FORM APPROVED COUNTY COUNSEL
BY: GREGORY P. PRIAMOS DATE 11/23/15

Departmental Concurrence

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

944

FROM: Human Resources Department

SUBMITTAL DATE:
November 18, 2015

SUBJECT: Ratify and approve the Group Agreement and Letter of Agreement with Kaiser Permanente for the 2015 Calendar Year. [District - All] [Total Cost - $0] [SOURCES OF FUNDS - Employee and Retiree Premiums]

RECOMMENDED MOTION: That the Board of Supervisors:

1. Ratify and approve the attached renewal Group Agreement (Attachment A) and Letter of Agreement (Attachment B), effective January 1, 2015 through December 31, 2015, for medical plans offered to eligible County employees and retirees through Kaiser Permanente;
2. Authorize the Chairperson to sign four (4) copies of the agreements;
3. Retain one (1) copy of the Group Agreement and one (1) copy of the Letter of Agreement and return three (3) copies of each Agreement to Human Resources for distribution.

BACKGROUND:
Summary
The attached Group Agreement and Letter of Agreement are official documents confirming the Kaiser Permanente rates and benefits. The 2015 rates were approved by the Board of Supervisors on July 29, 2014, Item 3-31 for active employees and early retirees and September 9, 2014, Item 3-66 for Medicare retirees.

Michael T. Stock
Asst. County Executive Officer/
Human Resources Director

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost:	POLICY/CONSENT (per Exec. Office)
COST	$	$	$	$	Consent ☐ Policy ☒
NET COUNTY COST	$	$	$	$	

SOURCE OF FUNDS: Employee and Retiree Premiums

Budget Adjustment: No
For Fiscal Year: 14/15-15/16

C.E.O. RECOMMENDATION:

APPROVE
BY: Lani Sioson
Lani Sioson

County Executive Office Signature

MINUTES OF THE BOARD OF SUPERVISORS

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

Ayes: Jeffries, Tavaglione, Washington, Benoit and Ashley
Nays: None
Absent: None
Date: December 8, 2015
xc: HR

Kecia Harper-Ihem
Clerk of the Board
By: Deputy

☐ Positions Added ☐ Change Order
☐ A-30 ☐ 4/5 Vote

Prev. Agn. Ref.: 07/29/14, 3-31 | **District: ALL** | **Agenda Number:** 3-29

Impact on Residents and Businesses
There is no direct impact to residents or private businesses in the County of Riverside.

SUPPLEMENTAL:
Additional Fiscal Information
In 2015, the total annual cost for this plan is expected to be $48 million. Currently, there are approximately 4,454 active employees and 153 early retirees, along with 704 Medicare retirees enrolled in the Kaiser Permanente plan. There is no direct cost to the County for the recommended action. Kaiser Permanente health insurance premiums are paid by employees and retirees enrolled in the plan.

Kaiser Permanente medical premium rates are competitive with the current market trend. The current market trend for HMO (actives & retirees is a 7.1% increase). For 2016, the Kaiser Permanente medical premium rates decreased by 2% for active employees, decreased by 28% for early retirees, and decreased 5% for Medicare retirees.

Contract History and Price Reasonableness
For more than a decade, the County has contracted with Kaiser Permanente for medical plan services. The prior Agreement was approved by the Board on April 22, 2014, Item 3-27.

Kaiser has been instrumental in implementing and offering innovative health care alternatives in lieu of traditional in-person physician visits, such as: online chat with a physician, virtual visits and mobile health clinics. Additionally, Kaiser Permanente has been consistent and committed to providing a high level of customer satisfaction and account management administration.

ATTACHMENTS (if needed, in this order):

A. Group Agreement

B. Letter of Agreement

Attachment A

DEC 0 8 2015 3-29

October 30, 2015

MICHAEL STOCK, ASSISTANT COUNTY EXECUTIVE OFFICER/HUMAN RESOURCES DIRECTOR
COUNTY OF RIVERSIDE
4080 LEMON ST, 7TH Floor
RIVERSIDE, CA 92501-3609

Re: Renewed *Group Agreement* for Group ID # 227016
Renewal effective date: 01/01/2015

Dear MICHAEL STOCK:

We value the ongoing relationship we have with you and we thank you for the opportunity to continue to serve as your Group's health plan.

We have enclosed the new *Group Agreement* between COUNTY OF RIVERSIDE and Kaiser Foundation Health Plan, Inc., for the contract period January 1, 2015, through December 31, 2015. Please refer to the enclosed 2015 *Group Agreement Summary of Changes and Clarifications* for a summary of the most important changes and clarifications.

Please review these documents carefully and keep the *Agreement* for your records. Also, please sign and mail the enclosed *Agreement* Signature Page in the envelope provided. If your Group does not wish to renew the *Agreement*, you must give us 15 days advance written notice in accord with the "Termination on Notice" in the "Termination of Agreement" section of your Group's *Agreement*.

If you have any questions or need enrollment material for your employees, please contact your Health Plan account manager Richard Cade at (818) 557-3684. Thank you again for continuing to offer Kaiser Permanente as a quality health care plan for your employees.

Sincerely,

Wade J. Overgaard
Senior Vice President, California Health Plan Operations

JOHN MOONEY
STACEY BEALE
DANA WEBB
HAROLD JONES

BRENT CRANE

Helpful information about disclosures that Group must make

Group is required to provide certain disclosures about its health care coverage to employees and dependents:

- As described in your *Group Agreement*, Group must notify subscribers and dependents about changes to coverage and provide an *Evidence of Coverage (EOC)*.
- If Group's coverage is subject to Affordable Care Act (ACA) mandates, Group must provide notices required under that law.
- If Group's plan is subject to ERISA, Group's plan administrator must provide certain disclosures in a Summary Plan Description. In addition, Groups may have additional reporting and disclosure obligations under ERISA. These additional requirements are beyond the scope of this document. For more information on your obligations under ERISA, we recommend that you seek the advice of your own legal counsel, You may also find general information at www.dol.gov/ebsa. A handy Reporting and Disclosure Guide for Employee Benefit Plans is also available at http://www.dol.gov/ebsa/pdf/rdguide.pdf

To assist Group in providing required disclosures, the *EOCs* that are part of your *Group Agreement* provide the notices described in this document. The information in this document applies to commercial group coverage offered by Health Plan in its Northern and Southern California Regions (it does not apply to Medicare coverage, the Federal Employees Health Benefit Plan, and self-funded coverage). This document is not legal advice. Group should consult its own legal counsel for specific guidance related to these requirements.

Disclosures required by the ACA

The *EOCs* include the following notices required by the ACA:

- **Grandfathered status:** In *EOCs* for grandfathered coverage, Health Plan includes a notice of grandfathered status in the "Benefit Highlights" section.
- **Choice of provider.** A notice about designating a Plan Primary Care Physician (including a pediatrician for a child) is provided under "Your Personal Plan Physician" in the "How to Obtain Care" section.
- **Access to Plan obstetricians and gynecologists.** A notice that prior authorization is not required to receive care from these specialists is provided under "Getting a Referral" in the "How to Obtain Care" section.
- **Claims procedure.** The procedure for post-service claims is explained in the "Post-Service Claims and Appeals" section. The procedure for all other requests for payment and services is explained in the "Dispute Resolution" section. The "Dispute Resolution" section says that binding arbitration is not required when governing law prevents the use of binding arbitration.

