CONSENT AGENDA

AGENDA ITEM 12.06
TO: Mayor and City Council

FROM: Teresia Haase, Director of Human Resources

SUBJECT: AUTHORIZE THE CITY MANAGER TO EXECUTE AN AGREEMENT BETWEEN THE CITY OF STOCKTON AND KAISER FOUNDATION HEALTH PLAN, INC.

RECOMMENDATION

It is recommended that the City Council authorize by motion the City Manager to execute a contract between the City of Stockton and Kaiser Foundation Health Plan, Inc. (Kaiser Permanente) and authorize the City Manager to take whatever actions are appropriate to implement the contract.

Summary

The City Council has previously adopted Memorandums of Understanding (MOU) with the following employee organizations where the parties agreed to provide a second alternative plan to the City’s Modified Medical Plan. These groups are Fire, Fire Management, OE3 Water Supervisors, OE3 Operations and Maintenance, OE3 Trades and Maintenance, B&C (Mid Management), SPMA and the unrepresented employees unit. This alternative plan does not apply to retirees, the POA or SCEA employee groups.

The contract before you tonight formalizes these MOU provisions on the addition of a lower cost HMO fully-insured medical plan as an alternative to the City’s self-funded PPO plan. Council had previously authorized the City’s health plan consultant and labor team to identify and negotiate a more cost-effective health plan alternative as part of the City Council Action Plan for Fiscal Sustainability.

The City has recently implemented contribution caps towards medical benefits. The Kaiser Permanente Deductible HMO Plan is an alternative plan which provides coverage for employees and their families at minimal to no premium cost to the employee above the City’s current contribution limits.

DISCUSSION

Background

Historically, the City of Stockton has offered its employees one medical plan, the Modified Employee Medical Plan. This self-funded medical plan was established on May 1, 1988.
AUTHORIZE THE CITY MANAGER TO EXECUTE AN AGREEMENT BETWEEN THE CITY OF STOCKTON AND KAISER FOUNDATION HEALTH PLAN, INC.

(Please 2)

Present Situation

Council authorized the labor relations team to negotiate an alternative to the City’s self-funded medical plan. The intent was to offer employees a plan with little or no employee contribution toward the monthly premium cost. The City’s health plan consultant reviewed available options for an alternative second fully-insured plan which could be offered at a lower cost, and recommended the Kaiser Permanente Deductible Health Maintenance Organization (HMO) plan. Several informational meetings were held with employees regarding the new Kaiser plan benefits and proposed premiums, and an abbreviated open enrollment was conducted in August to allow eligible interested employees who wished to move to the Kaiser HMO plan to do so effective September 1, 2011. This plan does not cover retirees or organizations that have not agreed to the additional plan.

This agenda item asks the Council to approve the contract with the Vendor, Kaiser Foundation Health Plan, Inc. in order to implement the MOU provisions. The Kaiser group agreement covers six plans offered by Kaiser, at this time the City is only implementing plan six, which is the Kaiser Permanente Deductible HMO Plan. Attachment A is the group agreement and the Evidence of Coverage for the selected plan which provides the detailed schedule of benefits provided under the high-deductible HMO plan.

FINANCIAL SUMMARY

This agreement establishes rates, effective September 1, 2011, through December 31, 2012, between Kaiser Foundation Health Plan, Inc. and the City of Stockton. Premium rates are noted below:

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Employer Contribution</th>
<th>Employee Contribution</th>
<th>Total Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$481.00</td>
<td>$0.00</td>
<td>$479.76</td>
</tr>
<tr>
<td>Employee + One</td>
<td>$875.00</td>
<td>$1.52</td>
<td>$876.52</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$1,165.00</td>
<td>$0.00</td>
<td>$1,164.38</td>
</tr>
</tbody>
</table>

Currently, 85 employees have elected to enroll in the City’s Kaiser plan. The City will be conducting the normal open enrollment process in November for changes effective January 1, 2012, and the Kaiser enrollment number may change. The City’s
AUTHORIZE THE CITY MANAGER TO EXECUTE AN AGREEMENT BETWEEN THE CITY OF STOCKTON AND KAISER FOUNDATION HEALTH PLAN, INC. (Page 3)

Kaiser contract cost is $75,000-$83,000/month. As evidenced by the premium rates above, this alternative plan currently provides medical coverage to employees and their families at little or no out-of-pocket premium cost contribution by the employee.

Respectfully submitted,

[Signature]

TERESIA HAASE
DIRECTOR OF HUMAN RESOURCES

APPROVED:

[Signature]

LAURIE MONTES
DEPUTY CITY MANAGER

BD/TH/TRM

Attachment A: Kaiser Group Agreement and Evidence of Coverage for the Kaiser Permanente Deductible HMO Plan
Group Agreement for
CITY OF STOCKTON

Group ID: 603693  Contract: 1  Version: 1

September 1, 2011, through December 31, 2012
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Introduction

This Group Agreement (Agreement), including the Evidence of Coverage (EOC) document(s) listed below, the group application that Group submitted to Health Plan, and any amendments to any of them, all of which are incorporated into this Agreement by reference, constitute the contract between Kaiser Foundation Health Plan, Inc., (Health Plan) and CITY OF STOCKTON (Group). In this Agreement, some capitalized terms have special meaning; please see the "Definitions" section in the EOC document(s) for terms you should know. Pursuant to this Agreement, Health Plan will provide covered Services to Members in accord with the following EOC document(s):

<table>
<thead>
<tr>
<th>Product name</th>
<th>Contract option name</th>
<th>EOC #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser Permanente Senior Advantage (HMO) with Part D</td>
<td>Sr Adv Grp HMO NCR</td>
<td>1</td>
</tr>
<tr>
<td>Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage</td>
<td>NCR Work Aged Assign</td>
<td>2</td>
</tr>
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<td>Kaiser Permanente Traditional Plan</td>
<td>Traditional HMO NCR</td>
<td>3</td>
</tr>
<tr>
<td>Kaiser Permanente Senior Advantage (HMO) with Part D</td>
<td>DHMO Sr Adv Grp Hmo NCR</td>
<td>4</td>
</tr>
<tr>
<td>Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage</td>
<td>DHMO NCR Work Aged Assign</td>
<td>5</td>
</tr>
<tr>
<td>Kaiser Permanente Deductible HMO Plan</td>
<td>DHMO NCR</td>
<td>6</td>
</tr>
</tbody>
</table>

Term of Agreement and Renewal

Term of Agreement

Unless terminated as set forth in the "Termination of Agreement" section, this Agreement is effective from September 1, 2011, through December 31, 2012.

