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ABOUT THIS HANDBOOK

This handbook presents summaries of the benefits provided to physicians employed by, or who are Partners of, the Southern California Permanente Medical Group (SCPMG) who qualify for benefits, and their eligible dependents, such as a spouse/domestic partner and children.

This benefits handbook is intended to serve as a Summary Plan Description (SPD) as defined by the Employee Retirement Income Security Act of 1974 (ERISA) for such programs described within that are governed by ERISA. It provides many, but not all, of the details of SCPMG benefit plans. If there should be any difference between this handbook and the official text of the plan documents, trust agreements, SCPMG Partnership Agreement, Partnership Agreement/Rules and Regulations, and insurance contracts, the official text will always be considered correct and will govern.

Words that are capitalized in this document, if not previously defined in this document, refer to terms defined in the SCPMG Partnership Agreement/Rules and Regulations.

Benefits May Be Amended or Terminated

While SCPMG expects to continue the benefits described in this handbook, benefits may be added, changed, and/or discontinued by the SCPMG Board of Directors. You will be notified of any benefits changes. The benefits featured in this handbook are listed below:

- **Health Care Benefits**
  - Kaiser Foundation Health Plan (KFHP)
  - Special Dependent Plan
  - Supplemental Medical Plan
  - Comprehensive Medical Plan (only for Partners on an approved Extended Educational Leave, Medical Service Leave, Military Leave and Retirees)
  - Dental Coverage
  - Alternate Mental Health Plan

- **Disability Income Benefits**
  - Sick Leave Programs
  - Compensation Continuance Program
  - Short-Term Disability Insurance
  - Long-Term Disability Insurance

- **Life and Accident Insurance Benefits**
  - Permanente Provided Life Insurance
  - Optional Life Insurance
  - Spouse/Domestic Partner Life Insurance
  - Business Travel Accident Insurance
• Time-Off Benefits
  - Vacation Leave
  - Educational Leave
  - Holidays and Holiday Pay
  - Extended Educational, Extended Medical Service, and Extended Military Service Leaves
  - Leave of Absence
  - Family Care and Medical Leave
  - Parenting Leave
  - Military Leave
  - Military Reserve Leave of Absence
  - Compassionate Leave
  - Jury Duty
  - Emergency Personal Leave
  - Other Miscellaneous Leaves

• Other Benefits
  - Dependent Care Spending Account
  - Health Care Spending Account
  - Commuter Choice Program
  - Long-Term Care Insurance
  - Mortgage Loan Program
  - Professional Liability Coverage.

Summary for Physicians
The summaries provided in this handbook reflect Southern California Permanente Medical Group (SCPMG) physician benefits only. There are other summaries available for the benefits provided to regular non-physician salaried and hourly employees of SCPMG. For retiree benefits see the Retiree Benefits Handbook.

Benefits are subject to change; therefore, the most recent changes may not be reflected in this handbook until it is updated again. If there should be any difference between this handbook and the official text of the plan documents, trust agreements, SCPMG Partnership Agreement, SCPMG Partnership Rules and Regulations, and insurance contracts, the official text will always be considered correct and will govern.

Summaries of Benefits and Coverage (SBCs)
As a result of the Patient Protection and Affordable Care Act, insurance companies and group health plans are now required to provide consumers with concise documents detailing, in plain language, simple and consistent information about health plan benefits and coverage. These documents will
summarize the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions. The Summaries are available on the SCPMG Physician Portal at http://scpmgphysician.kp.org/. See the Benefits page under the HR & Financials tab.

This Handbook Is Not a Contract

While SCPMG provides a benefit program for its physicians and their eligible dependents, this benefit program does not constitute a contract of employment with SCPMG, nor does it mean future employment for SCPMG is guaranteed.

The Permanente Human Resources and PHR Shared Services Departments

Permanente Human Resources is comprised of your benefits, retirement plans, compensation, and insurance plans, amongst other programs. Our department is located at the Regional Office at Walnut Center in Pasadena, California. The Permanente Human Resources Department enhances the resources we make available to our physicians by automating processes and improving communications.

PHR Shared Services strives to provide the highest level of customer service to our physicians and clients. We are committed to providing helpful and knowledgeable communication and information in a timely manner with a willing, welcoming and available atmosphere.

For any questions pertaining to active physician benefits, please contact PHR Shared Services at 1-877-608-0044 or PHRSharedServices@kp.org.

SUMMARY OF BENEFITS

A summary of the eligible active physician benefit classes are listed in the table below.

<table>
<thead>
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<th>Physician Benefit Class</th>
<th>Class Overview</th>
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<tr>
<td>Full-Time Regular (Associate)</td>
<td>A physician employed by SCPMG who works 8/10 or greater as defined in the Partnership Agreement/Rules and Regulations and does not participate in an outside medical practice for personal monetary gain.</td>
</tr>
<tr>
<td>Special Category</td>
<td>A physician who has been employed by SCPMG for a minimum of three full years and, because of age or administrative reasons, has been deemed ineligible for partnership. A physician may also be placed in Special Category for limited periods of time under certain circumstances.</td>
</tr>
<tr>
<td>Part-Time</td>
<td>A physician who is regularly employed by SCPMG at least half-time (5/10 but less than 8/10). Part-Time physicians may be permitted to have an outside medical practice for monetary gain.</td>
</tr>
<tr>
<td>Physician Category</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Full-Time Special</td>
<td>A physician employed by SCPMG who works 8/10 or greater and does not participate in an outside medical practice for monetary gain and is not eligible for partnership. A physician may also be placed in this category for administrative reasons.</td>
</tr>
<tr>
<td>Partner</td>
<td>In general, a physician who has been elected into the partnership. Multiple categories of Partner Physicians exist.</td>
</tr>
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</table>

Please see the current Partnership Agreement/Rules and Regulations for a more detailed description of these physician benefit classes. Regular Per Diem physicians are not eligible for most of the benefits and programs described in this handbook, including health care benefits, however, a retired physician with Partner Emeritus status may be entitled to retiree benefits. If you are a Per Diem physician, contact PHR Shared Services for more information regarding benefits and programs that may be available to you.

This handbook does not describe benefits or programs that may be available to postgraduate trainee physicians.

**BENEFITS OVERVIEW BY PHYSICIAN CATEGORY**

This chart is a summary of benefits available to physicians working for SCPMG. Details regarding each benefit can be found in the specific section of this handbook.

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<th>Special Category</th>
<th>Part-Time</th>
<th>Full-Time Special</th>
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<td>KFHP Coverage</td>
<td>At SCPMG expense</td>
<td>At SCPMG expense</td>
<td>SCPMG pays 50%</td>
<td>At SCPMG expense</td>
<td>Partner Imputed Income</td>
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<tr>
<td>Special Dependent</td>
<td>May purchase</td>
<td>May purchase</td>
<td>Not eligible</td>
<td>May purchase</td>
<td>May purchase</td>
</tr>
<tr>
<td>Supplemental Medical</td>
<td>At SCPMG expense</td>
<td>At SCPMG expense</td>
<td>Not Eligible</td>
<td>At SCPMG expense</td>
<td>Partner Imputed Income</td>
</tr>
<tr>
<td>Comprehensive Medical</td>
<td>Not Eligible</td>
<td>Not Eligible</td>
<td>Not Eligible</td>
<td>Not eligible</td>
<td>Partner Imputed Income</td>
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<tr>
<td>Dental</td>
<td>At SCPMG expense</td>
<td>At SCPMG expense</td>
<td>Not eligible</td>
<td>At SCPMG expense</td>
<td>Partner Imputed Income</td>
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<tr>
<td>Alternate Mental Health</td>
<td>At SCPMG expense</td>
<td>At SCPMG expense</td>
<td>Not eligible</td>
<td>At SCPMG expense</td>
<td>Partner Imputed Income</td>
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**Sick Leave Coverage**

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<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
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<tr>
<td>Acute Sick Leave</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Yes</td>
</tr>
<tr>
<td>Accumulated Acute Sick Leave</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Yes</td>
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<tr>
<td>Chronic Sick Leave</td>
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<td>Not eligible</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Yes</td>
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<tr>
<td>Accumulated Chronic Sick Leave</td>
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<td>Not eligible</td>
<td>Not eligible</td>
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<td>Compensation Continuance</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Not eligible</td>
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<td>At SCPMG expense</td>
<td>At SCPMG expense</td>
<td>At SCPMG expense</td>
<td>At SCPMG expense</td>
<td>Not eligible</td>
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<tr>
<td>Equal to 50% (Basic Level)</td>
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<td></td>
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<tr>
<td>Long-Term Disability</td>
<td>May purchase</td>
<td>May purchase</td>
<td>May purchase</td>
<td>May purchase</td>
<td>Partner Imputed Income</td>
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<td>Vacation Leave</td>
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<td>Yes</td>
<td>Yes</td>
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<td>Educational Leave</td>
<td>After 1 year</td>
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<td>Not eligible</td>
<td>Upon approval</td>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Extended Educ/Med/Mil Service Leave</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Yes</td>
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<td>Parenting Leave</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Family Care &amp; Medical Leave</td>
<td>Yes if meet service/hours worked requirement</td>
<td>Yes if meet service/hours worked requirement</td>
<td>Yes if meet service/hours worked requirement</td>
<td>Yes if meet service/hours worked requirement</td>
<td>Not eligible</td>
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<td>Military Leave</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Military Reserve Leave of Absence</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>Compassionate Leave</td>
<td>Upon approval</td>
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<td>Upon approval</td>
<td>Upon approval</td>
<td>Upon approval</td>
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<tr>
<td>Leave of Absence</td>
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<td>Upon approval</td>
<td>Upon approval</td>
<td>Upon approval</td>
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<tr>
<td>Emergency Personal Leave</td>
<td>Yes</td>
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<td>No</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Jury Duty</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td><strong>Life Insurance</strong></td>
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<td></td>
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<tr>
<td>Permanente Provided Life</td>
<td>After 3 years’ service</td>
<td>After 3 years’ service</td>
<td>After 3 years’ service</td>
<td>After 3 years’ service</td>
<td>After 3 years’ service</td>
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<tr>
<td>Optional Life (Includes AD&amp;D)</td>
<td>May purchase</td>
<td>May purchase</td>
<td>May purchase</td>
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<td>May purchase</td>
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<tr>
<td>Business Travel Accident</td>
<td>Yes</td>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Spouse/Domestic Partner Life Insurance</td>
<td>May purchase</td>
<td>May purchase</td>
<td>May purchase</td>
<td>May purchase</td>
<td>May purchase</td>
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<tr>
<td>Retiree Life (See Retiree Benefits Handbook for information)</td>
<td>Upon retirement</td>
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<td>Upon retirement</td>
<td>Upon retirement</td>
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<tr>
<td>Tapered Life* (See Retiree Benefits Handbook for information)</td>
<td>Upon retirement</td>
<td>Upon retirement</td>
<td>Upon retirement</td>
<td>Upon retirement</td>
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<tr>
<td><strong>Retirement Plans</strong></td>
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<tr>
<td>Common Plan**</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Tax Savings Retirement Plan (TSR)</td>
<td>After 6 months</td>
<td>Yes</td>
<td>After 6 months</td>
<td>After 6 months</td>
<td>Yes</td>
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<th>Full-Time Regular (Associate)</th>
<th>Special Category</th>
<th>Part-Time</th>
<th>Full-Time Special</th>
<th>Partner</th>
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<tr>
<td>Keogh Plan</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>Early Separation Program</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
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### Additional Benefits

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<tr>
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<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
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<tbody>
<tr>
<td>Dependent Care Spending Account</td>
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<tr>
<td>Health Care Spending Account</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commuter Choice Program</td>
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<tr>
<td>Long-Term Care Insurance</td>
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<tr>
<td>Education Half Day***</td>
<td>Upon approval</td>
<td>Yes</td>
<td>Not eligible</td>
<td>Upon approval</td>
<td>Yes</td>
</tr>
<tr>
<td>Mortgage Loan Program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Liability Coverage</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

* If in Optional Life prior to 12/31/90 and meet eligibility requirements at retirement.

** If .5 or greater work schedule and not engaged in a private practice outside of SCPMG.

*** If .8 or .9 work schedule and hired after June 10, 1986, may use ½ day per month.

THIS TABLE IS A SUMMARY OF BENEFITS THAT CAN BE USED TO COMPARE BENEFITS BY PHYSICIAN CATEGORY. IT DOES NOT INCLUDE ALL DETAILS AND EXCEPTIONS. REFER TO INDIVIDUAL CATEGORY TABLES ON THE FOLLOWING PAGES FOR ADDITIONAL DETAILS REGARDING BENEFITS FOR EACH CATEGORY.
### PHYSICIAN BENEFITS ELIGIBILITY TABLES

**FULL-TIME REGULAR (Associate)**

**8/10 – 10/10***

* This work schedule must be maintained to remain in this status. If less than 8/10, must transfer to part-time. Associate Physicians on a three-year partnership track are in this category.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Coverage Effective Date</th>
<th>Cost to Physician</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Coverage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KFHP Coverage</td>
<td>Date of hire</td>
<td>None**</td>
<td>Coverage for spouse/domestic partner and dependent children up to age 26. Continuation coverage may be available.</td>
</tr>
<tr>
<td>Special Dependent</td>
<td>Date of enrollment</td>
<td>100% paid by physician or by direct bill to participant</td>
<td>Coverage that may be purchased for certain individuals not eligible to participate as your dependents under other coverage. Conversion to Individual Plan is available.</td>
</tr>
<tr>
<td>Supplemental Medical</td>
<td>Date of hire</td>
<td>None**</td>
<td>Coverage for spouse/domestic partner and dependent children up to age 26. Continuation coverage may be available.</td>
</tr>
<tr>
<td>Dental</td>
<td>1st of month after date of hire</td>
<td>None**</td>
<td>Coverage for spouse/domestic partner and unmarried dependent children up to age 21, 25 if full-time student (19, 23 for United Concordia). May switch among plans once in any 12-month period: Delta, DeltaCare USA, United Concordia. Continuation coverage may be available.</td>
</tr>
<tr>
<td>Alternate Mental Health</td>
<td>Date of hire</td>
<td>None**</td>
<td>Coverage for spouse/domestic partner and dependent children up to age 26. Continuation coverage may be available.</td>
</tr>
</tbody>
</table>

### Sick Leave Coverage

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Coverage Effective Date</th>
<th>Cost to Physician</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Sick Leave</td>
<td>Date of hire</td>
<td>None</td>
<td>Up to 22 days per year, prorated to work schedule. During first year accrue monthly.</td>
</tr>
<tr>
<td>Accumulated Acute Sick Leave</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Sick Leave</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accumulated Chronic Sick Leave</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compensation Continuance</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Disability Coverage

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Coverage Effective Date</th>
<th>Cost to Physician</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-Term Disability Equal to 50% (Basic Level)</td>
<td>Date of hire</td>
<td>None</td>
<td>Enrollment automatic upon hire date. Company-paid benefits are taxable to the physician.</td>
</tr>
<tr>
<td>Long-Term Disability</td>
<td>Date of purchase</td>
<td>100% paid by physician</td>
<td>Must elect enrollment during new hire 60-day enrollment period. Enrollment not available after 60-day enrollment period. Benefits received are not taxable.</td>
</tr>
</tbody>
</table>

** Domestic partner benefits result in Imputed Income to physician.

(continued)
<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Coverage Effective Date</th>
<th>Cost to Physician</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time-Off Benefits</strong></td>
<td></td>
<td></td>
<td>ALL TIME-OFF BENEFITS ARE PRORATED TO THE WORK SCHEDULE</td>
</tr>
<tr>
<td>Vacation Leave</td>
<td>Date of hire</td>
<td>None</td>
<td>See handbook for accrual schedule.</td>
</tr>
<tr>
<td>Educational Leave</td>
<td>After 1 year</td>
<td>None</td>
<td>5 days per year (max accrual is 20 days).</td>
</tr>
<tr>
<td>Holidays and Holiday Pay</td>
<td>Date of hire</td>
<td>None</td>
<td>See handbook for observed holidays and rates of pay.</td>
</tr>
<tr>
<td>Ext. Educ/Med/Mil Service Leave</td>
<td></td>
<td>Not eligible</td>
<td></td>
</tr>
<tr>
<td>Parenting Leave</td>
<td>Date of hire</td>
<td>None</td>
<td>May use various leaves to provide time off for new parents.</td>
</tr>
<tr>
<td>Family Care &amp; Medical Leave</td>
<td>After meet service/ hours worked requirement</td>
<td>None</td>
<td>May use various leaves to provide time off for family/medical reasons.</td>
</tr>
<tr>
<td>Military Leave</td>
<td>Date of hire</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Military Reserve Leave</td>
<td>Date of hire</td>
<td>None</td>
<td>May take as a Leave of Absence or a Vacation Leave for up to four weeks. If taken as a Leave of Absence, will not affect Anniversary Date.</td>
</tr>
<tr>
<td>Compassionate Leave</td>
<td>Date of hire</td>
<td>None</td>
<td>5 days</td>
</tr>
<tr>
<td>Leave of Absence</td>
<td>Date of hire</td>
<td>None</td>
<td>Anniversary Date adjustment if more than 10 days per year, 60 days per lifetime.</td>
</tr>
<tr>
<td>Emergency Personal Leave</td>
<td>Date of hire</td>
<td>None</td>
<td>May use Vacation Leave or Leave of Absence (without pay) up to 5 days per year.</td>
</tr>
<tr>
<td>Jury Duty</td>
<td>Date of hire</td>
<td>None</td>
<td>Maximum of 10 days of paid Jury Duty leave in any 5-consecutive-year period. Additional time for Jury Duty must be taken as Vacation Leave or a Leave of Absence. Must provide copies of all court correspondence to Chief of Service and Area Medical Director.</td>
</tr>
<tr>
<td><strong>Life Insurance</strong></td>
<td></td>
<td></td>
<td>PREMIUM RATES SUBJECT TO CHANGE ANNUALLY. COVERAGE AMOUNTS PRORATED TO WORK SCHEDULE</td>
</tr>
<tr>
<td>Permanente Provided Life***</td>
<td>After 3 years’ Qualifying Service</td>
<td>Premium for amounts over $50,000 is Imputed Income</td>
<td>Eligible for 100% of Base Annual Compensation after 3 years’ Qualifying Service, 200% after 5 years’ Credited Service, 300% after 15 years’ Credited Service.</td>
</tr>
<tr>
<td>Age-Rated Optional Life (Includes AD&amp;D)***</td>
<td>Later of date of hire or date enrollment form signed</td>
<td>Premium rate based upon age</td>
<td>May purchase up to 600% of Base Annual Compensation. Proof of insurability required for all amounts over 200% within 60 days of hire. After 60 days, proof required for all amounts.</td>
</tr>
<tr>
<td>Spouse/Domestic Partner Life Insurance</td>
<td>Date of purchase</td>
<td>Premium rate based upon spouse’s/domestic partner’s age</td>
<td>May purchase up to $500,000 life insurance for spouse/domestic partner. Proof of insurability required for benefit over $100,000 within 60 days of hire. After 60 days, proof required for all amounts.</td>
</tr>
<tr>
<td>Business Travel Accident</td>
<td>Date of hire</td>
<td>None</td>
<td>While traveling on SCPMG business not commuting between home and work.</td>
</tr>
</tbody>
</table>

*** Combined coverage amounts of Permanente Provided Life plus Optional Life cannot exceed 600% of Base Annual Compensation or $2,000,000.
<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Coverage Effective Date</th>
<th>Cost to Physician</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retiree Life (See Retiree Benefits Handbook for information)</td>
<td>Upon retirement</td>
<td>None</td>
<td>$50,000 death benefit after retirement, if you meet eligibility requirements and not eligible for Tapered Life.</td>
</tr>
<tr>
<td>Tapered Life (See Retiree Benefits Handbook for information)</td>
<td>Upon retirement</td>
<td>Imputed Income for benefit greater than $50,000</td>
<td>Must have been enrolled in Optional Life prior to 12/31/90 and meet eligibility requirements.</td>
</tr>
<tr>
<td><strong>Retirement Plans</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common Plan</td>
<td>Date of hire</td>
<td>None</td>
<td>Begin accruing service time upon hire. Vested following 10 years’ Qualifying Service.</td>
</tr>
<tr>
<td>Physicians’ TSR Plan</td>
<td>6 months after hire</td>
<td>100% physician contribution</td>
<td>May enroll or discontinue contributions at any time. Defer from 1% to 75% of compensation, up to annual federal limit.</td>
</tr>
<tr>
<td>Keogh Plan</td>
<td>Not eligible</td>
<td></td>
<td>Must enroll after 6 months of active full-time employment.</td>
</tr>
<tr>
<td><strong>Early Separation Program</strong></td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Additional Plans</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent Care Spending Account</td>
<td>Date of enrollment</td>
<td>100% paid by physician</td>
<td>Open Enrollment once per year; mid-year enrollment may be available under certain circumstances.</td>
</tr>
<tr>
<td>Health Care Spending Account</td>
<td>Date of enrollment</td>
<td>100% paid by physician</td>
<td>Open Enrollment once per year; mid-year enrollment may be available under certain circumstances. Continuation coverage may be available.</td>
</tr>
<tr>
<td>Commuter Choice Program</td>
<td>Date of enrollment</td>
<td>100% paid by physician</td>
<td>Election to participate may be changed monthly for the following month.</td>
</tr>
<tr>
<td>Long-Term Care Insurance (through New York Life; enrollment closed to new applicants)</td>
<td>Date of enrollment and/or upon proof of insurability</td>
<td>100% paid by physician</td>
<td>Coverage is no longer available through New York Life. However, if you purchased a NYL policy prior to November 2012, you may continue to pay premiums.</td>
</tr>
<tr>
<td>Education Half Day</td>
<td>Upon approval</td>
<td>None</td>
<td>If regularly working .8 or .9 schedule, may take once per month; requires approval by Chief of Service and Area Medical Director.</td>
</tr>
<tr>
<td>Mortgage Loan Program</td>
<td>Date of hire</td>
<td>Varies</td>
<td>See handbook for details.</td>
</tr>
<tr>
<td>Professional Liability Coverage</td>
<td>Date of hire</td>
<td>None</td>
<td>Date-of-occurrence basis.</td>
</tr>
</tbody>
</table>

(continued)
**SPECIAL CATEGORY**
**8/10 – 10/10**

* This work schedule must be maintained to remain in this status. If less, must transfer to part-time. Three-year maximum in this category unless in category prior to 1988. If hired after 2/2/2007 can only remain in this category for 2 years.

<table>
<thead>
<tr>
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<tr>
<td><strong>Health Care Coverage</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>KFHP Coverage</td>
<td>Continues</td>
<td>None***</td>
<td>Coverage for spouse/domestic partner and dependent children up to age 26. Continuation coverage may be available.</td>
</tr>
<tr>
<td>Special Dependent</td>
<td>Date of enrollment</td>
<td>100% paid by physician or by direct bill to participant</td>
<td>Coverage that may be purchased for certain individuals not eligible to participate as your dependents under other coverage. Conversion to Individual Plan is available.</td>
</tr>
<tr>
<td>Supplemental Medical</td>
<td>Continues</td>
<td>None***</td>
<td>Coverage for spouse/domestic partner and dependent children up to age 26. Continuation coverage may be available.</td>
</tr>
<tr>
<td>Dental</td>
<td>Continues</td>
<td>None***</td>
<td>Coverage for spouse/domestic partner and unmarried dependent children up to age 21, 25 if full-time student (19, 23 for United Concordia). May switch among plans once in any 12-month period: Delta, DeltaCare USA, United Concordia. Continuation coverage may be available.</td>
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<tr>
<td>Alternate Mental Health</td>
<td>Continues</td>
<td>None***</td>
<td>Coverage for spouse/domestic partner and dependent children up to age 26. Continuation coverage may be available.</td>
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<tr>
<td><strong>Sick Leave Coverage</strong></td>
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<tr>
<td>Acute Sick Leave</td>
<td>Continues</td>
<td>None</td>
<td>22 days per year, prorated to work schedule.</td>
</tr>
<tr>
<td>Accumulated Acute Sick Leave</td>
<td>Not eligible</td>
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<tr>
<td>Chronic Sick Leave</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accumulated Chronic Sick Leave</td>
<td>Date of election into category</td>
<td>None</td>
<td>100% of unused Acute Sick Leave transfers in on Anniversary Date, maximum 66 days.</td>
</tr>
<tr>
<td>Compensation Continuance</td>
<td>Not eligible</td>
<td></td>
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</tr>
<tr>
<td><strong>Disability Coverage</strong></td>
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<tr>
<td>Short-Term Disability Equal to 50% (Basic Level)</td>
<td>Date of hire</td>
<td>None</td>
<td>Enrollment automatic upon hire date. Company-paid benefits are taxable to the physician.</td>
</tr>
<tr>
<td>Long-Term Disability</td>
<td>Date of purchase</td>
<td>100% paid by physician</td>
<td>Must elect enrollment during new hire 60-day enrollment period only. Enrollment not available after 60-day enrollment period. Benefits received are not taxable.</td>
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** Coverage Effective Date: If the chart reads “continues,” this implies no change in coverage when a physician moves from one physician category to another.

*** Domestic partner benefits result in Imputed Income to physician.

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<tr>
<td>Vacation Leave</td>
<td>Continues</td>
<td>None</td>
<td>See handbook for accrual schedule.</td>
</tr>
<tr>
<td>Educational Leave</td>
<td>Continues</td>
<td>None</td>
<td>5 days per year (max accrual is 20 days).</td>
</tr>
<tr>
<td>Holidays and Holiday Pay</td>
<td>Continues</td>
<td>None</td>
<td>See handbook for observed holidays and rates of pay.</td>
</tr>
<tr>
<td>Ext. Educ/Med/Mil Service Leave</td>
<td>Not eligible</td>
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<td></td>
</tr>
<tr>
<td>Parenting Leave</td>
<td>Continues</td>
<td>None</td>
<td>May use various leaves to provide time-off for new parents.</td>
</tr>
<tr>
<td>Family Care &amp; Medical Leave</td>
<td>Continues</td>
<td>None</td>
<td>May use various leaves to provide time-off for family/medical reasons</td>
</tr>
<tr>
<td>Military Leave</td>
<td>Continues</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Military Reserve Leave</td>
<td>Continues</td>
<td>None</td>
<td>May take as a Leave of Absence or a Vacation Leave for up to four weeks. If taken as a Leave of Absence, will not affect Anniversary Date.</td>
</tr>
<tr>
<td>Compassionate Leave</td>
<td>Continues</td>
<td>None</td>
<td>5 days.</td>
</tr>
<tr>
<td>Leave of Absence</td>
<td>Continues</td>
<td>None</td>
<td>Anniversary Date adjustment if more than 10 days per year, or 60 days per lifetime.</td>
</tr>
<tr>
<td>Emergency Personal Leave</td>
<td>Continues</td>
<td>None</td>
<td>May use Vacation Leave or Leave of Absence (without pay) up to 5 days per year.</td>
</tr>
<tr>
<td>Jury Duty</td>
<td>Continues</td>
<td>None</td>
<td>Maximum of 10 days of paid Jury Duty leave in any 5-consecutive-year period. Additional time for Jury Duty must be taken as Vacation Leave or a Leave of Absence. Limited to 10 days in a five-year period. Must provide copies of all court correspondence to Chief of Service and Area Medical Director.</td>
</tr>
<tr>
<td>Life Insurance</td>
<td></td>
<td></td>
<td>PREMIUM RATES SUBJECT TO CHANGE ANNUALLY. COVERAGE AMOUNTS PRORATED TO WORK SCHEDULE</td>
</tr>
<tr>
<td>Permanente Provided Life***</td>
<td>After 3 years’ Qualifying Service</td>
<td>Premium for amounts over $50,000 is Imputed Income</td>
<td>Eligible for 100% of Base Annual Compensation after 3 years’ Qualifying Service, 200% after 5 years’ Credited Service, 300% after 15 years’ Credited Service.</td>
</tr>
<tr>
<td>Age-Rated Optional Life (Includes AD&amp;D)***</td>
<td>Date enrollment form signed, upon approval by insurance company</td>
<td>Premium rate based upon age</td>
<td>May purchase up to 600% of Base Annual Compensation. Proof of insurability required for all amounts.</td>
</tr>
<tr>
<td>Business Travel Accident</td>
<td>Continues</td>
<td>None</td>
<td>While traveling on SCPMG business not commuting between home and work.</td>
</tr>
<tr>
<td>Spouse/Domestic Partner Life Insurance</td>
<td>Date of Purchase</td>
<td>Premium rate based upon spouse’s/domestic partner’s age</td>
<td>May purchase up to $500,000 life insurance for spouse/domestic partner. Proof of insurability required for all amounts.</td>
</tr>
<tr>
<td>Retiree Life (See Retiree Benefits Handbook for information)</td>
<td>Upon retirement</td>
<td>None</td>
<td>$50,000 death benefit after retirement, if you meet eligibility requirements and not eligible for Tapered Life.</td>
</tr>
</tbody>
</table>

** Coverage Effective Date: If the chart reads “continues,” this implies no change in coverage when a physician moves from one physician category to another.

*** Combined coverage amounts for Permanente Provided Life plus Optional Life cannot exceed 600% of Base Annual Compensation or $2,000,000.
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<th>Coverage Effective Date**</th>
<th>Cost to Physician</th>
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<tbody>
<tr>
<td>Tapered Life (See Retiree Benefits Handbook for information)</td>
<td>Upon retirement</td>
<td>Imputed Income for benefit greater than $50,000</td>
<td>Must have been enrolled in Optional Life prior to 12/31/90 and meet eligibility requirements.</td>
</tr>
<tr>
<td><strong>Retirement Plans</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common Plan</td>
<td>Service time accrual</td>
<td>None</td>
<td>Begin accruing service time upon hire. Vested following 10 years’ Qualifying Service.</td>
</tr>
<tr>
<td>Physicians’ TSR Plan</td>
<td>Continues</td>
<td>100% physician contribution</td>
<td>May enroll or discontinue contributions at any time. Defer from 1% to 75% of compensation, up to annual federal limit.</td>
</tr>
<tr>
<td>Keogh Plan</td>
<td>Not eligible</td>
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<tr>
<td>Early Separation Program</td>
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<td><strong>Additional Benefits</strong></td>
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<td>Dependent Care Spending Account</td>
<td>Date of enrollment</td>
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<td>Open Enrollment once per year; mid-year enrollment may be available under certain circumstances.</td>
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<tr>
<td>Health Care Spending Account</td>
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<td>100% paid by physician</td>
<td>Open Enrollment once per year; mid-year enrollment may be available under certain circumstances. Continuation coverage may be available.</td>
</tr>
<tr>
<td>Commuter Choice Program</td>
<td>Date of enrollment</td>
<td>100% paid by physician</td>
<td>Election to participate may be changed monthly for the following month.</td>
</tr>
<tr>
<td>Long-Term Care Insurance (through New York Life; enrollment closed to new applicants)</td>
<td>Upon age 40 or upon proof of insurability</td>
<td>100% paid by physician</td>
<td>Coverage is no longer available through New York Life. However, if you purchased a NYL policy prior to November 2012, you may continue to pay premiums.</td>
</tr>
<tr>
<td>Education Half Day</td>
<td>Upon approval</td>
<td>None</td>
<td>If regularly working .8 or .9 schedule, may take once per month, requires approval by Chief of Service and Area Medical Director.</td>
</tr>
<tr>
<td>Mortgage Loan Program</td>
<td>Continues</td>
<td>Varies</td>
<td>See handbook for details.</td>
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<tr>
<td>Professional Liability Coverage</td>
<td>Continues</td>
<td>None</td>
<td>Date-of-occurrence basis.</td>
</tr>
</tbody>
</table>

** Coverage Effective Date: If the chart reads “continues,” this implies no change in coverage when a physician moves from one physician category to another.
**Effective March 1, 2014**

FULL-TIME SPECIAL

10/10*

* 8/10 or 9/10 schedule may be approved by Chief of Service and Area Medical Director after two years of service. If less than 8/10, transfer to part-time.

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<tr>
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</tr>
<tr>
<td>KFHP Coverage</td>
<td>Date of hire</td>
<td>None**</td>
<td>Coverage for spouse/domestic partner and dependent children up to age 26. Continuation coverage may be available.</td>
</tr>
<tr>
<td>Special Dependent</td>
<td>Date of enrollment</td>
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<td>Coverage that may be purchased for certain individuals not eligible to participate as your dependents under other coverage. Conversion to Individual Plan is available.</td>
</tr>
<tr>
<td>Supplemental Medical</td>
<td>Date of hire</td>
<td>None**</td>
<td>Coverage for spouse/domestic partner and dependent children up to age 26. Continuation coverage may be available.</td>
</tr>
<tr>
<td>Dental</td>
<td>1st of month after date of hire</td>
<td>None**</td>
<td>Coverage for spouse/domestic partner and unmarried dependent children up to age 21, 25 if full-time student (19, 23 for United Concordia). May switch among plans once in any 12-month period: Delta, DeltaCare USA, United Concordia. Continuation coverage may be available.</td>
</tr>
<tr>
<td>Alternate Mental Health</td>
<td>Date of hire</td>
<td>None**</td>
<td>Coverage for spouse/domestic partner and dependent children up to age 26. Continuation coverage may be available.</td>
</tr>
<tr>
<td>Sick Leave Coverage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Sick Leave</td>
<td>Date of hire</td>
<td>None</td>
<td>22 days per year, prorated to work schedule.</td>
</tr>
<tr>
<td>Accumulated Acute Sick Leave</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Sick Leave</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accumulated Chronic Sick Leave</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compensation Continuance</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability Coverage</td>
<td></td>
<td></td>
<td>PREMIUM RATES SUBJECT TO CHANGE ANNUALLY</td>
</tr>
<tr>
<td>Short-Term Disability Equal to 50% (Basic Level)</td>
<td>Date of hire</td>
<td>None</td>
<td>Enrollment automatic upon hire date. Company-paid benefits are taxable to the employee.</td>
</tr>
<tr>
<td>Long-Term Disability</td>
<td>Date of enrollment</td>
<td>100% paid by physician</td>
<td>Must elect enrollment during new hire 60-day enrollment period only. Enrollment not available after 60-day enrollment period. Benefits received are not taxable.</td>
</tr>
<tr>
<td>Time-Off Benefits</td>
<td></td>
<td></td>
<td>ALL TIME-OFF BENEFITS ARE PRORATED TO THE WORK SCHEDULE</td>
</tr>
<tr>
<td>Vacation Leave</td>
<td>Date of hire</td>
<td>None</td>
<td>See handbook for accrual schedule.</td>
</tr>
<tr>
<td>Educational Leave</td>
<td>Upon approval</td>
<td>None</td>
<td>5 days per year (max accrual is 20 days).</td>
</tr>
</tbody>
</table>

** Domestic partner benefits result in Imputed Income to physician.
<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Coverage Effective Date</th>
<th>Cost to Physician</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holidays and Holiday Pay</td>
<td>Date of hire</td>
<td>None</td>
<td>See handbook for observed holidays and rates of pay.</td>
</tr>
<tr>
<td>Ext. Educ/Med/Mil Service Leave</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parenting Leave</td>
<td>Date of hire</td>
<td>None</td>
<td>May use various leaves to provide time-off for new parents.</td>
</tr>
<tr>
<td>Family Care &amp; Medical Leave</td>
<td>After meet service/ hours worked requirement</td>
<td>None</td>
<td>May use various leaves to provide time-off for family/medicinal reasons.</td>
</tr>
<tr>
<td>Military Leave</td>
<td>Date of hire</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Military Reserve Leave</td>
<td>Date of hire</td>
<td>None</td>
<td>May take as a Leave of Absence or a Vacation Leave for up to four weeks. If taken as a Leave of Absence, will not affect Anniversary Date.</td>
</tr>
<tr>
<td>Compassionate Leave</td>
<td>Date of hire</td>
<td>None</td>
<td>5 days.</td>
</tr>
<tr>
<td>Leave of Absence</td>
<td>Date of hire</td>
<td>None</td>
<td>Anniversary Date adjustment if more than 10 days per year or 60 days per lifetime.</td>
</tr>
<tr>
<td>Emergency Personal Leave</td>
<td>Date of hire</td>
<td>None</td>
<td>May use Vacation Leave or Leave of Absence (without pay) up to 5 days per year.</td>
</tr>
<tr>
<td>Jury Duty</td>
<td>Date of hire</td>
<td>None</td>
<td>Maximum of 10 days of paid Jury Duty leave in any 5-consecutive-year period. Additional time for Jury Duty must be taken as Vacation Leave or a Leave of Absence. Limited to 10 days in a five-year period. Must provide copies of all court correspondence to Chief of Service and Area Medical Director.</td>
</tr>
</tbody>
</table>

**Life Insurance**

**PREMIUM RATES SUBJECT TO CHANGE ANNUALLY. COVERAGE AMOUNTS PRORATED TO WORK SCHEDULE**

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Coverage Effective Date</th>
<th>Cost to Physician</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanente Provided Life***</td>
<td>After 3 years’ Qualifying Service</td>
<td>Premium for amounts over $50,000 is Imputed Income</td>
<td>Eligible for 100% of Base Annual Compensation after 3 years’ Qualifying Service, 200% after 5 years’ Credited Service, 300% after 15 years’ Credited Service.</td>
</tr>
<tr>
<td>Age-Rated Optional Life (Includes AD&amp;D)***</td>
<td>Date enrollment form signed, upon approval by insurance company</td>
<td>Premium rate based upon age</td>
<td>May purchase up to 600% of Base Annual Compensation. Proof of insurability required for all amounts over 600% within 60 days of hire. After 60 days, proof required for all amounts.</td>
</tr>
<tr>
<td>Business Travel Accident</td>
<td>Date of hire</td>
<td>None</td>
<td>While traveling on SCPMK business not commuting between home and work.</td>
</tr>
<tr>
<td>Spouse/Domestic Partner Life Insurance</td>
<td>Date of Purchase</td>
<td>Premium rate based upon spouse’s/ domestic partner’s age</td>
<td>May purchase up to $500,000 life insurance for spouse/domestic partner. Proof of insurability required for all amounts.</td>
</tr>
<tr>
<td>Retiree Life (See Retiree Benefits Handbook for information)</td>
<td>Upon retirement</td>
<td>None</td>
<td>$50,000 death benefit after retirement, if you meet eligibility requirements and not eligible for Tapered Life.</td>
</tr>
<tr>
<td>Tapered Life (See Retiree Benefits Handbook for information)</td>
<td>Upon retirement</td>
<td>Imputed Income for benefit greater than $50,000</td>
<td>Must have been enrolled in Optional Life prior to 12/31/90 and meet eligibility requirements.</td>
</tr>
</tbody>
</table>

*** Combined coverage amounts of Permanente Provided Life plus Optional Life cannot exceed 600% of Base Annual Compensation or $2,000,000.

Effective March 1, 2014
<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Coverage Effective Date</th>
<th>Cost to Physician</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retirement Plans</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common Plan</td>
<td>Service time accrual continues</td>
<td>None</td>
<td>Begin accruing service time upon hire. Vested following 10 years’ Qualifying Service.</td>
</tr>
<tr>
<td>Physicians’ TSR Plan</td>
<td>6 months after hire</td>
<td>100% physician contribution</td>
<td>May enroll or discontinue contributions at any time. Defer from 1% to 75% of compensation, up to annual federal limit.</td>
</tr>
<tr>
<td>Keogh Plan</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early Separation Program</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Additional Plans</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent Care Spending Account</td>
<td>Date of enrollment</td>
<td>100% paid by physician</td>
<td>Open Enrollment once per year; mid-year enrollment may be available under certain circumstances.</td>
</tr>
<tr>
<td>Health Care Spending Account</td>
<td>Date of enrollment</td>
<td>100% paid by physician</td>
<td>Open Enrollment once per year; mid-year enrollment may be available under certain circumstances. Continuation coverage may be available.</td>
</tr>
<tr>
<td>Commuter Choice Program</td>
<td>Date of enrollment</td>
<td>100% paid by physician</td>
<td>Election to participate may be changed monthly for the following month.</td>
</tr>
<tr>
<td>Long-Term Care Insurance (through New York Life; enrollment closed to new applicants)</td>
<td>Date of partnership, upon age 40 or upon proof of insurability</td>
<td>100% paid by physician</td>
<td>Coverage is no longer available through New York Life. However, if you purchased a NYL policy prior to November 2012, you may continue to pay premiums.</td>
</tr>
<tr>
<td>Education Half Day</td>
<td>Upon approval</td>
<td>None</td>
<td>If regularly working .8 or .9 schedule, may take once per month; requires approval by Chief of Service and Area Medical Director.</td>
</tr>
<tr>
<td>Mortgage Loan Program</td>
<td>Date of hire</td>
<td>Varies</td>
<td>See handbook for details.</td>
</tr>
<tr>
<td>Professional Liability Coverage</td>
<td>Date of hire</td>
<td>None</td>
<td>Date-of-occurrence basis.</td>
</tr>
</tbody>
</table>

(continued)
PART-TIME
5/10 – 7/10*

* This work schedule must be maintained to remain in this status. If less than 5/10, transfer to Per Diem.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Coverage Effective Date</th>
<th>Cost to Physician</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Coverage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KFHP Coverage</td>
<td>Eligible</td>
<td>50% paid by physician**</td>
<td>May purchase at 50% discounted rate. Coverage for spouse/domestic partner and dependent children up to age 26.</td>
</tr>
<tr>
<td>Special Dependent</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplemental Medical</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alternate Mental Health</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sick Leave Coverage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Sick Leave</td>
<td>Date of hire</td>
<td>None</td>
<td>22 days per year, prorated to work schedule. During first year accrue monthly.</td>
</tr>
<tr>
<td>Accumulated Acute Sick Leave</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Sick Leave</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accumulated Chronic Sick Leave</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compensation Continuance</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability Coverage</td>
<td></td>
<td></td>
<td>PREMIUM RATES SUBJECT TO CHANGE ANNUALLY</td>
</tr>
<tr>
<td>Short-Term Disability</td>
<td>Date of hire</td>
<td>None</td>
<td>Enrollment automatic upon hire date. Company-paid benefits are taxable to the physician.</td>
</tr>
<tr>
<td>Equal to 50% (Basic Level)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-Term Disability</td>
<td>Date of enrollment</td>
<td>100% paid by physician</td>
<td>Must elect enrollment during new hire 60 day enrollment period only. Enrollment not available after 60 day enrollment period. Benefits received are not taxable.</td>
</tr>
<tr>
<td>Time-Off Benefits</td>
<td></td>
<td></td>
<td>ALL TIME-OFF BENEFITS ARE PRORATED TO THE WORK SCHEDULE</td>
</tr>
<tr>
<td>Vacation Leave</td>
<td>Date of hire</td>
<td>None</td>
<td>See handbook for accrual schedule.</td>
</tr>
<tr>
<td>Educational Leave</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Holidays and Holiday Pay</td>
<td>Date of hire</td>
<td>None</td>
<td>See handbook for observed holidays and rates of pay.</td>
</tr>
<tr>
<td>Ext. Educ/Med/Mil Service Leave</td>
<td>Date of hire</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parenting Leave</td>
<td>Date of hire</td>
<td>None</td>
<td>May use various leaves to provide time-off for new parents.</td>
</tr>
<tr>
<td>Family Care &amp; Medical Leave</td>
<td>After meet service/ hours worked requirement</td>
<td>None</td>
<td>May use various leaves to provide time-off for family/medical reasons.</td>
</tr>
<tr>
<td>Military Leave</td>
<td>Date of hire</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

** Domestic partner benefits result in Imputed Income to physician.
<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Coverage Effective Date</th>
<th>Cost to Physician</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Military Reserve Leave</td>
<td>Date of hire</td>
<td>None</td>
<td>May take as a Leave of Absence or a Vacation Leave for up to four weeks. If taken as a Leave of Absence, will not affect Anniversary Date.</td>
</tr>
<tr>
<td>Compassionate Leave</td>
<td>Date of hire</td>
<td>None</td>
<td>5 days.</td>
</tr>
<tr>
<td>Leave of Absence</td>
<td>Date of hire</td>
<td>None</td>
<td>Anniversary Date adjustment if more than 10 days per year, 60 days per lifetime.</td>
</tr>
<tr>
<td>Emergency Personal Leave</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jury Duty</td>
<td>Date of hire</td>
<td>None</td>
<td>Maximum of 10 days of paid Jury Duty leave in any 5 consecutive year period. Additional time for Jury Duty must be taken as Vacation Leave or a Leave of Absence. Limited to 10 days in a five-year period. Must provide copies of all court correspondence to Chief of Service and Area Medical Director.</td>
</tr>
</tbody>
</table>

**Life Insurance**

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Coverage Effective Date</th>
<th>Cost to Physician</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanente Provided Life***</td>
<td>After 3 years’ Qualifying Service</td>
<td>Premium for amounts over $50,000 is Imputed Income</td>
<td>Eligible for 100% Base Annual Compensation after 3 years’ Qualifying Service, 200% after 5 years’ Credited Service, 300% after 15 years’ Credited Service.</td>
</tr>
<tr>
<td>Age-Rated Optional Life (Includes AD&amp;D)***</td>
<td>Later of date of hire or date enrollment form signed</td>
<td>Premium rate based upon age</td>
<td>May purchase up to 600% Base Annual Compensation. Proof of insurability required for all amounts over 600% within 60 days of hire. After 60 days, proof required for all amounts.</td>
</tr>
<tr>
<td>Business Travel Accident</td>
<td>Eligible</td>
<td>None</td>
<td>While traveling on SCPMG business not commuting between home and work.</td>
</tr>
<tr>
<td>Spouse/Domestic Partner Life Insurance</td>
<td>Date of Purchase</td>
<td>Premium rate based upon spouse’s/domestic partner’s age</td>
<td>May purchase up to $500,000 life insurance for spouse/domestic partner. Proof of insurability required for all amounts.</td>
</tr>
<tr>
<td>Retiree Life (See Retiree Benefits Handbook for information)</td>
<td>Upon retirement</td>
<td>None</td>
<td>$50,000 death benefit after retirement, if you meet eligibility requirements and not eligible for Tapered Life.</td>
</tr>
<tr>
<td>Tapered Life (See Retiree Benefits Handbook for information)</td>
<td>Upon retirement</td>
<td>Imputed Income for benefit greater than $50,000</td>
<td>Must have been enrolled in Optional Life prior to 12/31/90 and meet eligibility requirements.</td>
</tr>
</tbody>
</table>

