KAISER PERMANENTE®

Kaiser Foundation Health Plan of Colorado

A Colorado Nonprofit Corporation

2014

LARGE GROUP

GROUP AGREEMENT

Denver Fire Department

GROUP AGREEMENT

INTRODUCTION

This Group Agreement ("*Agreement"*), including the Rate Sheet(s), the Evidence of Coverage (*"EOC"*) brochure(s) the Group Application form, and the Performance Guarantees document, all of which are incorporated into this *Agreement* by reference, and any amendments to any of them, constitute the entire contract between the group named on the Rate Sheet ("Group") and Kaiser Foundation Health Plan of Colorado ("Health Plan"). In this *Agreement*, some capitalized terms have special meaning; please see the "Definitions" section in the *Evidence of Coverage* document for terms you should know. Pursuant to this *Agreement,* Health Plan will provide covered Services to Members in accord with the *Evidence of Coverage.* If Group does not renew this *Agreement*, Group must give Health Plan written notice as described in the "Termination of *Agreement*" Section.

TERM OF *AGREEMENT* and RENEWAL

Term of Agreement

This *Agreement* is effective for the term shown on the Rate Sheet, unless terminated as set forth in the "Termination of *Agreement*" section.

Renewal

This *Agreement* does not automatically renew. If Group complies with all of the terms of this *Agreement*, Health Plan will offer to renew this *Agreement* either by sending Group a new *Agreement* to become effective immediately after termination of this *Agreement*, or by offering to extend the term of this *Agreement* pursuant to "Amendments Effective on an Anniversary Date" in the "Amendment of *Agreement*" section. The new or extended Agreement will include a new term of Agreement and other changes that are mutually agreed upon in writing by Health Plan and Group.

Delegation of Signature Authority

The City authorizes the Executive Director of the Office of Human Resources, or the Executive Director's delegate, to sign any documents, rate sheets, or related documents necessary to implement this agreement.

AMENDMENT OF *AGREEMENT*

Amendments Effective on an Anniversary Date

Upon 60 days' prior written notice to Group with respect to proposed benefit or contract changes, or upon 30 days' prior written notice to Group with respect to proposed rate changes, or as otherwise agreed to by Health Plan and Group, Health Plan may offer to extend the term of this *Agreement* and propose amendments to this *Agreement* to be effective on any year's Anniversary Date (the Anniversary Date is shown on the Rate Sheet). Except as otherwise expressly stated in this *Agreement*, all amendments, including but not limited to benefit, contract and rate changes, must be mutually agreed upon in advance and in writing by Health Plan and Group.

Amendments Related to Government Approval or Mandated by Law

If Health Plan notified Group that Health Plan had not received all necessary government approvals related to this *Agreement*, Health Plan may propose to amend this *Agreement* by giving written notice to Group after receiving all necessary government approvals. Any such government-approved provisions go into effect on the Anniversary Date that next follows the Health Plan's original notice to Group of the provisions for which it had sought government approval (unless the government requires a later effective date), if the *Agreement* is renewed.

Amendment Due to Medicare Changes

Health Plan contracts on a calendar-year basis with the Centers for Medicare & Medicaid Services (CMS) to offer Kaiser Permanente Senior Advantage. Health Plan may amend this Agreement to change any Senior Advantage EOCs and Premiums effective January 1, 2009 (unless the federal government requires a different effective date). The amendment may include an increase or decrease in Premiums and Benefits including Member Cost Sharing and the Medicare Part D initial and catastrophic coverage levels; however, premium increases and Member Cost Sharing increases may not be made retroactive to a prior month. Health Plan will give Group at least 30 days advance written notice of any such amendment, so long as Health Plan is given 30-days notice of such changes by CMS or other governmental entity.

Service Area

Health Plan may amend this *Agreement* at any time by giving written notice to Group, via certified mail, in order to expand the Health Plan Service Area.

TERMINATION OF *AGREEMENT*

This *Agreement* will terminate under any of the conditions listed below. All rights to benefits under this *Agreement* end at 11:59 p.m. on the termination date, except as expressly provided in the *Evidence of Coverage*, and except as otherwise required by applicable law. Unless earlier termination is exercised pursuant to the terms herein, the termination date shall be December 31, 2014.

Health Plan will give Group written notice, via certified mail, if this *Agreement* terminates. Within five business days of receipt, Group will mail to each Subscriber a legible copy of the notice and will give Health Plan proof of that mailing and of the date thereof.

Termination on Notice

If Group has Kaiser Permanente Senior Advantage Members

If Group has Kaiser Permanent Senior Advantage Members enrolled under this *Agreement* at the time Health Plan receives written notice from Group that it is terminating this *Agreement*, Group may terminate this *Agreement* effective the anniversary date, if the anniversary date is the first of the month or the first of the month following the anniversary date if the anniversary date is not the first of the month, by giving at least 30 days' prior written notice to Health Plan and remitting all amounts payable relating to this *Agreement*, including Dues, for the period prior to the termination date.

If Group does not have Kaiser Permanente Senior Advantage Members

If Group does not have Kaiser Permanent Senior Advantage Members enrolled under this *Agreement* at the time Health Plan receives written notice from Group that it is terminating this *Agreement*, Group may terminate this *Agreement* effective the anniversary date, if the anniversary date is the first of the month or the first of the month following the anniversary date if the anniversary date is not the first of the month, by giving at least 60 days' prior written notice to Health Plan and remitting all amounts payable relating to this *Agreement*, including Dues, for the period prior to the termination date.

