KAISER PERMANENTE

Kaiser Foundation Health Plan, Inc.

Northern California Region

May 16, 2011

County of El Dorado
Attn: Janet Parnell, Risk Management
330 Fair Lane
Placerville, CA 95667

Dear Janet:

This letter confirms that all payments to Kaiser Permanente for the County of El Dorado should be submitted through Employee Benefits Specialists (EBS). EBS is the administrative intermediary for County of El Dorado and Kaiser Permanente. EBS is responsible for all billing and eligibility functions for Kaiser Permanente.

Eligibility adjustments reported to Kaiser Permanente after the date the invoice is prepared will be reflected on the subsequent month's invoice from EBS.

Please feel free to let me know if you have any questions.

Sincerely,

John Matocq
Area Director, Account Management
Kaiser Permanente

_____
County of El Dorado

_____
County of El Dorado

KAISER PERMANENTE®

April 25, 2011

JANET PARNELL, PRINCIPAL RISK MANAGEMENT ANAL
EL DORADO COUNTY
330 FAIR LN
PLACERVILLE, CA 95667-4103

Re: Renewed *Group Agreement* for Group ID # 34936
Renewal effective date: 07/01/2011

Dear JANET PARNELL:

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

We have enclosed the new *Group Agreement* between EL DORADO COUNTY and Kaiser Foundation Health Plan, Inc., for the contract period July 1, 2011, through December 31, 2011. Please refer to the enclosed 2011 *Group Agreement Summary of Changes and Clarifications* for a summary of the most important changes and clarifications.

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

Note: If your agreement for the following product(s) has been revised, the carrier will notify you under separate cover: PMI Dental Health Plan.

If you have any questions or need enrollment material for your employees, please contact your Health Plan account manager Catherine Guiao at (916) 614-4545. Thank you again for continuing to offer Kaiser Permanente as a quality health care plan for your employees.

Sincerely,

Jerry Fleming
Senior Vice President and Health Plan Manager

cc: LISA HOAAS
CHRISTINE KERNS

mr 30758-mr

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

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeals procedure as applicable to Kaiser Permanente Senior Advantage and Medicare Cost Members
- If coverage is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulations (29 CFR 2560.503-1), the claim is about an "adverse benefit determination" as defined in that regulation. Note: Claims about "adverse benefit determinations" are excluded from this binding arbitration requirement only until such time as the regulation prohibiting mandatory binding arbitration of this category of claim (29 CFR 2560.503-1(c)(4)) is modified, amended, repealed, superseded, or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without further notice

Signatures

EL DORADO COUNTY

Authorized Group officer signature

Please print your name and title
Board of Supervisors

Date signed

Kaiser Foundation Health Plan, Inc.
Northern California Region

Jerry Fleming
Authorized officer
Senior Vice President and Health Plan Manager

Executed in San Diego, CA effective 7/1/11
Date: 4/25/11

Please sign and mail us this copy of the *Agreement* Signature Page in the enclosed business-reply envelope to our California Service Center at P.O. Box 23448, San Diego, CA 92193-3448.

Information for Groups Subject to ERISA

Under the Employee Retirement Income Security Act (ERISA), the plan administrator of an employee welfare benefit plan (EWBP) subject to ERISA is responsible, among other things, for development and distribution of a *Summary Plan Description (SPD)* to plan participants. The plan administrator is often a designee of the employer or union plan sponsor. With respect to its fully-insured EWBP accounts, Kaiser Foundation Health Plan, Inc. (Health Plan) underwrites the fully-insured product through which the employer or union group health plan sponsor offers health care coverage to its plan participants. Accordingly, Health Plan is neither the "ERISA plan" nor the "plan administrator" with respect to its fully-insured group health plan accounts.

Disclosures Required by ERISA

The plan administrator of an EWBP subject to ERISA may satisfy certain ERISA disclosure obligations by incorporating the Health Plan *Evidence of Coverage (EOC)* into its *SPD*. However, the *EOC* by itself does not satisfy the disclosure requirements under ERISA for a compliant *SPD*. Moreover, if a required disclosure is not in the *EOC*, or if the plan administrator chooses to not incorporate the *EOC* in the *SPD*, the plan administrator must provide the disclosure in the *SPD*. In addition, if there are discrepancies between the description of covered group health plan benefits appearing in the *SPD* and those reflected in the *EOC*, the benefit description appearing in the *EOC* will control.

This overview of ERISA disclosure requirements is intended to help plan administrators ensure that their SPD accurately reflects the terms of their fully-insured group health care coverages, as required under ERISA. However, it is the plan administrator's responsibility to verify that the EWBP's *SPD* satisfies all ERISA disclosure requirements.

