COUNTY OF SAN MATEO
Inter-Departmental Correspondence
Health System

DATE: June 17, 2011
BOARD MEETING DATE: July 26, 2011
SPECIAL NOTICE/HEARING: None
VOTE REQUIRED: Majority

TO: Honorable Board of Supervisors, acting as the Governing Board of the Public Authority

FROM: Jean S. Fraser, Chief, Health System
Lisa Mancini, Director, Aging and Adult Services

SUBJECT: Agreement with the Health Plan of San Mateo

RECOMMENDATION:
Adopt a Resolution authorizing the President of this Governing Board to execute an Agreement with the San Mateo Community Health Authority, doing business as the Health Plan of San Mateo, to provide health benefits to independent providers of the In-Home Supportive Services program for the term July 1, 2011 through June 30, 2014 in an amount not to exceed $6,960,848

BACKGROUND:
In September 1993 your Board approved an Ordinance establishing a separate Public Authority (PA) to administer the provider components for In-Home Supportive Services (IHSS) and designating the San Mateo County Board of Supervisors as the Governing Board of the PA. The goal of IHSS is to assist eligible aged, blind, and disabled individuals to remain in their own homes as long as safely possible. Using independent providers, IHSS provides participants with a wide variety of personal care and domestic services such as meal preparation, feeding, bathing, dressing, transferring, protective supervision, laundry, shopping, transportation, and certain paramedical services authorized by a physician.

In November 2000 the IHSS PA signed a Memorandum of Understanding (MOU) with Service Employees International Union (SEIU), Local 521, which included the provision of health benefits for the independent providers. In accordance with the agreement between the PA and SEIU, independent providers who are authorized to work a minimum of 35 hours a month are offered the opportunity to request health benefits. This provision continues in the current MOU with SEIU.

Health insurance called HealthWorx was developed by the Health Plan of San Mateo (HPSM) specifically for independent providers of IHSS. On July 31, 2001, your Board, as the PA, approved the first agreement with HPSM to provide health benefits for the IHSS independent providers. In August 2001 the PA began providing health benefits to eligible providers.

DISCUSSION:

This Agreement allows the PA to continue to provide health insurance coverage to independent providers of IHSS through HPSM. The rate for the first year remains the same as the previous three-year agreement with HPSM. A new rate may be negotiated during the term of this Agreement, in which case an amendment to the Agreement would be brought to your Board for approval. The remainder of this new Agreement is substantially the same as the previous agreement, except the estimated number of Consolidated Omnibus Budget Reconciliation Act (COBRA) slots for extended health care coverage has increased by an additional 40 average per month pursuant to the current enrollment in COBRA. HPSM continues to be the best provider of health insurance for IHSS independent providers as the cost is low (e.g. health insurance through Kaiser for one County employee costs monthly $444.64 with an employee co-pay of $78.46; health insurance for one independent provider through HPSM costs monthly $185.31 with an independent provider co-pay of $10.00).

The Contractor assured compliance with the County's Contractor Employee Jury Service Ordinance, as well as all other contract provisions that are required by County ordinance and administrative memoranda, including but not limited to insurance, hold harmless, non-discrimination and equal benefits.

County Counsel has reviewed and approved the Resolution and Agreement as to form and content. This Agreement is on the Continuing Resolution. The Contractor's insurance has been reviewed and approved by Risk Management.

This Agreement contributes to the Shared Vision 2025 outcome of a Healthy Community by allowing Aging and Adult Services to continue to provide services that allow at-risk individuals to remain in the least restrictive setting possible. It is anticipated that 95% of at-risk individuals will be maintained in a least restrictive setting through case management. Support for independent providers of IHSS is an important element of maintaining clients in a least restrictive setting.

Performance Measure:

Measure	FY 2010-11 Estimate	FY 2011-12 Projected
Percent of at-risk individuals maintained in a least restrictive setting through case management	95%	95%

FISCAL IMPACT:

The term of the Agreement is July 1, 2011 through June 30, 2014. The maximum fiscal obligation is $6,960,848. The monthly premium per provider is $185.31 plus a $10.00 co-pay from the provider. The maximum number of providers who can be insured in FY 2011-12 is 950 per month with an additional average 40 COBRA members. The total annual cost of the Agreement is anticipated to be $2,320,283. The projected County share of this cost annually is $529,557 and the remainder is covered by State and federal funds. The total Net County Cost over the three year term is $1,588,671. The cost for the health insurance coverage has been included in the IHSS PA FY 2011-12 Recommended Budget.

