2004 *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 2004 *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 changes not listed in the summary below.

Group Contribution and Participation

We have added the following contribution and participation requirements to the Group Agreement, which are in addition to the ones stated in the *Requirements and Rate Assumptions.* Group must:

- Not hold open enrollment for 2005 until Group receives its 2005 Dues and coverage information from us. If Group holds the open enrollment without receiving 2005 Dues and coverage information, we may change Dues and coverage (including benefits, Copayments, and Coinsurance) when we issue Group's 2005 *Group Agreement*
- Ensure that at least 70 percent of eligible employees are covered by a group health care plan
- Ensure that all employees enrolled in Health Plan are covered by workers' compensation or the employer's liability benefits, unless not required by law to be covered

Notices

We have moved the mailing address for providing notices under this *Agreement* from the Signature Page to the "Notices" section.

Other Amendments

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 (we will give Group 30 days prior written notice of any such Dues increase), or (b) increase any benefits of any Medicare product approved by the Centers for Medicare and Medicaid Services (CMS), if applicable to this *Agreement*.

Retroactive Membership Changes and Retroactivity

We have clarified our provision on reporting membership changes: Group must report membership changes (including sending appropriate membership forms) within the time limit for retroactive changes. The time limit for retroactive membership changes is the calendar month when Health Plan's California Service Center receives Group's notice of the change plus the previous two months.

Evidence of Coverage (EOC) Changes and Clarifications

Each *Evidence of Coverage* document that is 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.

Benefit and Copayment changes

Please refer to the "Benefits" section in the *Evidence of Coverage* for benefit descriptions and the "Copayment and Coinsurance" section for the amount members must pay for covered benefits. Benefits are also subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section.

revised the list of persons who are not subject to this limitation. The following persons are not ineligible solely because they live in a service area of a Region outside California (changes are underlined): (1) a Subscriber who works inside our Service Area, (2) the Subscriber's or the Subscriber's Spouse's children, and (3) Members who are eligible under this *EOC* because of COBRA, Cal-COBRA, or USERRA coverage

- The following persons are barred from enrollment (changes are underlined):
  - persons who have had their entitlement to receive Services through Health Plan either rescinded or terminated for cause cannot enroll
  - persons who had entitlement to receive Services through Health Plan terminated for failure to pay [illegible] failure to pay any amounts owed to Health Plan or a Plan Provider cannot enroll, unless we agree to allow you to enroll after you pay all amounts owed by you and your dependents
- We have clarified that a Subscriber may enroll an otherwise-eligible child in response to a court or administrative order requiring the Subscriber to provide health coverage for the child

Exclusions, limitations, coordination of benefits, and reductions

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

- We clarified that when a service is not covered, all services related to the noncovered service are excluded, except that this exclusion does not apply to services we would otherwise cover to treat complications of the noncovered service
- We have deleted the exclusion for services not available within our Service Area
- We have added that speech therapy services to treat social, behavioral, or cognitive delays in speech or language development are not covered unless Medically Necessary
- We have revised the "Limitations" section to state that we will do our best to provide or arrange for our Members' health care needs in the event of unusual circumstances that delay or render impractical the provision of Services under this *EOC*, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor disputes.

How to obtain services and Plan Facilities

We have clarified the "How to Obtain Services" section to provide additional information about Medical Group authorization procedures. We have created a new section called "Plan Facilities," which lists all Plan Hospitals and most Plan Medical Offices. Also, the "Definitions" section has also been revised to address the new section in the definitions of Plan Hospital, Plan Medical Office, Plan Provider, Plan Facilities, and Plan Pharmacy.

Post-stabilization care

We have clarified the description of post-stabilization care to include more information about medically necessary transportation. Please refer to the "Emergency, Urgent, and Routine Care" section in the *Evidence of Coverage* for coverage information.

Requests for payment or services and dispute resolution

In the Traditional Plan *Evidence of Coverage*, we have clarified when members may ask the Department of Managed Health Care for assistance and we have revised the description of Independent Medical Review for clarity. Effective July 1, 2003, members may file a grievance through our Web site at *www.members.kp.org*. Also, we have clarified who may file a grievance. For Senior Advantage members, we have added information about expedited grievances.

Termination for cause

We have revised our termination for cause provision as follows:

- We have clarified that a membership may be terminated for cause if the member commits theft from Health Plan, from a Plan Provider, or at a Plan Facility
- We have clarified the termination effective date
- We may report fraud and other illegal acts to the authorities for prosecution

Termination for nonpayment of other charges

We revised this provision to say that we may terminate membership if a member fails to pay any amount that he or she owes Health Plan or a Plan Provider. We will send written notice of the termination to the Subscriber at

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:	26

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 / TRADITIONAL PLAN
2	KAISER PERMANENTE SENIOR ADVANTAGE / SENIOR ADVANTAGE
3	KAISER PERMANENTE SENIOR ADVANTAGE (MSP) / WORKING AGED RISK
11	KAISER PERMANENTE MEDICARE COST / MEDICARE COST GROUP MEMBERSHIP
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 / TRADITIONAL PLAN
2	KAISER PERMANENTE SENIOR ADVANTAGE / SENIOR ADVANTAGE
3	KAISER PERMANENTE SENIOR ADVANTAGE (MSP) / WORKING AGED RISK
11	KAISER PERMANENTE MEDICARE COST / MEDICARE COST GROUP MEMBERSHIP
14	MEDICARE OUT-OF-AREA PLAN / MED OOA NCR

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

SAN MATEO COUNTY

____
Authorized Group officer signature

____
Please print your name and title

____
Date signed

Kaiser Foundation Health Plan, Inc.
Northern California Region

Jerry Fleming
Authorized officer
Senior Vice President and Health Plan Manager

Executed in San Diego, CA effective 1/1/04
Date: 10/21/03

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.