

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



ITEM: 3.14
(ID # 15630)

MEETING DATE:
Tuesday, July 27, 2021

FROM: HUMAN RESOURCES:

SUBJECT: HUMAN RESOURCES: Ratify and Approve the Group Agreements and Letter of Agreements with Kaiser Foundation Health Plan, Inc. for the 2021 Calendar Year, All Districts. [Total Cost \$0, 100% Employee and Retiree Health Insurance Premiums]

RECOMMENDED MOTION: That the Board of Supervisors:

1. Ratify and approve the 2021 Group Agreement and Letter of Agreement for Active Employees (Attachments A and B), with Kaiser Foundation Health Plan, Inc., effective January 1, 2021 through March 31, 2021;
2. Ratify and approve the 2021 Group Agreement – Retirees and Letter of Agreement – for retirees who are non-Medicare eligible (Attachments D and E) with Kaiser Foundation Health Plan, Inc., effective January 1, 2021 through March 31, 2021;
3. Authorize the Chair of the Board to sign three (3) copies of each group agreement and each letter of agreement; and
4. Direct the Clerk of the Board to retain one (1) copy of each group agreement and each letter of agreement and return two (2) copies of each group agreement and each letter of agreement to Human Resources for distribution.

ACTION: Policy


Brenda Diederichs, Assistant CEO / Human Resources Director
7/27/2021

MINUTES OF THE BOARD OF SUPERVISORS

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

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

Kecia R. Harper
Clerk of the Board

By 
Deputy

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

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost
COST	\$0	\$0	\$0	\$0
NET COUNTY COST	\$0	\$0	\$0	\$0
SOURCE OF FUNDS: Employee and Retiree Health Premiums			Budget Adjustment: No	
			For Fiscal Year: 20/21	

C.E.O. RECOMMENDATION: Approve

BACKGROUND:

Summary

The attached Group Agreements, Letter of Agreements, and Evidence of Coverages (EOC) confirm the 2021 medical plan rates and provisions for active employees and retirees covered by Kaiser Foundation Health Plan, Inc. ("Kaiser Permanente"). Although the 2021 medical plan rates were previously approved, the terms and conditions of the 2021 agreements with regard to benefits offered had not been finalized. The prior 2020 Kaiser Permanente agreements were approved by the Board on June 30, 2020 (Item 3.24).

In an effort to avoid large fluctuations in premiums and to seek premium rate stability over time, Kaiser Permanente completed a separate health coverage rating renewal for early retirees, who are not Medicare eligible. Due to the new rating renewal for the early retiree population, a separate group agreement and letter of agreement was negotiated for Board approval for the 2021 plan year.

After much deliberation, the County and Kaiser Permanente have agreed to the terms and provisions set forth in the 2021 Plan Year agreements, for both active employees and retirees.

Prev. Agn. Ref.: 06/30/2020, Item 3.24 **District:** All

Impact on Residents and Businesses

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

Additional Fiscal Information

The 2021 premium rates were approved by the Board of Supervisors on August 25, 2020 (Item 3.39), for active employees and early retirees and approved rates on September 1, 2020 (Item 3.9) for Medicare eligible retirees. Kaiser Permanente health insurance premiums are paid by employees and retirees enrolled in the plan.

Contract History and Price Reasonableness

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

The County has contracted with Kaiser Permanente to provide medical services to its employees and retirees for more than a decade. Kaiser Permanente has remained consistent and committed to providing high levels of customer satisfaction and patient care.

Additionally, Kaiser has implemented several leading-edge medical trends, allowing optimal treatment and customer satisfaction with the use of online (virtual) chats with physicians, mobile health clinics, patient online access to medical records and robust retail pharmacy clinics.

The County offered Kaiser as a health plan selection for the 2021 Plan Year to eligible employees from January 1 – March 31, 2021, prior to the County transferring the remainder of its employee population to the CalPERS Health Program effective April 1, 2021. Kaiser will continue to be an offered health plan under the CalPERS Health Program for all County employees.

ATTACHMENTS

- A. 2021 Group Agreement – Active Employees
- B. 2021 Letter of Agreement – Active Employees
- C. Evidence of Coverage for 2021 Group Agreement – Active Employees
- D. 2021 Group Agreement – Retirees
- E. 2021 Letter of Agreement – Retirees
- F. Evidence of Coverage for 2021 Group Agreement – Retirees



Meghan Hahn, Administrative Analyst

7/19/2021



Gregory P. Priamos, Director County Counsel

7/15/2021



**Kaiser Foundation Health Plan, Inc.
Southern California Region**

A nonprofit corporation

**Group Agreement for
COUNTY OF RIVERSIDE - RETIREES**

Group ID: 233216 Contract: 1 Version: 15

January 1, 2021, through December 31, 2021

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Introduction

This Group Agreement (*Agreement*), including the *Evidence of Coverage (EOC)* and other 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 - RETIREES (Group).