RESOLUTION NO. _____

BOARD OF SUPERVISORS ACTING AS THE GOVERNING BOARD OF THE IN-HOME SUPPORTIVE SERVICES PUBLIC AUTHORITY OF THE COUNTY OF SAN MATEO, STATE OF CALIFORNIA

*** * * * * ***

RESOLUTION AUTHORIZING THE PRESIDENT OF THIS GOVERNING BOARD TO EXECUTE AN AGREEMENT WITH THE SAN MATEO COMMUNITY HEALTH AUTHORITY, DOING BUSINESS AS THE HEALTH PLAN OF SAN MATEO, TO PROVIDE HEALTH BENEFITS TO INDEPENDENT PROVIDERS OF THE IN-HOME SUPPORTIVE SERVICES PROGRAM FOR THE TERM JULY 1, 2011 THROUGH JUNE 30, 2014 IN AN AMOUNT NOT TO EXCEED $6,960,848

_____

RESOLVED, by the Board of Supervisors of the County of San Mateo, State of California, that

WHEREAS, in September 1993 your Board approved an Ordinance establishing a separate Public Authority (PA) to administer the provider components for In-Home Supportive Services (IHSS) and designating the San Mateo County Board of Supervisors as the Governing Board of the PA; and

WHEREAS, in November 2000 the IHSS PA signed a Memorandum of Understanding with the Service Employees International Union (SEIU), Local 521, which included the provision of health benefits for eligible independent providers of IHSS; and

WHEREAS, a health benefits product called HealthWorx was created by the Health Plan of San Mateo (HPSM) specifically for independent providers of IHSS; and

WHEREAS, there has been presented to this Governing Board for its consideration and acceptance an Agreement, reference to which is hereby made for further particulars, whereby the HPSM will continue to provide health benefits to independent providers of IHSS through the PA; and

WHEREAS, both parties now wish to enter into said Agreement to provide health benefits for the term July 1, 2011 through June 30, 2014, with a maximum fiscal obligation of $6,960,848; and

WHEREAS, this Governing Board has examined and approved the Agreement as to both form and content and desires to enter into the Agreement:

NOW, THEREFORE, IT IS HEREBY DETERMINED AND ORDERED that the President of this Governing Board be and is hereby authorized and directed to execute said Agreement with HPSM for and on behalf of the IHSS PA, and the Clerk of the Board shall attest the President's signature thereto.

* * * * * *

GROUP AGREEMENT
Between
San Mateo Community Health Authority
and
San Mateo County Public Authority

This Group Agreement (Agreement), including the Evidence of Coverage (EOC) document(s) and attachments listed below and incorporated herein by reference, and any amendments to any of them, constitutes the contract between the San Mateo Community Health Authority (Authority), dba Health Plan of San Mateo, (PLAN) and the San Mateo County Public Authority (Contract Holder). This Agreement is effective this 1st day of July, 2011 .

Product Name: HealthWorx
- Attachment A – Terms and Conditions
- Attachment B – Premium Schedule
- Attachment C – COBRA and Cal-COBRA
- Attachment D – Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Pursuant to this Agreement, PLAN will provide covered services and supplies to Members in accord with the terms, conditions, rights, and privileges as set forth in this Agreement and the EOC.

The PLAN is subject to the requirements of state and federal laws governing health care plans, including the Knox-Keene Act of 1975 and its amendments. Any provisions required to be in this Agreement by either the applicable Statute or Regulations will bind PLAN whether or not expressly stated in this Agreement.

If any provision of this Agreement is deemed to be invalid or illegal, such provision shall be fully severable and the remaining provisions of this Agreement shall continue in full force and effect.

This Agreement and its attachments have the same meaning given those terms in the EOC**.**

Group Agreement Effective Date: July 1, 2011
Contract Holder Number: 000001

San Mateo County Public Authority	San Mateo Community Health Authority
_____	_____
Signature	Signature
_Carole Groom, President_____	_____
Print Name	Print Name
_____	_____
Date	Date

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ATTACHMENT A
TERMS AND CONDITIONS

Recital:

A. Authority has entered into or will enter into and shall maintain a contract with the San Mateo County Public Authority pursuant to which individuals who subscribe and are enrolled under HealthWorx will receive, through the Authority, health services hereinafter defined as "Covered Services."

NOW, THEREFORE, it is agreed that the above Recital is true and correct and as follows:

SECTION 1
DEFINITIONS

As used in this Agreement, the following terms (listed alphabetically) shall have the meaning set forth herein below, except where, from the context, it is clear that another meaning is intended.

1.0 **"Agreement"** – shall mean the Group Agreement signed by PLAN and the Contract Holder which constitutes the Group Agreement regarding the benefits, exclusions and other conditions for PLAN's HealthWorx line of business.

1.1 **"Cal-COBRA" –** shall mean a California State law that requires employers to offer continued health insurance coverage under certain circumstances where coverage would otherwise terminate.

1.2 **"Authority" –** shall mean the San Mateo Community Health Authority.

1.3 **"Contract Holder" –** shall mean the San Mateo County Public Authority (SMCPA), the employer of record for San Mateo County In-Home Supportive Services (IHSS) workers. SMCPA is the entity responsible for purchasing medical coverage on behalf of eligible IHSS workers and authorizing the Agreement with the PLAN.

1.4 **"Consolidated Omnibus Budget Reconciliation Act (COBRA)"** – shall mean a federal law that, among other things, requires employers to offer continued health insurance coverage to certain employees and their beneficiaries who have had their group health insurance coverage terminated.

1.5 **"Co-payment"** – shall mean the portion of health care costs for covered services for which the Member has financial responsibility under the HealthWorx Program.

1.6 **"Covered Services"** – shall mean those health care services and supplies which a Member is entitled to receive under the HealthWorx Program and which are set forth in the HealthWorx Program Evidence of Coverage.

1.7 **"Evidence of Coverage"** – shall mean the document issued by the PLAN to Members that describes Covered Services and Non-Covered Services in the HealthWorx Program.