Termination for Nonpayment

Health Plan may terminate this *Agreement* by giving advance written notice to Group, via certified mail, if Group fails to make any past-due Dues payment during Health Plan's grace period. The advance written notice will indicate the termination date. A grace period of 31 days is observed by Health Plan, during which time the amounts specified in the Rate Sheet may be paid by the Group without loss of benefits. The grace period shall apply to all payments except the first payment and coverage shall remain in effect if payment is made during the grace period. Group is liable for all unpaid Dues through the termination date. In the event that any Dues payment is not timely received by Health Plan, Health Plan will send the Group a notice of Dues owed. Such notice shall specify the delinquent Dues payment and the date upon which the 31 day grace period ends. Health Plan will give written notice to Group of final termination of this *Agreement* via certified mail.

If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan gives written notice to Group, Health Plan may terminate this *Agreement* effective on one date with respect to Members other than Senior Advantage Members and

effective on a later date with respect to Senior Advantage Members in order to comply with CMS termination notice requirements.

Termination for Fraud or for Intentionally Furnishing Materially Misleading or Fraudulent Information

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

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

Termination for Violation of Contribution or Participation Requirements

If Group fails to comply with Health Plan's contribution or participation requirements as set forth in the "Contribution and Participation Requirements" section of this *Agreement*, Health Plan may terminate this *Agreement* by giving advance written notice to Group, and Group is liable for all unpaid Dues up to the termination date.

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

Termination for Movement Outside the Service Area

Health Plan may terminate this *Agreement* upon 30 days' prior written notice, via certified mail, to Group if no eligible person lives, resides, or works in Health Plan's Service Area as described in the *Evidence of Coverage.*

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

Health Plan may terminate a particular product or all products offered in the group market as permitted by law. If Health Plan discontinues offering a particular product in the group market, Health Plan may terminate this *Agreement* with respect to that product upon 90 days' prior written notice, via certified mail, to Group. Health Plan will offer Group another product that it makes available in the group market. If Health Plan discontinues offering all products in the group market, Health Plan may terminate this *Agreement* upon 180 days' written notice, via certified

mail, to Group and Health Plan will not offer any other product to Group. A "product" is a combination of benefits and services that is defined by a distinct evidence of coverage.

DUES

Only Members for whom Health Plan has received the appropriate Dues payment listed on the Rate Sheet are entitled to coverage under this *Agreement*, and then only for the period for which Health Plan has received appropriate payment.

If Group does not prepay the Full Dues by the first of the coverage month or by the date otherwise agreed to by Health Plan and Group, the Dues may include an additional administrative charge upon renewal. "Full Dues" means 100 percent of monthly Dues for each enrolled Member, as set forth in this "Dues" section.

Dues Rebates

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

New Members

Dues are payable for the entire month for new Members unless otherwise agreed to by Health Plan.

Terminating Members

Pursuant to C.R.S. 10-16-103.5, dues are payable for each Member:

- Through the date that Health Plan receives written notice from Group that a Member is no longer eligible or covered; or
- Through the date that Health Plan receives written notice from Group that it no longer intends to maintain coverage for its Members through Health Plan.

Involuntary Kaiser Permanente Senior Advantage Membership Terminations

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

coverage or has lost Medicare eligibility). The membership termination date is the first of the month following 30 days after the date when Health Plan receives a Senior Advantage membership termination notice unless Group specifies a later termination date. For example, if health Plan receives a termination notice on March 5, for a Senior Advantage Member, the earliest termination date is May 1 and Group is required to pay applicable Dues for the months of March and April.

Voluntary Kaiser Permanente Senior Advantage Membership Termination

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

SUBSCRIBER CONTRIBUTIONS FOR MEDICARE PART C AND PART D COVERAGE

Medicare Part C Coverage

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

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

Medicare Part D Coverage

This “Subscriber Contributions for Medicare Part D Coverage” section, applies only to Group’s Kaiser Permanente Senior Advantage coverage that includes Medicare Part D coverage. Group’s Senior Advantage Dues include the Medicare Part D premium. Group may determine how much it

will require Subscribers to contribute toward the Medicare Part D premium for each Senior Advantage Member in the Subscriber's Family Unit, subject to the following restrictions:

- If Group requires different contribution amounts for different classes of Senior Advantage Members for the Medicare Part D premium, then Group agrees to the following:

  - any such differences in classes of Members are reasonable and based on objective business criteria, such as years of service, business location, and job Group will not require different Subscriber contributions toward the Medicare Part D category, and are not based on eligibility for the Part D Low Income Subsidy (a subsidy described in 42 C.F.R. 423 Subpart P, which is offered by the Medicare Program to certain low-income Medicare beneficiaries enrolled in Medicare Part D, and which reduces the Medicare beneficiaries' Medicare Part D premiums or Medicare Part D cost-sharing amounts)

  - Group will not require different Subscriber contributions toward the Medicare Part D premium for Members within the same class.

- Group will not require Subscribers to pay a contribution for prescription drug coverage for a Senior Advantage Member who exceeds the Dues for prescription drug coverage (including the Medicare Part D premium). The Group will pass through direct subsidy payments received from CMS to reduce the amount the Member contributes toward the Medicare Part D premiums.