**Retirement Plans**

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Coverage Effective Date</th>
<th>Cost to Physician</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common Plan</td>
<td>Date of hire</td>
<td>None</td>
<td>Part-time physicians do not accrue service time if involved in an outside practice.</td>
</tr>
<tr>
<td>Physicians’ TSR Plan</td>
<td>6 months after hire</td>
<td>100% physician contribution</td>
<td>May enroll or discontinue contributions at any time. Defer from 1% to 75% of compensation, up to annual federal limit.</td>
</tr>
<tr>
<td>Keogh Plan</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early Separation Program</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*** Combined coverage amounts of Permanente Provided Life plus Optional Life cannot exceed 600% of Base Annual Compensation or $2,000,000.
<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Coverage Effective Date</th>
<th>Cost to Physician</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Additional Plans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent Care Spending Account</td>
<td>Date of enrollment</td>
<td>100% paid by physician</td>
<td>Open Enrollment once per year; mid-year enrollment may be available under certain circumstances.</td>
</tr>
<tr>
<td>Health Care Spending Account</td>
<td>Date of enrollment</td>
<td>100% paid by physician</td>
<td>Open Enrollment once per year; mid-year enrollment may be available under certain circumstances. Continuation coverage may be available.</td>
</tr>
<tr>
<td>Commuter Choice Program</td>
<td>Date of enrollment</td>
<td>100% paid by physician</td>
<td>Election to participate may be changed monthly for the following month.</td>
</tr>
<tr>
<td>Long-Term Care Insurance (through New York Life; enrollment closed to new applicants)</td>
<td>Date of hire, upon age 40 or upon proof of insurability</td>
<td>100% paid by physician</td>
<td>Coverage is no longer available through New York Life. However, if you purchased a NYL policy prior to November 2012, you may continue to pay premiums.</td>
</tr>
<tr>
<td>Education Half Day</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortgage Loan Program</td>
<td>Date of hire</td>
<td>Varies</td>
<td>See handbook for details.</td>
</tr>
<tr>
<td>Professional Liability Coverage</td>
<td>Date of hire</td>
<td>None</td>
<td>Date-of-occurrence basis.</td>
</tr>
</tbody>
</table>

(continued)
### PARTNER
### ANY WORK SCHEDULE

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Coverage Effective Date*</th>
<th>Cost to Physician</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Care Coverage</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KFHP Coverage</td>
<td>Continues</td>
<td>Imputed Income</td>
<td>Coverage for spouse/domestic partner and dependent children up to age 26. Continuation coverage may be available.</td>
</tr>
<tr>
<td>Special Dependent</td>
<td>Date of enrollment</td>
<td>100% paid by physician or by direct bill to participant</td>
<td>Coverage that may be purchased for certain individuals not eligible to participate as your dependents under other coverage. Conversion to Personal Advantage is available.</td>
</tr>
<tr>
<td>Supplemental Medical</td>
<td>Continues</td>
<td>Imputed Income</td>
<td>Coverage for spouse/domestic partner and dependent children up to age 26. Continuation coverage may be available.</td>
</tr>
<tr>
<td>Comprehensive Medical (Only on an approved sabbatical)</td>
<td>May Elect if on Extended Leave (Educational/Medical/Military)</td>
<td>Imputed Income</td>
<td>You may elect this coverage if you are on an approved Extended Leave (Educational/Medical/Military) and reside outside of a Kaiser Permanente Service area.</td>
</tr>
<tr>
<td>Dental</td>
<td>Continues</td>
<td>Imputed Income</td>
<td>Coverage for spouse/domestic partner and unmarried dependent children up to age 21, 25 if full-time student (19, 23 for United Concordia). May switch among plans once in any 12-month period: Delta, DeltaCare USA, United Concordia. Continuation coverage may be available.</td>
</tr>
<tr>
<td>Alternate Mental Health</td>
<td>Continues</td>
<td>Imputed Income</td>
<td>Coverage for spouse/domestic partner and dependent children up to age 26. Continuation coverage may be available.</td>
</tr>
<tr>
<td><strong>Sick Leave Coverage</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Sick Leave</td>
<td>Continues</td>
<td>None</td>
<td>22 days per year, prorated to work schedule.</td>
</tr>
<tr>
<td>Accumulated Acute Sick Leave</td>
<td>Maximum 44 days</td>
<td>None</td>
<td>20% of unused Acute Sick Leave balance transfers to Accumulated Acute on Anniversary Date. May re-accumulate.</td>
</tr>
<tr>
<td>Chronic Sick Leave</td>
<td>528 days</td>
<td>None</td>
<td>Balance available upon election to partnership. Does not re-accumulate.</td>
</tr>
<tr>
<td>Accumulated Chronic Sick Leave</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compensation Continuance</td>
<td>Up to 5 months</td>
<td>None</td>
<td>60% of Monthly Base or Gross Compensation.</td>
</tr>
<tr>
<td><strong>Disability Coverage</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short-Term Disability Equal to 50% (Basic Level)</td>
<td>Not Eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-Term Disability</td>
<td>Upon election to partnership</td>
<td>Imputed Income</td>
<td>Premiums paid by SCPMG. Benefits received are not taxable.</td>
</tr>
</tbody>
</table>

*(continued)*

* Coverage Effective Date: If the chart reads “continues,” this implies no change in coverage when a physician moves from one physician category to another.
<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Coverage Effective Date*</th>
<th>Cost to Physician</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time-Off Benefits</strong></td>
<td></td>
<td></td>
<td>ALL TIME-OFF BENEFITS ARE PRORATED TO THE WORK SCHEDULE</td>
</tr>
<tr>
<td>Vacation Leave</td>
<td>Continues</td>
<td>None</td>
<td>See handbook for accrual schedule.</td>
</tr>
<tr>
<td>Educational Leave</td>
<td>Continues</td>
<td>None</td>
<td>5 days per year (max accrual is 20 days).</td>
</tr>
<tr>
<td>Holidays and Holiday Pay</td>
<td>Continues</td>
<td>None</td>
<td>See handbook for observed holidays.</td>
</tr>
<tr>
<td>Ext. Educ/Med/Mil Service Leave</td>
<td>Every 5 years of service, 66 days</td>
<td>None</td>
<td>Both leaves paid at 50%. Extended Educational Leave only: last 22 days of a 66-or-more-day leave is paid at 100% for Partners with at least 10 years of service.</td>
</tr>
<tr>
<td>Parenting Leave</td>
<td>Continues</td>
<td>None</td>
<td>May use various leaves to provide time-off for new parents.</td>
</tr>
<tr>
<td>Family Care &amp; Medical Leave</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Military Leave</td>
<td>Continues</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Military Reserve Leave</td>
<td>Continues</td>
<td>None</td>
<td>May take as a Leave of Absence or a Vacation Leave for up to four weeks. If taken as a Leave of Absence, will not affect Anniversary Date.</td>
</tr>
<tr>
<td>Compassionate Leave</td>
<td>Continues</td>
<td>None</td>
<td>5 days.</td>
</tr>
<tr>
<td>Leave of Absence</td>
<td>Continues</td>
<td>None</td>
<td>Anniversary Date adjustment if more than 10 days per year or 60 days per lifetime.</td>
</tr>
<tr>
<td>Emergency Personal Leave</td>
<td>Continues</td>
<td>None</td>
<td>May use Vacation Leave or Leave of Absence (without pay) up to 5 days per year.</td>
</tr>
<tr>
<td>Jury Duty</td>
<td>Continues</td>
<td>None</td>
<td>Maximum of 10 days of paid Jury Duty leave in any 5 consecutive year period. Additional time for Jury Duty must be taken as Vacation Leave or a Leave of Absence. Limited to 10 days in a five-year period. Limited to 10 days in a five-year period. Must provide copies of all court correspondence to Chief of Service and Area Medical Director.</td>
</tr>
<tr>
<td><strong>Life Insurance</strong></td>
<td></td>
<td></td>
<td>PREMIUM RATES SUBJECT TO CHANGE ANNUALLY. COVERAGE AMOUNTS PRORATED TO WORK SCHEDULE</td>
</tr>
<tr>
<td>Permanente Provided Life**</td>
<td>After 3 years’ Qualifying Service</td>
<td>Imputed Income</td>
<td>Eligible for 100% Base Annual Compensation after 3 years’ Qualifying Service, 200% after 5 years’ Credited Service, 300% after 15 years’ Credited Service.</td>
</tr>
<tr>
<td>Age-Rated Optional Life (includes AD&amp;D)**</td>
<td>Later of date of hire or date enrollment form signed</td>
<td>Premium rate based upon age</td>
<td>May purchase up to 600% Base Annual Compensation. Proof of insurability required for all amounts over 600% within 60 days of hire. After 60 days, proof required for all amounts.</td>
</tr>
<tr>
<td>Business Travel Accident</td>
<td>Continues</td>
<td>None</td>
<td>While traveling on SCPMG business not commuting between work and home.</td>
</tr>
<tr>
<td>Spouse/Domestic Partner Life Insurance</td>
<td>Date of Purchase</td>
<td>Premium rate based upon spouse’s/domestic partner’s age</td>
<td>May purchase up to $500,000 life insurance for spouse/domestic partner. Proof of insurability required for all amounts.</td>
</tr>
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* Coverage Effective Date: If the chart reads “continues,” this implies no change in coverage when a physician moves from one physician category to another.

** Combined coverage amount for Permanente Provided Life and Optional Life cannot exceed 600% of Base Annual Compensation or $2,000,000.

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<td>Retiree Life (See Retiree Benefits Handbook for information)</td>
<td>Upon retirement</td>
<td>Imputed Income</td>
<td>$50,000 death benefit after retirement, if you meet eligibility requirements and not eligible for Tapered Life.</td>
</tr>
<tr>
<td>Tapered Life (See Retiree Benefits Handbook for information)</td>
<td>Upon retirement</td>
<td>Imputed Income</td>
<td>Must have been enrolled in Optional Life prior to 12/31/90 and meet eligibility requirements.</td>
</tr>
<tr>
<td><strong>Retirement Plans</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Common Plan</td>
<td>Service time accrual continues</td>
<td>None</td>
<td>Begin accruing service time upon hire. Vested for benefits following 10 years’ Qualifying Service if work schedule is at least 5/10.</td>
</tr>
<tr>
<td>Physicians’ TSR Plan</td>
<td>Continues</td>
<td>100% physician contribution</td>
<td>May enroll or discontinue contributions at any time. Defer from 1% to 75% of compensation, up to annual federal limit.</td>
</tr>
<tr>
<td>Keogh Plan</td>
<td>Upon partnership</td>
<td>100% physician contribution</td>
<td>Participation level (selected 6 months after date of hire) begins immediately upon election to partnership.</td>
</tr>
<tr>
<td>Early Separation Program</td>
<td>Must be at least age 58</td>
<td>None</td>
<td>May retire between ages 58 – 65. Requires at least 10 years’ Qualifying Service and one year’s notice to Board of Directors.</td>
</tr>
<tr>
<td><strong>Additional Plans</strong></td>
<td></td>
<td></td>
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<tr>
<td>Dependent Care Spending Account</td>
<td>Not eligible</td>
<td></td>
<td></td>
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<tr>
<td>Health Care Spending Account</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commuter Choice Program</td>
<td>Not eligible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-Term Care Insurance (through New York Life; enrollment closed to new applicants)</td>
<td>Upon date of partnership, upon age 40 or upon proof of insurability</td>
<td>100% paid by physician</td>
<td>Coverage is no longer available through New York Life. However, if you purchased a NYL policy prior to November 2012, you may continue to pay premiums.</td>
</tr>
<tr>
<td>Long-Term Care Insurance (through Genworth)</td>
<td>Eligible upon date of partnership</td>
<td>100% paid by physician</td>
<td>Limited medical underwriting if enrolled during the first 31 days from date of partnership. After the initial enrollment period, you and your family members between ages 18 and 75 are also eligible with full medical underwriting. See the Genworth section on pg. 172 for more information.</td>
</tr>
<tr>
<td>Education Half Day</td>
<td>Continues</td>
<td>None</td>
<td>.8 work schedule and above.</td>
</tr>
<tr>
<td>Mortgage Loan Program</td>
<td>Continues</td>
<td>Varies</td>
<td>See handbook for details.</td>
</tr>
<tr>
<td>Professional Liability Coverage</td>
<td>Continues</td>
<td>None</td>
<td>Date-of-occurrence basis.</td>
</tr>
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* Coverage Effective Date: If the chart reads “continues,” this implies no change in coverage when a physician moves from one physician category to another.
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HEALTH CARE BENEFITS

SCPMG’s health care benefits are designed to give you and your eligible dependents valuable protection against your health care expenses. The following plans may be available to you as an active physician:

- **Kaiser Foundation Health Plan (KFHP)** provides coverage for medical care — from routine checkups to major surgery, usually at no charge to you.
  - Special Dependent Coverage is considered a feature within KFHP and enables you to provide medical care for certain individuals who may not qualify as dependents under other medical care coverage.

- **Supplemental Medical Plan coverage** can provide benefits for some medical services that may not be available under KFHP Coverage or that exceed plan limits.

- **Comprehensive Medical Plan coverage** provides benefits for you while you are on extended educational/medical service leave outside of a Kaiser Permanente service area when you cannot avail yourself of or do not choose KFHP coverage. It is not a substitute for KFHP coverage.

- **Alternate Mental Health Plan coverage** provides you with benefits for inpatient and outpatient treatment for mental health and substance abuse through any facility or provider.

- **Dental Coverage.** You have a choice of plans: Delta Dental PPO, DeltaCare USA and United Concordia.

Eligibility and Enrollment

You and your eligible dependents may enroll in health care benefits. Your health care benefits consist of six plans:

- **Kaiser Foundation Health Plan (KFHP),**
  - Special Dependent Coverage

- **Supplemental Medical Plan,**

- **Comprehensive Medical Care Plan (only for Partners on an approved Extended Educational Leave, Medical Service Leave, Military Leave and Retirees)**

- **Alternate Mental Health Plan, and**

- **Dental Care Plan(s).**

Each plan is described later in this handbook. You can obtain the appropriate enrollment forms at your local Permanente Human Resources Department (payroll office), on the SCPMG Physicial Portal (http://scpmgphysician.kp.org) or by calling PHR Shared Services (1-877-608-0044). Although enrollment in health care benefits for you is automatic, you need to complete the enrollment form to indicate any eligible dependents you wish to enroll and to select a dental option. If you do not choose a dental option, you will not receive dental benefits.
option within 31 days of your eligibility date, you will be enrolled in Delta Dental.

Per Diem physicians are not eligible for health care benefits. Part-time Associate Physicians and their eligible dependents may enroll in the KFHP if they pay one-half of the premium. Part-time Associate Physicians are not eligible for other health care coverage through SCPMG.

Your coverage under KFHP, Supplemental Medical and Alternate Mental Health begins on your date of hire provided you are actively at work on that date. Coverage under Special Dependent or Comprehensive Medical is effective on the first of the month following receipt of enrollment application forms. Your dental coverage is effective on the first of the month following your date of hire or following the date you first become eligible. If your date of hire is the first of the month, your dental coverage begins on your date of hire.

**Dependent Eligibility**

Eligible dependents include:

- your spouse/domestic partner (see Domestic Partner Eligibility below), and
- your or your spouse's/domestic partner’s dependent children up to the age limit specified for each plan.

Dependent children must be your or your spouse's/domestic partner’s children by birth, legal adoption, or legal guardianship. (The legal guardianship must be finalized prior to your dependent reaching age 18.)

Your foster children do not qualify for these health care benefits.

Dependent children also include children who are covered under a valid Qualified Medical Child Support Court Order, as defined by ERISA (the Employee Retirement Income Security Act).

**Domestic Partner Eligibility**

A domestic partner is a person living with you who is not a relative or your associate. Only one person at a time can be a domestic partner. At least 12 months must elapse between the enrollment date of one domestic partner and the enrollment date of a subsequent domestic Partner (except in the event of death).

In order for your domestic partner and his/her dependent children to be enrolled in your health care benefits, both you and your domestic partner must complete the Affidavit in Support of Eligibility for Health Care Coverage for Domestic Partners of All Physicians of Southern California Permanente Medical Group. This affidavit is available from PHR Shared Services. Per Diem physicians are not eligible to enroll domestic partners for health care benefits. A retired physician working per diem and who is enrolled in health plan benefits can enroll a domestic partner.
If you are an Associate Physician, health care benefit costs attributed to your domestic partner and/or your domestic partner’s dependents may be taxable to you. If you are an SCPMG Partner, you will pay Imputed Income for the full value of all of your health care benefits including your domestic partner’s health care benefits.

If your domestic partner relationship ends, continuation coverage through COBRA will be offered to your ex-domestic partner (see COBRA Coverage for Domestic Partners and Same-Sex Spouses). You must notify PHR Shared Services promptly at 1-877-608-0044 when dissolution of your domestic partnership occurs.

Same Sex-Spouse Eligibility

If you have a same-sex spouse recognized under California law or federal law, your same-sex spouse will be treated as a spouse for the purposes of eligibility and enrollment, and you may enroll your spouse and his/her dependent children, if any, normally without completing the Affidavit in Support of Eligibility for Health Care Coverage for Domestic Partners of All Physicians of Southern California Permanente Medical Group. If you are an SCPMG Partner, you will pay Imputed Income for the value of all of your health care benefits. If your same-sex marriage ends, continuation coverage through COBRA will be offered to your ex-spouse (See COBRA Coverage for Domestic Partners and Same-Sex Spouses).

Enrolling/Deleting Eligible Dependents (a.k.a. Family Status Changes)

You must notify PHR Shared Services immediately at 1-877-608-0044 of any family status changes that may impact your coverage, such as:

- marriage/domestic partnership
- divorce/dissolution of domestic partnership
- death of spouse/domestic partner
- birth/adoption/legal guardianship
- when dependent children are no longer an eligible dependent
- gain/loss of coverage under a Medicaid or CHIP program or your dependent gains eligibility for a premium assistance subsidy under a Medicaid or CHIP program.
- gain/loss of coverage through a spouse/domestic partner’s group health plan
- gain/loss of coverage as a result of an address change

Adding dependents to benefits coverage is not automatic. Eligible dependents will be covered when you complete the necessary enrollment forms and provide the following proof of the dependent relationship:
Family Status Change | Proof of Dependent Relationship
--- | ---
marriage | marriage certificate
add or change domestic partner | SCPMG domestic partner affidavit form (and Certificate of Registration of Domestic Partnership, if registered with the state of California)
divorce | divorce decree/dissolution of domestic partner
spouse’s/domestic partner’s death | death certificate
birth | birth certificate
adoption/legal guardianship | court order documents
Medicaid/CHIP events | documentation from the applicable state agency or program indicating a gain/loss of coverage under the program or eligibility for a premium assistance subsidy

Your dependent will be added retroactive to the date of the family status change if PHR Shared Services is notified and receives the completed enrollment/change forms and proof of relationship documents within 30 days of the family status change event.

If PHR Shared Services receives the completed enrollment/change forms and proof of relationship documents after 30 days, your dependent will be added/deleted on the first of the month following your completion of the necessary enrollment/change forms.

If your Family Status Change is a Medicaid/CHIP event, you will have 60 days to notify and provide PHR Shared Services with appropriate documentation to make an election change. If you do not enroll within 60 days of a Medicaid/CHIP event, your election change will occur on the first of the month following your completion of the necessary enrollment/change forms.

**Dependents of a Deceased Physician**

If you are eligible for KFHP benefits and you die leaving a surviving spouse/domestic partner and/or eligible dependents, your spouse/domestic partner and/or eligible dependents will continue to receive the KFHP. Contact PHR Shared Services for more information.

If your surviving spouse remarries, or your domestic partner enters a new domestic partner relationship, he/she will lose his/her eligibility under the plan; however, he/she may elect to continue coverage through COBRA. See the Limited Continuation of Benefits Available (COBRA) section for more information.

If your surviving spouse dies or remarries, any eligible dependents will...
retain KFHP coverage until they reach age 26. There is no age limit for eligible disabled dependent children (however, proof of disability may be required annually. You must apply and be approved for disabled dependent benefit by Kaiser Foundation Health Plan prior to reaching benefit-limit age. Contact the Kaiser Permanente California Service Center - Disabled Dependent Department at 1-800-731-4661, ext. 3584 to obtain a Disabled Dependent application). If there is no surviving spouse but your dependents are under age 26, they will be provided with KFHP coverage until they reach age 26. Dependents who lose KFHP and/or other coverage eligibility may be able to continue coverage through COBRA. See the Limited Continuation of Benefits Available (COBRA) section for more information.

If you are a Partner, your surviving dependents will be required to pay income tax on the value of the health and welfare benefit coverage.

**Cost**

SCPMG pays the full cost of coverage for you and your eligible dependents for:

- KFHP (part-time physicians who enroll must pay 50% of the monthly premium)
- Supplemental Medical Plan*
- Comprehensive Medical Plan* (only for Partners on an approved Extended Educational Leave, Medical Service Leave, Military Leave and Retirees)
- Alternate Mental Health Plan*
- Dental Care*

* Part-time Associate Physicians are not eligible for these benefits.

You may elect to purchase Special Dependent Coverage* for certain other individuals who do not qualify as your eligible dependents under another medical plan option.

The cost and payment for your health care benefits may be affected by leave-related and other events, such as your participation in a form of time-off benefit or continuation in your coverage via COBRA. See the Leave of Absence section for more information and the Limited Continuation of Health Benefits Available (COBRA) section for a general discussion of COBRA and Cal-COBRA. In all instances, contact PHR Shared Services for additional information at 1-877-608-0044.
**Imputed Income**

Imputed Income is income you earn but receive as something of value rather than as money. The law requires that you be taxed on this income, just as any other income.

**Partner Physicians**

The value of health care benefits provided to you and your eligible dependents is considered Imputed Income and appears as taxable income on your annual SCPMG Schedule K-1, as applicable.

**Associate Physicians**

The value of the health care benefits for your domestic partner is considered Imputed Income and appears as taxable income on your annual Form W-2, as applicable.

**Example 1: Partner Physician — Imputed Income**

A Partner with a spouse and two dependent children participates in all available SCPMG benefit options, including KFHP coverage, Supplemental Medical Coverage, Alternate Mental Health Coverage and Dental Coverage through Delta Dental. The value of the family coverage provided to the Partner will be included as taxable income in the Partner’s annual SCPMG Statement of Partner Earnings.

**Example 2: Associate Physician — Imputed Income**

An Associate Physician with one dependent child and a domestic partner participates in all available SCPMG benefit options, including KFHP coverage, Supplemental Medical Coverage, Alternate Mental Health Coverage and Dental Coverage through Delta Dental. The Associate Physician is the biological parent of the one dependent child. The value of the coverage attributable to the domestic partner will be included as taxable income in the Associate Physician’s annual Form W-2, as applicable.

**Termination of Coverage**

Your coverage, including KFHP, will cease at the end of the month upon termination of employment, retirement, withdrawal from the partnership or when you elect to waive coverage.

**Termination of Dependent Coverage**

Dependents will be terminated from coverage as follows:

- your spouse (in the event of divorce) at the end of the month in which PHR Shared Services receives an Enrollment Application or Change Form and the divorce decree.
- your domestic partner (in the event of dissolution) at the end of the month in which PHR Shared Services receives an Enrollment Application or Change Form.
- your children — at the end of the month:
  - in which their 26th birthday occurs (unless approved by Kaiser Foundation Health Plan for disabled dependent benefit; contact the Kaiser Permanente California Service Center - Disabled Dependent Department at 1-800-731-4661, ext. 3584 to obtain a Disabled Dependent application), or
  - when they are otherwise no longer an eligible dependent.
Coordination of Benefits Coverage

If a covered person has other medical coverage not provided by SCPMG, the claims administrator will coordinate the benefits payable under this plan with those of the other plan. One plan is primary and the other is secondary. The primary plan pays regular benefits in full. The secondary plan pays a reduced amount which, when added to the benefits paid by the primary plan, will not exceed 100% of allowable expenses.

A plan that does not coordinate with other plans is always the primary plan. If both plans coordinate, the primary plan is determined as follows:

- The plan that covers the patient as an Associate Physician (or Partner) rather than as a dependent is primary. The plan covering the patient as a dependent is the secondary plan.
- If a dependent child is covered under both parents’ plans, the plan covering the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents share the same birthdays, the plan covering the parent longer is the primary plan.
- If a dependent child is covered under both parents’ plans but the parents are separated or divorced, the primary plan will be determined in this order:
  - the plan of the parent awarded financial responsibility by a court decree for the child’s health care expenses,
  - the plan of the parent with custody of the child,
  - the plan of the stepparent married to the parent with custody of the child, then
  - the plan of the parent not having custody of the child.

If none of the above rules applies, then the plan covering the patient the longest is the primary plan (except that a plan covering a retiree will be secondary).

Dual Coverage

Dual coverage is defined as having coverage when you are covered under KFHP as both a subscriber and a dependent of another KFHP subscriber. While you are continuing to work in a benefit-eligible category, being covered under two plans is allowable. Once you become covered under Senior Advantage (at age 65) or another Medicare-assigned program and are eligible for Medicare Part A and B, KFHP, Inc. will not allow you to be covered under KFHP with dual coverage. You will need to select which one plan to be maintained, and you will need to drop the other. Being covered under two Medicare-assigned programs, such as Senior Advantage, is not allowed.
KAISER FOUNDATION HEALTH PLAN (KFHP)

Eligibility and Enrollment
Eligible physicians are automatically enrolled in KFHP. Dependent enrollment is not automatic. Eligible dependents must be enrolled to receive benefits. Eligibility requirements are described in the Eligibility and Enrollment section above and the Eligible Dependents section below.

Eligible Dependents
Dependents eligible for KFHP include:

• your spouse/domestic partner,

• your or your spouse’s/domestic partner’s dependent children up to age 26,

• your dependent children over age 26 who were disabled before age 26 and are incapable of self-support due to a mental or physical handicap. Proof of disability may be required annually. You must apply and be approved for disabled dependent benefit prior to reaching benefit-limited age. Contact the Kaiser Permanente California Service Center - Disabled Dependent Department at 1-800-731-4661, ext. 3584, to obtain a Disabled Dependent application, and

• 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 meet the following requirements: (i) They are under age 26; (ii) They are not married and do not have a legally recognized domestic partner; (iii) They receive all of their support and maintenance from you or your spouse; (iv) They permanently reside with you or your spouse.

Dependents of a Deceased Physician
If you die while practicing with SCPMG, your spouse/domestic partner and eligible dependents will be provided KFHP coverage at SCPMG expense. This benefit is not dependent on your age or years of service at the time of your death.

If your surviving spouse dies or remarries, or your surviving domestic partner dies or enters a new relationship, any eligible dependents will retain KFHP coverage until they reach age 26. There is no age limit for eligible disabled dependent children.

If the surviving spouse remarries, the surviving spouse’s eligibility for KFHP coverage will end. A surviving spouse may be able to continue coverage. See Limited Continuation of Benefits Available (COBRA) below. Conversion to an Individual Plan may be available.

If there is no surviving spouse but your dependents are under age 26, they
will be provided with KFHP coverage until they reach age 26.

**Disabled Physicians**

If you are eligible for Disability Retirement under the Common Plan, you, your spouse/domestic partner, and any eligible dependents will retain KFHP coverage as if you were an eligible retiree. Generally, if you leave SCPMG due to disability with at least five years of Common Plan Qualifying Service, but not enough service for retiree benefits, you will have health plan coverage continued for yourself and eligible dependents at SCPMG’s expense. Supplemental Medical Coverage will cease.

See *Common Plan* in the *Retirement and Savings Plan* section for details on Disability Retirement, or contact PHR Shared Services for additional information at 1-877-608-0044.

**Coverage Highlights**

KFHP coverage benefits are described in detail in a brochure that is available from your regional PHR Shared Services or local Permanente Human Resources Department (payroll office). The benefits may be subject to change annually due to contract revisions.

Listed below are highlights of some of the benefits available to you and your covered dependents under KFHP. Be sure to refer to the brochure for complete details.

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Your Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In the Medical Office</strong></td>
<td></td>
</tr>
<tr>
<td>Doctor office visits, including physicals</td>
<td>No charge</td>
</tr>
<tr>
<td>Well-child care, vision and hearing exams</td>
<td>No charge</td>
</tr>
<tr>
<td>Lab, X-rays, and other tests</td>
<td>No charge</td>
</tr>
<tr>
<td>Physical, occupational, and speech therapy</td>
<td>No charge</td>
</tr>
<tr>
<td>Behavioral health treatment for autism spectrum disorders</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>In the Hospital</strong></td>
<td></td>
</tr>
<tr>
<td>Hospital room and board, intensive care</td>
<td>No charge</td>
</tr>
<tr>
<td>Physician and surgeon services, general nursing services</td>
<td>No charge</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Your Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood components and blood transfusions</td>
<td>No charge</td>
</tr>
<tr>
<td>Drugs, medicines, dressings, and casts</td>
<td>No charge</td>
</tr>
<tr>
<td>Lab, X-rays and other tests</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Maternity Care</strong></td>
<td></td>
</tr>
<tr>
<td>Office visits, lab and other tests, hospitalization, and full care of newborn while the mother is in hospital</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Prescriptions</strong></td>
<td></td>
</tr>
<tr>
<td>Up to a 100-day supply filled in any Plan pharmacy; prescriptions must fall within Kaiser Permanente’s formulary guidelines</td>
<td>$5 per prescription</td>
</tr>
<tr>
<td>For formulary information, contact Kaiser Permanente Member Services at 1-800-464-4000 or <a href="http://www.kp.org">www.kp.org</a>; click the “Health Plans &amp; Services” tab, then click on “Using Our Services”</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health Care</strong></td>
<td></td>
</tr>
<tr>
<td>Unlimited inpatient and outpatient visits per calendar year</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Care for Alcoholism and Chemical Dependency</strong></td>
<td></td>
</tr>
<tr>
<td>In the medical office — counseling for dependency and medical management of withdrawal symptoms</td>
<td>No charge</td>
</tr>
<tr>
<td>In the hospital — when necessary for medical management of withdrawal symptoms, recovery services for dependency including education and counseling</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Vision Care</strong></td>
<td></td>
</tr>
<tr>
<td>Vision exams</td>
<td>No charge</td>
</tr>
<tr>
<td>Optical</td>
<td>$175 allowance every 24 months</td>
</tr>
<tr>
<td><strong>Hearing Care</strong></td>
<td></td>
</tr>
<tr>
<td>Hearing tests and hearing aids</td>
<td>$2,500 allowance per device, per member, every 3 years. 20% discount on hearing aid purchases</td>
</tr>
<tr>
<td>For more information, contact HEARx at 1-877-714-2828 or visit <a href="http://www.hearusa.com">www.hearusa.com</a></td>
<td></td>
</tr>
</tbody>
</table>

(continued)
## Covered Services

<table>
<thead>
<tr>
<th>Emergency Services in Southern California Service Area</th>
<th>Your Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>In a Plan facility</td>
<td>You pay only the copayments that normally apply to the services you receive</td>
</tr>
<tr>
<td>In a non-Plan facility</td>
<td>If determined to be an emergency by the Plan, you pay any copayments that normally would apply had you received the services from a Plan Provider</td>
</tr>
</tbody>
</table>

## Declining Coverage

KFHP coverage may be declined only in two situations. You may decline coverage if you are covered as a dependent by your spouse/domestic partner who is a Kaiser employee or physician with Kaiser Permanente and who has health plan benefits. Or, you may decline coverage if you are covered under a health plan of a previous employer through COBRA continuation coverage if it would be detrimental to you to give up the COBRA benefits.

If you decline KFHP coverage, then all other health care benefits are also declined, including Supplemental Medical Coverage, Alternate Mental Health Coverage, and Dental Coverage.

## Termination of Coverage

If you terminate service with SCPMG, KFHP coverage will terminate for you and your eligible dependents at the end of the month in which your service ends.

Dependents will be terminated from coverage as follows:

- spouse (in the event of divorce) — at the end of the month in which PHR Shared Services receives the Enrollment Application or Change Form and the divorce decree.
- domestic partner (in the event of dissolution) — at the end of the month in which PHR Shared Services receives the Enrollment Application or Change Form.
- children — at the end of the month:
  - in which their 26th birthday occurs,
  - when they are no longer a dependent.
Conversion of Coverage

If you terminate service with SCPMG, KFHP coverage for you and your dependents will terminate at the end of the month in which your service terminates. If you or your eligible dependents lose KFHP coverage, you will be given an opportunity to convert your KFHP group coverage to a conversion policy through Health Plan without a medical review.

For more information about conversion rights, please contact Kaiser Permanente Member Services at 1-800-464-4000.

Limited Continuation of Benefits Available (COBRA)

If you and/or your dependents lose KFHP coverage benefits due to termination of employment, reduction of scheduled hours, disability, death, divorce, or children reaching the limiting age, KFHP coverage benefits may be purchased through COBRA for a maximum of 18, 29 or 36 months, depending on the reason for the termination of coverage. The coverage you purchase will be identical to the coverage you had. Premium rates are available from PHR Shared Services. Cal-COBRA may also be available to you after COBRA ends. See Limited Continuation of Health Benefits Available (COBRA) in the Administration section for a general discussion of COBRA and Cal-COBRA.

SPECIAL DEPENDENT COVERAGE
(Under Kaiser Foundation Health Plan)

Eligibility and Enrollment

Active physicians in all categories, except part-time and Per Diem (excluding Partner Emeritus physicians), can enroll Special Dependents in KFHP coverage at their own expense, called Special Dependent coverage. Special Dependents are limited to:

• your parents,
• the parents of your spouse/domestic partner,
• your step-parents or the step-parents of your spouse/domestic partner,
  • coverage is restricted to one set of parents for the physician and one set of parents for the spouse/domestic partner
• your over-age children and their eligible dependents.

Physicians eligible to enroll their Special Dependents include:

• associate physicians (working an 8/10 schedule or more)
• partner physicians
• retirees eligible for post-retirement health benefits
Special Dependents Over Age 65

Any Special Dependent who is over age 65 and eligible for Medicare must enroll in Senior Advantage. (See Glossary for a description of Senior Advantage.) Kaiser Foundation Health Plan (KFHP) will notify your Special Dependent(s) approximately 90 days before enrollment in Senior Advantage.

KFHP sends out the Senior Advantage enrollment to the Special Dependent approximately 90 days before reaching age 65. KFHP and SCPMG do not send any notification to the sponsored physicians.

Senior Advantage provides all of the benefits provided by Medicare as well as certain additional benefits. When first enrolled, your Special Dependent will have KFHP coverage and be charged the standard KFHP rate. Once the Health Care Financing Administration notifies Kaiser Foundation Health Plan that your Special Dependent is an eligible Medicare member, he/she will be transferred to the Senior Advantage premium.

Surcharges are applied to the KFHP premium, if your Special Dependent:
• is neither eligible nor enrolled for either Part A or B of Medicare, or
• has Medicare but has not assigned it to Kaiser Foundation Health Plan, or
• has assigned his/her Medicare to another risk provider.

Your Special Dependent is not entitled to Medicare reimbursement.

Dependents of a Retired or Deceased Physician

Special Dependents may retain their KFHP coverage upon your retirement or death as long as you meet eligibility requirements for retirement at the time of retirement or death. If you were paying the premiums through payroll deduction, payment of premiums will be directly billed to your Special Dependent.

How the Plan Works

Special Dependents are eligible for KFHP coverage at your or your Special Dependent’s expense provided they permanently reside in the California service area, and:
• they are not hospital-confined at the time of enrollment, or
• they do not have end-stage renal disease.

Premiums may be paid either by payroll deduction or direct billing to your Special Dependents.

You may obtain an enrollment application for Special Dependent coverage at your local Permanente Human Resources Department (payroll office), on the SCPMG Physician Portal (http://scpmgphysician.kp.org) or by calling PHR Shared Services (1-877-608-0044). The Special Dependent and the
HEALTH CARE BENEFITS

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physician will be required to complete the necessary Special Dependent Enrollment Forms.

Special Dependent status is not available on a temporary or short-term basis (such as for Vacation Leaves).

Only KFHP coverage is available to Special Dependents; the other health care benefits including Supplemental Medical Coverage, Alternate Mental Health Coverage and Dental Coverage are not available to Special Dependents.

Termination of Coverage

If you do not meet the eligibility requirements for retirement when you leave SCPMG, your Special Dependents will be removed from KFHP coverage, and they will have the opportunity to convert to a Conversion Policy. Contact PHR Shared Services for additional information at 1-877-608-0044 or Member Services at 1-800-464-4000 for conversion policy information.

Conversion of Coverage

In the event of divorce, your former spouse is not eligible for Special Dependent status. Instead, your former spouse may be able to continue KFHP coverage through the COBRA program. See Limited Continuation of Health Benefits Available (COBRA) in the Administration section for a general discussion of COBRA and Cal-COBRA. Conversion to a Conversion Policy may also be available. Conversion Policy is not described in this handbook. For more information about Conversion Policy and conversion rights, contact Kaiser Permanente Member Services at 1-800-464-4000.

Note: You may not add any new Special Dependents after you transfer to an associate part-time or Per Diem status. However, retirees receiving retiree medical benefits may add new Special Dependents.

Limited Continuation of Benefits Available (COBRA)

Continuation coverage is not available for Special Dependents who lose their eligibility to participate in Special Dependent Coverage.

SUPPLEMENTAL MEDICAL COVERAGE

SCPMG’s Supplemental Medical Coverage is intended to cover some medical services that are either not included or for which benefits exceed KFHP limits. Supplemental Medical Coverage is not an alternative to using your KFHP benefits. If you or your dependents elect to use facilities or services other than those offered or available from Kaiser Foundation Health Plan, any expense you incur will be excluded under Supplemental Medical Coverage.
Supplemental Medical Coverage may not be used for routine care outside of a Kaiser Foundation Health Plan service area.

**Eligibility and Enrollment**
If you are eligible for coverage, you will automatically be enrolled in Supplemental Medical Coverage. Dependent enrollment is not automatic. You must enroll eligible dependents in order for them to receive benefits; however, if you have enrolled your dependents in the KFHP, they will be automatically be enrolled in Supplemental Medical Coverage. Eligibility requirements are described under *Eligibility and Enrollment* in the *Kaiser Foundation Health Plan (KFHP)* section and *Eligible Dependents* section below.

**Eligible Dependents**
Dependents eligible for Supplemental Medical include:

- your spouse/domestic partner,
- your or your spouse's/domestic partner’s dependent children up to age 26,
- your dependent children over age 26 who were disabled before age 26 and are incapable of self-support due to a mental or physical handicap. Proof of disability may be required annually. Must apply and be approved for disabled dependent benefit by Kaiser Foundation Health Plan prior to reaching benefit limited age. Contact the Kaiser Permanente California Service Center - Disabled Dependent Department at 1-800-731-4661, extension 3584, to obtain a Disabled Dependent application, and
- 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 meet the following requirements: (i) They are under age 26; (ii) They are not married and do not have a legally recognized domestic partner; (iii) They receive all of their support and maintenance from you or your spouse; (iv) They permanently reside with you or your spouse.

**Dependents of a Deceased Physician**
If you die after having met the age and service requirements for retirement. Supplemental Medical Coverage will be continued for your surviving spouse/domestic partner until death or remarriage or until he/she enters into a subsequent domestic partnership. It will also continue for any eligible dependent children until they reach age 26. There is no age limit for coverage for disabled dependent children (as described under *Eligible
Dependents in the beginning of this section).

How Benefits Work

- To qualify for Supplemental Medical Coverage, you must first pay an individual and/or family deductible each year. (Additional details are provided under Deductibles and Maximum Benefits for Partners and Deductibles and Maximum Benefits for Associate Physicians at the end of this section.)

- After you have met the calendar-year deductible requirement, Supplemental Medical Coverage will pay benefits equal to 100%, 80%, or 50% of the reasonable and customary (R&C) cost of covered charges.

- Supplemental Medical Coverage provides benefits up to specific maximum levels based on your category. (Additional details are provided under Deductibles and Maximum Benefits for Partners and Deductibles and Maximum Benefits for Associate Physicians at the end of this section.)

- If you see a provider who is not in the Kaiser network, you must submit a claim form and the itemized bill to receive reimbursement for covered services, unless the provider is in the Aetna PPO network (in which case the provider would bill Meritain).

Covered Charges

Supplemental Medical Coverage only pays for a portion of the charges for medical care that is either not included in, or that exceeds, KFHP Coverage limits. KFHP provides benefits for such services as hospitalization, physician fees and prescription drugs. See Kaiser Foundation Health Plan (KFHP) for more details. As a result, these items are not covered charges under Supplemental Medical Coverage.

In some cases, you may be required to provide a “denial” letter from Kaiser Foundation Health Plan indicating that a given service is not covered or that you have surpassed the coverage maximum. See Filing Claims in this section.

Covered charges under Supplemental Medical Coverage are paid at 100%, 80%, or 50% of the R&C cost for the area in which you receive services.

If you have any questions about a covered charge, you can request pre-authorization from the claims administrator in writing or by calling Meritain Health at 1-888-711-7876. (See the Administration section for additional contact information.)

Charges covered at 100% of the reasonable and customary cost include:

- hospice care. A Health Plan denial letter is required.
Any charge that is not payable under hospice care, but would be payable under another section of this Supplemental Medical Coverage, will be payable as stated in that section.

Charges covered at 80% of the reasonable and customary cost include:

- acupuncture services performed by a licensed acupuncturist for medically necessary treatment.
- blood, blood products, blood transfusions, and their administration only if they are not available through KFHP.
- convalescent care in a skilled nursing facility or a hospital. Covered charges include rehabilitation benefits such as physical, occupational, speech, respiratory, or radiation therapy. A Health Plan denial letter is required. Care must be provided by skilled personnel such as RNs or LVNs. Coverage for care in an intermediate facility is provided in most cases.
- chiropractic care performed by a licensed chiropractor for the medically necessary treatment of an illness or injury.
- outpatient durable medical equipment, such as wheelchairs, braces, and hospital beds. A Health Plan denial letter is required.
- alcohol and chemical dependency services on an inpatient basis. A Health Plan denial letter is required.
- mental health services
  - you must receive a diagnosis of psychosis and a Kaiser treatment plan
  - if a treatment plan is not available within Kaiser, you must obtain a Health Plan denial letter, in addition to a provider letter stating a diagnosis of psychosis, in order to receive covered treatment outside of Kaiser
- infertility services, including services for artificially-induced contraception, in vitro fertilization, ovum transplant, gamete and zygote intralosalpinx transfer, the cost of donor semen and donor eggs, and treatment to reverse voluntary surgically-induced fertility. A Health Plan denial letter is required. Storage or freezing of eggs is not covered.
- jaw joint disorder treatments (such as TMJ). A Health Plan denial letter is required.
- dental work required as the result of — and begun within one year of — an accident. A Health Plan denial letter is required.
- podiatry services for medically necessary foot care that are not covered by KFHP.
- cosmetic surgery required due to an accident while insured under this plan. (This also applies to children born with a congenital abnormality while insured by this plan.)
Charges covered at 50% of the reasonable and customary cost of services include, but are not limited to:

- custodial care, either at home or at a skilled nursing facility, with evidence of total and permanent disability.

**Important Definitions**

**Custodial care** is defined as care primarily required to meet the needs of the activities of daily living (ADLs), such as walking, dressing, and caring for personal hygiene. The individual must be diagnosed as totally and permanently disabled in order to use the custodial care benefit. The care can be provided either at home or at an eligible facility. If provided at home, care must be provided by state licensed home health aides. Examples of these individuals include home caregivers, certified nursing assistants, or residential assistants. (In-home skilled nursing care is covered under KFHP.) Care provided by family members or other informal caregivers is not covered.

- An eligible facility may be a licensed nursing home, a licensed skilled nursing facility, or a hospital.
- Adult day care centers are not considered eligible facilities.
- Managed care consulting is provided if deemed necessary by a continuing care nurse who contracts with Meritain Health for managed care services.

**Psychosis** is defined as a mental disorder characterized by fundamental disturbances in reality-relationships and concept formations, with subsequent behavioral and intellectual disturbances in varying degrees and mixture.

**Exclusions**

The following services and supplies are not covered by Supplemental Medical Coverage; however, they may be covered under another plan such as KFHP. This list is only a summary; if you have questions about a specific service or supply, call Meritain Health, the claims administrator. (See the Administration section for contact information.)

