CLARK COUNTY
STAFF REPORT

DEPARTMENT: Human Resources

DATE: December 17, 2013

REQUEST: Approval of Regence Medicare Advantage Contract

CHECK ONE: __X__ Consent ______ CAO

BACKGROUND

The Regence Medicare Advantage contract provides a new plan of comprehensive coverage for PERS retirees over age 65 or Medicare eligible, and LEOFF 1 Retirees over age 65 or Medicare eligible. The cost savings associated with this plan provides PERS Retirees a reduction from $357 per month to $208 per month. LEOFF 1 Retirees, whom the county is required to provide coverage, will have a reduction to $300 per month saving the County approximately $11,000 per year in premiums. In addition, this change reduces the impact on our claims cost related to the Regence plan due to the claims experience for this group being pooled with the Medicare population covered by Regence. This should help the County to further manage future health care costs.

COMMUNITY OUTREACH

Community outreach was not a consideration in this manner.

BUDGET AND POLICY IMPLICATIONS

There are no budget or policy implications with this change.

FISCAL IMPACTS

☐ **Yes (see attached form)** ☑ **No**

ACTION REQUESTED

Approve the Regence Medicare Advantage contract to be effective January 1, 2014.

DISTRIBUTION

Kathy Meyers, Benefits Manager

Francine Reis
Human Resources Director

Approved:

CLARK COUNTY
BOARD OF COMMISSIONERS

DEC 17, 2013 SR 274-13

Regence Cost Proposal:

Clark County 2014 Group MAPD
This proposal is valid for an effective date on January 1, 2014

We are pleased to offer the following Regence MedAdvantage Plan Options:

Regence MedAdvantage + Rx Enhanced (PPO)

Proposed Package Options:

We are offering the following proposed options:

Check Option	Option	Covered Area	Plan Type	Pricing*
X	1A	LEOFF1 Members	Standard Enhanced Only with Rx Option 1	$300.00
X	1A	PERS Members	Standard Enhanced Only with Rx Option 1	$208.00

*Pricing is per member per month (PMPM) and contingent upon full member enrollment as per above selected option.

EMPLOYER ACCEPTANCE
I acknowledge that this document includes all selected benefit options and rates associated with these benefits. Furthermore, I agree to the effective date of coverage, contingencies and assumptions as listed in this document.
Authorized Signature: [signature] Date: DEC. 17, 2013

Regence

CONTRACT for:

Clark County

Evidence of Coverage Type:

Regence MedAdvantage, Regence MedAdvantage + Rx Classic, Regence MedAdvantage + Rx Enhanced

Evidence of Coverage Description

Regence BlueCross BlueShield of Oregon, an independent licensee of the Blue Cross and Blue Shield Association, agrees to provide the Medicare Advantage health care benefits described in this Contract to eligible retirees of the Group named above, and their eligible dependents, who become enrolled under this Contract. The benefits to be provided and all other terms and conditions are set forth in this Contract, including the attached Evidence of Coverage.

IN WITNESS WHEREOF, the parties have executed this Contract.

Regence BlueCross BlueShield of Oregon

____
Signature

____
Name

____
Title

____
Date

CLARK COUNTY

Signature

Steve Stuart
Name

Chair Board of Commissioners
Title

DEC 17, 2013
Date

Medicare Advantage Group Contract

Regence BlueCross BlueShield of Oregon Contract

This Contract, including the Group's application, the Evidence of Coverage and any amendments, endorsements or riders and any subsequent renewals thereof is the entire understanding between the Group and Regence BlueCross BlueShield of Oregon concerning the subject matter of this Contract. It states all the terms of the coverage and supersedes and cancels all and any prior contracts to provide Medicare Advantage health benefits issued to the Group by Us. No modifications of or additions to this Contract will be binding upon Us unless set forth in an amendment, endorsement or rider issued by Us and signed by one of Our authorized officers.

DEFINITIONS

The terms "We," "Us," and "Our" means Regence BlueCross BlueShield of Oregon.

The term "Group" means the organization named above whose eligible retirees and their eligible dependents may participate under this coverage.

The Contract Effective Date is **January 1, 2014**.

The Renewal Date is **January 1** of each subsequent year.

