Agreement Signature Page

Acceptance of *Agreement*

Group acknowledges acceptance of this *Agreement* by signing the Signature Page and returning it to Health Plan. If Group does not return it to Health Plan, Group will be deemed as having accepted this *Agreement* if Group pays Health Plan any amount toward Dues.

Group may **not** change this *Agreement* 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. Health Plan will issue a new *Agreement* or amendment if Health Plan and Group agree on any changes.

Binding Arbitration

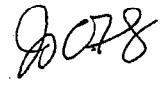
Disputes between Members, their heirs, or associated parties (on the one hand) and Health Plan, its health care providers, or other associated parties (on the other hand) for alleged violation of any duty arising out of or related to this *Agreement*, including any claim for medical or hospital malpractice,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

- Claims within the jurisdiction of Small Claims Court
- Claims subject to a Medicare appeals procedure as applicable to Kaiser Permanente Senior Advantage and Medicare Cost Members
- If the Member's Group must comply with the Employee Retirement Income Security Act (ERISA) requirements, the claim is a benefit-related request that constitutes a "benefit claim" in Section 502(a)(1)(B) of ERISA. Note: Benefit claims under this Section of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor regulation prohibiting mandatory binding arbitration of this category of claim (29 CFR 2560.503-1(c)(4)) is modified, amended, repealed, superseded, or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without further notice

Signatures

PAUL HACKLEMAN, BENEFITS MGR
SAN MATEO COUNTY
455 COUNTY CTR PMB 133
REDWOOD CITY, CA 94063-1663

Kaiser Foundation Health Plan, Inc.
Northern California Region
1950 Franklin Street
Oakland, CA 94612



Authorized Group officer signature

Jerry Fleming
Authorized officer
Senior Vice President and Health Plan Manager

Please print your name and title

Executed in Oakland, CA effective 1/1/03
Date: 11/23/02

Date signed

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

2003 *Group Agreement* Summary of Changes and Clarifications

The following is a summary of the most important changes and clarifications that we have made to the enclosed 2003 *Group Agreement*, including the *Evidence of Coverage (EOC)* document(s). This summary does not include any changes we may have made at your Group's request. Please refer to the "Dues" section in the *Group Agreement* for the dues that are effective on your Group's renewal anniversary date.

Unless otherwise indicated, the changes will be effective on your Group's renewal anniversary date and apply to each type of coverage you have purchased. Please read the *Group Agreement* for the complete text of these changes, as well as non-substantive changes not listed in the summary below.

Participation Requirements

We have added the following new participation requirement: Groups must meet all Health Plan underwriting requirements set forth in the *Underwriting Requirements and Assumptions* document.

Renewability and Amendments

Under the "Renewability" section of the *Group Agreement*, we have added that we will send a new *Agreement* 30 days prior to the Group's anniversary date. If we renew the *Agreement* pursuant to the "Amendment of *Agreement*" section, we will send the amendment 30 days prior to the Group's anniversary date.

We have clarified in the "Other Amendments" section that we may amend Group's *Agreement* at any time by giving written notice to Group, in order to (a) address any law or regulatory requirement, which may include amending dues to reflect an increase in costs to Health Plan or Plan Providers (or any of their activities), (b) expand the Health Plan Service Area, or (c) increase any benefits of any Medicare product approved by the Centers for Medicare and Medicaid Services (CMS), if applicable to Group's *Agreement*.

Evidence of Coverage (EOC) Changes and Clarifications

Each *Evidence of Coverage* incorporated into the *Group Agreement* contains a description of benefits and coverage. The following is a summary of the most important changes and clarifications that have been made to the *Evidence of Coverage* documents.

Copayment changes

Allergy tests. Allergy testing visits will be provided at the provider office visit copayment. This increases the copayment for allergy testing visits.

Billing for copayments. We have clarified that copayments are due when members receive the service, but for items ordered in advance, the copayment will be the copayment in effect on the order date (though we will not cover the item unless the member still has coverage for it on the date he or she receives it). Also, in some cases, we may agree to bill a member for a copayment. We have increased the amount we charge for billing for copayments from $5 to $13.50.

Health education. We cover a variety of health education programs to help protect and improve the health of members, including programs for smoking cessation, stress management, and chronic conditions (such as diabetes and asthma). The copayment for covered group health education visits has been eliminated.

Imaging, laboratory, and special procedures. Any *Evidence of Coverage* with a $3 or $4 copayment for imaging, laboratory, and special procedures will be changed to $5.