1.8 **"Health Insurance Portability and Accountability Act of 1996 (HIPAA)"** – shall mean a federal law that, among other things, provides guaranteed renewability of health care coverage to certain employees who no longer qualify for group health insurance through their employer and have an opportunity to purchase coverage from another insurer.

1.9 **"Hospital"** – shall mean a licensed general acute care hospital.

1.10 **"Individual Conversion Product"** – shall mean a HPSM product for HealthWorx Members who have exhausted their COBRA and Cal-COBRA continuation coverage.

1.11 **"Member"** – shall mean an enrolled IHSS worker who has been determined for HealthWorx by the Contract Holder or designee or a former worker enrolled in COBRA or Cal-COBRA.

1.12 **"Participating Provider"** – shall mean a Provider who has entered into an Agreement with the PLAN to provide Covered Services to Members. The terms "Participating Provider" and "Contracting Provider" may be used interchangeably.

1.13 **"PLAN" –** shall mean the HPSM, which is governed by the Authority and which provides health services coverage through Medi-Cal, Healthy Families, Healthy Kids, and HealthWorx and Care Advantage lines of business.

1.14 **"Premium"** – shall mean the amount paid by Contract Holder per Member per month to PLAN for providing coverage to Members under this Agreement.

1.15 **"Protected Health Information"** – shall mean individually identifiable health information as defined by the HIPAA.

1.16 **Provider"** – shall mean any health professional or institution certified to render Covered Services to Members.

SECTION II
ENROLLMENT

2.0 Members may enroll with the PLAN after one month. To be eligible, Members must work 35 hours or more per month.

2.1 The Contract Holder or designee shall be responsible for forwarding completed enrollment information on eligible Members to the PLAN electronically no later than 5:00 p.m. on the twenty-second day of each month.

2.2 The Contract Holder or designee shall also be responsible for forwarding enrollment information on HealthWorx Members eligible through COBRA and shall provide Members who exhaust their COBRA benefits an application and information regarding benefits under Cal-COBRA.

2.3 The PLAN will enroll Members in Cal-COBRA and inform Members when they exhaust their Cal-COBRA benefits and become eligible for continuation coverage under the PLAN's Individual Conversion Product.

2.4 The Contract Holder shall not change the eligibility requirements used to determine membership in the group during the term of the Agreement, unless agreed to in writing by the PLAN.

2.5 The PLAN will provide biannual orientation for Members if requested by Contract Holder.

SECTION III
PREMIUMS

3.0 Premiums for the Covered Benefits under this Agreement are set forth in Attachment B, attached hereto, which is fully incorporated herein by reference.

3.1 Premium Change

3.1.1 PLAN may change the Premium with thirty-one (31) days written notice to Contract Holder as follows:

3.1.2 Upon parties' agreement to amend Attachment B of this Agreement.

3.1.3 Upon the effective date of any applicable law or regulation having a direct and material impact on the cost of providing coverage to Members.

3.1.4 Payment of the applicable Premium on and after that date shall constitute acceptance of those changes by the Contract Holder, individually and on behalf of all Members enrolled under this Agreement.

3.2 Premium Payment

Premiums are payable to the PLAN at the PLAN's corporate office by electronic file transfer via ACH, wire transfer or check via mail addressed to: Finance Department, Health Plan of San Mateo, 701 Gateway Blvd, Ste. 400, South San Francisco, CA 94080.

3.3 Premium due date and grace period

3.3.1 The Premium due date will be the first of the month for which coverage is provided. A five (5) day grace period will allow the Agreement to be in force beyond the premium due date. The Contract Holder remains liable for the payment of the Premium for the time coverage was in effect during the grace period and Members will remain liable for co-payments. A check is not a payment until it is cleared by the PLAN's bank.

3.3.2 Premiums shall be paid in full for Members whose coverage is effective on the Premium due date or whose coverage terminates on the last day of the Premium period.

3.4 Credit for Member terminations

3.4.1 Contract Holder may receive a maximum of two (2) months credit for Member terminations which occurred more than thirty-one (31) days prior to the date PLAN was notified of the Member's termination. Retroactive additions will be honored at the discretion of the PLAN based upon the eligibility guidelines described in the EOC and on the Schedule of Benefits. Retroactive additions are subject to payment of applicable premiums.

3.4.2 The Contract Holder shall be responsible for any claims paid by PLAN and Member to the extent PLAN relied on the Contract Holder's submitted enrollment to confirm coverage where coverage was not valid.

3.5 Non-payment of Premium

If the Premiums are not paid by the Premium due date, PLAN will require the Contract Holder to pay interest on the overdue amount at 1 1/2% for each month overdue, commencing on the thirty first (31st) day after the Premium due date.

SECTION IV
TERM AND TERMINATION

4.0 Effective Date

This Agreement shall become effective on July 1, 2011

4.1 Term

The term of the Agreement shall be July 1, 2011 through June 30, 2014.

4.2 Termination on Notice

PLAN or Contract Holder may terminate this Agreement with or without cause. PLAN may terminate with sixty (60) days written notice. Contract Holder may terminate with thirty (30) days written notice.

In the event of termination, PLAN shall furnish Contract Holder access to data for Members covered under this Agreement.