In consideration of timely payment of Premium, Health Plan will provide or arrange for covered Services to Members in accord with the following document(s):

Health Plan products, including Ancillary Coverage offered by Health Plan:

<u>Product name</u>	<u>Contract option name for product</u>	<u>EOC #</u>
Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage	WORKING AGED HI	1
Kaiser Permanente Traditional HMO Plan	TRADITIONAL HMO HI	2
Kaiser Permanente Senior Advantage (HMO) with Part D	SR ADV GRP HMO HI	3
American Specialty Health Plans Chiropractic Plan	CHIROPRACTIC HI	4
Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage	WORKING AGED LOW	5
Kaiser Permanente Traditional HMO Plan	TRADITIONAL HMO LOW	6
Kaiser Permanente Senior Advantage (HMO) with Part D	SR ADV GRP LOW	7
American Specialty Health Plans Chiropractic Plan	CHIROPRACTIC LOW	8
Chiropractic Services and Silver&Fit Healthy Aging and Exercise Program	SLVRFIT CHIRO SCR HI	9
Chiropractic Services and Silver&Fit Healthy Aging and Exercise Program	SLVRFIT CHIRO LOW	10

Pediatric dental coverage:

Not applicable

Other Ancillary Coverage:

Not applicable

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*.

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, 2021, through December 31, 2021.

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 your Group’s 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 your Group’s 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, 2021 (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, 2022 (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, 2022, the last minute this *Agreement* was in effect was at 11:59 p.m. on December 31, 2021).

If Health Plan terminates this *Agreement*, Health Plan will give Group written notice. In the case of "Termination for Nonpayment," "Termination for Fraud or Intentionally Furnishing Incorrect or Incomplete Information," and "Termination for Discontinuance of a Product or all Products within a Market," Health Plan will provide both advance notice of the termination in addition to a final notice of termination. Within five business days of receipt of an advance or final notice of termination, 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 Group gives Health Plan 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

Premiums are due for the Full Premium owed as described in the “Premiums” section. If Health Plan does not receive the required Premium payment for all coverage issued under this *Agreement* 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 do not receive the required Premiums when due, the *Agreement* will terminate and all coverage issued under the *Agreement* will end 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 material 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:

- Ensure that:
 - ◆ 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
- Meet all applicable legal and contractual requirements, such as:
 - ◆ meet all Health Plan requirements set forth in the “Rate Assumptions and Requirements” section of the *Rate Proposal* document (Group’s Health Plan account manager can provide Group with a copy of the Rate Proposal if Group does not have one)
 - ◆ offer enrollment in accord with eligibility requirements in state law (for example, domestic partners must be eligible if married spouses are eligible and disabled dependents must be eligible if dependent children are eligible)

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 must retain documentation of each Member’s acceptance of the use of binding arbitration, and upon request, must be able to produce documentation relating to a specific Member to Health Plan at any time. In the event that the contract between Health Plan and Group terminates or Group is unable to comply with this document retention requirement, Group must transfer possession of all such documentation to Health Plan in a mutually agreeable manner. Group’s Health Plan account manager can provide Group with Health Plan’s current requirements for enrollment application forms and systems.

Grandfathered Health Plan Coverage

For any coverage identified in an *EOC* as a “grandfathered health plan” under the Patient Protection and Affordable Care Act and regulations, Group must immediately inform Health Plan if this coverage does not meet (or no longer meets) the requirements for grandfathered status including but not limited to any change in its contribution rate to the cost of any grandfathered health plan(s) during the plan year. Group represents that, for any coverage identified as a “grandfathered health plan” in the applicable *EOC*, Group has not decreased its contribution rate more than five percent (5%) for any rate tier for such grandfathered health plan when compared to the contribution rate in effect on March 23, 2010 for the same plan. Health Plan will rely on Group’s representation in issuing and continuing any and all grandfathered health plan coverage.

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 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 ("Member Materials"):

- A *Disclosure Form (DF)* for each non-Medicare coverage. Group will provide *DFs* (or combined *DF/EOCs*) 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* (or combined *DF/EOCs*) to Subscribers, except that Health Plan will provide *EOCs* (or combined *DF/EOCs*) to Members and potential Members who make a request to Health Plan

If Group receives the *Agreement* or Member Materials in electronic form, Group is not authorized to modify or alter in any way the text or the formatting of the electronic *Agreement* or Member Materials.

Health Plan assumes no responsibility for any changes in text or formatting that may occur in the *Agreement* or Member Materials after they are provided to Group. If Group posts the electronic *Agreement* or Member Materials on its intranet site, it shall do so in such a way so as to permit employees of Group to download and print a complete and accurate copy of the *Agreement* or Member Materials.