Disclosures required by ERISA

ERISA is a federal law that sets minimum standards for ERISA-covered employee benefit plans established by private employers and employee organizations. The plan administrator of an ERISA-covered employee benefit plan is responsible for development and distribution of a *Summary Plan Description (SPD)* to plan participants and beneficiaries. The plan administrator is an employee or designee of the employer or union plan sponsor. Health Plan underwrites coverage that plan sponsors offer, but Health Plan is neither the "ERISA plan" nor the "plan administrator."

The plan administrator of an ERISA-covered employee benefit plan may satisfy the Group's ERISA disclosure obligations by incorporating the *EOC* into the Group's *SPD by reference*. However, the *EOC* by itself does not satisfy the disclosure requirements under ERISA. If a disclosure required under ERISA is not in the *EOC*, or if the plan administrator chooses to not incorporate the *EOC* in the *SPD*, the plan administrator must provide the disclosure in the Group's *SPD*. If there are discrepancies between the description of Kaiser Permanente HMO-covered group health plan benefits appearing in the Group's *SPD* and those reflected in the *EOC*, the benefit description appearing in Kaiser Permanente's *EOC* will control.

The chart below provides an overview of certain key ERISA disclosure requirements. It is intended to help plan administrators ensure that their Group's *SPD* accurately reflects the terms of the Group's fully-insured health care coverage as required under ERISA. However, it is the plan administrator's responsibility to verify that the Group's *SPD* satisfies all ERISA disclosure requirements. For more information about ERISA, visit the Department of Labor website at www.dol.gov/ebsa

SPD Disclosure	EOC Disclosure
Eligibility	The *EOC* does not explain in detail Group's eligibility requirements (other than the Health Plan eligibility requirements that appear in the "Premiums, Eligibility, and Enrollment" section). The plan administrator must include Group's eligibility information in the Group's *SPD*. Note: Health Plan does not impose preexisting condition exclusions or waiting periods, or require that employees be actively at work at the time of enrollment. Therefore, the *EOC* does not contain a notice of preexisting condition exclusions, waiting periods, or actively-at-work requirements.
Special enrollment, including: • Special enrollment due to new dependents • Special enrollment due to loss of other coverage • Special enrollment due to eligibility for premium assistance • Special enrollment due to court or administrative order	The *EOC* explains special enrollment rights in "Special enrollment" under "When You Can Enroll and When Coverage Begins" in the "Premiums, Eligibility and Enrollment" section. The plan administrator is required to document that plan participants and beneficiaries have been informed of these rights. The *EOC* does not describe the procedures governing qualified medical child support order (QMCSO) determinations or state that plan participants and beneficiaries can obtain, without charge, a copy of those procedures from the plan administrator. The plan administrator should include this information in the Group's *SPD*.
Michelle's law	Dependent children who are under the dependent child age limit meet the eligibility age requirement whether or not they are attending school. Therefore, Health Plan provides a notice about student leaves of absence only in *EOCs* where the student age limit is higher than the non-student dependent child age limit. If the student age limit is higher, the notice appears in the "Who Is Eligible" section under "Additional eligibility requirements."
Description of coverage, including: • Cost sharing • Exclusions and limitations • Prior authorization requirements • Provider network • Claims procedure	Under ERISA, a Group's *SPD* may provide only a general description of plan benefits as long as the *SPD* references a detailed schedule of benefits and incorporates it by reference. That detailed schedule of benefits can be the Health Plan *EOC*, which offers a clear description of the benefits and the rules for obtaining those benefits. If the plan administrator chooses to incorporate the *EOC* by reference into the Group's *SPD*, the Group may satisfy the ERISA coverage disclosure requirements by including the following text *without changes* as the introduction to the benefit chart in the Group's *SPD*: This benefit chart provides summary information only. It does not fully describe your benefit coverage. For details on your benefit coverage, please refer to your Kaiser Foundation Health Plan, Inc. (Health Plan) *Evidence of Coverage*. The Health Plan *Evidence of Coverage* is the binding document between Health Plan and its members. As a condition of coverage, a Health Plan physician must determine that any requested services and items are medically necessary to prevent, diagnose, or treat a medical condition. Generally, requested services and items must be provided, prescribed, authorized, or directed by a Health Plan provider. Except as otherwise noted in the Health Plan *Evidence of Coverage*, you must receive the requested services and items from a Health Plan-designated provider inside the Health Plan Service Area in which you are enrolled except as specifically noted in the *Evidence of Coverage*. For details on the benefit and claims review and adjudication procedures, please refer to the Health Plan *Evidence of Coverage*.
Newborns' and Mothers' Health Protection Act (Newborn Act)	Health Plan covers hospital lengths of stay following childbirth for mothers and newborns in accord with the Newborn Act. To assist the plan administrator in complying with the ERISA notice requirement, a Newborn Act notice is included under "ERISA notices" in the "Miscellaneous Provisions" section of the *EOC*.

SPD Disclosure	EOC Disclosure
Women's Health and Cancer Rights Act (WHCRA)	Health Plan covers mastectomy and reconstructive surgery and related services as required by WHCRA. To assist the plan administrator in complying with the ERISA notice requirement, a WHCRA notice is included under "ERISA notices" in the "Miscellaneous Provisions" section of the EOC.
ERISA rights	The *EOC* does not include a statement of ERISA rights. The plan administrator should include this information in the Group's *SPD*.
HIPAA Certificate of Creditable Coverage	In general, Health Plan furnishes members with HIPAA certificates of creditable coverage upon termination of coverage. The *EOC* explains these certificates under "HIPAA Certificates of Creditable Coverage" in the "Termination of Membership" section.
COBRA	The *EOC* states that continuation health care coverage under federal COBRA or under state continuation coverage laws may be available following termination of group health coverage. If your employee benefit plan offers COBRA continuation coverage, your plan administrator is responsible for administration of this coverage (for example, your plan administrator is responsible for providing all notices related to continuation coverage, eligibility, and participation).
Information about the employee benefit plan and how it is administered, such as: • Name of the plan • Name and address of the entity maintaining the plan • Employer identification number, plan number, type of plan, and how it is administered • The plan administrator's authority to terminate the plan or amend benefits, circumstances that may trigger ineligibility, denial, or reduction of benefits, and rights upon termination of plan or amendment of benefits	Health Plan does not collect this information from groups and cannot include it in the *EOC*. The plan administrator must include this information in the Group's*SPD*.

2015 *Group Agreement* Summary of Changes and Clarifications

The following is a summary of changes and clarifications that we have made to the *2015 Group Agreement*, including the *Evidence of Coverage (EOC)* documents. This summary does not include minor changes and clarifications that Health Plan is making to improve the readability and accuracy of the *Group Agreement* and any changes we have made at your Group's request. Please refer to the "Premiums" section in the *Group Agreement* for the Premiums that are effective on your Group's renewal anniversary date.

Unless otherwise indicated, the changes described below will be effective on your Group's renewal anniversary date and apply to each type of coverage purchased by your Group. Please read the *Group Agreement* for the complete text of these changes.

Note: Some capitalized terms in this document have special meaning. Please see the "Definitions" section of an Evidence of Coverage (*EOC*) document for terms you should know. In this document "Medicare *EOCs*" means Kaiser Permanente Senior Advantage *EOCs*, and "non-Medicare *EOCs*" means all *EOCs* other than Senior Advantage *EOCs*.