SPD Disclosure	EOC Disclosure
Description of coverage, including: • Cost sharing • Exclusions and limitations • Prior authorization requirements • Provider network • Claims procedure	Under ERISA, an *SPD* may provide only a general description of plan benefits as long as the SPD references a detailed schedule of benefits and incorporates it by reference. That detailed schedule of benefits can be the *EOC* that Health Plan provides to your Group, which offers a clear description of the scope of benefits covered under the plan and the rules for obtaining those benefits. If the plan administrator chooses to incorporate the *EOC* by reference into the *SPD*, it may satisfy the applicable ERISA coverage disclosure requirements by including the following language *without changes* as the introduction to the benefit chart in the *SPD*: ♦ This benefit chart provides summary information only. It does not fully describe your benefit coverage. For details on your benefit coverage, please refer to your Kaiser Foundation Health Plan, Inc. (Health Plan) Evidence of Coverage. The Evidence of Coverage is the binding document between Health Plan and its members. ♦ As a condition of coverage, a Health Plan physician must determine that any requested services and supplies are medically necessary to prevent, diagnose, or treat a medical condition. Generally, requested services and supplies must be provided, prescribed, authorized, or directed by a Health Plan provider. Except as otherwise noted in the Evidence of Coverage, you must receive the requested services and supplies from a Health Plan-designated provider inside your Health Plan Service Area except as specifically noted in the Evidence of Coverage, ♦ For details on the benefit and claims review and adjudication procedures, please refer to the Evidence of Coverage.
Newborns' and Mothers' Health Protection Act (Newborn Act)	Health Plan provides coverage for hospital lengths of stay following childbirth for mothers and newborns in accordance with the Newborn Act. A disclosure of hospital length of stay requirements is provided in the "Hospital Inpatient Care" section of the *EOC*. To assist the plan administrator in complying with ERISA, a Newborn Act notice is included in the "Miscellaneous Provisions" section of the EOC.

Additional information about ERISA claims

With respect to ERISA covered EWBPs, plan participants' requests for payment or services may be subject to both ERISA requirements and California law.

Required Disclosure	EOC Disclosure
Claims procedures	The disclosure concerning post-service claims for emergency services, post-stabilization care, and out-of-area urgent care from non-Plan providers appears under "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section of the EOC. The disclosure concerning pre-service claims, concurrent care claims, and post-service claims other than claims for emergency, post-stabilization, or out-of-area urgent care from non-Plan providers appears under "Grievances" in the "Dispute Resolution" section of the EOC. Note: the "Binding Arbitration" section specifies that binding arbitration is not required for certain benefit-related claims subject to ERISA.

2011 *Group Agreement* Summary of Changes and Clarifications

The following is a summary of changes and clarifications that we have made to the *2011 Group Agreement*, including the *Evidence of Coverage (EOC)* documents. This summary does not include minor changes and clarifications that Health Plan is making to improve the readability and accuracy of the *Agreement* and any changes we have made at your Group's request. Please refer to the "Premiums" section in the *Group Agreement* for the Premiums that are effective on your Group's renewal anniversary date.

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

Note: In this document "non-Medicare *EOCs*" means all *EOCs* other than Senior Advantage or Medicare Cost *EOCs*.

Changes and Clarifications to the *Group Agreement*, including *EOC* documents, in response to the Patient Protection and Affordable Care Act

We are making the changes described below to non-Medicare *EOCs* in response to the Patient Protection and Affordable Care Act (PPACA).

Appeals

We are analyzing the new regulations and will update our *EOCs* as necessary so that the language reflects the new mandate.

Choice of Primary Care Physicians

We have confirmed that our operations are already compliant with the federal mandate. We will update our *EOCs* so that the language reflects the new mandate.

Dependent Coverage to Age 26

We are changing the limiting age for Dependent children to 26, meaning that Dependent children will now lose eligibility when they turn 26, regardless of student status. (If your group currently has a higher limiting age for Dependents or students, we will not change that age limit.) We are also making changes to the Dependent eligibility criteria, such as removing the requirement that Dependent children must be unmarried, live with the Subscriber or Spouse, or be dependent upon the Subscriber or Spouse. However, state mandates related to dependent eligibility continue to apply. For example, if your Group covers Dependent children:

- Your Group must also cover dependent Children who do not meet the age limit if they meet the eligibility requirements for disabled dependents
- For a newly adopted child or child placed with you or your Spouse for adoption, coverage is effective on the date when you or your Spouse gain the legal right to control the child's health care. For purposes of this requirement, "legal right to control health care" means you have a signed written document (such as a health facility minor release report, a medical authorization form, or a relinquishment form) or other evidence that shows you or your Spouse have the legal right to control the child's health care

Direct access to obstetrics/gynecology

We have confirmed that our operations already are compliant with the federal mandate. We will update our *EOCs* so that the language reflects the new mandate.