Renewal

This Agreement does not automatically renew. If Group complies with all of the terms of this Agreement, Health Plan will offer to renew the Agreement, upon 60 days prior written notice to Group, by doing one of the following:

• Providing Group with a new Group Agreement to become effective immediately after termination of this Agreement
• Extending the term of this Agreement and making other changes pursuant to "Amendments Effective on January 1 (Anniversary Date)" in the "Amendment of Agreement" section
• Sending Group a renewal notice, which will include a summary of changes to this Agreement that will become effective immediately after termination of this Agreement. The new Group Agreement will incorporate the changes summarized in the renewal notice. Health Plan will send Group the new Group Agreement after Group confirms it wants to make additional changes or 60 days after Group's Anniversary Date, if Group does not confirm

If Group does not renew the Agreement, Group must give Health Plan written notice as described under "Termination on Notice" or "Termination due to Nonacceptance of Amendments" in the "Termination of Agreement" section.

Amendment of Agreement

Amendments Effective on January 1 (Anniversary Date)

Upon 60 days prior written notice to Group, Health Plan may extend the term of this Agreement and make other changes by amending this Agreement effective January 1 (the Anniversary Date).
Amendments Related to Government Approval

If Health Plan notified Group that Health Plan had not received all necessary governmental approvals related to this Agreement, Health Plan may amend this Agreement by giving written notice to Group after receiving all necessary governmental approvals. Any such government-approved provisions go into effect on January 1, 2011 (unless the government requires a later effective date).

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 Kaiser Permanente Senior Advantage EOCs and Premiums effective January 1, 2012 (unless the federal government requires or allows a different effective date). The amendment may include an increase or decrease in Premiums and benefits (including Member Cost Sharing and any Medicare Part D coverage level thresholds). Health Plan will give Group written notice of any such amendment.

In addition, Health Plan may amend this Agreement at any time by giving written notice to Group, in order to increase any benefits of any Medicare product approved by the Centers for Medicare & Medicaid Services (CMS).

Amendment Due to Tax or Other Charges

If a government agency or other taxing authority imposes or increases a tax or other charge (other than a tax on or measured by net income) upon Health Plan or Plan Providers (or any of their activities), then upon 60 days prior written notice, Health Plan may increase Group’s Premiums to include Group’s share of the new or increased tax or charge. Group’s share will be determined by dividing the number of Members enrolled through Group by the total number of members enrolled in the Northern California Region.

Other Amendments

Health Plan may amend this Agreement at any time by giving written notice to Group, in order to address any law or regulatory requirement, which may include an increase in Premiums to reflect an increase in costs to Health Plan or Plan Providers (Health Plan will give Group 60 days prior written notice of any increase in Premiums or reduction in benefits).

Acceptance of Amendments

All amendments are deemed accepted by Group unless Group gives Health Plan written notice of nonacceptance within 15 days after the date of Health Plan’s amendment notice, in which case this Agreement will terminate pursuant to "Termination due to Nonacceptance of Amendments" in the "Termination of Agreement" section.

Termination of Agreement

This Agreement will terminate under any of the conditions listed below. All rights to benefits under this Agreement end on the termination date, except as expressly provided in the "Termination of Membership" or "Continuation of Membership" sections of an Evidence of Coverage. The termination date is the first day when this Agreement is no longer in effect (for example, if the termination date is January 1, 2012, the last minute this Agreement was in effect was at 11:59 p.m. on December 31, 2011).

If Health Plan terminates this Agreement, Health Plan will give Group written notice. 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**

Group may terminate this *Agreement* effective January 1 (the Anniversary Date) by giving at least 15 days prior written notice to Health Plan and remitting all amounts payable relating to this *Agreement*, including Premiums, for the period prior to the termination date.

**Termination Due to Nonacceptance of Amendments**

All amendments are deemed accepted by Group unless Group gives Health Plan written notice of nonacceptance within 15 days after the date of Health Plan's amendment notice and remits all amounts payable relating to this *Agreement*, including Premiums, for the period prior to the amendment effective date. This *Agreement* will terminate the day before the effective date of the amendment.

**Termination for Nonpayment**

If Group fails to make any past-due payment within 15 days after Health Plan's initial written notice to Group of the amount payable, Health Plan may terminate this *Agreement* immediately by giving written notice to Group, and Group is liable for all unpaid Premiums up to the termination date.

**Termination for Fraud or Intentionally Furnishing Incorrect or Incomplete Information**

Health Plan may terminate this *Agreement* upon 15 days prior written notice to Group, if Group commits fraud or intentionally furnishes incorrect or incomplete material information to Health Plan.

**Termination for Violation of Contribution or Participation Requirements**

Health Plan may terminate this *Agreement* upon 15 days prior written notice to Group, if Group fails to comply with Health Plan's participation or contribution requirements (including those discussed in the "Contribution and Participation Requirements" section).

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

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

**Contribution and Participation Requirements**

No change in Group's contribution or participation requirements listed below is effective for purposes of this *Agreement* unless Health Plan consents in writing. As a condition to consenting to Group's revised contribution and participation requirements, Health Plan may require Group to agree to amend the Premiums, benefits, or other provisions of this *Agreement*.

Group must:
- Contribute to all health care coverage available through Group on a basis that does not financially discriminate against Health Plan or against people who choose to enroll in Health Plan
For each Family, Group's contribution must be an amount that is at least 50 percent of the Premiums required for a single Subscriber for the coverage in which the Subscriber is enrolled.

Ensure that:
- all employees enrolled in Health Plan work at least 20 hours per week unless Health Plan agrees otherwise in writing;
- 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;
- at least 75 percent of eligible employees are covered by a group health care plan;
- all Subscribers live or work inside the Service Area applicable to their coverage when they enroll (except that Group must ensure that Subscribers live inside the Service Area applicable to their coverage when they enroll if Group chooses not to have a "live or work" eligibility rule, and that Kaiser Permanente Senior Advantage Members live inside the Service Area applicable to their coverage when they enroll in Senior Advantage and thereafter);
- at least one employee, proprietor, or partner who lives or works inside the Service Area is eligible to enroll as a Subscriber;
- the number of Subscribers enrolled under this Agreement does not fall below the greater of five employees or five percent of the total number of eligible employees;
- the ratio between the number of Subscribers and the total number of people who are eligible to enroll as Subscribers will not drop by 20 percent or more. For the purpose of computing this percentage requirement, Group may include subscribers and those eligible to enroll as subscribers under all other agreements between Group and Health Plan and all other Regions;

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. Also, Group must not hold open enrollment for 2012 until Group receives its 2012 group agreement Premium and coverage information from Health Plan. If Group holds the open enrollment without receiving 2012 group agreement Premium and coverage information, Health Plan may change Premiums and coverage (including benefits and Cost Sharing) when it offers to renew Group's Agreement as described under "Renewal" in the "Term of Agreement and Renewal" section.