In the event Health Plan reasonably concludes that Group is either using the electronic *Agreement* or Member Materials in a manner not permitted by this *Agreement* or is not providing Subscribers with access to the Member Materials in accord with applicable laws, then Health Plan will print copies of the *Agreement* or Member Materials and Group will cooperate with Health Plan to ensure that printed copies of the *Agreement* or Member Materials are provided in a timely manner to all employees of Group enrolled with Health Plan. Group agrees to reimburse Health Plan for the reasonable cost of printing and delivering the *Agreement* or Member Materials.

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 must be sent to:

BRENDA DIEDERICH, HUMAN RESOURCES DIRECTOR
 COUNTY OF RIVERSIDE - RETIREES
 PO BOX 1569
 RIVERSIDE, CA 92502-1569

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

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

Notices from Group to Health Plan must be sent to:

Kaiser Permanente
1950 Franklin Street
Oakland, CA 94612
Attn: Wade J. Overgaard, Senior Vice President, Health Plan Operations

Open Enrollment

Group must hold an annual open enrollment period during which all eligible people, in accord with state law, may enroll in Health Plan or in any other health care plan available through Group. Also, Group must not hold open enrollment for 2022 until Group receives its 2022 group agreement Premium and coverage information from Health Plan. If Group holds the open enrollment without receiving 2022 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

Other Group coverage that covers 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 coverage.
- 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 coverage 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.

Representation regarding communication of membership changes

Group represents that its communication regarding membership changes to Health Plan is accurate. Group and its representative are bound by all membership data, including any changes or updates that it, or its representative, submits to Health Plan via any medium, electronic or otherwise, including but not limited to the following:

- Electronic data submissions regarding enrollment and eligibility
- Health Plan approved online tool for submission of data
- Paper enrollments submitted through postal mail or fax

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.

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.

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 in non-Medicare coverage 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 and will not exceed the waiting period established by Group. 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.

Right to Examine Records

Upon reasonable notice, Health Plan may examine Group's records with respect to contribution and participation requirements, eligibility, and payments under this *Agreement*.

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 Full Premium payment as described below are entitled to coverage under this *Agreement*, and then only for the period for which Health Plan (or its designee) has received required Premium 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 (or subgroup) 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 all of the coverage issued to each enrolled Member, as set forth under "Calculating Premiums" in this "Premiums" section.

New Members

Premiums are payable for the entire month for a new Member whose coverage effective date falls between the first day of the month and the fifteenth day of the month. No Premiums are due for the month for a new Member whose coverage becomes effective after the fifteenth day of 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, 2022, the last minute of coverage was at 11:59 p.m. on December 31, 2021).

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 a Kaiser Permanente Senior Advantage *EOC* (including inability to enroll under that *EOC* because they do 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.

If a Member age 65 or over who is eligible for Medicare as primary coverage and enrolled under a Kaiser Permanente Senior Advantage *EOC* 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. As applicable, 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 Premiums

To calculate the amount of Full Premiums that apply to a Family (a Subscriber and all of their Dependents):

1. Determine the coverage (*EOCs* and contract options) that apply to each Member in the Family (for example, Traditional Plan and any Ancillary Coverage).
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 (including contract options issued through a separate contract) based on the family role type and Medicare status of each Member:
 - Premiums for coverage issued under this *Agreement* appear in the Premium tables below.
 - If Ancillary Coverage has been issued under a separate contract and Premiums for that coverage are not listed in the Premium tables below, refer to that contract for Premiums. This Ancillary Coverage is part of the contract options selected by Group, and Group submits payment for this Ancillary Coverage as part of Full Premium.
4. Add the amount of Premiums for each Member together to arrive at the total, Full Premiums required for the Family.

Monthly Premiums for Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage — EOC # 1

WORKING AGED HI

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	\$1,079.83
1st Dependent	\$1,075.19
2nd Dependent	\$643.25

Monthly Premiums for Kaiser Permanente Traditional HMO Plan — EOC # 2

TRADITIONAL HMO HI

COUNTY OF RIVERSIDE - RETIREES

Group ID: 233216

Contract: 1 Version: 15 Effective: 1/1/21–12/31/21

Date: November 5, 2020

Members under age 65 who are not eligible for Medicare	
Family role type	Premiums
Subscriber	\$1,079.83
1st Dependent	\$1,075.19
2nd Dependent	\$643.25
Each additional Dependent	\$0.00

Members under age 65 who are eligible for or have Medicare Part A only	
Family role type	Premiums
Subscriber	\$1,079.83
1st Dependent	\$1,075.19
2nd Dependent	\$643.25
Each additional Dependent	\$0.00

Members under age 65 who are eligible for or have Medicare Part B only	
Family role type	Premiums
Subscriber	\$1,079.83
1st Dependent	\$1,075.19
2nd Dependent	\$643.25
Each additional Dependent	\$0.00