An "employee" of the Group is an individual who works for the Group on a full-time basis and has a normal work week of 30 or more hours, or by agreement between the Group and Us, a normal work week of between 20 and 30 hours. An employee includes a sole proprietor, a partner of a partnership and an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of an employer. Public officers and public employees designated by an employer are employees without regard to the number of hours worked.

An "eligible retiree" is a person who (a) was at one time an employee of the Group, (b) has retired from the Group, (c) is classified by the Group as a retiree for the purposes of eligibility for coverage under the group health plan, and (d) is eligible to elect a Medicare Advantage plan pursuant to 42 C.F.R. § 422.50.

An "Enrolled Retiree" is an eligible retiree who has completed an enrollment form and is enrolled under this Contract.

An "eligible dependent" is a "dependent," as described in the "Dependent Eligibility" section, below, who is eligible to elect a Medicare Advantage plan pursuant to 42 C.F.R. § 422.50.

An "Enrolled Dependent" is an eligible dependent who has completed an enrollment form and is enrolled under this Contract.

A "Member" is an Enrolled Retiree or Enrolled Dependent.

A "retiree" is a person who (a) was at one time an employee of the Group, (b) has retired from the Group, and (c) is classified by the Group as a retiree for the purposes of eligibility for coverage under the group health plan.

GROUP ELIGIBILITY

The Group must continuously satisfy the requirements of this section, this Contract, and the Group's application in order to be eligible to enroll and keep enrolled Members under this Contract.

Group Qualification

- In order to qualify as an employer and to maintain eligibility for this employer health insurance Contract, the Group must be a bona fide person (including sole proprietors or self-employed individuals), firm, corporation (including Limited Liability Companies, or LLCs), trust, partnership (including Limited Liability Partnerships (LLPs)), labor union or political subdivision. In order to be eligible, a Group must: accept billing on a consolidated basis and collect any required Member contributions via payroll deductions;
- be actively engaged in legal business activity;
- be licensed to conduct business in the state and obtain other business licenses as required by law;
- have employed an average of at least two employees, who meet the qualifications to be an eligible retiree. In all cases, a bona fide employer-employee relationship must have existed in order for a Group to be eligible; and
- have a status as a legal entity with authority to contract for health insurance coverage and not be formed primarily for purposes of buying health insurance.

Employer Contribution and Retiree and Dependent Participation

Coverage under this Contract is contingent upon the Group satisfying all eligibility, participation, Group size, contribution and other requirements as specified in the Group's application.

MEMBER ELIGIBILITY

A retiree is eligible for benefits under this Contract beginning on the first day on which the Centers for Medicare and Medicaid Services deems the Member to be enrolled in Our Medicare Advantage plan.

The Group agrees that We have the right to examine employee records for purposes of confirming any Member's status as eligible retiree or eligible dependent.

DEPENDENT ELIGIBILITY

Dependents include an Enrolled Retiree's legal spouse and dependent children of the Enrolled Retiree who is eligible to elect a Medicare Advantage plan pursuant to 42 C.F.R. § 422.50..

TERM, MODIFICATION, TERMINATION

Term

This Contract goes into effect on the Contract Effective Date. The Contract will be renewed and remain in effect from one Renewal Date to the next unless otherwise terminated as described in the "renewal and termination" provision.

Modification

We have the right to modify or amend any provision of this Contract, including premium rates, on any Renewal Date by giving the Group at least 30 days advance written notice. No modification or

amendment will be effective until at least 30 days after such advance notice has been given. Any modification will be uniform within the product line and at the time of renewal.

However, when a change in the Contract is beyond Our control (e.g., legislative or regulatory changes take place, the Group size increases or decreases by ten or more percent or the Group initiates a benefit change), We may modify or amend the Contract on a date other than the Renewal Date, including changing the premium rates, as of the date of the change in the Contract. We will give the Group prior notice of a change in premium rates when feasible. If prior notice is not feasible, We will notify the Group in writing of a change of premium rates within 30 days after:

- the later of the effective date or the date of Our implementation of a statute or regulation;
- the Premium Due Date following Our knowledge of a Group size change of ten percent or more; or
- reaching agreement with the Group on a Group-initiated benefit change.