- allergy testing and treatment
- ambulance service
- anesthesia
- blood, blood products, blood transfusions and their administration if offered by Kaiser Foundation Health Plan
- chelation therapy
- contact lenses
- corrective eye surgery
- cosmetic services
- dialysis and transplants (inpatient and outpatient)
- dressings, casts, and inpatient durable medical equipment
- education, training, instruction or educational therapy
- electronic voice producing machines
- emergency room visits
- excess prescriptions (charges for any prescription filled in excess of the
number specified by a physician, or any refill dispensed after one year from the date of the physician’s original order

- experimental or investigational charges
- eye examinations for eyeglasses
- eyeglass frames and lenses
- general health services not addressed to a specific condition
- health education publications
- hearing tests and hearing aids
- hospital care, including room and board, and a private room
- immunizations in general use
- immunosuppressive drugs
- injury or illness caused by war or an act of war
- injectable contraceptives
- intensive care
- internally-implanted, time-released drugs (including contraceptives)
- Kaiser Foundation Health Plan co-pays or coinsurance
- laboratory tests, X-ray services, and other diagnostic tests, including electrocardiograms, mammograms, and Pap smears
- luxury services and no-charge services
- obesity treatment
- obstetrical services
- on-the-job accidents or illnesses covered by Workers’ Compensation or similar laws
- operating and recovery room
- physician and surgical services
- physician home visits and routine office visits
- prenatal care
- prescribed drugs, supplies and supplements
- prescription drugs obtained at Kaiser Permanente pharmacies, including copayment limit
- preventive care, including routine physical exams and gynecological visits
- prosthetic and orthotic devices and braces
- radioactive materials used for therapeutic purposes
- reconstructive surgery
- respiratory therapy
• routine care inside or outside a Kaiser Foundation Health Plan service area
• treatment for medical conditions resulting from participation in felonious activity
• treatment at a Veteran’s Administration Hospital or by a V.A. physician
• ultraviolet light treatment
• visiting nurse home visits
• well baby care.

Filing Supplemental Medical Coverage Claims
Claims are only required if you see an out-of-network provider (an in-network provider will file reimbursement claims for you). Submit claims directly to Meritain Health, the claims administrator. Payments are sent to your home or to your provider.

If a Health Plan denial letter is required, you must obtain one by calling Member Services at 1-800-464-4000. Be sure to attach a copy of the denial letter to your claim form. Contact information for Meritain Health may be found in the Administration section.

Claim forms may be obtained from PHR Shared Services at 1-877-608-0044 or the SCPMG Physician Portal at http://scpmqphysician.kp.org/.

Deductibles and Maximum Benefits for Partners
This section provides additional details about Supplemental Medical Coverage that are specific to Partners.

Annual Deductibles
To qualify for Supplemental Medical benefits, you must first pay an annual deductible:
• Individual deductible: $50 per person per calendar year.
• Family deductible: $100 per family per calendar year.

When two or more individuals in a family incur covered charges that are used to satisfy their individual deductible amounts in the same calendar year and the total is at least $100, then no further deductible amounts are required for the rest of the year for that family for all covered expenses.

After you have met the calendar-year deductible requirement, Supplemental Medical Coverage will pay benefits as described earlier in this section.

Deductibles and Maximum Benefits for Associate Physicians
This section provides additional details about Supplemental Medical
Coverage that are specific to Associate Physicians (who work an 8/10 schedule or more).

**Annual Deductibles**
To qualify for Supplemental Medical benefits, you must first pay an annual deductible:

- Individual deductible: $100 per person per calendar year.
- Family deductible: $200 per family per calendar year.

When two or more individuals in a family incur covered charges that are used to satisfy their individual deductible amounts in the same calendar year and the total is at least $200, then no further deductible amounts are required for the rest of the year for that family for all covered expenses.

After you have met the calendar-year deductible requirement, Supplemental Medical Coverage will pay benefits as described earlier in this section.

**Calendar Year and Lifetime Maximum**
For Associate Physicians, the following services and/or supplies are limited by a calendar-year or lifetime maximum benefit amount.

**Calendar Year Maximums**
- chiropractic care is limited to $1,000 per person.

**Lifetime Maximum Benefits**
- alcohol and chemical dependency inpatient/outpatient is covered at 80%.
- infertility treatments are limited to $30,000 per covered person.
- jaw joint disorder treatments (such as TMJ) are limited to $2,000 per covered person.

**Declining Coverage**
If KFHP Coverage is declined, then Supplemental Medical Coverage is also declined. See Declining Coverage in the Kaiser Foundation Health Plan (KFHP) section for more details.

**Termination of Coverage**
If you terminate service with SCPMG, Supplemental Medical Coverage will terminate for you and your eligible dependents at the end of the month in which your service ends.

In addition, dependents will be terminated from coverage as follows:
- spouse (in the event of divorce) — at the end of the month in which PHR
Shared Services receives the Enrollment Application or Change form and the divorce decree.

- domestic partner (in the event of dissolution) — at the end of the month in which PHR Shared Services receives the Enrollment Application or Change Form.
- children — at the end of the month in which their 26th birthday occurs.

**No Conversion**
Conversion to an individual policy is not available under this coverage.

**Limited Continuation of Benefits Available (COBRA)**
If you and/or your dependents lose Supplemental Medical Coverage due to termination of employment, reduction of scheduled hours, disability, death, divorce or children reaching the limiting age, Supplemental Medical Coverage may be purchased through COBRA for a maximum of 18, 29 or 36 months, depending on the reason for the termination of coverage. The coverage you purchase will be identical to the coverage you had. In order to be eligible for Supplemental Medical Coverage through COBRA, you must also be enrolled in KFHP Coverage. Premium rates are available from PHR Shared Services. See **Limited Continuation of Health Benefits Available (COBRA)** in the Administration section for a general discussion of COBRA.

**COMPREHENSIVE MEDICAL PLAN**
The Comprehensive Medical Plan is an alternative to KFHP for:

- physicians on extended educational/medical service/military leave outside of a Kaiser Permanente service area, and
- eligible retirees. For more information regarding retiree benefits, see the Leaving SCPMG section in this handbook as well as the Retiree Benefits Handbook.

The Comprehensive Medical Plan provides a complete package of health care benefits.

**Eligibility and Enrollment**
The Plan is available to eligible retirees and physicians on extended educational/medical/military service leave outside of a Kaiser Permanente service area. It is intended for those physicians who cannot avail themselves of — or choose not to use — KFHP. It is not a substitute for KFHP for active physicians. If you are eligible for health care benefits in retirement, you may elect the Comprehensive Medical Plan in place of KFHP or Senior Advantage if living outside the Kaiser Permanente service area.

With 30 days’ notice, you may change to Comprehensive Medical Plan.

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coverage upon moving out of a Kaiser Permanente service area. You must re-enroll in KFHP if living in a Kaiser Permanente service area.

How the Plan Works
The Comprehensive Medical Plan allows you to visit any doctor or facility to receive services.

After you meet an annual deductible, you share the cost of covered services by paying a coinsurance, which is a percentage of the reasonable and customary (R&C) charges for the service received. However, you should be prepared to pay the full amount at the time of service, since you will need to file a claim to receive reimbursement from the SCPMG's third-party administrator, Meritain Health.

When Meritain Health receives your claim, they will authorize payment of their percentage of the R&C charges, which they determine by reviewing the cost of similar claims in your geographical area. You will be responsible for paying the remaining percentage and for the full amount of any costs in excess of the R&C charges.

Annual Deductible
The annual deductible is $300 per person, or $600 per family.

Annual Out-of-Pocket Maximum
The annual out-of-pocket maximums are $5,000 per person $10,000 per family. Once the out-of-pocket maximum is met, the plan will cover 100% of R&C charges for all charges normally covered at 80%.

Charges covered at 50% will not be counted toward the out-of-pocket maximum, and you will still be required to pay 50% coinsurance for these charges after reaching the annual out-of-pocket maximum.

Any deductibles you pay are not counted toward out-of-pocket maximums.

Individual Benefit Maximum
The lifetime individual benefit maximum under the Comprehensive Medical Plan is $1,000,000.

Covered Services
Covered services are paid at either 50% or 80% after the annual deductible has been met. Following is a list of many of the services covered under Comprehensive Medical Plan. You may contact Meritain Health at 1-888-711-7876 if you have a question about a service not listed.

Charges covered at 50% include (coinsurance payouts are not counted toward annual out-of-pocket maximum):
• home health services (custodial care)
• outpatient mental health (may be subject to case management)
• outpatient substance abuse (may be subject to case management).

Charges covered at 80% include:
• acupuncture
• adult physical exams, limited to one per year
• allergy testing and treatment
• ambulance
• anesthesia
• blood, blood products, blood transfusions, and their administration
• chiropractic, limited to $1,000 per year
• dental services for accidental injuries only; services must be received within 12 months of the accident
• diagnosis and treatment of illness or injury
• dialysis
• dressings and casts
• durable medical equipment, limited to $2,000 per year
• emergency services
• family planning counseling
• hearing tests
• home visits by physician or visiting nurse
• hospital admissions kit
• hospital alternative treatment services
• hospital services, inpatient or outpatient
• immunizations in general use
• immunosuppressive drugs
• infertility services, limited to a lifetime maximum of $30,000
• inpatient mental health (may be subject to case management)
• inpatient-prescribed drugs and medical supplies
• inpatient rehabilitation
• intensive care
• jaw joint disorder, limited to a lifetime maximum of $2,000
• lab and X-ray services, including electrocardiograms, mammograms and Pap smears (preventive Pap smears and mammograms are limited to one per year)
• maternity care, inpatient and outpatient
• obstetrical and gynecological services
• operating room and recovery
• preventive care, limited to annual physical exam and gynecological visits
• prosthetic devices and braces, limited to $2,000 per year
• psychological testing
• radioactive materials used for therapeutic purposes
• reconstructive breast surgery (all stages) as a result of a mastectomy on one or both breasts, as determined by the attending physician to be appropriate, to restore and achieve symmetry between the two breasts
• reconstructive surgery, non-cosmetic
• respiratory therapy
• skilled nursing facility (services covered at 50% if care is custodial)
• sterilization
• substance abuse, inpatient, limited to a maximum of 30 days per calendar year (may be subject to case management)
• therapy — occupational, physical and speech — inpatient and outpatient
• transplants
• ultraviolet light treatment
• well baby/well child care; after age two exams are limited to one per year.

Charges covered at 100% include:
• hospice services.

**Prescription Drugs, Supplies and Supplements**

The Comprehensive Medical Plan covers up to a 30-day supply if filled at network pharmacies and a 90-day supply if filled by mail order for prescription drugs when prescribed by a licensed physician or dentist for the treatment of an illness or injury. Ostomy and diabetic supplies are also covered. Copayment amounts are listed below.

- $0 copayment for generic drugs or $3 copayment for brand name drugs from Express Scripts.
- $5 copayment for generic drugs or $10 copayment for brand name drugs at an Express Scripts participating pharmacy.
- $10 plus 20% of cost for drugs at a non–Express Scripts participating pharmacy.

Contact information for Express Scripts may be found in the Administration section.

**Vacation Leave Override**

Call Meritain Health to receive an override of the 30/90-day limit if
you will be on an extended Vacation Leave. You can get up to a six-month supply of prescriptions. This Vacation Leave override may be used no more than twice in any calendar year.

**Vision Care**

The Comprehensive Medical Plan provides R&C reimbursement for an eye examination once per calendar year. The maximum for lenses and frames is $65. Frames are covered once in a 24-month period. Lenses are covered when a change of prescription is required, but not more often than once in a 24-month period.

**Services Not Covered**

The following list is only a summary of excluded services under the Comprehensive Medical Plan. Contact Meritain Health, the claims administrator, for more information regarding services not covered under the Comprehensive Medical Plan. See the Administration section for contact information.

- charges for a physician acting outside the scope of his license
- charges for any treatment not recommended or approved by a physician
- chelation therapy
- cosmetic services
- education, training or instruction
- electronic voice-producing machines
- employer’s medical clinic
- excess prescriptions (charges for any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician’s original order)
- experimental or investigational charges
- health education publications
- hearing aids
- injectable contraceptives
- internally-implanted, time-released drugs, including contraceptives
- luxury services
- obesity
- over-the-counter drugs
- private room
- public programs
- routine foot care
- sales tax
HEALTH CARE BENEFITS

• self-inflicted injuries
• services provided by a relative
• speech therapy (unless to restore speech loss, or correct an impairment due to an accidental injury or illness (other than a functional nerve disorder) sustained while covered under this Plan; or a congenital malformation for which corrective surgery has been performed while participant was covered under this Plan)
• standby physician services
• technical medical assistance
• telephone consultations
• transsexual surgery
• travel expenses
• treatment for medical conditions resulting from participation in a felonious activity
• treatment in U.S. government hospitals
• treatment not provided by a physician
• unnecessary hospital treatment
• vision correction surgery
• vitamins, nutritional supplements
• war-related expenses
• Workers’ Compensation claims.

Coordination of Benefits

If you have coverage under any other group insurance plan or government plan, you may be able to receive benefits under both plans. This will happen if both you and your spouse/domestic partner work and both of you carry family coverage through your respective employers.

You will need to submit a Meritain Health Coordination of Benefits form and follow the steps outlined below in order to receive coordinated benefits. In addition to the information you will need from the other insurance plan described below, you must send copies of itemized bills or receipts to Meritain Health. See the Administration section in this handbook for contact information.

If you are the patient:

• After you receive Meritain Health’s payment, send a copy of the Explanation of Benefits (provided with your Meritain Health check) to the other insurance company.

If your spouse/domestic partner is the patient:

• His or her insurance company pays first.

Effective March 1, 2014
• After you receive payment from the other insurance company, send a copy of the Explanation of Benefits (provided with the check) from the other insurance company to Meritain Health.

**If your child is the patient:**

• If your child is the patient and your spouse/domestic partner has a birthday that falls earlier in the year than yours, your spouse/domestic partner’s coverage should pay first. Meritain Health will pay second.

• If your child is the patient and your spouse/domestic partner has a birthday that falls later in the year than yours, Meritain Health should pay first. Your spouse’s/domestic partner’s coverage should pay second.

• For dependent children of separated or divorced parents, the plan of the parent with legal custody generally pays first. Then, if the parent remarries, the new spouse’s plan pays second. The plan of the parent without custody pays last. This rule takes precedence over all other coordination of benefit rules.

**Termination of Coverage**

Your Comprehensive Medical Plan coverage ends on the last day of the month in which your partnership with SCPMG ends or you no longer meet eligibility requirements. Coverage for your dependents will end when yours does, or at the end of the month during which they become ineligible for coverage.

When coverage ends, you and your dependents may be able to continue health care coverage under COBRA provisions. (See the Administration section for details). There is no conversion option for the Comprehensive Medical Plan.

**No Conversion**

Conversion to an individual policy is not available under this coverage.

**Limited Continuation of Benefits Available (COBRA)**

If you and/or your dependents lose Comprehensive Medical Plan coverage due to termination of employment, reduction of scheduled hours, disability, death, divorce or children reaching the limiting age, Comprehensive Medical Plan coverage may be purchased through COBRA for a maximum of 18, 29 or 36 months, depending on the reason for the termination of coverage. The coverage you purchase will be identical to the coverage you had. Premium rates are available from PHR Shared Services. See Limited Continuation of Health Benefits Available (COBRA) in the Administration section for a general discussion of COBRA.
ALTERNATE MENTAL HEALTH COVERAGE

The Alternate Mental Health Plan coverage and the KFHP mental health benefit are both designed to provide care for acute psychiatric conditions and mental illness or disorders. You may elect to use either:

- KFHP coverage. Mental health care must be provided through Kaiser Permanente facilities and providers (see the KFHP section), or
- Alternate Mental Health Plan. Mental health care may be provided by any facility or provider. Certain copayments and utilization limits apply.

Eligibility and Enrollment

Eligible physicians are automatically enrolled in the Alternate Mental Health Plan. Dependent enrollment is not automatic; however, if you have enrolled your dependents in KFHP Coverage, they will be automatically enrolled in the Alternate Mental Health Plan. Eligible dependents must be enrolled to receive benefits. Eligibility requirements are described under Eligibility and Enrollment in the Kaiser Foundation Health Plan section and the Eligible Dependents section below.

If KFHP coverage is declined, then the Alternate Mental Health Plan coverage is also declined. See Declining Coverage in the Kaiser Foundation Health Plan section for more details.

Eligible Dependents

Dependents eligible for the Alternate Mental Health Plan coverage include:

- your spouse/domestic partner,
- your or your spouse’s/domestic partner’s dependent children up to age 26,
- your dependent children over age 26 who were disabled before age 26 and are incapable of self-support due to a mental or physical handicap. Proof of disability may be required annually. Must apply and be approved for disabled dependent benefit by Kaiser Foundation Health Plan prior to reaching benefit-limit age. Contact the Kaiser Permanente California Service Center - Disabled Dependent Department at 1-800-731-4661, extension 3584, to obtain a Disabled Dependent application, and
- 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 meet the following requirements: (i) They are under age 26; (ii) They are not married and do not have a legally recognized domestic partner; (iii) They receive all of their support and maintenance from you or your spouse; (iv) They permanently reside with you or your spouse.
Dependents of a Deceased Physician

This benefit is not continued for dependents upon the death of a physician, unless purchased through COBRA. See the Administration section of this benefits handbook for details regarding COBRA coverage.

What the Benefit Pays

Associates hired in 2010 and earlier will continue at their current benefit levels until they attain Partner status and move to Partner-level coverage. Associates hired after January 1, 2011 automatically participate in Partner-level coverage.

For a Partner, the Alternate Mental Health Plan pays:

- **Hospitalization**: 80% of the reasonable and customary cost of treatment in the area you receive services for mental illness during hospitalization for up to 31 days per calendar year.
- **Outpatient visits**: 80% of the reasonable and customary cost of treatment in the area you receive services for up to 40 days per calendar year.
- **Alcohol and chemical dependency** (Partner plan only): 80% of the reasonable and customary cost for outpatient individual or group therapy. This benefit does not count against the annual number of outpatient visits per calendar year.
- **Day or night care treatment**: 80% of the reasonable and customary cost of treatment in the area you receive services for the first 90 days of treatment in a calendar year. The 90-day period will be reduced by two days, however, for each full day of inpatient psychiatric care under these provisions.
- **Marriage counseling**: 80% of the reasonable and customary cost for up to 12 counseling visits per calendar year. This benefit does not count against the annual outpatient visit limits.

For an Associate hired before January 1, 2011, the Alternate Mental Health Plan pays:

- **Hospitalization**: 100% of the reasonable and customary cost of treatment in the area you receive services for mental illness during hospitalization. Unlimited visits.
- **Outpatient visits**: 100% of the reasonable and customary cost of treatment in the area you receive services. Unlimited visits.
- **Day or night care treatment**: 100% of the reasonable and customary cost of treatment in the area you receive services. Unlimited visits.
- **Marriage counseling**: 100% of the reasonable and customary cost for up to 12 counseling visits per calendar year. This benefit does not count
Exclusions
The following services and supplies are not covered by the Alternate Mental Health Plan benefit; however, they may be covered under another plan such as KFHP coverage.

Charges not covered under this benefit include:

- Expenses for psychoanalysis
- Treatment of drug addiction or alcoholism, except for covered outpatient individual or group therapy
- Treatment of chronic or organic psychiatric conditions or other conditions which are not subject to significant improvement through short-term therapy
- Treatment of mental retardation
- Testing for intelligence, aptitude, or interest
- Charges for psychiatric treatment or testing ordered by a court or ordered as a condition of parole or probation.

Filing Alternate Mental Health Claims

- Claims are only required if you see an out-of-network provider (an in-network provider will file reimbursement claims for you). Submit claims directly to Meritain Health, the claims administrator. Payments are sent to your home or to your provider. Claim forms may be obtained from PHR Shared Services at 1-877-608-0044 or the SCPMG Physician Portal at http://scpmgphysician.kp.org/.

- Claims and costs must be submitted within one year of the date treatment is provided (even if you have left SCPMG) in order to qualify as a covered expense.

- Most types of treatment and providers are covered by this benefit. The diagnosis must be identified by a standard mental health diagnostic code. If you have any questions about a type of therapy or the type of credential the provider must have, you can request pre-authorization from the claims administrator in writing or by calling Meritain Health at 1-888-711-7876.

Maximum Benefits for Partners

This section provides additional details about the Alternate Mental Health Coverage that are specific to Partners.

Outpatient Visits

The plan provides a maximum of 40 outpatient visits per calendar year.

Effective March 1, 2014
• The outpatient visits are covered at 80% of the reasonable and customary cost of treatment in the area you receive services.

• Any doctor’s visits while hospitalized will not count against the 40 maximum outpatient visits per year.

• If a family consultation is required, the visit(s) will be charged to the person receiving the therapy. Each individual is allowed up to two such family consultations per lifetime.

• An outpatient group therapy or conjoint therapy session will be counted as a half visit for determining covered visits.

**Maximum Benefits for Associate Physicians**

This section provides additional details about the Alternate Mental Health Benefits that are specific to Associate Physicians hired before January 1, 2011.

**Outpatient Visits**

The plan provides an unlimited number of outpatient visits per calendar year.

• The outpatient visits are covered at 100% of the reasonable and customary cost of treatment in the area you receive services.

• If a family consultation is required, the visit(s) will be charged to the person receiving the therapy.

• An outpatient group therapy or conjoint therapy session will be counted as a half visit for determining covered visits.

**Termination of Coverage**

If you terminate service with SCPMG, the Alternate Mental Health Plan coverage benefit will terminate for you and your eligible dependents at the end of the month in which your service ends. In addition, dependents will be terminated from coverage as follows:

• spouse (in the event of divorce) — at the end of the month in which PHR Shared Services receives the Enrollment Application or Change form and the divorce decree.

• domestic partner (in the event of dissolution) — at the end of the month in which PHR Shared Services receives the Enrollment Application or Change Form.

• children — at the end of the month:
  – in which their 26th birthday occurs, or
  – when they are no longer a dependent.
HEALTH CARE BENEFITS

No Conversion
Conversion to an individual policy is not available under this coverage.

Limited Continuation of Benefits Available (COBRA)
If you and/or your dependents lose Alternate Mental Health Plan coverage due to termination of employment, reduction of scheduled hours, disability, death, divorce, or children reaching the limiting age, Alternate Mental Health Plan coverage may be purchased through COBRA for a maximum of 18, 29, or 36 months, depending on the reason for the termination of coverage. The coverage you purchase will be identical to the coverage you had. Premium rates are available from PHR Shared Services. See Limited Continuation of Health Benefits Available (COBRA) in the Administration section for a general discussion of COBRA.

EMPLOYEE ASSISTANCE PROGRAM
The Employee Assistance Program (EAP) offers free and confidential services for all Kaiser Permanente physicians, employees and their dependent family members. EAP counselors are licensed, trained clinicians offering counseling for short-term problem solving on issues including:

- work or personal stress
- emotional or psychological concerns
- family and relationship difficulties
- alcohol and drug abuse
- domestic violence
- financial and legal referrals
- child and elderly care issues

EAP counselors will assess if services are needed on a longer term basis and will assist with referrals to providers outside the Kaiser network for benefits under the Alternate Mental Health Plan (refer to page 56). For assistance or referral information, contact your local EAP office or visit insidekp.kp.org/scal, click on the All Sites tab and scroll down to locate the link for Employee Assistance Program.

DENTAL COVERAGE

Eligibility and Enrollment
If you are an eligible physician, you will automatically be enrolled for Dental Coverage. This benefit becomes effective the first of the month following your eligibility. You may select one of three dental plans. Unless you choose a dental option within 31 days of your initial eligibility date, you will be
enrolled in Delta Dental.

Dependent enrollment is not automatic. Eligible dependents must be enrolled to receive benefits; however, if you have enrolled your dependents in KFHP Coverage, they will be enrolled for Dental Coverage and will receive coverage under the same dental plan that you are enrolled in. Eligibility requirements are described under Eligibility and Enrollment in the Kaiser Foundation Health Plan (KFHP) Coverage section and Eligible Dependents section below.

If KFHP Coverage is declined, then Dental Coverage is also declined. See Declining Coverage in the Kaiser Foundation Health Plan (KFHP) Coverage section for more details.

**Eligible Dependents**

Dependents eligible for Dental Coverage include:

- your spouse/domestic partner
- your or your spouse’s/domestic partner’s dependent children up to age 26 (regardless of their student, financial, and marital status)
- your dependent children over age 26 who were disabled before age 26 and are incapable of self-support due to a mental or physical handicap. Proof of disability may be required annually. You must apply and be approved for disabled dependent benefit by Kaiser Foundation Health Plan prior to reaching benefit-limit age. Contact the Kaiser Permanente California Service Center - Disabled Dependent Department at 1-800-731-4661, ext. 3584, to obtain a Disabled Dependent application
- your 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 meet the following requirements: (i) They are under age 26; (ii) They are not married and do not have a legally recognized domestic partner; (iii) They receive all of their support and maintenance from you or your spouse; (iv) They permanently reside with you or your spouse.

**Dental Care Options**

SCPMG offers you a choice of three dental plan options:

- Delta Dental PPO
- DeltaCare USA, and
- United Concordia.

If you select DeltaCare USA or United Concordia, you must complete an enrollment form. If you do not complete an enrollment form within 31 days of your initial eligibility, you will automatically be enrolled in Delta Dental PPO. You may obtain an enrollment form from and submit it to PHR Shared Services.
You may switch from one dental plan to another once in a 12-month period by completing a new enrollment form.

Delta Dental PPO is an indemnity plan and allows you to see any dentist. However, by using a PPO participating dentist, you will pay less out of pocket. DeltaCare USA and United Concordia are both prepaid group practice plans using their own panels of dentists. The plans are described below.

### Summary of Dental Benefits

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Delta Dental — Group #814-0001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examinations</td>
<td>Covered at 100% (twice in a calendar year)</td>
</tr>
<tr>
<td>Prophylaxis with or without fluoride</td>
<td>Covered at 100% (twice in a calendar year)</td>
</tr>
<tr>
<td>Bitewing X-rays</td>
<td>Covered at 100% (twice in a calendar year)</td>
</tr>
<tr>
<td>Full mouth X-rays</td>
<td>Covered at 100% (once in a calendar year)</td>
</tr>
<tr>
<td>Oral surgery, periodontics, endodontics, restorative dentistry, prosthetics</td>
<td>Pays 80% of usual, customary, and reasonable charges</td>
</tr>
<tr>
<td>Maximum annual benefit</td>
<td>$1,500 per family member per calendar year (excluding children’s orthodontia)</td>
</tr>
<tr>
<td>Orthodontics (limited to dependent children up to age 21)</td>
<td>Covered at 50% up to a lifetime maximum of $1,250 per eligible dependent</td>
</tr>
<tr>
<td>Choice of dentist</td>
<td>To receive full benefits as indicated above, a participating member dentist or orthodontist of Delta Dental must be selected</td>
</tr>
<tr>
<td>Emergency dental treatment</td>
<td>Emergency treatment may be performed by any licensed dentist. The amount paid would be based upon procedures performed</td>
</tr>
<tr>
<td>Conversion privilege</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefits</th>
<th>DeltaCare USA — Group #01001-0018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examinations</td>
<td>Covered at 100%</td>
</tr>
<tr>
<td>Office visit — after regular hours Broken appointments — without 24-hour notice</td>
<td>You pay a $20 copayment You pay $10 per 15 minutes of appointment time up to a maximum of $40 (1 hour)</td>
</tr>
<tr>
<td>Prophylaxis with or without fluoride</td>
<td>Covered at 100% (one treatment each six-month period)</td>
</tr>
</tbody>
</table>

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Effective March 1, 2014
<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bitewing X-rays</td>
<td>Covered at 100% (once every 12 months)</td>
</tr>
<tr>
<td>Full mouth X-rays</td>
<td>Covered at 100% (once every two years)</td>
</tr>
<tr>
<td>Gingivectomy or gingivoplasty</td>
<td>You pay $75 per quadrant ($15 per tooth)</td>
</tr>
<tr>
<td>Gingival flap procedures, including root planing</td>
<td>You pay $75 per quadrant</td>
</tr>
<tr>
<td>Oral surgery, periodontics, endodontics, restorative dentistry, prosthetics</td>
<td>Most services covered at 100%</td>
</tr>
<tr>
<td>Removal of impacted tooth</td>
<td>You pay $30 per partially bony tooth and $40 for completely bony tooth</td>
</tr>
<tr>
<td>Emergency (palliative) treatment of dental pain rendered by your participating dental office</td>
<td>You pay $5 for each treatment</td>
</tr>
<tr>
<td>Maximum annual benefit</td>
<td>No maximum</td>
</tr>
<tr>
<td>Orthodontics (limited to dependent children up to age 18)</td>
<td>You pay start-up fees plus $1,000. The start-up fees are approximately $350. Additional charges are covered at 100%. Retainers and head gear are not covered. Treatment is limited to 24 months.</td>
</tr>
<tr>
<td>Orthodontics (adult)</td>
<td>You pay $1,800 co-pay. Treatment is limited to 24 months.</td>
</tr>
<tr>
<td>Choice of dentist</td>
<td>You must select a dentist or Dental Group from a list of participating panel dentists. All covered family members must receive care from the same DeltaCare USA dentist.</td>
</tr>
<tr>
<td>Emergency dental treatment</td>
<td>Maximum payment of $100 during each 12 calendar months. Benefit is payable only if services were rendered more than 35 miles from your participating DeltaCare USA dentist’s office. There is a $5 co-pay.</td>
</tr>
<tr>
<td>Conversion privilege</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Benefits**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>United Concordia — Group #740153-000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examinations</td>
<td>Covered at 100%</td>
</tr>
<tr>
<td>Broken appointments — without 24-hour</td>
<td>A “Broken Appointment” fee may apply per the dental office if appointments are canceled without 24-hour notice</td>
</tr>
<tr>
<td>Prophylaxis with or without fluoride</td>
<td>Covered at 100% (two treatments in any 12- month period). If you have more than two cleanings in a 12-month period, you pay $10 for each cleaning thereafter for that period. Fluoride treatment for eligible dependent children twice a year.</td>
</tr>
<tr>
<td>Bitewing X-rays</td>
<td>Covered at 100% (two sets per year)</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Full mouth X-rays</td>
<td>Covered at 100% (once every three years)</td>
</tr>
<tr>
<td>Sealants</td>
<td>Covered at 100% (one per tooth once every three years through age 10 on permanent first molars and through age 15 on permanent second molars)</td>
</tr>
<tr>
<td>Oral surgery, periodontics, endodontics, restorative dentistry, prosthetics</td>
<td>Covered at 100%</td>
</tr>
<tr>
<td>Subgingival curettage, root planing</td>
<td>Covered at 100% (two per year). If you have more than two treatments in a 12-month period, you pay $10 for each treatment thereafter for that period.</td>
</tr>
<tr>
<td>Maximum annual benefit</td>
<td>No maximum</td>
</tr>
<tr>
<td>Orthodontics (limited to dependent children up to age 18)</td>
<td>You pay start-up fees of $265 plus the first $1,500. Additional charges are covered at 100%. A copayment of $240 is required for retainers. Treatment is limited to 24 months.</td>
</tr>
<tr>
<td>Orthodontics (adult)</td>
<td>You pay a $2,000 co-pay. Covered $2,000 lifetime maximum benefit.</td>
</tr>
<tr>
<td>Choice of dentist</td>
<td>You must select a dentist or dental group from a list of participating panel dentists. Each covered family member may choose his or her own participating dentist or dental group.</td>
</tr>
<tr>
<td>Emergency dental treatment</td>
<td>Maximum payment of $50 during each 12 calendar months. Benefit is payable only if services were rendered more than 50 miles from your home.</td>
</tr>
<tr>
<td>Conversion privilege</td>
<td>Yes</td>
</tr>
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</table>

**Delta Dental**

The maximum benefit payment per person per calendar year is $1,500 (excluding children’s orthodontia).

The plan will pay the percentage shown below of Delta Dental dentists’ usual, customary and reasonable fees:

<table>
<thead>
<tr>
<th>100%</th>
<th>80%</th>
<th>50%</th>
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</thead>
<tbody>
<tr>
<td><strong>Diagnostic Preventive Services Including:</strong></td>
<td><strong>Basic Dentistry Including:</strong></td>
<td><strong>Children’s Orthodontia</strong>*</td>
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<tr>
<td>• Prophylaxis (twice per calendar year)</td>
<td>• Oral Surgery</td>
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<tr>
<td>• Examinations (twice per calendar year)</td>
<td>• Restorative Dentistry</td>
<td></td>
</tr>
<tr>
<td>• Bitewing X-rays (twice per calendar year)</td>
<td>• Endodontics</td>
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<tr>
<td>• Full mouth X-rays (once per 3 years)</td>
<td>• Periodontics</td>
<td></td>
</tr>
<tr>
<td>• Space maintainers (for children under age 18)</td>
<td>• Prosthodontics</td>
<td></td>
</tr>
</tbody>
</table>

* Orthodontia benefits are available to dependent children provided treatment begins before age 21. The program pays 50% of covered orthodontia expenses up to a maximum benefit of $1,250 per child per lifetime. Orthodontic services provide procedures for the correction of teeth and jaws which are maligned so as to significantly interfere with their normal functions.
Restorative Dentistry provides procedures for amalgam, synthetic porcelain, and plastic restorations for treatment of cavities. Gold or cast restorations, crowns, and jackets will be provided only when teeth cannot be restored with the above procedures.

Replacement of prosthodontic appliances will be provided only once in any five-year period.

In all cases in which there are optional plans of treatment with different fees, Delta Dental will pay the applicable percentage of the lesser fee.

Usual, customary, and reasonable fee means a fee that:

- is the fee usually charged for a specified service by the dentist,
- is within the range of customary fees charged by dentists of similar training and experience in the local area for a specified service, and
- is reasonable considering the special circumstances of the particular case in question.

**Predetermination of Dental Benefits**

Any time dental work is likely to cost more than $100, you should ask your dentist to send a treatment plan to Delta Dental before beginning your dental work. Delta Dental will let you and your dentist know exactly how much of the proposed charges will be paid by the plan.

Follow this procedure:

- The dentist will list each service and the related charge on the form and send it to Delta Dental. (This is called a treatment plan.)
- Delta will send you and the dentist a Predetermination of Benefits Statement. The statement tells you what charges are covered and how much the plan will pay.
- You should discuss the treatment plan and the costs with your dentist before treatment begins.
- If the treatment plan changes, the benefits paid by Delta may change. If the change is significant, your dentist should send a new Attending Dentist’s Statement to Delta Dental.
- If you use a non-participating dentist, give him or her a Delta Attending Dentist’s Statement form. (Delta dentists already have these forms.)

**Services Not Covered**

The Delta Dental Plan does not cover:

- services for
  - congenital malformations
  - developmental malformations
  - cosmetic surgery
  - purely cosmetic reasons
– the replacement and/or repair of an orthodontic appliance furnished under this program
– restoring tooth structure lost from wear
– rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion
– stabilizing teeth
– adult orthodontia
– jaw realignment
– dental implants

• prosthodontic services or devices or any single procedure started before the patient became eligible for this benefit
• prescribed drugs and anesthesia
• hospital costs and related professional fees
• services provided under any governmental program
• experimental procedures

Additional exclusions and limitations may apply.

Filing Claims
Approximately 90% of California dentists are Delta Dental member dentists. Before starting treatment, advise your dentist that you are a member of the SCPMG Delta Dental Program, Group Number 814-0001, and give your Social Security number. Your spouse/domestic partner and dependents must also give your Social Security number.

If you do not use a Delta Dental dentist, the plan will pay 80% of the Delta Dental table of allowances rather than 80% of the usual, customary and reasonable fees. This payment usually approximates 50% of non-Delta Dental dentists’ fees.

Claim forms are available at Delta Dental dentists’ offices. Most Delta Dental members will file the claim on your behalf.

Coordination of Coverage
If you or one of your eligible dependents is eligible for dental benefits under another group plan, the claims administrator will coordinate the benefits payable under this plan with those of the other plan. The combined benefits payable to you or your eligible dependent(s) under the coordinated group dental plans may not exceed 100% of the allowable expenses incurred during the calendar year.

Termination of Coverage
If you terminate service with SCPMG, Delta Dental coverage will terminate for you and your eligible dependents at the end of the month in which your service ends.
In addition, dependents will be terminated from coverage as follows:

- Spouse (in the event of divorce) — at the end of the month in which PHR Shared Services receives the Enrollment Application or Change Form and the divorce decree.
- Domestic partner (in the event of dissolution) — at the end of the month in which PHR Shared Services receives the Enrollment Application or Change Form.
- Children — at the end of the month in which their 26th birthday occurs.

**Limited Continuation of Benefits Available (COBRA)**

If you and/or your dependents lose Delta Dental coverage due to termination of employment, reduction of scheduled hours, disability, death, divorce or children reaching the limiting age, Delta Dental coverage may be purchased through COBRA for a maximum of 18, 29, or 36 months, depending on the reason for the termination of coverage. The coverage you purchase will be identical to the coverage you had. Premium rates are available from PHR Shared Services. See *Limited Continuation of Health Benefits Available (COBRA)* in the Administration section for a general discussion of COBRA.

**No Conversion**

Conversion to an individual policy is not available under this coverage.

**DeltaCare USA**

Under the DeltaCare USA Plan, you must receive your treatment from one of their panel of dentists and all of your family members must use the same dental office. A list of participating dental offices is included in the plan enrollment material.

The maximum annual benefit is unlimited and most listed procedures are provided with no charge to the member. Included are diagnostic and preventive services, restorative dentistry, crowns and bridges, pontics, periodontics, endodontics, prosthetics, oral surgery, space maintainers, and X-rays.

Adult orthodontic treatment is available with an $1,800 co-pay. Orthodontic treatment is also available to dependent children provided treatment begins before age 18; you pay the start-up fees of approximately $350 plus the first $1,000, and the plan pays the balance. Under the plan, orthodontic treatment must be completed within 24 months.

A representative list of covered services is provided with the enrollment material. In general, most procedures are provided at no charge. Exceptions are listed in the *Description of Benefits and Copayments* provided by DeltaCare USA.
Emergency Services
If you are more than 35 miles from your selected dental office, you may select any dentist and receive palliative care. You will be reimbursed up to $100 per member per year, after paying a $5 co-pay. If you are closer than 35 miles to your selected dental office, call that office to reach the 24-hour answering service to arrange for treatment.

For any questions or problems, call DeltaCare USA at 1-800-422-4234 or PHR Shared Services at 1-877-608-0044.

Exclusions
The DeltaCare USA Plan does not cover:
• procedures not specifically listed as a covered benefit
• cosmetic dental care
• general anesthesia and the services of a special anesthesiologist
• fees that are collectible from a third party
• hospital charges of any kind
• treatment of fractures and dislocations
• loss or theft of dentures or bridgework
• lost, stolen, or broken orthodontic applications.

Service Limitations
Services are limited per individual as follows:
• prophylaxis limited to one treatment in any six-month period
• full upper and/or lower dentures not to exceed one each in any five-year period
• upper and/or lower partial dentures not to exceed one each in a five-year period unless necessary due to natural tooth loss and where the addition to an existing partial is not feasible
• denture relines limited to one per denture during any 12 consecutive months
• periodontal treatments limited to four quadrants per 12 consecutive months
• no more than one series of four films in any 12-month period for bitewing X-rays
• one set of full mouth X-rays per 24 consecutive months
• crowns and bridges not to be replaced within five years from initial placement.

Filing Claims
No claim forms are required. DeltaCare USA provides each panel office with a listing of those eligible who have selected that office. The office handles all claims administration.

Coordination of Coverage
If you or one of your eligible dependents is eligible for dental benefits under another group plan, the claims administrator will coordinate the benefits payable under this plan with those of the other plan. The combined benefits payable to you or your eligible dependent(s) under the coordinated group dental plans may not exceed 100% of the allowable expenses incurred during the calendar year.

Termination of Coverage
If you terminate service with SCPMG, DeltaCare USA coverage will terminate for you and your eligible dependents at the end of the month in which your service ends.

In addition, dependents will be terminated from coverage as follows:

- Spouse (in the event of divorce) — at the end of the month in which PHR Shared Services receives the Enrollment Application or Change Form and the divorce decree.
- Domestic partner (in the event of dissolution) — at the end of the month in which PHR Shared Services receives the Enrollment Application or Change Form.
- Children — at the end of the month in which their 26th birthday occurs.

Limited Continuation of Benefits Available (COBRA)
If you and/or your dependents lose DeltaCare USA coverage due to termination of employment, reduction of scheduled hours, disability, death, divorce or children reaching the limiting age, DeltaCare USA coverage may be purchased through COBRA for a maximum of 18, 29 or 36 months, depending on the reason for the termination of coverage. The coverage you purchase will be identical to the coverage you had. Premium rates are available from PHR Shared Services. See Limited Continuation of Health Benefits Available (COBRA) in the Administration section for a general discussion of COBRA.

Conversion
Conversion to an individual policy is available under this coverage. Conversion information is available directly from DeltaCare USA at 1-800-422-4234.

United Concordia
Under the United Concordia Plan, you must receive treatment from a
member of their panel of dentists. You and your family members may choose your own participating dental office. A list of participating dental offices is included in the plan enrollment material.

The maximum annual benefit is unlimited and most listed procedures are provided with no charge to the member. Included are diagnostic and preventive services, restorative dentistry, crowns and bridges, pontics, periodontics, endodontics, prosthetics, oral surgery, space maintainers, and X-rays.

Adult orthodontic treatment is available with a $2,000 co-pay. Orthodontic treatment is also available to dependent children provided treatment begins before age 18; you pay the start-up fees of $265 plus the first $1,500 and the plan pays the balance. There is a copayment of $240 required for retainers. Under the plan, orthodontic treatment must be completed within 24 months.

A schedule of benefits outlining covered services is provided with the enrollment material. In general, most procedures are provided at no charge. Any exceptions are listed in the Schedule of Dental Benefits provided by United Concordia.

Services not on the list are available at the dentist’s usual and customary fees.

**Emergency Services**

You may obtain emergency treatment at any time by calling your selected dental office. If your dental office is unavailable, you should contact the United Concordia Customer Service Department at 1-800-937-6432 for assistance.

If the emergency occurs outside United Concordia’s regular business hours and your dental office is unavailable, palliative dental services may be obtained from any licensed dentist. You are also covered for emergency palliative dental treatment while temporarily more than 50 miles from your home. You will be reimbursed up to $50 per member per year. In either case, an itemized bill and a cover letter explaining the emergency should be submitted to United Concordia within 30 days of the emergency treatment date to be considered for reimbursement.

For any questions or problems, call United Concordia at 1-800-937-6432 or PHR Shared Services at 1-877-608-0044.

**Alternative Treatment**

Occasionally there is more than one way to treat a dental condition successfully. If you select an alternative treatment plan, the dental benefit will be based on the usual, customary, and reasonable charge for the service that is covered. You will be responsible for any difference between the covered service and the alternate treatment, plus any copayment.
Services Not Covered

The United Concordia Plan does not cover:

- procedures not specifically listed as a covered benefit
- services not provided by your selected dental office and not preauthorized by United Concordia (including specialty services)
- services that are not clinically necessary to maintain or improve dental health
- charges for services required because the patient did not follow a documented prescribed course of treatment
- treatment started by a previous United Concordia dental office
- any treatment started before coverage under the United Concordia plan began
- consultation by a specialist for services that are not covered by the plan
- services that do not meet accepted standards of dental practice, are experimental in nature, or are considered enhancements to standard dental care
- hospitalization costs for any dental procedures
- prescriptions and medications not normally dispensed by a dental office
- the administration of general anesthesia or nitrous oxide, intravenous sedation, and the services of an anesthesiologist
- elective surgery
- surgery for congenital malformations
- treatment for fractures, dislocations, cysts, malignancies, or neoplasms
- implants
- services or supplies that are cosmetic in nature, including (but not limited to) bonding, bleaching teeth, personalization of dentures, and posterior composites (white fillings)
- procedures to alter, restore, or maintain occlusion, or to change vertical dimension
- consultation and treatment (including appliances) for TMJ
- replacement of dentures, appliances, crowns, or bridgework due to loss or theft
- duplicate prosthetic device or appliance
- precision attachments or stress breakers
- fees collectible from a third party
- replacement or repair of orthodontic appliances, orthodontic extractions, special orthodontic appliances, retreatment of orthodontic cases, changes in orthodontic treatment necessitated by patient neglect, or orthodontic treatment that exceeds 24 months.
Service Limitations
Services limited per individual include:

• two sets of bitewing X-rays per year
• one set of full mouth X-rays every three years
• one denture relining and rebasing per appliance per year
• periodontal scaling and root planing limited to four quadrants per year
• replacement of crowns, bridges, and full and partial dentures if:
  − the replacement is required to replace one or more teeth extracted after the existing appliance was placed, and
  − the existing crown, denture or bridgework cannot be made serviceable
• referrals for specialty care, limited to orthodontics, oral surgery, periodontics, endodontics and pedodontics.

You must remain covered under the United Concordia Plan while your eligible dependent child is receiving orthodontic treatment; otherwise, there will be a pro-rata charge for all unfinished work at the time your coverage ends.

Additional exclusions and limitations may apply. See your United Concordia Schedule of Benefits.

Filing Claims
No claim forms are required. United Concordia provides each panel dentist’s office with a listing of those eligible who have selected that office. The office handles all claims administration.

Coordination of Coverage
If you or one of your eligible dependents is eligible for dental benefits under another group plan, the claims administrator does not coordinate with other plans, so this benefit is primary under all circumstances.

Termination of Coverage
If you terminate service with SCPMG, United Concordia coverage will terminate for you and your eligible dependents at the end of the month in which your service ends.

In addition, dependents will be terminated from coverage as follows:

• spouse (in the event of divorce) — at the end of the month in which PHR Shared Services receives the Enrollment Application or Change Form and the divorce decree.
• domestic partner (in the event of dissolution) — at the end of the month in which PHR Shared Services receives the Enrollment Application or Change Form.
• children — at the end of the month in which their 26th birthday occurs.

**Limited Continuation of Benefits Available (COBRA)**

If you and/or your dependents lose United Concordia coverage due to termination of employment, reduction of scheduled hours, disability, death, divorce, or children reaching the limiting age, United Concordia coverage may be purchased through COBRA for a maximum of 18, 29, or 36 months, depending on the reason for the termination of coverage. The coverage you purchase will be identical to the coverage you had. Premium rates are available from PHR Shared Services. See *Limited Continuation of Health Benefits Available (COBRA)* in the *Administration* section for a general discussion of COBRA.

**Conversion**

Conversion to an individual policy is available under this coverage. Conversion information is available directly from United Concordia at 1-800-937-6432.