- Health Plan will credit Group with any Low Income Subsidy amounts that Health Plan receives from CMS for Group's Members and Health Plan will identify those Members for Group as required by CMS. For those Members, Group will first credit the Low Income Subsidy amount toward the Subscriber's contribution for that Member's Senior Advantage premium for the same month, and will then apply any remaining portion of the Member's Low Income Subsidy toward the portion of the Senior Advantage premium that Group pays on behalf of that Member for that month. If Group is unable to reduce the Subscriber's contribution before the Subscriber makes the contribution, Group shall, consistent with CMS guidance, refund the Low Income Subsidy amount to the Subscriber (up to the amount of the Subscriber Premium contribution for the Member for that month) within 45 days after the date Health Plan receives the Low Income Subsidy amount from CMS. Health Plan reserves the right to periodically require Group to certify that Group is either reducing Subscribers' monthly Premium contributions or refunding the Low Income Subsidy amounts to Subscribers in accord with CMS guidance.

- For any Members who are eligible for the Low Income Subsidy, if the amount of that Low Income Subsidy is less than the Member's contribution for the Medicare Part D premium, then Group should inform the Member of the financial consequences of the Member's enrolling in the Member's current coverage, as compared to enrolling in another Medicare Part D plan with a monthly premium equal to or less than the Low Income Subsidy amount.

Late Enrollment Penalty

If any Members are subject to the Medicare Part D late enrollment penalty, Premiums for those Members will increase to include the amount of that penalty.

CONTRIBUTION AND PARTICIPATION REQUIREMENTS

No change in Group's contribution or participation requirements is effective for purposes of this *Agreement* unless Health Plan consents in writing. If Group fails to satisfy the Contribution and Participation Requirements of this section, the Health Plan may terminate this *Agreement* as set forth in the **Termination for Violation of Contribution or Participation Requirements** in this *Agreement*.

The Group must:

- Contribute to all health care plans available through Group on a basis that does not financially discriminate against Health Plan or against people who choose to enroll in Health Plan. In no case will Group's contribution be less than one-half the rate required for a single Subscriber for the plan in which the Subscriber is enrolled.

- Ensure that:
    - All eligible employees enrolled in Health Plan meet the eligibility requirements of the Group.
    - All eligible employees enrolled in Health Plan are covered by Workers' Compensation, unless not required by law to be covered.
    - All Health Plan Subscribers live or work inside Health Plan's Service Area when they enroll.
    - The number of active, eligible employee Subscribers enrolled under this *Agreement* does not fall below 10 and the ratio between the number of Members and the total number of people who are eligible to enroll as Members will not drop by 20 percent or more (based upon all subscribers for all of Kaiser's plans). For the purpose of computing this percentage requirement, Group may include members and those eligible to enroll as members under all other agreements between Group and Health Plan and all other Kaiser Foundation Health Plans and Group Health Cooperative.

- There is a bona fide employer/employee relationship to those offered our plan, except eligible Taft-Hartley trusts and partnerships, and except as otherwise set forth in the agreed upon eligibility requirements.

- Hold an annual open enrollment period during which all eligible people may enroll in Health Plan or in any other health care plan available through Group.

- Meet all applicable legal and contractual requirements, such as:

  - Group must adhere to all requirements set forth in the applicable *Evidence of Coverage*, as amended.

  - Group must obtain Health Plan's prior written approval of any Group eligibility or participation or contribution requirements that are not stated in the applicable *Evidence of Coverage*, as amended.

  - Group must use Member enrollment application forms that are provided or approved by Health Plan.

  - Comply with Centers for Medicare & Medicaid Services (CMS requirements governing enrollment in, and disenrollment from Kaiser Permanente Senior Advantage (KPSA).

- Meet all Health Plan requirements set forth in the "Underwriting Assumptions and Requirements " document.

- Offer enrollment in Health Plan to all eligible people on conditions no less favorable than those for any other health care plan available through Group.

- Permit Health Plan to examine Group's records with respect to contribution and participation requirements, eligibility, and payments under this *Agreement*, except as restricted by the laws of the City and County of Denver ("City"), State of Colorado law, or federal law.

INSURANCE

Health Plan shall, at its own cost and expense, maintain in full force and effect, during the term of this *Agreement*, professional (malpractice) and general liability insurance with minimum limits of at least $10,000,000 per occurrence. All such policies shall provide for the Group to receive at least thirty (30) days written notice from the insurance carrier or carriers prior to any cancellation or material change in any such policy. Health Plan shall provide to the Group, upon execution of this *Agreement*, and upon renewal of such insurance programs certificates of insurance for all such insurance carried. All insurance coverage must be written by companies authorized to do business in the State of Colorado. All such insurance shall cover claims occurring during the term of this *Agreement*, including claims which may be asserted after the termination of this *Agreement*.

Notwithstanding the foregoing, Health Plan may utilize a combination of insurance and alternative risk management programs, including self-insurance to provide for its contractual obligations under this *Agreement*. Evidence of such financial responsibility will be provided upon execution of this *Agreement.*

Each of the Health Plan's agreements with providers in its provider network does, and during the initial term and any renewal term of this *Agreement*, will require maintenance of levels of professional liability insurance consistent with industry standards and applicable law.

Health Plan covenants and agrees that at all times it will maintain and carry statutory workers' compensation insurance with an authorized insurance company or through an authorized self-insurance plan approved by the State of Colorado. Such insurance shall insure payment for such workers' compensation claims to all of Health Plan's employees, including specifically but not by way of limitation, all of its employees who in any manner perform work or provide services to fulfill Health Plan's obligations under this *Agreement*. Health Plan agrees to provide the Administrator with certificates, in number as required, satisfactorily evidencing the existence of the workers' compensation insurance.