Provided We give notice of a change in premium rates within the above period, the change in premium rates shall be effective from the date for which the change in the Contract is implemented, which may be retroactive.

Payment of new premium rates after receiving notice of a premium change constitutes the Group's acceptance of a premium rate change.

Changes can be made only through a modified Contract, amendment, endorsement or rider authorized and signed by one of Our officers. No other agent or employee of Ours is authorized to change this Contract.

Renewal and Termination

The Contract is renewable at the option of the Group, except that We may discontinue or nonrenew this Contract with no less than 30 days written notice if there is no longer any Member covered through the Group who lives, resides or works in Our service area or in the area in which We are authorized to do business. We may non-renew or terminate this Contract on the date that our Medicare Advantage contract with the Centers for Medicare and Medicaid Services is not renewed or terminated for any reason.

We may also discontinue this Contract or coverage for a Member on any Premium Due Date with written notice and/or re-rate and collect any additional funds from the Group as follows:

- For the Group's failure to pay the required premiums by the end of the grace period (also see "Payment of Premiums" below).
- For fraud or intentional misrepresentation of material fact by the Group.
- For the Group's failure to respond to Our written request for current status information including group size, participation and contribution.
- For the Group's failure to comply with Our minimum participation requirements or employer contribution requirements.

In the event We eliminate the coverage described in this Contract for the Group and all other enrolled groups, We will provide 90-days written notice to the Group and all Members covered through the Group. We will make available to the Group, on a guaranteed issue basis and without regard to the claims experience of the Group or health status of any Member covered through it, the option to purchase other group coverage(s) being offered by Us for which the Group qualifies.

The Group may terminate this Contract on any Premium Due Date without cause upon 35 prior written notice to Us.

The Group shall provide each Member no less than 21 days prior written notice of termination and notify the Members of any right which may exist to continue coverage upon termination.

Retroactive Termination of Members

The Group may not retroactively terminate a Member to a date more than 90 days before the date on which We receive the Group's request of his or her termination. If a Member for which the Group requests retroactive termination incurs expenses and We pay claims after the requested termination date, premium is due and must be paid for that Member for the monthly period in which claims are incurred.

PREMIUMS

The date the monthly premium is due is the Premium Due Date.

Payment of Premiums

The Group must pay Us the premium for each Member before the Premium Due Date for each month this Contract is in effect. The Premium Due Date is the first of each month, regardless of the date coverage became effective.

Nonpayment of Premiums

If the Group does not pay the premium for the Group or any Member within 10 days of the Premium Due Date, We will send the Group a notice that the premium is overdue and that, if it is not paid within two calendar months (the grace period), the Group's or Member's coverage will end automatically and without further prior written notice. If termination for nonpayment of premiums is effective later than the last date for which premium has been received by Us, We shall be entitled to collect premium for the period between the last date through which premium was paid and the effective date of termination.

In the event this Contract ends for nonpayment of premium, it may be reinstated at Our option and only by Our written agreement. In the event this Contract ends and the disenrollment was not legally valid, this Contract may be reinstated only by Our written agreement. Unless reinstated, this Contract shall remain terminated regardless of the fact that after the termination date We send monthly billing statements to the Group or, for security purposes, deposit payments received from the Group.

Subject to the provisions of this Contract, no person shall be entitled to coverage under this Contract during any period of time for which payment of the required premium on his or her behalf has not been made. Receipt by Us of any sum on account for any individual not entitled to coverage under this Contract during the period for which such premium has been paid shall not constitute Our acceptance of the individual.

Refunds of Premiums

If premiums are paid for someone who is not eligible for coverage, We shall refund the amount paid in error as long as no claims have been paid for expenses incurred during the period of noneligibility. If We have paid claims for the Member in question, premium is due and must be paid for that Member during the period in which claims are incurred.

In the event this Contract is terminated, We shall refund any unearned premiums to the Group. In the event this Contract is terminated because of material misrepresentation, We shall refund to the Group any unearned premiums less the amount of paid claims.

OUT-OF-AREA SERVICES

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever Members access health care services outside the geographic area We serve, the claim for those services may be processed through one of these Inter-Plan Programs and presented to Us for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Members under this Contract are described generally below.