**HEALTH CARE NOTICES**

**Women’s Health and Cancer Rights Act**

Pursuant to the Women’s Health and Cancer Rights Act, the medical plans provided under the Kaiser Foundation Health Plan and described in this handbook provide benefits for the restoration of breasts in connection with a mastectomy, specifically:

• reconstruction of the breast on which the mastectomy was performed,
• surgery and reconstruction of the other breast to produce a symmetrical appearance, and
• prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The Kaiser Foundation Health Plan will determine the manner of coverage in consultation with the patient and the attending doctor. Coverage for breast reconstruction and related services will be subject to any deductibles and coinsurance amounts consistent with those that apply to other health benefits under the plan.
Newborns’ and Mothers’ Health Protection Act

Pursuant to the Newborns’ and Mothers’ Health Protection Act, the medical plans provided under the Kaiser Foundation Health Plan and described in this handbook provide maternity benefits including expenses for you or your enrolled spouse/domestic partner or child.

This federal law provides that hospital stays for services for the mother and newborn child cannot be less than 48 hours following a normal vaginal delivery, or 96 hours following a caesarean birth, unless the attending physician, after consulting with the mother, discharges the mother or newborn child earlier. The physician is not required to pre-certify the maternity hospital stay if it falls within these limits.

Health Insurance Portability and Accountability Act — Privacy of Health Information

SCPMG and Kaiser Foundation Health Plan take the security of your health information very seriously. SCPMG maintains a Notice of Privacy Practices that describes the circumstances in which SCPMG may use or disclose your health information. This Notice of Privacy Practices is available at www.kp.org. For additional information, or to obtain a paper copy of the Notice of Privacy Practices, please contact Member Services at 1-800-464-4000.

Genetic Information Nondiscrimination Act

SCPMG and Kaiser Foundation Health Plan will not request, require, or otherwise collect genetic information pertaining to you or your family members for the purposes of limiting your benefits or for any other purpose in violation of the Genetic Information Nondiscrimination Act. For more information, please contact Member Services at 1-800-464-4000.

Michelle’s Law

Michelle’s Law extends health coverage under group health plans for dependent college students who take a medically necessary leave of absence from school for a period of up to one (1) year. You must request certification of medical necessity from the treating physician and this must be provided to the health plan.

Eligibility

A “qualified dependent” means a dependent child who meets the definition for full-time student dependent eligibility under a benefit plan described in Section I of this handbook. To be eligible for coverage under Michelle’s Law, the dependent student must have been covered under the plan immediately before the first day of the medically necessary qualified leave.

A “qualified leave of absence” means:

• a leave of absence from a post-secondary institution that begins while the child is suffering from a serious illness or injury,
• the leave is medically necessary as certified by the treating physician, and
• the leave results in the child losing student status for purposes of coverage under the Plan.

If approved, the dependent will be entitled to the same level of benefits during the medically necessary leave of absence as would have been provided to him/her as a full-time student. Eligibility under Michelle’s Law will be extended for up to one (1) year or until the coverage would otherwise have terminated pursuant to the terms and conditions of the Plan, whichever occurs first. California insurance law may provide similar rights for certain benefits described in this Section I. If you have any questions about your rights under either Michelle’s Law or California law, please contact the Member Services at 1-800-464-4000.
SECTION: II

DISABILITY INCOME BENEFITS
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## Sick Leave and Disability Benefits Timelines

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DISABILITY INCOME BENEFITS

The SCPMG Sick Leave programs, in combination with the Disability Income Insurance Plans, are designed to provide you with continued full or partial income in the event of a covered disabling illness or injury. The amount and duration of the benefits are based on your length of service and physician category. For a graphic representation of how the plans are integrated, see the timelines at the end of this section.

Sick Leave Programs

SCPMG provides the following benefits at no cost to you (as specified in the Partnership Agreement/Rules and Regulations):

- **Acute Sick Leave** covering all physicians, except Per Diem
- **Accumulated Acute Sick Leave** covering Partners
- **Chronic Sick Leave** covering Partners
- **Accumulated Chronic Sick Leave** covering Special Category Physicians
- **Compensation Continuance Program** covering Partners.

Disability Income Insurance Plans

SCPMG also offers the following insured benefits:

- **Short-Term Disability** (STD) available to Associate Physicians and special category physicians at no cost
- **Long-Term Disability** (LTD) available to Associate Physicians for a monthly premium and to Partners at no cost.

SICK LEAVE PROGRAMS

Sick Leave Benefits

Sick Leave benefits are provided by SCPMG for all physician categories, except Per Diem or Partner Emeritus. The type and amounts of Sick Leave benefits depend on your physician category and work schedule.

You can use Sick Leave benefits to cover brief illnesses and — for illnesses lasting more than 30 days — as a supplement to:

- Short-Term Disability (STD) Insurance benefits for Associate Physicians, Special Category Physicians, or
- Compensation Continuance Program for Partners.

The Sick Leave programs are described in the Partnership Agreement/ Rules and Regulations, Article 12 and the Partnership Agreement/Rules and Regulations, Section 7. A brief summary of these programs follows. All benefits paid under the Sick Leave programs are taxable.

Effective March 1, 2014
**Acute Sick Leave**

Acute Sick Leave benefits are available for all physicians, except Per Diem. Acute Sick Leave pays 100% of Base Compensation.

During your first year, you will accumulate Acute Sick Leave days at the rate of 0.85 days per pay period. On each Anniversary Date, any remaining balance is deleted and 22 days are added to your Acute Sick Leave account. The number of days available is prorated to your work schedule in effect on your Anniversary Date.

If you are a former Kaiser Foundation Hospital resident, you will receive up to 22 days of Acute Sick Leave at the beginning of your first year, but you will not accrue additional Acute Sick Leave days during your first year of service.

You may work a reduced schedule with the recommendation of the Chief of Service and approval of your Area Medical Director for up to six weeks while recovering from an acute illness that persists for at least one week. The regularly scheduled hours you do not work will be compensated and deducted from your Acute Sick Leave.

You may use up to one half of your annual Acute Sick Leave to care for your spouse, domestic partner, parent or child, including a child of your domestic partner, in the event of illness. See the Family Care and Medical Leave section of this handbook for more information. You are required to take Acute Sick Leave in conjunction with a leave related to your pregnancy. See the Acute Sick Leave section of the Partnership Agreement/Rules and Regulations or contact PHR Shared Services for additional information at 1-877-608-0044.

If you use 22 days or less of Acute Sick Leave during any one year, your Anniversary Date will be not be adjusted. If your Sick Leave exceeds one month (22 working days) in an Anniversary Year, your Anniversary Date will be adjusted on a day-by-day basis according to the rules for Leave of Absence. Contact PHR Shared Services for additional information at 1-877-608-0044.

If your Acute Sick Leave has been exhausted, you may be eligible for other forms of leave. Please review the Time-Off Benefits section of this handbook for other time-off benefits that may be available to you.

**Accumulated Acute Sick Leave (For Partners Only)**

Partners will have 20% of their unused Acute Sick Leave balance transferred to their Accumulated Acute Sick Leave (AASL) account on each Anniversary Date following their first year of partnership. The maximum AASL account balance is 44 days. AASL may be used when you have exhausted your annual Acute Sick Leave account. Use of AASL will not affect your Anniversary Date. AASL can be re-accumulated.

You may draw from your AASL account in full- or partial-day increments of:
• 100 percent Base Compensation for a full day,
• 40 percent of a day, or
• 25 percent of a day,
as needed to supplement the compensation continuance and/or LTD
benefits, if applicable.

For example: Partner Dr. Lee has 10 days of AASL in her account. Once Dr. Lee has exhausted her Acute Sick Leave, Dr. Lee could draw from her AASL balance in any of the following combinations (the following list is not exhaustive):
• 10 days of AASL at 100% of Base Compensation,
• 25 days of AASL at 40% of Base Compensation (to supplement a claim under the Compensation Continuance Program), or
• 40 days of AASL at 25% of Base Compensation (to supplement a Long-Term Disability claim).

Chronic Sick Leave (For Partners Only)
Chronic Sick Leave is used only in conjunction with the Compensation Continuance Program and LTD benefits for Partners and is available for use for a certified disability as determined by CIGNA, the third-party administrator for the disability plans.

Upon attaining partnership, 528 working days are available for use for a certified disability:
• Continuation of your partnership and 25% of monthly Base Compensation (prorated to your average work schedule) for 132 working days (six months) of Chronic Sick Leave, and
• Continuation of your partnership without compensation for up to 396 days (eighteen months) of Chronic Sick Leave without compensation except for Year-End Performance Draw.

For each day of Chronic Sick Leave taken, your Anniversary Date will be adjusted by one working day.

Your partnership and health care benefits are maintained while on Chronic Sick Leave. You are also eligible for adjustments to your Base Compensation. Sick Leave, Vacation Leave, and Educational Leave will not accrue while on Chronic Sick Leave. Once used, Chronic Sick Leave cannot be replaced or re-accumulated.

Your Chronic Sick Leave benefits will be based on a calculation of your average work schedule during your work history with SCPMG as of the end of the calendar year preceding your current Chronic Sick Leave (excluding all unpaid Leaves of Absence). If your percent of time worked is in excess of 95%, the Chronic Sick Leave will be paid based on a 10/10 work schedule. If it is 95% or less, Chronic Sick Leave will be paid based on the average work schedule. Chronic Sick Leave is charged on a five-day workweek regardless of the current work schedule.

You may be able to supplement benefits you receive under Chronic Sick
Leave with Compensation Continuance or Long-Term Disability Insurance benefits. The benefits you receive under the Sick Leave programs will be limited when combined with the Compensation Continuance Program. Under no circumstances will you be able to combine other Sick Leave benefits with the Compensation Continuance Program in order to receive greater than 100% of your Base Compensation or gross compensation. See Compensation Continuance Program in this section for proper service instructions. See Chronic Sick Leave in section 7 of the Partnership Agreement/Rules and Regulations, or contact PHR Shared Services at 1-877-608-0044 for additional information about Chronic Sick Leave.

**Accumulated Chronic Sick Leave (For Special Category Physicians Only)**

Accumulated Chronic Sick Leave (ACSL) is available to Special Category Physicians only. ACSL is used in conjunction with the disability insurance benefit for these physicians. After your first year as a Special Category Physician, 100% of your unused Acute Sick Leave balance is transferred to your ACSL account.

The maximum benefit is 66 working days (three months) paid at 50% of Base Compensation (prorated to your average work schedule), limited to the days accumulated. Once 66 days of ACSL have been accumulated, no additional days will be added.

For each day of ACSL taken, your Anniversary Date will be adjusted by one work day.

The Sick Leave Programs and Short-Term Disability (STD) Insurance (described later in this section) are integrated to provide special category physicians with the continuation of a portion of income when disabled. See Chronic Sick Leave in section 7 of the Partnership Agreement/Rules and Regulations, or contact PHR Shared Services at 1-877-608-0044 for additional information about Chronic Sick Leave.

**Compensation Continuance Program (For Partners Only)**

Compensation Continuance is provided to all Partners at SCPMG expense. This benefit is taxable to you when received.

If you become disabled for 31 days or more, Compensation Continuance is payable for up to 22 weeks, provided you remain disabled.

The benefit payable is the greater of:

- 60% of your monthly Base Compensation (pro-rated to your work schedule), or
- 60% of your average monthly gross compensation (for the 12-month period ending December 31 or June 30) immediately preceding the onset of disability.
The following Sick Leave benefits may be used in order to supplement this benefit:

- You may draw from your Accumulated Acute Sick Leave (AASL) in 40% increments, or
- You may draw from your Chronic Sick Leave in 25% increments.

**Example 1:** Partner Dr. Simes has 10 days of AASL, is temporarily disabled, and has satisfied the 30-calendar-day waiting period (22 work days) before commencing benefits from the Compensation Continuance Program. Dr. Simes will use 25 days of AASL (10 days in 40% increments) to supplement his payments from the Compensation Continuance Program. Benefits from AASL will be prorated to his current work schedule.

**Note:** If Dr. Simes is receiving Disability benefits or other Sick Leave benefits, his Sick Leave benefits will be limited when combined with the Compensation Continuance Program to ensure he does not receive greater than 100% of his Base Compensation or gross compensation.

**Example 2:** Partner Dr. Berman is temporarily disabled and has satisfied the 30 day waiting period. Dr. Berman has no AASL, therefore his Compensation Continuance payments will be supplemented with 25% pay from his Chronic Sick Leave bank.

**Note:** If Dr. Berman is receiving disability benefits or other Sick Leave benefits, his Sick Leave benefits will be limited when combined with the Compensation Continuance Program to ensure he does not receive greater than 100% of his Base Compensation or gross compensation.

The Compensation Continuance Program is a non-insured benefit administered by CIGNA. In order for benefits to be paid, you must submit proof of your disability to CIGNA. CIGNA will provide SCPMG with an Advice to Pay benefits allowance under the Compensation Continuance Program indicating how many days of Compensation Continuance benefits you will be eligible to receive. CIGNA and your attending physician or an independent medical examiner will make the determination of disability, not SCPMG. This ensures a high level of confidentiality for disabled physicians.

**Partial Disability**

If, after you have met the 30-day waiting period, you return to practice on a part-time basis, you may receive benefits from the Compensation Continuance Program and any applicable Sick Leave benefits for the days you do not work (in accordance with your last work schedule).

The reduced work schedule must be approved by your Chief of Service and your Area Medical Director.

Contact PHR Shared Services for more information about the Compensation Continuance Program at 1-877-608-0044.

**Additional Information for Partners**

The Board of Directors has the discretionary authority to convert a Partner’s Leave of Absence, Extended Educational Leave, or Medical Service Leave
to Sick Leave in the event the Partner becomes seriously disabled or is hospitalized.

Partners who have notified the Executive Medical Director and the Board of Directors of an intent to retire or terminate from the partnership will be entitled to benefits under Acute Sick Leave, accrued AASL, Chronic Sick Leave, and the Disability programs should they become ill or injured during the interim period prior to their retirement or termination.

A Partner on Sick Leave or Disability is not eligible for Early Separation. Contact PHR Shared Services for additional information at 1-877-608-0044.

**SHORT-TERM DISABILITY INSURANCE**

**Eligibility**

All actively at work Associate Physicians, except Per Diem, are eligible for Short-Term Disability Insurance.

The insurer is Life Insurance Company of North America, a CIGNA company.

The terms of the Short-Term Disability Insurance plan are contained in a member certificate. In the event of any contradictions or disputes as to the terms contained in this section and the member certificate, the member certificate will govern.

You can obtain a copy of the member certificate by contacting PHR Shared Services at 1-877-608-0044.

**Benefits**

The coverage provides a benefit equal to 50% of your monthly base pay to a maximum benefit of $3,462 per week. This is equivalent to a monthly benefit of $15,000.

There is a minimum benefit of $25 per week.

STD benefits will be determined by your monthly Base Compensation (prorated to your work schedule) in effect just prior to the date your disability began. Any increase in your monthly Base Compensation that occurs during the first six months of your disability will be reflected in your STD benefit.

Benefits are payable from the 31st calendar day of disability due to injury or illness. Payments continue for up to 22 weeks for each period of disability, provided CIGNA certifies that you are disabled.

**When Benefits End**

STD benefits will end on the earliest of:

- the date you earn more than 80% of your Indexed Covered Earnings,
Definition of Disability
In order to be considered disabled, you must be unable to perform all of the material duties of your regular occupation or be unable to earn more than 80% of your Indexed Covered Earnings solely due to injury or sickness.

Pre-Existing Condition Limitation
If your STD insurance has been in effect for less than 12 months, no benefits will be paid as a result of a pre-existing condition. A pre-existing condition means any injury or sickness for which you incurred expenses; received medical treatment, care, or services, including diagnostic measures; prescription drugs or medicines; or consultation with a physician within 12 months of your coverage start date.

Successive Periods of Disability
Once you are eligible to receive STD benefits, periods of disability due to the same or related causes will be considered the same period of continuous disability if you return to active service for more than one day but less than 14 consecutive days.

Social Security Disability Benefit
The amount of your STD benefit is not integrated with Social Security. If you become disabled and are certain that your disability will be of a permanent or indefinite duration, CIGNA will assist you in applying for your Social Security Disability benefit, or you may apply for your Social Security Disability benefit by contacting the Social Security Administration directly.

State Disability
Associate Physicians are eligible for State of California Disability benefits. These benefits are not integrated with STD insurance. Claims can be filed online by visiting edd.ca.gov/Disability/SDI_Online.html. For more information, contact the California State Disability Insurance office at 1-800-480-3287.

Work Incentive Benefit
The Work Incentive Benefit permits you to return to your regular occupation...
on a part-time basis, or to any other occupation on a full-time or part-time basis. However, your STD benefit may be reduced if the total of your STD benefit and current earnings exceed 100% of your monthly Base Compensation.

**Current Earnings**

Included in current earnings are any wages or salary for work performed while you are receiving STD benefits.

**Rehabilitation Program**

You may qualify to participate in the rehabilitation program if CIGNA determines that you are a suitable candidate for rehabilitation. Through this program, CIGNA will provide, arrange and authorize vocational or physical rehabilitation services for you. While you participate in the program, you could receive payment of your:

- medical expenses,
- education expenses,
- moving expenses,
- accommodation expenses, or
- family care expenses.

**Reasonable Accommodation Benefit**

If you are a disabled Associate Physician, SCPMG may provide reasonable accommodation so that you are able to return to work. A reasonable accommodation is any modification or adjustment to a job, an employment practice, or the work environment that makes it possible for a disabled person to perform the material duties of any occupation without causing undue hardship on SCPMG. SCPMG may receive reimbursement for any expenses incurred in providing the reasonable accommodation if the following conditions are met:

- the accommodation is made on your behalf and results in your ability to return to any occupation with SCPMG,
- the accommodation is approved in writing by CIGNA before it is implemented or any expense incurred, and
- the accommodation meets the federal standards of a reasonable accommodation as detailed in the Americans With Disabilities Act of 1990, as amended.

**Exclusions**

STD benefits are not payable for a disability that results, directly or indirectly, from:
• suicide, attempted suicide, or intentionally self-inflicted injuries,
• war or any act of war, whether declared or undeclared,
• serving on full-time active duty in any armed forces,
• terrorism or active participation in a riot,
• commission of a felony,
• revocation, restriction, or non-renewal of your license, permit, or certification necessary to perform the duties of your occupation, or
• cosmetic surgery or surgical procedure that is not medically necessary. Medically necessary means that the surgery:
  – is prescribed by a doctor as required treatment of the injury or sickness, and
  – is appropriate according to conventional medical practice for the injury or sickness
• any period of disability during which you are incarcerated in a penal or correction institution.

Termination of Insurance
Your STD insurance coverage terminates on the date any of the following situations occur:
• you are no longer in active service,
• you no longer qualify for coverage, or
• the policy is terminated.
During an approved leave of absence, STD insurance coverage can continue for up to 12 months if you pay the required premiums.

No Conversion
Conversion to an individual policy is not available under this coverage.

Claims
You will receive instructions from PHR Shared Services. Prompt response to the instructions will help ensure timely payment of your disability benefits.

Cost
SCPMG pays for the cost of this benefit.

Tax Implications
Benefits received under the Basic level of coverage are taxable since SCPMG is paying the premium.
Continuation of Other Benefits

SCPMG will continue to pay for benefits provided at SCPMG expense during the period of your STD leave, as long as you remain employed. Associate Physicians who pay for certain benefits will be able to continue these benefits at their own expense during the period of STD leave. Contact PHR Shared Services at 1-877-608-0044 for more information about STD leave, including how to continue paying for benefits at your own expense.

LONG-TERM DISABILITY INSURANCE

Eligibility

All actively at-work physicians, except Per Diem, are eligible for Long-Term Disability (LTD) Insurance. Associate Physicians may enroll, at their own expense, within 60 days of hire without proof of insurability. There is no enrollment after 60 days of hire.

Partner Physicians are automatically enrolled at SCPMG expense upon election to partnership. The coverage may not be declined.

The insurer is Life Insurance Company of North America, a CIGNA company.

The terms of the Long-Term Disability Insurance plan are contained in a member certificate. In the event of any contradictions or disputes as to the terms contained in this section and the member certificate, the member certificate will govern.

You can obtain a copy of the member certificate by contacting PHR Shared Services at 1-877-608-0044.

Benefits

The LTD benefit is equal to 50 percent of your monthly covered earnings. Covered earnings means the greater of:

- 50 percent of your monthly Base Compensation as of the onset of disability prorated to your work schedule at that time (including compensation increases during the first six months of disability), or
- 50 percent of your average monthly gross compensation for the 12 months ending the June 30 or December 31 immediately preceding the onset of disability.

Gross compensation means your monthly Base Compensation plus overnight and extra duty pay, but excludes amounts received as bonuses, awards, Imputed Income, or year-end performance draw.

The maximum amount of monthly covered earnings is $40,000, for a maximum LTD benefit of $20,000 per month. The minimum LTD benefit
is $100 per month. The LTD benefit may also be subject to the limitations described later under Benefit Reductions.

During the benefit period, you may be required to provide periodic proof that you remain disabled. CIGNA may reasonably require that you have an examination at any time you are claiming benefits.

**Benefit Waiting Period**

The benefit waiting period is the period of time you must be continuously disabled before LTD benefits can begin. Your benefit waiting period is six months, during which time you may be eligible to receive SCPMG Sick Leave pay and Compensation Continuance or STD insurance benefits.

**Maximum Benefit Period**

LTD benefits will be paid on a monthly basis and will continue as long as you remain disabled in accordance with the following schedule:

<table>
<thead>
<tr>
<th>Age When Disability Begins</th>
<th>Maximum Benefit Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>62 or younger</td>
<td>Your 65th birthday or 42 monthly payments, if later</td>
</tr>
<tr>
<td>63</td>
<td>36 monthly payments</td>
</tr>
<tr>
<td>64</td>
<td>30 monthly payments</td>
</tr>
<tr>
<td>65</td>
<td>24 monthly payments</td>
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<tr>
<td>66</td>
<td>21 monthly payments</td>
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<td>67</td>
<td>18 monthly payments</td>
</tr>
<tr>
<td>68</td>
<td>15 monthly payments</td>
</tr>
<tr>
<td>69 or older</td>
<td>12 monthly payments</td>
</tr>
</tbody>
</table>

**When Benefits End**

LTD benefits will end on the earliest of:
- the date you earn more than 80% of your Indexed Covered Earnings,
- the date CIGNA determines you are not disabled,
- the end of the maximum benefit period, or
- the date of your death.
Definition of Disability

You will be considered disabled if, because of a covered injury or sickness, you are unable to perform all the material duties of your regular occupation, or solely due to injury or sickness, you are unable to earn 80% or more of your covered earnings.

Benefit Reductions

If, for any reason, your LTD benefit, plus any other income benefits (defined below), exceeds 60% of your monthly covered earnings, the LTD benefit will be reduced to bring the total to no more than 60%. (There is no reduction of this benefit if you are also collecting payments from an individual, privately purchased policy.)

Other Income Benefits

Included in other income benefits are:

- any amounts you or your dependents receive under the Canada and Quebec Pension Plans; the Railroad Retirement Act; any local, state, provincial or federal government disability or retirement plan or law; 50 percent of any Accumulated Acute Sick Leave (AASL) and Chronic Sick Leave (CSL), provided they do not exceed 25 percent of your monthly Base Compensation; any work loss provision in mandatory no-fault auto insurance; any Workers’ Compensation, occupational disease, unemployment compensation law or similar state or federal law, including all permanent and temporary disability benefits,
- any Social Security disability benefits you or a third party receive for yourself or your dependents because of your entitlement to the Social Security benefit,
- any SCPMG-funded retirement plan benefits, excluding the Common Plan,
- any proceeds payable under any franchise or group insurance or similar plan, or
- any wage or salary for work performed, but only to the extent provided for under the Work Incentive Benefit section.

Pre-Existing Condition Limitation

If your LTD insurance has been in effect for less than 12 months, no benefits are paid as a result of a pre-existing condition. A pre-existing condition means any injury or sickness for which you incurred expenses; received medical treatment, care, or services, including diagnostic measures; prescription drugs or medicines; or consultation with a physician within three months of your coverage start date.
Benefit Limit for Mental Illness and Substance Abuse

LTD benefits are limited for a disability caused or contributed to by a mental illness or substance abuse. The plan provides coverage up to a lifetime maximum of 24 monthly payments. Once the 24 monthly payments have been made, no further benefits will be payable for any of the following conditions:

- alcoholism,
- anxiety disorders,
- delusional (paranoid) disorders,
- depressive disorders,
- drug addiction or abuse,
- eating disorders,
- mental illness (bipolar affective disorder, psychotic disease, and schizophrenia will be paid for the duration of the disability or to age 65, whichever occurs first), or
- somatoform disorders (psychosomatic illness).

While certain benefits may not be payable under LTD, they may be covered under the Alternate Mental Health Benefit.

If you are confined in a hospital for more than 14 consecutive days for one of the conditions listed above, the confinement will not count toward the lifetime maximum. However, the hospital confinement must occur before you reach the lifetime maximum benefit limit.

Work Incentive Benefit

If you are able to return to work for either SCPMG or another employer while disabled, you may continue to receive LTD benefits — known as a work incentive benefit — during a period of partial disability. Any reduced work schedule must be approved by your Chief of Service and the Area Medical Director.

However, your LTD benefits could be reduced as described below.

For the first 24 months you return to work:

Subject to the Disability benefit limitations discussed in previous sections, if the combination of the following three sources of benefits or income exceeds 100 percent of your indexed covered earnings in any month, the LTD benefit will be reduced to bring the total to no more than 100 percent of:

- your LTD benefit,
- plus your current earnings,
- plus any other income benefits.
After the first 24 months:

Subject to the Disability benefit limitations discussed in previous sections, the LTD benefit is reduced by 50 percent of your current earnings received during any month you return to work. If the combination of the following three sources of benefits or income exceeds 80 percent of your Indexed Covered Earnings in any month, the LTD benefit will be further reduced to bring the total to no more than 80 percent of:

- your LTD benefit,
- plus your current earnings,
- plus any other income benefits.

Progressive Illness Benefit

You may qualify for this enhancement if you are diagnosed with a slowly debilitating medical condition that forces you to reduce your work schedule and ultimately stop working. If a LTD claim is filed due to the disabling condition, the Progressive Illness enhancement allows the monthly LTD benefit to be calculated using your income at the time of diagnosis, not your base annual compensation when you stop working.

Current Earnings

Included in current earnings are any wages or salary for work performed while you are receiving LTD benefits.

Rehabilitation Program

You may qualify to participate in the rehabilitation program if the insurance company determines that you are a suitable candidate for rehabilitation. Through this program, the insurance company will provide, arrange, and authorize vocational or physical rehabilitation services for you. While you participate in the program, you could receive payment of your:

- medical expenses,
- education expenses,
- moving expenses,
- accommodation expenses,
- family care expenses.

Reasonable Accommodation Benefit

If you are a disabled Associate Physician, SCPMG may provide reasonable accommodation so that you are able to return to work. A reasonable accommodation is any modification or adjustment to a job, an employment practice, or the work environment that makes it possible for a disabled person to perform the material duties of any occupation without causing
undue hardship on SCPMG. SCPMG may receive reimbursement for any expenses incurred in providing the reasonable accommodation if the following conditions are met:

- the accommodation is made on your behalf and results in your ability to return to any occupation with SCPMG,
- the accommodation is approved in writing by the insurance company before it is implemented or any expense incurred, and
- the accommodation meets the federal standards of a reasonable accommodation as detailed in the Americans With Disabilities Act of 1990, as amended.

**Spousal/Domestic Partner Rehabilitation Program**

At CIGNA's determination, your spouse/domestic partner may qualify to participate in a rehabilitation program if the following conditions are met:

- you must be continuously disabled for 12 months,
- your spouse/domestic partner earns less than 60 percent of your covered earnings, and
- your spouse/domestic partner is determined to be a suitable candidate for rehabilitation.

Your spouse must be your lawful spouse living with you on the date your disability begins. Your domestic partner must be a person who is registered as your domestic partner with the California Secretary of State or who has a current domestic partner affidavit on file with SCPMG. The rehabilitation program will end if your spouse/domestic partner is not living with you during the term of the program.

The LTD benefit will be reduced by 50 percent of your spouse’s/domestic partner’s earnings from rehabilitative work. If your spouse/domestic partner was working before the rehabilitation program begins, the LTD benefit will be reduced by 50 percent of the increase in income that results from your spouse’s/domestic partner’s participation in the program.

Your spousal/domestic partner rehabilitation program could include payment of your spouse’s/domestic partner’s:

- education expenses,
- reasonable job placement expenses,
- moving expenses, and
- family care expenses, if necessary for your spouse/domestic partner to be retrained under the program.

**Survivor Benefit**

If you received at least six months of LTD benefits prior to your death, your survivor will receive a lump sum payment equal to six monthly benefit
payments plus any current earnings by which your last LTD monthly benefit was reduced.

Under LTD insurance, survivor means your lawful spouse or domestic partner. If you do not have a spouse or domestic partner at the time of your death, benefits will be paid to your unmarried children under age 21 who are dependent on you for support and maintenance.

**Exclusions**

LTD benefits are not payable for a disability that results, directly or indirectly, from:

- suicide, attempted suicide, or intentionally self-inflicted injuries,
- war or any act of war, whether declared or undeclared,
- serving on full-time active duty in any armed forces,
- terrorism or active participation in a riot,
- commission of a felony,
- revocation, restriction, or non-renewal of your license, permit, or certification necessary to perform the duties of your occupation, or
- any period of disability during which you are incarcerated in a penal or corrections institution.

**Termination of Insurance**

Your LTD insurance coverage terminates on the date any of the following situations occur:

- you are no longer in active service,
- you do not pay the premiums required for coverage,
- you no longer qualify for coverage, or
- the policy is terminated.

During an approved unpaid leave of absence, LTD insurance coverage can continue for up to 12 months if you pay the required premiums.

**Waiver of Premium**

For Associate Physicians, if you leave work due to a certified disability, premiums will continue to be due until your Disability benefit is approved and payment begins. After that time, premium payment is waived while benefits are payable.

For Partner Physicians, the waiver of premium provision begins after you have been approved to receive a disability benefit and payment begins. The waiver of premium will continue while benefits are payable. You will save additional taxes due on the premium amount (Imputed Income) since SCPMG is no longer required to pay the premiums.
No Conversion
Conversion to an individual policy is not available under this coverage.

Claims
PHR Shared Services or CIGNA can assist you in filing your claim. Prompt response to PHR Shared Services and/or CIGNA will help ensure timely payment of your Disability benefits.

Cost
For Associate Physicians, premiums are paid by the physician. For Partner Physicians, premiums are paid by SCPMG.

Tax Implications
Benefits received are not taxable for either the Associate Physician or Partner. Associate Physicians will pay for coverage on a post-tax basis through payroll deductions. For Partners, the value of this benefit is considered Imputed Income (unless the waiver of premium provision is in effect) and appears as taxable income on the annual SCPMG Statement of Partner Earnings.

Continuation of Other Benefits While on LTD
Medical (including KFHP coverage) and dental benefits may be continued until your termination from SCPMG.

For Partner Physicians, SCPMG will continue these benefits until the end of the month of your termination from the partnership.

For Associate Physicians, SCPMG will continue these benefits for three months after you have exhausted your paid Sick Leave.

Part-time physicians may only continue KFHP coverage and are still responsible for 50 percent of the cost.

If you enrolled in Permanente Provided Life Insurance prior to your disability, you may be eligible for your life insurance to continue at the Medical Group’s expense while you are on a certified disability. You will also be eligible to continue your Optional Life Insurance at SCPMG’s expense while you are on a certified disability. See the Life and Accident Insurance section of this handbook for more information, or contact PHR Shared Services for additional information at 1-877-608-0044.

Your premiums for LTD coverage will be waived while you are receiving LTD benefits.
SICK LEAVE AND DISABILITY BENEFITS TIMELINES

Partners

Your Sick Leave and Disability programs are integrated to keep you in active Partner status for as long as possible. Partnership status may be active even if you are on a leave that is not paid. The timeline below depicts the range of time that these benefits continue from the first day of disability to the partnership end date. The time available depends on your Sick Leave balances at the time you become disabled. This timeline assumes a Partner has a full bank of all Sick Leave benefits.

Month: 0 1 6 12 30 36 Termination

SCPMG Pay

<table>
<thead>
<tr>
<th>Month</th>
<th>ASL 100%</th>
<th>CC 60%, AASL 40%</th>
<th>CSL 25%</th>
</tr>
</thead>
</table>

Partnership Continues

<table>
<thead>
<tr>
<th>Month</th>
<th>ASL 100%</th>
<th>AASL, CC 5 months</th>
<th>CSL 25% 6 months</th>
<th>CSL 0% 18 months</th>
<th>LWOP 6 months</th>
<th>Maximum 36 months</th>
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</table>

CIGNA Benefit

<table>
<thead>
<tr>
<th>Month</th>
<th>6-Month Waiting Period</th>
<th>LTD 50%,* To Age 65 (or ADEA Schedule)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

* Monthly benefit limited to $20,000/month.

Glossary of Terms for All Tables

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>AASL</td>
<td>Accumulated Acute Sick Leave</td>
</tr>
<tr>
<td>ACSL</td>
<td>Accumulated Chronic Sick Leave</td>
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<td>ADEA</td>
<td>Age Discrimination in Employment Act</td>
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<td>ASL</td>
<td>Acute Sick Leave</td>
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<td>CC</td>
<td>Compensation Continuance Program</td>
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<td>CIGNA</td>
<td>Disability Insurance Carrier</td>
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<td>CSL</td>
<td>Chronic Sick Leave</td>
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<td>LTD</td>
<td>Long-Term Disability</td>
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<tr>
<td>LWOP</td>
<td>Leave Without Pay</td>
</tr>
<tr>
<td>STD</td>
<td>Short-Term Disability</td>
</tr>
</tbody>
</table>
**Associate Physicians (Except Special Category)**

Your Sick Leave and Disability programs are integrated to keep you on active status for as long as possible. Employment status may be active even if you are on a leave that is not paid. The timeline below depicts the range of time that these benefits continue from the first day of disability to the employment end date. The time available depends on your Acute Sick Leave balance at the time you become disabled. This timeline assumes the Associate Physician has a full bank of Acute Sick Leave.

<table>
<thead>
<tr>
<th>Month: 0</th>
<th>1</th>
<th>4</th>
<th>Termination</th>
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<tr>
<td>SCPMG Pay</td>
<td>ASL 100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment Continues</td>
<td>ASL 100%</td>
<td>LWOP</td>
<td>Maximum 4 months</td>
</tr>
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<td>CIGNA Benefit</td>
<td>30-Day Waiting Period</td>
<td>STD 50%,*</td>
<td>LTD 50%,** (if purchased)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 months</td>
<td>To Age 65 (or ADEA Schedule)</td>
</tr>
</tbody>
</table>

* Weekly benefit limited to $3,462/week.
** Monthly benefit limited to $15,000/month.

**Special Category Physicians**

Your Sick Leave and Disability programs are integrated to keep you on active status for as long as possible. Employment status may be active even if you are on a leave that is not paid. The timeline below depicts the range of time that these benefits continue from the first day of disability to the employment end date. This timeline assumes a special category physician has a full bank of Sick Leave benefits.

<table>
<thead>
<tr>
<th>Month: 0</th>
<th>1</th>
<th>4</th>
<th>7</th>
<th>Termination</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCPMG Pay</td>
<td>ASL 100%</td>
<td>ACSL 50%</td>
<td>Maximum 3 months</td>
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<tr>
<td>Employment Continues</td>
<td>ASL 100%</td>
<td>ACSL</td>
<td>LWOP</td>
<td>Maximum 7 months</td>
</tr>
<tr>
<td></td>
<td>3 months</td>
<td>3 months</td>
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<td></td>
</tr>
<tr>
<td>CIGNA Benefit</td>
<td>30-Day Waiting Period</td>
<td>STD 50%,* 5 months</td>
<td>LTD 50%,** (if purchased) To Age 65 (or ADEA Schedule)</td>
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<tr>
<td>---------------</td>
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<td>-----------------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
* Weekly benefit limited to $3,462/week.
** Monthly benefit limited to $15,000/month.
SECTION: III

LIFE AND ACCIDENT INSURANCE BENEFITS
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*Effective March 1, 2014*
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Effective March 1, 2014
LIFE AND ACCIDENT INSURANCE BENEFITS

SCPMG’s life and accident insurance programs provide financial protection for you and your beneficiaries in the event of your death or accidental loss of limb. The life and accident insurance program available to active physicians is made up of the following benefits:

- Permanente Provided Life Insurance, available to all physicians except Per Diem,
- Optional Life Insurance, available to all physicians except Per Diem,
- Disabled Physicians Life Insurance, available to all physicians, except Per Diems enrolled in Permanente Provided and/or Optional Life Insurance who are totally disabled and receiving benefits under SCPMG’s Long-Term Disability Insurance coverage,
- Spouse/Domestic Partner Life Insurance available to the spouses/domestic partners of all physicians, except Per Diem, and
- Business Travel Accident Insurance, available to all physicians including Per Diem.

There are several terms used to describe your group life insurance program at SCPMG, such as:

- Actively At Work,
- Credited Service,
- Qualifying Service, and
- Base Annual Compensation*.

* For Life Insurance purposes only is defined as base compensation and excludes bonuses, awards and overtime. For a more precise definition, please refer to the CIGNA Life Insurance certificate.

You’ll find these terms and others described in the Glossary.

Additional life insurance benefits that may be available to you after your service with SCPMG ends are briefly described in the Leaving SCPMG section of this and in greater detail in the Retiree Benefits Handbook.

Combined Coverage Limitations

There are limitations on the total amount of insurance you can have from the combined SCPMG life insurance plans (not including Business Travel Accident Insurance and the Accidental Death and Dismemberment portion of Optional Life Insurance).

- The combined total of the Permanente Provided and Optional Life Insurance cannot exceed 600% of Base Annual Compensation, with a combined dollar maximum of $2,000,000.
- The Permanente Provided Life Insurance coverage for physicians age 65 or older will continue at the normal multiple Base Annual Compensation.
(100%, 200% or 300% based on physician service) until the Partner terminates from the Partnership or the Associate terminates employment with SCMPG.

- The Optional Life Insurance coverage for physicians age 65 or older will continue at the normal multiple of Base Annual Compensation (100%, 200%, 300%, 400%, or 500%) until the Partner terminates from the Partnership, or the Associate terminates employment with SCPMG.

Whenever your total amount of insurance exceeds the dollar limit, the Optional Life Insurance amount will be reduced to keep your coverage within these maximums. Over time, as your Permanente Provided coverage increases, your Optional Life coverage may decrease. Consequently, any amount you pay in premiums may be reduced.

PERMANENTE PROVIDED LIFE INSURANCE

The insurer is Life Insurance Company of North America, a CIGNA company. An overview of the Permanente Provided Life Insurance coverage is described below. See the group insurance certificate for this coverage for more details. You may obtain a copy of this certificate by contacting PHR Shared Services at 1-877-608-0044.

Eligibility

All active physicians except Per Diem are eligible for this insurance.

Enrollment

No enrollment is necessary. We will notify you when you become eligible that your coverage is about to begin. The insurance is automatically effective, unless you decline it in writing or you are not actively at work on the effective date. If you decline and subsequently wish to participate, you will have to provide proof of insurability.

Effective Date

This insurance becomes effective once you meet the years of service criteria as outlined below provided you are actively at work.

Coverage Amount

The coverage amount provided depends on your years of service as shown on the schedule below, your Base Annual Compensation, and your work schedule. For example, if you have eight years of credited service and Base Annual Compensation of $180,000, you will have $360,000 of this insurance. However, if you work a reduced schedule, the coverage is reduced. For example, an 8/10 schedule physician would have a coverage
amount of $288,000 ($360,000 x .8).

<table>
<thead>
<tr>
<th>Years of Service</th>
<th>% of Base Annual Compensation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 3 years of qualifying service</td>
<td>0%</td>
</tr>
<tr>
<td>3 years of qualifying service but less than 5 years of credited service</td>
<td>100%</td>
</tr>
<tr>
<td>5 years but less than 15 years of credited service</td>
<td>200%</td>
</tr>
<tr>
<td>15 or more years of credited service</td>
<td>300%</td>
</tr>
</tbody>
</table>

Your Permanente Provided Life Insurance — combined with any other SCPMG life insurance coverage you may elect (excluding Business Travel Accident Insurance and the Accidental Death and Dismemberment portion of Optional Life Insurance) — cannot exceed a maximum of $2,000,000.

There are no additional benefits paid under this policy for accidental death or injury, although a terminal illness benefit may be available to you if you are terminally ill. See the Important Information About Your Life Insurance Coverage section for more details.

**Exception to Work Schedule Proration**

If you are working a reduced schedule due to partial disability, or you are age 55 or older and you work a reduced schedule, you may pay the premium for the additional coverage required to maintain your level of coverage in effect prior to the reduction in your work schedule. Contact PHR Shared Services at 1-877-608-0044 for more information.

**Naming a Beneficiary**

You may name anyone you wish as beneficiary and may change your beneficiary at any time without the consent of the beneficiary provided you have not irrevocably assigned your ownership interest. (See the Important Information About Your Life Insurance Coverage section for more details.)

Your designation must be in writing. Once a change of beneficiary form is received by PHR Shared Services, it is effective the date you signed the form.

Since California is a community property state, you should be aware that any beneficiary designation that does not comply with community property statutes may be challenged. If you name someone other than your spouse as primary beneficiary (including a trust), it is recommended that your spouse consent in writing to this designation. Otherwise, the proceeds may not be distributed as you intend.

If no beneficiary is named or surviving upon your death, the insurance will be paid to the first beneficiary listed below who is living at the time of your
death: 1) your spouse, 2) your children, in equal shares, 3) your parents, in equal shares 4) your siblings, in equal shares, or 5) the executor or administrator of your estate as determined by the insurance company in accordance with state law.

Please contact your local Permanente Human Resources Department for a beneficiary designation form or you can download a form from the SCPMG Physician Portal at http://scpmgphysician.kp.org.

When Coverage Ends
See Important Information About Your Life Insurance Coverage at the end of this section.

Cost
SCPMG pays the full cost of Permanente Provided Life Insurance.
If you are a Partner, the premiums paid on your behalf are considered Imputed Income and appear as taxable income on your annual SCPMG Statement of Partner Earnings.
If you are an Associate Physician, the premiums for the portion of all life insurance benefits in excess of $50,000 are subject to Imputed Income. Premiums attributable to that portion of the insurance will appear as taxable income on your Form W-2 and you will see this amount monthly on your paycheck stub.

OPTIONAL LIFE INSURANCE
The insurer is Life Insurance Company of North America, a CIGNA company. An overview of the Optional Life Insurance coverage is described below. See the group insurance certificate for this coverage for more details. You may obtain a copy of this certificate by contacting PHR Shared Services at 1-877-608-0044.

Eligibility
All active physicians except Per Diem are eligible for this insurance.

Enrollment
Optional Life Insurance is offered during the 60-day period following either your date of hire or your election to Partnership. If the insurance is elected during either of these 60-day periods, coverage up to a maximum of 600% of your Base Annual Compensation can be issued upon application. (Your Local and Regional Permanente Human Resources Office has the necessary forms.) Any amount over 600% of your Base Annual Compensation or $2,000,000 (whichever is less) is subject to evidence of insurability satisfactory to the
insurance company. Your insurance coverage will not become initially effective before the date you are actively at work.

Optional Life Insurance requested at any time other than the two 60-day eligibility periods is subject to evidence of insurability with no guaranteed minimum coverage.

**Effective Date**

The guaranteed portion (up to 600% of your Base Annual Compensation) of this insurance is effective on the date you sign the enrollment form and authorize payroll deduction during one of the 60-day eligibility periods, provided you are actively at work. If you are not actively at work, your coverage will become effective on the first day you return to active service with SCPMG. Any amount in excess of 600% or applications outside the 60-day eligibility period are generally subject to evidence of insurability and become effective on the date approved in writing by the insurance company. However, you may increase your optional life insurance coverage amount by one benefit level up to the Guaranteed Issue Amount, without satisfying an insurability requirement. See the *Important Information About Your Life Insurance Coverage* section for more details.

**Benefit Amount**

You may elect to purchase a benefit of 100%, 200%, 300%, 400%, 500%, or 600% of your Base Annual Compensation, prorated to your work schedule; however, there are limitations on the total amount of insurance you can have from the combined SCPMG life insurance plans. See *Combined Coverage Limitations* at the beginning of this section for details. A terminal illness benefit may be available to you if you are terminally ill. See the group insurance certificate or contact PHR Shared Services at 1-877-608-0044 for more information.

**Exception to Work Schedule Proration**

If you are working a reduced schedule due to partial disability, or you are age 55 or older and you work a reduced schedule, you may pay the premium for the additional coverage required to maintain your level of coverage in effect prior to the reduction in your work schedule. Contact PHR Shared Services at 1-877-608-0044 for more information.

**Death Due to Any Cause — Suicide Limitation**

This benefit will be paid to your beneficiary upon your death due to any cause; however, payment will not be made for death due to suicide during the first two years of coverage. This limitation also applies to any additional or increases in benefits.

Effective March 1, 2014
Naming a Beneficiary

You may name anyone you wish as your beneficiary and change your beneficiary at any time without the consent of the beneficiary, provided you have not irrevocably assigned your ownership interest. (See the Important Information About Your Life Insurance Coverage section for more details.) Your designation must be in writing. Once a change of beneficiary form is received by PHR Shared Services, it becomes effective the date you signed the form.

Since California is a community property state, you should be aware that any beneficiary designation that does not comply with community property statutes may be challenged. If you name someone other than your spouse as primary beneficiary (including a trust), it is recommended that your spouse consent in writing to the designation. Otherwise, the proceeds may not be distributed as you intend.