There shall be a waiver of subrogation in favor of the City for workers' compensation and professional errors and omission coverage**.**

Insurance coverage specified herein constitutes the minimum requirements, and said requirements shall in no way lessen or limit the liability of Health Plan under the terms of the *Agreement*. Health Plan shall procure and maintain, at its own expense and cost, any additional kinds and amounts of insurance that, in its judgment, may be necessary for its proper protection in the prosecution of the services hereunder.

INDEMNIFICATION

Health Plan agrees to defend, release, indemnify and save and hold harmless the City, and its agents, officers and employees acting in their capacity as agents of the City against any and all claims, demands, costs (including reasonable attorney's fees) suits, actions, liabilities, causes of action or legal or equitable proceedings of any kind or nature, including workers' compensation claims, of or by anyone whomsoever, to the extent that they arise out of Health Plan's acts or omissions under this *Agreement*, including acts or omissions of Health Plan or to the extent that they are acting in their capacity as agents of Health Plan, its officers, employees, representatives, suppliers, invitees, licensees, subconsultants, subcontractors, and agents; provided, however, that Health Plan need not indemnify and save harmless the City, its officers, agents, and employees from damages arising out of the sole negligence of the City or the City's officers, agents, and employees acting in their capacity as agents of the City. This indemnity clause shall also cover the City's defense costs, in the event that the City, in its sole discretion, except as provided below, elects to provide its own defense. To the

extent there is not a conflict, the City shall tender to Health Plan the opportunity, at Health Plan's expense, to arrange and direct the defense of any action or lawsuit related to the claim. If Health Plan accepts the tender, then Health Plan shall have no obligation to the City with respect to attorney's fees incurred by the City relating to the claim. Upon request, the City shall provide Health Plan all information and assistance reasonably necessary for the defense of the claim. In the event of a conflict and insurance counsel is needed, Health Plan will pay for separate counsel for the City. The City will select insurance counsel that normally or routinely works on insurance matters, and Health Plan may propose a list containing at least three (3) counsel alternatives from which the City may select.

PERFORMANCE GUARANTEES

The Performance Guarantees as set forth in the attached Performance Guarantees document are incorporated into this *Agreement*.

MISCELLANEOUS PROVISIONS

Acceptance of *Agreement*

Group acknowledges acceptance of this *Agreement* by signing one original Rate Sheet, with all signatures required by the Group, and returning it to Health Plan.

Note: Group and Heath Plan may not change this *Agreement* unilaterally by adding or deleting words, and any such addition or deletion is void. If Group wishes to change anything in this *Agreement*, Group must contact its Health Plan account manager, and Health Plan must contact the Group as set forth in the Amendments section of this *Agreement*. Health Plan will issue a new agreement or amendment if Health Plan and Group agree on any changes.

Assignment

Health Plan may not assign, transfer, pledge, or hypothecate in any way this *Agreement*. Group may not assign this *Agreement* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without Health Plan's prior written consent. Notwithstanding the foregoing, if Health Plan assigns, sells or otherwise transfers substantially all of its assets and business to another corporation, firm, or person, with or without recourse, this *Agreement* will continue in full force and effect as if such corporation, firm or person were a party to this *Agreement*, provided that such corporation, firm or person continues to provide prepaid health services. No duties imposed by this *Agreement* be delegated without the approval of the other party, except that Health Plan may delegate certain functions, including but not limited to medical management, utilization review, credentialing and/or claims payment, to provider groups or other certified organizations which contract with Health Plan and that Health Plan may contract with its corporate affiliates to perform certain management and administrative services for Health Plan.

Certificates of Creditable Coverage

This "HIPAA Certificates of Creditable Coverage" section does not apply if Group has a written agreement with Health Plan that Group will mail certificates of creditable coverage.

If Group has a waiting period of affiliation period, when Group reports an enrollment of a new hire and any eligible Dependents who enroll at the same time (other than a [Kaiser Permanente Senior Advantage] [or] [Kaiser Permanente Medicare Cost] enrollment)_ with a membership effective date that occurs during the term of this *Agreement*, Group must provide the following information in a format Health Plan approves:

- Enrollment reason. (If Group does not provide an enrollment reason, Health Plan will assume that Subscriber is not a new hire, and certificate for the Subscriber and any Dependents who enrolled at the same time will indicate that there was no waiting period or affiliation period)

- Hire date of the Subscriber. (If the enrollment reason is "new hire" and Group does not provide a hire date, Health Plan will assume that the hire date is the effective date of coverage for the Subscriber and any Dependents who enrolled at the same time, and certificate for those Members will indicate there was no waiting period or affiliation period)

- Effective date of coverage.

Group has a waiting period or affiliation period if the membership effective date for a new hire and any eligible Dependents who enroll at the same time is not the hire date (for example, if the membership effective date is the first of the month following the hire date).

Upon Health Plan request (whether or not Group has a waiting period of affiliation period), Group must provide any other information that Health Plan needs in order to complete certificates of creditable coverage.

When Health Plan mails a certificate of creditable coverage, the number of months of creditable coverage that Health Plan reports will be based on the information Health Plan has at the time the certificate is mailed.