Typically, Members, when accessing care outside the geographic area We serve, obtain care from Providers that have a contractual agreement (i.e., are "Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from Nonparticipating Providers. Our payment practices in both instances are described below.

BLUECARD® PROGRAM

Under the BlueCard® Program, when Members access Covered Services within the geographic area served by a Host Blue, We will remain responsible to the Group for fulfilling Our contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its Participating Providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

LIABILITY CALCULATION METHOD PER CLAIM

The calculation of the Member liability on claims for Covered Services processed through the BlueCard Program will be based on the lower of the Participating Provider's billed covered charges or the negotiated price made available to Us by the Host Blue.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's Provider contracts. The negotiated price made available to Us by the Host Blue may represent a payment negotiated by a Host Blue with a Provider that is one of the following:

A. An actual price. An actual price is a negotiated payment without any other increases or decreases, or
B. An estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or
C. An average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its Providers or a similar classification of its Providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to Providers or anticipated to be paid to or received from Providers). However, the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price

submitted by a Host Blue to Us is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

A small number of states require a Host Blue either (i) to use a basis for determining Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should the state in which health care services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, We would then calculate Member liability in accordance with applicable law.

RETURN OF OVERPAYMENTS

Under the BlueCard Program, recoveries from a Host Blue or its Participating Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, health care Provider/Hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

NEGOTIATED NATIONAL ACCOUNT ARRANGEMENTS

As an alternative to the BlueCard Program, the Member's claim for Covered Services may be processed through a negotiated national account arrangement with a Host Blue.

If We have arranged for (a) Host Blue(s) to make available (a) custom health care Provider network(s) in connection with this Policy, then the terms and conditions set forth in Our negotiated national account arrangements with such Host Blue(s) shall apply.

Member liability calculation will be based on the lower of either billed covered charges or negotiated price (refer to the description of negotiated price above) made available to Us by the Host Blue that allows Members access to negotiated participation agreement networks of specified Participating Providers outside of Our service area.

NONPARTICIPATING PROVIDERS OUTSIDE OF OUR SERVICE AREA

A. Member Liability Calculation

When Covered Services are provided outside of Our service area by Nonparticipating Providers, the amount an Member pays for such services will generally be based on either the Host Blue's Nonparticipating Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the Nonparticipating Provider bills and the payment We will make for the Covered Services as set forth in this paragraph.

B. Exceptions

In some exception cases, We may pay claims from Nonparticipating Providers outside of Our service area based on the Provider's billed charge, such as in situations where an Member did not have reasonable access to a Participating Provider, as determined by Us or by applicable state law. In other exception cases, We may pay such a claim based on the payment We would make if We were paying a Nonparticipating Provider inside of Our service area, as described elsewhere in this Policy, where the Host Blue's corresponding payment would be more than Our in-service area Nonparticipating Provider payment, or We may negotiate a payment with such a Provider on an exception basis. In any of these exception situations, the Member may be responsible for the

difference between the amount that the Nonparticipating Provider bills and payment We will make for the Covered Services as set forth in this paragraph.

GENERAL PROVISIONS

Medicare Advantage Notice Requirements

Group shall disseminate to Members Evidences of Coverage and all other beneficiary communications that provide descriptions of benefits under this Contract. Group shall disseminate such communications in a timely manner. We shall provide Group with an Evidence of Coverage for each Medicare Advantage plan offered under this Contract.

Medicare Advantage Premium Requirements

Group may subsidize premium for different classes of Members in different amounts, provided that the classes are reasonable and based on objective business criteria. Group may not subsidize different amounts of premium based on Enrolled Members' eligibility for the Medicare Part D Low Income Subsidy.

Group may not vary the amount of its premium subsidy within a class of Members.

Group may not require a Member to pay more for Medicare Part D prescription drug premium than We charge Group for the Member's Medicare Part D premium, including the premium components for both basic prescription drug coverage and supplemental prescription drug benefits, if any.

Group must offset the amount a Member pays for Medicare Part D prescription Drug premium with any Medicare Part D Low Income Subsidy for which the Member is eligible. Group may only retain a part of any such premium subsidy when the Member pays no Part D premium.