In the event of termination, all finished or unfinished documents, data, studies, maps, photographs, reports, and materials (hereafter referred to as materials) prepared by PLAN under this Agreement shall become the property of the Contract Holder and shall be promptly delivered to the Contract Holder. Upon termination, the PLAN may make and retain a copy of such materials. Subject to availability of funding, PLAN shall be entitled to receive payment for work/services provided prior to termination of the Agreement. Such payment shall be that portion of the full payment which is determined by comparing the work/services completed to the work/services required by the Agreement.

4.3 Termination Based upon inability to perform due to changed legal, contractual, or regulatory circumstances

In the event there are (1) changes effected in the PLAN's Medi-Cal contract with the State of California, or (2) changes effected in HealthWorx, or (3) changes in the Federal Medicaid or SCHIP Programs, or (4) changes in the Federal Medicare Program, or (5) substantial changes under other public or private health care insurance programs or policies, any of which changes will have a material detrimental financial effect on the operations of the Contract Holder or PLAN, Contract Holder or PLAN may terminate this Agreement upon providing the other party with thirty (30) days prior written notice. In any case where such notice is provided, both parties shall negotiate in good faith during such thirty (30) day period in an effort to develop a revised Agreement**,** which, to the extent reasonably practicable, under the circumstances, will adequately protect the interests of both parties in light of the governmental program or private insurance policy changes which constituted the basis for the exercise of this termination provision.

4.4 Termination for Insufficient Provider Participation

4.4.1 If for any reason, PLAN is unable to enter into or maintain service contracts with sufficient numbers of providers (hospitals and physicians) to assure adequate Member access to needed Covered Services, the PLAN may terminate this Agreement upon sixty (60) days written notice to the Contract Holder; or

4.4.2 If, the qualification of PLAN under the Federal Social Security Act is terminated or ceases for any reason or if the PLAN's contract with the

State of California is terminated or ceases for any reason, Plan shall give Contract Holder immediate written notice of the foregoing termination(s) and this Agreement shall terminate in accordance with the terms of Section 4.2 of this Agreement.

4.5 Effect of Termination

As of the date of termination pursuant to any provision of this Agreement, this Agreement shall be of no further force or effect whatsoever and each of the parties hereto shall be relieved and discharged from any of the obligations it has undertaken except that the Contract Holder shall remain liable for due, unpaid Premiums and the PLAN shall remain liable for all Benefits rendered to Members up to the date of termination and for any Covered Services covered by the term of the Premium or required by law, whichever is later, rendered hereunder after such date until such time as appropriate transfer (or other medically acceptable disposition) of Members receiving inpatient services as of the date of termination is achieved.

4.6 Amendment of Agreement

4.6.1 This Agreement may be amended at any time upon written agreement of PLAN and Contract Holder. Upon 30 days prior written notice to Contract Holder, Plan may extend the term of this Agreement and/or make other changes to this Agreement. Extending the term of this Agreement will be contingent upon Contract Holder's acceptance of all amendments, including Premiums and benefits.

4.6.2 This Agreement may be amended by the PLAN upon thirty (30) days written notice to the Contract Holder. If the Contract Holder does not give written notice of termination within thirty (30) days, Contract Holder agrees that any such amendment by the PLAN shall be part of the Agreement.

4.6.3 The terms of the Agreement shall be subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975 (the Act), as amended and the regulations promulgated thereunder (the Regulations), to the extent applicable hereto, and any provision required to be in this Agreement by either the Act or Regulations shall bind the PLAN and the Primary Care Provider as appropriate, whether or not provided herein. If the Director of the Department of Managed Health Care or his/her successor requires further amendments to this Agreement, the PLAN shall notify the Contract Holder in writing of such amendments. The Contract Holder agrees to work with the PLAN in a good faith effort to accept such an amendment. If Contract Holder does not agree to accept such an amendment, the PLAN may terminate this Agreement. Amendments for this purpose shall include, but not be limited to, material changes to the PLAN's Utilization Management, Quality Assessment and Improvement

and Complaint and Grievance Programs and procedures and to the health care services covered by this Agreement.

4.7 Availability of Funds

The Contract Holder may terminate this Agreement or a portion of the services referenced in the Attachments and Exhibits based upon unavailability of Federal, State, or County funds, by providing written notice to PLAN as soon as is reasonably possible after the Contract Holder learns of said unavailability of outside funding.

SECTION V
MEMBER NOTIFICATION OF TERMINATION OF AGREEMENT

5.0 It is the responsibility of the Contract Holder or designee to notify the Members of the termination of the Agreement in compliance with all applicable laws. However, PLAN reserves the right to notify Members of termination of the Agreement for any reason, including non-payment of Premium. When PLAN delivers a notice of cancellation or termination to Contract Holder, Contract Holder or designee will promptly mail a notification of action to each Member under this Agreement at the Member's current address.

5.1. In accordance with the EOC, the Contract Holder or designee shall also provide written notice to Members of their continuation and conversion rights upon termination of coverage.

5.2 Termination shall not relieve the Contract Holder or PLAN from any obligation incurred prior to the date of termination of this Agreement.