Delegation of Claims Review Authority

Group delegates to Health Plan the discretion to determine whether a Member is entitled to benefits under this *Agreement*. In making these determinations, Health Plan has authority to review claims in accord with the procedures contained in this *Agreement* and to construe this *Agreement* to determine whether the Member is entitled to benefits, subject to the claims review process available to the Member or other actions permitted by law and this *Agreement*. For health benefit plans that are subject to the Employee Retirement Income Security Act (ERISA), Health Plan is a "named claims fiduciary" with respect to review of claims under this *Agreement.*

Governing Law

Except as preempted by federal law, this *Agreement* will be governed in accord with the laws of the State of Colorado and with the Charter and Revised Municipal Code of the City and County of Denver, and the ordinances, regulations, and Executive Orders enacted and/or promulgated pursuant thereto. The Charter and Revised Municipal Code of the City and County of Denver, as the same may be amended from time to time, are hereby expressly incorporated into this *Agreement* as if fully set out herein by this reference. Venue for any action brought as a result of this *Agreement* shall be in the District Court in and for the City and County of Denver. Any provision required to be in this *Agreement* by State of Colorado law or federal law shall bind Group and Health Plan whether or not set forth herein, and Health Plan will promptly notify Group if Health Plan discovers or has notice of any such provision.

Member Information

Group will inform Subscribers of eligibility requirements for Members and when coverage becomes effective and terminates.

When Health Plan notifies Group about proposed changes to this *Agreement*, or changes mandated by Governing Law above, or provides Group other information that affects Members, Group will disseminate the information to Subscribers by the next regular communication to them, but in no event later than 30 days after Group receives the information.

Group will provide electronic or paper summaries of benefits and coverage (SBCs) to participants and beneficiaries to the extent required by law, except that Health Plan will provide SBCs to Members who make a request to Health Plan.

Relationship of Parties.

Group is not the agent or representative of Health Plan, and shall not be liable for any acts or omissions of Health Plan, its agents or its employees, or Plan Providers. Member is not the agent or representative of Health Plan, and shall not be liable for any acts or omissions of Health Plan, its agents or its employees. Plan Providers are independent contractors and are not the agents, employees or servants of Health Plan. It is understood and agreed by and between the parties that the status of Health Plan shall be that of an independent contractor and of a corporation retained on a contractual basis to perform professional or technical services for limited periods of time as described in Section 9.1.2. (C) of the Charter of the City and it is not intended, nor shall it be construed, that Health Plan's personnel are employees or officers of the City under Chapter 18 of the Denver Revised Municipal Code or for any purpose whatsoever. Health Plan shall pay when due all required employment taxes and income tax withholding, shall provide and keep in force Workers' Compensation and unemployment compensation insurance in the amounts required by law.

Access to Books and Records.

Health Plan and the Group shall have the right to access the others' books and records for audit of compliance with the terms and conditions of this *Agreement*. Any such access shall not include the right to access any of Health Plan's books and records that would include protected health information about any of the Members in the Health Plan. However, Health Plan can provide the Group with those books and records to the extent personally identifiable information has been eliminated.

Health Plan agrees that it will keep and preserve for at least six (6) years after the final payment under this *Agreement* all directly pertinent books, documents, papers and records of Health Plan involving transactions related to this *Agreement.*

Confidentiality.

Health Plan agrees to maintain and preserve the confidentiality of any and all medical records of Member in accordance with all applicable Colorado State and federal laws, including HIPAA. However, Health Plan has access to any and all of Member's medical records for purposes of utilization review, quality review, processing of any claim, financial audit, coordination of benefits, or for any other purpose reasonably related to the provision of benefits under this *Agreement* to Health Plan, its agents and employees, Plan Providers, and appropriate governmental agencies, to the extent permitted by HIPAA. Health Plan will not release any information to Group which would directly or indirectly indicate to the Group that a Member is receiving or has received Covered Services, unless authorized to do so by the Member. Except as necessary to effectuate this *Agreement*, but only to the extent permitted by HIPAA and applicable Colorado law, Health Plan shall not at any time or in any manner, either directly or indirectly, divulge, disclose or communicate to any person, firm or corporation in any manner whatsoever any information which is not subject to public disclosure, including without limitation the trade secrets of business or entities doing business with the Group, the data contained in any of the data bases of the Group, and other privileged or confidential information. This obligation shall survive the termination of this *Agreement*. Health Plan shall advise its employees, agents and subcontractors, if any, that they are subject to these confidentiality requirements. Further Health Plan shall provide its employees, agents and subcontractors, if any, with a copy or written explanation of these confidentiality requirements before access to confidential data is permitted.

No Waiver

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

Notices

Notices must be delivered in writing to the address listed below, except that

- Health Plan and Group may each change its notice address by giving written notice, via certified mail, to the other.

Notices are to be sent via certified mail and are deemed given when delivered in person or deposited in a U.S. Postal Service receptacle for the collection of U.S. mail.

Notices from Health Plan to Group:

Benefit Manager
Office of Human Resources
201 W. Colfax Ave., Dept. 412
Denver, CO 80202

Notices from Group to Health Plan:

Kaiser Foundation Health Plan of Colorado
2500 South Havana Street
Aurora, Colorado 80014-1622

Social Security and Tax Identification Numbers

Within 30 – 60 days after Health Plan sends a Group a written request, Group will send Health Plan a list of all Members covered under this Group Agreement, along with the following:

- The Member's Social Security number
- The tax identification number of the employer of the Subscriber in the Member's [Family Unit]
- Any other information that Health Plan is required by law to collect

Time Limit on Reporting Membership Changes

Group must report membership changes (including sending appropriate membership forms) within the time limit for retroactive changes and in accord with any applicable "recission" provisions of the Patient Protection and Affordable Care Act and regulations. The time limit for retroactive membership additions is the calendar month when Health Plan receives Group's notification of the change plus the previous two months, unless Health Plan agrees otherwise in writing.

