the Medicare Part D Low Income Subsidy (the subsidies described in 42 C.F.R. Section 423 Subpart P, which are offered by the Medicare program to certain low-income Medicare beneficiaries enrolled in Medicare Part D, and which reduce the Medicare beneficiaries' Medicare Part D premiums and/or Medicare Part D cost-sharing amounts)
  - Group will not require different Subscriber contributions toward the Medicare Part D premium for Members within the same class
- Group will not require Subscribers to pay a contribution for prescription drug coverage for a Senior Advantage Member that exceeds the Premium for prescription drug coverage (including the Medicare Part D premium). The Group will pass through direct subsidy payments received from CMS to reduce the amount the Member contributes toward the Medicare Part D premium
- Health Plan will credit Group with any Low Income Subsidy amounts that Health Plan receives from CMS for Group's Members, and Health Plan will identify those Members for Group as required by CMS. For those Members, Group will first credit the Low Income Subsidy amount toward the Subscriber's contribution for that Member's Senior Advantage Premium for the same month, and will then apply any remaining portion of the Member's Low Income Subsidy toward the portion of the Senior Advantage Premium that Group pays on behalf of that Member for that month. If Group is unable to reduce the Subscriber's contribution before the Subscriber makes the contribution, Group shall, consistent with CMS guidance, refund the Low Income Subsidy amount to the Subscriber (up to the amount of the Subscriber Premium contribution for the Member for that month) within 45 days after the date Health Plan receives the Low Income Subsidy amount from CMS. Health Plan reserves the right to periodically require Group to certify that Group is either reducing Subscribers' monthly Premium contributions or refunding the Low Income Subsidy amounts to Subscribers in accord with CMS guidance
- For any Members who are eligible for the Low Income Subsidy, if the amount of that Low Income Subsidy is less than the Member's contribution for the Medicare Part D premium, then Group should inform the Member of the financial consequences of the Member's enrolling in the Member's current coverage, as compared to enrolling in another Medicare Part D plan with a monthly premium equal to or less than the Low Income Subsidy amount

Late Enrollment Penalty. If any Members are subject to the Medicare Part D late enrollment penalty, Premiums for those Members will increase to include the amount of the penalty.

Calculating Monthly Premiums

To calculate the monthly Premiums that apply to a Family (a Subscriber and all of his or her Dependents):

1. Determine the coverages (*EOCs* and contract options) that apply to each Member in the Family (for example, Traditional Plan and ancillary coverages)
2. Determine the family role type and Medicare status of each Member (for family role types, please see the "Definitions" section of the *EOC* for the definition of Subscriber, Dependent, and Spouse)
3. Identify the Premiums for each Member for each *EOC* and contract option in the Premium tables below based on the family role type of each Member
4. Add the amount of Premiums for each Member together to arrive at the total Premiums required for the Family

Note: *EOC* number is also known as "contract option ID."

American Specialty Health Plans Chiropractic Plan — *EOC # 1*

Chiropractic For Actives And Retirees Prior 01/01/

Family role type	Premiums
Subscriber	$2.00
1st Dependent	$2.00
2nd Dependent	$1.00

Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage — *EOC # 2*

Working Aged Risk For Actives

For Members enrolled in Senior Advantage when federal law requires that Group's health care plan be primary and Medicare coverage be secondary, the Premiums are:

Family role type	Premiums
Subscriber	$456.00
1st Dependent	$455.00
2nd Dependent	$274.00

COBRA and Cal-COBRA administrative charge

For each Subscriber for whom Health Plan bills directly for group continuation coverage under COBRA or Cal-COBRA, add an administrative charge of $2.00.

Kaiser Permanente Traditional Plan — *EOC # 3*

Traditional HMO For Actives

Members under age 65 (or 65 and over if Medicare is secondary)	
Family role type	Premiums
Subscriber	$456.00
1st Dependent	$455.00
2nd Dependent	$274.00
Each additional Dependent	$0.00

Members age 65 and over whose Medicare eligibility is unknown or who are eligible for or have Medicare Part B only	
Family role type	Premiums
Subscriber	$1,925.00
1st Dependent	$1,925.00
2nd Dependent	$1,925.00
Each additional Dependent	$1,925.00

Members age 65 and over who are eligible for or have Medicare Part A	
Family role type	Premiums
Subscriber	$1,612.00
1st Dependent	$1,612.00
2nd Dependent	$1,612.00
Each additional Dependent	$1,612.00

Members enrolled in another carrier's Medicare Risk product	
Family role type	Premiums
Subscriber	$1,925.00
1st Dependent	$1,925.00
2nd Dependent	$1,925.00
Each additional Dependent	$1,925.00

Note: Members who are "eligible for" Medicare Part A or B are those who would qualify for Medicare Part A or B coverage if they applied for it. Members who "have" Medicare Part A or B are those who have been granted Medicare Part A or B coverage. Medicare Part A provides inpatient coverage and Part B provides outpatient coverage.