If no beneficiary is named or surviving upon your death, the insurance will be paid to the first beneficiary listed below who is living at the time of your death: 1) your spouse, 2) your children, in equal shares, 3) your parents, in equal shares, 4) your siblings, in equal shares, or 5) the executor or administrator of your estate as determined by the insurance company in accordance with state law.

Please contact your local Permanente Human Resources Department for a beneficiary designation form, or you can download a form from the SCPMG Physician Portal at http://scpmgphysician.kp.org.

Coverage After Age 65

If you continue to work (except Per Diem) after the month you reach age 65, you may choose to do one of the following:

- You may continue to purchase Optional Life Insurance. If you do not request to discontinue it in writing, the premiums will automatically continue to be deducted from your paychecks, or
- If you have met the eligibility requirements for Tapered Life Insurance, you may request a transfer to the Tapered Life Insurance program for which you are eligible. See the Leaving SCPMG section for more detailed information.

When Coverage Ends

See Important Information About Your Life Insurance Coverage at the end of this section.

Accidental Death and Dismemberment

If death or dismemberment is due to, and occurs within 365 days of, an accident, the following benefit will be paid in addition to any Optional
Life Insurance that is payable:

- 100% of insurance amount, up to a maximum of $200,000, for loss of:
  - life
  - two or more losses (hand, foot, or entire sight of one eye as defined below)
- 50% of insurance amount, up to a maximum of $100,000, for loss of:
  - hand at or above the wrist
  - foot at or above the ankle
  - entire sight of one eye
- 25% of insurance amount, up to a maximum of $50,000, for loss of thumb and index finger of the same hand.

Under this coverage, the loss of a hand or foot means the complete severance through or above the wrist or ankle joint. Loss of sight means the total, permanent and irrecoverable loss of sight of the eye. Loss of a thumb and index finger means the complete severance through or above the metacarpophalangeal joints.

Provided you have not irrevocably assigned your ownership interest, accidental death benefits will be paid to the beneficiary designated on your Optional Life Insurance. Payment for accidental dismemberment losses will be made to you. If you have irrevocably assigned your ownership interest, payment will be made to the owner of your insurance benefit. Accidental Death and Dismemberment benefits are in addition to the $2,000,000 aggregate limit on life insurance from SCPMG.

Accidental Death and Dismemberment benefits are not payable for losses resulting from:

- suicide, attempted suicide or intentionally self-inflicted injury.
- sickness, disease or bodily infirmity; medical or surgical treatment; or bacterial or viral infection no matter how contracted. This does not include bacterial infection that is the result of an accidental bodily injury or food poisoning.
- full-time active duty in any armed forces for more than 30 days. Reserve or National Guard active duty or training are not excluded unless it extends beyond 31 days.
- commission of a felony.
- voluntary self-administration of any drug or chemical substance not prescribed by and taken according to a doctor’s direction. Accidental ingestion of a poisonous substance is not excluded.
- war or any act of war, whether or not declared, or
- travel or flight in or getting in or out of:
  - an aircraft being used for a test or experiment,
  - a military aircraft, unless it is operated by the U.S. Military Airlift
Command (MAC) or its foreign equivalent,
- an aircraft the physician is flying or learning to fly,
- a pilot or crew member in any aircraft,
- an aircraft owned or leased by or for SCPMG, the physician or the physician’s family,
- an aircraft that is not flown by a pilot with a valid license, or
- an aircraft that does not have a valid FAA normal or transport type certificate of airworthiness.

**Cost**

Optional Life Insurance premiums are based on your age. Ages are grouped as follows:

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Premium Range</th>
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<tbody>
<tr>
<td>Under age 20</td>
<td>50 – 54</td>
</tr>
<tr>
<td>20 – 24</td>
<td>55 – 59</td>
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<tr>
<td>25 – 29</td>
<td>60 – 64</td>
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<tr>
<td>30 – 34</td>
<td>65 – 69</td>
</tr>
<tr>
<td>35 – 39</td>
<td>70 – 74</td>
</tr>
<tr>
<td>40 – 44</td>
<td>75 – 79</td>
</tr>
<tr>
<td>45 – 49</td>
<td>80 and over</td>
</tr>
</tbody>
</table>

When you reach a new age group, or your compensation increases, your monthly premiums are automatically increased. Premium rates are subject to change after the guarantee period. You may obtain the current rates from your local Permanente Human Resources Department or from PHR Shared Services at 1-877-608-0044.

Physicians who were enrolled in the Group Rated Optional Life Insurance program prior to January 1, 1996, and did not elect the age-rated life plan, have their premiums based on a composite (group) rate, as opposed to rates based on age. Contact PHR Shared Services at 1-877-608-0044 if you have any questions.

**Imputed Income**

Although Associate Physicians pay the premium for this insurance, you may still be required to pay Imputed Income on a portion of the total premium amount. If the total of premiums paid for all SCPMG life insurance is lower than the IRS tables require, the difference results in Imputed Income on the Associate Physician’s Form W-2. You will see this amount reported on your paycheck.

*Effective March 1, 2014*
DISABLED PHYSICIANS LIFE INSURANCE

The insurer is Life Insurance Company of North America, a CIGNA company. An overview of the Permanente Disabled Physicians Life Insurance coverage is described below. See the group insurance certificate for this coverage for more details. You may obtain a copy of this certificate by contacting PHR Shared Services at 1-877-608-0044.

Eligibility

Disabled Physicians Life Insurance is available to all physicians, except Per Diem, with Permanente Provided and/or Optional Life Insurance, who are totally disabled for six months or longer and are receiving benefits under SCPMG’s Long-Term Disability Insurance coverage. See the group insurance certificate or contact PHR Shared Services at 1-877-608-0044 for more information about what it means to be “disabled” for the purposes of this coverage.

Enrollment

There is no enrollment for this coverage. Your Permanente Provided and/or Optional Life Insurance will become Disabled Physicians Life Insurance once you meet the eligibility criteria described above.

Effective Date

Your Disabled Physicians Life Insurance will be effective on the date you meet the eligibility criteria described above.

Benefit Amount

Your benefit amount will be equal to the amount of Permanente Provided and/or Optional Life Insurance coverage you had on the date you meet the eligibility criteria described above; however, there are limitations on the total amount of insurance you can have from the combined SCPMG life insurance plans. See Combined Coverage Limitations at the beginning of this section for details. If you change physician benefit classes while insured under Disabled Physicians Life Insurance, your coverage will be adjusted and effective as of the date of your physician benefit class change (except your coverage will end if you change to Per Diem). See Important Information About Your Life Insurance Coverage at the end of this section. A terminal illness benefit may be available to you if you are terminally ill. See the Important Information About Your Life Insurance Coverage section for more details.

Naming a Beneficiary

The beneficiary or beneficiaries you selected for your Permanente Provided Life and/or Optional Life Insurance coverage will remain your beneficiary or...
beneficiaries for your Disabled Physicians Life Insurance coverage.

You may name anyone you wish as your beneficiary and change your beneficiary at any time without the consent of the beneficiary, provided you have not irrevocably assigned your ownership interest. (See the Important Information About Your Life Insurance Coverage section for more details.) Your designation must be in writing. Once a change of beneficiary form is received by PHR Shared Services, it becomes effective the date you signed the form.

Since California is a community property state, you should be aware that any beneficiary designation that does not comply with community property statutes may be challenged. If you name someone other than your spouse as primary beneficiary (including a trust), it is recommended that your spouse consent in writing to the designation. Otherwise, the proceeds may not be distributed as you intend.

If no beneficiary is named or surviving upon your death, the insurance will be paid to the first beneficiary listed below who is living at the time of your death: 1) your spouse 2) your children, in equal shares 3) your parents, in equal shares 4) your siblings, in equal shares or 5) the executor or administrator of your estate as determined by the insurance company in accordance with state law.

Please contact your local Permanente Human Resources Department for a beneficiary designation form, or you can download a form from the SCPMG Physician Portal at http://scpmgphysician.kp.org.

**Premiums While Disabled**

You will pay no premiums for your Disabled Physicians Life Insurance coverage. If you return to active service with SCPMG, your Disabled Physicians Life Insurance coverage will revert to Permanente Provided and/or Optional Life Insurance coverage, and you will again pay premiums for any Optional Life Insurance coverage you maintain. You will be subject to Imputed Income.

**When Coverage Ends**

Your coverage under Disabled Physicians Life Insurance ends when you are no longer Totally Disabled or on the date you reach age 65. See Important Information About Your Life Insurance Coverage for additional information at the end of this section.

**Imputed Income**

If you are a Partner, the premiums paid on your behalf are considered Imputed Income and appear as taxable income on your annual SCPMG Statement of Partner Earnings.

If you are an Associate Physician, the premiums for the portion of all life
insurance benefits in excess of $50,000 are subject to Imputed Income. Premiums attributable to that portion of the insurance will appear as taxable income on your Form W-2 and you will see this amount monthly on your paycheck stub.

**SPOUSE/DOMESTIC PARTNER LIFE INSURANCE**

The insurer is Life Insurance Company of North America, a CIGNA company. An overview of the Permanente Spouse/Domestic Partner Life Insurance coverage is described below. See the group insurance certificate for this coverage for more details. You may obtain a copy of this certificate by contacting PHR Shared Services at 1-877-608-0044.

**Eligibility**

Spouses or domestic Partners under age 70 of all physicians except Per Diem are eligible for this insurance. Your spouse must be your lawful spouse and not legally separated, divorced, or widowed from you. A “domestic partner” for the purposes of this insurance coverage means a person who has a current Domestic Partner Affidavit on file with SPCM G.

**Enrollment**

You must elect coverage for your spouse or domestic partner within 60 days after you become a member of an eligible physician class, within 60 days of a life status change, or within 60 days of your election to Partner status. Elections for coverage more than 60 days after one of these events will be subject to evidence of insurability.

**Effective Date**

Spouse/domestic partner Life Insurance coverage is effective on the latest to occur of:

- The date SPCM G receives your completed enrollment request,
- The date you authorize payroll deduction for this coverage,
- The date you are actively at work, or
- The date SPCM G and CIGNA agree in writing to provide this coverage.

**Benefit Amount**

You may elect to purchase a benefit in $50,000 increments from $50,000 up to a maximum of $500,000. A benefit amount in excess of $100,000 will be subject to evidence of insurability. If you elect coverage for your spouse or domestic partner more than 60 days after one of the events described above under the *Enrollment* heading, your spouse or domestic partner will be subject to evidence of insurability. Spouse/domestic partner Life Insurance coverage is not subject to SPCM G combined coverage.
limitations. A terminal illness benefit may be available to if your spouse/domestic partner is terminally ill. See the Important Information About Your Life Insurance Coverage section for more details.

**Death Due to Any Cause — Suicide Limitation**

This benefit will be paid to your spouse/domestic partner’s beneficiary upon their death due to any cause; however, payment will not be made for death due to suicide during the first two years of coverage. This limitation also applies to any additional or increases in benefits.

**Naming a Beneficiary**

Your spouse/domestic partner may name anyone as the beneficiary and change their beneficiary at any time without the consent of the beneficiary, provided they have not irrevocably assigned their ownership interest. (See the Important Information About Your Life Insurance Coverage section for more details.) The designation must be in writing. Once a change of beneficiary form is received by PHR Shared Services, it becomes effective the date your spouse/domestic partner signed the form.

Since California is a community property state, your spouse/domestic partner should be aware that any beneficiary designation that does not comply with community property statutes may be challenged. If they name someone other than their spouse/domestic partner as primary beneficiary (including a trust), it is recommended that their spouse/domestic partner consent in writing to the designation. Otherwise, the proceeds may not be distributed as they intend.

If no beneficiary is named or surviving upon your spouse/domestic partner’s death, the insurance will be paid to the first beneficiary listed below who is living at the time of their death: 1) spouse/domestic partner, 2) spouse/domestic partner’s children, 3) spouse/domestic partner’s parents, 4) spouse/domestic partner’s siblings, or 5) spouse/domestic partner’s estate as determined by the insurance company in accordance with state law.

Please contact your local Permanente Human Resources Department for a beneficiary designation form, or you can download a form from the SCPMG Physician Portal at [http://scpmgphysician.kp.org](http://scpmgphysician.kp.org).

**When Coverage Ends**

See Important Information About Your Life Insurance Coverage at the end of this section.

**Cost**

Spouse/domestic partner life insurance premiums are based on your spouse/domestic partner’s age. Ages are grouped as follows:
When your spouse/domestic partner reaches a new age group, the monthly premiums are automatically increased. Premium rates are subject to change after the guaranteed period. You may obtain the current rates from your local Permanente Human Resources Department or from PHR Shared Services at 1-877-608-0044.

**Imputed Income**

Although Associate Physicians pay the premium for this insurance, you may still be required to pay Imputed Income on a portion of the total premium amount. If the total of premiums paid for all SCPMG life insurance is lower than the IRS tables require, the difference results in Imputed Income on the Associate Physician’s Form W-2. You will see this amount reported on your paycheck.

**IMPORTANT INFORMATION ABOUT YOUR LIFE INSURANCE COVERAGE**

**Terminal Illness Benefit Option**

The SCPMG life insurance plans include a terminal illness benefit option that allows a portion of your insurance benefit to be paid to you (provided you have not irrevocably assigned your ownership interest — see below for more details on assignment of life insurance benefits) while you are still living rather than to your beneficiary after your death. With the exception of Business Travel Accident Insurance, this special option is available in all of the following group life insurance plans you have through SCPMG:

- Permanente Provided Life Insurance
- Optional Life Insurance
- Disabled Physicians Life Insurance
- Spouse/Domestic Partner Life Insurance.

The benefit is equal to 50% of the insurance amount in effect (combined total of all of the group life insurance you have through SCPMG) at the time the insurance company determines that you qualify for this option.
The maximum terminal illness benefit payable is $250,000 and is payable only once in your lifetime. The remaining benefit will be paid to your beneficiary/certificate owner upon your death.

If you elect to use this option, you must provide satisfactory evidence that your life expectancy is 12 months or less. This evidence includes a written diagnosis and prognosis including supportive evidence satisfactory to CIGNA, including but not limited to radiological, histological, or laboratory reports by two doctors licensed to practice in the U.S. The insurance company may investigate further to verify your eligibility. In addition, any automatic increase in life insurance benefits will end when benefits are payable under this provision.

Assignment of Life Insurance Benefits

Assignment is the transfer of all incidents of ownership to another person or, in some instances, to a trust. This includes your right to name or change beneficiaries. Assignment is irrevocable except with the written agreement of the assigned owner, and the tax consequences vary for each individual based on his or her circumstances. The benefits of assignment of life insurance for your particular situation should be discussed with an advisor who specializes in estate planning.

An assignment will apply to the following group life insurance plans you have through SCPMG:

- Permanente Provided Life Insurance
- Optional Life Insurance
- Disabled Physicians Life Insurance
- Spouse/Domestic Partner Life Insurance.

Your ability to make an assignment may be affected if you have a spouse. Contact CIGNA for details. Contact information for CIGNA may be found in the Administration section.

Payment of Benefits

Under the Permanente Provided and Optional Life Insurance plans, insurance proceeds are placed in an interest-bearing checking account in the name of the beneficiary. If there is more than one beneficiary, each one will receive a separate account. With this account, the beneficiary has immediate access to the insurance proceeds. The account earns interest from the day it is opened to the day of withdrawal, at money market rates.

There are no monthly service charges, no per-check charge, and no monthly maintenance charges associated with this account. Monthly statements are provided reporting all account activities. The account holder may name a beneficiary.
Termination

Provided you do not decline coverage, your Permanente Provided, Optional Life, Disabled Physicians Life, and Spouse/Domestic Partner Life Insurance remain in effect until the earliest of the following occurs:

- the end of the month for which premiums are paid,
- you or your spouse/domestic partner are no longer eligible for coverage,
- the insurance policy terminates,
- you retire,
- you terminate your service, or
- the date you or your spouse/domestic partner are eligible for coverage under a plan intended to replace this coverage.

SCPMG intends to maintain the life insurance benefits described in this handbook indefinitely, but reserves the right to change, amend, or terminate benefits for physicians at any time without liability.

Conversion of Life Insurance

If your Permanente Provided Life, Optional Life, Disabled Physicians Life, or Spouse/Domestic Partner Life Insurance terminates for any reason except non-payment of premiums, you may convert part or all of it to an individual policy at your own expense.

If insurance ends due to termination of the policy or it is no longer offered for your class of covered individuals, you must have been insured under the plan for at least three years in order to convert to an individual policy. In this case, the amount of conversion insurance will be the benefit in force under the policy prior to termination or $10,000, whichever is less.

You must apply for and pay the premium for your age and class of risk within 90 days after your termination date from SCPMG. Evidence of insurability will not be required.

If you die during the 90-day conversion period, your beneficiary will receive the insurance amount, whether or not you applied for conversion coverage.

Your spouse/domestic partner may also convert their Spouse/Domestic Partner Life Insurance coverage in the event of your termination or your divorce or legal separation. See the group insurance certificate or contact PHR Shared Services at 1-877-608-0044 for more information about conversion options for Spouse/Domestic Partner Life Insurance coverage.

The conversion insurance may be a type of life insurance currently being offered for conversion by the insurance company at your age and in the amount requested. It may not be term insurance, and it may not be for an amount greater than the life insurance benefits in force under the policy. The conversion policy will not provide accident, disability, or other benefits.
Portability of Life Insurance
Life Insurance Company of North America, a CIGNA company, will allow you to port some or all of your Permanente Provided Life, Optional Life, Disabled Physicians Life, or Spouse/Domestic Partner Life Insurance. You may either convert your insurance to a whole life policy (as mentioned above) or port it into a term life policy. The portability policy will be issued without proof of medical insurability. This may be advantageous if you have a health condition that could make it difficult to obtain individual coverage elsewhere, although the cost may be higher than a private policy obtained on your own. The option to port all or a part of your life insurance extends to age 80 with a $500,000 insurance maximum above age 70.

A spouse/domestic partner will also have the opportunity to port some or all of Spouse/Domestic Partner Life Insurance in the event eligibility is lost because the insured physician’s employment terminates or in the event the spouse/domestic partner no longer qualifies as your spouse/domestic partner due to legal separation, divorce, or the physician’s death. A spouse/domestic partner who continues coverage through portability will be issued a separate certificate of insurance by CIGNA.

Portability to Term Life Option
Contact PHR Shared Services at 1-877-608-0044 to request an Application for Continuation of Term Life Insurance (Portability) and premium rate sheet. Application must be made within 90 days from the date you lose coverage. If you wish to exercise your portability option, request, complete, and forward the application to: NEBCO, P.O. Box 152501, Irving, TX 75015. If you have any questions, you may contact NEBCO at 1-800-423-1282.

BUSINESS TRAVEL ACCIDENT INSURANCE
Business Travel Accident Insurance provides benefits if you die or are injured in an accident while traveling on official business for SCPMG. Your normal commuting to and from work is not included. The insurer is MetLife Life Insurance Company.

Eligibility
This insurance is provided for all physicians, including Per Diem.

Enrollment
No enrollment is necessary.

Effective Date
This insurance is effective on your date of hire.
**Benefit Amount**

Your Business Travel Accident Insurance amount is equal to four times your Base Annual Compensation, up to a maximum insurance amount of $250,000. The minimum you are insured for is $100,000.

If a covered accident results in your death or serious accidental injury, you or your beneficiary(ies) will receive all or part of the plan’s benefit, depending on the extent of your injuries. The loss must be directly related to the accidental injury and must occur within 365 days after the accident.

The following chart shows the percentage of your insurance amount that may be payable.

<table>
<thead>
<tr>
<th>Type of Loss</th>
<th>Benefit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental death</td>
<td>100% of insurance amount</td>
</tr>
<tr>
<td>Both hands or both feet</td>
<td>100% of insurance amount</td>
</tr>
<tr>
<td>Sight of both eyes</td>
<td>100% of insurance amount</td>
</tr>
<tr>
<td>Speech and hearing in both ears</td>
<td>100% of insurance amount</td>
</tr>
<tr>
<td>One hand and one foot</td>
<td>100% of insurance amount</td>
</tr>
<tr>
<td>Either hand or foot and sight of one eye</td>
<td>100% of insurance amount</td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>100% of insurance amount</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>75% of insurance amount</td>
</tr>
<tr>
<td>Either hand or foot</td>
<td>50% of insurance amount</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>50% of insurance amount</td>
</tr>
<tr>
<td>Speech or hearing in both ears</td>
<td>50% of insurance amount</td>
</tr>
<tr>
<td>Sight of one eye</td>
<td>50% of insurance amount</td>
</tr>
<tr>
<td>Thumb and index finger of the same hand</td>
<td>25% of insurance amount</td>
</tr>
</tbody>
</table>

If more than one loss arises from the same accident, only the one largest benefit will be payable. Under Business Travel Accident Insurance, the term “loss” has the following meanings:

- hand or foot — complete severance through or above the wrist or ankle joint
- thumb and index finger — actual severance through or above metacarpophalangeal joints
• sight — entire and irrecoverable loss of sight of the eye
• speech — entire and irrecoverable loss of the ability to speak
• hearing — entire and irrecoverable loss of hearing in both ears
• quadriplegia — complete and irreversible paralysis of both upper and lower limbs
• paraplegia — complete and irreversible paralysis of both lower limbs
• hemiplegia — complete and irreversible paralysis of upper and lower limbs on one side of the body.

Scope of Coverage
Business Travel Accident Insurance provides accident coverage:
• 24 hours a day,
• anywhere in the world, and
• when traveling on SCPMG business by:
  – automobile,
  – bus,
  – train,
  – airplane,*
  – motorcycle, or
  – ship.

* Only civil aircraft with a current and valid airworthiness certificate and operated by a certified pilot (excluding a plane owned or operated by you or SCPMG).

Coverage begins when you leave your house or your place of employment and is continuous until you return, provided you are on SCPMG business.

Disappearance
Business Travel Accident Insurance will pay death benefits in the event that your body is not found within one year of your disappearance, forced landing, stranding, sinking or wrecking of the vehicle in which you were traveling.

Seat Belt Benefit
Your beneficiary could receive an additional benefit from the Business Travel Accident Insurance plan if you lose your life due to an accident while you are driving or riding as a passenger in any private passenger automobile. At the time of the accident, you must have been wearing a properly fastened, factory-installed seat belt.

The additional seat belt benefit is 10% of your full insurance amount or $25,000, whichever is less.

Effective March 1, 2014
**Limit on Benefits**

The maximum Business Travel Accident Insurance benefit for all losses resulting from a single accident is $5 million. The benefit amount payable would be prorated among the beneficiaries, up to a total of $5 million.

**Age-Related Insurance Amount**

The Business Travel Accident Insurance amount reduces at certain ages, according to the following schedule:

<table>
<thead>
<tr>
<th>Age at Date of Loss</th>
<th>% of Insurance Amount In Force</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 74 or younger</td>
<td>100%</td>
</tr>
<tr>
<td>75 – 79</td>
<td>45%</td>
</tr>
<tr>
<td>80 – 84</td>
<td>30%</td>
</tr>
<tr>
<td>85 or older</td>
<td>15%</td>
</tr>
</tbody>
</table>

**Beneficiary**

Death benefits will be paid to the beneficiary(ies) named in your:

- Optional Life Insurance, and/or
- Permanente Provided Life Insurance.

If the beneficiaries on the Optional and Permanente Provided Life Insurance are different, the proceeds from the Business Travel Accident policy will be divided equally among all beneficiaries named (regardless of the allocation of proceeds under those policies).

If no beneficiary is named, payment will be made to your survivor(s) in the following order:

- spouse,
- children, in equal shares,
- parents, in equal shares,
- brothers and sisters, in equal shares, then
- executor or administrator of your estate.

Dismemberment benefits will be paid to you.

**Exclusions and Limitations**

This insurance does not cover loss resulting from:

- commuting to, from, or among your place(s) of employment,
- suicide or attempted suicide while sane,
• self-destruction or attempted self-destruction while insane,
• disease of any kind,
• bacterial infections, except pyogenic infection that occurs through an accidental cut or wound,
• hernia of any kind,
• riding in any vehicle or device for aerial navigation,
• declared or undeclared war or any act of war,
• service in the military, naval, or air service of any country,
• flying in an aircraft owned by you or SCPMG, or
• flying in any aircraft being used for crop dusting, seeding or spraying, fire fighting, exploration, pipe or power line inspection, any form of hunting, bird or fowl herding, aerial photography, banner towing, testing, or experimental purposes.

When Coverage Ends
This insurance ends on your termination date from SCPMG.

No Conversion or Portability Benefit
Conversion or portability to an individual policy is not available under this coverage.

Cost
SCPMG pays the full cost of this benefit.
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TIME-OFF BENEFITS

This section represents only a summary of the time-off benefits available and may not include all applicable details. The Partnership Agreement/Rules and Regulations is the governing document and will always be used to determine benefits. The current Partnership Agreement/Rules and Regulations is available for viewing or download from the SCPMG Physician Portal at http://scpmgphysician.kp.org, or you may contact PHR Shared Services for an up-to-date copy.

VACATION LEAVE

Vacation Leave is accrued in hours on a bi-weekly basis according to the schedules for Vacation Leave accrual provided below. Per Diem physicians are not eligible for Vacation Leave.

Vacation Leave Accrual

The accruals listed below are based on a 10/10 work week — all of the Vacation Leave hours are pro-rated according to your work schedule.

Partner and Special Category Physicians

<table>
<thead>
<tr>
<th>* Benefits Anniversary Year</th>
<th>Vacation Leave Days</th>
<th>Bi-Weekly Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 4</td>
<td>23</td>
<td>7.08</td>
</tr>
<tr>
<td>5 – 9</td>
<td>28</td>
<td>8.61</td>
</tr>
<tr>
<td>10 or more</td>
<td>33</td>
<td>10.15</td>
</tr>
</tbody>
</table>

Associate Physicians

<table>
<thead>
<tr>
<th>* Benefits Anniversary Year</th>
<th>Vacation Leave Days</th>
<th>Bi-Weekly Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 4</td>
<td>18</td>
<td>5.54</td>
</tr>
<tr>
<td>5 – 9</td>
<td>23</td>
<td>7.07</td>
</tr>
<tr>
<td>10 or more</td>
<td>28</td>
<td>8.61</td>
</tr>
</tbody>
</table>

* Combine benefits anniversary years as Associate and Partner Physician.

Vacation Leave accrual will be prorated for physicians working less than a 10/10 work schedule. You will see your Vacation Leave balance reflected on your bi-weekly paycheck stub. Vacation Leave accruals are processed bi-weekly, or 26 times per year.

Effective March 1, 2014
Vacation Leaves should be scheduled in advance and approved by your Chief of Service. Ordinarily, Vacation Leave should be taken in the year following the Anniversary Year in which it is earned; however, you may use accrued Vacation Leave during your current Anniversary Year.

Vacation Leave will not accrue for any physician while on Chronic Sick Leave, Extended Educational Leave, Extended Military Service Leave, Extended Medical Service Leave, Military Leave, or Leave of Absence (longer than 10 days). However, if you are on a Military Leave covered by the Uniformed Services Employment and Reemployment Rights Act (USERRA), your period of leave will be credited toward your years of service for determining Vacation Leave accrual. (See the Military Leave section of this handbook for more details.)

**Borrowing Vacation Leave Time**

You are able to borrow Vacation Leave time or run a negative balance for Parenting Leave or an unforeseeable health emergency of your spouse, domestic partner, child, or parent. Appropriate documentation will be required. You must first receive the approval of your Area Medical Director and the Permanente Human Resources Department. If you have Sick Leave benefits available, you must exhaust available Sick Leave before you may borrow Vacation Leave time.

If you have a negative Vacation Leave balance you will begin to “pay down” your negative balance at a rate of 100% of your bi-weekly accrual. If you have borrowed Vacation Leave and subsequently leave SCPMG, any used but unearned Vacation Leave must be repaid.

**Physicians will receive compensation in lieu of Vacation Leave in the following circumstances:**

- **Excess Vacation Leave Cash Out**
  
  Your Vacation Leave balance may accumulate to a maximum of 90 working days as of your Anniversary Date. At the conclusion of each Anniversary Year, the value of any Vacation Leave days over 90 will be paid in your paycheck following the one in which your Anniversary Date occurs. Your accumulated Vacation Leave balance will be reduced to 90 days.

- **Voluntary Vacation Leave Cash Out**
  
  If you have accumulated 20 or more days of Vacation Leave, you may make an election during the annual Open Enrollment period (November of each calendar year) to cash out your Vacation Leave accruals that you will earn in the next calendar year. Your election for Vacation Leave cash-out, once made, is irrevocable. If you fail to request a cash-out for the following year’s accrued Vacation Leave during the Open Enrollment period, you have waived your ability to cash-out Vacation Leave until the next Open Enrollment period.
• **Financial Hardship Vacation Leave Cash Out**

You may cash out Vacation Leave for a severe financial hardship due to an unforeseeable emergency such as an illness or accident, loss of property due to casualty, or other similar extraordinary circumstance beyond your control.

When applying for a financial hardship Vacation Leave cash-out, you are eligible only for the amount necessary to meet the expenses related to the hardship. Cash-out of Vacation Leave for financial hardship requires the approval of your Area Medical Director, the Executive Medical Director, and the Permanente Human Resources Department.

You must present supporting documentation when requesting a financial hardship Vacation Leave cash-out.

All Vacation Leave cash-outs will be reflected on the paycheck in the pay period following approval of your request.

**Illness While on Vacation Leave**

If you develop a serious illness or are hospitalized while on Vacation Leave, the Area Medical Director may approve the physician’s request to count the time for the illness as Sick Leave, thereby converting a portion of the Vacation Leave to Acute Sick Leave.

**Termination**

If you are a Partner Physician and leave the partnership, or an Associate Physician who terminates employment, all of your accrued but not taken Vacation Leave will be paid out at your Base Compensation rate at time of termination or resignation.

If you are a Partner Physician who retires at the end of the year in which you turn age 65, or who elects Early Separation or Early Retirement, you will have your Vacation Leave accrual paid out at your Base Compensation rate at the time of your retirement. All payments will be included in that year’s Statement of Partner Earnings.

**Former Kaiser Foundation Hospital (KFH) Residents**

Former KFH residents may transfer up to 10 days of Vacation Leave to SCPMG upon hire as a full-time Associate Physician. In order to be eligible for this transfer, you must:

• join SCPMG within 90 days of termination from Kaiser Foundation Hospital, and

• elect to transfer the Vacation Leave prior to terminating from Kaiser Foundation Hospital.

Vacation Leave will be credited to you at your new rate of pay as an SCPMG Associate Physician. You may not take this Vacation Leave under
the SCPMG pay rate until you have completed one month of service with SCPMG.

**ANNUAL EDUCATIONAL LEAVE**

**Eligibility**

The Annual Educational Leave program is available to the following physician categories:

- Active Partners (inactive Partners are ineligible),
- Full-Time Regular,
- Special Category, and
- Full-Time Special (must be approved in advance by Chief of Service and Area Medical Director).

Part-time and Per Diem physicians are not eligible for Educational Leave.

**Purpose of the Program**

Educational Leave is granted for the mutual benefit of the individual physician and SCPMG. It must be used for bona fide programs, such as attending educational meetings, taking courses or participating in university medical teaching, and must be approved in advance by the Chief of Service and the Area Medical Director. Educational Leave may be taken to study for specialty or subspecialty board exams. Time to take the specialty, subspecialty, or recertification board examination plus appropriate time for travel will be considered work time.

**How the Program Works**

Educational Leave is a paid benefit. Eligible physicians earn five days of Educational Leave per Anniversary Year (prorated to your work schedule). Associate Physicians do not earn Educational Leave during their first year of full-time employment with SCPMG.

You do not have to use your Educational Leave in the year it is earned. Your balance will continue to accrue until you reach the maximum of 20 days. At that point, no further days will be earned until your balance is less than 20 days. Upon approval from the Chief of Service, the Area Medical Director and the Executive Area Medical Director, an additional ten days per year are permitted if you forfeit your weekly education half day; however, your maximum balance remains at 20 days.

Upon approval by the Chief of Service and Area Medical Director, up to a maximum of one year’s (five days, prorated to the physician’s work schedule) Educational Leave may be borrowed in advance from your next Anniversary Year. Any days recorded as Educational Leave will be unpaid and recorded as leave without pay if your balance is already -5.00 days. You
can take Educational Leave in half-day increments. Your Educational Leave balance is reflected on your paycheck stub.

Educational Leave may be taken:

- In lieu of regularly scheduled work. Educational Leave is to be scheduled in advance with the approval of the Chief of Service, or
- During non-work hours, i.e., not during regularly scheduled work. Upon approval, you may take up to one day of Educational Leave per calendar year for Continuing Medical Education (CME) activities.

Educational Leave will not accrue if you are on Chronic Sick Leave, Extended Educational Leave, Extended Military Service, Extended Medical Service Leave, Military Leave, or Leave of Absence (longer than 10 days). In addition, Educational Leave cannot follow an overnight duty.

**Termination**

Unused Educational Leave is not compensable. No Educational Leave will be granted during the 90-day period immediately preceding your resignation or termination.

If you retire from SCPMG, you may be granted Educational Leave up to 30 days prior to retirement. If it is taken 30 days prior to retirement, it will be recorded as Vacation Leave or leave without pay.

If you terminate from SCPMG for any reason and subsequently return to SCPMG, you will receive no credit for unused Educational Leave from your prior association with SCPMG.

If you have borrowed Educational Leave and subsequently leave SCPMG, any used but unearned Educational Leave must be repaid.

**HOLIDAYS**

**Eligibility**

All physicians, except Per Diem and inactive Physicians, are eligible for holidays.

**Observed Holidays**

SCPMG observes six holidays each year. The six observed holidays are:

- New Year’s Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day.
How the Program Works
Partner Physicians working less than an 8/10 schedule will be paid for observed holidays on a prorated basis. All Associate Physicians working less than a 10/10 schedule will be paid for observed holidays on a prorated basis. Physicians who work on a holiday will receive additional compensation.

Physicians who have been on disability for more than 30 days will not be paid for observed holidays if the physician is on disability leave at the time of the holiday.

EXTENDED EDUCATIONAL AND EXTENDED MEDICAL SERVICE LEAVES

Eligibility
If you are a Partner Physician, you are eligible to take Extended Educational or Extended Medical Service Leaves. Inactive Partners are ineligible until they return to active status.

How the Program Works
If you are a Partner, for each five years of service with SCPMG you will accumulate three months (66 days) of leave to be used for either an Extended Educational Leave or an Extended Medical Service Leave. Extended Leave is based on full five-year periods. Fractions of five-year periods will not increase the amount of time for which you are eligible, nor is borrowing of time permitted under any circumstances. All service is included in the five-year service period, except for any Per Diem time.

Extended Educational and Extended Medical Service Leaves are granted at the discretion of SCPMG and must be approved in writing and in advance by the Chief of Service, the Area Medical Director, and the Executive Medical Director. It is the requesting Partner’s responsibility to see that the approval form is completed.

If more time is desired than the amount for which you are eligible, you must request it as either Vacation Leave or leave without pay. The maximum cumulative amount of time for all these leaves that can be taken by any Partner at any one time will not exceed one year.

For both types of leave, you will receive one half of your current Base Compensation, with one exception described below under Extended Educational Leave. Base Compensation at the time of applying for leave will reflect the work pattern of your previous five years of service.

If you are a Partner, you may accept the following items if specifically furnished in conjunction with the purpose for which the leave is granted: transportation, housing, and stipend (if it will not cause your income to
TIME-OFF BENEFITS

Effective March 1, 2014

exceed Base Compensation).

Vacation Leave and Educational Leave will not accrue during the leave.
Partners on Extended Educational Leave or Extended Medical Service Leave will receive an applicable share of Year-End Performance Draw based on your working pattern during the previous five years of service.

If You Become Disabled

A Partner who becomes seriously disabled during one of these leaves may request, upon approval by the Board of Directors, to revert from leave status to active status. Doing so will enable you to draw on any unused Acute and Chronic Sick Leave available. Upon recovery, you may not return to Extended Educational Leave or Extended Medical Service Leave status. (See the Short-Term Disability Insurance and the Long-Term Disability Insurance sections for more information about disability determinations.)

Extended Educational Leave

Extended Educational Leave is to be used only for full-time educational purposes through an established and formalized program with a recognized educational institution. This means that:

• the activity must be formally scheduled for five full days per week. Full- or half-days off must be taken as Vacation Leave. Holidays are not paid during Extended Educational Leave, so you must take either leave without pay or Vacation Leave,

• the activity must be one of physician learning, not one in which you are teaching. Therefore, going to another institution to serve as faculty will not be eligible for an Extended Educational Leave,

• the activity must be at a recognized teaching institution,

• the teaching institution may either have a set program or may tailor the program to your needs, but it must be well-described (location, time, and mentor) before the leave will be approved, and

• leave cannot be used for any activity of less than three weeks’ duration.

Extended Educational Leave may also be used for research if the research requires at least three months of full-time work and is done in conjunction with an established research institution in which the full facilities of the institution are available. Extended Educational Leave must be taken for a continuous period of time and cannot be used for courses of less than three weeks’ duration.

Partners who have been with SCPMG at least 10 years are eligible to have the last month (22 days) of a three or more month leave paid at 100% of Base Compensation. To qualify for the 100% payment, the Extended Educational Leave must be taken within 10 years of being earned. If you or the leave does not meet these criteria, then 50% of Base Compensation
is paid for the entire leave.

For the duration of the Extended Educational Leave, credit under the Common Plan will be granted for:

- 100% toward Qualifying Service,
- a maximum of 90 days of Credited Service.

**Extended Medical Service Leave**

Extended Medical Service Leave is to be used only for full-time, formalized, and established medical service programs under the auspices of a recognized national or international agency that has been involved in this type of program, or a program that SCPMG would sponsor independently. This means that:

- The activity must be formally scheduled for five full days per week.
  Full- or half-days off must be taken as Vacation Leave. Holidays are not paid during Extended Medical Service Leaves, so either leave without pay or Vacation Leave pay must be taken.
- The leave may not be used to teach or practice medicine, unless it is sponsored by an American or international agency that arranges this type of activity for others, or is one that SCPMG would sponsor.

Participation in a medical service program is a volunteer activity and requires a determination of malpractice coverage through the Medical-Legal Department.

Credit for the Common Plan is granted at 50% for both Qualifying and Credited Service for the entire Extended Medical Service Leave period.

**LEAVE OF ABSENCE**

**How the Program Works**

Leave of Absence (without pay) is available upon approval in advance by the Chief of Services and the Area Medical Director. If the Leave of Absence will be more than 10 days, the Executive Medical Director must also approve it in advance. Unless approved by the Board of Directors, if you are on a Leave of Absence, you may not engage in the practice of medicine for compensation except for a stipend received during a residency or fellowship approved by SCPMG, or pay for working for a Permanente Medical Group, The Permanente Federation, LLC, or The Permanente Company, LLC.

Partners and Special Category physicians may request up to a one-year Leave of Absence. Associate Physicians (other than Special Category) will be considered for short leaves (three months or less) only. Per Diem physicians are not eligible for Leaves of Absence.

Your Anniversary Date will be adjusted on a day-for-day basis when the
combined Leaves of Absence exceed:

- 10 working days in any Anniversary Year, or
- 60 days in aggregate during your career with SCPMG.

Vacation Leave accruals will be proportionally reduced in any Anniversary Year that the combined number of days of Leave of Absence exceeds 10. The reduction will be calculated based on the number of days taken in excess of 10. (Physicians may opt to use accrued paid leave prior to requesting and taking a Leave of Absence.)

If you are a Partner Physician, your Year-End Performance Draw will be reduced proportionately for Leaves of Absence in excess of 10 days during any calendar year, or cumulative Leaves of Absence in excess of 60 days during your career with SCPMG.

**During a Disability**

If you are a Partner Physician who becomes seriously disabled during a Leave of Absence, you may, upon approval of the SCPMG Board of Directors, be permitted to revert from Leave of Absence status to active status, and use available Acute or Chronic Sick Leave. Following recovery, you may not return to Leave of Absence status.

Associate Physicians cannot convert Leave of Absence to Acute or Chronic Sick Leave.

**Benefit Continuation**

**Partners**

SCPMG will continue to pay premiums for the following benefits during the first full month following the month in which the Leave of Absence begins:

- Kaiser Foundation Health Plan
- Supplemental Medical Plan
- Dental Coverage
- Alternate Mental Health Plan
- Long-Term Disability Insurance.

You may elect to continue these benefits during the remainder of your Leave of Absence at your own expense.

**For Example**

If your leave begins on February 15, premiums will be billed to you beginning the month of April for these benefits (including Optional Life Insurance, Spouse/Domestic Partner Life Insurance, Special Dependent, and Long-Term Care Insurance premiums if you are enrolled in these plans). Permanente Provided Life Insurance will continue to be paid by SCPMG throughout your Leave of Absence.
**Associate Physicians**

SCPMG will continue to pay premiums for the following benefits through the end of the month in which the Leave of Absence begins:

- Kaiser Foundation Health Plan
- Supplemental Medical Insurance
- Dental Care Program
- Alternate Mental Health Insurance
- Short-Term Disability Insurance equal to 50% of income replacement

You may elect to continue these benefits during the remainder of your Leave of Absence at your own expense.

**For Example**

If your leave begins on February 15, premiums will be billed to you beginning the month of March for these benefits, including: Optional Life Insurance, Spouse/Domestic Partner Life Insurance, Special Dependent and Long-Term Care Insurance, Short-Term Disability (50%) and Long-Term Disability premiums if you are enrolled in these plans. Permanente Provided Life Insurance premiums (if you are enrolled) will continue to be paid by SCPMG throughout your Leave of Absence.

Associate Physicians may not take Leaves of Absence for a partial workday unless the Leave of Absence is a Family Care and Medical Leave (described below).

**FAMILY CARE AND MEDICAL LEAVE**

**Eligibility**

The Family and Medical Leave Act of 1993 (FMLA) provides up to 12 weeks of unpaid leave to eligible Associate Physicians for certain family and medical reasons.

This federal statute applies to Associate Physicians with 12 or more months of service. In addition:

- You are also required to work at least 1,250 hours in the preceding 12 months prior to the FMLA leave, and
- Other classes of physicians are not subject to the hours worked requirement.

The combination of SCPMG’s various time-off benefits meets the majority of the requirements of FMLA. These benefits include Parenting Leave, Emergency Personal Leave, Vacation Leave, and Leave of Absence (without pay).

If there are situations addressed by FMLA but not by SCPMG’s existing policies, time-off dictated by FMLA will prevail. **FMLA does not apply to Partners**; however, Partners are eligible for Parenting Leave, Emergency
Personal Leave, Vacation Leave, and Leave of Absence (without pay).

**How the Program Works**

After completion of one year of continuous service, you may request a Family Care or Medical Leave for one of the following reasons:

- the birth of your child or for the adoption or foster care placement of a child in your care,
- to care for your child, parent or spouse with a serious health condition,
- your own serious health condition, or
- to take care of any urgent matters (called “qualifying exigencies”) for your spouse, child, or parent who is on active duty or who has been notified of an impending call or order to active duty in the U.S. Armed Forces.

You may be entitled to up to 26 weeks of unpaid, job-protected leave during each 12-month period to care for your spouse, child, parent, or next of kin who incurs a serious injury or serious health condition during active military service in the U.S. Armed Forces. You may take the 26-week leave period intermittently or on a reduced-schedule basis. Your combined total for all types of FMLA leave may not exceed 26 weeks in a single 12-month period.

Leave taken for any of these reasons will be counted toward your annual Family Care and Medical Leave and shall run concurrently with any other leave for which you are entitled.

You must provide at least 30 days’ notice before your leave begins, unless such notice is unreasonably difficult or impractical under the circumstances. You must submit to your Chief of Service and Area Medical Director proper notification and medical certification as a condition of eligibility for the leave. If your need for the leave is not foreseeable, notice must be provided as soon as practical — no later than one or two days of learning of the need for the leave.

**Continuation of Benefits**

During your leave, you and your covered dependents will continue to have all of your health care benefits. Once you have used 10 days of leave without pay, you will be offered the opportunity to pay the monthly premiums for your life insurance benefits and disability coverage for the remaining duration of your leave. If you do not return to work within three days from the expiration of your leave, you are required to repay any premiums paid on your behalf by SCPMG, unless you do not return due to a serious health condition or circumstance beyond your control.
Medical Leave
A serious health condition is an illness, injury, or impairment, or physical or mental condition that involves:

- inpatient care in a hospital, hospice or residential medical facility, or
- continuing treatment by a health care provider.

If your leave request is to care for a seriously ill child, spouse or parent, or because of your own serious health condition, you must provide a certificate from a health care provider which includes:

- the date the serious health condition began,
- the probable duration of the condition,
- the amount of time the health care provider estimates you need to care for the individual if the need for the leave is due to an ill family member, and
- a statement that you are needed either to care for or to participate in the care of the ill person or are unable to perform your job functions due to your own illness.

Family Care Leave
Eligibility for Family Care Leave because of the birth or placement of a child expires one year after the birth or placement. Family Care Leaves are provided on an unpaid basis (with the exception of use of Vacation Leave) and may be requested for a maximum of 12 weeks in a 12-month period. Sick Leave and Disability benefits cannot be used in conjunction with a Family Care Leave unless the leave is for your own serious health condition (including maternity leave). These benefits must then be exhausted as part of your Family Care Leave. In certain circumstances, you may take Family Care Leave intermittently or on a reduced work schedule. You may qualify to take up to one-half of your annual accrual of Acute Sick Leave to care for your spouse, parent or child who is ill. See the Disability Income Benefits section of this handbook for more details.