Optical. If the *Evidence of Coverage* includes optical coverage as described under "Vision Services" in the "Benefits" section, we will provide an allowance toward the price of eyeglass lenses, frames, and contact lenses

every 24 months. We will not provide the allowance if we have covered lenses or frames within the previous 24 months. Also, the allowance can only be used at the initial point of sale. If members do not use all of their allowance at point of sale, they cannot use it later. Members pay the difference between the allowance and the price of the eyewear. Besides the Kaiser Permanente Senior Advantage-MSP *EOC*, the following *Evidence of Coverage* document(s) include this optical benefit:

Evidence of Coverage and EOC#	**Allowance**
Senior Advantage *EOC* #2	$150
Medicare Cost *EOC* #11	$175
Medicare Out-of-Area plan *EOC* #14	$175

Other Copayments. The following copayments will be effective on your Group's renewal anniversary date (please refer to the "Copayments" section of the *Evidence of Coverage* for other copayments that are effective at renewal).

Evidence of Coverage	**Provider office visit**	**Prescription Drugs**	**ER visit**	**DME/P&O**	**Ambulance**
Traditional Plan *EOC* #1	$10	$5 generic $15 brand	$50	20%	$50
Senior Advantage *EOC* #2	$10	$10	$20	$0	$0
Medicare Cost *EOC* #11	$10	$10	$35	$0	$0
Medicare Out-of-Area plan *EOC* #14	$10	$10	$35	$0	$0

Note: No action is necessary if your Group is satisfied with all the copayments listed above. If your Group wants to change any of the copayments listed, please contact your Health Plan account manager immediately to discuss.

Drug plan

Outpatient prescription drug plans have been revised as follows:

- Compounded products will not be covered unless the product is listed on the drug formulary, or one of the ingredients requires a prescription by law. For compounded products that are covered, the copayment is the same as brand-name drugs
- Drugs to shorten the duration of the common cold will not be covered
- If a drug for which a prescription is required by law is no longer covered, and we had been covering and providing it to a member for a use approved by the FDA, we will continue to provide the drug to that member upon payment of 50 percent of Charges if a Plan Physician continues to prescribe the drug for the same condition (see "Terminology (defined terms)" below for the meaning of Charges)
- We will not cover any requested packaging (such as dose packaging), other than the dispensing pharmacy's standard packaging
- The day supply dispensed at the copayment for outpatient drugs may be reduced if the pharmacy limits the amount dispensed because the drug is in limited supply in the market
- Smoking cessation drugs will no longer be limited to just one course of treatment per year. They will be provided at the copayment when medically necessary and if the member is participating in a smoking cessation behavioral modification class

Durable medical equipment and prosthetics and orthotics

The copayments for prosthetics/orthotics and durable medical equipment will be made the same if they are currently different (for most Groups they are already the same).

When the copayment for durable medical equipment is 20% of Charges, the following applies:

- The copayment for repair and replacement of durable medical equipment is also 20% of Charges
- For Traditional Plan members, external sexual dysfunction devices, if covered, will be provided at 50% of Charges (see "Terminology (defined terms)" below for the meaning of Charges)

- The copayment for ostomy and urological supplies will be changed to equal the prosthetics/orthotics and DME copayment, which is 20% of Charges (see "Terminology (defined terms)" below for the meaning of Charges)

Eligibility

The "Who Is Eligible" and "Conversion of Group Membership to an Individual Plan" sections of the Traditional Plan *Evidence of Coverage* have been revised to address a new eligibility requirement. The new requirement is that persons who live in or move to the service area of a Region outside California will not be eligible for membership, or conversion of membership, under this *Group Agreement* (unless they are one of the exceptions listed below).

Region means a Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. For the purposes of this eligibility rule, these non-California service areas may change on January 1 of each year and are currently the District of Columbia and parts of Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington.

We will terminate the memberships of any such members effective on your Group's renewal date. These members may be able to enroll in the new service area if there is an agreement with your Group in that area. However, eligibility requirements, benefits, dues, and copayments may not be the same in the other service area. Please contact your Health Plan account manager for information about establishing an agreement in a service area outside California.