Changes to the *Group Agreement*, including *EOC* documents (CHANGES TO NON-MEDICARE *EOCs* ARE PENDING REGULATORY APPROVAL)

Anticancer Drugs

In non-Medicare EOCs, Cost Share for anticancer drugs is now described in a separate table in the Outpatient Prescription Drugs, Supplies, and Supplements section of your EOC for readability. Additionally, in accordance with state law, Cost Share for oral anti-cancer drugs will not exceed a maximum of $200 per 30-day supply.

HIPAA Certificates of Creditable Coverage

In non-Medicare EOCs, under the "Termination of Membership" section, we have removed the "HIPAA Certificates of Creditable Coverage" disclosure because the requirement to provide these certificates has been eliminated effective December 31, 2014 by federal law.

Medicare Part D outpatient prescription drug coverage

*In accord with the Centers for Medicare & Medicaid Services requirements, the Senior Advantage Medicare Part D Catastrophic Coverage Stage threshold is increasing from **$4,550** to **$4,700** for calendar year 2015.*

- *The Initial Coverage Stage threshold is increasing from **$2,850** to **$2,960** per calendar year. This change only applies if your drug plan includes a Coverage Gap Stage*

Out-of-Pocket Maximum and Essential Health Benefits

The Affordable Care Act requires that non-grandfathered large group plans accrue cost share for essential health benefits to a single out-of-pocket maximum. We have updated the language in non-Medicare EOCs for non-grandfathered coverage to specify that outpatient prescription drugs that are essential health benefits accumulate to the plan out-of-pocket maximum. We have also updated the disclosure of the out-of-pocket maximum to list the Services that do not apply to the maximum.

Preventive Care Services

Affordable Care Act mandates are monitored and added to your plan as required. We have updated 2015 EOCs that include the Affordable Care Act preventive care package and Medicare EOCs to include the following services with no cost share when ordered by a Plan Provider:

- *Screening CT scans for lung cancer*
- *Physical therapy for adults to prevent falls*

Visiting Member Care in Ohio

Effective October 1, 2013, Kaiser Permanente in Ohio became HealthSpan. The health plan is no longer operated by the Kaiser Permanente Medical Care Program. Kaiser Permanente Members who visit the former Ohio Region can receive

visiting member care through HealthSpan, but only until December 31, 2014. We have removed references to the Kaiser Permanente Region in Ohio from 2015 EOCs.

Waiting Periods

In response to waiting period requirements in the Affordable Care Act and regulations, we have added the following provision to the *Group Agreement*:

Representation Regarding Waiting Periods

By entering into this Agreement, Group hereby represents that Group does not impose a waiting period exceeding 90 days on employees who meet Group's eligibility requirements. For purposes of this requirement, a "waiting period" is the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective in accord with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.

In addition, Group represents that eligibility data provided by the Group to Health Plan will include coverage effective dates for Group's employees that correctly account for eligibility in compliance with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations. For example, if the hire date of an otherwise-eligible employee is January 19, the waiting period begins on January 19 and the effective date of coverage cannot be any later than April 19. Note: If the effective date of your Group's coverage is always on the first day of the month, in this example the effective date cannot be any later than April 1.

Also, we have revised the following provision in non-Medicare *EOCs*:

Effective date of coverage. The effective date of coverage for new employees and their eligible family Dependents is determined by your Group in accord with waiting period requirements in state and federal law. Your Group is required to inform the Subscriber of the date your membership becomes effective. For example, if the hire date of an otherwise-eligible employee is January 19, the waiting period begins on January 19 and the effective date of coverage cannot be any later than April 19. Note: If the effective date of your Group's coverage is always on the first day of the month, in this example the effective date cannot be any later than April 1.

Clarifications to the Group Agreement, including *EOC* documents (CLARIFICATIONS TO NON-MEDICARE *EOCs* ARE PENDING REGULATORY APPROVAL)

Agreement

We have added the following disclosure to *EOCs* to comply with requirements in state law:

This *Evidence of Coverage* is part of the *Agreement* between Health Plan and your Group. The *Agreement* contains additional terms such as Premiums, when coverage can change, the effective date of coverage, and the effective date of termination. The *Agreement* must be consulted to determine the exact terms of coverage. A copy of the *Agreement* is available from your Group.

Benefits not included in the plan

If optional benefits are not included in the plan, the non-Medicare *EOC* will specifically state that those Services are not covered. For example, if a non-Medicare *EOC* does not include coverage for infertility Services, the "Infertility Services" section will indicate that infertility Services are not covered.

Definition of Region

We have updated the definition of Region in *EOCs* to say that Regions can change on January 1 of each year, and that a current list of Regions can be obtained by visiting **kp.org** or calling our Member Service Contact Center.

Definition of Spouse

We have revised the definition of Spouse for clarity:

> **Spouse:** The person to whom the Subscriber is legally married under applicable law. For the purposes of this *Evidence of Coverage*, the term "Spouse" includes the Subscriber's domestic partner. "Domestic partners" are two people who are registered and legally recognized as domestic partners by California (if your Group allows enrollment of domestic partners not legally recognized as domestic partners by California, "Spouse" also includes the Subscriber's domestic partner who meets your Group's eligibility requirements for domestic partners).

Durable Medical Equipment (DME) for Home Use

In non-Medicare *EOCs* that include coverage for DME items that are not essential health benefits, we have revised the exclusions for Durable Medical Equipment for Home Use to specify that items for recreational purposes are excluded:

- Items not intended for maintaining normal activities of daily living, such as exercise equipment (including devices intended to provide additional support for recreational or sports activities) and hygiene equipment

Hearing and Vision Screenings that are part of a routine physical maintenance exam

In non-Medicare *EOC*s, routine vision and hearing screenings are listed in the "Preventive Care Services" bullets in the "Outpatient Care" section. These Services were duplicated in the "Hearing Services" and "Vision Services" sections. Vision and hearing screening Services continue to be listed in the "Outpatient Care" section. The duplicate references under "Hearing Services" and "Vision Services" sections have been replaced with cross-references back to the "Outpatient Care" section.

Interactive Video Visits

The Plan has added the following description to the "How to Obtain Services" section:

> **Interactive video visits**
>
> Interactive video visits between you and your provider are intended to make it more convenient for you to receive covered Services, when a Plan Provider determines it is medically appropriate for your medical condition. You may receive covered Services via interactive video visits, when available and if the Services would have been covered under the "Benefits and Your Cost Share" section (subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section) if provided in person. You are not required to use interactive video visits. If you do agree to use interactive video visits, you may be charged Cost Share for the Services you receive. (For example, if you have an interactive video visit consultation with a specialist, you may be charged the specialty care visit Cost Share.)

Notes: These services are provided at no charge for Senior Advantage Members.

Outpatient Surgery and Outpatient Procedures

We have standardized our disclosure about outpatient surgery and outpatient procedures for all plans. *EOCs* will list the Cost Share for outpatient surgery and procedures that take place in settings where staff must monitor your vital signs separately from procedures that do not require such monitoring.

Premiums, Eligibility, and Enrollment

We have made several clarifications on the eligibility provisions and premium effective dates, including the following:

- We have added a paragraph describing when coverage is effective for newborns
- We have clarified the eligibility rules for subscribers and dependents
- We have clarified the certification requirements for disabled dependents

Primary and Specialty Care Visits

The definitions of primary care visits and specialty care visits now print in all *EOCs*. Cost Share amounts for both types of visits will always print, even when the Cost Share for primary care visits and specialty care visits is the same.