Members under age 65 who are eligible for or have Medicare Parts A&B	
Family role type	Premiums
Subscriber	\$1,079.83
1st Dependent	\$1,075.19
2nd Dependent	\$643.25
Each additional Dependent	\$0.00

Members under age 65 who are enrolled in another carrier's Medicare Risk product	
Family role type	Premiums
Subscriber	\$1,361.35
1st Dependent	\$1,361.35
2nd Dependent	\$1,361.35
Each additional Dependent	\$1,361.35

Members under age 65 when Medicare is secondary	
Family role type	Premiums
Subscriber	\$1,079.83
1st Dependent	\$1,075.19
2nd Dependent	\$643.25
Each additional Dependent	\$0.00

Members age 65 and over whose Medicare eligibility is unknown	
Family role type	Premiums
Subscriber	\$1,361.35
1st Dependent	\$1,361.35
2nd Dependent	\$1,361.35
Each additional Dependent	\$1,361.35

Members age 65 and over who are eligible for or have Medicare Part A only	
Family role type	Premiums
Subscriber	\$1,048.34
1st Dependent	\$1,048.34
2nd Dependent	\$1,048.34
Each additional Dependent	\$1,048.34

Members age 65 and over who are eligible for or have Medicare Part B only	
Family role type	Premiums
Subscriber	\$1,361.35
1st Dependent	\$1,361.35
2nd Dependent	\$1,361.35
Each additional Dependent	\$1,361.35

Members age 65 and over who are eligible for or have Medicare Parts A&B	
Family role type	Premiums
Subscriber	\$1,048.34
1st Dependent	\$1,048.34
2nd Dependent	\$1,048.34
Each additional Dependent	\$1,048.34

Members age 65 and over who are enrolled in another carrier's Medicare Risk product	
Family role type	Premiums
Subscriber	\$1,361.35
1st Dependent	\$1,361.35
2nd Dependent	\$1,361.35
Each additional Dependent	\$1,361.35

Members age 65 and over when Medicare is secondary	
Family role type	Premiums
Subscriber	\$1,079.83
1st Dependent	\$1,075.19
2nd Dependent	\$643.25
Each additional Dependent	\$0.00

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.

Monthly Premiums for Kaiser Permanente Senior Advantage (HMO) with Part D — EOC # 3

SR ADV GRP HMO HI

Family role type	Medicare Parts A & B	Medicare Part B only
Subscriber	\$258.91	\$570.91
1st Dependent	\$258.91	\$570.91
2nd Dependent	\$258.91	\$570.91

Family role type	Medicare Parts A & B	Medicare Part B only
Each additional Dependent	\$258.91	\$570.91

Monthly Premiums for American Specialty Health Plans Chiropractic Plan — EOC # 4

CHIROPRACTIC HI

Family role type	Premiums
Subscriber	\$1.44
1st Dependent	\$1.44
2nd Dependent	\$0.85

Monthly Premiums for Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage — EOC # 5

WORKING AGED 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	\$1,079.83
1st Dependent	\$1,075.19
2nd Dependent	\$643.25

Monthly Premiums for Kaiser Permanente Traditional HMO Plan — EOC # 6

TRADITIONAL HMO LOW

Members under age 65 who are not eligible for Medicare	
Family role type	Premiums
Subscriber	\$1,079.83
1st Dependent	\$1,075.19
2nd Dependent	\$643.25
Each additional Dependent	\$0.00

Members under age 65 who are eligible for or have Medicare Part A only	
Family role type	Premiums
Subscriber	\$1,079.83
1st Dependent	\$1,075.19
2nd Dependent	\$643.25
Each additional Dependent	\$0.00

Members under age 65 who are eligible for or have Medicare Part B only	
Family role type	Premiums
Subscriber	\$1,079.83
1st Dependent	\$1,075.19
2nd Dependent	\$643.25
Each additional Dependent	\$0.00

Members under age 65 who are eligible for or have Medicare Parts A&B	
Family role type	Premiums
Subscriber	\$1,079.83
1st Dependent	\$1,075.19
2nd Dependent	\$643.25
Each additional Dependent	\$0.00

Members under age 65 who are enrolled in another carrier's Medicare Risk product	
Family role type	Premiums
Subscriber	\$1,361.35
1st Dependent	\$1,361.35
2nd Dependent	\$1,361.35
Each additional Dependent	\$1,361.35

Members under age 65 when Medicare is secondary	
Family role type	Premiums
Subscriber	\$1,079.83
1st Dependent	\$1,075.19
2nd Dependent	\$643.25
Each additional Dependent	\$0.00

Members age 65 and over whose Medicare eligibility is unknown	
Family role type	Premiums
Subscriber	\$1,361.35
1st Dependent	\$1,361.35
2nd Dependent	\$1,361.35
Each additional Dependent	\$1,361.35