Meet all applicable legal and contractual requirements, such as:
- distribute the Disclosure Form or the Summary of Group Plan Provisions, as applicable, to Subscribers and potential Subscribers and the Evidence of Coverage to Subscribers in accord with applicable laws, including the Medicare-as-Secondary-Payer laws;
- adhere to all requirements set forth in the applicable Evidence of Coverage;
- obtain Health Plan's prior written approval of any Group eligibility requirements that are not stated in the applicable Evidence of Coverage;
- use Member enrollment application forms that are provided or approved by Health Plan as described under "Enrollment Application Requirements" in the "Miscellaneous Provisions" section;
- For any coverage identified in an EOC as a "grandfathered health plan" under the Patient Protection and Affordable Care Act, immediately inform Health Plan if this coverage does not meet (or no longer meets) the requirements for grandfathered status;
- comply with CMS requirements governing enrollment in, and disenrollment from, Kaiser Permanente Senior Advantage;

Meet all Health Plan requirements set forth in the "Rate Assumptions and Requirements" section of the Rate Proposal 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.
Miscellaneous Provisions

Assignment

Health Plan may assign 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. This Agreement shall be binding on the successors and permitted assignees of Health Plan and Group.

Attorney Fees and Costs

If Health Plan or Group institutes legal action against the other to collect any sums owed under this Agreement, the party that substantially prevails will be reimbursed for its reasonable litigation expenses, including attorneys' fees, by the other party.

Confidential Information about Health Plan or its Affiliates

For the purposes of this "Confidential Information about Health Plan or its Affiliates" section, "Confidential Information" means any oral, written, or electronic information concerning Health Plan or its affiliates, if the information either is marked "confidential" or is by its nature proprietary or non-public, except that it does not include any of the following:

- Information that is or becomes available to the public other than as a result of disclosure by Group or its employees, advisors, or representatives
- Information that was available to Group or within its knowledge before Health Plan disclosed it to Group
- Information that becomes available to Group from a source other than Health Plan, but only if that source is not bound by a confidentiality agreement with Health Plan

If Group receives any Confidential Information, it will use that information only to evaluate Health Plan and actual or proposed group agreements with Health Plan. Group will ensure that the information is not disclosed to anyone other than a limited number of Group's employees and advisors, and only to the extent necessary in connection with the evaluation of Health Plan and actual or proposed group agreements with Health Plan. Group will inform any such employees and advisors that the information is confidential and that they must treat it confidentially.

Upon Health Plan’s request Group will promptly return to Health Plan all Confidential Information, and will destroy any other copies and any notes or other Group documents about the information.

If Group is requested or required (by oral questions, interrogatories, request for information or documents, subpoena, civil investigative demand, or similar process) to disclose any Confidential Information, Group will give Health Plan prompt notice of the request or requirement, and Group will cooperate with Health Plan in seeking to legally avoid the disclosure. If, in the absence of a protective order, Group is legally compelled, in the opinion of its counsel, to disclose any of the information, Health Plan either will seek and obtain appropriate protective orders against the disclosure or will be deemed to waive Group’s compliance with the provisions of this "Confidential Information about Health Plan or its Affiliates" section to the extent necessary to satisfy the request or requirement.

Group understands (and will inform any employees and advisors who receive Confidential Information) that United States securities laws prohibit anyone who has material non-public information about a company from buying or selling that company's securities in reliance upon that information or from communicating the information to any other person or entity under circumstances in which it is reasonably foreseeable that the person or entity is likely to buy or sell that company's securities in reliance upon the information. Group agrees that it and its affiliates, associates, employees, agents, and advisors will not rely on any Confidential Information in directly or indirectly buying or selling any Health Plan securities.

Monetary damages would not be a sufficient remedy for any breach or threatened breach of this "Confidential Information about Health Plan or its Affiliates" section. Health Plan will be entitled to equitable relief by way of injunction or specific
performance if Group or any of its officers, directors, employees, attorneys, accountants, agents, advisors, or representatives breach, or threaten to breach, any of the provisions of this "Confidential Information about Health Plan or its Affiliates" section.

Group's obligations under this "Confidential Information about Health Plan or its Affiliates" section will continue indefinitely and will survive the termination or expiration of this Agreement.

Contract Providers

Health Plan will give Group written notice within a reasonable time of any termination or breach of contract by, or inability to perform of, any health care provider that contracts with Health Plan if Group may be materially and adversely affected thereby.

Delegation of Claims Review

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 discretionary 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. If coverage under an EOC is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), Health Plan is a "named claims fiduciary" to review claims under that EOC.

Enrollment Application Requirements

Group must use enrollment application forms that are provided by Health Plan. If Group wants to use a different form or system for enrolling Members, Group must obtain Health Plan's approval of the form or system. Other forms and systems include a "universal" enrollment application form, interactive voice recording (IVR) enrollment system, or intranet online enrollment system. All forms and systems must meet Health Plan requirements for enrolling Members, including disclosure of binding arbitration in accord with Section 1363.1 of the California Health and Safety Code and other applicable law. Group's Health Plan account manager can provide Group with Health Plan's current requirements for enrollment application forms and systems.

Governing Law

Except as preempted by federal law, this Agreement will be governed in accord with California law and any provision that is required to be in this Agreement by state or federal law, shall bind Group and Health Plan whether or not set forth in this Agreement.

Member Information

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

When Health Plan notifies Group about changes to this Agreement 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.

No Waiver

Health Plan'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 right thereafter to require Group's strict performance of any provision.
Notices

Notices must be sent to the addresses listed below. Health Plan or Group may change its addresses for notices by giving written notice to the other. All notices 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 will be sent to:
TERESIA HAASE, DIRECTOR OF HUMAN RESOURCES
CITY OF STOCKTON
22 E WEBER AVE STE 150
STOCKTON, CA 95202-2326

If Group has chosen to receive group agreements electronically through Health Plan’s website at kp.org/yourcontract, Health Plan will send a notice to Group at the address listed above when a group agreement has been posted to that website.

Note: When Health Plan sends Group a new (renewed) Agreement, Health Plan will enclose a summary of changes that discusses the changes Health Plan has made to the Group Agreement. Groups that want information about changes before receiving the Agreement may request advance information from Group’s Health Plan account manager. Also, if Group designates a third party in writing (for example, “Broker of Record” statements), Health Plan may send the advance information to the third party rather than to Group (unless Group requests a copy too).