Prior Authorization

The "Getting a Referral" section has been revised to indicate that the list of Services that require prior authorization is available on kp.org or by calling the Member Service Contact Center:

Medical Group authorization procedure for certain referrals

The following are examples of Services that require prior authorization by the Medical Group for the Services to be covered ("prior authorization" means that the Medical Group must approve the Services in advance):

- Durable medical equipment
- Ostomy and urological supplies
- Services not available from Plan Providers
- Transplants

For the complete list of Services that require prior authorization, and the criteria that are used to make authorization decisions, please visit our website at **kp.org** or call our Member Service Contact Center. Please refer to "Post-Stabilization Care" under "Emergency Services" in the "Emergency Services and Urgent Care" section for authorization requirements that apply to Post-Stabilization Care from Non–Plan Providers.

Prosthetic and Orthotic Devices Exclusions

In non-Medicare *EOCs*, we have revised the exclusions for prosthetic and orthotic devices to specify that items for recreational purposes and most footwear are excluded:

- Shoes, shoe inserts, arch supports, or any other footwear, even if custom-made, except footwear described above in this "Prosthetic and Orthotic Devices" section for diabetes-related complications
- Orthotic devices not intended for maintaining normal activities of daily living (including devices intended to provide additional support for recreational or sports activities)

Specialty Drugs

In non-Medicare *EOCs*, the Cost Share that you pay for drugs depends upon whether the drug is on the generic, brand-name, or specialty tier. Specialty drugs are high-cost drugs that are on our specialty drug list. If your group has requested that specialty drugs are covered at a different Cost Share than generic or brand-name drugs, your *EOC* will reflect this change.

Vision Services

In non-Medicare *EOCs*, we have clarified that routine eye exams are a different type of visit than Specialty Care Visits for diagnosis and treatment of diseases of or injuries to the eye. The Specialty Care Visit Cost Share applies to visits to diagnose or treat injuries or diseases of the eye.

Enrollment Unit Chart

The chart below lists the products that your Group has purchased. It also describes how these products (called *contract options*) are organized into administrative groupings (called *enrollment units*) for the purposes of enrollment and billing. Please keep this document handy for future reference as the information it contains will be helpful when reporting membership changes.

***Contract option*:** A unique *contract option* name and number exists for each coverage option (product including benefits and eligibility) that you offer to your members. For example, if you offer the same benefits to all of your members, but have different eligibility rules for different segments of your membership, you will have a separate *contract option* for each coverage option. You will find an *Evidence of Coverage (EOC)* incorporated into the enclosed *Group Agreement* (as described in the "Introduction" section of the *Group Agreement*) if the *contract option* is a Kaiser Foundation Health Plan, Inc., product. Note: *Contract option* ID is the same number as *EOC* number.

Enrollment unit: An *enrollment unit* represents a grouping of *contract options* based on product offerings and billing requirements. If there are *contract options* only available to a specific segment of your member population, then there will be a distinct *enrollment unit* for that segment. If your membership population is billed separately, there will be a separate *enrollment unit* for each segment (or billing unit).

Contract name:	COUNTY OF RIVERSIDE
Group ID:	227016
Contract:	1

The following are the *enrollment units* associated with this contract #1:

Enrollment unit number: 0 **Name:** COUNTY OF RIVERSIDE ACTIVE **Billing contact:** Dana Webb	
Contract option ID/EOC #	**Product/contract option names**
1	American Specialty Health Plans Chiropractic Plan / CHIROPRACTIC FOR ACTIVES AND RETIREES PRIOR 01/01/
2	Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage / WORKING AGED RISK FOR ACTIVES
3	Kaiser Permanente Traditional Plan / TRADITIONAL HMO FOR ACTIVES
4	Kaiser Permanente Senior Advantage (HMO) with Part D / SR ADV GRP HMO SCR FOR ACTIVES AND RETIREES PRIOR

Enrollment unit number: 1 **Name:** COR RETIREES UNDER 65 **Billing contact:** Dana Webb	
Contract option ID/EOC #	**Product/contract option names**
9	Kaiser Permanente Traditional Plan / TRADITIONAL HMO FOR EARLY AND MEDICARE RETIREES
10	Kaiser Permanente Senior Advantage (HMO) with Part D / SR ADV GRP HMO FOR EARLY RETIREES AFTER 01/01/2009
11	Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage / WORKING AGED RISK FOR EARLY RETIREES AFTER 01/01/2
12	American Specialty Health Plans Chiropractic Plan / CHIROPRACTIC FOR EARLY RETIREES AFTER 01/01/2009

Enrollment unit number: 2 **Name:** COR RETIREES OVER 65 **Billing contact:** Dana Webb	
Contract option ID/EOC #	**Product/contract option names**
9	Kaiser Permanente Traditional Plan / TRADITIONAL HMO FOR EARLY AND MEDICARE RETIREES
10	Kaiser Permanente Senior Advantage (HMO) with Part D / SR ADV GRP HMO FOR EARLY RETIREES AFTER 01/01/2009
11	Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage / WORKING AGED RISK FOR EARLY RETIREES AFTER 01/01/2
12	American Specialty Health Plans Chiropractic Plan / CHIROPRACTIC FOR EARLY RETIREES AFTER 01/01/2009

Enrollment unit number: 3 **Name:** COR RETIREES UNDER 65 AFTER 01/01/2009 **Billing contact:** Dana Webb	
Contract option ID/EOC #	**Product/contract option names**
9	Kaiser Permanente Traditional Plan / TRADITIONAL HMO FOR EARLY AND MEDICARE RETIREES
10	Kaiser Permanente Senior Advantage (HMO) with Part D / SR ADV GRP HMO FOR EARLY RETIREES AFTER 01/01/2009
11	Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage / WORKING AGED RISK FOR EARLY RETIREES AFTER 01/01/2
12	American Specialty Health Plans Chiropractic Plan / CHIROPRACTIC FOR EARLY RETIREES AFTER 01/01/2009

Enrollment unit number: 7 **Name:** COUNTY OF RIVERSIDE - LOW - ACTIVE **Billing contact:** none	
Contract option ID/EOC #	**Product/contract option names**
18	Kaiser Permanente Traditional Plan / TRADITIONAL HMO FOR ACTIVES - LOW
19	Kaiser Permanente Senior Advantage (HMO) with Part D / SR ADV GRP HMO SCR FOR ACTIVES AND RETIREES - LOW
20	Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage / WORKING AGED RISK FOR ACTIVES - LOW
21	American Specialty Health Plans Chiropractic Plan / CHIROPRACTIC FOR ACTIVES & RETIREES - LOW

Enrollment unit number: 8 **Name:** COR - LOW-RETIREES UNDER 65 **Billing contact:** none	
Contract option ID/EOC #	**Product/contract option names**
22	Kaiser Permanente Traditional Plan / TRADITIONAL HMO FOR EARLY AND MEDICARE RETIREES - LOW
23	Kaiser Permanente Senior Advantage (HMO) with Part D / SR ADV GRP HMO FOR EARLY RETIREES - LOW
24	Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage / WORKING AGED RISK FOR EARLY RETIREES - LOW
25	American Specialty Health Plans Chiropractic Plan / CHIROPRACTIC FOR EARLY RETIREES - LOW