Exceptions —This restriction does not apply to the following persons:

- Members who are eligible because of COBRA or USERRA coverage
- The subscriber's or the subscriber's spouse's children who are attending an accredited college or vocational school
- A dependent whom the subscriber or subscriber's spouse is required to cover pursuant to a Qualified Medical Child Support Order

Note: In accord with CMS requirements, Kaiser Permanente Senior Advantage or Medicare Cost members cannot live anywhere outside the Service Area unless they were enrolled and lived outside our Service Area on December 31, 1998.

In addition, we have clarified for consistency that an adopted child includes a child who has been placed with the adoptive parents for adoption.

Emergency, urgent, and routine care

We have created a new section devoted to emergency, urgent, and routine care to better explain these three types of care, and more. This section explains how to obtain care and provides coverage information about emergency care and Out-of-Area urgent care received from non–Plan Providers, which was previously discussed in the "Benefits" section. Please read this new section, as it is essential to understanding how care is provided.

Special note about post-stabilization care. The Traditional Plan *Evidence of Coverage* previously stated that we did not cover care received from non–Plan Providers in an emergency after the member could, without medically harmful results, be moved to a facility we designated (this care is known as post-stabilization care). Please be aware that the *Evidence of Coverage* now states that we will cover post-stabilization care if we authorize it (the telephone number to request authorization is on the back of Health Plan ID cards). Please refer to the "Emergency, Urgent, and Routine Care" section in the *Evidence of Coverage* for coverage information.

Exclusions, limitations, coordination of benefits, and reductions

The following changes have been made to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section:

- If an *Evidence of Coverage* includes the Coordination of Benefits (COB) provision, the title of this section has been changed to include COB for ease of reference. This is in response to feedback we received from Groups who had difficulty locating the COB section. Also, the COB description has been simplified

- The dental care exclusion has been revised. The exclusion does not apply to evaluation, extraction, dental X-rays, or fluoride treatment, if a Plan Physician refers the member to a dentist to prepare their jaw for radiation treatment of cancer
- The following subjects have been moved from the "Exclusions" section to the "Reductions" section:
  - employer requirements
  - government agencies
  - military service
  - workers' compensation or employer's liability
- We have added an exclusion for hair loss or growth treatment
- The surrogacy exclusion has been revised to clarify that we do cover otherwise-covered services to a member who is a surrogate. We have added to the "Reductions" section a requirement that members reimburse us for certain services we covered. The member's obligation is limited to the compensation a member is entitled to receive under a surrogacy arrangement
- We have removed the limitation relating to members who refuse to accept services recommended by their Plan Physician. We will provide services as Medically Necessary and covered under the *Evidence of Coverage*

How to obtain services

The "How to Obtain Services" section has been revised to provide additional information about referrals, second opinions, and authorization procedures. The topic "Contracts with Plan Providers" has been moved into this section from the "Miscellaneous Provisions" section and the information about pregnancies has been revised in the discussion about terminated providers. The paragraph "Moving Outside our Service Area" has been deleted, as it is now addressed in the "Who Is Eligible" section (except for the Medicare Out-of-Area plan).

Kaiser Permanente Senior Advantage capacity limit

We will not be able to enroll new members into Senior Advantage if the applicant isn't already a member and he or she resides in an area in which we have reached a capacity limitation approved by the federal Centers for Medicare & Medicaid Services (CMS). This limitation does not apply to existing members who are eligible for Medicare (including when they turn age 65).

Mental health

We have deleted the mental health exclusions in the "Benefits" section because they are unnecessary.

Physical, occupational, and speech therapy and multidisciplinary rehabilitation services

In the Traditional Plan *Evidence of Coverage*, we have deleted the reference to a two-month limit because we provide physical, occupational, and speech therapy and multidisciplinary rehabilitation services when Medically Necessary. Also, we have deleted the limitation that speech therapy is limited to treatment for communication and swallowing impairments of specific organic origin, as it is unnecessary (we cover services that are Medically Necessary).

Requests for payment or services and dispute resolution

We have revised the *Evidence of Coverage* in accord with federal and state law. The revision addresses new disclosure requirements and response times required under ERISA if applicable to the *Evidence of Coverage* (ERISA dispute resolution requirements don't apply to Medicare plans). Please read the "Requests for Payment or Services" and "Dispute Resolution" sections of the *Evidence of Coverage.*

Arbitration. The arbitration provision has been revised to state that ERISA "benefit claims" are not subject to binding arbitration (unless the regulation is later changed to allow binding arbitration of these claims). This exception to the binding arbitration requirement only applies to members of Groups that must comply with the Employee Retirement Income Security Act (ERISA) requirements. The "Binding Arbitration" section that was formerly in the "Appendix" has been moved into the "Dispute Resolution" section for ease of reference. You will also notice that the "Appendix" has been removed, as it is no longer necessary.