Group shall make available to Us upon request documentation necessary to demonstrate Group's compliance with these Medicare Advantage Premium Requirements.

Medicare Advantage Enrollment and Disenrollment Requirements

With respect to each Member, Group must provide Us all information that the Centers for Medicare and Medicaid Services requires for a complete enrollment request transaction and any information Group has on other insurance coverage for purposes of coordination of benefits.

We shall provide to Group and Group shall disseminate to each prospective Member at least 21 calendar days prior to the prospective Member's enrollment:

- Notice that the Group intends to enroll the prospective Member in Our Medicare Advantage plan on the applicable enrollment date;
- Notice that the prospective Member may opt-out of the enrollment, including a clear explanation of the process for opting-out and any consequences to Member's eligibility for Group's benefits if Member does opt-out;
- A Summary of Benefits offered under Our Medicare Advantage plan and an explanation of how to (a) get more information on Our Medicare Advantage plan and (b) contact Medicare for other options available to a Medicare beneficiary; and
- Certain notices and disclaimers required by the Centers for Medicare and Medicaid Services on enrollment applications.

If Group terminates this Contract or determines that a Member is no longer eligible to participate in the Group's group health plan, Group shall provide each affected Member notice that it intends to disenroll the Member. Group shall provide the notice at least 21 calendar days prior to the effective date of termination or disenrollment. The notice shall contain information on (a) other coverage options that may be available to the Member through the Group and (b) how the Member may contact Medicare for

information about other Medicare options that may be available. Group shall provide Us all information that the Centers for Medicare and Medicaid Services requires for a complete disenrollment request transaction.

Group Responsibilities

The Group agrees to the following:

- Handle and distribute enrollment materials in a timely manner and promptly provide to Us the information necessary to administer this Contract. There is an understanding and agreement that the Group's failure to provide information in a timely manner may substantially delay and/or jeopardize the enrollment of eligible Members.
- Restrict enrollment and payment of premiums through the Group to eligible Members.
- Make payroll deductions for and verify with Us the eligibility of any Member on a temporary leave of absence.
- Remit premiums for a terminating Member through the end of the monthly coverage period in which the Member terminates (except as provided under Refund of Premiums), unless otherwise agreed in advance in writing.
- Delete terminations from the billing in a timely manner, and the Group further agrees that any refund of the number of months of premiums paid by the Group in error or for an ineligible Member shall be made only if claims have not been paid.
- Provide each Member no less than 21 days prior written notice of termination of this Contract, including any termination due to the Group's failure to pay premiums.
- Notify each Member of any right(s) that may exist to continue coverage upon termination, as provided by any applicable law or as otherwise described in the Evidence of Coverage, and collect and forward associated timely enrollment forms and premiums.
- Provide those notices, in a timely manner, that a group health plan is required by law to provide (e.g., notices of special enrollment rights provisions). The Group agrees to indemnify and hold Us harmless from any damages, loss, action, claim or suit (including court costs and attorney's fees) arising from or related to its failure to provide such legally-required notices.
- Report monthly the names of new Members, cancelled Members and Members electing any statutory continuance of coverage.
- Maintain workers' compensation coverage for all Members, to the extent required by law.
- Maintain Group eligibility in accordance with the minimum standards of applicable statutory continuances of coverage, unless We have agreed in advance and in writing to the Group's use of standards more generous to Members.
- If We provide Our enrollment and/or change forms ("Forms") and/or any summary plan descriptions, benefit summaries and/or comparison sheets ("Documents") in an electronic medium for inclusion on the Group's internal intranet or by similar means, Group agrees that:
  - electronic access shall be limited to the Group's enrolling Members and covered Members and be restricted to a "read-only" or similar basis;
  - they will replace any hard-copy Forms that have been modified by Us;
  - the hard-copy documents on file with Us shall control in the event of any discrepancy; and
  - the Group remains solely responsible for the content of the documents and all other legal requirements pertaining to them (e.g., distribution).