Emergency Services

We have replaced the term "Emergency Care" with "Emergency Services," and have revised the definitions of "Emergency Services," "Emergency Medical Condition," and "Stabilize." Also, we have revised the definition of "Emergency Medical Condition" in accord with California Assembly Bill 235 to indicate that a mental health condition is an Emergency Medical Condition when it meets the requirements of the definition under PPACA, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to himself or herself or to others

We have revised the "Special enrollment" section of non-Medicare and Senior Advantage *EOCs* to clarify that someone must have declined all coverage offered by the group at open enrollment in order for loss of group coverage to be a special enrollment qualifying event.

Ultraviolet light treatment

For Deductible HMO Plans other than HSA-Qualified Deductible HMO Plans, *ultraviolet light treatment Services will not be subject to the Deductible*. We are making this change for ease of administration.

Other Clarifications to the *Group Agreement*, including *EOC* documents

Clinical Trials

Effective January 1, 2011, Senior Advantage Members who receive routine Services from a Non-Plan Provider as part of a Medicare-approved clinical trial will pay the Cost Sharing that applies for Services provided by Plan Providers under their Senior Advantage *EOC*. Prior authorization is not required, but Members must inform Health Plan before they start participating in a trial. Previously, Members paid the Original Medicare cost sharing. The Cost Sharing Members pay for these Services will apply towards the annual out-of-pocket maximum.

Contraceptives

We have clarified that contraceptive rings and patches are covered.

Exclusions

We have made the following revisions in the "Exclusions" section:

- We have clarified that when a service is excluded, it is excluded regardless of whether the services are within the scope of a provider's license or certificate
- We have revised the exclusion for services performed by unlicensed people for clarity. Services performed by unlicensed people are services that are performed safely and effectively by people who do not require licenses or certificates by the state to provide health care services and where the Member's condition does not require that the services be provided by a licensed health care provider
- We have added an exclusion for massage therapy

Home dialysis

We have clarified that the Cost Sharing for Services related to home dialysis is "no charge" (subject to any applicable Deductible).

Medicare Part D outpatient prescription drug coverage

Effective January 1, 2011, Medicare's Coverage Gap Discount Program may provide manufacturer discounts on brand name drugs if (1) the Member is not already receiving "Extra Help," (2) Medicare is not secondary for the Member, and (3) the amount that the Member and any Medicare Part D plan spend for the Member's covered Part D drugs reaches $2,840 in a calendar year.

When applicable, we will automatically apply Medicare's discount when Members pay their prescription Copayment or Coinsurance and their *Explanation of Benefits* will show any discount provided. The amount discounted by the manufacturer counts toward their out-of-pockets costs as if they had paid the amount.

Medical advice

In non-Medicare *EOCs*, we have clarified that licensed health care professionals are available 24 hours a day, seven days a week to help Members decide what kind of care they need and how and where to get care. We hare making this clarification in response to the requirements in Section 1300.67.2.2 of Title 28 the California Code of Regulations.

Non-health care items and services

We have clarified that for Services to be covered, the Services must be one of the following:

- Health care items and services for preventive care

Testicular implants

We have revised the cosmetic services exclusion to clarify that we cover testicular implants that are associated with reconstructive surgery, if a Plan Physician determines they are necessary to improve function, or create a normal appearance, to the extent possible.

Vision Services

In *EOCs* that cover supplemental optical coverage, we have made the following revisions for clarity:

- The exclusion for eye surgery, eyeglasses, and contact lenses, and contact lens eye examinations has been modified to clarify that non-surgical vision correction procedures are also excludedIn Medicare *EOCs*, we have clarified that we only cover one pair of eyeglasses or contact lenses after any cataract surgery that includes insertion of an intraocular lens

Enrollment Unit Chart

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

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

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

Contract name:	EL DORADO COUNTY
Purchaser ID:	34936
Contract:	1
Version:	56

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

Enrollment unit number: 0 **Name:** EL DORADO COUNTY
Billing contact: HUMAN RESOURCES DIRECTOR

Contract option ID/EOC #	Product/contract option names
1	Kaiser Permanente Senior Advantage (HMO) with Part D / SENIOR ADVANTAGE
2	Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage / WORKING AGED
3	American Specialty Health Plans Chiropractic Plan / HMO CHIRO
5	Kaiser Permanente Traditional Plan / TRADITIONAL PLAN
6	PMI Dental Health Plan / DENTAL RISK

Enrollment unit number: 1 **Name:** EL DORADO COUNTY
Billing contact: HUMAN RESOURCES DIRECTOR