Enrollment unit number: 9 **Name:** COR - LOW-RETIREES OVER 65 **Billing contact:** none	
Contract option ID/EOC #	**Product/contract option names**
22	Kaiser Permanente Traditional Plan / TRADITIONAL HMO FOR EARLY AND MEDICARE RETIREES - LOW
23	Kaiser Permanente Senior Advantage (HMO) with Part D / SR ADV GRP HMO FOR EARLY RETIREES - LOW
24	Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage / WORKING AGED RISK FOR EARLY RETIREES - LOW
25	American Specialty Health Plans Chiropractic Plan / CHIROPRACTIC FOR EARLY RETIREES - LOW

Enrollment unit number: 4901 **Name:** COUNTY OF RIVERSIDE ACT/AB1401 **Billing contact:** none	
Contract option ID/EOC #	**Product/contract option names**
1	American Specialty Health Plans Chiropractic Plan / CHIROPRACTIC FOR ACTIVES AND RETIREES PRIOR 01/01/
2	Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage / WORKING AGED RISK FOR ACTIVES
3	Kaiser Permanente Traditional Plan / TRADITIONAL HMO FOR ACTIVES
4	Kaiser Permanente Senior Advantage (HMO) with Part D / SR ADV GRP HMO SCR FOR ACTIVES AND RETIREES PRIOR

Enrollment unit number: 5000 **Name:** COUNTY OF RIVERSIDE ACTIVE/COB **Billing contact:** none	
Contract option ID/EOC #	**Product/contract option names**
1	American Specialty Health Plans Chiropractic Plan / CHIROPRACTIC FOR ACTIVES AND RETIREES PRIOR 01/01/
2	Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage / WORKING AGED RISK FOR ACTIVES
3	Kaiser Permanente Traditional Plan / TRADITIONAL HMO FOR ACTIVES
4	Kaiser Permanente Senior Advantage (HMO) with Part D / SR ADV GRP HMO SCR FOR ACTIVES AND RETIREES PRIOR

Enrollment unit number: 8500 **Name:** COUNTY OF RIVERSIDE - LIS REFUNDS **Billing contact:** Dana Webb	
Contract option ID/EOC #	**Product/contract option names**
3	Kaiser Permanente Traditional Plan / TRADITIONAL HMO FOR ACTIVES

Enrollment unit number: 8700 **Name:** COUNTY OF RIVERSIDE/DBL COV **Billing contact:** Dana Webb	
Contract option ID/EOC #	**Product/contract option names**
13	Kaiser Permanente Double Covered Plan for Seniors / KPSA/DBL COV
14	Kaiser Permanente Senior Advantage (HMO) with Part D / SR ADV GRP HMO SCR/DBL COV
15	American Specialty Health Plans Chiropractic Plan / CHIROPRACTIC FOR DBL COV

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Southern California Region

A nonprofit corporation

Group Agreement for
COUNTY OF RIVERSIDE

Group ID: 227016 Contract: 1 Version: 51

January 1, 2015, through December 31, 2015

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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 definitions of terms that are used in *EOC* document(s) and this *Agreement*. 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
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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
Kaiser Permanente Traditional Plan	Traditional HMO For Actives - Low	18
Kaiser Permanente Senior Advantage (HMO) with Part D	Sr Adv Grp HMO SCR For Actives And Retirees - Low	19
Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage	Working Aged Risk For Actives - Low	20
American Specialty Health Plans Chiropractic Plan	Chiropractic For Actives & Retirees - Low	21
Kaiser Permanente Traditional Plan	Traditional HMO For Early And Medicare Retirees - Low	22
Kaiser Permanente Senior Advantage (HMO) with Part D	Sr Adv Grp HMO For Early Retirees - Low	23
Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage	Working Aged Risk For Early Retirees - Low	24
American Specialty Health Plans Chiropractic Plan	Chiropractic For Early Retirees - Low	25

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, 2015, through December 31, 2015.

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 60 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 want to 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.

Note: Your Group's Anniversary Date is January 1.

Amendment of *Agreement*

Amendments Effective on January 1 (Anniversary Date)

Upon 60 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, 2015 (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, 2016 (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 60 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 Health Plan's 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 60 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, 2016, the last minute this *Agreement* was in effect was at 11:59 p.m. on December 31, 2015).

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

If Group has Kaiser Permanente Senior Advantage Members

If Group has Senior Advantage Members enrolled under this *Agreement* at the time Health Plan receives written notice from Group that it is terminating this *Agreement*, Group may terminate this *Agreement* effective January 1 (the Anniversary Date) by giving at least 30 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.

If Group does not have Kaiser Permanente Senior Advantage Members

If Group does not have Senior Advantage Members enrolled under this *Agreement* at the time Health Plan receives written notice from Group that it is terminating this *Agreement*, 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 Health Plan receives Group's written notice of nonacceptance within 15 days after the date of Health Plan's amendment notice and Group remits all amounts payable related to this *Agreement*, including Premiums, for the period prior to the amendment effective date, in which case this *Agreement* will terminate on the following date, as applicable:

- In the case of amendments described in the "Amendment of *Agreement*" section under "Amendments Related to Government Approval" and "Amendments Due to Medicare Changes," and amendments described under "Other Amendments" that do not require 60 days notice by Health Plan, if Group has Kaiser Permanente Senior Advantage

Members enrolled under this *Agreement* at the time Health Plan receives written notice of nonacceptance, the termination date will be first of the month following 30 days after Health Plan receives written notice of nonacceptance

- In all other cases, the termination date will be the day before the effective date of the amendment

Termination for Nonpayment

Premium payments are due as described in the "Premiums" section. If Health Plan does not receive full Premium payment on or before the due date, we will send a notice of nonpayment to Group as described under "Notices" in the "Miscellaneous Provisions" section. This notice will include the following information:

- A statement that we have not received full Premium payment and that we will terminate this *Agreement* for nonpayment if we do not receive the required Premiums by the specified date
- The amount of Premiums that are due

If we terminate this *Agreement* because we did not receive the required Premiums when due, the *Agreement* will terminate on the date specified in the notice of nonpayment, which will be at least 30 days after the date of the notice. The *Agreement* will remain in effect during this grace period, but upon termination Group will be responsible for paying all past due Premiums, including the Premiums for this grace period.

We will mail a termination notice to Group as described under "Notices" in the "Miscellaneous Provisions" section if we do not receive full Premium payment within 30 days after the date of the notice of nonreceipt of payment.

If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan gives written notice to Group, Health Plan may terminate this *Agreement* effective on one date with respect to Members other than Senior Advantage Members and effective on a later date with respect to Senior Advantage Members, in order to comply with CMS termination notice requirements.

Termination for Fraud or Intentionally Furnishing Incorrect or Incomplete Information

If Group commits fraud or intentionally furnishes incorrect or incomplete information to Health Plan, Health Plan may terminate this *Agreement* by giving advance written notice to Group, and Group is liable for all unpaid Premiums up to the termination date.

If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan gives written notice to Group, Health Plan may terminate this *Agreement* effective on one date with respect to Members other than Senior Advantage Members and effective on a later date with respect to Senior Advantage Members, in order to comply with CMS termination notice requirements.

Termination for Violation of Contribution or Participation Requirements

If Group fails to comply with Health Plan's participation or contribution requirements (including those discussed in the "Contribution and Participation Requirements" section), Health Plan may terminate this *Agreement* by giving advance written notice to Group, and Group is liable for all unpaid Premiums up to the termination date.

If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan gives written notice to Group, Health Plan may terminate this *Agreement* effective on one date with respect to Members other than Senior Advantage Members and effective on a later date with respect to Senior Advantage Members, in order to comply with CMS termination notice requirements.