Involuntary Kaiser Permanente Senior Advantage Membership Termination

Group must give Health Plan 30 days prior written notice of Senior Advantage Medicare Plus involuntary membership terminations. An involuntary membership termination that is not in response to a disenrollment notice issued by CMS to Health Plan or received by Health Plan directly

from a Member (these events are usually in response to a Member's request for disenrollment to CMS because the Member has enrolled in another Medicare health plan or wants Original Medicare coverage or has lost Medicare eligibility). The membership termination date is the first of the month following 30 days after the date when Health Plan receives a Senior Advantage Medicare Plus membership termination notice unless Group specifies a later termination date. For example, if Health Plan receives a termination notice on March 5 for a Senior Advantage Medicare Plus Member, the earliest termination date is May 1 and Group is required to pay applicable Premiums for the months of March and April.

Voluntary Kaiser Permanente Senior Advantage Membership Termination

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

The administration of COBRA and State Continuation of Coverage participants will be in accord with applicable Federal and State laws.

Colorado Governmental Immunity Act.

The parties hereto understand and agree that the Group is relying upon, and has not waived, the monetary limitations and all other rights, immunities and protection provided by the Colorado Governmental Immunity Act, C.R.S. §24-10-101 et seq.

Conflict of Interest.

The parties agree that no employee of the Group shall have any personal or beneficial interest whatsoever in the services or property described herein and Health Plan further agrees not to hire or contract for the services of any employee or officer of the Group which would be in violation of the Denver Revised Municipal Code Chapter 2, Article IV, Code of Ethics, or Denver City Charter Sections 1.2.9 and 1.2.12.

Severability.

It is understood and agreed by the parties hereto that if any part, term, or provision of this *Agreement*, except for the provisions of this *Agreement* requiring prior appropriation of funds and limiting the total amount payable by the Group, is held to be unenforceable for any reason, or in conflict with any law of the State of Colorado, the validity of the remaining portions or provisions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if this *Agreement* did not contain the particular part, term, or provision held to be invalid.

Survival of Certain Agreement Provisions.

The parties understand and agree that all terms and conditions of this *Agreement*, together with the exhibits and attachments hereto, if any, any or all of which, by reasonable implication, contemplate continued performance or compliance beyond the expiration or termination of this *Agreement* (by expiration of the term or otherwise), shall survive such expiration or termination and shall continue to be enforceable as provided herein.

Appropriation Required and Contract Maximum.

Notwithstanding any other term, condition, or covenant hereof, it is understood and agreed that any payment obligation of the Group hereunder, whether direct or contingent, shall extend only to funds appropriated by the Denver City Council for the purpose of this *Agreement*, encumbered for the purpose of this *Agreement* and paid into the Treasury of the City and County of Denver. Health Plan acknowledges that (i) the Group does not by this *Agreement* irrevocably pledge present cash reserves for payments in future fiscal years, and (ii) this *Agreement* is not intended to create a multiple-fiscal year direct or indirect debt or financial obligation of the Group. The maximum contract amount for the Group's obligations under this *Agreement* and for payment of Dues, collectively, shall not exceed **SIXTEEN MILLION FORTY-FOUR THOUSAND AND NO/100 DOLLARS ($16,044,000)** unless additional appropriation is made by Group and this *Agreement* is amended by the parties pursuant to the **AMENDMENT OF *AGREEMENT*** section of this *Agreement*. If Group fails to pay Dues within the grace period, Health Plan may exercise its rights under the **Termination for Nonpayment** section of this *Agreement* or other applicable rights of Health Plan under this *Agreement*. Only Enrollees for whom Dues are received by Health Plan are entitled to health care benefits as described in this *Agreement*, and then only for the period for which such payment is received, except as otherwise required by law.

Arbitration: Disputes Between Health Plan and the Group.

All disputes between the City and Health Plan or Group and Health Plan, other than tort claims, shall be resolved by binding arbitration before the Commercial Arbitration Rules of the American Arbitration Association to the extent permitted by Colorado law and by the Colorado Uniform Arbitration Act, unless both parties agree in writing to use another form of alternative dispute resolution (e.g., mediation). The parties will seek to mutually agree on the appointment of an arbitrator, consistent with Colorado law. Arbitration hearings will be held at the neutral administrator's offices in Denver, Colorado, or at another location agreed upon in writing by the parties. The results of the binding arbitration shall be final, and no further recourse in a court of law or otherwise will be available to either Health Plan or the Group or City, except as otherwise provided by the Colorado Uniform Arbitration Act. The arbitrator(s) will prepare in writing an award that includes the legal and factual reasons for the decision. Judgment upon the award rendered by the arbitrator(s) shall be entered into any court having jurisdiction. The parties shall equally share the costs of arbitration; however, each party shall be individually responsible for the expenses related to its attorney, experts and evidence.

[THIS SPACE INTENTIONALLY LEFT BLANK]

[THE DENVER CONTRACT SYSTEM WILL GENERATE SIGNATURE PAGES TO REPLACE THIS PAGE]

Contract Control Number:

IN WITNESS WHEREOF, the parties have set their hands and affixed their seals at Denver, Colorado as of

SEAL

CITY AND COUNTY OF DENVER

ATTEST:

By_____

_____

APPROVED AS TO FORM:

REGISTERED AND COUNTERSIGNED:

By_____

By_____

By_____

Contract Control Number: CSAHR-201419383-00

Contractor Name: Kaiser Foundation Health Plan of Colorado

By: Donna Lynne

Name: Donna Lynne
(please print)

Title: Regional President
(please print)

ATTEST: [if required]

By: _____

Name: _____
(please print)