Contract option ID/EOC #	Product/contract option names
1	Kaiser Permanente Senior Advantage (HMO) with Part D / SENIOR ADVANTAGE
3	American Specialty Health Plans Chiropractic Plan / HMO CHIRO
5	Kaiser Permanente Traditional Plan / TRADITIONAL PLAN
6	PMI Dental Health Plan / DENTAL RISK

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Northern California Region

A nonprofit corporation

Group Agreement for
EL DORADO COUNTY

Group ID: 34936 Contract: 1 Version: 56

July 1, 2011, through December 31, 2011

TABLE OF CONTENTS

Introduction

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

Product name	Contract option name	*EOC #*
Kaiser Permanente Senior Advantage (HMO) with Part D	Senior Advantage	1
Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage	Working Aged	2
American Specialty Health Plans Chiropractic Plan	HMO Chiro	3
Kaiser Permanente Traditional Plan	Traditional Plan	5

Term of *Agreement* and Renewal

Term of *Agreement*

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

Renewal

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

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

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

Amendment of *Agreement*

Amendments Effective on January 1 (Anniversary Date)

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

Termination on Notice

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

Termination Due to Nonacceptance of Amendments

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

Termination for Nonpayment

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

Termination for Fraud or Intentionally Furnishing Incorrect or Incomplete Information

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

Termination for Violation of Contribution or Participation Requirements

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

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

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

Contribution and Participation Requirements

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

Group must:

- Contribute to all health care coverage available through Group on a basis that does not financially discriminate against Health Plan or against people who choose to enroll in Health Plan

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

Notices

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

Notices from Health Plan to Group will be sent to:

JANET PARNELL, PRINCIPAL RISK MANAGEMENT ANAL
EL DORADO COUNTY
330 FAIR LN
PLACERVILLE, CA 95667-4103

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

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

Notices from Group to Health Plan must be sent to:

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

Reporting Membership Changes and Retroactivity

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

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

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

Medicare

Medicare as primary coverage

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

- Kaiser Permanente Senior Advantage

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

Medicare as secondary coverage

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

Subscriber Contributions for Medicare Part C and Part D Coverage

Medicare Part C coverage

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

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

Medicare Part D coverage

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

Kaiser Permanente Senior Advantage (HMO) with Part D — *EOC # 1*

Senior Advantage

Family role type	Medicare Parts A & B	Medicare Part B only
Subscriber	$407.57	$717.57
1st Dependent	$407.57	$717.57
2nd Dependent	$407.57	$717.57
Each additional Dependent	$407.57	$717.57

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

Working Aged

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	$605.92
1st Dependent	$605.91
2nd Dependent	$502.92

American Specialty Health Plans Chiropractic Plan — *EOC # 3*

HMO Chiro

Family role type	Premiums
Subscriber	$1.71
1st Dependent	$1.72
2nd Dependent	$1.42

Kaiser Permanente Traditional Plan — *EOC # 5*

Traditional Plan

Members under age 65 (or 65 and over if Medicare is secondary)	
Family role type	Premiums
Subscriber	$605.92
1st Dependent	$605.91
2nd Dependent	$502.92
Each additional Dependent	$0.00

Members age 65 and over whose Medicare eligibility is unknown or who are eligible for or have Medicare Part B only	
Family role type	Premiums
Subscriber	$1,486.60
1st Dependent	$1,486.60
2nd Dependent	$1,486.60
Each additional Dependent	$1,486.60

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

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeals procedure as applicable to Kaiser Permanente Senior Advantage and Medicare Cost Members
- If coverage is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulations (29 CFR 2560.503-1), the claim is about an "adverse benefit determination" as defined in that regulation. Note: Claims about "adverse benefit determinations" are excluded from this binding arbitration requirement only until such time as the regulation prohibiting mandatory binding arbitration of this category of claim (29 CFR 2560.503-1(c)(4)) is modified, amended, repealed, superseded, or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without further notice

Signatures

EL DORADO COUNTY

Authorized Group officer signature

Please print your name and title

Date signed

Kaiser Foundation Health Plan, Inc.
Northern California Region

Jerry Fleming
Authorized officer
Senior Vice President and Health Plan Manager

Executed in San Diego, CA effective 7/1/11
Date: 4/25/11

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

Administrator: The County Officer or employee with responsibility for administering this Agreement is Janet Parnell, Principal Risk Management Analyst, Human Resources, Risk Management Division, or successor.

Entire Agreement: This document and the documents referred to herein or exhibits hereto are the entire Agreement between the parties and they incorporate or supersede all prior written or oral Agreements or understandings.

Requesting Contract Administrator Concurrence:

By: _____ Dated: 5/23/11

Janet Parnell
Principal Risk Management Analyst
Human Resources Department, Risk Management Division

Requesting Department Head Concurrence:

By: _____ Dated: 5/24/11

Allyn Bulzomi
Director
Human Resources Department