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

Grandfathered products

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 grandfathered 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*.

All other products

Health Plan may terminate a particular product or all products offered in the group market as permitted or required by law. If Health Plan discontinues offering a particular product (other than a grandfathered product) in the group 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 the group market. If Health Plan discontinues offering all products in the group market, 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 an average of 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 2016 until Group receives its 2016 group agreement Premium and coverage information from Health Plan. If Group holds the open enrollment without receiving 2016 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 disclosures about coverage as described under "Member Information" in the "Miscellaneous Provisions" section
  - adhere to all requirements set forth 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 Members and prospective Members of eligibility requirements for Subscribers and Dependents 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 Members by the next regular communication to them, but in no event later than 30 days after Group receives the information.

For each Health Plan coverage included in this *Agreement*, Health Plan will provide Group with the following disclosures for Group to distribute in accord with applicable laws, including the Medicare-as-Secondary-Payer laws:

- A Disclosure Form for each non-Medicare coverage. Group will provide *Disclosure Forms* to Subscribers and potential Subscribers when the coverage is offered
- A *Summary of Benefits and Coverage* (*SBC*) for each non-Medicare coverage other than retiree plans with fewer than two current employees. Group will provide electronic or paper *SBCs* to Members and potential Members to the extent required by law, except that Health Plan will provide *SBCs* to Members who make a request to Health Plan
- Pre-enrollment materials that CMS requires for Kaiser Permanente Senior Advantage coverage, which are available upon request from Health Plan. Group will provide these materials to potential Members before they enroll in Senior Advantage coverage
- An *EOC* for each non-Medicare coverage. Group will provide *EOCs* to Subscribers, except that Health Plan will provide *EOCs* to Members and potential Members who make a request to Health Plan

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 COUNTY EXECUTIVE OFF
COUNTY OF RIVERSIDE
4080 LEMON ST
RIVERSIDE, CA 92501-3609

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: Wade J. Overgaard, Senior Vice President, California Health Plan Operations

Other Group coverages that cover essential health benefits

For each non-grandfathered non-Medicare Health Plan coverage, except for any retiree-only coverage, Group must do all of the following if Group provides Health Plan Members with other medical or dental coverage (for example, separate pharmacy coverage) that covers any Essential Health Benefits:

- Notify Health Plan of the out-of-pocket maximum (OOPM) that applies to the Essential Health Benefits in each of the other medical or dental coverages.
- Ensure that the sum of the OOPM in Health Plan's coverage plus the OOPMs that apply to Essential Health Benefits in all of the other medical and dental coverages does not exceed the annual limitation on cost sharing described in 45 CFR 156.130.

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.

Involuntary Kaiser Permanente Senior Advantage Membership Terminations

Group must give Health Plan's California Service Center 30 days' prior written notice of Senior Advantage involuntary membership terminations. An involuntary membership termination is a termination that is not in response to a disenrollment notice issued by CMS to Health Plan or received by Health Plan directly from a Member (these events are usually in response to a Member's request for disenrollment to CMS because the Member has enrolled in another Medicare health plan or wants Original Medicare coverage or has lost Medicare eligibility). 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.

Voluntary Kaiser Permanente Senior Advantage Membership Terminations

If Health Plan's California Service Center receives a disenrollment notice from CMS or a membership termination request from the Member, the membership termination date will be in accord with 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.

Representation Regarding Waiting Periods

By entering into this Agreement, Group hereby represents that Group does not impose a waiting period exceeding 90 days on employees who meet Group's eligibility requirements. For purposes of this requirement, a "waiting period" is the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective in accord with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.

In addition, Group represents that eligibility data provided by the Group to Health Plan will include coverage effective dates for Group's employees that correctly account for eligibility in compliance with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations. For example, if the hire date of an otherwise-eligible employee is January 19, the waiting period begins on January 19 and the effective date of coverage cannot be any later than April 19. Note: If the effective date of your Group's coverage is always on the first day of the month, in this example the effective date cannot be any later than April 1.

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.

Membership Termination

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

Note: The membership termination date is the first day a Member is not covered (for example, if the termination date is January 1, 2016, the last minute of coverage was at 11:59 p.m. on December 31, 2015).

Involuntary Kaiser Permanente Senior Advantage Membership Terminations

Group must give Health Plan's California Service Center 30 days' prior written notice of Senior Advantage involuntary membership terminations. An involuntary membership termination is a termination that is not in response to a disenrollment notice issued by CMS to Health Plan or received by Health Plan directly from a Member (these events are usually in response to a Member's request for disenrollment to CMS because the Member has enrolled in another Medicare

health plan or wants Original Medicare coverage or has lost Medicare eligibility). 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.

Voluntary Kaiser Permanente Senior Advantage Membership Terminations

If Health Plan's California Service Center receives a disenrollment notice from CMS or a membership termination request from the Member, the membership termination date will be in accord with CMS requirements.

Premium Rebates

If state or federal law requires Health Plan to rebate premiums from this or any earlier contract year and Health Plan rebates premiums to Group, Group represents that Group will use that rebate for the benefit of Members, in a manner consistent with the requirements of the Public Health Service Act and the Affordable Care Act and if applicable with the obligations of a fiduciary under the Employee Retirement Income Security Act (ERISA).

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 Health Plan's 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 Health Plan's 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 and not eligible for Medicare. In addition, Members for whom Medicare is secondary who meet the Kaiser Permanente Senior Advantage eligibility requirements may also enroll in the Senior Advantage plan under this *Agreement* that is applicable when Medicare is secondary. 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* that is 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 and Medicare status 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	$586.00
1st Dependent	$583.00
2nd Dependent	$352.00

COBRA and Cal-COBRA billing charge

For each Subscriber for whom Health Plan bills directly for group continuation coverage under COBRA or Cal-COBRA, add a billing 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	$586.00
1st Dependent	$583.00
2nd Dependent	$352.00
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	$1,217.00
1st Dependent	$1,217.00
2nd Dependent	$1,217.00
Each additional Dependent	$1,217.00

Members age 65 and over who are eligible for or have Medicare Part A	
Family role type	Premiums
Subscriber	$904.00
1st Dependent	$904.00
2nd Dependent	$904.00
Each additional Dependent	$904.00

Members enrolled in another carrier's Medicare Risk product	
Family role type	Premiums
Subscriber	$1,217.00
1st Dependent	$1,217.00
2nd Dependent	$1,217.00
Each additional Dependent	$1,217.00

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 billing charge

For each Subscriber for whom Health Plan bills directly for group continuation coverage under COBRA or Cal-COBRA, add a billing 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	$254.00	$566.00
1st Dependent	$254.00	$566.00
2nd Dependent	$254.00	$566.00
Each additional Dependent	$254.00	$566.00

COBRA and Cal-COBRA billing charge

For each Subscriber for whom Health Plan bills directly for group continuation coverage under COBRA or Cal-COBRA, add a billing 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	$930.00

Members under age 65 (or 65 and over if Medicare is secondary)	
Family role type	Premiums
1st Dependent	$926.00
2nd Dependent	$554.00
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	$1,217.00
1st Dependent	$1,217.00
2nd Dependent	$1,217.00
Each additional Dependent	$1,217.00

Members age 65 and over who are eligible for or have Medicare Part A	
Family role type	Premiums
Subscriber	$904.00
1st Dependent	$904.00
2nd Dependent	$904.00
Each additional Dependent	$904.00