Members age 65 and over who are eligible for or have Medicare Part A only	
Family role type	Premiums
Subscriber	\$1,048.34
1st Dependent	\$1,048.34
2nd Dependent	\$1,048.34
Each additional Dependent	\$1,048.34

Members age 65 and over who are eligible for or have Medicare Part B only	
Family role type	Premiums
Subscriber	\$1,361.35
1st Dependent	\$1,361.35
2nd Dependent	\$1,361.35
Each additional Dependent	\$1,361.35

Members age 65 and over who are eligible for or have Medicare Parts A&B	
Family role type	Premiums
Subscriber	\$1,048.34
1st Dependent	\$1,048.34
2nd Dependent	\$1,048.34
Each additional Dependent	\$1,048.34

Members age 65 and over who are enrolled in another carrier's Medicare Risk product	
Family role type	Premiums
Subscriber	\$1,361.35
1st Dependent	\$1,361.35
2nd Dependent	\$1,361.35
Each additional Dependent	\$1,361.35

Members age 65 and over when Medicare is secondary	
Family role type	Premiums
Subscriber	\$1,079.83
1st Dependent	\$1,075.19
2nd Dependent	\$643.25
Each additional Dependent	\$0.00

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.

Monthly Premiums for Kaiser Permanente Senior Advantage (HMO) with Part D — EOC # 7

SR ADV GRP LOW

Family role type	Medicare Parts A & B	Medicare Part B only
Subscriber	\$174.04	\$486.04
1st Dependent	\$174.04	\$486.04
2nd Dependent	\$174.04	\$486.04
Each additional Dependent	\$174.04	\$486.04

Monthly Premiums for American Specialty Health Plans Chiropractic Plan — EOC # 8

CHIROPRACTIC LOW

Family role type	Premiums
Subscriber	\$1.44
1st Dependent	\$1.44
2nd Dependent	\$0.85

Monthly Premiums for Chiropractic Services and Silver&Fit Healthy Aging and Exercise Program — EOC # 9

SLVRFIT CHIRO SCR HI

Family role type	Premiums
Per Member, per month	\$1.44

Monthly Premiums for Chiropractic Services and Silver&Fit Healthy Aging and Exercise Program — EOC # 10

SLVRFIT CHIRO LOW

Family role type	Premiums
Per Member, per month	\$1.44

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 - RETIREES

Kaiser Foundation Health Plan, Inc.
Southern California Region

Karen S. Spiegel

Authorized Group officer signature

Wade J. Overgaard
Authorized officer

KAREN SPIEGEL

Senior Vice President, Health Plan Operations

CHAIR, BOARD OF SUPERVISORS

Please print your name and title

Executed in San Diego, CA effective 1/1/21

JUL 27 2021

Date: 11/5/20

Date signed

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 R. HARPER, Clerk

By *[Signature]*
DEPUTY

FORM APPROVED COUNTY COUNSEL
BY: *[Signature]* 7/15/2021
LISA SANCHEZ DATE

**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* for Group ID 233216 (Retirees) and *Evidences of Coverage* (collectively, the *Agreement*) previously entered into by and between the parties for the contract year beginning January 1, 2021 and ending March 31, 2021.

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, 2021 (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, 2022, the last minute this *Agreement* was in effect was at 11:59 p.m. on December 31, 2021).

If Health Plan terminates this *Agreement*, Health Plan will give Group written notice. In the case of "Termination for Nonpayment", "Termination for Fraud or Intentionally Furnishing Incorrect or Incomplete Information", and "Termination for Discontinuance of a Product or all Products within a Market," Health Plan will provide both advance notice of the termination in addition to a final notice of termination. Within five business days of receipt of advance or final notice of termination, 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 Group gives Health Plan 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 material information to Health Plan, 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 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.

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 accordance with Section 1363.1 of the California and Health Safety Code and other applicable law. Group must retain documentation of each Member's acceptance of the use of binding arbitration during the term of this *Agreement* and for six (6) years after the termination of this *Agreement*, and upon request, must be able to produce documentation relating to a specific Member to Health Plan during such retention period. In the event that Group is unable to comply with this document retention requirement, Group must transfer possession of all such documentation to Health Plan in a mutually agreeable manner. 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*. 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.

Unless the parties by mutual written agreement terminate or amend this LOA, this LOA will remain in effect unless and until the *Agreement* is terminated.

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

COUNTY OF RIVERSIDE:

By: 
Deputy

By: 
Chair, Board of Supervisors

KAREN SPIEGEL

Date: JUL 27 2021

Date: JUL 27 2021

Approved as to Form:

Gregory P. Priamos
County Counsel

By: 
Deputy County Counsel

LISA SANCHEZ

Date: 7/15/2021

KAISER FOUNDATION HEALTH PLAN, INC.