When You Return
When you return from Family Care or Medical Leave (FMLA), you will be reinstated to the same position you held when the leave began or to an equivalent position with equivalent benefits and pay. SCPMG is not required to reinstate you when you return from FMLA if:

- during your leave, the same or comparable position ceases to exist because of legitimate business reasons, and
- had you not taken the leave, you would not otherwise have been employed at the time you requested reinstatement.

If you return from a leave that extends beyond the maximum time allowed
under the state and federal laws, you cannot be guaranteed a position. If you do not qualify for any open position, your employment will be terminated.

**California Family Rights Act (CFRA)**

You may have additional rights under the California Family Rights Act. For more information on CFRA, contact the California Department of Fair Employment and Housing at 1-800-884-1684 or online at [www.DFEH.CA.gov](http://www.DFEH.CA.gov).

Your family and medical leave covered by the FMLA and CFRA leave will run concurrently, if applicable.

**PARENTING LEAVE**

**Eligibility**

Partners and Associate Physicians (except Per Diem) are eligible for Parenting Leave.

**How the Program Works**

If you become a parent, through the birth of a child or adoption of a child less than two years of age, you may take a Parenting Leave of up to 120 calendar days. Parenting Leave will run concurrently with any FMLA leave you may be entitled to take. (See the *Family Care and Medical Leave* section for details on FMLA.)

You must submit proper notification and documentation to your Chief of Service.

During Parenting Leave, you may use (without possibility of denial) accrued Vacation Leave, Leave of Absence or, if eligible, Sick Leave.

**Continuation of Benefits**

SCPMG will continue to pay your Health Care benefits, Permanente Provided Life Insurance, and Short-Term Disability equal to 50%. If you participate in Optional Life Insurance, Spouse/Domestic Partner Life Insurance, Special Dependent, Long-Term Care, or Long Term Disability Insurance you may be billed for the monthly premiums.

**Birth of a Child**

The period of Parenting Leave will begin no earlier than 30 days before the date of the birth of your child. This means that, even if the pregnancy requires you to stop working more than 30 days before your child’s birth, your 120 days of Parenting Leave will not begin until 30 days before the date of your child’s birth. Therefore, you will always be permitted at least
90 days after the date of birth for Parenting Leave. Once the disability period ends (six or eight weeks postpartum), you may use accrued Vacation Leave or Leave of Absence (without pay) for the remainder of Parenting Leave.

A physician who has given birth and is requesting Parenting Leave to care for that child may use Sick Leave and must follow the Sick Leave/Disability benefits program as described in the Income Protection section of this handbook.

**MILITARY LEAVE**

**Eligibility**

All physicians (except Per Diem) who are called to active military duty will be placed on Military Leave of Absence.

Partner Physicians with five or more years of service may qualify for Extended Military Service Leave. See the Extended Military Service Leave section for more detailed information.

**Effect on Status**

The following will apply:

- **Partnership Status**
  Partners become inactive Partners during the period of Military Leave. You must notify the Board of Directors in writing within 30 days of discharge of your intention to return to SCPMG and must return to practice within 90 days of discharge. An inactive Partner who does not return to SCPMG within the above guidelines will be considered to have voluntarily resigned.

- **Associate Status**
  Associate Physicians are covered by the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended. In order to be covered by the provisions of USERRA, you must give advance written or verbal notice of your intent to take Military Leave to the Chief of Service or your Area Medical Director, unless giving this notice is impossible or unreasonable. USERRA provides the following notification requirements when an Associate Physician is returning to SCPMG from active duty:
    - If the military service was less than 31 days, you must report back to work on the first full regular work day following your return home.
    - If the military service was greater than 30 days but less than 181 days, you must submit an application for reemployment within 14 days after your military service has been completed.
    - If the military service was greater than 180 days, you must submit an application for reemployment within 90 days after your military
service has been completed.

An Associate Physician not returning to SCPMG within the guidelines above will be considered to have voluntarily resigned. If the Military Leave was greater than 30 days, SCPMG may request documentation of your Military Leave dates in order to honor any reemployment application.

For other job restoration rights related to your return from Military Leave, contact PHR Shared Services.

**Effect on SCPMG Benefits**

- **Health Care**
  All health care benefits (Kaiser Foundation Health Plan, Supplemental Medical Health Plan, Alternate Mental Health Plan, and Dental) continue at SCPMG expense for you and your eligible dependents for up to 24 months. For any part-time Associate Physicians, PHR Shared Services will bill you for your Kaiser Health Plan premiums on a monthly basis.

  These benefits are provided automatically to both you and your eligible dependents. However, if you are a Partner and if coverage for you will be of little or no benefit during your period of military leave, you may discontinue your coverage under some or all of the plans. Discontinuing your benefits may reduce the amount of Imputed Income for the year. If you wish to do this, contact PHR Shared Services for assistance.

- **Life Insurance**
  Permanente Provided Life Insurance coverage will be continued at SCPMG expense for a maximum of one year.

  Optional Life Insurance coverage can continue up to a maximum of one year during Military Leave. You will be billed for the premiums on a monthly basis. If you choose not to pay your premiums during your Military Leave, you will be required to provide proof of insurability if you again elect Optional Life Insurance coverage upon reemployment.

  Life insurance benefits are payable in the event of your death even if engaged in active military conflict. However, the Accidental Death and Dismemberment provisions of the Optional Life Insurance coverage do not apply.

- **Disability Benefits**
  If you are a Partner Physician, you are eligible for the Compensation Continuance Program during the first year of Military Leave if you become disabled and the compensation continuance payments are approved by the disability insurance carrier. You are eligible for long-term disability payments if you become disabled during your Military Leave, as determined by the disability insurance carrier. However, disability payments will not be approved if the disability is determined to
be a result of active duty injuries. SCPMG will continue to pay long-term disability premiums for a Partner Physician up to a maximum of one year.

If you are an Associate Physician, you are eligible for short-term disability and/or long-term disability payments if you become disabled during your Military Leave, as determined by the disability insurance carrier, as long as you have paid the required premiums for coverage. However, disability payments will not be approved if the disability is determined to be a result of active duty injuries. You may continue to pay your short- and long-term disability premiums during your Military Leave for up to one year. If you choose not to pay premiums during this time, you will be required to provide proof of insurability in order to be covered by SCPMG’s disability plans upon reemployment.

- **Retirement Plans**
  Common Plan — Partner and Associate Physicians who return from Military Leave within the time frames previously specified will receive both Qualifying Service and Credited Service for the period of Military Leave.

  Keogh Plan — Partner Physicians currently participating in the Keogh Plan will remain a participant while on Military Leave. However, because contributions are based on Partner earnings, any period of Military Leave may reduce the maximum annual contribution you can make. If, at the end of the year (when Year-End Performance Draw and Imputed Income are calculated), an additional contribution is required, it will be taken from your Year-End Performance Draw.

  Tax Savings Retirement Plan — Because contributions to this plan can be made only by payroll deduction, contributions will cease while you are on Military Leave.

- **Vacation Leave, Sick Leave, and Education Leave Accruals**
  During the period of Military Leave, no additional benefits will accrue. The benefits earned up until the time of Military Leave will be frozen. Upon your return from Military Leave, benefits will begin to accrue.

- **Vacation Leave Payoff**
  Any accrued but unused Vacation Leave can be paid if you request a payoff, or the unused Vacation Leave can be held in reserve for use when you return from Military Leave. The rate of pay for the payout will be your Base Compensation rate on your last day worked. Payoff requests require approval by your Area Medical Director and the Medical Director if your accrued Vacation Leave balance is less than 60 days.

  You can only elect to cash-out Vacation Leave during the annual Open Enrollment period. Refer to the Vacation Leave section under Excess Vacation Leave Cash Out for more information.

- **Leave of Absence**
  The time that you are on Military Leave will not be counted against either
the 10 days of Leave of Absence (without pay) in an Anniversary Year or the 60-day lifetime Leave of Absence maximum.

EXTENDED MILITARY SERVICE LEAVE

Eligibility
Partner Physicians are eligible to take Extended Military Service Leaves. Inactive Partners are ineligible until they return to active status.

How the Program Works
Extended Military Service Leaves are granted at the discretion of SCPMG and must be approved in writing and in advance by the Chief of Service, the Area Medical Director and the Associate Medical Director of Clinical and Quality Analysis (acting on behalf of the SCPMG Executive Medical Director). It is your responsibility to see that the approval form is completed.

You will receive one half of your current Base Compensation during your period of Extended Military Service Leave. You will also receive an applicable share of Year-End Performance Draw. The work schedule at the time of application, averaged for five years prior to the time of application, will determine the work schedule used for the duration of the leave. You will be permitted to retain the pay you receive from the U.S. Military during your period of leave; however, your total income under Extended Military Service Leave, including the U.S. Military pay you receive, is not to exceed your Base Compensation.

For the duration of the Extended Military Service Leave, full credit under the Common Plan will be granted toward Qualifying Service and Credited Service.

MILITARY ACTIVE RESERVE LEAVE OF ABSENCE

Eligibility
All physicians except Per Diem are eligible for Military Reserve Leave of Absence.

How the Program Works
Physicians who are on active military reserve for the United States of America and who are ordered for up to four weeks of active service can use Military Active Reserve Leave of Absence or Vacation Leave to supplement their reserve pay. Military Active Reserve Leave of Absence will not affect your Anniversary Date and will not be counted under the Anniversary Date adjustment rules. Your Anniversary Date will be adjusted
for Leave of Absence taken for active reserve service greater than four weeks per year. (See Leave of Absence earlier in this section for details.) If you are not required to use your medical expertise during a Military Active Reserve Leave of Absence, you may retain your military reserve income.

COMPASSIONATE LEAVE

Eligibility

All physicians except Per Diem are eligible for Compassionate Leave of Absence.

How the Program Works

Up to a maximum of five working days of Compassionate Leave may be extended for the death of members of your immediate family. These family members include your:

- spouse,
- domestic partner,
- children,
- parents,
- brothers,
- sisters,
- in-laws,
- grandparents,
- grandchildren,
- stepparents,
- stepchildren, and
- legal wards.

Family members also include your spouse’s or domestic partner’s parents, children, brothers and sisters.

The amount of Compassionate Leave available is prorated to your work schedule.

Compassionate Leave usage must be approved by your Chief of Service and the Area Medical Director.
**JURY DUTY**

**Eligibility**
All physicians except Per Diem are eligible for Jury Duty.

**How the Program Works**
SCPMG’s Jury Duty policy allows for 10 days of jury service (prorated to work schedule) in any five consecutive calendar years. Any additional Jury Duty time must be taken as Vacation Leave or Leave of Absence (without pay).

If you are required to serve on Jury Duty, you will receive your regular compensation during the period you serve as a juror. Be sure your time is reported as “Jury Duty.” The applicable payment you receive for jury service (normally $5 per day) will be deducted from your paycheck for each day you are paid by the court. You keep the check you receive from the court for jury service (including mileage).

Jury Duty is fully compensable only if you present to your Chief of Service and Area Medical Director all correspondence with the court and its representatives. In addition, you must document all possible steps you have taken to be excused from Jury Duty.

To minimize the impact on patient schedules, check with the court system to see if you can:
- defer jury service to a future date, if needed, to avoid canceling patients,
- request “same day” status (in many L.A. courts, this is called “Group 98”), so the court either uses you on a jury or releases you on the first day, or
- request a “short trial,” which is defined as less than 5 days

**EMERGENCY PERSONAL LEAVE**

**Eligibility**
Emergency Personal Leave is available for all physicians working at least an 8/10 work schedule.

**How the Program Works**
You may take up to five days in any Anniversary Year as Emergency Personal Leave. This leave may be taken at short notice in circumstances of personal hardship.

If you have accrued Vacation Leave available, this leave will be paid to you from your Vacation Leave balance. If you do not have sufficient accrued Vacation Leave available, Emergency Personal Leave will be
uncompensated and will count toward your Leave of Absence (without pay) maximums.
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COMMUTER CHOICE PROGRAM  
(For Associate Physicians Only)

The Commuter Choice Program is designed to help you set aside a portion of your income to help pay for public transportation, commuter highway transportation, and parking expenses for your commute to and from work.

Eligibility and Enrollment

You may participate in the Commuter Choice Program if you are an Associate Physician (except Per Diem), regardless of your work schedule. Partner Physicians are not eligible to participate in this program.

To enroll, complete the Commuter Choice Enrollment/Change Form, which is located at the back of the Commuter Choice Program brochure. Submit the completed form to PHR Shared Services. Contact PHR Shared Services at 1-877-608-0044 to request a copy of the Commuter Choice Program brochure, or download a copy from the SCPMG Physician Portal at http://scpmgphysician.kp.org. You will receive a confirmation and claim form when your enrollment is processed by Ceridian, the program claims administrator.

Tax Savings

Your contributions to the Commuter Choice Program will be deducted from your pay on a pre-tax basis. Your contributions reduce your taxable income. The amount you contribute is not subject to federal income taxes, Social Security taxes, or most state and local income taxes. Your reimbursements for eligible expenses are tax-free; you will not be taxed at a later date. Your tax savings will depend on your household income, your tax filing status, and your eligible expenses. Consult your tax adviser if you have any questions.

How the Program Works

When you enroll in the program, the amount you contribute is automatically deducted from your paycheck on the first pay period of each month. Your contributions are held in your Commuter Choice account. Once your account is set up and you start contributing, you submit your claims for parking costs or transit passes, along with proper receipts to Ceridian. If you do not have receipts, you may include a brief explanation with your signed certification with your claim form. You may submit claims by mail or fax.

You have two payment options:

1. You can have Ceridian send a reimbursement check for eligible expenses (based on your existing Commuter Choice account balance) to your home address. A statement providing your account balance information will be included with your reimbursement check.
2. You can have reimbursements electronically deposited into your bank account through the Direct Deposit feature. You will need to complete the Direct Deposit application you receive with your claim forms in order to use this feature.

Claims are processed every Friday. If you submit a claim via fax or mail, Ceridian must receive it no later than Tuesday at 2:00 p.m. Pacific Standard Time in order for your claim to be reimbursed by Friday of the same week.

If you do not have sufficient funds in your Commuter Choice account to cover your entire claim amount, you will receive a reimbursement for eligible expenses up to your existing account balance. The unreimbursed portion of your eligible expenses will be paid to you as soon as you have sufficient funds in your account.

All claims for reimbursement from your Commuter Choice account must be submitted within 180 days from the date the eligible expense is incurred.

Your Contributions and Maximum Monthly Reimbursement

You may make monthly contributions to your Commuter Choice account up to the maximum limits described below. These limits also represent the maximum monthly reimbursement available to you:

- $130 per month for combined commuter highway vehicle transportation and transit passes
- $250 per month for qualified parking
- $380 per month combined.

The maximum amount you may contribute will be reduced by any subsidy or discounts that may be provided by a given mode of transportation or facility.

Changing Your Contributions

You may change your contribution amount no more than once per month. To do so, complete a Commuter Choice Enrollment/Change Form and submit it to PHR Shared Services. You will receive a confirmation from Ceridian when your change is processed. You can obtain the Contribution Change Form from the Ceridian website at www.ceridian-benefits.com — Commuter Administrator page, on the SCPMG Physician Portal at http://scpmgphysician.kp.org, or by contacting PHR Shared Services at 1-877-608-0044.

Your election change will be effective beginning the first pay period of the month following the receipt of your Commuter Choice Enrollment/Change Form by PHR Shared Services.

Eligible Expenses

Expenses generally eligible for reimbursement from your Commuter
Choice account include:

- bus, train, subway, and ferry fares and passes,
- commuter highway vehicle transportation monthly expenses, and
- parking at transit station facilities or at or near work.

**Ineligible Expenses**

Expenses not eligible for reimbursement from your Commuter Choice account include:

- carpooling expenses,
- non-work related transportation and parking,
- parking/transportation expenses reimbursed by SCPMG,
- monthly expenses above the contribution limits described under Your Contributions above,
- bridge/road tolls and transponders,
- gasoline expenses, and
- parking/transportation expenses for your spouse, domestic partner or dependents.

**Rollover of Unused Funds and Termination**

Any unused funds remaining in your Commuter Choice account will roll over to the following month (including the following year if December). These funds will remain in your account to reimburse you for eligible expenses. Your reimbursements will continue to be limited to the contribution limits described under Your Contributions above. Since funds can roll over from month to month, your account balance remains available so long as you are an Associate Physician with SCPMG. If your account balance grows to a significant amount, you may wish to temporarily stop contributions and reduce your account balance through reimbursements of your eligible expenses.

You may continue to request reimbursement for eligible expenses until you stop participating in the program (see If You Terminate Employment below). If you terminate from SCPMG, your participation in the program will automatically terminate at the end of your termination month or upon transferring to partnership status.

**Claims Administrator**

The program is administered by Ceridian, who maintains your account records, issues reimbursement, and provides you with individual account statements. Send all claims to:
If You Terminate Employment

If you terminate employment with SCPMG as an Associate Physician for any reason (including election to the partnership), any unused money in your Commuter Choice account will remain available for eligible expenses that were incurred prior to your termination. You will have 31 days from your termination/retirement date to submit a claim. Any unreimbursed money in your account after this period will be forfeited.

FLEXIBLE SPENDING ACCOUNTS
(For Associate Physicians Only)

Flexible Spending Accounts let you pay for certain health and dependent care expenses with tax-free dollars. Because you don’t pay taxes on these dollars, you have more money to use for these expenses.

You can set aside money through payroll deductions — before taxes are withheld — to cover eligible health care and dependent care expenses. You are able to reimburse yourself for eligible expenses.

You have two Flexible Spending Account options:

- The Health Care Flexible Spending Account (HCFSA) helps you save money on your out-of-pocket medical, dental, vision, and hearing expenses.
- The Dependent Care Flexible Spending Account (DCFSA) helps you save money on the cost of your dependent care expenses.

See the following descriptions of each account.

Eligibility

Associate Physicians (except Per Diem) may enroll in one or both Flexible Spending Accounts within 31 days of hire, experience a qualifying family or employment status change, or during Open Enrollment period each November. You may also choose not to participate. Federal tax rules do not permit Partner Physicians to participate in Flexible Spending Accounts. You will be required to elect to enroll in the Flexible Spending Accounts annually. Your previous elections will not automatically carry over into the next plan year.
Contributions

Your elected amount to contribute, called your annual election, is deducted from your pay, before taxes, and “deposited” into your Flexible Spending Account(s). Your annual contributions will be taken over 26 pay periods.

HCFSA

- The annual maximum contribution is:
  - $2,500 per family, or
  - Your annual taxable income if you earn less than $2,500.

DCFSA

- The annual maximum contribution is:
  - $5,000 per family, or
  - Your annual taxable income if you earn less than $5,000.

Note: Additional limits may apply to the Dependent Care FSA if you are married and file separate tax returns. Refer to the Dependent Care FSA brochure for more detail information.

How the Accounts Work

If you choose to participate, you decide how much money to set aside in each account, and you can make before-tax contributions from your pay. The amount you select is deducted automatically from your paycheck each pay period. When you enroll, you should carefully estimate your expenses for the coming plan year because IRS rules say:

- Re-enrollment is required each year in order to continue participation.
- If you don’t use all the money in your account, you forfeit whatever is left over.
- You cannot transfer money between your Flexible Spending Accounts.
- You cannot change the set amounts you choose to contribute during the benefit plan year, unless you have a qualified change in status (see Changing Your Selections below).
- You will lose your unused account balances at the end of the grace period (March 31) following the benefit plan year.
- If you leave SCPMG mid-year or become ineligible to participate, you may continue to file claims up to the grace period (March 31) for expenses incurred prior to termination or change in status.
- If you terminate employment with SCPMG, you may elect to continue HCFSA coverage through COBRA; your contribution will be made on an after-tax basis so you will not realize any tax savings.
- If you terminate employment with SCPMG or become ineligible to participate, you may continue to file DCFSA claims up to the grace period.
period (March 31) for expenses incurred through the end of the benefit plan year.

- You cannot file for an income tax deduction or tax credit for expenses reimbursed through the HCFSA or DCFSA.

**Plan Your Expenses**

Before you enroll in a Flexible Spending Account, you should carefully estimate your health care and dependent care expenses for the year — because in exchange for the tax savings you receive, the Internal Revenue Service places several restrictions on the money you contribute. If you plan ahead, you can save money on eligible expenses through the before-tax feature of Flexible Spending Accounts.

**How You Save Money**

Your Flexible Spending Account contributions reduce your taxable income. That means the amount you contribute is not subject to federal income taxes, Social Security taxes, or most state and local income taxes. Your reimbursements for eligible expenses are tax-free; you will not be taxed at a later date.

Your tax savings will depend on your household income, your tax filing status, and your eligible expenses. You may want to consult your tax adviser if you have any questions.

**Requesting Reimbursement**

During the benefit plan year, you can use the money in your accounts to reimburse yourself when you pay an eligible expense. You have until March 31 of the following year to submit any claims for reimbursement for expenses incurred during the previous calendar year. The reimbursement process is a little different for each Flexible Spending Account. Here is a description of each process:

**HCFSA**

Once your reimbursement account is set up, you will receive claim forms from Ceridian, the HCFSA claims administrator. As you incur eligible health care expenses, submit a claim form along with appropriate documentation to the claims administrator to request payment from your reimbursement account. Mail or fax the claim form to the claims administrator for reimbursement. You can also submit your claims online through the Ceridian website at www.ceridian-benefits.com.

You have two payment options with your claim form:

1. You can have Ceridian mail a check directly to you.
2. You can have reimbursements electronically deposited into your bank account through the direct deposit feature. You will need to complete the Direct Deposit application you receive with your claim forms to use this feature.
OTHER BENEFITS

Claims are normally processed one day after Ceridian receives a completed claims form. Your reimbursement cannot exceed your total HCFSA election for the year minus any previous reimbursements made to you during the year (including the grace period).

**HCFSA Claims Administrator**

Claims are administered by Ceridian, who maintains the account records, issues reimbursements, and sends out individual quarterly account statements.

Send all claims for reimbursement directly to:

Ceridian  
P.O. Box 534055  
St. Petersburg, FL 33747-4055  
1-877-799-8820  
1-888-342-5333 (fax)

You can submit your claims online through the Ceridian website at [www.ceridian-benefits.com](http://www.ceridian-benefits.com).

**DCFSA**

Once your reimbursement account is set up, you will receive claim forms from Ceridian, the DCFSA claims administrator. As you incur eligible dependent care expenses, submit a claim form along with appropriate documentation to the claims administrator to request payment from your reimbursement account. Mail or fax the claim form to the claims administrator for reimbursement. You can also submit your claim online thru the Ceridian website at [www.ceridian-benefits.com](http://www.ceridian-benefits.com).

You have three payment options with your claims form:

1. You can have Ceridian mail a check directly to you;
2. You can have Ceridian electronically direct deposited. You will need to complete the direct deposit application you receive with your claim forms to use this feature.
3. You can choose Ceridian to pay your provider. Ceridian will pay only one provider directly. If you have multiple providers, then you have to pay the second provider and submit your claim form to Ceridian to reimburse yourself.

Provided there are funds in your reimbursement account, claim forms are processed every Friday. Claims received via fax or mail must be received no later than Tuesday at 2:00 p.m. Pacific Standard Time in order to be reimbursed on Friday.

You must report your provider’s Social Security number or the taxpayer identification number of the institution when you file a claim and when you file your federal income taxes.

*Effective March 1, 2014*
DCFSA Claims Administrator

Claims are administered by Ceridian, who maintains the account records, issues reimbursement checks, and sends out individual quarterly account statements. Send all claims for reimbursement directly to:

Ceridian
P.O. Box 534134
St. Petersburg, FL 33747-4134
1-877-488-6454 (fax)

You can also submit your claims online through the Ceridian website at www.ceridian-benefits.com.

Unused Amounts Will Be Forfeited

The deadline to incur expenses is December 31. You have until March 31 of the following year to submit reimbursement claims for expenses incurred during the previous calendar year. Unused amounts in your Flexible Spending Accounts will be forfeited.

Example

If you contributed $1,000 to the HCFSA, but you submitted only $800 in eligible expenses, you forfeit the $200 balance in your account. In addition, you contributed $2,000 to the DCFSA and submitted $2,200 in eligible expenses. You would be reimbursed the full $2,000 you contributed for the year. But, you could not use the $200 you forfeited in the HCFSA to cover the remaining $200 of dependent care expenses.

<table>
<thead>
<tr>
<th></th>
<th>Health Care</th>
<th>Dependent Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your annual contributions</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Your total eligible expenses</td>
<td>$ 800</td>
<td>$2,200</td>
</tr>
<tr>
<td>Your reimbursement</td>
<td>$ 800</td>
<td>$2,000</td>
</tr>
<tr>
<td>Amount you forfeit</td>
<td>$ 200</td>
<td>$ 0</td>
</tr>
</tbody>
</table>

You may use the remaining balance in your HCFSA for:

- an extra pair of glasses, prescription sunglasses, or contact lenses
- contact lens cleaning solution and disinfectants
- acupuncture, if your doctor recommends it
- physical exams, dental exams, or diagnostic tests before the benefit plan year ends
- replacement of old or worn fillings before the benefit plan year ends, if your dentist recommends it
- travel and lodging away from home for medical reasons (Limitations may apply. See IRS Publication 502 for details.)
tuition and tutoring for a child with severe learning disabilities, including dyslexia

over-the-counter drugs (e.g., antacids, pain relievers, and cold or other allergy medications)

vitamins by prescription

weight-loss programs prescribed by a physician for a specific ailment

nursing care for a dependent (such as your dependent elderly parents) if it is not custodial nursing home care

other expenses that are considered tax-deductible by the IRS. These include the cost of many services and equipment for the disabled.

For a complete list of eligible expenses, see IRS Publication 502, available at http://www.irs.gov/pub/irs-pdf/p502.pdf or from your local IRS office. To order a copy from the IRS call 1-800-829-3676.

Changing Your Selections

Per IRS rules, the salary reduction amount you elect must remain in effect for the entire plan year and cannot be changed or stopped, unless there is a qualifying change in status that affects your dependent care expenses. The plan administrator assesses your situation and determines if your change is a qualified change in status as defined by the IRS.

To make changes in your HCFSA or DCFSA elections, all three of the following must occur:

- You experience a qualified change in status as defined by the IRS (see following list).
- The change in status causes a gain or loss of eligibility under SCPMG’s benefits, your spouse’s plan, or the plan of your dependent’s employer.
- Your new election is consistent with the change in status (i.e., you may decrease your DCFSA election in the event your dependent child no longer qualifies as a dependent for DCFSA reimbursement).

Qualified Changes in Status

- Marriage, divorce, or annulment;
- Birth, adoption, or placement for adoption of a dependent child;
- Death of your spouse or dependent child;
- A change in your employment status or that of your spouse or a dependent, including commencement or termination of employment, a strike or lockout, the commencement of or return from an unpaid leave of absence, or a change in worksite;
- A change in the employment status of you, your spouse, or a dependent such that the affected individual becomes or ceases to be eligible under SCPMG benefits or another benefit plan, such as your spouse’s annual
enrollment period;

- A change in eligibility when a dependent ceases to satisfy the requirements for coverage due to attainment of age, change in employment status, full-time student status change, or similar event;
- Significant increases or decreases in your dependent care expenses, as determined by the plan administrator (DCFSA only);
- Eligibility/ineligibility for Medicare or Medicaid of you or a dependent (HCFSA only); and
- Entry/expiration of a judgment, decree, or order that requires you to cover a child under one or more SCPMG benefit options (HCFSA only).

You have 31 days after a qualified change in status to enroll or to change your existing selection. The change you make must relate directly to your change in status, and you will have to submit documentation of the event. For example, if you marry and wish to increase your contribution to the plan, you must submit a copy of your marriage license along with your election form.

**Note:** You cannot decrease your salary reduction to less than the amount that has already been reimbursed for that year. Also, increases in salary reduction may be applied only to expenses incurred after the effective date of the change in status.

**Contact PHR Shared Services at 1-877-608-0044 for more information regarding permissible Flexible Spending Account election changes when you have a change in status.**

**Health Care Flexible Spending Account Plan (HCFSA)**

You can use the HCFSA for health care expenses that are considered eligible deductions on your federal income tax return (with the exception of insurance premiums) and that are not reimbursed by another health plan. Eligible expenses may include your share of the cost of medical, dental, vision, and hearing care for you or a dependent.

**Note:** Many health care expenses are not eligible for reimbursement, such as any payroll deductions for your medical and/or dental plan contributions.

**Eligibility**

Health care expenses can be for:

- yourself
- your spouse
- your dependent children, up to the end of the month that they turn age 26 (provided they are tax dependent for federal tax purposes)

If you are divorced or legally separated, expenses for your children who are considered your dependents for federal tax purposes are eligible.
Eligible Health Care Expenses

The HCFSA reimburses you for the following eligible expenses:

- medical and dental plan copayments, deductibles and coinsurance
- charges above the medical and dental plans’ usual, reasonable, and customary limits.
- Expenses that are partially covered by your medical or dental plan, such as the cost of:
  - alcoholism/substance abuse (chemical dependency) treatment (including meals and lodging provided by a treatment center)
  - birth control devices
  - chiropractic or physical therapy
  - dental bridges and dentures
  - eyeglasses or contact lenses
  - hearing aids and their batteries
  - infertility services
  - medical equipment, such as crutches or wheelchairs
  - mental health treatment
  - orthodontia
  - periodontal cleanings
  - prescription drug co-payments and coinsurance
  - Retin A (when medically necessary and not for cosmetic purposes)
  - speech therapy
  - certain expenses that are not covered by your medical or dental plan (but can be reimbursed), such as the cost of:
    > acupuncture
    > contact lens replacement insurance
    > home modifications to accommodate a disabled person (including disabilities caused by arthritis)
    > laser eye surgery, such as LASIK, radial keratotomy, and penetrating keratoplasty
    > removal of lead-based paint to prevent your young child who has (or had) lead poisoning from eating paint
    > massage therapy
    > orthopedic shoes
    > over-the-counter medications
    > smoking-cessation programs (does not include expenses for drugs that do not require a prescription, such as nicotine gum or patches)
    > sterilization reversal
    > TMJ post-surgery therapy and appliances.

For a complete list of covered expenses see the Health Care Expense eligibility list.
Ineligible Health Care Expenses

The HCFSA does not reimburse you for the following (even if they are recommended by your doctor):

- Cosmetic treatment (unless the treatment corrects a deformity arising from or directly related to a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease). Cosmetic treatment includes, but is not limited to, teeth bleaching, laser peels, chemical peels, hair transplants and treatment for male pattern baldness.

- Drugs prescribed for cosmetic purposes (such as Rogaine, a drug prescribed for hair-loss treatment)

- Dance or swimming lessons

- Electrolysis

- Expenses reimbursed through any health insurance policy or plan, such as your spouse’s health plan or Medicare

- Expenses you or a family member incurred before the effective date of your HCFSA election, or change of your HCFSA election

- Expenses you or a family member incurs after the end of the benefit plan year (December 31)

- Health club dues, YMCA dues, and related expenses

- Household help

- Liposuction

- Marriage or family counseling

- Maternity clothes, diaper service, and related expenses

- Non-prescription drugs or vitamins (unless prescribed by a physician as periodically necessary to treat a specific disease or condition)

- Custodial nursing home care

- Premiums for automobile insurance, including premiums to insure medical care for persons injured by or in your car

- Premiums for life, disability, or accidental death and dismemberment (AD&D) insurance

- Premiums for medical, dental, and vision insurance, including COBRA premiums

- Transportation to and from work (even if your condition requires special means of transportation)

- Trips or Vacation Leaves taken for relief of a condition, change in environment, improvement of morale, or general health purposes

- Tuition for a child with disciplinary problems who is enrolled in a special school

- Uniforms
• weight-loss programs (unless prescribed by a doctor as medically necessary for the treatment of a specific disease or condition)

• any other expenses that are not deductible on a federal income tax return. (See IRS Publication 502 available at http://www.irs.gov/pub/irs-pdf/p502.pdf or from your local IRS office. Or, order a copy from the IRS by calling 1-800-829-3676.) For a complete list of covered expenses see the Health Care Expense eligibility list.

**Dependent Care Flexible Spending Account Plan (DCFSA)**

The DCFSA can save you money if you use it to pay for the services of a day care provider while you work. If you are married, to be eligible to use a DCFSA, your spouse also must work (or actively be searching for work). The only exception is if he or she is disabled or a full-time student at least five months of the year.

If you are divorced or legally separated, you can use the DCFSA if you have custody of your child for a longer period of the year than does your child’s other parent. In addition, your child must be your tax dependent for federal tax purposes.

Eligible expenses include the cost of day care for your dependent children under age 13. Day care also can be for a spouse or dependent who is incapable of caring for himself or herself regardless of their age.

**Eligible Dependents**

Day care expenses that can be reimbursed through the DCFSA include day care for:

• children (including stepchildren, adopted children, and grandchildren) under age 13 whom you claim as exemptions on your federal income tax return

• a spouse who is mentally or physically incapable of caring for him- or herself

• parents, grandparents, children age 13 or older, or other relatives or members of your household who:
  – are claimed as a dependent on your federal income tax return,
  – spend at least eight hours each day in your home,
  – receive more than half of their support from you, and
  – are physically or mentally incapable of caring for themselves.

If your spouse is incapable of caring for him- or herself, the expenses you incur for his or her care must enable you to be gainfully employed, and your spouse must:

• have a physical or mental condition that does not allow him or her to take care of personal, hygienic, or nutritional needs, or

• require full-time attention for safety reasons.
The fact that your spouse is unable to engage in substantial gainful activity or perform his or her normal functions is not necessarily sufficient for day care expenses to be reimbursed under the plan.

For additional details go to www.myceridian.com/129.

**Eligible Dependent Care Expenses**

Expenses eligible for reimbursement include:

- The cost of day care provided in or out of your home (including Social Security taxes you pay on behalf of your provider) by an eligible babysitter.
- The cost of day care provided at a licensed day care center or kindergarten that cares for at least six people and complies with applicable state and local regulations (but not services from a facility that charges no fee).
- The cost of day care provided at a day camp (but not tuition and other fees unrelated to day care and not at an overnight camp).
- The cost of day care provided at a private school (but not tuition and other fees unrelated to day care if the child is in kindergarten or above).
- Any nonrefundable fees to secure your dependent’s place in a day care center.
- Any other expenses that would be considered eligible for a dependent care credit for federal income tax purposes.

For a complete list of these expenses, see IRS Publication 503, available here [http://www.irs.gov/pub/irs-pdf/p503.pdf](http://www.irs.gov/pub/irs-pdf/p503.pdf) or from your local IRS office. Or order a copy from the IRS by calling 1-800-829-3676.

**Who is a Qualified Caregiver?**

Your day care provider can be a babysitter if his or her services enable you and your spouse to work, look for work, or attend school, but cannot be any of the following:

- your spouse
- your child’s other parent
- your child who is under age 19 at the end of the benefit plan year
- a person whom you or your spouse claims as a dependent for income tax purposes.

**Know Your Caregiver’s Tax Number**

If you use the DCFSA, you have to provide your caregiver’s taxpayer identification (or Social Security) number on your claim forms. IRS rules will not allow your expenses to be reimbursed if you do not provide the number.
Ineligible Dependent Care Expenses

The following expenses are not eligible for reimbursement under the DCFSA:

- child support payments
- clothing, entertainment or food expenses
- day care costs for hours when you or your spouse is not working or is working as a volunteer
- expenses for day care while you or your spouse is away from work because of Vacation Leave, illness, or leave of absence
- expenses you or a family member incurred before the effective date of, or a change in, your DCFSA election
- expenses that are reimbursed by another plan, such as your spouse’s or a government plan
- expenses that occurred before you enroll in the DCFSA or after your participation ends
- expenses that occur during any time you cannot claim your dependent as an exemption on your federal income tax return
- day care costs incurred after the benefit plan year ends (December 31)
- finder’s fees for placement of an au pair or nanny
- full-time convalescent or nursing home expenses (except care for a mentally disabled child under age 13)
- overnight camp expenses
- transportation expenses for your caregiver or your dependent
- tuition for kindergarten or beyond
- any other expenses not eligible as a dependent care credit for federal income tax purposes. (See IRS Publication 503 available at http://www.irs.gov/pub/irs-pdf/p503.pdf or from your local IRS office, or order a copy from the IRS by calling 1-800-829-3676.)

Contribution Limits

Each benefit plan year, you can set aside up to $5,000 per year in your DCFSA. However, special limits apply if you are married, as shown in the following table:

<table>
<thead>
<tr>
<th>If this is your situation...</th>
<th>Then your maximum annual contribution is...</th>
</tr>
</thead>
<tbody>
<tr>
<td>You or your spouse earns less than $5,000</td>
<td>The amount the lower-paid spouse earns, up to $5,000.</td>
</tr>
</tbody>
</table>
OTHER BENEFITS

<table>
<thead>
<tr>
<th>Condition</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>You and your spouse file a joint income tax return and your spouse also participates in a dependent care Flexible Spending Account plan</td>
<td>$5,000 for your combined accounts.</td>
</tr>
<tr>
<td>You and your spouse file separate income tax returns</td>
<td>$2,500 under the SCPMG DCFSA.</td>
</tr>
</tbody>
</table>
| Your spouse is a full-time student for at least five months of the year | • $3,000 (or $250 for each month that your spouse is a student) if you have one dependent.  
• $5,000 (or $500 for each month that your spouse is a student) if you have two or more dependents. |
| Your spouse is disabled | • $3,000 (or $250 for each month that your spouse is disabled) if you have one dependent.  
• $5,000 (or $500 for each month that your spouse is disabled) if you have two or more dependents. |

How Other Benefits Are Affected

Your Flexible Spending Account contributions will not affect your other SCPMG benefits that are based on your pay. These other benefits such as life insurance, disability, and retirement benefits will continue to be based on your full pay.

However, your contributions to a Flexible Spending Account could affect the amount of your Social Security benefits at the time you draw them because your Social Security benefits are based on your average annual taxable income — up to the Social Security annual wage base — over your entire career. Your Flexible Spending Account contributions lower your taxable income, so your Social Security benefits at retirement or disability may be slightly less if:

• you earn less than the Social Security annual wage base for the current year, or  
• your before-tax contributions reduce your taxable income below the Social Security annual wage base.

If you earn more than the Social Security annual wage base, your Social Security benefits are not affected.

HCFSA vs. Tax Deduction

Even though the HCFSA reimbursements can save you money on taxes, the federal income tax deduction can provide greater tax savings for some associates. To claim such a deduction, your out-of-pocket health care expenses must exceed 7.5% of your adjusted gross income. Most physicians find that their eligible health care expenses do not reach that level. Ask your tax adviser which method is best for your personal situation.
DCFSA vs. Tax Credit

Another way to reduce federal income taxes with dependent care expenses is to claim the child care credit on your tax return. The combination of DCFSA reimbursements and tax credits that provides the greatest tax saving for you depends on your household income, the number of your eligible dependents, and your income tax filing status.

You have the option to use both the DCFSA and the tax credit. However, the IRS does not allow you to claim a tax credit for any expenses reimbursed under the DCFSA. In other words, you cannot “double deduct” these expenses to receive a tax saving twice.

Moreover, the amount of expenses that qualify for a tax credit is reduced — dollar for dollar — by the amount that you receive from the DCFSA. You should consult your tax adviser about how to utilize both the DCFSA and tax credit.

Note: You are responsible for ensuring that the expenses are valid IRS deductions. The claims administrators and SCPMG are not responsible for verifying that your claims are valid tax deductions. You should consult your tax adviser with any questions regarding your income tax obligations.

When Your Participation Ends

Your participation in the HCFSA and DCFSA end and your contributions stop when the first of these events occurs:

• you or your dependents are no longer eligible to participate,
• you fail to make an election for a benefit plan year,
• the plan terminates,
• your employment is terminated, or
• you have a change of status.

HCFSA

You can submit claims that you incur before your participation in the Flexible Spending Accounts end. The deadline to submit claims is March 31, three months after the benefit plan year ends.

Claims that you incur after your participation ends are not eligible for reimbursement, and you lose any money left in your accounts. However, under certain circumstances, when your coverage otherwise would end, you may continue participating in the HCFSA by making after-tax contributions through COBRA. When you elect COBRA, you can submit expenses for reimbursement and use the balance in your HCFSA until the end of the benefit plan year. See Limited Continuation of Health Benefits Available (COBRA) in the Administration section for a general discussion of COBRA, or contact PHR Shared Services at 1-877-608-0044 for more information about continuing participation in the HCFSA through COBRA.
OTHER BENEFITS

DCFSA
If your participation in the DCFSA ends due to employment termination or status change, you can still submit claims for expenses incurred through the end of the benefit plan year. The deadline to submit claims is March 31, three months after the benefit plan year ends.

Leaves of Absence
Your contributions will stop if you are on a Personal Leave of Absence. When you return to active work status, your contributions will be reactivated. Contact PHR Shared Services at 1-877-608-0044 for more information.

LONG-TERM CARE INSURANCE (Through New York Life Insurance Company)
Long-Term Care Insurance is designed to provide you and/or your eligible family members with financial protection for services rendered in connection with nursing home and/or home- and community-based care. Coverage is available at your own expense.

The information presented below is applicable to policies purchased through New York Life Insurance Company prior to November 2012. New York Life has since suspended new enrollment. For information on the new Long-Term Care Insurance program, refer to the Genworth Life Insurance Company section on page 172.

Eligibility
All active physicians, except Per Diem, are eligible to enroll without providing evidence of insurability:

- upon hire,
- upon election into SCPMG Partnership, or
- upon attainment of age 40.

These are the insurance company’s defined Open Enrollment periods. Only active physicians who enroll during an Open Enrollment period may complete the Guaranteed Issue Form (form #1) and will not be subject to the underwriting requirements for their age.

You may apply for the long-term care coverage at any other time; however, you need to provide evidence of insurability and meet the insurance company's underwriting requirements.

Physicians who are receiving disability benefits or who are on Sick Leave or a Leave of Absence are not eligible.
Family Members’ Eligibility

Your eligible family members may apply for this insurance whether you apply for this coverage or not. Persons eligible for coverage are:

- your spouse/domestic partner,
- your children age 18 or older,
- your parents
- your spouse’s parents, or
- a surviving spouse of a deceased SCPMG physician.

The maximum age for enrollment is age 80.

Underwriting Requirements

The Insurance Company can conduct the phone history interview or face to face assessment at their discretion. The underwriting requirements for the various eligible groups are listed in the chart below:

<table>
<thead>
<tr>
<th>Underwriting Guidelines</th>
<th>Guaranteed Issue Form #1</th>
<th>Short Form #2</th>
<th>Long Form #3</th>
<th>Medical Records</th>
<th>Phone History</th>
<th>Face to Face Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Physicians (Open Enrollment period only)</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active Physicians (late entry)</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes Age 55 to 74</td>
<td></td>
<td>Yes Age 75+</td>
</tr>
<tr>
<td>Retired Physicians Under Age 75</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retired Physicians Age 75+</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouses Less than Age 55 (Open Enrollment period only)</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouses Less than Age 55 (late entry)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouses Ages 55 to 74</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouses Ages 75+</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Individuals who are required to complete the Long Form (form #3) will have their medical records requested from the attending physician listed by them. Phone history interviews will be required of applicants between the ages of 55-74, in addition to the Long Form and medical records. The phone history interview lasts between 5 and 15 minutes and consists of questions that are intended to confirm information given on the application, to expand on the medical information provided and to record responses to cognitive-related questions.

Applicants age 75 and over are required to have a face-to-face assessment conducted in the applicant’s home at the insurance company’s expense. The assessment measures the applicant’s functional and cognitive status and is performed by an independent professional of a case management network hired by the insurance company.

If you are approved and enroll during an Open Enrollment period your effective date is the first of the month after the insurance company receives your application. For all other applications, the effective date is the first of the month following the underwriting approval of the application by the insurance company.

For active physicians and their family members, premiums can be paid by payroll deduction, direct billing or automatic debit from a checking or savings account.

**How the Plan Works**

Under the Long-Term Care Insurance program, you can choose either the Basic Plan or the Deluxe Plan. Under each Plan, you have the option of selecting a Maximum Daily Benefit (MDB) that pays benefits of either $60 per day or $100 per day. Your choices are:

- **Basic Plan**
  - MDB of $60 per day, or
  - MDB of $100 per day
• **Deluxe Plan**
  - MDB of $60 per day, or
  - MDB of $100 per day

Both Plans cover care provided:

- in a skilled or intermediate nursing facility,
- in a custodial care facility, or
- at home by skilled caregivers.

The difference between the two plans is that the Deluxe Plan has the following features:

- inflation protection,
- informal care,
- reduced paid-up benefit, and
- return of premium upon death benefit.

Each of these features is described later in this section.

**Eligibility for Benefits**

Eligibility for benefits is determined by the individual’s ability to perform the seven Activities of Daily Living (ADLs):

- ambulating,
- bathing,
- maintaining continence,
- dressing,
- feeding,
- toileting, and
- transferring.

In order to receive nursing home benefits, you must be unable to perform three out of the seven ADLs, or be cognitively impaired. For home- and community-based care, you must be unable to perform two out of the seven ADLs or be cognitively impaired.

**Lifetime Maximums**

The lifetime maximum available to you is determined by the Maximum Daily Benefit (MDB) you select. This lifetime maximum functions like an account which you use to pay for care as needed. The length of time you can receive benefits is determined only by the amount of money available in your account, not by a specified length of time.

There are two components to the lifetime maximum:

- the nursing home maximum benefit, and
• the home- and community-based care maximum benefit.

The home- and community-based care maximum benefit includes the informal care provision, as well as the respite care and therapeutic devices maximums.