Members enrolled in another carrier's Medicare Risk product	
Family role type	Premiums
Subscriber	$1,217.00
1st Dependent	$1,217.00
2nd Dependent	$1,217.00
Each additional Dependent	$1,217.00

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 billing charge

For each Subscriber for whom Health Plan bills directly for group continuation coverage under COBRA or Cal-COBRA, add a billing 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	$254.00	$566.00
1st Dependent	$254.00	$566.00
2nd Dependent	$254.00	$566.00
Each additional Dependent	$254.00	$566.00

COBRA and Cal-COBRA billing charge

For each Subscriber for whom Health Plan bills directly for group continuation coverage under COBRA or Cal-COBRA, add a billing 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	$930.00
1st Dependent	$926.00
2nd Dependent	$554.00

COBRA and Cal-COBRA billing charge

For each Subscriber for whom Health Plan bills directly for group continuation coverage under COBRA or Cal-COBRA, add a billing 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	$182.60

COBRA and Cal-COBRA billing charge

For each Subscriber for whom Health Plan bills directly for group continuation coverage under COBRA or Cal-COBRA, add a billing 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	$254.00	$566.00
1st Dependent	$254.00	$566.00
2nd Dependent	$254.00	$566.00
Each additional Dependent	$254.00	$566.00

COBRA and Cal-COBRA billing charge

For each Subscriber for whom Health Plan bills directly for group continuation coverage under COBRA or Cal-COBRA, add a billing 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

Kaiser Permanente Traditional Plan — *EOC # 18*

Traditional HMO For Actives - Low

Members under age 65 (or 65 and over if Medicare is secondary)	
Family role type	Premiums
Subscriber	$586.00
1st Dependent	$583.00
2nd Dependent	$352.00
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	$1,217.00
1st Dependent	$1,217.00
2nd Dependent	$1,217.00
Each additional Dependent	$1,217.00

Members age 65 and over who are eligible for or have Medicare Part A	
Family role type	Premiums
Subscriber	$904.00
1st Dependent	$904.00
2nd Dependent	$904.00
Each additional Dependent	$904.00

Members enrolled in another carrier's Medicare Risk product	
Family role type	Premiums
Subscriber	$1,217.00
1st Dependent	$1,217.00
2nd Dependent	$1,217.00
Each additional Dependent	$1,217.00

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 billing charge

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

Kaiser Permanente Senior Advantage (HMO) with Part D — *EOC # 19*

Sr Adv Grp HMO SCR For Actives And Retirees - Low

Family role type	Medicare Parts A & B	Medicare Part B only
Subscriber	$175.00	$487.00
1st Dependent	$175.00	$487.00
2nd Dependent	$175.00	$487.00
Each additional Dependent	$175.00	$487.00

COBRA and Cal-COBRA billing charge

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

Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage — *EOC # 20*

Working Aged Risk For Actives - Low

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	$586.00
1st Dependent	$583.00
2nd Dependent	$352.00

COBRA and Cal-COBRA billing charge

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

American Specialty Health Plans Chiropractic Plan — *EOC # 21*

Chiropractic For Actives & Retirees - Low

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

Kaiser Permanente Traditional Plan — *EOC # 22*

Traditional HMO For Early And Medicare Retirees - Low

Members under age 65 (or 65 and over if Medicare is secondary)	
Family role type	Premiums
Subscriber	$930.00
1st Dependent	$926.00
2nd Dependent	$554.00
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	$1,217.00
1st Dependent	$1,217.00
2nd Dependent	$1,217.00
Each additional Dependent	$1,217.00

Members age 65 and over who are eligible for or have Medicare Part A	
Family role type	Premiums
Subscriber	$904.00
1st Dependent	$904.00
2nd Dependent	$904.00
Each additional Dependent	$904.00

Members enrolled in another carrier's Medicare Risk product	
Family role type	Premiums
Subscriber	$1,217.00
1st Dependent	$1,217.00
2nd Dependent	$1,217.00
Each additional Dependent	$1,217.00

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 billing charge

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

Kaiser Permanente Senior Advantage (HMO) with Part D — *EOC # 23*

Sr Adv Grp HMO For Early Retirees - Low

Family role type	Medicare Parts A & B	Medicare Part B only
Subscriber	$175.00	$487.00
1st Dependent	$175.00	$487.00
2nd Dependent	$175.00	$487.00
Each additional Dependent	$175.00	$487.00

COBRA and Cal-COBRA billing charge

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

Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage — *EOC # 24*

Working Aged Risk For Early Retirees - Low

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	$930.00
1st Dependent	$926.00
2nd Dependent	$554.00

COBRA and Cal-COBRA billing charge

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

American Specialty Health Plans Chiropractic Plan — *EOC # 25*

Chiropractic For Early Retirees - Low

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

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, relatives, or associated parties (on the one hand) and Health Plan, Kaiser Permanente 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 or items 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 the Small Claims Court
- Claims subject to a Medicare appeals procedure as applicable to Kaiser Permanente Senior Advantage Members
- Claims that cannot be subject to binding arbitration under governing law

Signatures

COUNTY OF RIVERSIDE

Marion Ashley

Authorized Group officer signature

MARION ASHLEY

CHAIRMAN, BOARD OF SUPERVISORS

Please print your name and title

DEC 08 2015

Date signed

Kaiser Foundation Health Plan, Inc.
Southern California Region

Wade J. Overgaard
Authorized officer
Senior Vice President, California Health Plan Operations

Executed in San Diego, CA effective 1/1/15
Date: 10/24/14

FORM APPROVED COUNTY COUNSEL
BY: TAWNY V. LIEU 11/23/15 DATE

Please keep this copy with your *Agreement*. An extra copy of the Signature Page is enclosed for mailing to Health Plan's California Service Center at P.O. Box 23448, San Diego, CA 92193-3448.

ATTEST:
KECIA HARPER-IHEM, Clerk
BY DEPUTY

Attachment B

LETTER OF AGREEMENT BETWEEN
COUNTY OF RIVERSIDE
AND
KAISER FOUNDATION HEALTH PLAN, INC.
SOUTHERN CALIFORNIA REGION

This Letter of Agreement ("LOA") between County of Riverside ("Group"), a political subdivision of the State of California, and Kaiser Foundation Health Plan, Inc. ("Health Plan"), a California public body, amends the *Group Agreement* and *Evidences of Coverage*) (collectively, the *Agreement*) previously entered into by and between the parties for the contract year beginning January 1, 2015.

Notwithstanding any other provisions in the Group Agreement and Evidences of Coverage between Group and Health Plan the following provision applies to and shall upon execution of this document be fully incorporated into the Agreement:

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

The following section is added to the Agreement:

Public Disclosure of Documents

The parties acknowledge that Group is a governmental entity subject to the public records and meetings laws of the State of California, including the California Public Records Act (Government Code Section 6250 et seq.) and the California Brown Act (Government Code Section 54590 et seq.) Notwithstanding any other provisions contained in this Agreement, any information (including Confidential Information), communications, and documents given by Health Plan to the Group and meetings involving the Group may be subject to disclosure pursuant to the Public Records Act and Brown Act. To the extent Group is required by law to disclose the above-described information (including Confidential Information), communications, and documents, Group will comply with such law.

The following sections of the *Agreement* are deleted in their entirety and replaced with the following:

Amendments Effective on January 1 (Anniversary Date)

Upon 60 days prior written notice to Group and subject to Group's approval, Health Plan may extend the term of this *Agreement* and make other changes by amending this *Agreement* effective January 1 (the Anniversary 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, 2016 (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 60 day prior 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). Health Plan will give Group 60 days prior written notice of any such amendment.