By: 

Printed Name: Kate Ferrante

Title: VP- Strategic Accounts

Date: 5-18-21



**Kaiser Foundation Health Plan, Inc.
Southern California Region**

A nonprofit corporation

Group Agreement for COUNTY OF RIVERSIDE

Group ID: 227016 Contract: 1 Version: 67

January 1, 2021, through December 31, 2021

JUL 27 2021 3.14

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Introduction

This Group Agreement (*Agreement*), including the *Evidence of Coverage (EOC)* and other 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 consideration of timely payment of Premium, Health Plan will provide or arrange for covered Services to Members in accord with the following document(s):

Health Plan products, including Ancillary Coverage offered by Health Plan:

<u>Product name</u>	<u>Contract option name for product</u>	<u>EOC #</u>
American Specialty Health Plans Chiropractic Plan	CHIROPRACTIC - ACTIVE AND COBRA	1
Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage	WORKING AGED RISK - HI ACTIVE AND COBRA	2
Kaiser Permanente Traditional HMO Plan	TRADITIONAL HMO - HI ACTIVE AND COBRA	3
Kaiser Permanente Senior Advantage (HMO) with Part D	SR ADV GRP HMO SCR - HI ACTIVE AND COBRA	4

Pediatric dental coverage:

Not applicable

Other Ancillary Coverage:

Not applicable

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*.

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, 2021, through December 31, 2021.

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 your Group’s 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 your Group’s 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, 2021 (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, 2022 (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, 2022, the last minute this *Agreement* was in effect was at 11:59 p.m. on December 31, 2021).

If Health Plan terminates this *Agreement*, Health Plan will give Group written notice. In the case of "Termination for Nonpayment," "Termination for Fraud or Intentionally Furnishing Incorrect or Incomplete Information," and "Termination for Discontinuance of a Product or all Products within a Market," Health Plan will provide both advance notice of the termination in addition to a final notice of termination. Within five business days of receipt of an advance or final notice of termination, 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 Group gives Health Plan 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

Premiums are due for the Full Premium owed as described in the “Premiums” section. If Health Plan does not receive the required Premium payment for all coverage issued under this *Agreement* 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 do not receive the required Premiums when due, the *Agreement* will terminate and all coverage issued under the *Agreement* will end 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 material 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:

- Ensure that:
 - ◆ 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
- Meet all applicable legal and contractual requirements, such as:
 - ◆ meet all Health Plan requirements set forth in the “Rate Assumptions and Requirements” section of the *Rate Proposal* document (Group’s Health Plan account manager can provide Group with a copy of the Rate Proposal if Group does not have one)
 - ◆ offer enrollment in accord with eligibility requirements in state law (for example, domestic partners must be eligible if married spouses are eligible and disabled dependents must be eligible if dependent children are eligible)

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 must retain documentation of each Member’s acceptance of the use of binding arbitration, and upon request, must be able to produce documentation relating to a specific Member to Health Plan at any time. In the event that the contract between Health Plan and Group terminates or Group is unable to comply with this document retention requirement, Group must transfer possession of all such documentation to Health Plan in a mutually agreeable manner. Group’s Health Plan account manager can provide Group with Health Plan’s current requirements for enrollment application forms and systems.

Grandfathered Health Plan Coverage

For any coverage identified in an *EOC* as a “grandfathered health plan” under the Patient Protection and Affordable Care Act and regulations, Group must immediately inform Health Plan if this coverage does not meet (or no longer meets) the requirements for grandfathered status including but not limited to any change in its contribution rate to the cost of any grandfathered health plan(s) during the plan year. Group represents that, for any coverage identified as a “grandfathered health plan” in the applicable *EOC*, Group has not decreased its contribution rate more than five percent (5%) for any rate tier for such grandfathered health plan when compared to the contribution rate in effect on March 23, 2010 for the same plan. Health Plan will rely on Group’s representation in issuing and continuing any and all grandfathered health plan coverage.

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 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 ("Member Materials"):

- A *Disclosure Form (DF)* for each non-Medicare coverage. Group will provide *DFs* (or combined *DF/EOCs*) 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* (or combined *DF/EOCs*) to Subscribers, except that Health Plan will provide *EOCs* (or combined *DF/EOCs*) to Members and potential Members who make a request to Health Plan

If Group receives the *Agreement* or Member Materials in electronic form, Group is not authorized to modify or alter in any way the text or the formatting of the electronic *Agreement* or Member Materials.

Health Plan assumes no responsibility for any changes in text or formatting that may occur in the *Agreement* or Member Materials after they are provided to Group. If Group posts the electronic *Agreement* or Member Materials on its intranet site, it shall do so in such a way so as to permit employees of Group to download and print a complete and accurate copy of the *Agreement* or Member Materials.