The following chart provides some details for the Basic and Deluxe Plans:

<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>Basic Plan</th>
<th>Deluxe Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nursing Home Maximum Daily Benefit (MDB): $60 or $100</strong></td>
<td>Yes</td>
<td>Yes $60 MDB grows to $159 in 20 years $100 MDB grows to $265 in 20 years</td>
</tr>
<tr>
<td><strong>Overall Lifetime Maximum Benefit</strong></td>
<td>$60 = $112,500</td>
<td>$60 = $298,125*</td>
</tr>
<tr>
<td></td>
<td>$100 = $187,500</td>
<td>$100 = $496,875*</td>
</tr>
<tr>
<td><strong>Home- and Community-Based Care up to $50 per day</strong></td>
<td>Yes</td>
<td>Yes (grows to $132.50 with inflation adjustment)</td>
</tr>
<tr>
<td><strong>Informal Care</strong></td>
<td>No</td>
<td>Yes (grows to $132.50 with inflation adjustment)</td>
</tr>
<tr>
<td><strong>Home- and Community-Based Care Lifetime Maximum</strong></td>
<td>$60 = $45,000</td>
<td>$60 = $119,250*</td>
</tr>
<tr>
<td></td>
<td>$100 = $75,000</td>
<td>$100 = $198,750*</td>
</tr>
<tr>
<td><strong>Respite Care — 21 days per year</strong></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Therapeutic Device Maximum</strong></td>
<td>$1,000</td>
<td>$2,650*</td>
</tr>
<tr>
<td><strong>90-Day Waiting Period</strong></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Inflation Protection</strong></td>
<td>No</td>
<td>Yes, 5% compounded annually for 20 years</td>
</tr>
<tr>
<td><strong>Return of Premium Upon Death Benefit</strong></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Reduced Paid-Up Benefit</strong></td>
<td>No</td>
<td>Yes</td>
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<tr>
<td><strong>Waiver of Premium</strong></td>
<td>Yes</td>
<td>Yes</td>
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* Includes adjustments for inflation.

**What’s Included in Both Plans**

Both plans have the following features:

• **90-Day Waiting Period**
  
  There is a one-time only waiting period of 90 days before benefits can be paid from the plans. If there are subsequent periods of benefit usage, no additional waiting period is required.
• **Respite Care**
  Respite care allows a caregiver to take a break from that role and either hire a substitute caregiver or place the patient in a nursing home for up to 21 days per year. The plan pays up to $50 (which grows to $132.50 with the inflation protection in the Deluxe Plan) per day for home- and community-based care, or up to the MDB for respite care received in a nursing home.

• **Therapeutic Devices**
  The plans will pay up to the limits listed in the chart above for devices such as grab bars and ramps, which help the individual perform the basic ADLs without another person’s assistance. The 90-day waiting period does not apply to therapeutic devices. Expenses incurred for covered therapeutic devices will also count against both the lifetime maximum benefit and the lifetime home- and community-based care maximum for the plan you select.

• **Waiver of Premium**
  After you have received long-term care benefits for 90 days, premium payments are waived. Once benefits have not been received for 180 days, premium payments must resume in order to keep your policy in force.

**What the Deluxe Plan Covers**

The Deluxe Plan provides benefits for the following services:

• **Inflation Protection**
  The Deluxe Plan includes a 5% compounded annual increase in all your Maximums for 20 years. This will increase your nursing home, home- and community-based care, and therapeutic devices daily maximums.

• **Informal Care**
  The Deluxe Plan covers care provided by any caregiver, including family members not living with you, friends, or neighbors. Regardless of the MDB you select, informal care is paid at a maximum rate of $50 per day, which increases to $132.50 over 20 years.

• **Reduced Paid-Up Benefit**
  This feature provides that if for any reason you cease paying premiums after your policy has been in force for at least 10 years, you will have purchased a reduced paid-up policy. This benefit provides 30% of the MDB you selected. For each year over 10 that you paid premiums, the benefit will increase by an additional 3%, up to a maximum of 75% of the amount of your original coverage. The lifetime maximum will be proportionately reduced.
Example:
If you purchased the $100 MDB and stopped paying premiums after 10 years, you would have purchased a reduced, paid-up policy with an MDB of $30. If you stopped paying after 15 years, you would have purchased a $45-per-day benefit. Inflation protection is not included once you use this feature.

Return of Premium Upon Death Benefit
If you die at age 65 or younger, your estate will be refunded 100% of the premiums you paid for the coverage, minus any claims that were reimbursed. If you are over age 65 at the time of death, your estate will receive 100% of the premiums you paid, reduced by 10% for each year you were over age 65. Premiums returned will be reduced by any claims reimbursed.

Example:
If you purchased $60 per day MDB at age 54 and had no claims for reimbursement up to the time of death:
- Premium: $84.30 per month
- Age at death: 68
- Total premiums paid: $14,162.40 (assuming 14 years of payments)
- 10% reduction for each year over 65 (total = 30%) at time of death: $4,248.72
- Total premium returned to estate: $9,913.68

Pre-Existing Condition
A pre-existing condition is any condition that was treated within the six-month period immediately prior to the policy start date. The plans will cover a pre-existing condition as follows:

- If the condition was not disclosed on the application, the condition will be covered after the policy has been in effect for six months.
- If the condition was disclosed on the application, the condition will be covered immediately.

Coordination With Other Benefits
Long-Term Care Insurance is coordinated with your SCPMG Supplemental Medical Coverage.

Any claims that are eligible for payment under Supplemental Medical Coverage should be filed first with that plan. After you have been reimbursed for any eligible charges by the Supplemental Medical Plan, then submit the unpaid balance to your Long-Term Care Insurance.

By coordinating the benefits in this manner, your lifetime maximums under Long-Term Care Insurance can be extended.
**Termination**

Your Long-Term Care Insurance policy is portable; you can retain the policy when you leave SCPMG. Other family members’ coverage is also portable and is not dependent on your status with SCPMG.

If you are paying the premiums by payroll deduction at the time you leave SCPMG, PHR Shared Services will notify the insurance company so that premiums will be billed to you directly if you wish to continue the coverage.

**Tax Considerations**

The legislation affecting the deductibility of premiums and claims paid changes frequently. This is a tax-qualified plan, so please contact your tax adviser for more information.

**Cost**

You pay the entire cost for the Long-Term Care Insurance. Each insured individual pays a premium based on his or her age at the time of enrollment. Premium rates are subject to change, but the insured individual will always pay the rate for his or her age at the time of enrollment.

**LONG-TERM CARE INSURANCE (Through Genworth Life Insurance Company)**

Effective March 2014, SCPMG offers Long-Term Care Insurance underwritten by Genworth Life Insurance Company. This program is available to Partner physicians, their spouses or domestic partners and other family members. Specifically, eligible individuals include:

- Partner physicians working at least 20 hours per week
- Family members of an eligible Partner who are between ages 18 and 75, including your:
  - spouse or domestic partner
  - adult children
  - siblings
  - parents, parents-in-law, step parents, step parents-in-law
  - grandparents, grandparents-in-law, step grandparents, step grandparents-in-law

If you are paying premiums on a New York Life Long-Term Care policy obtained previously through SCPMG, it may be beneficial for you to continue your New York Life coverage. The New York Life rates are very favorable and are based on your age at the time you enrolled. You may want to contact a Genworth program expert at 800-416-3624 to determine if Genworth can supplement your New York Life policy and enhance your existing Long-Term Care coverage.

Detailed information about Genworth, including costs and what the
program covers, can be found on the SCPMG Physician Portal (http://scpmgphysician.kp.org) on the Benefits page under the HR & Financials tab.

**MORTGAGE LOAN PROGRAMS**

SCPMG offers two mortgage loan programs from Bank of America and Wells Fargo to provide custom-tailored residential mortgages. Both programs are designed with higher loan amounts, lower up-front costs, and flexible financing options.

**Eligibility**

All SCPMG physicians except Per Diem are eligible for these programs.

**How to Apply**

For further information or to request an application form, contact the following bank representatives:

Bank of America: Caroline Sutherland, 949-467-7312, caroline.sutherland@bankofamerica.com

Wells Fargo: Richard Duncan, 626-535-0741, richard.m.duncan@wellsfargo.com

**PROFESSIONAL LIABILITY COVERAGE**

This plan provides financial protection for physicians against malpractice claims that may be filed as a result of actions taken or not taken within the course of the scope of your professional duties performed for SCPMG. This coverage may not be declined.

**Eligibility**

This coverage is provided for all physicians.

**Enrollment**

Coverage is automatic; no enrollment is necessary.

**Effective Date**

The coverage is effective on your date of hire.

**Description**

Complete professional liability coverage is provided on a date-of-occurrence basis; this means you are covered for professional activities performed for SCPMG even if you are no longer on staff when the action is filed.
Covered Outside Activities

Coverage is also available for approved outside professional activities for all SCPMG physicians, except part-time and Per Diem. Professional activities, other than those performed for SCPMG, which may also be covered include:

- assistance given at an outside emergency (such as first aid at the scene of an accident),
- participation in approved outside educational activities, whether on SCPMG or personal time (any professional liability coverage provided by the academic institution would be used first), and
- volunteer community activities when there is no other malpractice coverage available, as long as:
  - the services are provided without compensation,
  - the services are for a well-established, well-recognized nonprofit civic or community organization,
  - the physician meets community standards (by training and experience) to provide the required professional services,
  - the volunteer activity is not considered “high risk,” and
  - approval is obtained as described below.

Approval Required for Outside Activities

To be covered while providing volunteer services, you must:

- obtain a Voluntary Activity Report available at http://kpnet.kp.org:81/california/qmrs/scpmglegal/physician_volunteer_activities.html,
- complete either the paper version or the electronic version and send it to SCPMG Counsel at Walnut Center, and
- be approved for coverage by your Area Medical Director and the SCPMG Legal Department.

All requests will be approved or denied based on the criteria above.

Condition of Coverage

As a condition of the right of professional liability coverage, you must:

- cooperate in the investigation and/or defense of malpractice claims,
- use legal services exclusively provided or selected by SCPMG,
- attend meetings, hearings, depositions, arbitrations and trials, and
- assist in effecting settlement.

The time you spend on these activities will be administrative time. If you are no longer associated with SCPMG, you will receive payment at the last hourly rate of pay while with SCPMG for time spent in actual attendance. There will be no additional charge by you to the entities of the Kaiser Permanente.
Permanente Medical Care Program for these services.

**Exclusions**

Any practice outside SCPMG is not covered. This includes any services rendered for which value is received by you. It is most important that all services for which payment is expected be billed through SCPMG.

Service as a camp doctor in any camp run for profit, whether you receive direct compensation or not, is not covered.

**Termination**

This coverage terminates on the date your service with SCPMG ends; however, you will be protected for all professional activities you performed for SCPMG regardless of when the suit is filed.

**No Conversion**

Conversion to individual coverage is not available.

**Cost**

This coverage is provided at no cost to all physicians.
SECTION: VI

RETIREMENT AND SAVINGS PLANS
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Effective March 1, 2014
## EARLY SEPARATION PROGRAM

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As an SCPMG physician, you have a number of retirement plans to choose from. Kaiser Foundation Health Plan, Inc. provides a retirement program for physicians serving Health Plan members, and SCPMG provides three Retirement and Savings Plans designed to assist you in maintaining financial independence during your retirement years:

- **Common Plan**, provided by Kaiser Foundation Health Plan, is generally available to eligible physicians except Per Diem to provide a monthly retirement income during your lifetime. Optional forms of payment can be elected which provide benefits to a survivor if you wish.

- **Keogh Plan**, available to all Partner Physicians and Partner Emeriti enrolled in the Keogh Plan at the time of retirement, offers a tax-deductible way to save through convenient payroll deductions or by making lump sum contributions to the Plan. The Plan provides a wide choice of investment options, including a self-directed brokerage fund.

- **Physicians’ Tax Savings Retirement Plan (TSR)**, available to all Partner and Associate Physicians, including ex-Partners employed on a Per Diem basis. You can set aside up to 75% of your gross compensation each pay period on a tax-deferred basis up to the annual maximum limit. A selection of investment funds provides flexibility for investing your money in the Plan.

- **Early Separation Program**, available to all Partner Physicians between the ages of 58 and 65, can provide a monthly retirement benefit to supplement your income until you reach age 65.

This section of the handbook provides a summary of each of the SCPMG-sponsored retirement plans. Information related to the Common Plan can be found by either accessing documentation on the SCPMG Physician Portal at http://scpmgphysician.kp.org, or by contacting the Kaiser Permanente Retirement Center website at www.ibenefitscenter.com/kp. You should note that the information provided below is simply a summary of the official Plan document for each Plan and, to the extent of inconsistencies between the summary and the Plan document, the provisions of the Plan document will govern.

### COMMON PLAN

The Retirement Plan for Physicians Serving Members of Kaiser Foundation Health Plan, Inc., is referred to as the “Common Plan.”

This Plan was established and is sponsored by Kaiser Foundation Health Plan, Inc. to provide a non-qualified defined benefit pension plan for SCPMG physicians.

The rules of the Common Plan can be found in the Common Plan Summary Plan Explanation by referring to the SCPMG Physician Portal at http://scpmgphysician.kp.org, or the Kaiser Permanente Retirement Center website at www.ibenefitscenter.com/kp.

*Effective March 1, 2014*
For additional information related to the Common Plan, contact the Kaiser Permanente Retirement Center at 1-800-721-3647.

**KEOGH PLAN**

The Southern California Permanente Medical Group Retirement Plan is referred to as the Keogh Plan. It is a defined contribution plan which is designed to qualify for certain tax advantages under Internal Revenue Code Section 401(a).

The Keogh Plan is designed to allow Partners to make tax-deductible contributions to a retirement plan and to allow the funds to accrue tax-deferred earnings until distributed from the Plan at retirement from the partnership. The following information is a summary of Keogh Plan provisions. For additional information refer to the *Southern California Permanente Medical Group Retirement Plan Summary Plan Description*.

**Eligibility**

Eligibility for physicians is limited to Partner Physicians and Partner Emeriti enrolled in the Keogh Plan at the time of retirement who do not own more than a 10% interest in either the capital or profits of the partnership. The individual who was the Business Administrator (Operations) on or after 1/1/2004 and the individual who was the Business Administrator (Finance, Systems, and Consulting) on or after 1/1/2004 are also eligible to participate.

Partner Physicians are eligible on the later of (i) the date they become a Partner or (ii) completion of two years of eligibility service. The Business Administrator (Operations) and the Business Administrator (Finance, Systems, and Consulting) are eligible on the later of (i) the date specified in the above paragraph for their position or (ii) completion of two years of eligibility service.

**How Physicians Elect to Participate**

Approximately four months after your date of hire, you will receive a Welcome Package that will include a Keogh Plan Enrollment Guide booklet and a Keogh Plan enrollment form. You must sign and return the enrollment form to the Recordkeeper, Schwab Retirement Plan Services Company, no later than six months after your employment with SCPMG commences. This form allows you to indicate whether or not you will participate in the Keogh Plan when you become a Partner of SCPMG.

Your election to participate or not participate is irrevocable and cannot be changed for any reason. Electing to participate in the Keogh Plan means that you are making an irrevocable commitment to make an annual contribution of the amount required for your selected level of participation, if and when you become a Partner of SCPMG. If you do not
elect to participate by the sixth month after your employment with SCPMG commences, you will not be able to commence participation at a later date. Your participation will continue until you are no longer a Partner Physician or in an eligible category.

Partner Emeriti Participants
Partner Emeriti (retired partners who continue to work per diem post-retirement) who previously elected Keogh must continue making Keogh contributions at the same level they were contributing prior to retirement (25%, 50%, 70% or 100%). When making Keogh contributions, a Partner Emeritus cannot make lump sum contributions. Instead, the physician must contribute to Keogh through bi-weekly payroll deductions.

Partner Emeriti are not permitted to make Keogh contributions post-retirement if they (i) retired prior to December 31, 2012 (ii) retire on or after January 1, 2013 but experience a break in service of 180 days or more, or (iii) retire on or after January 1, 2013 but did not previously contribute to the Keogh Plan.

Non-Physician Participants
Participation in the Keogh Plan for the Business Administrators identified above in the Eligibility section is automatic.

Contribution Level
Partner Physicians generally have four Keogh Plan contribution levels from which to choose. You can choose to contribute 100%, 70%, 50% or 25% of the contribution level determined for the Plan.

The Business Administrators participating in the Plan receive an annual contribution equal to 70% of the contribution level determined each year.

For example, the 2014 100% contribution level is 14% of Partnership Income, the 70% level is 9.8% of Partnership Income, the 50% contribution level is 7% of Partnership Income and the 25% contribution level is 3.5% of Partnership Income. The percentage is determined each year based on information provided by an outside actuarial firm hired by the SCPMG Board of Directors.

The level of contribution you select when you complete the Keogh Plan enrollment form is irrevocable. You cannot change from one contribution level to another and you may not suspend contributions for any reason.
**Partnership Income** is your annual income from SCPMG including Imputed Income and Year-End Performance Draw, adjusted to take into account the deduction for unreimbursed business expenses and self-employment taxes. Your contributions to the Physicians’ Tax Savings Retirement Plan are included in your Partnership Income for purposes of determining your annual contributions to the Keogh Plan.

**Imputed Income** includes the cost of medical, dental, disability and life insurance benefits paid by SCPMG on your behalf. Year-End Performance Draw is your share of the amount that is distributed among Partners at the end of the year.

The Year-End Performance Draw is processed in March of the following year for the previous year. (Example: December 31, 2010 — Year-end processing completed in March 2011).

**No Individual Keogh Plans**
As a Partner in a partnership, you are not eligible to have an individual Keogh Plan even if you elect **not** to participate in the SCPMG Keogh Plan. Individual Keogh plans are also not available for Business Administrators.

**Federal Limits on Contributions**
Federal regulations limit Keogh Plan contributions to the lesser of:

- the amount generated by the annual contribution level (this formula is calculated by an outside actuarial firm, and it compares physician benefits to those provided to specified associates of SCPMG), or
- in 2014: $52,000 for physicians under age 50 (may be adjusted for future years), $57,500 for physicians over age 50, or
- up to 100% of your Partnership Income (provided the aggregate of the contributions of all Plan participants does not exceed 25% of the aggregate of all Partners’ Partnership Income net of contributions to the Keogh and Physicians’ Tax Savings Retirement Plan) or 100% of your annual earnings if you are a Business Administrator.

It is expected that the annual contribution level will continue to produce the lowest limit and, therefore, will determine the maximum contribution amount each year. This formula produces a contribution percentage that changes from year to year. In 2014, the percentage is 14% of a Partner’s annual Partnership Income.

The maximum amount of Partnership Income or annual earnings on which Keogh Plan contributions can be calculated is $260,000 in 2014. If you earn more than $260,000 in 2014, your Partnership Income or annual earnings for Plan purposes will be limited to $260,000 and, as a result, your contribution will be lower than if your total compensation were used. The $260,000 limit is increased from time to time as specified by the IRS.

**How Contributions Are Made**
Keogh contributions are based on Partner earnings. Contributions for Partners can be made by either of two methods: payroll deduction or
lump sum. In any case, you are always 100% vested in the total value of your account.

**Payroll Deductions**

Under the payroll deduction method, a percentage will be determined each year that will be used to deduct contributions from your bi-weekly paychecks. These payroll deductions will begin automatically on the pay period in which you become a Partner.

**Lump Sum Contribution**

Annual lump sum contributions are permitted, and may be made by sending a check to Schwab Retirement Plan Services Company. Lump sum contributions should be made before the second pay period of the new plan year.

Lump sum contributions cannot be accepted for first-year contributions that begin mid-year.

Lump sum contributions should be made by mailing a check to Charles Schwab Bank for SCPMG Keogh Plan, FBO Participant Name. A lump sum contribution form is required and can be printed from the Schwab website at www.401kaccess.com/scpmg.

**Method to Obtain Maximum Contribution**

Each pay period, your year-to-date earnings and year-to-date Keogh Plan contributions will be compared to ensure that you have contributed your allowable maximum based on your elected contribution level.

**Keogh Catch-Up**

If additional contributions are required, catch-up deductions will be taken. These additional deductions are known as Keogh Catch-Up. The maximum Keogh Catch Up deduction permitted per pay period is $300 and will normally occur after the first pay period of the year, since Keogh Plan deductions are not taken from the first paycheck, and

**Year-End Processing**

Once your eligible compensation is known, it may be determined that an additional Keogh contribution may be required. Any necessary prior-year deductions will be taken from your final partnership distribution in March or any other eligible compensation as determined by the Board of Directors.

If you over-contributed to the Keogh Plan for the year, the excess contribution will be refunded to you by April 15 of the following year. The likelihood of over-contribution is small because SCPMG continually monitors both the Keogh maximum and the federal combined (Keogh and TSR) maximum contribution amount.
If it is then determined that you have an additional amount to contribute for the previous year, that amount will be divided by the number of pay periods remaining prior to April 15, the tax deadline of the current year. These additional prior year contributions will be deducted in addition to your current year deductions.

**Coordination With the TSR Plan**

Federal law limits the amount of contributions to all defined contribution plans to the lesser of 100% of Partnership Income or $52,000 in 2014 ($57,500 for physicians over age 50). This limit applies to your combined Keogh and TSR contributions (described later in this section).

- Contributions to the Keogh and TSR Plans will be stopped if your combined contributions reach $52,000 ($57,500 for physicians over age 50), even if you have not reached the individual plan contribution limits.

**Investment of Contributions**

You are responsible for directing how your contributions are invested among the investment funds offered under the Plan. Your fund elections will remain in effect until you make a change with the Recordkeeper, Schwab Retirement Plan Services Company. Changes become effective immediately if the change is made prior to 1 p.m. Pacific Time, if made after 1 p.m. Pacific Time the change will be the next business day. (See the Administration section for information on how to contact the Recordkeeper.)

If you do not provide Schwab Retirement Plan Services Company with your investment elections, all of your contributions will automatically be deposited to the age-appropriate Vanguard Target Retirement Trust as determined by your assumed retirement at age 65.

Contributions to the Plan are not insured by any federal agency.

**Payroll Deduction Method**

Core and Self-Directed — Contributions are wired to the Recordkeeper each payroll Friday and posted to your account the next business day.

**Lump Sum Method**

Core Funds and Self-Directed — Your contribution will be invested upon receipt of your check by the Recordkeeper.

**Transfers**

**Fund-to-Fund Transfers**

Transfers are permitted daily. Requests made before 1:00 p.m. Pacific
Time will become effective the next business day. You may transfer any whole percentage of your fund balances to any other investment fund(s).

**Self-Directed Account Transfers**
You may transfer any whole percentage or dollar amount of your Self-Directed Account cash balance to any other investment fund(s). Securities must be liquidated and available in the cash account before transfer to a core fund(s).

**Investment Funds**
The core funds available through the Keogh Plan are funds that have been pre-selected by SCPMG to provide flexibility in creating a diversified portfolio reflecting your retirement savings style. The list of funds can be located on the Schwab website at www.401kaccess.com/scpmg or by calling Schwab at 1-888-256-8830.

**Account Fees**
Account fees are deducted directly from your plan assets. Fees that can be deducted from your assets include recordkeeping fees, Self-Directed Brokerage Account and transaction fees, and trust services fees. In order to deduct fees from participant accounts, the Keogh plan has limited account holdings and future fund elections within the plan’s available brokerage options (Schwab PCRA or retain self-directed brokerage) to a maximum of 99%. This allows participants to establish the maximum allocation to brokerage account investment options while allowing for liquidity for fee payments. To change fund elections or request a current balance transfer, visit www.401kaccess.com/scpmg or call Participant Services at 1-888-256-8830.

**Self-Directed Account**
As a participant in the Keogh Plan, you have the opportunity to take advantage of a self-directed fund. The Self-Directed Account supplements your other Keogh Plan investment options by allowing you access to
individual securities such as stocks, bonds and mutual funds, as well as other types of investments.

You can invest two ways: Personal Choice Retirement Account (PCRA), known as the self-directed account, or the External Self-Directed Brokerage Account (ESDBA).

**Schwab Personal Choice Retirement Account (PCRA)**

The Schwab PCRA is a self-directed brokerage account designed for sophisticated investors who have a good understanding of the stock market and general knowledge of investment principles. PCRA introduces a broader range of investment options than those offered in the Keogh Plan’s core funds.

PCRA is an optional account, and you may pay additional fees for transactions. For more information on charges, you may view the PCRA Pricing Summary at www.401kaccess.com/scpmsg.

If you choose to invest using a Schwab PCRA, you will need to complete an online PCRA application, available at www.401kaccess.com/scpmsg.

**External Self-Directed Brokerage Account (ESDBA)**

The ESDBA is intended for those investors who prefer to access a wider range of investment choices and maintain relationships with a broader base of outside broker-dealers who do not trade on the Schwab platform.

The investment option means your Keogh Plan account will incur additional fees based on the asset level of your account. There is also a specific list of broker-dealers with which the Keogh Plan can accommodate retail ESDBAs.

If interested in the ESDBA option, you may request additional information by going to www.401kaccess.com/scpmsg or calling Schwab Participant Services at 1-888-256-8830.

**Approved Investments**

Regardless of the type of Self-Directed Account you open, your transactions must fall within the “approved investment” guidelines of the Keogh Plan. Go to the Schwab website at www.401kaccess.com/scpmsg or the SCPMG Physician Portal at http://scpmsgphysician.kp.org to access the Investment Policy Guidelines and Objectives or for more information.

**Published Investment Results**

Monthly Investment returns for the core funds are updated by the Retirement Committee Investment Advisors.

Prospectuses are provided upon eligibility and are included in the enrollment packet. If you would like a prospectus, fund fact sheet or a summary annual report on any of the investment funds, contact the...
Loans
Loans are not available from the Keogh Plan.

Withdrawals
Withdrawals are not permitted from your tax-deductible account.

When You Can Receive Benefits

Pre-1987 Distribution Rules
If you have a pre-1987 post-tax nondeductible contribution balance (contributions made prior to December 31, 1986), you may withdraw any part or all of your contributions. If you are married, your spouse must give written consent prior to the date of the withdrawal. A maximum of four withdrawals may be made each year from this balance. Withdrawals are permitted at any time. Earnings on these contributions may not be withdrawn.

Withdrawals of nondeductible contributions are not taxed since these contributions were made with after-tax dollars.

Pre-1994 Distribution Rules
Any contributions made prior to December 31, 1993 may be distributed to you at any time following your termination of employment with the partnership, regardless of your age and years of Qualified Service, upon your death, your disability, or your ceasing to be a Partner. Any earnings on those contributions must remain in the Plan.

Your December 31, 1993 account balance remains eligible for distribution in the forms available under the rules in effect prior to 1994. Therefore, the following additional forms of benefit payment are available for that portion of a distribution which is equal to your December 31, 1993 Keogh account balance:

- **Lump Sum**
  - You will receive your account balance in one single payment or can be rolled over into a qualified IRA.
  - Participants and beneficiaries with monies in the self-directed fund who elect lump sum payments may elect to receive self-directed fund monies in cash, in-kind, or a combination of both.

- **Single Life Annuity**
  - Your account balance is used to purchase a single premium annuity contract.
- Monthly payments continue to you for your lifetime.
- All payments cease at your death.

- **Contingent Annuity**
  - That portion of your Keogh account balance which is equal to your December 31, 1993 account balance is used to purchase a single premium annuity contract.
  - You receive reduced monthly payments for the remainder of your life.
  - Upon your death, your contingent annuitant, if still living, receives 50%, 66 2/3%, 75%, or 100% of such reduced monthly payments for the remainder of his or her life.
  - If your contingent annuitant predeceases you, you continue to receive 100% of your reduced monthly payments for your lifetime; payments would then stop upon your death.

- **Joint and Survivor Annuity**
  - Your account balance is used to purchase a single premium annuity contract.
  - You receive monthly payments while both you and your joint annuitant are living (these payments will be smaller than the monthly payments under the single life annuity).
  - In addition, the survivor (either you or your joint annuitant) receives monthly payments equal to 50%, 66 2/3%, 75%, or 100% of the amount that was paid while you both were living. Payments continue for the survivor’s lifetime.
  - The higher the percentage you elect to continue to the survivor, the lower the payments will be while you are both living.

- **Monthly, Quarterly or Annual Installments**
  - You elect to receive your payments in substantially equal monthly, quarterly or annual installments over a specified number of years. The payment period cannot extend beyond your or your beneficiary’s joint life expectancy.

- **Combination**
  - That portion of your Keogh account balance that is equal to your December 31, 1993 account balance is paid out partly as a cash payment and partly as an annuity.

**Post 1994 Distribution Rules**

The net value of your account will be paid according to the benefit option selected. When you incur a termination of employment with the partnership, you must meet one of the following eligibility requirements in order to receive a distribution of contributions made on and after January 1, 1994 and earnings since January 1, 1994:

- you reach early retirement age, which is age 55 with 15 years of
Qualified Service,

- your age plus years of Qualified Service total at least 75,
- you reach normal retirement age, which is age 65, or
- you die.

If you do not meet the age and service requirements listed above, then you must be at least age 65 in order to receive a distribution.

**How Benefits Are Paid**

The way your retirement benefits are paid depends on when payments are to begin and the type of benefit payment you choose. When you become eligible for a distribution of benefits, you may elect to receive the balance in your Keogh Plan account in any one of the following forms:

- **Lump Sum**
  - You will receive your account balance in one single payment or can be rolled over into a qualified IRA.
  - Participants and beneficiaries with monies in the self-directed fund who elect lump sum payments may elect to receive self-directed fund monies in cash, in-kind, or a combination of both.

- **Single Life Annuity**
  - Your account balance is used to purchase a single premium annuity contract.
  - Monthly payments continue to you for your lifetime.
  - All payments cease at your death.

- **Joint and Survivor Annuity**
  - Your account balance is used to purchase a single premium annuity contract.
  - You receive monthly payments while both you and your joint annuitant are living (these payments will be smaller than the monthly payments under the single life annuity).
  - In addition, the survivor (either you or your joint annuitant) receives monthly payments equal to 50%, 66⅔%, 75%, or 100% of the amount that was paid while you both were living. Payments continue for the survivor’s lifetime.
  - The higher the percentage you elect to continue to the survivor, the lower the payments will be while you are both living.

- **Monthly, Quarterly or Annual Installments**
  - You elect to receive your payments in substantially equal monthly, quarterly or annual installments over a specified number of years. The payment period cannot extend beyond your or your beneficiary’s joint life expectancy.

The normal form of distribution under the Keogh Plan generally is a lump
sum. However, special qualified joint and survivor annuity (QJSA) and qualified pre-retirement survivor annuity (QPSA) rules apply to your account if you have at any time elected an annuity form of payment under the Keogh. You will be given more information about the QJSA/QPSA requirements if these special rules apply to you.

If you have any nondeductible contributions in your account and elect installments or a form of annuity, you may elect to receive your nondeductible contributions in a single sum with your first distribution payment rather than pro rata.

**Keogh In-Service Distribution Rule**

This provision provides physicians who obtain Normal Retirement age (which is age 65) the ability to withdraw their Post-1994 Keogh account balance and continue working to the end of the year that they turn age 65, while also continuing to work as a Partner Emeritus after retirement.

- This one-time In-Service distribution may be requested at the time the physician turns 65 and anytime thereafter.
- The request must be made to Schwab and can be processed as a lump sum cash withdrawal or a direct rollover to an IRA.
- Once you no longer work as a Partner Emeritus, any remaining balance after the In-Service distribution will be automatically distributed as a second payment in the same manner as the In-Service distribution was received (i.e., cash or direct rollover to IRA). Schwab will set up an automatic trigger to send out the second lump sum payment (or rollover to an IRA) once they are notified that you are no longer working.

**When Payments Begin**

Payments will begin as soon as possible after you request a distribution for which you are eligible. You may defer receiving your distribution under any of these options up to April 1 following the year you reach age 70½. If you continue working beyond April 1 following the year you attain age 70½, payments will not be made to you until you stop working completely for SCPMG.

If you fail to request distribution after receiving notice that you are eligible to receive payments, you will be deemed to have elected the following:

- to defer distribution until April 1 following the year you reach age 70½ or stop working for SCPMG after age 70½, and
- to receive the lump sum form of distribution (or annuity if you are subject to the QJSA/QPSA requirements described above).

Once you stop working for SCPMG, you may elect to receive your benefit in any option offered under the Plan prior to April 1 following your attainment...
of age 70½ by submitting a distribution request. All options are revocable until payment begins or an annuity contract is purchased for you. Monthly, quarterly, or annual installments are also revocable during the payment period, but only if you wish to receive a final lump sum payment of your remaining Keogh balance. All other options are irrevocable once a payment is made.

Under any deferred option, your account balance will remain in the Keogh Plan.

Payment at Your Death

If you die before payments under the Keogh Plan begin and your beneficiary is your spouse, your spouse may select any of the previously described forms of payment. If your beneficiary is not your spouse, your beneficiary will receive payment in a lump sum (subject to the distribution rules outlined below).

All distributions to beneficiaries are subject to the following additional restrictions:

- if your beneficiary is not your spouse, payments must begin by December 31 following the year of your death.
- if your beneficiary is your spouse, your account may be paid out over his or her life expectancy beginning no later than April 1 following the year you would have attained age 70½, or pursuant to any faster method.

If you die after payment under the Plan has begun, and you have elected an annuity form of distribution, the terms of the annuity will govern. If you have elected installment payments, your beneficiary(ies) may elect continuation of installments or request payment in a lump sum.

If you are married, you should be aware that federal law requires your spouse to be the beneficiary in the event of your death, unless your spouse consents in writing to your election of another beneficiary. The consent must be witnessed by either a Notary Public or a Plan Representative.

Divorce

Because the Keogh Plan is a federally qualified plan under ERISA, it requires the joinder process established under the California Civil Code as well as a Qualified Domestic Relations Order (QDRO, as stipulated by the Retirement Equity Act) before benefits can be made to an alternate payee. Model QDROs are available from Schwab Retirement Plan Services Company.

The Plan will comply with a QDRO (as stipulated by the Retirement Equity Act) providing child support, alimony, or marital property rights to spouses, former spouses, or other payees. In the event of a QDRO, a former spouse or other dependent could receive a portion of your benefits, even if you continue working. The order must specify:
• the names and addresses of the Plan participant and each payee, and
• the amount or percentage of the participant’s benefit to be paid (or how the amount is to be determined).

The order cannot:
• provide benefits to be paid in any form or amount inconsistent with Plan provisions, or
• be inconsistent with any other existing order.

Should the Plan receive a QDRO that affects your benefits, Schwab will notify you. A copy of the procedures and QDRO model is available from Schwab. There are additional fees associated with a QDRO. Please refer to the Schwab website at www.401kaccess.com/scpmg.

Taxes and Rollover or Transfer of Benefits

How your benefits are taxed when they are distributed depends on a number of factors, including the tax laws in effect at the time of the distribution, your age, and the circumstances under which they are paid. You should seek professional tax advice when you are deciding when and how you will receive your benefits.

In general, the funds in your account will usually be taxable as income when they are paid. (The distribution of any post-tax nondeductible you may have made prior to December 31, 1986 is not subject to tax.) They may be subject to ordinary income tax or you or your beneficiary may be eligible for certain special tax treatment, such as income averaging. If you elect to receive the funds in your account in a lump sum and subsequently roll over such amount or you elect to directly roll over your lump sum to an individual retirement account or to another qualified plan, you may further defer the taxation of these funds. If you elect to have your distribution paid directly to you and subsequently roll it over, the amount distributed to you will be subject to mandatory federal tax withholding of 20%. Federal taxes will not be withheld if you elect that such amounts be paid directly to an individual retirement account (IRA) or to another employer’s qualified plan as part of a “direct rollover.”

In certain circumstances, distributions before age 59½ may be subject to a 10% federal excise tax and a 2.5% California state excise tax. There are some exceptions. For instance, under present law, this tax will not be imposed if the distribution is due to death or total disability or is made on account of termination of employment at or after age 55. You should consult a tax adviser concerning the applicability of this tax to any distribution you may elect to receive prior to age 59½.

There are many requirements and restrictions concerning rollovers and lump sum distributions that are not discussed here. You should consult a tax adviser before electing a payment option.
Transfers From Other Plans
You may elect to transfer your benefit under the qualified plan of another employer directly to this Plan, subject to the conditions imposed on transfers by the IRS. In addition, if you have received a distribution from another qualified plan which qualifies for rollover treatment, you may elect to roll the distribution over to this Plan, subject to the rules imposed by the IRS. All age and service distribution rules applying to contributions made after 1/1/1994 also apply to incoming rollovers to the Keogh Plan.

See Your Tax Consultant
The proper selection of your benefit option can offer both legal and tax advantages. See your legal and/or tax consultant for advice.

Reports and Statements
Each year, you will receive a statement from SCPMG that will inform you of the final contribution amount for the previous year. This statement will be included with the mailing of your Partner Statement of Earnings (From K-1). Each quarter you will receive a quarterly account statement from Schwab by the 15th business day of the month following quarter-end. By default, you will receive your statement in the mail, but you may opt to receive an electronic statement at any time.
In addition, if you have a Schwab Personal Choice Retirement Account (PCRA) and/or an External Self-Direct Brokerage Account (ESDBA), you will receive monthly statements that provide full details on all activity in your account.

No Assignment
Because the Plan is a tax-qualified retirement plan, assignment of benefits is not permitted except in the case of a Qualified Domestic Relations Order (generally involving divorce; see the section titled Divorce) or in the case of an IRS tax lien.

Limitation of Rights
Except as may be required by law, neither SCPMG nor the Trustee has any liability for payment of benefits beyond the assets of the Plan.

Cost
You pay the costs of administrative services for your Keogh Plan core fund account and PCRA or ESDBA. You can receive a copy of the fee schedules by contacting Schwab at 1-888-256-8830 or www.401kaccess.com/scpmg.

Effective March 1, 2014
Top-Heavy Rules
There are certain provisions that become effective if the Plan becomes “top-heavy” as defined by federal tax laws. A plan is considered top-heavy if benefit values for certain key associates exceed 60% of the value of all benefits for all plan participants. You will be notified in the event this occurs and if you are affected.

Vesting
Your contributions are always immediately 100% vested.

How Service is Credited

Qualifying Service
Qualifying Service is time counted to determine if you are eligible to participate in the Plan and to receive distributions from the Plan prior to age 65. Qualifying Service includes both full-time and part-time (half-time or more) service, and can include periods devoted to certain other activities, such as medical research and advanced study, approved by the Plan’s Administrative Committee. Qualifying Service will not accrue for:

• time spent in postgraduate training as an associate of Kaiser Foundation Hospitals,
• part-time Associate Physicians who have an outside medical practice, and
• physicians who work less than a 5/10 work schedule.

Military Leave of Absence
If you are on a Military Leave of Absence, contributions to the Plan stop for as long as the leave continues. However, federal law provides rights to certain re-employed veterans for service credit and make-up contributions for all or a portion of your military service. Contact the Plan Administrator if you have any questions about how a Military Leave impacts your Keogh contributions and rights under the Keogh Plan.

Extended Educational and Extended Medical Service Leases
If you are on paid leave for full-time education purposes qualifying as an Extended Educational Leave under the terms of the Partnership Agreement and its rules and regulations, the period of your leave is counted as Qualifying Service. One half (50%) of the period during which you are on a paid leave for full-time, formalized, and established medical service programs qualifying as an extended medical service leave under the terms of the Partnership Agreement and its rules and regulations will be counted.
as Qualifying Service.

Contributions to the Plan will continue during your Extended Educational or Extended Medical Service Leave as long as you are receiving Partnership Income.

General Information

General information or questions regarding Keogh Plan operations or charges may be addressed to PHR Shared Services, 393 E. Walnut Street, 3rd Floor, Pasadena, CA 91188-8018, telephone number 1-877-608-0044. You may also contact Schwab directly for information.

The Recordkeeper for the Keogh Plan is Schwab Retirement Plan Services Company, Participant Services, P.O. Box 202710, Austin, TX 78720-2710, telephone number 1-888-256-8830, website www.401kaccess.com/scpmg.

The Trustee for the Plan is Charles Schwab Trust Company, 211 Main Street, 14th Floor, San Francisco, CA 94105.

PHYSICIANS’ TAX SAVINGS RETIREMENT PLAN (TSR)

The Southern California Permanente Medical Group Physicians’ Tax Savings Retirement Plan (TSR) is designed to provide all Partner and Associate Physicians (as well as former Partners in a Per Diem status) with a means to accumulate retirement funds on a tax-deferred basis through deferrals of compensation. This plan is a qualified defined contribution plan under Internal Revenue Code Sections 401(a) and 401(k). Contributions are also referred to as “401(k) deferrals.”

The following information is a summary of TSR Plan provisions. For additional information refer to the Southern California Permanente Medical Group Retirement Plan Summary Plan Description.

Eligibility

You are eligible to participate in the TSR Plan once you have completed six months of eligible service. Former Partners continuing to work as a Partner Emeritus or Per Diem are eligible to participant in this Plan. Regular Per Diem physicians are not eligible to participate in this Plan.

Physicians employed on a Per Diem basis include those who work for hourly pay and are not eligible for SCPMG benefits.

Enrollment

To participate, you must enroll online with Participant Services at 1-888-256-8830 or go online to www.401kaccess.com/scpmg. You may indicate the percentage of your pay that you want deducted as a salary
deferral contribution each payroll period to be contributed to the Plan on your behalf. You may enroll at any time after your first six months of employment with SCPMG. Charles Schwab Retirement Plan Services Company will provide a Welcome Packet by mail that will detail everything required.

**Your Contributions**

You may contribute a maximum of 1% – 75% (whole percentages only) of your compensation per pay period.

The compensation on which your contribution is based depends on your status:

- If you are a Partner who has elected to participate in the Keogh Plan, compensation is your Partnership Income reduced by the amount of your Keogh Plan contributions. Your compensation for purposes of this Plan excludes your “at risk” compensation, payments attributable to a prior year, bonuses, and special allowances.

- If you are an Associate Physician, compensation is your cash compensation reported on your Form W-2 plus amounts deferred under the TSR Plan. Compensation does not include bonuses or special allowances.

You may change your rate of contribution at any time. Your election to change or suspend contributions will be effective as of the pay period following the processing of your request via the Recordkeeper, Schwab Retirement Plan Services Company. See the Administration section for information about how to contact the Recordkeeper.

Due to laws regarding partnership tax accounting, contributions will not be taken from Year-End Performance Draw.

**Note:** Lump sum contributions to this Plan are not permitted. Contributions are based solely on payroll deductions from eligible compensation made during the calendar year.

**Federal Limits on Contributions**

The maximum amount you can contribute to the Plan changes from year to year based on changes in the cost-of-living index. In the year 2014, the maximum amount you can contribute is $17,500.

The $17,500 limit applies to pre-tax contributions to this and any other 401(k) plan.

**Catch-Up Contributions**

If you are age 50 or older, or if you will reach age 50 before the end of the year, you are eligible to make additional catch-up contributions to the Plan. You may contribute an additional $5,500 during 2014 if you are eligible to
make catch-up contributions. This limit is subject to change periodically.

Catch-up contributions are made through automatic payroll deductions just like your other TSR Plan contributions. This process is automatic. You will not need to make a separate enrollment election. Your contributions will simply continue once you hit the $17,500 limit, at the same contribution percentage rate you elected until you reach the combined limit of $23,000 ($17,500 + $5,500 for 2014) or until you elect to stop them. If you elect not to participate in the “catch-up” contributions, you need to go online to Schwab Retirement Plan Services Company at www.401kaccess.com/scpmg and change your election to “0” or opt out.

**Discrimination Test**

The amount you may contribute to the TSR Plan is subject to a federally required discrimination test that applies to this type of plan. The test compares the 401(k) deferrals of the “highly compensated” to the 401(k) deferrals of the “non-highly compensated” participants in all of the 401(k) plans sponsored by SCPMG and may require a reduction in the 401(k) deferral percentages for the “highly compensated” participants. Because of this test, the Plan Administrator may inform you that your contribution percentage must be reduced, or that contributions may need to be refunded for a particular plan year.

**Coordination With the Partners’ Keogh Plan**

Federal law limits the amount of contributions to all defined contribution plans to the lesser of 100% of compensation or $52,000 ($57,500 for physicians over age 50). This limit applies to the combination of the contributions you make to the Keogh and TSR Plans.

Contributions to the TSR and Keogh Plans will be stopped if your combined contributions reach $52,000 ($57,500 for physicians over age 50), even if you have not reached the individual plan maximums.

**Investment Funds**

There are several investment funds available with varying degrees of risk. These funds are chosen by the Retirement Committee and approved by the Board of Directors and may change from time to time. You may:

- invest in one fund,
- allocate new contributions to various funds, or
- transfer assets among funds.

The investment funds currently available under the Plan can be found on Charles Schwab’s website at www.401kaccess.com/scpmg.
**Investment of Contributions**

You are responsible for directing how your contributions are invested among the investment funds offered under the Plan. Your fund elections will remain in effect until you make a change with the Recordkeeper, Schwab Retirement Plan Services Company. (See the Administration section for information about how to contact the Recordkeeper.) This change will become effective immediately.

*If you do not provide Schwab Retirement Plan Services Company with your investment elections, all of your contributions will automatically be deposited to the age-appropriate Vanguard Target Retirement Trust as determined by your assumed retirement at age 65.*

**Transfers**

Transfers among funds are permitted on a daily basis. This includes money invested by default into the age-appropriate Vanguard Target Retirement Trust as determined by your assumed retirement at age 65. Your transfer request must be made through the Recordkeeper, Schwab Retirement Plan Services Company. (See the Administration section for information about how to contact the Recordkeeper.) Transactions processed after 11:00 a.m. Pacific Time will become effective the next business day.

You may transfer any whole percentage of your fund balances among the various investment funds.

**Published Investment Results**

Monthly Investment returns for the core funds are updated by the Retirement Committee Investment Advisors.

Prospectuses and fund fact sheets are provided automatically upon eligibility and included in the enrollment packet. If you would like a prospectus or a summary annual report on any of the investment funds, contact the Recordkeeper, Schwab Retirement Plan Services Company at 1-888-256-8830 or via the website at [www.401kaccess.com/scpmg](http://www.401kaccess.com/scpmg).