Title: _____
(please print)

EXHIBIT A

TO 2014
LARGE GROUP
GROUP AGREEMENT

Insurance policy information

DENVER FIRE DEPARTMENT
MEDICARE EMPLOYEES

EVIDENCE OF COVERAGE AMENDMENT - 2014

I. The following eligibility and enrollment requirements are *in addition* to those detailed in this Evidence of Coverage (EOC), Eligibility and Enrollment section:

ELIGIBILITY AND ENROLLMENT

Eligible Dependents

Dependent is any spouse, including those defined as common-law under the state, Same Gender Domestic Partner (a.k.a. Spousal Equivalent), or child meeting the Dependent Age Limits, below (including a step-child, child for whom the Insured Employee, his/her spouse, or his/her Same Gender Domestic Partner (a.k.a. Spousal Equivalent) is required by a qualified medical child support order to provide health care coverage (even if the child does not reside at the same legal residence of the parent), a child for whom you or your spouse has court-ordered custody, or adopted child or child placed for adoption), or unmarried incapacitated and physically disabled children who are legal dependents of the Insured Employee or legal dependents of a Same Gender Domestic Partner (a.k.a. Spousal Equivalent), of an Insured Employee, who meet the eligibility requirements set forth in the Summary Plan Description and Disclosure Form and for whom applicable Dues are received.

Dependent Child Age Limits: A child shall be covered to the end of the year that he/she turns age 26 and unmarried legal dependents who are mentally or physically disabled shall be covered regardless of age, all of whom must also be legal dependents of the Insured Employee or of a Same Gender Domestic Partner (a.k.a. Spousal Equivalent).

Same Gender Domestic Partner (a.k.a. Spousal Equivalent) is defined as an adult of the same gender who shares an emotional, physical, and financial relationship with the employee, similar to that of a spouse. A Subscriber of the group may enroll a sole Same Gender Domestic Partner (a.k.a. Spousal Equivalent) of the same sex and children of the sole Same Gender Domestic Partner (a.k.a. Spousal Equivalent) as Eligible Dependents. A sole Same Gender Domestic Partner (a.k.a. Spousal Equivalent) is a person who meets the following requirements for eligibility:

- Is 18 years of age or older;
- Is mentally competent to consent to contract;
- Has an exclusive, committed relationship with the Subscriber with the intent for the relationship to last indefinitely;
- Shares basic living expenses with the Subscriber;
- Is unmarried; and
- Is not related by blood to the Subscriber such as a parent, brother, sister, half brother, half sister, niece, nephew, aunt, uncle, grandparent or grandchild.

II. The following requirements regarding Domestic Partnership coverage supersede those detailed in the Domestic Partner rider found at the end of this Evidence of Coverage (EOC) booklet:

The Subscriber and the sole Same Gender Domestic Partner (a.k.a. Spousal Equivalent) must complete an affidavit of Domestic Partnership confirming the following information:

- The partners have an exclusive, committed relationship and hold ourselves out as committed partners;
- Both partners share basic living expenses with the intent for the relationship to last indefinitely;
- Are both 18 years of age or older;
- Neither partner is married;
- Neither partner is related by blood to the other as described above; and
- Neither partner has had a different domestic partner within six (6) months of filing with the employer a statement of termination of domestic partnership.

The Affidavit of Domestic Partnership is available through the Group's Benefit Manager and will be maintained by the employer. The Employee agrees to immediately notify the employer in writing if there is any change of circumstances attested to in the Affidavit.

III. The following information is added and becomes part of this Evidence of Coverage (EOC):

Employee Eligibility. An Eligible Member is a retired classified member of the Denver Fire Department (Group), who is age 65 or older and who is eligible for Medicare ("Retiree"), and who meets any other eligibility requirements of the Group. Retirees must live in the Service Area.

The following conditions of enrollment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the attached Evidence of Coverage brochure. To the extent that any of the following conditions contradict those stated in the attached Evidence of Coverage brochure, the following shall prevail:

Eligibility Rules: No waiting period

Please NOTE that while active Fire Fighters can live or work in the Service Area, Retirees MUST live in the Service Area.

DENVER FIRE DEPARTMENT
NON-MEDICARE EMPLOYEES

EVIDENCE OF COVERAGE AMENDMENT - 2014

I. The following eligibility and enrollment requirements are *in addition* to those detailed in this Evidence of Coverage (EOC), Eligibility and Enrollment section:

ELIGIBILITY AND ENROLLMENT

Eligible Dependents

The following persons qualify as **Dependents**:

- Any spouse, including those defined as common-law in the state and Same Gender Domestic Partners (a.k.a. Spousal Equivalent).
- Any child meeting the Dependent Age Limits. This includes:
    - A step-child;
    - A child for whom the Insured Employee or his/her spouse is required by a qualified medical child support order to provide health care coverage;
    - A child for whom you or your spouse has court-ordered custody;
    - An adopted child;
    - A child placed for adoption; or
    - An unmarried incapacitated and physically disabled child who is a legal dependents of the Insured Employee or his/her spouse, who meets the eligibility requirements set forth in the Summary Plan Description and Disclosure Form and for whom applicable Dues are received.