Notices from Group to Health Plan must be sent to:
Kaiser Permanente
1950 Franklin Street
Oakland, CA 94612
Attn: Jerry Fleming, Senior Vice President and Health Plan Manager

Reporting Membership Changes and Retroactivity

Group must report membership changes (including sending appropriate membership forms) within the time limit for retroactive changes and in accord with any applicable “rescission” provisions of the Patient Protection and Affordable Care Act and regulations. Except for Senior Advantage membership terminations discussed below, the time limit for retroactive membership changes is the calendar month when Health Plan’s California Service Center receives Group’s notification of the change plus the previous 2 months.

In accord with the Centers for Medicare & Medicaid Services (CMS) requirements, Senior Advantage members must receive 21 days prior written notice before their membership terminates. This means that Group may not retroactively terminate Senior Advantage membership. In addition, Group must give Health Plan’s California Service Center 30 days prior written notice of Senior Advantage involuntary membership terminations. The effective date of membership termination is determined by the date when Group gives notice to the Service Center. The membership termination date is the first of the month following 30 days after the date when Health Plan’s California Service Center receives a Senior Advantage membership termination notice unless Group specifies a later termination date. For example, if Health Plan’s California Service Center 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 Premiums for the months of March and April. Note: If Health Plan’s California Service Center receives a disenrollment notice from CMS or the Member, the effective date of membership termination will be in accord with that notice and CMS requirements.

Health Plan’s Administrative Handbook includes the details about how to report membership changes. Group’s Health Plan account manager can provide Group with an Administrative Handbook if Group does not have one.
Social Security and Tax Identification Numbers

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

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

Premiums

Only Members for whom Health Plan (or its designee) has received the appropriate Premium payment listed below are entitled to coverage under this Agreement, and then only for the period for which Health Plan (or its designee) has received appropriate payment. Group is responsible for paying Premiums, except that Members who have Cal-COBRA coverage under an EOC that is included in this Agreement are responsible for paying Premiums for Cal-COBRA coverage.

Due Date and Payment of Premiums

The payment due date for each enrollment unit associated with Group will be reflected on the monthly membership invoice if applicable to Group (if not applicable, then as specified in writing by Health Plan). If Group does not pay Full Premiums by the first of the coverage month, the Premiums may include an additional administrative charge upon renewal. "Full Premiums" means 100 percent of monthly Premiums for each enrolled Member, as set forth under "Calculating Monthly Premiums" in this "Premiums" section.

New Members

Premiums are payable for a new Member for the entire month when the Member's coverage effective date is any day during that month.

Note: Membership begins at the beginning (12:00 a.m.) of the effective date of coverage.

Member Termination

Premiums are payable for the entire month for a Member whose last day of coverage is any day during that month.

In accord with the Centers for Medicare & Medicaid Services (CMS) requirements, the effective date of Senior Advantage involuntary membership termination is the first of the month following 30 days after the date when Health Plan's California Service Center receives a Senior Advantage membership termination notice unless Group specifies a later termination date. For example, if Health Plan's California Service Center 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 Premiums for the months of March and April. Note: If Health Plan's California Service Center receives a disenrollment notice from CMS or the Member, the effective date of membership termination will be in accord with that notice and CMS requirements.

Note: The membership termination date is the first day a Member is not covered (for example, if the termination date is January 1, 2012, the last minute of coverage was at 11:59 p.m. on December 31, 2011).
Medicare

Medicare as primary coverage
For Members who are (or the subscriber in the family is) retired, age 65 or over, and eligible for Medicare as primary coverage, Premiums are based on the assumption that Health Plan or its designee will receive Medicare payments for Medicare-covered services provided to Members whose Medicare coverage is primary. If a Member age 65 or over is (or becomes) eligible for Medicare as primary coverage and is not for any reason enrolled through Group under an EOC that requires Members to have Medicare (including inability to enroll under that EOC because he or she does not meet the plan's eligibility requirements, the plan is not available through Group, or the plan is closed to enrollment), Group must pay the Premiums listed below for the EOC under which the Member is enrolled that apply to Members age 65 or over who are not enrolled through Group under one of our Medicare plans. The following plans require Members to have Medicare:

- Kaiser Permanente Senior Advantage

If a Member age 65 or over who is eligible for Medicare as primary coverage and enrolled under an EOC that requires Members to have Medicare is no longer eligible for that plan, Health Plan may transfer the Member's membership to one of Group's plans that does not require Members to have Medicare, and Group must pay the Premiums listed below for the EOC under which the Member is enrolled that apply to Members age 65 or over who are not enrolled through Group under one of our Medicare plans.

Medicare as secondary coverage
Medicare is the primary coverage except when federal law requires that Group's health care coverage be primary and Medicare coverage be secondary. Members entitled to Medicare when Medicare is secondary by law, are subject to the same Premiums and receive the same benefits as Members who are under age 65 not eligible for Medicare. In addition, any such Members for whom Medicare is secondary and who meet the Kaiser Permanente Senior Advantage eligibility requirements, may also enroll in the Kaiser Permanente Senior Advantage plan applicable when Medicare is secondary under this Agreement. These Members receive the benefits and coverage described in both the EOC for the non-Medicare plan (the plan that does not require Members to have Medicare) and the Senior Advantage EOC applicable when Medicare is secondary.

Subscriber Contributions for Medicare Part C and Part D Coverage

Medicare Part C coverage
This "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 "Medicare Part D coverage" section applies only to Group's Kaiser Permanente Senior Advantage coverage that includes Medicare Part D prescription drug coverage. Group's Senior Advantage Premiums 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, 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 category, and are not based on eligibility for the Medicare Part D Low Income Subsidy (the subsidies described in 42 C.F.R. Section 423 Subpart P, which are offered by the Medicare program to certain low-income Medicare beneficiaries enrolled in Medicare Part D, and which reduce the Medicare beneficiaries' Medicare Part D premiums and/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 that exceeds the Premium 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 premium

- 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 the penalty.