SECTION VI
OBLIGATIONS UNDER COBRA, CAL-COBRA, CALIFORNIA LAW GOVERNING INDIVIDUAL CONVERSION PRODUCTS

6.0 The Contract Holder is subject to the requirements of state and federal law governing continuation of health care coverage for Members. The federal law is the Consolidated Omnibus Budget Reconciliation Act (COBRA). The California State law is the California Continuation Benefits Replacement Act (Cal-COBRA). Obligations of the Contract Holder under COBRA and Cal-COBRA are summarized in Attachment C. Any provisions required to be in this Agreement by either the applicable Code or Regulation governing COBRA or Cal-COBRA will bind the Contract Holder whether or not expressly stated in the Agreement or any Attachments. Contract Holder hereby acknowledges its obligations and agrees to comply with all applicable legal requirements with respect to COBRA and/or Cal-COBRA continuation coverage.

6.1 The PLAN is subject to California law and regulations regarding continuation coverage when a Member exhausts COBRA and Cal-COBRA benefits. Obligations of the PLAN under California State law are summarized in Attachment D.

SECTION VII
THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

7.0 The Contract Holder is subject to the requirements of state and federal law governing the portability of health care coverage for Members (creditable coverage). Obligations of the Contract Holder regarding continuation coverage under HIPAA are summarized in Attachment D. Any provisions required to be in this Agreement by either the applicable Statute or Regulation governing HIPAA will bind the Contract Holder whether or not expressly stated in the Agreement or any Attachments.

Contract Holder hereby acknowledges its obligations and agrees to comply with all applicable legal requirements with respect to HIPAA continuation coverage.

7.1 The PLAN is subject to the requirements of state and federal laws governing the privacy and security of Members' protected health information. Obligations of the PLAN and the Contract Holder regarding the privacy and security of Members' protected health information under HIPAA are summarized in Attachment D.

The PLAN hereby acknowledges its obligations and agrees to comply with all applicable legal requirements with respect to the Administrative Simplification Provision under HIPAA, which include Privacy and Security of Member protected health information.

SECTION VIII
INDEPENDENT CONTRACTOR RELATIONSHIPS

8.0 <u>Between Participating Providers and PLAN.</u>

The relationship between PLAN and Participating Providers is a contractual relationship among independent contractors. Participating Providers are not agents or employees of PLAN nor is PLAN an agent or employee of any Participating Provider. Participating Providers maintain the provider-patient relationship with Members and are solely responsible to their Member patients for any health services rendered to their Member patients.

A Participating Provider's participation may be terminated at any time by either the Participating Provider or the PLAN and PLAN makes no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any physician, hospital or other participating

provider. In no event will PLAN be liable for the negligence, wrongful acts, or omissions in a participating provider's delivery of services regardless of whether such services are or would be covered under this Agreement, nor will PLAN be liable for services or facilities which for any reason beyond its control are unavailable to the Member.

8.1 Between the Contract Holder and PLAN.

None of the provisions of this Agreement are intended to create nor shall be deemed or construed to create any relationship between the parties hereto other than that of independent entities contracting with each other hereunder solely for the purposes of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees or workers, shall be construed to be the agent, the employee or the representative of the other.

SECTION IX
RECORDS

9.0 The PLAN maintains records and information to allow the administration of a Member's coverage. The Contract Holder or designee shall provide the PLAN information to allow for the administration of a Member's benefits. This includes information on enrollment, continued eligibility, and termination of eligibility. The PLAN shall not be obligated to provide coverage prior to receipt of information needed to administer the benefits or confirm eligibility in a form satisfactory to the PLAN.

The Contract Holder or designee shall make payroll and other records directly related to Member's coverage under this Agreement available to PLAN for inspection, at PLAN's expense, at the Contract Holder's or designee's office, during regular business hours, upon reasonable advance request from PLAN. This provision shall survive the termination of this Agreement as necessary to resolve outstanding financial or administrative issues pursuant to this Agreement. PLAN's performance of any obligation that depends on information to be furnished by Contract Holder or designee or Member will not arise prior to receipt of that information in the form requested by PLAN. Nor will PLAN be liable for any obligation due to information incorrectly supplied by Contract Holder or designee or Member. All records of Contract Holder that have a bearing on coverage shall be open for inspection by PLAN at any reasonable time.

SECTION X
ADMINISTRATION OF THE AGREEMENT

PLAN may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this Agreement.

10.0 Entire Agreement

This Agreement, including the Group Application, Evidence of Coverage, Schedule of Benefits, any amendments, endorsements, insets or attachments, constitutes the entire Agreement between the Contract Holder and the PLAN, and on the effective date as set forth in Section IV, supersedes all other prior and contemporaneous arrangements, understandings, agreements, negotiations and discussions between the parties, whether written or oral, regarding services provided by the Agreement.

10.1 Insurance

Upon request: Each party shall furnish the other party with a certificate of insurance evidencing the required coverage set forth herein.

Bodily Injury Liability and Property Damage Liability Insurance: Each party shall maintain during the life of this Agreement such Bodily Injury Liability and Property Damage Insurance, self-insurance, or a combination thereof, as shall protect both parties from any and all claims for damages for bodily injury, including accidental death, as well as any and all claims for property damage which may arise from operations under this Agreement. Such insurance shall be combined single limit bodily injury and property damage for each occurrence and shall not be less than the amount specified below.