The following persons qualify as **Same Gender Domestic Partners (a.k.a. Spousal Equivalent)**:

- An adult of the same gender who shares an emotional, physical, and financial relationship with the employee, similar to that of a spouse, who:
    - Is 18 years of age or older;
    - Is mentally competent to consent to contract;
    - Has an exclusive, committed relationship with the subscriber with the intent for the relationship to last indefinitely;
    - Shares basic living expenses with the Subscriber;
    - Is unmarried; and
    - Is not related by blood to the Subscriber such as a parent, brother, sister, half brother, half sister, niece, nephew, aunt, uncle, grandparent or grandchild.
- A subscriber of the group may enroll a sole Same Gender Domestic Partner (a.k.a. Spousal Equivalent) of the same sex and children of the sole Same Gender Domestic Partner (a.k.a. Spousal Equivalent) as Eligible Dependents.

Dependent Child Age Limits:

- A dependent shall be covered to the end of the month that he/she turns age 26.
- Unmarried legal dependents who are mentally or physically disabled shall be covered regardless of age.

II. The following requirements regarding Domestic Partnership coverage supersede those detailed in the Domestic Partner rider found at the end of this Evidence of Coverage (EOC) booklet:

The subscriber and sole Same Gender Domestic Partner (a.k.a. Spousal Equivalent) must complete an **Affidavit of Domestic Partnership** confirming the following information:

- The subscriber and his/her partner have an exclusive, committed relationship and hold themselves out as committed partners;
- Both partners share basic living expenses with the intent for the relationship to last indefinitely;

- Both partners are 18 years of age or older;
- Neither partner is married;
- Neither partner is related by blood to the other such as a parent, brother, sister, half sister, niece, nephew, aunt, uncle, grandparent or grandchild; and
- Neither partner had a different domestic partner within six (6) months of filing with the employer a statement of termination of domestic partnership.

The Affidavit of Domestic Partnership is available through the Group's Benefit Manager and will be maintained by the employer. The Employee agrees to immediately notify the employer in writing if there is any change of circumstances attested to in the Affidavit.

III. The following information is added and becomes part of this Evidence of Coverage (EOC):

Employee Eligibility. The following persons qualify to be Eligible Members:

- A classified member of the Denver Fire Department;
- A retired classified member of the Denver Fire Department who is:
    - Under age 65;
    - Not eligible for Medicare; and
    - Meets any other eligibility requirements of the Denver Fire Department; or
- A member who is not retired, but is defined as an employee under State and Federal Law.

Residence Requirements:

- Active employees must live or work in the Service Area.
- Inactive employees must live in the Service Area.
- Retirees who select the HMO or Triple Option must live in the Service Area.; and
- Retirees who live out of the Service Area are only eligible for the out-of-network option.

Additional Requirements for Classified Members of the Denver Fire Department: The following conditions of enrollment and eligibility shall be applicable to subscribing classified members of the Denver Fire Department, in addition to the conditions specified above and in the attached Evidence of Coverage brochure. If any of the following conditions contradict those stated in the attached Evidence of Coverage brochure, the conditions stated here shall prevail:

- **Eligibility for New Hires**: No new hire waiting period.
- **Coverage Effective Date for New Hires**: Coverage is immediate.
- **Standard Leave of Absence**.
    - A member who elects to take an authorized Standard Leave of Absence may be eligible for coverage as permitted by Civil Service Rules.
    - For non-medical leaves over 30 days, the employee must elect COBRA in order to continue coverage.

EXHIBIT B

TO 2014
LARGE GROUP
GROUP AGREEMENT

Certificate of Liability Insurance

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 01/01/2014

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
MARSH RISK & INSURANCE SERVICES
345 CALIFORNIA STREET, SUITE 1300
CALIFORNIA LICENSE NO. 0437153
SAN FRANCISCO, CA 94104

10171-CO-CAS-2015 GL CO

CONTACT NAME:
PHONE (A/C, No, Ext): **FAX (A/C, No):**
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Safety National Casualty Corp.	15105
INSURER B : N/A	N/A
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
KAISER FOUNDATION HEALTH PLAN OF COLORADO
KAISER FOUNDATION HOSPITALS
10350 EAST DAKOTA AVENUE
DENVER, CO 80231

COVERAGES **CERTIFICATE NUMBER:** SEA-002364890-17 **REVISION NUMBER:** 4

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY	X		GL4048017	01/01/2014	01/01/2015	EACH OCCURRENCE	$ 10,000,000
	[X] COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 1,000,000
	[ ] CLAIMS-MADE [X] OCCUR						MED EXP (Any one person)	$ 10,000
							PERSONAL & ADV INJURY	$ 10,000,000
							GENERAL AGGREGATE	$ 10,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$ 10,000,000
	[ ] POLICY [ ] PRO-JECT [ ] LOC							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	[ ] ANY AUTO						BODILY INJURY (Per person)	$
	[ ] ALL OWNED AUTOS [ ] SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	[ ] HIRED AUTOS [ ] NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	[ ] UMBRELLA LIAB [ ] OCCUR						EACH OCCURRENCE	$
	[ ] EXCESS LIAB [ ] CLAIMS-MADE						AGGREGATE	$
	[ ] DED [ ] RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						[ ] WC STATU-TORY LIMITS [ ] OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] (Mandatory in NH)	N/A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

THE CITY AND COUNTY OF DENVER ARE ADDITIONAL INSUREDS UNDER THE GENERAL LIABILITY POLICY SOLELY AS RESPECTS WORK PERFORMED BY OR FOR THE NAMED INSURED IN CONNECTION WITH THE CONTRACT AGREEMENT.

CERTIFICATE HOLDER

CITY AND COUNTY OF DENVER
CAREER SERVICE AUTHORITY (CSA)
201 WEST COLFAX AVENUE, DEPARTMENT 412
DENVER, CO 80202

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh Risk & Insurance Services

Myrna Lee