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 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 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

EL DORADO 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 7/1/08
Date: 5/5/08

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

2008 preliminary summary of changes to the Group Agreement

The following is a preliminary summary of the most important coverage changes that we intend to make to the 2008 California Group Agreements, including *Evidence of Coverage* documents. This summary is subject to change and regulatory approval and doesn't include any changes we may make at your group's request. 2008 Renewal Notices and the *2008 Group Agreement Summary of Changes and Clarifications* that accompany the 2008 Group Agreements will confirm the changes we have made.

DURABLE MEDICAL EQUIPMENT

Most durable medical equipment (DME) for home use isn't covered outside our service area. In 2008 non-Medicare *EOCs*, we will clarify that we cover the following DME items for members who live outside our service area when the item is dispensed at a Plan facility or pharmacy:

- Standard curved-handle cane
- Standard crutches
- For diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Insulin pumps and supplies to operate the pump (but not insulin or any other drugs) after training on the use of the pump is completed

New national Medicare prescription formulary

On April 16, 2007, we submitted a single, national Medicare Part D formulary to the Centers for Medicare & Medicaid Services (CMS). Pending CMS approval, this national formulary will allow for consistency throughout our regions.

- For treating pediatric asthma, nebulizers and their supplies
- Peak flow meters

Also, effective January 1, 2008, the Health Plan will cover quad canes, forearm crutches, and dry pressure pads under the base DME benefit statewide.

PROSTHETIC AND ORTHOTIC DEVICES

In response to a recent state law (AB 2012), covered prosthetic and orthotic devices will be provided at no charge for:

All non-Medicare members effective July 1, 2007

Members with Medicare (except those enrolled in Kaiser Permanente Senior Advantage) as contracts renew effective January 1, 2008

NO COPAYMENT FOR ROUTINE RETINAL PHOTOGRAPHY SCREENINGS FOR ALL MEMBERS*

Retinal photography screenings are an important part of primary care, especially for members with diabetes. Early detection and intervention can help prevent vision loss and blindness. These screenings will be covered at no charge for all members. Currently, both preventive and nonpreventive screenings are covered at the same level of cost sharing that applies for imaging services, after any applicable deductible has been met.

COVERAGE FOR HOME INFUSION DRUGS NOW UNDER MEDICARE PART C*

Home infusion drug therapies involve administering medications either into the bloodstream (intravenous), under the skin (subcutaneous), or into the membranes surrounding the spinal cord (epidural). Antibiotics, chemotherapy, parenteral nutrition, immune globulin, and some pain management drugs fall into this class.

Originally, the CMS required home infusion drugs not covered under Medicare Parts A or B to be covered under Part D. On March 22, 2007, the CMS issued new guidance allowing Medicare Advantage plans to provide home infusion drugs as a supplemental benefit under Part C. We will cover these drugs as bundled services under our Medicare Advantage (or Medicare Part C) program at no charge.

COVERAGE CHANGE TO THE HMO PORTION OF THE POINT-OF-SERVICE (POS) PLAN

Effective January 1, 2008, diagnostic testing and therapeutic imaging, such as X-rays, mammograms, ultrasounds, and magnetic resonance imaging (MRI), will no longer be covered under Tier 1 of the POS plan when prescribed by non-Plan physicians. Such services will continue to be covered under Tier 1 of the POS plan when prescribed by a Plan physician.

KAISER PERMANENTE INSURANCE COMPANY (KPIC) PPO EMERGENCY CARE COINSURANCE LEVEL

The following change applies to the KPIC Certificate of Insurance, which is separate from the Health Plan Group Agreement:

For all KPIC PPO plans effective on and after January 1, 2008, the coinsurance level for the out-of-network tier for emergency care will be equal to the PPO tier. The out-of-network tier, however, is subject to balance billing.

Information in this flyer was accurate at the time of production. Details may have changed. Contact your account manager for current information.

*Benefits changes are pending CMS approval. Kaiser Permanente is a Medicare Advantage organization with a Medicare contract. This contract is renewed annually and coverage beyond the end of the contract year is not guaranteed.

kp.org

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KAISER PERMANENTE