COBRA and Cal-COBRA administrative charge

For each Subscriber for whom Health Plan bills directly for group continuation coverage under COBRA or Cal-COBRA, add an administrative charge of $2.00.

Kaiser Permanente Senior Advantage (HMO) with Part D — *EOC # 4*

Sr Adv Grp HMO SCR For Actives And Retirees Prior

Family role type	Medicare Parts A & B	Medicare Part B only
Subscriber	$235.00	$547.00
1st Dependent	$235.00	$547.00
2nd Dependent	$235.00	$547.00
Each additional Dependent	$235.00	$547.00

COBRA and Cal-COBRA administrative charge

For each Subscriber for whom Health Plan bills directly for group continuation coverage under COBRA or Cal-COBRA, add an administrative charge of $2.00.

Kaiser Permanente Traditional Plan — *EOC # 9*

Traditional HMO For Early And Medicare Retirees

Members under age 65 (or 65 and over if Medicare is secondary)	
Family role type	Premiums
Subscriber	$708.00
1st Dependent	$707.00
2nd Dependent	$424.00
Each additional Dependent	$0.00

Members age 65 and over whose Medicare eligibility is unknown or who are eligible for or have Medicare Part B only	
Family role type	Premiums
Subscriber	$1,925.00
1st Dependent	$1,925.00
2nd Dependent	$1,925.00
Each additional Dependent	$1,925.00

Members age 65 and over who are eligible for or have Medicare Part A	
Family role type	Premiums
Subscriber	$1,612.00

1st Dependent	$1,612.00
2nd Dependent	$1,612.00
Each additional Dependent	$1,612.00

Members enrolled in another carrier's Medicare Risk product	
Family role type	Premiums
Subscriber	$1,925.00
1st Dependent	$1,925.00
2nd Dependent	$1,925.00
Each additional Dependent	$1,925.00

Note: Members who are "eligible for" Medicare Part A or B are those who would qualify for Medicare Part A or B coverage if they applied for it. Members who "have" Medicare Part A or B are those who have been granted Medicare Part A or B coverage. Medicare Part A provides inpatient coverage and Part B provides outpatient coverage.

COBRA and Cal-COBRA administrative charge

For each Subscriber for whom Health Plan bills directly for group continuation coverage under COBRA or Cal-COBRA, add an administrative charge of $2.00.

Kaiser Permanente Senior Advantage (HMO) with Part D — *EOC #10*

Sr Adv Grp HMO For Early Retirees After 01/01/2009

Family role type	Medicare Parts A & B	Medicare Part B only
Subscriber	$235.00	$547.00
1st Dependent	$235.00	$547.00
2nd Dependent	$235.00	$547.00
Each additional Dependent	$235.00	$547.00

COBRA and Cal-COBRA administrative charge

For each Subscriber for whom Health Plan bills directly for group continuation coverage under COBRA or Cal-COBRA, add an administrative charge of $2.00.

Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage — *EOC #11*

Working Aged Risk For Early Retirees After 01/01/2

For Members enrolled in Senior Advantage when federal law requires that Group's health care plan be primary and Medicare coverage be secondary, the Premiums are:

Family role type	Premiums
Subscriber	$708.00
1st Dependent	$707.00
2nd Dependent	$424.00

COBRA and Cal-COBRA administrative charge

For each Subscriber for whom Health Plan bills directly for group continuation coverage under COBRA or Cal-COBRA, add an administrative charge of $2.00.

American Specialty Health Plans Chiropractic Plan — *EOC # 12*

Chiropractic For Early Retirees After 01/01/2009

Family role type	Premiums
Subscriber	$2.00
1st Dependent	$2.00
2nd Dependent	$1.00

Kaiser Permanente Double Covered Plan for Seniors — *EOC # 13*

KPSA/Dbl Cov

Family role type	Premiums
Per Member, per month	$155.00

COBRA and Cal-COBRA administrative charge

For each Subscriber for whom Health Plan bills directly for group continuation coverage under COBRA or Cal-COBRA, add an administrative charge of $2.00.

Kaiser Permanente Senior Advantage (HMO) with Part D — *EOC # 14*

Sr Adv Grp HMO SCR/Dbl Cov

Family role type	Medicare Parts A & B	Medicare Part B only
Subscriber	$235.00	$547.00
1st Dependent	$235.00	$547.00
2nd Dependent	$235.00	$547.00
Each additional Dependent	$235.00	$547.00

COBRA and Cal-COBRA administrative charge

For each Subscriber for whom Health Plan bills directly for group continuation coverage under COBRA or Cal-COBRA, add an administrative charge of $2.00.

American Specialty Health Plans Chiropractic Plan — *EOC # 15*

Chiropractic For Dbl Cov

Family role type	Premiums
Subscriber	$2.00
1st Dependent	$2.00
2nd Dependent	$1.00