Calculating Monthly Premiums

To calculate the monthly Premiums that apply to a Family (a Subscriber and all of his or her Dependents):
1. Determine the coverages (EOCs and contract options) that apply to each Member in the Family (for example, Traditional Plan and ancillary coverages)
2. Determine the family role type and Medicare status of each Member (for family role types, please see the "Definitions" section of the EOC for the definition of Subscriber, Dependent, and Spouse)
3. Identify the Premiums for each Member for each EOC and contract option in the Premium tables below based on the family role type of each Member
4. Add the amount of Premiums for each Member together to arrive at the total Premiums required for the Family

Note: EOC number is also known as "contract option ID."
### Kaiser Permanente Senior Advantage (HMO) with Part D — EOC #1

<table>
<thead>
<tr>
<th>Family role type</th>
<th>Medicare Parts A &amp; B</th>
<th>Medicare Part B only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber</td>
<td>$261.14</td>
<td>$571.14</td>
</tr>
<tr>
<td>1st Dependent</td>
<td>$261.14</td>
<td>$571.14</td>
</tr>
<tr>
<td>2nd Dependent</td>
<td>$261.14</td>
<td>$571.14</td>
</tr>
<tr>
<td>Each additional Dependent</td>
<td>$261.14</td>
<td>$571.14</td>
</tr>
</tbody>
</table>

### Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage — EOC #2

**NCR Work Aged Assign**

For Members enrolled in Senior Advantage when federal law requires that Group’s health care plan be primary and Medicare coverage be secondary, the Premiums are:

<table>
<thead>
<tr>
<th>Family role type</th>
<th>Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber</td>
<td>$521.33</td>
</tr>
<tr>
<td>Spouse</td>
<td>$417.06</td>
</tr>
<tr>
<td>1st child without Spouse</td>
<td>$417.06</td>
</tr>
<tr>
<td>1st child with Spouse</td>
<td>$312.80</td>
</tr>
</tbody>
</table>

### Kaiser Permanente Traditional Plan — EOC #3

#### Traditional HMO NCR

<table>
<thead>
<tr>
<th>Members under age 65 (or 65 and over if Medicare is secondary)</th>
<th>Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family role type</td>
<td></td>
</tr>
<tr>
<td>Subscriber</td>
<td>$521.33</td>
</tr>
<tr>
<td>Spouse</td>
<td>$417.06</td>
</tr>
<tr>
<td>1st child without Spouse</td>
<td>$417.06</td>
</tr>
<tr>
<td>1st child with Spouse</td>
<td>$312.80</td>
</tr>
<tr>
<td>Each additional Dependent</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Members age 65 and over whose Medicare eligibility is unknown or who are eligible for or have Medicare Part B only</th>
<th>Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family role type</td>
<td></td>
</tr>
<tr>
<td>Subscriber</td>
<td>$1,445.77</td>
</tr>
<tr>
<td>Spouse</td>
<td>$1,445.77</td>
</tr>
<tr>
<td>1st child without Spouse</td>
<td>$1,445.77</td>
</tr>
<tr>
<td>1st child with Spouse</td>
<td>$1,445.77</td>
</tr>
<tr>
<td>Each additional Dependent</td>
<td>$1,445.77</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Members age 65 and over who are eligible for or have Medicare Part A</th>
<th>Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family role type</td>
<td></td>
</tr>
<tr>
<td>Subscriber</td>
<td>$1,035.12</td>
</tr>
<tr>
<td>Spouse</td>
<td>$1,035.12</td>
</tr>
<tr>
<td>1st child without Spouse</td>
<td>$1,035.12</td>
</tr>
<tr>
<td>1st child with Spouse</td>
<td>$1,035.12</td>
</tr>
</tbody>
</table>
Each additional Dependent $1,035.12

<table>
<thead>
<tr>
<th>Members enrolled in another carrier's Medicare Risk product</th>
<th>Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family role type</td>
<td>Premiums</td>
</tr>
<tr>
<td>Subscriber</td>
<td>$1,445.77</td>
</tr>
<tr>
<td>Spouse</td>
<td>$1,445.77</td>
</tr>
<tr>
<td>1st child without Spouse</td>
<td>$1,445.77</td>
</tr>
<tr>
<td>1st child with Spouse</td>
<td>$1,445.77</td>
</tr>
<tr>
<td>Each additional Dependent</td>
<td>$1,445.77</td>
</tr>
</tbody>
</table>

Note: Members who are "eligible for" Medicare Part A or B are those who would qualify for Medicare Part A or B coverage if they applied for it. Members who "have" Medicare Part A or B are those who have been granted Medicare Part A or B coverage. Medicare Part A provides inpatient coverage and Part B provides outpatient coverage.

**Kaiser Permanente Senior Advantage (HMO) with Part D — EOC # 4**

**DHMO St Adv Grp Hmo NCR**

<table>
<thead>
<tr>
<th>Family role type</th>
<th>Medicare Parts A &amp; B</th>
<th>Medicare Part B only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber</td>
<td>$261.14</td>
<td>$571.14</td>
</tr>
<tr>
<td>1st Dependent</td>
<td>$261.14</td>
<td>$571.14</td>
</tr>
<tr>
<td>2nd Dependent</td>
<td>$261.14</td>
<td>$571.14</td>
</tr>
<tr>
<td>Each additional Dependent</td>
<td>$261.14</td>
<td>$571.14</td>
</tr>
</tbody>
</table>

**Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage — EOC # 5**

**DHMO NCR Work Aged Assign**

For Members enrolled in Senior Advantage when federal law requires that Group's health care plan be primary and Medicare coverage be secondary, the Premiums are:

<table>
<thead>
<tr>
<th>Family role type</th>
<th>Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber</td>
<td>$414.91</td>
</tr>
<tr>
<td>Spouse</td>
<td>$331.93</td>
</tr>
<tr>
<td>1st child without Spouse</td>
<td>$331.93</td>
</tr>
<tr>
<td>1st child with Spouse</td>
<td>$248.94</td>
</tr>
</tbody>
</table>

**Kaiser Permanente Deductible HMO Plan — EOC # 6**

**DHMO NCR**

<table>
<thead>
<tr>
<th>Members under age 65 (or 65 and over if Medicare is secondary)</th>
<th>Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family role type</td>
<td>Premiums</td>
</tr>
<tr>
<td>Subscriber</td>
<td>$414.91</td>
</tr>
<tr>
<td>Spouse</td>
<td>$331.93</td>
</tr>
<tr>
<td>1st child without Spouse</td>
<td>$331.93</td>
</tr>
<tr>
<td>1st child with Spouse</td>
<td>$248.94</td>
</tr>
<tr>
<td>Each additional Dependent</td>
<td>$0.00</td>
</tr>
<tr>
<td>Family role type</td>
<td>Premiums</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Subscriber</td>
<td>$1,339.16</td>
</tr>
<tr>
<td>Spouse</td>
<td>$1,339.16</td>
</tr>
<tr>
<td>1st child without Spouse</td>
<td>$1,339.16</td>
</tr>
<tr>
<td>1st child with Spouse</td>
<td>$1,339.16</td>
</tr>
<tr>
<td>Each additional Dependent</td>
<td>$1,339.16</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family role type</th>
<th>Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber</td>
<td>$928.51</td>
</tr>
<tr>
<td>Spouse</td>
<td>$928.51</td>
</tr>
<tr>
<td>1st child without Spouse</td>
<td>$928.51</td>
</tr>
<tr>
<td>1st child with Spouse</td>
<td>$928.51</td>
</tr>
<tr>
<td>Each additional Dependent</td>
<td>$928.51</td>
</tr>
</tbody>
</table>

**Note:** Members who are "eligible for" Medicare Part A or B are those who would qualify for Medicare Part A or B coverage if they applied for it. Members who "have" Medicare Part A or B are those who have been granted Medicare Part A or B coverage. Medicare Part A provides inpatient coverage and Part B provides outpatient coverage.
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 Premiums.