In the event Health Plan reasonably concludes that Group is either using the electronic *Agreement* or Member Materials in a manner not permitted by this *Agreement* or is not providing Subscribers with access to the Member Materials in accord with applicable laws, then Health Plan will print copies of the *Agreement* or Member Materials and Group will cooperate with Health Plan to ensure that printed copies of the *Agreement* or Member Materials are provided in a timely manner to all employees of Group enrolled with Health Plan. Group agrees to reimburse Health Plan for the reasonable cost of printing and delivering the *Agreement* or Member Materials.

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 must be sent to:

BRENDA DIEDERICH, HUMAN RESOURCES DIRECTOR
COUNTY OF RIVERSIDE
PO BOX 1569
RIVERSIDE, CA 92502-1569

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

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

Notices from Group to Health Plan must be sent to:

Kaiser Permanente
1950 Franklin Street
Oakland, CA 94612
Attn: Wade J. Overgaard, Senior Vice President, Health Plan Operations

Open Enrollment

Group must hold an annual open enrollment period during which all eligible people, in accord with state law, may enroll in Health Plan or in any other health care plan available through Group. Also, Group must not hold open enrollment for 2022 until Group receives its 2022 group agreement Premium and coverage information from Health Plan. If Group holds the

open enrollment without receiving 2022 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

Other Group coverage that covers 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 coverage.
- 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 coverage 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.

Representation regarding communication of membership changes

Group represents that its communication regarding membership changes to Health Plan is accurate. Group and its representative are bound by all membership data, including any changes or updates that it, or its representative, submits to Health Plan via any medium, electronic or otherwise, including but not limited to the following:

- Electronic data submissions regarding enrollment and eligibility
- Health Plan approved online tool for submission of data
- Paper enrollments submitted through postal mail or fax

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.

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.

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 in non-Medicare coverage 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 and will not exceed the waiting period established by Group. 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.

Right to Examine Records

Upon reasonable notice, Health Plan may examine Group's records with respect to contribution and participation requirements, eligibility, and payments under this *Agreement*.

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 Full Premium payment as described below are entitled to coverage under this *Agreement*, and then only for the period for which Health Plan (or its designee) has received required Premium 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 (or subgroup) 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 all of the coverage issued to each enrolled Member, as set forth under "Calculating 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, 2022, the last minute of coverage was at 11:59 p.m. on December 31, 2021).

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 a Kaiser Permanente Senior Advantage *EOC* (including inability to enroll under that *EOC* because they do 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.

If a Member age 65 or over who is eligible for Medicare as primary coverage and enrolled under a Kaiser Permanente Senior Advantage *EOC* 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. As applicable, 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 Premiums

To calculate the amount of Full Premiums that apply to a Family (a Subscriber and all of their Dependents):

1. Determine the coverage (*EOCs* and contract options) that apply to each Member in the Family (for example, Traditional Plan and any Ancillary Coverage).
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 (including contract options issued through a separate contract) based on the family role type and Medicare status of each Member:
 - Premiums for coverage issued under this *Agreement* appear in the Premium tables below.
 - If Ancillary Coverage has been issued under a separate contract and Premiums for that coverage are not listed in the Premium tables below, refer to that contract for Premiums. This Ancillary Coverage is part of the contract options selected by Group, and Group submits payment for this Ancillary Coverage as part of Full Premium.
4. Add the amount of Premiums for each Member together to arrive at the total, Full Premiums required for the Family.

Monthly Premiums for American Specialty Health Plans Chiropractic Plan — EOC # 1

CHIROPRACTIC - ACTIVE AND COBRA

Family role type	Premiums
Subscriber	\$1.56
1st Dependent	\$1.55
2nd Dependent	\$0.96

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

WORKING AGED RISK - HI ACTIVE AND COBRA

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	\$734.25
1st Dependent	\$730.51
2nd Dependent	\$441.07

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.

Monthly Premiums for Kaiser Permanente Traditional HMO Plan — EOC # 3

TRADITIONAL HMO - HI ACTIVE AND COBRA

Members under age 65 who are not eligible for Medicare	
Family role type	Premiums
Subscriber	\$734.25
1st Dependent	\$730.51
2nd Dependent	\$441.07
Each additional Dependent	\$0.00

Members under age 65 who are eligible for or have Medicare Part A only	
Family role type	Premiums
Subscriber	\$734.25
1st Dependent	\$730.51
2nd Dependent	\$441.07
Each additional Dependent	\$0.00

Members under age 65 who are eligible for or have Medicare Part B only	
Family role type	Premiums
Subscriber	\$734.25
1st Dependent	\$730.51
2nd Dependent	\$441.07
Each additional Dependent	\$0.00

Members under age 65 who are eligible for or have Medicare Parts A&B	
Family role type	Premiums
Subscriber	\$734.25
1st Dependent	\$730.51
2nd Dependent	\$441.07
Each additional Dependent	\$0.00

Members under age 65 who are enrolled in another carrier's Medicare Risk product	
Family role type	Premiums
Subscriber	\$1,361.35
1st Dependent	\$1,361.35
2nd Dependent	\$1,361.35
Each additional Dependent	\$1,361.35