Such insurance shall include:

(a) Comprehensive General Liability	$1,000,000.00
(b) Motor Vehicle Liability Insurance	$1,000,000.00
(c) Professional Liability	$2,000,000.00
(d) Workers' Compensation	Statutory

10.1.3 Contract Holder shall carry at its sole expense general and professional liability insurance or self-insurance of at least one million dollars ($1,000,000) per person per occurrence, three million dollars ($3,000,000) aggregate. If Contract Holder obtains one or more claims-made insurance policies to fulfill its obligations under this Section, Contract Holder will purchase or provide coverage that assures protection against claims based on acts or omissions that occur during the period of this Agreement but which are asserted after the claims-made insurance policy has expired. This insurance is against professional errors and omissions in providing services under the terms of this Agreement and is solely for the protection of the interest and property of Contract Holder and its employees.

10.1.4 Each party shall provide a certificate of insurance so that the other party shall be given immediate notice of lapse, termination, amendment or changes of coverage of any policy or insurance maintained by the other party.

10.2 Mutual Hold Harmless

a. It is agreed that PLAN shall defend, save harmless and indemnify Contract Holder, its officers and employees from any and all claims which arise out of the terms and conditions of this Agreement and which result from the negligent acts or omissions of PLAN, its officers and/or employees.

b. It is agreed that Contract Holder shall defend, save harmless, and indemnify PLAN, its officers and employees from any and all claims for injuries or damage to persons and/or property which arise out of the terms and conditions of this Agreement and which result from the negligent acts or omissions of Contract Holder, its officers and/or employees.

c. In the event of concurrent negligence of Contract Holder, its officers and/or employees, and PLAN, its officers and/or employees, then the liability for any and all claims for injuries or damage to persons and/or property which arise out of terms and conditions of this Agreement shall be apportioned according to the California theory of comparative negligence.

10.3 Compliance with Applicable Law

All services to be performed by PLAN pursuant to this Agreement shall be performed in accordance with all applicable Federal, State, County, and municipal laws, ordinances and regulations, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Federal Regulations promulgated thereunder, as amended, and will comply with the Business Associate requirements set forth in Attachment "H," and the Americans with Disabilities Act of 1990, as amended, and Section 504 of the Rehabilitation Act of 1973, as amended and attached hereto and incorporated by reference herein as Attachment "I," which prohibits discrimination on the basis of handicap in programs and activities receiving any Federal or County financial assistance. Such services shall also be performed in accordance with all applicable ordinances and regulations, including, but not limited to, appropriate licensure, certification regulations, provisions pertaining to confidentiality of records, and applicable quality assurance regulations. In the event of a conflict between the terms of this Agreement and State, Federal, County, or municipal law or regulations, the requirements of the applicable law will take precedence over the requirements set forth in this Agreement.

In the event of a conflict between the terms of this Agreement and State, Federal, County, or municipal law or regulations, the requirements of the applicable law will take precedence over the requirements set forth in this Agreement.

PLAN will timely and accurately complete, sign, and submit all necessary documentation of compliance.

10.4 Non-Discrimination and Other Requirements

a. Section 504 applies only to contractors who are providing services to members of the public. PLAN shall comply with § 504 of the Rehabilitation Act of 1973, which provides that no otherwise qualified handicapped individual shall, solely by reason of a disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination in the performance of this Agreement.

b. General non-discrimination. No person shall, on the grounds of race, color, religion, ancestry, gender, age (over 40), national origin, medical condition (cancer), physical or mental disability, sexual orientation, pregnancy, childbirth or related medical condition, marital status, or political affiliation be denied any benefits or subject to discrimination under this Agreement.

c. Equal employment opportunity. PLAN shall ensure equal employment opportunity based on objective standards of recruitment, classification, selection, promotion, compensation, performance evaluation, and management relations for all employees under this Agreement. PLAN's equal employment policies shall be made available to County of San Mateo upon request.

d. Violation of Non-discrimination provisions. Violation of the non-discrimination provisions of this Agreement shall be considered a breach of this Agreement and subject the PLAN to penalties, to be determined by the Contract Holder, including but not limited to

    - termination of this Agreement;
    - disqualification of the PLAN from bidding on or being awarded a County contract for a period of up to 3 years;
    - liquidated damages of $2,500 per violation; and
    - imposition of other appropriate contractual and civil remedies and sanctions, as determined by the Contract Holder.

To effectuate the provisions of this section, the Contract Holder shall have the authority to examine PLAN's employment records with respect to compliance with this paragraph and/or to set off all or any portion of the amount described in this paragraph against amounts due to PLAN under the Agreement or any other Agreement between PLAN and Contract Holder.

PLAN shall report to the Contract Holder the filing by any person in any court of any complaint of discrimination or the filing by any person of any and all charges with the Equal Employment Opportunity Commission, the Fair Employment and Housing Commission or any other entity charged with the investigation of allegations within 30 days of such filing, provided that within such 30 days such entity has not notified Contract Holder that such charges are dismissed or otherwise unfounded. Such notification shall include the name of the complainant, a copy of such complaint, and a description of the circumstance. PLAN shall provide Contract Holder with a copy of their response to the Complaint when filed.

e. Compliance with Equal Benefits Ordinance. With respect to the provision of employee benefits, PLAN shall comply with the County Ordinance which prohibits contractors from discriminating in the provision of employee benefits between an employee with a domestic partner and an employee with a spouse.

f. The PLAN shall comply fully with the non-discrimination requirements required by 41 CFR 60-741.5(a), which is incorporated herein as if fully set forth.