Group may not change this Agreement by adding or deleting words, and any such addition or deletion is void. Health Plan might not respond to any changes or comments submitted on or with this Signature Page. Group may not construe Health Plan's lack of response to any submitted changes or comments to imply acceptance. 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

As more fully set forth in the arbitration provision in the applicable Evidence of Coverage, disputes between Members, their heirs, relatives, 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 (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), 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 the Small Claims Court
- Claims subject to a Medicare appeals procedure as applicable to Kaiser Permanente Senior Advantage and Medicare Cost Members
- For coverage under an Evidence of Coverage that is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), claims that are about an "adverse benefit determination" as defined in that regulation. Note: Claims about "adverse benefit determinations" are excluded from this binding arbitration requirement only until such time as the 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

CITY OF STOCKTON

Kaiser Foundation Health Plan, Inc.
Northern California Region

Authorized Group officer signature

Jerry Fleming
Authorized officer
Senior Vice President and Health Plan Manager

Executed in San Diego, CA effective 9/1/11
Date: 8/1/11

Date signed

Please keep this copy with your Agreement. An extra copy of the Signature Page is enclosed for mailing to our California Service Center at P.O. Box 23448, San Diego, CA 92193-3448.

CITY OF STOCKTON
Group ID: 603693
Contract: 1 Version: 1 Effective: 9/1/11--12/31/12
Date: August 1, 2011
Kaiser Permanent Deductible HMO Plan
Evidence of Coverage for
CITY OF STOCKTON

Group ID: 603693  Contract: 1  Version: 1  EOC Number: 6

September 1, 2011, through December 31, 2012

Member Service Call Center
Weekdays 7 a.m.–7 p.m.; weekends 7 a.m.–3 p.m.
(except holidays)
1-800-464-4000 toll free
1-800-777-1370 (toll free TTY for the hearing/speech impaired)
kp.org
Help in your language
Interpreters are available 24 hours a day, seven days a week, at no cost to you. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. In addition, you may be able to get materials written in your language. For more information, call our Member Service Call Center at 1-800-464-4000 or 1-800-777-1370 (TTY) weekdays from 7 a.m. to 7 p.m., and weekends from 7 a.m. to 3 p.m.

Ayuda en su propio idioma
Tenemos disponibles intérpretes 24 horas al día, 7 días a la semana, sin ningún costo para usted. También podemos ofrecerle a usted, sus familiares y sus amigos cualquier tipo de ayuda que necesiten para tener acceso a nuestras instalaciones y servicios. Además, usted puede obtener materiales escritos en su idioma. Para más información, llame a nuestro Centro de Llamadas de Servicios a los Miembros al 1-800-788-0616 ó 1-800-777-1370 (TTY) los días de semana de 7 a.m. a 7 p.m., y los fines de semana de 7 a.m. a 3 p.m.

語言翻譯協助
提供每週七天，每天廿四小時翻譯。我們也向會員及其親友提供利用我處設施及服務所需之任何協助。此外會員還可索取以其母語編寫的資料。若需更多資訊，請於週一至週五上午七時至下午七時及週末上午七時至下午三時致電會員服務電話中心，電話號碼為 1-800-757-7585 或 1-800-777-1370（聽障專線）。
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<td>Preventive Care Services</td>
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<td>Chemical Dependency Services</td>
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<td>Dialysis Care</td>
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<td>Durable Medical Equipment for Home Use</td>
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<td>Health Education</td>
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<td>Hearing Services</td>
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<td>Infertility Services</td>
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<td>Mental Health Services</td>
<td>32</td>
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<td>Ostomy and Urological Supplies</td>
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<td>Outpatient Imaging, Laboratory, and Special Procedures</td>
<td>33</td>
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<td>Outpatient Prescription Drugs, Supplies, and Supplements</td>
<td>34</td>
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<td>Prosthetic and Orthotic Devices</td>
<td>37</td>
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<tr>
<td>Reconstructive Surgery</td>
<td>38</td>
</tr>
</tbody>
</table>

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**Benefit Highlights**

### Annual Out-of-Pocket Maximum for Certain Services

For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services, plus all your Deductible payments (except prescription drugs), add up to one of the following amounts:

- For self-only enrollment (a Family of one Member)........................... $3,000 per calendar year
- For any one Member in a Family of two or more Members .............. $3,000 per calendar year
- For an entire Family of two or more Members ............................... $6,000 per calendar year

### Deductible for Certain Services as specified below

You must pay Charges for Services you receive in a calendar year until you reach one of the following Deductible amounts:

- For self-only enrollment (a Family of one Member)........................... $1,000 per calendar year
- For any one Member in a Family of two or more Members .............. $1,000 per calendar year
- For an entire Family of two or more Members ............................... $2,000 per calendar year

### Lifetime Maximum

**Lifetime Maximum**

### Professional Services (Plan Provider/Office Visit)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Deductible Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most primary and specialty care consultations and exams</td>
<td>$30 per visit</td>
</tr>
<tr>
<td>Routine physical maintenance exams</td>
<td>No charge</td>
</tr>
<tr>
<td>Well-child preventive exams (through age 23 months)</td>
<td>No charge</td>
</tr>
<tr>
<td>Family planning counseling</td>
<td>No charge</td>
</tr>
<tr>
<td>Scheduled prenatal care exams and first postpartum follow-up consultation and exam</td>
<td>No charge</td>
</tr>
<tr>
<td>Eye exams for refraction</td>
<td>No charge</td>
</tr>
<tr>
<td>Hearing exams</td>
<td>No charge</td>
</tr>
<tr>
<td>Urgent care consultations and exams</td>
<td>$30 per visit</td>
</tr>
<tr>
<td>Physical, occupational, and speech therapy</td>
<td>$30 per visit after Deductible</td>
</tr>
</tbody>
</table>