Notice Under This Contract

Any notice required under this Contract shall be deemed to be properly given if written notice is deposited in the United States mail or with a private mail carrier. Notices to a Member, or to the Group shall be addressed to the Member, or to the Group at the last known address appearing in Our records. If We receive a United States Postal Service change of address form for a Member, We will update Our records accordingly. Additionally, We may forward any notice for a Member to the Group administrator if We become aware that We do not have a valid mailing address for the individual.

Any notice to Us will not be deemed to have been given to and received by Us until physically received by Us. Notices the Group gives to Us must be sent to Us at Our principal mailing address of:

Regence BlueCross BlueShield of Oregon
P.O. Box 1271
Portland, OR 97201

Choice of Forum

Any legal action arising out of this Contract must be filed in a court in the state of Oregon.

Governing Law and Discretionary Language

The Contract will be governed by and construed in accordance with the laws of the United States of America and, to the extent applicable, by the laws of the State of Oregon without regard to its conflict of law rules.

Arbitration

Any controversy or claim between the Group and Us arising out of or relating to this Contract, or the breach thereof, whether involving a claim in tort, contract or otherwise, shall be subject to final resolution through binding arbitration. The parties agree that the arbitrator's award shall be binding, may include an apportionment of attorney fees and other fees and costs and may be enforced in any court with the requisite jurisdiction. Any such arbitration shall be conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association and in Multnomah County, Oregon, unless mutually agreed otherwise by the parties.

If any Member or former Member (or person claiming to be a Member or former Member) makes any claim or brings any action or proceeding arising out of or relating to this Contract to which We or the Group become a party, We and/or the Group agree to cooperate in the defense of such claim, action or proceeding and to resolve any controversy or claim between Us and the Group through arbitration under this paragraph only after the resolution of the Member's (or alleged Member's) claim.

No Waiver

The failure or refusal of either party to demand strict performance of this Contract or to enforce any provision will not act as or be construed as a waiver of that party's right to later demand its performance or to enforce that provision. No provision of this Contract will be deemed waived by Us unless such waiver is reduced to writing and signed by one of Our authorized officers.

Representations Are Not Warranties

In the absence of fraud, all statements made in an application by the Group or an enrollment form by a Member shall be deemed representations and not warranties. No statement made for the purpose of obtaining coverage shall void such coverage or reduce benefits unless contained in a written document signed by the Group or the enrolled person, a copy of which has been furnished to the Group or the enrolled person.

Group's Bankruptcy

If bankruptcy, receivership or liquidation proceedings are commenced with respect to the Group, and if this Contract has not otherwise been terminated, then We may suspend all further performance of this Contract pursuant to Section 365 of the Bankruptcy Code or any similar or successor provision of federal or state law. Any such suspension or further performance by Us pending the Group's assumption or rejection shall not be a breach of this Contract and shall not affect Our right to pursue or enforce any of the rights under this Contract or otherwise.

Funding

The Group shall adopt policies and procedures regarding the funding of the Group's payment obligations under this Contract. This includes the collecting premiums from retirees and/or the payment of the Group's contributions from the general assets of the Group. Amounts paid (either directly or withheld by payroll deduction) by Members for benefits under the plan shall be used for the exclusive benefit of the Members and the Group shall not divert such amounts for any purpose other than for the payment of the Group's obligations hereunder. Amounts paid (either directly or withheld by payroll deduction) by Members shall be transferred to Us by the Group prior to the payment of Group contributions from the general assets of the Group.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

The Group on behalf of itself and its Members hereby expressly acknowledges its understanding that the Contract constitutes an agreement solely between the Group and Regence BlueCross BlueShield of Oregon, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the Association), permitting Us to use the Blue Cross and Blue Shield Service Marks in the state of Oregon and in Clark County in the state of Washington and that We are not contracting as the agent of the Association. The Group on behalf of itself and its Members further acknowledges and agrees that it has not entered into the Contract based upon representations by any person or entity other than Regence BlueCross BlueShield of Oregon and that no person or entity other than Regence BlueCross BlueShield of Oregon will be held accountable or liable to the Group or the Members for any of Our obligations to the Group or the Members created under the Contract. This paragraph will not create any additional obligations whatsoever on the part of Regence BlueCross BlueShield of Oregon other than those obligations created under other provisions of the Contract.