10.5 Compliance with Employee Jury Service Ordinance

PLAN shall comply with the County Ordinance with respect to provision of jury duty pay to employees and have and adhere to a written policy that provides that its employees shall receive from the PLAN, on an annual basis, no less than five days of regular pay for actual jury service in San Mateo County. The policy may provide that employees deposit any fees received for such jury service with the PLAN or that the PLAN deduct from the employees' regular pay the fees received for jury service.

10.6 Retention of Records, Right to Monitor and Audit

a. PLAN shall maintain all required records for three (3) years after the Contract Holder makes final payment and all other pending matters are closed, and shall be subject to the examination and/or audit of the County, a Federal grantor agency, and the State of California.

b. Reporting and Record Keeping: PLAN shall comply with all program and fiscal reporting requirements set forth by appropriate Federal, State and local agencies, and as required by the Contract Holder.

c. PLAN agrees to provide to Contract Holder, to any Federal or State department having monitoring or review authority, to Contract Holder's authorized representatives, and/or their appropriate audit agencies upon

reasonable notice, access to and the right to examine all records and documents necessary to determine compliance with relevant Federal, State, and local statutes, rules and regulations, and this Agreement, and to evaluate the quality, appropriateness and timeliness of services performed.

10.7 Merger Clause

This Agreement, including the Exhibits attached hereto and incorporated herein by reference, constitutes the sole Agreement of the parties hereto and correctly states the rights, duties, and obligations of each party as of this document's date. In the event that any term, condition, provision, requirement or specification set forth in this body of the Agreement conflicts with or is inconsistent with any term, condition, provision, requirement or specification in any exhibit and/or attachment to this Agreement, the provisions of this body of the Agreement shall prevail. Any prior Agreement, promises, negotiations, or representations between the parties not expressly stated in this document are not binding. All subsequent modifications shall be in writing and signed by the parties.

10.8 Forms

PLAN shall supply the Contract Holder or designee with a reasonable supply of its forms and descriptive literature. The Contract Holder or designee shall distribute PLAN's forms and descriptive literature to any individual who becomes eligible for coverage. The Contract Holder shall, within sixty-two (62) days of receipt from an eligible individual, forward all applicable forms and other required information to PLAN.

10.9 Clerical Errors

Incorrect information furnished to PLAN may be corrected, provided that PLAN has not acted to its prejudice in reliance thereon. Clerical errors or delays in keeping or reporting data relative to coverage will neither invalidate coverage which would otherwise be in force, continue coverage which would otherwise be validly terminated if PLAN, in its sole discretion, determines that a clerical error has been made, nor grant additional benefits to Members. Upon discovery of such errors or delay, an adjustment of Premiums shall be made. In no case will adjustments in coverage or Premiums be made effective more than two (2) Premium due dates prior to the date PLAN is notified in writing, on a form satisfactory to PLAN, of the requested addition, deletion, or change in coverage.

10.10 Claim Determinations

PLAN has complete authority to review all claims for Covered Benefits under this Agreement. In exercising such responsibility, PLAN shall have discretionary authority to determine whether and to what extent eligible individuals and Members are entitled to coverage and construe any disputed or doubtful terms

under this Agreement. PLAN shall be deemed to have properly exercised such authority unless PLAN abuses its discretion by acting arbitrarily and capriciously.

10.11 Fraudulent or Material Misstatements

If any relevant fact as to a Member is found to have been misstated, an equitable adjustment of Premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is to remain in force. In no case will adjustments in coverage or Premiums be made effective more than two (2) Premium due dates prior to the date PLAN is notified in writing, on a form satisfactory to PLAN, of the requested addition, deletion, or change in coverage.

10.12 Assignability

No rights or benefits under this Agreement are assignable by the Contract Holder to any other party unless approved by PLAN.

10.13 Waiver

PLAN's failure to implement, or insist upon compliance with, any provision of this Agreement or the terms of the EOC incorporated hereunder, at any given time or times, shall not constitute a waiver of PLAN's right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of Premiums or benefits. This applies whether or not the circumstances are the same.

10.14 Notices

Any notice required or permitted under this Agreement shall be in writing and shall be deemed to have been given on the date when delivered in person, or, on the date received if delivered by first-class United States mail, UPS, FedEx, or other traceable mail service, proper postage prepaid, and properly addressed to the offices of the Contract Holder or the PLAN at the following addresses:

Executive Director
San Mateo Community Health Authority
701 Gateway Blvd., Suite 400
South San Francisco, CA 94080

Program Director
San Mateo County Public Authority
225 37th Avenue
San Mateo, CA 94403

10.15 Third Parties

This Agreement shall not confer any rights or obligations on third parties except as specifically provided herein.

10.16 Inability to Arrange Services

In the event that due to circumstances not within the reasonable control of PLAN, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of PLAN's Participating Providers or entities with whom PLAN has arranged for services under this Agreement, or similar causes, the rendition of medical or Hospital benefits or other services provided under this Agreement is delayed or rendered impractical, PLAN shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid Premiums held by PLAN on the date such event occurs. PLAN is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

10.17 Use of the HealthWorx Name and all Symbols, Trademarks, and Service Marks

PLAN reserves the right to control the use of its name and all symbols, trademarks, and service marks presently existing or hereinafter established with respect to it. The Contract Holder agrees that it will not use such name, symbols, trademarks, or service marks in advertising or promotional materials or otherwise without prior written consent of PLAN and will cease any and all usage immediately upon request of PLAN or upon termination of this Agreement.