### Outpatient Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient surgery and certain other outpatient procedures</td>
<td>30% Coinsurance after Deductible</td>
</tr>
<tr>
<td>Allergy injections (including allergy serum)</td>
<td>No charge after Deductible</td>
</tr>
<tr>
<td>Most immunizations (including the vaccine)</td>
<td>No charge after Deductible</td>
</tr>
<tr>
<td>Most X-rays and laboratory tests</td>
<td>$10 per encounter after Deductible</td>
</tr>
<tr>
<td>Preventive X-rays, screenings, and laboratory tests as described in the</td>
<td>No charge after Deductible</td>
</tr>
<tr>
<td>&quot;Benefits and Cost Sharing&quot; section</td>
<td>No charge after Deductible</td>
</tr>
<tr>
<td>MRL, most CT, and PET scans</td>
<td>$50 per procedure after Deductible</td>
</tr>
<tr>
<td>Health education:</td>
<td>No charge after Deductible</td>
</tr>
<tr>
<td>Covered individual health education counseling</td>
<td>No charge after Deductible</td>
</tr>
<tr>
<td>Covered health education programs</td>
<td>No charge after Deductible</td>
</tr>
</tbody>
</table>

### Hospitalization Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs</td>
<td>30% Coinsurance after Deductible</td>
</tr>
</tbody>
</table>

### Emergency Health Coverage

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department visits</td>
<td>30% Coinsurance after Deductible</td>
</tr>
</tbody>
</table>

### Ambulance Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services</td>
<td>$150 per trip after Deductible</td>
</tr>
</tbody>
</table>
### Prescription Drug Coverage

Covered outpatient items in accordance with our drug formulary guidelines from Plan Pharmacies or from our mail-order service:

- Most generic items: $10 for up to a 100-day supply (Deductible doesn’t apply)
- Most brand-name items: $30 for up to a 100-day supply after $100 drug Deductible

### Durable Medical Equipment

Most covered durable medical equipment for home use in accordance with our durable medical equipment formulary guidelines: 20% coinsurance (Deductible doesn’t apply)

### Mental Health Services

- Inpatient psychiatric hospitalization: 30% coinsurance after Deductible
- Outpatient mental health evaluation and treatment: $30 per individual visit (Deductible doesn’t apply), $15 per group visit (Deductible doesn’t apply)

### Chemical Dependency Services

- Inpatient detoxification: 30% coinsurance after Deductible
- Individual outpatient chemical dependency counseling and treatment: $30 per visit (Deductible doesn’t apply)
- Group outpatient chemical dependency counseling and treatment: $5 per visit (Deductible doesn’t apply)

### Home Health Services

- Home health care (up to 100 visits per calendar year): No charge (Deductible doesn’t apply)

### Other

- Skilled Nursing Facility care (up to 100 days per benefit period): 30% coinsurance after Deductible
- All covered Services related to infertility treatment: 50% coinsurance (Deductible doesn’t apply)
- Hospice care: No charge (Deductible doesn’t apply)

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the "Benefits and Cost Sharing" and "Exclusions, Limitations, Coordination of Benefits, and Reductions" sections.
Introduction

This Evidence of Coverage describes the health care coverage of "Kaiser Permanente Deductible HMO Plan" provided under the Group Agreement (Agreement) between Health Plan (Kaiser Foundation Health Plan, Inc.) and your Group (the entity with which Health Plan has entered into the Agreement). For benefits provided under any other Health Plan program, refer to that plan's evidence of coverage.

In this Evidence of Coverage, Health Plan is sometimes referred to as "we" or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this Evidence of Coverage; please see the "Definitions" section for terms you should know.

Please read the following information so that you will know from whom or what group of providers you may get health care. It is important to familiarize yourself with your coverage by reading this Evidence of Coverage completely, so that you can take full advantage of your Health Plan benefits. Also, if you have special health care needs, please carefully read the sections that apply to you.

Term of this Evidence of Coverage

This Evidence of Coverage is for the period September 1, 2011, through December 31, 2012, unless amended. Your Group can tell you whether this Evidence of Coverage is still in effect and give you a current one if this Evidence of Coverage has expired or been amended.

About Kaiser Permanente

Kaiser Permanente provides Services directly to our Members through an integrated medical care program. Health Plan, Plan Hospitals, and the Medical Group work together to provide our Members with quality care. Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital care, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in the "Benefits and Cost Sharing" section. Plus, our health education programs offer you great ways to protect and improve your health.

We provide covered Services to Members using Plan Providers located in our Service Area, which is described in the "Definitions" section. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in the "Getting Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Cost Sharing" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Hospice care as described under "Hospice Care" in the "Benefits and Cost Sharing" section

Definitions

Some terms have special meaning in this Evidence of Coverage. When we use a term with special meaning in only one section of this Evidence of Coverage, we define it in that section. The terms in this "Definitions" section have special meaning when capitalized and used in any section of this Evidence of Coverage.

Charges: "Charges" means the following:

- For Services provided by the Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of Medical Group and Kaiser Foundation Hospitals charges for Services provided to Members
- For Services for which a provider (other than the Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider
- For items 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 (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan)
- For all other Services, the payments that Kaiser Permanente makes for the Services or, if Kaiser Permanente subtracts Cost Sharing from its payment, the amount Kaiser Permanente would have paid if it did not subtract Cost Sharing

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service as described in the "Benefits and Cost Sharing" section.
Copayment: A specific dollar amount that you must pay when you receive a covered Service as described in the "Benefits and Cost Sharing" section. Note: The dollar amount of the Copayment can be $0 (no charge).

Cost Sharing: The amount you are required to pay for a covered Service, for example: the Deductible, Copayment, or Coinsurance.

Deductible: The amount you must pay in a calendar year for certain Services before we will cover those Services at the applicable Copayment or Coinsurance in that calendar year. Please refer to the "Benefits and Cost Sharing" section for the Services that are subject to the Deductible(s) and the Deductible amount(s).

Dependent: A Member who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

A mental health condition is an Emergency Medical Condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to himself or herself or to others
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder

Emergency Services: All of the following with respect to an Emergency Medical Condition:

- A medical screening exam that is within the capability of the emergency department of a hospital, including ancillary services (such as imaging and laboratory Services) routinely available to the emergency department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the hospital, Medically Necessary examination and treatment required to Stabilize the patient (once your condition is Stabilized, Services you receive are Post Stabilization Care and not Emergency Services)

Evidence of Coverage (EOC): This Evidence of Coverage document, which describes the health care coverage of "Kaiser Permanente Deductible HMO Plan" under Health Plan's Agreement with your Group.

Family: A Subscriber and all of his or her Dependents.

Group: The entity with which Health Plan has entered into the Agreement that includes this Evidence of Coverage.

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. This Evidence of Coverage sometimes refers to Health Plan as "we" or "us."