Acceptance of Amendments

All amendments are deemed accepted by Group unless Group gives Health Plan written notice of nonacceptance within 30 days after the date, plus three business days, 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, 2016, the last minute this *Agreement* was in effect was at 11:59 p.m. on December 31, 2015).

If Health Plan terminates this *Agreement,* Health Plan will give Group written notice prior to termination of Agreement. Within five business days of receipt, Group will provide to each Subscriber a legible copy of the notice and will give Health Plan, upon written request,, a sample copy of that notice and the date notice was provided . In the event of a dispute related to termination notice to the Subscriber, with reasonable notice, the County will provide Health Plan proof of that mailing and of the date thereof.

Termination on Notice

If Group has Kaiser Permanente Senior Advantage Members

If Group has Senior Advantage Members enrolled under this *Agreement* at the time Health Plan receives written notice from Group that it is terminating this *Agreement*, Group may terminate this *Agreement* by giving at least 30 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.

If Group does not have Kaiser Permanente Senior Advantage Members

If Group does not have Senior Advantage Members enrolled under this *Agreement* at the time Health Plan receives written notice from Group that it is terminating this *Agreement*, Group may terminate this *Agreement* 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 Health Plan receives Group's written notice of nonacceptance within 30 days after the date, plus three business days, of Health Plan's amendment notice and Group remits all amounts payable related to this *Agreement*, including Premiums, for the period prior to the amendment effective date, in which case this *Agreement* will terminate on the following date, as applicable:

- In the case of amendments described in the "Amendment of *Agreement*" section under "Amendments Related to Government Approval" and "Amendments Due to Medicare Changes," and amendments described under "Other Amendments" that do not require 60 days notice by Health Plan, if Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan receives written notice of nonacceptance, the termination date will be the first of the month following 30 days after Health Plan receives

written notice of nonacceptance

- In all other cases, the termination date will be the day before the effective date of the amendment.

Termination for Nonpayment

Premium payments are due as described in the "Premiums" section. If Health Plan does not receive full Premium payment on or before the due date, we will send a notice of nonpayment to Group as described under "Notices" in the "Miscellaneous Provisions" section. This notice will include the following information:

- A statement that we have not received full Premium payment and that we will terminate this *Agreement* for nonpayment if we do not receive the required Premiums by the specified date
- The amount of Premiums that are due

If we terminate this *Agreement* because we did not receive the required Premiums when due, the *Agreement* will terminate on the date specified in the notice of nonpayment, which will be at least 45 days after the date of the notice. The *Agreement* will remain in effect during this grace period, but upon termination Group will be responsible for paying all past due Premiums, including the Premiums for this grace period.

We will mail a termination notice to Group as described under "Notices" in the "Miscellaneous Provisions" section if we do not receive full Premium payment within 45 days after the date of the notice of nonreceipt of payment.

If Group has Kaiser Permanente Senior Advantage Members enrolled under this Agreement at the time Health Plan gives written notice to Group, Health Plan shall comply with the CMS termination notice requirements with respect to Senior Advantage Members and the termination of this *Agreement* shall be effective on the same date for all Members, including Senior Advantage Members.

Termination for Fraud or Intentionally Furnishing Incorrect or Incomplete Information

If Group commits fraud or intentionally furnishes incorrect or incomplete information to Health Plan, Health Plan may terminate this *Agreement* by giving thirty (30) days advance days written notice to Group, and Group is liable for all unpaid Premiums up to the termination date.

If Health Plan commits fraud or intentionally furnishes incorrect or incomplete information to Group, Group may terminate this *Agreement by* giving thirty (30) days advance written notice to Health Plan.

If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan gives written notice to Group, Health Plan shall comply with the CMS termination notice requirements with respect to Senior Advantage Members and the termination of this *Agreement* shall be effective on the same date for all Members, including Senior Advantage Members.

Termination for Violation of Contribution or Participation Requirements

If Group fails to comply with Health Plan's participation or contribution requirements (including those discussed in the "Contribution and Participation Requirements" section), Health Plan may terminate this *Agreement* by giving thirty (30) days advance written notice to Group, and Group is liable for all unpaid Premiums up to the termination date.

If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan gives written notice to Group, Health Plan shall comply with the CMS termination notice requirements with respect

to Senior Advantage Members and the termination of this *Agreement* shall be effective on the same date for all Members, including Senior Advantage Members.

Assignment

This *Agreement* or any of the rights, interests, claims for money due, benefits, or obligations hereunder shall not be assigned by Health Plan or Group without the prior written consent of the other party. This *Agreement* shall be binding on the successors and permitted assignees of Health Plan and Group.

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

"Confidential Information" does not include the "*Agreement*" between Health Plan and Group

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 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.

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 notify Health Plan as soon as reasonably possible, taking into account of the circumstances of the request or requirement to disclose, but in no event later than 5 business days of the request or demand to disclose. To the extent it is legally permissible in the opinion of Group's counsel, Group will cooperate with Health Plan to protect the Confidential Information from further disclosure (for purposes of this Agreement, "further disclosure" means any disclosure not necessary to the use and purpose outlined in the preceding paragraph). 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.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*. The applicable provisions of the Government Claims Act (California Government Code Section 900, et seq.) must be followed for any disputes under this *Agreement*

Any action and proceeding arising from disputes related to the interpretation, or enforcement of any provision, of this *Agreement* not otherwise subject to arbitration shall be tried and litigated exclusively in a state court or federal court (if permitted by law and a party elects to file an action in federal court) located in the County of Los Angeles, State of California.

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

The parties acknowledge that except as indicated above, this LOA does not change or alter the parties' obligations, requirements and conditions set forth in the *Agreement* and shall not otherwise supersede or amend any provision of the *Agreement*. Without limiting the generality of the foregoing, no additional oral promise or statement, nor any action, inaction, delay, failure to require performance or other course of conduct between the parties in furtherance of this LOA shall operate as, or be evidence of, an amendment or waiver of any provision of the *Agreement*. To the extent any waiver is granted, it shall be limited to the specific circumstance expressly described in such waiver, and shall not apply to any subsequent or other circumstance, whether similar or dissimilar, or give rise to, or evidence, any obligation or commitment to grant any further waiver.

This LOA will remain in effect until the Group *Agreement* is terminated by either Health Plan or the Group; provided, however, if the *Agreement* is renewed following the 2015 contract year, this LOA shall also renew for each such renewed contract year that follows, unless and until termination or amendment of this LOA is mutually agreed to between the parties in a writing that specifically references this addendum.

(Signatures on Following Page)

IN WITNESS WHEREOF, the authorized representatives of the parties to the *Agreement* hereby execute this LOA effective with the underlying *Agreement*.

ATTEST:
Clerk of the Board
Kecia Harper-Ihem

By: _____
Deputy

Date: DEC 08 2015

COUNTY OF RIVERSIDE:

By: _____
Chairman, Board of Supervisors
MARION ASHLEY

Date: DEC 08 2015

Approved as to form:

Gregory P. Priamos
County Counsel

By: _____
Deputy County Counsel

CONTRACTOR: KAISER FOUNDATION HEALTH PLAN, INC.

By: _____
Printed Name: Cynthia Striegel
Title: VP - Strategic Accounts
Date: 11-5-2015