10.18 Workers' Compensation

The Contract Holder is responsible for protecting PLANS’s interest in any workers’ compensation claims or settlements with any eligible individual. PLAN shall be reimbursed for all paid medical expenses which have occurred as a result of any work related injury that is compensable or settled in any manner.

ATTACHMENT B

PREMIUM SCHEDULE FOR 2011
(July 1, 2011 – June 30, 2014)

Premium: **$195.31/per Member/per month**

ATTACHMENT C

CONTRACT HOLDER'S OBLIGATIONS UNDER COBRA and CAL-COBRA

A. All parties will comply with applicable federal law, regulations and requirements regarding continuation of benefits.

B. All parties will comply with applicable state law, regulations and requirements regarding continuation of benefits.

C. All parties agree to forward in a timely manner copies of any and all notices provided to Members regarding COBRA or Cal-COBRA continuation coverage.

D. Contract Holder will administer or contract for the administration of coverage under COBRA.

E. PLAN will provide Contract Holder’s Initial COBRA Notification to Members in new Member packets.

F. PLAN will administer coverage under Cal-COBRA and HIPAA Individual Conversion Plan.

G. Contract Holder or designee must also notify qualified Members of the ability to continue coverage prior to terminating an Agreement (such as this Agreement) under which a qualified Member is receiving continuation coverage. This notification shall be provided either thirty (30) days prior to the Agreement termination or when all other enrolled employees are notified, whichever is greater. Contract Holder or designee must notify any successor PLAN in writing of the qualified Members currently receiving continuation coverage to enable the successor PLAN, contracting employer (employer of record), or administrator to provide such qualified Members with the premium information, enrollment forms, and disclosures necessary to allow the qualified Members to continue coverage under other available group plans.

H. If Contract Holder fails to meet these obligations, PLAN will not provide continuation coverage to qualified Members under COBRA. Contract Holder hereby acknowledges its obligations and agrees to comply with all applicable legal requirements with respect to COBRA.

ATTACHMENT D

OBLIGATIONS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

1. Continuation Coverage Provisions

   A. Contract Holder is obligated under both federal and state law with regard to the renewablility of health care coverage for Members under certain circumstances where coverage would otherwise terminate ("creditable coverage"). The federal law is the Health Insurance Portability and Accountability Act (HIPAA). The guaranteed renewability provision of HIPAA entitles a Member, who is disenrolled or terminated from employment, an opportunity to purchase a health insurance plan that provides the same scope of benefits that the Member received through the Contract Holder program.

   B. PLAN will provide a certificate of "creditable coverage" which details the scope of benefits and the length of enrollment in the Contract Holders program. The obligation to provide notice includes both general notification to Members of their right to purchase renewable coverage and specific notification of the right to renewable coverage within a specific time period after the occurrence of the event which triggers the coverage option.

2. Administrative Simplification Provisions (Privacy and Security)

   A. The PLAN is subject to the requirements of state and federal laws governing the privacy and security of Member's protected health information (PHI) , including the Administrative Simplification provisions under HIPAA.

   B. In order for the PLAN to disclose Members' PHI to the Contract Holder under HIPAA requirements, the Contract Holder must certify that its plan documents, including Member informing materials, have been amended to incorporate the following provisions to which the Contract Holder agrees to:

      1. Not to use or further disclose Member PHI other than as permitted or required by the PLAN documents or as required by law;

      2. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI created, received, maintained, or transmitted to or by the Contract Holder on behalf of the PLAN;

      3. Ensure that any agents, including a subcontractor, to whom the Contract Holder provides PHI received from the PLAN agree to the same

restrictions and conditions that apply to the Contract Holder with respect to such information, including the conditions for reasonable and appropriate security measures described in paragraph 2 above;

4. Not use or disclose Member PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Contract Holder;

5. Report to the PLAN any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which the Contract Holder becomes aware, including breaches to the security of PHI;

6. Make available Member PHI in accordance with 45 CFR §164.524;

7. Make available Member PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526;

8. Make available Member PHI required to provide an accounting of disclosures in accordance with 45 CFR §164.528;

9. Make Contract Holder's internal practices, books, and records relating to the use and disclosure of Member PHI received from the PLAN available to the Secretary of State for purposes of determining compliance by the PLAN with 45 CFR §164, Subpart E;

10. If feasible, return or destroy all PHI received from the PLAN that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

11. Ensure that adequate separation between the PLAN and the Contract Holder is established and documented. Documentation should:

    a. Describe those employees or classes of employees or other persons under the control of the Contract Holder to be given access to the PHI to be disclosed by the PLAN.

    b. Restrict the access to and use by such employees and other persons described in paragraph 11(a) of this section to the PLAN administration functions that the Contract Holder performs for the PLAN; and

c. Provide an effective mechanism for resolving any issues of noncompliance by persons described in paragraph 11(a) of this section with the PLAN document provisions required herein.

12. Ensure that the adequate separateness described in paragraph 11 above is supported by reasonable and appropriate security measures.