Kaiser Permanente: Kaiser Foundation Hospitals (a California nonprofit corporation), Health Plan, and the Medical Group.

Medical Group: The Permanente Medical Group, Inc., a for-profit professional corporation.

Medically Necessary: A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). In this Evidence of Coverage, Members who are "eligible for" Medicare Part A or B are those who would qualify for Medicare Part A or B coverage if they applied for it. Members who "have" Medicare Part A or B are those who have been granted Medicare Part A or B coverage.

Member: A person who is eligible and enrolled under this Evidence of Coverage, and for whom we have received applicable Premiums. This Evidence of Coverage sometimes refers to a Member as "you."

Non-Plan Hospital: A hospital other than a Plan Hospital.

Non-Plan Physician: A physician other than a Plan Physician.

Non-Plan Provider: A provider other than a Plan Provider.

Out-of-Area Urgent Care: Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health resulting from an unforeseen
Evidence of Coverage, except that you are responsible for paying Premiums if you have Cal-COBRA coverage.

Primary Care Physicians: Generalists in internal medicine, pediatrics, and family practice, and specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Please refer to our website at kp.org for a directory of Primary Care Physicians, except that the directory is subject to change without notice. For the current list of physicians that are available as Primary Care Physicians, please call the personal physician selection department at the phone number listed in Your Guidebook.

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. For information about Region locations in the District of Columbia and parts of Southern California, Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia and Washington, please call our Member Service Call Center.

Service Area: The following counties are entirely inside our Service Area: Alameda, Contra Costa, Marin, Sacramento, San Francisco, San Joaquin, San Mateo, Solano, and Stanislaus. Portions of the following counties are also inside our Service Area, as indicated by the ZIP codes below for each county:

- Amador: 95640, 95669
- El Dorado: 95613-14, 95619, 95623, 95633-35, 95651, 95664, 95667, 95672, 95682, 95762
- Kings: 93230, 93232, 93242, 93631, 93656
- Madera: 93601-02, 93604, 93614, 93623, 93626, 93636-39, 93643-45, 93653, 93669, 93720
- Mariposa: 93601, 93623, 93653
- Napa: 94503, 94508, 94515, 94558-59, 94562, 94567 (except that Knoxville is not in our Service Area), 94573-74, 94576, 94581, 94589-90, 94599, 95476
- Placer: 95602-04, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677-78, 95681, 95692, 95703, 95722, 95736, 95746-47, 95765
of the California Family Code, the term "Spouse" also includes the Subscriber's domestic partner who meets your Group's eligibility requirements for domestic partners.

Stabilize: To provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver (including the placenta).

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

Urgent Care: Medically Necessary Services for a condition that requires prompt medical attention but is not an Emergency Medical Condition.

**Premiums, Eligibility, and Enrollment**

**Premiums**

Your Group is responsible for paying Premiums, except that you are responsible for paying Premiums as described in the "Continuation of Membership" section if you have Cal-COBRA coverage under this Evidence of Coverage. If you are responsible for any contribution to the Premiums that your Group pays, your Group will tell you the amount and how to pay your Group (through payrol deduction, for example).

**Who Is Eligible**

To enroll and to continue enrollment, you must meet all of the eligibility requirements described in this "Who Is Eligible" section.

**Group eligibility requirements**

You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of its eligibility requirements, such as the minimum number of hours that employees must work.
Service Area eligibility requirements

The "Definitions" section describes our Service Area and how it may change.

Subscribers must live or work inside our Service Area at the time they enroll. If after enrollment the Subscriber no longer lives or works inside our Service Area, the Subscriber can continue membership unless (1) he or she lives inside or moves to the service area of another Region and does not work inside our Service Area, or (2) your Group does not allow continued enrollment of Subscribers who do not live or work inside our Service Area.

Dependent children of the Subscriber or of the Subscriber's Spouse may live anywhere inside or outside our Service Area. Other Dependents may live anywhere, except that they are not eligible to enroll or to continue enrollment if they live in or move to the service area of another Region.

If you are not eligible to continue enrollment because you live in or move to the service area of another Region, please contact your Group to learn about your Group health care options:

- **Regions outside California.** You may be able to enroll in the service area of another Region if there is an agreement between your Group and that Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same. For the purposes of this eligibility rule, the Regions outside California 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.

- **Southern California Region's service area.** Your Group may have an arrangement with us that permits membership in the Southern California Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this Evidence of Coverage. All terms and conditions in your application for enrollment in the Northern California Region, including the Arbitration Agreement, will continue to apply if the Subscriber does not submit a new enrollment form.

For more information about the service areas of the other Regions, please call our Member Service Call Center.

Additional eligibility requirements

You may be eligible to enroll and continue enrollment as a Subscriber if you are:

- An employee of your Group
- A proprietor or partner of your Group
- Otherwise entitled to coverage under a trust agreement, retirement benefit program, or employment contract (unless the Internal Revenue Service considers you self-employed)

If you are a Subscriber under this Evidence of Coverage (or if you are a subscriber under Kaiser Permanente Senior Advantage or one of our other plans that your Group offers that requires members to have Medicare) and if your Group allows enrollment of Dependents, the following persons may be eligible to enroll as your Dependents under this Evidence of Coverage:

- Your Spouse. For the purposes of this Evidence of Coverage, the term "Spouse" includes the Subscriber's same-sex spouse if the Subscriber and spouse are a couple who meet all of the requirements of Section 308(c) of the California Family Code, or your registered domestic partner who meets all of the requirements of Sections 297 or 299.2 of the California Family Code. If your Group allows enrollment of domestic partners who do not meet all of the requirements of Sections 297 or 299.2 of the California Family Code, the term "Spouse" also includes your domestic partner who meets your Group's eligibility requirements for domestic partners.
- Your or your Spouse's children (including adopted children or children placed with you or your Spouse for adoption) who are under age 26
- Children (not including foster children) for whom you or your Spouse is the court-appointed guardian (or was when the person reached age 18) if they are under age 26
- Children whose parent is a Dependent under your family coverage (including adopted children or children placed with your Dependent for adoption, but not including foster children) if they are under age 26
- Dependents who meet the Dependent eligibility requirements, except for the age limit, are eligible as disabled dependents if they meet all of the following requirements:
  - your Group permits enrollment of dependent children
  - they are your or your Spouse's children, your or your Spouse's adopted children, children placed with you or your Spouse for adoption, or children for whom you or your Spouse is the legal guardian
  - they are incapable of self-sustaining employment because of a physically- or mentally-disabling injury, illness, or condition that occurred before they reached the age limit for Dependents
  - they receive 50 percent or more of their support and maintenance from you or your Spouse