Members under age 65 when Medicare is secondary	
Family role type	Premiums
Subscriber	\$734.25
1st Dependent	\$730.51
2nd Dependent	\$441.07
Each additional Dependent	\$0.00

Members age 65 and over whose Medicare eligibility is unknown	
Family role type	Premiums
Subscriber	\$1,361.35

Members age 65 and over whose Medicare eligibility is unknown	
Family role type	Premiums
1st Dependent	\$1,361.35
2nd Dependent	\$1,361.35
Each additional Dependent	\$1,361.35

Members age 65 and over who are eligible for or have Medicare Part A only	
Family role type	Premiums
Subscriber	\$1,048.34
1st Dependent	\$1,048.34
2nd Dependent	\$1,048.34
Each additional Dependent	\$1,048.34

Members age 65 and over who are eligible for or have Medicare Part B only	
Family role type	Premiums
Subscriber	\$1,361.35
1st Dependent	\$1,361.35
2nd Dependent	\$1,361.35
Each additional Dependent	\$1,361.35

Members age 65 and over who are eligible for or have Medicare Parts A&B	
Family role type	Premiums
Subscriber	\$1,048.34
1st Dependent	\$1,048.34
2nd Dependent	\$1,048.34
Each additional Dependent	\$1,048.34

Members age 65 and over who are enrolled in another carrier's Medicare Risk product	
Family role type	Premiums
Subscriber	\$1,361.35
1st Dependent	\$1,361.35
2nd Dependent	\$1,361.35
Each additional Dependent	\$1,361.35

Members age 65 and over when Medicare is secondary	
Family role type	Premiums
Subscriber	\$734.25
1st Dependent	\$730.51
2nd Dependent	\$441.07
Each additional Dependent	\$0.00

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.

Monthly Premiums for Kaiser Permanente Senior Advantage (HMO) with Part D — EOC # 4

SR ADV GRP HMO SCR - HI ACTIVE AND COBRA

Family role type	Medicare Parts A & B	Medicare Part B only
Subscriber	\$244.52	\$556.52
1st Dependent	\$244.52	\$556.52
2nd Dependent	\$244.52	\$556.52
Each additional Dependent	\$244.52	\$556.52

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.

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

Kaiser Foundation Health Plan, Inc.
Southern California Region

Karen S. Spiegel



Authorized Group officer signature

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

KAREN SPIEGEL

CHAIR, BOARD OF SUPERVISORS

Please print your name and title

Executed in San Diego, CA effective 1/1/21

JUL 27 2021

Date: 11/7/20

Date signed

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 R. HARPER, Clerk

By *Priscilla Gasso*

DEPUTY

FORM APPROVED COUNTY COUNSEL

BY: *Lisa Sanchez* 7/15/2021
LISA SANCHEZ DATE

**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* for Group ID 227016 and *Evidences of Coverage* (collectively, the *Agreement*) previously entered into by and between the parties for the contract year beginning January 1, 2021 and ending March 31, 2021.

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, 2021 (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, 2022, the last minute this *Agreement* was in effect was at 11:59 p.m. on December 31, 2021).

If Health Plan terminates this *Agreement*, Health Plan will give Group written notice. In the case of "Termination for Nonpayment", "Termination for Fraud or Intentionally Furnishing Incorrect or Incomplete Information", and "Termination for Discontinuance of a Product or all Products within a Market," Health Plan will provide both advance notice of the termination in addition to a final notice of termination. Within five business days of receipt of advance or final notice of termination, 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 Group gives Health Plan 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 material information to Health Plan, 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 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.

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 accordance with Section 1363.1 of the California and Health Safety Code and other applicable law. Group must retain documentation of each Member's acceptance of the use of binding arbitration during the term of this *Agreement* and for six (6) years after the termination of this *Agreement*, and upon request, must be able to produce documentation relating to a specific Member to Health Plan during such retention period. In the event that Group is unable to comply with this document retention requirement, Group must transfer possession of all such documentation to Health Plan in a mutually agreeable manner. 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*. 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.

Unless the parties by mutual written agreement terminate or amend this LOA, this LOA will remain in effect unless and until the *Agreement* is terminated.

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

COUNTY OF RIVERSIDE:

By: [Signature]
Deputy

Date: JUL 27 2021

By: [Signature]
Chair, Board of Supervisors
KAREN SPIEGEL

Date: JUL 27 2021

Approved as to Form:

Gregory P. Priamos
County Counsel

By: [Signature]
Deputy County Counsel
LISA SANCHEZ

Date: 7/15/2021

KAISER FOUNDATION HEALTH PLAN, INC.

By: [Signature]

Printed Name: Kate Ferrante

Title: VP- Strategic Accounts

Date: 5-18-21