Termination for cause

We have revised our termination for cause provision as follows:

- We have revised the subject addressing disruptive and unruly members for clarity. We will terminate a membership if the member's behavior threatens the safety of Plan personnel, or of any person or property at a Plan Facility
- We have deleted the bullet that stated a membership could be terminated if the member failed to establish and maintain a satisfactory provider-patient relationship
- If a dependent commits one of the acts stated in the "Termination for Cause" section, we will no longer terminate the memberships of everyone in the family unit. We will terminate the membership of the dependent who committed the act

Terminology (defined terms)

The following new terms have been added to the "Definitions" section for clarity:

- Charges, which replaces "Non-Member Rates." Charges means either (1) for Services for which the provider was compensated on a capitation basis, the charges in the provider's schedule of charges for Services provided to the general public (or, for Members, the provider's schedule of charges for Services provided to Members, if different), (2) for items covered under "Drugs, supplies, and supplements" and obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item, or (3) for all other Services, the payments that Kaiser Permanente made for the Services
- Clinically Stable
- Emergency Care
- Emergency Medical Condition
- Medically Necessary
- Out-of-Area Urgent Care
- Post-stabilization Care
- Region, which replaces "Division"
- Services
- Service Area includes zip code revisions

Transplants

We have clarified the transplant benefit description in the "Benefits" section of the *Evidence of Coverage* to better explain that we cover certain transplants at non–Plan facilities upon Medical Group's referral to the facility.

Uniformed services employment and reemployment rights act (USERRA)

We have added information to the "Termination of Membership" section explaining that members may continue group coverage as required by the federal USERRA law if they have been called to active duty in the uniformed services.

Other *Evidence of Coverage* changes

Each *Evidence of Coverage* has been revised, as appropriate, to comply with applicable law:

- SB 37—We have added a new benefit description to the *Evidence of Coverage:* "Services Associated with Clinical Trials." We have always covered Medically Necessary services associated with Plan clinical trials. This new benefit description acknowledges that coverage is in accord with applicable law. This change does not apply to the Kaiser Permanente Senior Advantage *Evidence of Coverage* because clinical trials services continue to be covered by Medicare directly
- AB 892—The description of hospice coverage in the "Benefits" section has been revised further to comply with state law
- HIPAA—We have revised our "Privacy practices" notice in the "Miscellaneous Provisions" section to comply with new disclosure requirements under HIPAA
- AB 1503—The "Notice to New Enrollees about Continuity of Care" in the *Evidence of Coverage* has been revised to include acute, serious, or chronic psychiatric conditions

Enrollment Unit Chart

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

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

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

Contract name:	SAN MATEO COUNTY - ACTIVE
Purchaser ID:	7056
Contract:	1
Version:	24

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

Enrollment unit number: 0 **Name:** SAN MATEO COUNTY - ACTIVES
Billing contact: ATTN: FILOMENA VIVEIROS

Contract option ID/EOC #	Product/contract option names
1	KAISER PERMANENTE TRADITIONAL PLAN / KAISER PERMANENTE TRADITIONAL PLAN
2	KAISER PERMANENTE SENIOR ADVANTAGE / KAISER PERMANENTE SENIOR ADVANTAGE
3	KAISER PERMANENTE SENIOR ADVANTAGE (MSP) / WORKING AGED RISK
11	KAISER PERMANENTE MEDICARE COST / KAISER PERMANENTE MEDICARE COST
14	MEDICARE OUT-OF-AREA PLAN / MED OOA NCR

Enrollment unit number: 7000 **Name:** SAN MATEO COUNTY - COBRA
Billing contact: FILOMENA VIVEIROS

Contract option ID/EOC #	Product/contract option names
1	KAISER PERMANENTE TRADITIONAL PLAN / KAISER PERMANENTE TRADITIONAL PLAN
2	KAISER PERMANENTE SENIOR ADVANTAGE / KAISER PERMANENTE SENIOR ADVANTAGE
3	KAISER PERMANENTE SENIOR ADVANTAGE (MSP) / WORKING AGED RISK
11	KAISER PERMANENTE MEDICARE COST / KAISER PERMANENTE MEDICARE COST
14	MEDICARE OUT-OF-AREA PLAN / MED OOA NCR