Group Is Agent

The Group is the agent of the Members for all purposes under this Contract and not the agent of Regence BlueCross BlueShield of Oregon. Members are entitled to health care benefits pursuant to this agreement between Us and the Group. The Group agrees to act as agent for Members in acknowledging their agreement of the terms, provisions, limitations and exclusions contained in this Contract and the Evidence of Coverage.

Medication Rebate

We participate in arrangements with medication manufacturers that allow Us to receive rebates based on the volume of certain prescription medications purchased on behalf of Members. Any rebates We receive from medication manufacturers are credited to reduce rate increases. We will withhold a percentage of the total rebate to cover Our costs of collecting and administering the rebate program.

COBRA CONTINUATION OF COVERAGE

This section applies only when the benefit plan is subject to the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Certain circumstances, called qualifying events, could give Members the right to continue this coverage beyond the time it ordinarily would have ended. COBRA continuation rights and obligations are governed by the COBRA law, as amended, and if there is any conflict between the provisions of this Contract and COBRA, COBRA's minimum requirements will govern. This section will automatically cease to apply when federal law requiring COBRA continuation no longer applies to the benefit plan. This section does not provide a full description of COBRA, which would be the Group's obligation.

The basic Part A, Part B and Part D benefits and any other benefits financed by Medicare through rebate dollars are not subject to COBRA continuation of coverage requirements. The Group, however, may be required by COBRA to offer continuation coverage for supplemental benefits that are financed outside of Medicare. At its option, the Group may elect to provide continuation coverage for the entire benefit plan (Medicare benefits and non-Medicare supplemental benefits). If electing to offer continuation coverage for the entire benefit plan, the Group must comply with Medicare prospective termination requirements, and may charge no more than 100% of the premium for the Medicare portion of the benefits offered. (The Group generally may charge up to 102% of the portion of the premium that is attributable to the non-Medicare supplemental benefits.)

Notification Responsibilities

In order to preserve rights under COBRA, Members and the Group must meet certain notification, election and payment deadline requirements. It is therefore very important that Members keep the Group informed of the current address of all persons who are or may become qualified beneficiaries.

Members must inform the Group in writing within 60-days of divorce or legal separation, or a loss of dependent child status. The Group is responsible for notifying Members of the right to elect COBRA continuation due to any of the other qualifying events.

Once the Group is notified or aware of a qualifying event, it sends Members information concerning continuation options, including the necessary COBRA continuation election forms. Members have 60-days from the later of the date of the qualifying event or the date of the Group's notice to a Member in which to make an election.

If Members Do Not Elect COBRA Continuation

If Members do not elect COBRA continuation coverage, coverage will end according to the terms of this Contract and We will not pay claims for services provided on and after the date coverage ends.

MEDICARE SECONDARY PAYOR RULES

The federal government has adopted Medicare secondary payer (MSP) rules for determining which are the primary and secondary payers when a Member is covered under both Medicare and a group health plan. The rules depend on:

- whether the Medicare eligible person is active or retired (or the spouse of such person);

- whether the person has Medicare because of reaching age 65, disability or end stage renal disease; and
- the size of employer sponsoring the group health plan.

In order to administer claims in compliance with the MSP rules, We need to know certain information. Accordingly, in the event this Contract covers active employees as a subscriber or dependent, the Group must advise Us in writing within 30 days of a change in the number of employees as described in the following bulleted paragraphs:

- When the number of employees in a "current employment status" according to federal regulations increases to 20 or more, or decreases below 20. For purposes of this calculation, the Group will be considered to employ 20 or more employees if it has had 20 or more full- or part-time employees for each working day in each of 20 or more calendar weeks in the current Calendar Year or the preceding Calendar Year.
- When the number of employees in a current employment status increases to 100 or more or decreases below 100. For purposes of this calculation, the Group will be considered to employ 100 or more employees if it had 100 or more full- or part-time employees on 50 percent or more of its regular business days in the previous Calendar Year.
- When an employee retires and eligibility under this Contract allows retired employees to remain enrolled.

The Group shall be responsible for claim amounts or penalties payable to the federal government resulting from noncompliance with the MSP rules caused by its failure to give Us notice of a Group size change under this provision.