**Loan Program**

You may borrow from your TSR Plan. There is a limit of three loans that you may have outstanding from your TSR at one time. Plan loans are subject to the following limits:

- each loan taken from the Plan must be at least $1,000, and
- the maximum loan available under the Plan is equal to the lesser of:
  - 50% of your TSR account balance minus any current outstanding loans, or
  - $50,000 minus the highest outstanding loan balance during the prior 12-month period.
The interest rate for all loans is the prime rate +1% as published in the money rates tables of the west coast edition of *The Wall Street Journal* for the 15th business day of the third month of the calendar quarter preceding the quarter during which the loan is made. The rate is valid for six weeks from the date the loan application is mailed to the participant.

**Repayment of Loans**

All loans are repaid by bi-weekly payroll deductions. For personal loans, repayment cannot exceed five years. For loans to purchase your primary residence, repayment cannot exceed 15 years.

You may continue to repay a loan on a direct-billed basis after you leave SCPMG (either due to retirement or termination) as long as you defer receipt of your TSR balance. Inactive participants must continue to make timely loan payments directly to Schwab Retirement Plan Services Company. Once you leave SCPMG, the outstanding balance of your loan(s) may not exceed 50% of your Plan account balance; your loan will be considered in default in the event the outstanding loan balance exceeds the 50% limit.

Loans may be repaid in full at any time. Please contact Schwab Retirement Plan Services Company, Participant Services at 1-888-256-8830 to find out your payoff amount.

If you choose to receive a lump sum payment before your loan is fully repaid, you will be required to repay the outstanding balance of your loan in full before the lump sum is paid. If you do not repay the loan before the lump sum payment is made, the payment you will receive will equal your TSR Plan balance minus the amount of your outstanding loan(s).

**In-Service Withdrawals**

You are generally not allowed to withdraw amounts from your TSR Plan until you stop working with SCPMG. Withdrawals are allowed while you are actively working, however, in two limited circumstances: (i) after you have attained age 59½ and (ii) if you have a financial hardship that satisfies the specific requirements outlined below. Rollover contributions may not be withdrawn for any reason while you are working with SCPMG.

If you are married, you must obtain the notarized consent of your spouse before your withdrawal request can be considered.

Withdrawals are taxed as ordinary income in the year they are received. Withdrawals due to financial hardship (prior to age 59½) may be subject to an additional 10% federal excise tax. A California state excise tax of 2.5% may also be due on the withdrawn amount.
Age 59½ Withdrawals

You are allowed to withdraw contributions and earnings any time after you attain age 59½. You may take a maximum of four withdrawals (while employed by SCPMG) once you are age 59½ or older. Withdrawals are not permitted before age 59½ except in the case of financial hardship, as described below.

Hardship Withdrawals

Amounts available to be loaned from this Plan and any other plans sponsored by SCPMG or any of its related organizations must be exhausted before a hardship withdrawal can be made.

A hardship distribution is allowed only if you certify that you have incurred an immediate and heavy financial need as defined by the IRS and the distribution is necessary to satisfy that need. Any money rolled over from another employer’s plan or a conduit IRA is not eligible for a hardship withdrawal.

You will only qualify for a financial hardship withdrawal if the financial need requires payment of the requested amount within 90 days or less. In addition, the requested amount must be at least $1,000.

You must certify that the hardship distribution is necessary because the financial need cannot be relieved through other resources. In making this certification, you are required to take into account any resources, including assets of your spouse and minor children that are reasonably available to you. Thus, for example, a vacation home owned by you and your spouse, whether as a community property, joint tenants, tenants by the entirety, or tenants-in-common, will be deemed an available resource. However, property held for your child under an irrevocable trust (or under the Uniform Gifts to Minors Act, for example), will not be treated as an available resource. Additionally, all resources available though the TSR loan process must be requested before a hardship withdrawal can be requested.

A distribution will be treated as necessary to satisfy an immediate and heavy financial need if, and only if, the distribution is not in excess of the amount required to relieve the financial need, including taxes or penalties reasonably anticipated to result from the distribution.

If you receive a financial hardship withdrawal from the TSR Plan, your contributions to the Plan will be suspended for a period of six months following the date of the withdrawal.

See the Summary Plan Description (SPD) for more detailed information on the Physicians Portal and on the Schwab website at www.401kaccess.com/scpmg.

To take any of the above withdrawals, contact Schwab Retirement Plan Services Company, Participant Services, P.O. Box 202710, Austin, TX 78720-2710, or call 1-888-256-8830.

Effective March 1, 2014
When You Can Receive Benefits
The net value of your account will be paid according to the benefit option you select (see How Benefits Are Paid below for a description of the options available under the Plan). The benefits can be paid upon:

- retirement,
- termination of employment with SCPMG — with no intent to return to the medical group,
- total and permanent disability, or
- death.

Total and permanent disability is defined as “the total and permanent incapacity of a participant to render substantial services to the partnership by reason of mental or physical disability.” Your attending physician and the individual or group of individuals who approved your original grant of Chronic Sick Leave must certify in writing that you are so disabled. Disability distributions are not subject to the 10% federal excise tax nor the 2.5% California state excise tax that generally applies to all distributions prior to age 59½.

How Benefits Are Paid
The following forms of benefit payment are generally available:

- **Lump sum**
  - you receive your account balance in one single cash payment or a rollover of funds to another qualified retirement plan or IRA.

- **Single life annuity**
  - your account balance is used to purchase a single premium annuity contract.
  - monthly payments continue to you for your lifetime.
  - all payments cease at your death.

- **Joint and survivor annuity**
  - your account balance is used to purchase a single premium annuity contract.
  - you receive reduced monthly payments while both you and your joint annuitant are living (these payments will be smaller than the monthly payments under the single life annuity).
  - in addition, the survivor (either you or your joint annuitant) receives monthly payments equal to 50%, 66⅔%, 75%, or 100% of the amount that was paid while you were both living. Payments continue for the survivor’s lifetime.
  - the higher the percentage you elect to continue to the survivor, the lower the payments will be while you are both living.

Your December 31, 1993 account balance remains eligible for the
distribution in the forms available under the rules in effect prior to 1994. Therefore, the following additional forms of benefit payment are available for that portion of a distribution which is equal to (or does not exceed) your December 31, 1993 TSR account balance:

- **Monthly, quarterly, or annual installments**
  - you may elect to receive that portion of your TSR account balance which is equal to your December 31, 1993 account balance in equal monthly, quarterly or annual installments over a specified period of years, but not to exceed your life expectancy (or, if married, the joint life expectancies of you and your spouse).

- **Contingent annuity**
  - that portion of your TSR account balance which is equal to your December 31, 1993 account balance is used to purchase a single premium annuity contract.
  - you receive reduced monthly payments for the remainder of your life.
  - upon your death, your contingent annuitant, if still living, receives 50%, 66 ⅔%, 75% or 100% of such reduced monthly payments for the remainder of his or her life.
  - if your contingent annuitant predeceases you, you continue to receive 100% of your reduced monthly payments for your lifetime; payments would stop upon your death.

- **Combination**
  - that portion of your TSR account balance which is equal to your December 31, 1993 account balance is paid out partly as a cash payment and partly as an annuity.

The normal form of distribution under the TSR generally is a lump sum. However, special qualified joint and survivor annuity (QJSA) and qualified pre-retirement survivor annuity (QPSA) rules apply to your account if you have at any time elected an annuity form of payment under the TSR Plan. You will be given more information about the QJSA/QPSA requirements if these special rules apply to you.

### When Payments Begin

Assuming you are eligible for a distribution, payments will begin as soon as possible after you request distribution. You may defer receiving your distribution until as late as April 1 following the year in which you reach age 70½ or, if later, stop working with SCPMG.

If you fail to request a distribution after receiving notice that you are eligible to receive payments once you no longer work with SCPMG, you will be deemed to have elected to defer distribution until April 1 following the year you reach age 70½, but you can receive distribution at any time before then if you later submit a request.
Note: If you are still working for SCPMG on April 1 following the year in which you reach age 70½, you will not receive distributions until April 1 following the year you terminate employment.

All options are revocable until payment begins or an annuity contract is purchased for you. Monthly, quarterly, or annual installments (if applicable) are also revocable during the payment period if you request that all remaining installments be paid in a single payment at any time thereafter. All other options are irrevocable once a payment is made.

Under any deferred option, your account balance will remain in the TSR investment fund(s) of your choice.

Payment at Your Death

If you die before payment under the TSR Plan begins and your beneficiary is your spouse, your spouse may select any of the previously described forms of payment. If your beneficiary is not your spouse, your beneficiary will receive payment in a lump sum.

All distributions to beneficiaries are subject to the following additional restrictions:

- if your beneficiary is not your spouse, payments must begin by December 31 following the year of your death.
- if your beneficiary is your spouse, your account may be paid out over his or her life expectancy beginning no later than December 31 of the calendar year following the calendar year in which your death occurs or December 31 of the calendar year you would have attained age 70½, if later.

If you die after payment under the TSR Plan has begun, and you have elected an annuity form of distribution, the terms of the annuity will govern. If you have elected installment payments, your beneficiary(ies) may elect continuation of installments or payment in a lump sum.

If you are married, you should be aware that federal law requires your spouse to be the beneficiary in the event of your death, unless your spouse consents in writing to your election of another beneficiary. The consent must be witnessed by either a Notary Public or a Plan Representative.

Divorce

Because the TSR Plan is a federally qualified plan under ERISA, it requires the joinder process established under the California Civil Code as well as a Qualified Domestic Relations Order (QDRO, stipulated by the Retirement Equity Act) before benefits can be made to an alternate payee. Model QDROs are available from Schwab Retirement Plan Services Company.

The Plan will comply with a QDRO (as stipulated by the Retirement Equity Act) providing child support, alimony, or marital property rights to spouses,

Effective March 1, 2014
former spouses or other payees. In the event of a QDRO, a former spouse or other dependent could receive a portion of your benefits, even if you continue working. The order must specify:

- the names and addresses of the Plan participant and each payee, and
- the amount or percentage of the participant’s benefit to be paid (or how the amount is to be determined).

The order cannot:

- provide benefits to be paid in any form or amount inconsistent with Plan provisions, or
- be inconsistent with any other existing order.

Should the Plan receive a QDRO that affects your benefits, Schwab Retirement Plan Services Company will notify you. A copy of the procedures and QDRO model is available from Schwab Retirement Plan Services Company. There are additional fees associated to the QDRO. Please refer to the Schwab Retirement Plan Services Company website at www.401kaccess.com/scpmg.

**Taxes and Rollover or Transfer of Benefits**

How your benefits are taxed when they are distributed depends on a number of factors, including the tax laws in effect at the time of the distribution, your age, and the circumstances under which they are paid. You should seek professional tax advice when you are deciding when and how you will receive your benefits.

In general, the funds in your accounts will usually be taxable as income when they are paid. They may be subject to ordinary income tax, or you or your beneficiary may be eligible for certain special tax treatment, such as income averaging. If you elect to receive the funds in your accounts in a lump sum and subsequently roll over such amounts, or you elect to directly roll over your lump sum to an individual retirement account or to another qualified plan, you may further defer the taxation of these funds. If you elect to have your distribution paid directly to you and subsequently roll it over, the amount distributed to you will be subject to mandatory federal tax withholding of 20%. Federal taxes will not be withheld if you elect that such amounts be paid directly to an individual retirement account (IRA) or to another employer’s qualified plan as part of a “direct rollover.”

In certain circumstances, distributions before age 59½ may be subject to a 10% federal excise tax and a 2.5% California state excise tax. There are some exceptions. For instance, under present law, this tax will not be imposed if the distribution is due to death or total disability or is made on account of termination of employment at or after age 55. You should consult a tax adviser concerning the applicability of this tax to any distribution you may elect to receive prior to age 59½.

There are many requirements and restrictions concerning rollovers that
are not discussed here. You should consult a tax adviser before electing a payment option.

**Transfers From Other Plans**

You may elect to transfer your benefit under the qualified plan of another employer directly to this Plan, subject to the conditions imposed on transfers by the IRS. In addition, if you have received a distribution from another qualified plan which qualifies as a lump sum distribution, you may elect to roll the distribution over to this Plan, subject to the rules imposed by the IRS.

**See Your Tax Consultant**

The proper selection of your payment option can offer both legal and tax advantages. See your legal and/or tax consultant for advice.

**Reports and Statements**

Each quarter you will receive a quarterly account statement from Schwab by the 15th business day of the month following quarter-end. By default, you will receive your statement in the mail, but you may opt to receive an electronic statement at any time.

The quarterly statement of your account will provide you the details of the contributions made, as well as investment gains or losses and any fees associated with this Plan.

**No Assignment**

Because the Plan is a tax-qualified retirement plan, assignment of benefits is not permitted except in the case of a Qualified Domestic Relations Order (generally involving divorce; see the section titled Divorce) or in the case of an IRS tax lien.

**Effects on Other Benefits and Social Security**

Participation in this Plan will not reduce your:

- benefits or compensation increases — they will be based on your full compensation and not the reduced amount, or
- Social Security (FICA) or self-employment taxes or benefits, if applicable (would apply only to Associates, not Partners).

**Limitation of Rights**

Except as may be required by law, neither SCPMG nor the Trustee has any liability for payment of benefits beyond the assets of the Plan.
**Top-Heavy Rules**

There are certain provisions that become effective if the Plan becomes “top-heavy” as defined by federal tax laws. A plan is considered top-heavy if benefit values for certain key associates exceed 60% of the value of all benefits for all plan participants. You will be notified in the event that occurs and if you are affected.

**Vesting**

Your contributions are always immediately 100% vested.

**Military Leave of Absence**

If you are on a Military Leave of Absence, contributions to the Plan stop for as long as the leave continues. However, federal law provides rights to certain re-employed veterans for service credit and make-up contributions for all or a portion of your military service. Special rules also apply if you have a plan loan that is outstanding during your Military Leave of Absence. Please contact the Plan Administrator if you have any questions about how a Military Leave impacts your contributions and rights under the TSR Plan.

**Extended Educational and Extended Medical Service Leaves**

If you are on paid leave for full-time education purposes qualifying as an Extended Educational Leave under the terms of the Partnership Agreement and its rules and regulations, contributions will continue during your leave as long as you are receiving Partnership Income. Contributions will also continue for any period during which you are on a paid leave for full-time, formalized, and established medical service programs qualifying as an extended Medical Service Leave under the terms of the Partnership Agreement and its rules and regulations.

**Cost**

You bear the costs of maintaining your TSR Plan account. These costs include recordkeeping fees, trustee fees, loan fees and disbursement fees as shown below. These fees are described in the TSR Plan Fee Schedule, which you can obtain from Schwab Retirement Plan Services Company.

*Note:* All fees are prorated monthly and deducted from your account or payroll.

**General Information**

General information or questions regarding TSR Plan operations or charges may be addressed to the Schwab Retirement Plan Services Company, Participant Services, P.O. Box 202710, Austin, TX 78720-2710, telephone Effective March 1, 2014
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number 1-888-256-8830, website www.401kaccess.com/scpmg.
The Recordkeeper for the TSR Plan is Schwab Retirement Plan Services
Company.
The Trustee for the Plan is Charles Schwab Trust Company, 211 Main Street,
14th floor, San Francisco, CA 94105, telephone number 1-512-344-3000.

EARLY SEPARATION PROGRAM

The Early Separation Program (formerly known as the Full Early Retirement
Plan) is designed to allow Partner Physicians between the ages of 58 and 65
an opportunity for early retirement. This program is separate and distinct
from the Common Plan. The Early Separation Program is sponsored by
SCPMG.
The rules of the Early Separation Program can be found in the Early
Separation Program Summary Plan Explanation by referring to the SCPMG
You should note that the information provided below is simply a summary
of the official Plan document for each Plan and to the extent of
inconsistencies between the summary and the Plan document, the
provisions of the Plan document will govern.

Eligibility

Any Partner is eligible who:

- is between the ages of 58 and 65,
- has 10 years of qualifying service with SCPMG, working at least a 5/10
  schedule,
- has obtained advance approval of the SCPMG Board of Directors,
- has retired from the partnership (Per Diem work is sometimes permitted),
  and
- has signed a SCPMG release
- is not receiving group disability insurance

Application and Approval Required

All applications for Early Separation must:

- be in writing,
- be filed at least one year in advance of the requested retirement
date, and
- be reviewed and approved by the SCPMG Board of Directors.
The Board of Directors may:
- grant the request,
• waive all or part of the one year notification requirement, or
• delay the retirement for up to one additional year.

Once the application is submitted, it is irrevocable.

Once the application is approved, you may not rescind or change the date of your retirement (which is also your withdrawal date from the partnership) except upon written application to and approval by, the Board of Directors prior to the effective date of your retirement.

**Benefit Amount**

The amount is based on your years of credited service with SCPMG and your highest average compensation that is equal to the total of (i) 2% of your highest average compensation, multiplied by (ii) SCPMG credited service up to 20 years, plus (iii) 1% of your highest average compensation, multiplied by (iv) SCPMG credited service in excess of 20 years.

The benefit is paid monthly beginning within two months from your retirement date at the end of every month (after age 58) and continues until the end of the month in which you reach age 65 or die, whichever occurs first. If you work until the end of the month and retire, your first Early Separation Retirement benefit will be paid by the last day of the following month.

Early Separation Program benefits are paid immediately after you separate from service and cannot be deferred until a later date. Assuming you have met distribution requirements, Common Plan benefits may be deferred or they may be received concurrently with Early Separation benefits. However, notification of your impending retirement to SCPMG for Early Separation Program benefits is not notification to Health Plan for Common Plan purposes.

The Early Separation Program has no death benefit. Payments under the Early Separation Program end at the earlier of: the end of month in which you either attain age 65, or your date of death.

**Early Separation and Sick Leave**

In the event of illness or injury beginning prior to the start of Early Separation, any available Sick Leave may be used and Early Separation delayed. Group disability insurance benefits and Early Separation payments cannot be received concurrently.

**Benefits From Current Operating Funds**

All Early Separation Program benefits are paid from current SCPMG operating funds.
Benefit Upon Re-Employment

If you retire and continue to work for SCPMG at 45% or less of your final average hours (FAH), if approved, then you will receive the Early Separation Part II benefit following retirement from SCPMG. If you retire and continue to work for SCPMG Partnership between the ages of 58 and 65 and work at 50% or more of your FAH, then you will generally receive the Early Separation program benefit after you stop working for SCPMG or when you permanently reduce your hours to 45% or less of FAH.

The rate of pay upon rehire will be the then current starting Per Diem rate of your specialty. You will be eligible for increases made to the starting Per Diem rate, but you are not eligible for any other increases in compensation.

Contact PHR Shared Services at 1-877-608-0044 for this information.

Program May Be Amended or Terminated

The SCPMG Board of Directors may amend or terminate the program at any time.

No amendment may reduce the benefits being paid to a retiree except:

- in case of extreme financial circumstances, or
- the termination of benefits in the event of dissolution of the partnership.

Other Early Separation Program Benefits

Medical Group pays for the following benefits for Early Separation retirees:

- Kaiser Foundation Health Plan coverage (Senior Advantage at age 65) for the retired Partner and eligible dependents (Comprehensive Health Coverage may be elected).

- Supplemental Medical coverage for the retired Partner and dependents, if eligible. (See the Leaving SCPMG section of this handbook.)

- Optional Life Insurance to age 65 when Tapered Life begins, if eligible. Special provisions implemented in 1990 define the length of time Optional Life premiums will continue to be paid by SCPMG:
  - If you had 10 years of Optional Life Insurance participation by December 31, 1990, premiums for Optional Life will be paid by SCPMG until age 65 when tapering begins.
  - If you have less than 10 years of Optional Life Insurance participation by the time you take early Separation, premiums for Optional Life will be paid by SCPMG until you attain 10 years of Optional Life participation; tapering will begin at that time.
  - If you have 10 years of participation in the Optional Life Insurance by the time of your Early Separation (but not by December 31, 1990), tapering will begin upon Early Separation.

- Retiree Life Insurance: you will be provided with $50,000 of Retiree Life Insurance.
Insurance effective the first of the month after your Early Separation date if:
- you were not enrolled in the Optional Life Insurance program prior to 1/1/91, and
- you meet the eligibility requirements (See the Leaving SCPMG section of this handbook).

Cost
Benefits are taxable as ordinary income and self employment tax income and you will receive the appropriate tax form after the end of the year. If you reside outside of the state of California, you may be subject to California withholding. Please consult your tax adviser.

PARTNER EMERITUS CATEGORY (Impact to Benefits)
The Partner Emeritus category will pay a premium to high caliber Early Separation or Age 65 retiring partners who wish to continue to provide medical care, leadership, teaching, and research for SCPMG.

Former Partners will be classified as Partner Emeriti if they work for SCPMG after the following:
- retiring under the Early Separation Program (ages 58 to 64),
- retiring from the partnership upon attaining age 65, or
- retiring from the partnership on December 31 of the year in which they attain age 65.

Eligibility
To be eligible for the Partner Emeritus category:
- a position must be available, as determined by the Chief of Service, as well as the Area Medical Director or Medical Director of Operations, Clinical Analysis or Business Management,
- physician must be an Age 65 Retiree or Early Separated,
- physician must be board certified, and
- physician must have no disciplinary or remedial actions or compensation reductions in the 24 months prior to retirement.

There is no guarantee that there will be a position available or that such position will be the same as the Partner Emeritus’s former position with SCPMG. The duty requirements and obligations of the position are to be defined by the Chief of Service and Area Medical Director based on operational needs that support the overall quality, service, and access strategies of SCPMG.

Retiring Partners who wish to continue to provide medical care, leadership, teaching, and research for SCPMG should begin conversations regarding
the availability of a Partner Emeritus position with their Chief of Service and Area Medical Director as soon as possible.

**Health Care and Life Insurance**

Physicians who retire with at least 10 years of SCPMG service, or qualify for the Early Separation Program, will receive Retiree Health and Life Insurance benefits. There is no change to these benefits if a physician works in a Partner Emeritus status post-retirement.

**Impact to Keogh Plan**

If a Partner Emeritus previously participated in the Keogh Plan, contributions are required to continue unless a break in service of 180 days or greater occurs. The Partner Emeritus will continue to make contributions at the same level that they were contributing before retirement (25%, 50%, 70%, or 100%). When making Keogh contributions, a Partner Emeritus cannot make lump sum contributions. Instead, the physician must contribute to the Keogh Plan through bi-weekly payroll deductions.

Partner Emeriti are not permitted to make Keogh contributions post-retirement if they:

- retired prior to December 31, 2012,
- retire on or after January 1, 2013, but did not previously contribute to Keogh, or
- retire on or after January 1, 2013 but experience a break in service of 180 days or more.

Permanente Human Resources will monitor any breaks in service and will notify the physician by mail once a break in service reaches approximately 120 days (4 months). Keogh contributions will cease the pay period following the 180th day of the break in service. Once Keogh contributions have been discontinued, they cannot be resumed for any reason.

Keogh distribution options are not impacted by the new Partner Emeritus classification. A physician may access their entire 1993 and prior balance once retired from the partnership. Once retired from the partnership, Partner Emeriti who retired upon attaining age 65 or at the end of the year in which they attained age 65, are eligible for a one-time “In-service” distribution from any post-1993 balance. A physician retains full access to their Keogh account once completely separated from SCPMG and the age and service requirements are met.

**Impact to Physicians’ Tax Savings Retirement (TSR) Plan**

Contributions and percentage changes are still permitted for accounts in the TSR Plan while in Partner Emeritus status. Distribution options are not impacted; a physician may access their entire account balance at age 59.
The physician retains full access to their TSR account once completely separated from SCPMG.

**Impact to Common Plan**

Following retirement, a Partner Emeritus may work any amount of hours and collect their Common Plan Part I benefit. However, in order to collect a Common Plan Part II benefit, physicians must consider the following:

- A physician who retires between age 58 and before the end of the year in which they attain age 65
  - If the physician continues to work after retirement, they must work at a level of less than 45% of Final Average Hours (FAH) in order to collect a vested Common Plan Part II benefit. If the physician works a schedule of 50% or more of FAH, Common Plan Part II benefits are not generally payable until the physician reduces their hours worked to 45% or less of FAH, or until another payment event is incurred.

- A physician who continues to work until the end of the year in which they attain age 65
  - Upon retirement, the physician will generally have the Common Plan Part II benefit begin the month following retirement (January 31 of the following year). If there are no deferral elections in place for either Separation from Service or Fixed Payment Date, the physician can generally work on an unrestricted basis.

If a physician has made a deferral election for their Common Plan Part II benefit, please contact the Kaiser Permanente Retirement Center at 1-800-721-3647 to determine the impact working after retirement may have on the payment of benefits. For planning purposes, this inquiry should be done no less than 14 months in advance of retirement. This will allow each physician to have information on the maximum amount of hours that they may be able to work following retirement, which can be used in discussions with the Chief and Area Medical Director on the availability of a Partner Emeritus position.

**Impact to Early Separation Retirees**

A physician may collect Early Separation Program benefits as early as age 58, if approved by the Board of Directors. However, a physician collecting ESP benefits may only work up to 45% of their Final Average Hours (FAH) worked in the 36 months immediately prior to retirement.

A physician working as a Partner Emeritus will be asked to sign a contract in which they agree to work up to a maximum of 45% FAH. If this percentage is exceeded, the physician will not be eligible to receive ESP benefits. The physician will also likely be required to pay severe taxes and penalties, and will forfeit any future ESP benefits while working over the allowable 45% FAH. Ultimately, it is the physician’s responsibility to monitor the number of hours worked.
SECTION: VII

LEAVING SCPMG
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LEAVING SCPMG

This section summarizes your benefits when you leave SCPMG due to retirement, termination, disability, or death. For detailed information about retiree benefits please see the *Retiree Benefits Handbook*.

Health Care Benefits

**Eligibility**

To be eligible for health care benefits in retirement, a physician must:

- attain age 55 with 15 or more years of Common Plan Qualifying Service (CPQS), or
- attain age 65 with at least 10 years of CPQS, or
- have age plus year of CPQS equal 75 (with 10 years or more of Qualifying Service), or
- be approved for Early Separation.

All Early Separation Program participants and Early Retirees are eligible for Health Plan benefits. However, Early Separation Program participants and Early Retirees are eligible for Supplemental Medical benefits only if they meet one of the age and years of service requirements indicated above. For example, an Early Separation Program participant age 58 with 10 years of CPQS would be eligible for Health Plan benefits, but not for Supplemental Medical.

Health care and Supplemental Medical may be continued or the retired physician will be enrolled in the Comprehensive Medical Plan if living outside the Kaiser service area. All eligible dependents must be enrolled in the same program as the physician.

A physician who leaves SCPMG due to disability with at least five years of Common Plan Qualifying Service, but not enough service for retiree benefits, will have Health Plan coverage continued for himself/herself and eligible dependents at Medical Group expense. Supplemental Medical coverage will cease.

For more detailed information refer to the *Retiree Benefits Handbook*.

**Comprehensive Medical Plan**

Retirees living out of the Kaiser Permanente service area may be eligible for this benefit. It is not a substitute for KFHP for active physicians. For more detailed information refer to the *Retiree Benefits Handbook*.

**Retiree Age 65 and Older**

If you stop working on or after your 65th birthday, you are required to apply for Medicare A and B and enroll in Senior Advantage.

Your spouse should enroll in Medicare when he or she reaches age 65.

*Effective March 1, 2014*
unless you are still working regardless of your age. When you stop practicing with SCPMG, you and your spouse would then both enroll in Medicare and Senior Advantage. Your Senior Advantage benefits are identical to your benefits under KFHP.

For more detailed information refer to the Retiree Benefits Handbook.

**Retire Due to Disability**

If you leave SCPMG due to disability with at least five years of Common Plan Qualifying Service, but not enough service for retiree benefits, you will have Kaiser Foundation Health Plan (KFHP) Coverage continued for yourself and your eligible dependents at SCPMG expense. Supplemental Medical Coverage will cease unless you meet the age and years of service requirement described above.

If you are eligible for Disability Retirement under the Common Plan, you, your spouse/domestic partner and any eligible dependents will retain Kaiser Foundation Health Plan (KFHP) Coverage as if you were an eligible retiree.

**Supplemental Medical Coverage**

If you met the age and years of service requirements described above, you will have Supplemental Medical coverage in retirement.

For additional information refer to the Retiree Benefits Handbook.

**Alternate Mental Health Coverage**

This benefit ends on the last day of the month you retire, terminate, or die. It is not available when you leave SCPMG and may not be converted to an individual policy.

**Dental Benefits**

This benefit ends on the last day of the month you retire, terminate, or die. The Delta Dental Plan does not offer dental coverage to individuals and cannot be converted to an individual policy. Conversion is available for DeltaCare USA and United Concordia dental coverage.

**COBRA and Cal-COBRA**

You and/or your dependents may be able to continue certain health care benefits described in this handbook when you leave SCPMG. Refer to the individual health care benefits descriptions in the Health Care Benefits or Administration sections of this handbook for more details regarding COBRA and Cal-COBRA coverage.
Life and Accident Insurance

Retiree Life Insurance
Retiree life benefits are provided when you leave SCPMG as an eligible retiree having met the above requirements for age and years of service. For additional information refer to the Retiree Benefits Handbook.

Conversion of Life Insurance
When you leave SCPMG, you will be offered the opportunity to convert your life insurance coverage amounts to individual policies (including your Permanente Provided Life, Optional Life, Spouse/Domestic Partner Life Insurance). You must apply for and pay the premium for your age and class of risk within 90 days after your termination date from SCPMG. Evidence of insurability will not be required. This may be advantageous if you have a medical condition that might preclude you from qualifying for an individual life insurance policy.

If you die during the 90-day conversion period, your beneficiary will receive the insurance amount, whether or not you applied for conversion coverage.

The conversion insurance may be a type of life insurance currently being offered for conversion by the insurance company at your age and in the amount requested. It may not be term insurance and it may not be for an amount greater than the life insurance benefits in force under the Policy. The conversion policy will not provide accident, disability or other benefits. You will receive a Notice of Conversion from PHR Shared Services when you lose any of your Permanente Provided or Optional Life Insurance. The types of policies available under conversion are determined by the insurance company and may change from time to time. Refer to Important Information About Your Life Insurance Coverage in the Life Insurance section for more details.

Portability of Life Insurance
Life Insurance Company of North America, a CIGNA company, will allow you to port some or all of your Permanente Provided Life, Optional Life, Disabled Physicians Life, or Spouse/Domestic Partner Life Insurance. You may either convert your insurance to a whole life policy (as mentioned above) or port it into a term life policy. The portability policy will be issued without proof of medical insurability. This may be advantageous if you have a health condition that could make it difficult to obtain individual coverage elsewhere, although the cost may be higher than a private policy obtained on your own.

The option to port all or a part of your life insurance extends to age 80 with a $500,000 insurance maximum above age 70.

A spouse/domestic partner will also have the opportunity to port some or all of Spouse/Domestic Partner Insurance in the event eligibility is lost.
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because the insured physician’s employment terminates or in the event
the spouse/domestic partner no longer qualifies as your spouse/domestic
partner due to legal separation, divorce, or the physician’s death. A spouse/
domestic partner who continues coverage through portability will be issued
a separate certificate of insurance by CIGNA.

Portability to Term Life Option

Contact PHR Shared Services at 1-877-608-0044 to request an Application
for Continuation of Term Life Insurance (Portability) and premium rate
sheet. Application must be made within 90 days from the date you lose
coverage. If you wish to exercise your portability option, request, complete,
and forward the application to: NEBCO, P.O. Box 152501, Irving, TX 75015.
If you have any questions, you may contact NEBCO at 1-800-423-1282.

Benefits When You Leave SCPMG

The following tables provide a basic summary of benefits that are available
to you when you leave SCPMG in a variety of circumstances, including
retirement, termination, disability, or death. While this section provides
information regarding benefits available when you retire, you should consult
the Retiree Benefits Handbook for more information on retirement benefits.

Retiree Benefits information is also available on the SCPMG Retiree Website
which can be accessed at http://scpmgretiree.kp.org.

Retirement from SCPMG may occur after you have turned at least
age 55 and have met the eligibility requirements for one of the
categories listed below:

<table>
<thead>
<tr>
<th>Retiree Benefit Class</th>
<th>Age at Retirement</th>
<th>Years of Qualifying Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal Retirement</td>
<td>Age 65 or older, or the end of the year in which</td>
<td>At least 10 years of Common Plan Qualifying Service</td>
</tr>
<tr>
<td>(Partner or Associate)</td>
<td>you turn age 65</td>
<td></td>
</tr>
<tr>
<td>Early Separation Program</td>
<td>Between age 58 and 65 with SCPMG Board of Director’s</td>
<td>10 years or more of SCPMG Qualifying Service</td>
</tr>
<tr>
<td>(Partner only)</td>
<td>approval</td>
<td></td>
</tr>
<tr>
<td>Early Retirement</td>
<td>At least age 55</td>
<td>15 years or more of Common Plan Qualifying Service</td>
</tr>
<tr>
<td>(Partner or Associate)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early Retirement</td>
<td>Age plus Years of Service equals at least 75</td>
<td>10 years of Common Plan Qualifying Service</td>
</tr>
<tr>
<td>(Partner or Associate)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you do not meet any of the above criteria, contact PHR Shared
Services at 1-877-608-0044 to determine if you are eligible for
retirement benefits.
NORMAL RETIREMENT

- Age 65 or Year-End Age 65
- Partner or Associate Physician

This chart is a summary of benefits available when you retire from SCPMG and are eligible for Normal Retirement. Details regarding each benefit may be found in this handbook and/or the Retiree Benefits Handbook.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Highlights</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser Foundation Health Plan (KFHP)</td>
<td>• Coverage continues for you up to age 65 or until you stop working</td>
</tr>
<tr>
<td>Required to enroll in Senior Advantage</td>
<td>• You are required to enroll in Senior Advantage when you turn age 65 AND stop working</td>
</tr>
<tr>
<td>at age 65 or when you stop working in a Partner or Associate Physician</td>
<td>• Your spouse/domestic partner continues KFHP coverage until age 65, then he/she must enroll in Senior Advantage</td>
</tr>
<tr>
<td></td>
<td>• Your eligible dependents continue coverage until age 26 unless disabled and approved by KFHP</td>
</tr>
<tr>
<td></td>
<td>• Your dependents are eligible for COBRA when coverage ends</td>
</tr>
<tr>
<td>Special Dependent Coverage (KFHP)</td>
<td>• Coverage may continue through direct billing when you retire</td>
</tr>
<tr>
<td></td>
<td>• You may add new, eligible Special Dependent(s)</td>
</tr>
<tr>
<td>Comprehensive Medical Coverage*</td>
<td>• You are required to elect this coverage if you reside outside of the KFHP service area</td>
</tr>
<tr>
<td></td>
<td>(California) and wish to have health coverage; otherwise you may waive coverage</td>
</tr>
<tr>
<td>Kaiser Permanente Multi-Site Plan (KPMP)*</td>
<td>• You are required to elect this coverage if you reside outside of California but within the</td>
</tr>
<tr>
<td></td>
<td>service area of other Kaiser Permanente participating providers; otherwise you may waive</td>
</tr>
<tr>
<td></td>
<td>coverage</td>
</tr>
<tr>
<td></td>
<td>• Dependent eligibility varies</td>
</tr>
<tr>
<td>Supplemental Medical Coverage Plan*</td>
<td>• Coverage continues for you and your spouse/domestic partner if you are enrolled in KFHP</td>
</tr>
<tr>
<td></td>
<td>or Senior Advantage</td>
</tr>
<tr>
<td></td>
<td>• Coverage continues for your eligible dependents until age 26</td>
</tr>
<tr>
<td></td>
<td>• Dependents eligible for COBRA when coverage ends</td>
</tr>
<tr>
<td>Medicare Part B Premium Reimbursement Program*</td>
<td>• You are eligible when you turn age 65 and are retired; your eligible spouse/domestic partner</td>
</tr>
<tr>
<td></td>
<td>who is age 65 or older is eligible for participation in the program</td>
</tr>
<tr>
<td></td>
<td>• You and your eligible spouse/domestic partner will be reimbursed when you enroll in Senior</td>
</tr>
<tr>
<td></td>
<td>Advantage AND assign your Medicare Part A and B to KFHP</td>
</tr>
<tr>
<td>Alternate Mental Health Coverage</td>
<td>• Coverage ends upon retirement</td>
</tr>
<tr>
<td></td>
<td>• You, your spouse/domestic partner, and eligible dependents are eligible for COBRA</td>
</tr>
<tr>
<td></td>
<td>coverage</td>
</tr>
<tr>
<td></td>
<td>• Mental health care is available through KFHP or Senior Advantage</td>
</tr>
<tr>
<td>Dental Coverage</td>
<td>• Coverage ends upon retirement</td>
</tr>
<tr>
<td></td>
<td>• You, your spouse/domestic partner, and eligible dependents are eligible for COBRA</td>
</tr>
<tr>
<td></td>
<td>coverage</td>
</tr>
<tr>
<td></td>
<td>• Dental coverage is available through Senior Advantage once you reach age 65</td>
</tr>
<tr>
<td>Short-Term Disability (Associate Physicians only)</td>
<td>• Coverage ends upon retirement</td>
</tr>
<tr>
<td>Compensation Continuance (Partner Physicians only)</td>
<td>• Coverage ends upon retirement</td>
</tr>
<tr>
<td>Long-Term Disability Insurance</td>
<td>• Coverage ends upon retirement</td>
</tr>
<tr>
<td>Optional Life Insurance</td>
<td>• Coverage ends upon retirement</td>
</tr>
<tr>
<td></td>
<td>• Conversion/portability available</td>
</tr>
<tr>
<td>Permanente Provided Life Insurance</td>
<td>• Conversion/portability available</td>
</tr>
</tbody>
</table>

(continued)

* To be eligible, you must be age 55 with 15 years of Qualifying Service, age 65 with 10 years of Qualifying Service; between age 58 and 65 with SCPMG Board of Director’s approval and 10 years of SCPMG Qualifying Service; or age plus years of Qualifying Service must equal at least 75 with 10 or more years of Qualifying Service.
### Benefit Highlights

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Highlights</th>
</tr>
</thead>
</table>
| **Disabled Physicians Life Insurance**       | • Coverage ends when no longer Totally Disabled or on the date you turn age 65  
                                           | • Conversion/portability available                                                                                                       |
| **Spouse/Domestic Partner Life Insurance**  | • Coverage ends upon retirement  
                                           | • Conversion/portability available                                                                                                       |
| **Tapered Life Insurance**                   | • Coverage may begin at age 65 if you are eligible, or when Optional Life is no longer maintained  
                                           | • You must have enrolled in Optional Life prior to 1/1/1991 and meet a combined age and service requirements  
                                           | • You may have Tapered Life OR Retiree Life, NOT both                                                                                   |
| **Retiree Life Insurance**                   | • Coverage of $50,000 begins when all above insurances end if you are not eligible for and/or enrolled in Tapered Life  
                                           | • You can have Tapered Life OR Retiree Life, NOT both                                                                                   |
| **Business Travel Accident Insurance**       | • Coverage ends upon requirement                                                                                                        |
| **Professional Liability Insurance**         | • Coverage ends upon retirement or when you cease to perform medical services for KFHP members, whichever is later                           |
| **Vacation Leave**                           | • Paid off for accrued balance                                                                                                          |
| **Educational Leave**                        | • Benefit ends upon retirement                                                                                                          |
| **Sick Leave**                               | • Benefit ends upon retirement                                                                                                          |
| **Flexible Spending Accounts**               | • Partner Physicians are not eligible  
                                           | • Associate Physician contributions cease upon retirement  
                                           | • In the year of retirement, an Associate Physician may request reimbursement for eligible expenses incurred  
                                           | • Claims for the retirement year must be filed by 3/31 of the following year                                                            |
| **Long-Term Care Insurance**                 | • If you are enrolled, the policy is portable; not provided by SCPMG  
                                           | • Payments are transferred to direct billing  
                                           | • If not enrolled, you may purchase coverage if you meet underwriting criteria                                                            |

*To be eligible, you must be age 55 with 15 years of Qualifying Service, age 65 with 10 years of Qualifying Service; between age 58 and 65 with SCPMG Board of Director’s approval and 10 years of SCPMG Qualifying Service; or age plus years of Qualifying Service must equal at least 75 with 10 or more years of Qualifying Service.*
### EARLY SEPARATION PROGRAM
- Only for Partner Physicians age 58 to age 64
- Associate Physician are NOT eligible

This chart is a summary of benefits available when you retire from SCPMG and are eligible for Early Separation. Details regarding each benefit may be found in this handbook and/or the *Retiree Benefits Handbook*.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Highlights</th>
</tr>
</thead>
</table>
| Kaiser Foundation Health Plan (KFHP)* Required to enroll in Senior Advantage at age 65 | • Your coverage continues until age 65  
• At age 65, you are required to enroll in Senior Advantage  
• Your spouse/domestic partner continues KFHP coverage until age 65, then he/she must enroll in Senior Advantage  
• Your eligible dependents continue coverage until age 26 unless disabled and approved by KFHP  
• Your dependents are eligible for COBRA when coverage ends |
| Special Dependent Coverage (KFHP) | • Coverage may continue through direct billing when you retire  
• You may add new, eligible Special Dependent(s) |
| Comprehensive Medical Coverage* | • You are required to elect this coverage if you reside outside of the KFHP service area (California) and wish to have health coverage; otherwise you may waive coverage |
| Kaiser Permanente Multi-Site Plan (KPMP)* | • You are required to elect this coverage if you reside outside of California but within the service area of other Kaiser Permanente participating providers; otherwise you may waive coverage  
• Dependent eligibility varies |
| Supplemental Medical Coverage Plan* | • Coverage continues for you and your spouse/domestic partner if enrolled in KFHP or Senior Advantage  
• Coverage continues for eligible dependents until age 26  
• Dependents eligible for COBRA when coverage ends |
| Medicare Part B Premium Reimbursement Program* | • You are eligible when you turn age 65 and are retired; your eligible spouse/domestic partner who is age 65 or older is eligible for participation in the program  
• You and your eligible spouse/domestic partner will be reimbursed when you enroll in Senior Advantage AND assign your Medicare Part A and B to KFHP |
| Alternate Mental Health Coverage | • Coverage ends upon retirement  
• You, your spouse/domestic partner, and eligible dependents are eligible for COBRA coverage  
• Mental health care is available through KFHP or Senior Advantage |
| Dental Coverage | • Coverage ends upon retirement  
• You, your spouse/domestic partner, and eligible dependents are eligible for COBRA coverage  
• Dental coverage is available through Senior Advantage once you reach age 65 |
| Long-Term Disability Insurance | • Coverage ends upon retirement |
| Optional Life Insurance | • Coverage ends upon retirement  
• Conversion/portability available |
| Permanente Provided Life Insurance | • Coverage ends upon retirement  
• Conversion/portability available |
| Spouse/Domestic Partner Life Insurance | • Coverage ends upon retirement  
• Conversion/portability available |

* To be eligible, you must be age 55 with 15 years of Qualifying Service, age 65 with 10 years of Qualifying Service; between age 58 and 65 with SCPMG Board of Director’s approval and 10 years of SCPMG Qualifying Service; or age plus years of Qualifying Service must equal at least 75 with 10 or more years of Qualifying Service.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Highlights</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tapered Life Insurance</strong>*</td>
<td>• Coverage can begin at age 65 if you are eligible, or when Optional Life is no longer maintained&lt;br&gt;• You must have enrolled in Optional Life prior to 1/1/1991 and meet a combined age and service requirements&lt;br&gt;• You can have Tapered Life OR Retiree Life, NOT both</td>
</tr>
<tr>
<td><strong>Retiree Life Insurance</strong>*</td>
<td>• Coverage of $50,000 begins when all above insurances end if you are not eligible for and/or enrolled in Tapered Life&lt;br&gt;• You can have Tapered Life OR Retiree Life, NOT both</td>
</tr>
<tr>
<td><strong>Business Travel Accident Insurance</strong></td>
<td>• Coverage ends upon requirement</td>
</tr>
<tr>
<td><strong>Professional Liability Insurance</strong></td>
<td>• Coverage ends upon retirement or when you cease to perform medical services for KFHP members, whichever is later</td>
</tr>
<tr>
<td><strong>Vacation Leave</strong></td>
<td>• Benefit ends upon retirement</td>
</tr>
<tr>
<td><strong>Educational Leave</strong></td>
<td>• Benefit ends upon retirement</td>
</tr>
<tr>
<td><strong>Sick Leave</strong></td>
<td>• Paid off for accrued balance</td>
</tr>
<tr>
<td><strong>Long-Term Care Insurance</strong></td>
<td>• If you are enrolled, the policy is portable; not provided by SCPMG&lt;br&gt;• Payments are transferred to direct billing&lt;br&gt;• If not enrolled, you may purchase coverage if you meet underwriting criteria</td>
</tr>
</tbody>
</table>

* To be eligible, you must be age 55 with 15 years of Qualifying Service, age 65 with 10 years of Qualifying Service; between age 58 and 65 with SCPMG Board of Director’s approval and 10 years of SCPMG Qualifying Service; or age plus years of Qualifying Service must equal at least 75 with 10 or more years of Qualifying Service.
**EARLY RETIREMENT**

- At least age 55 at least 15 years of CPQS; or
- Age plus years of CPQS equal at least 75 with at least 10 years of CPQS

This chart is a summary of benefits available when you leave SCPMG due to Early Retirement. Details regarding each benefit may be found in this handbook and/or the Retiree Benefits Handbook.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Highlights</th>
</tr>
</thead>
</table>
| Kaiser Foundation Health Plan (KFHP)* Required to enroll in Senior Advantage at age 65 | • Your coverage continues until age 65  
• At age 65, you are required to enroll in Senior Advantage  
• Your spouse/domestic partner continues KFHP until age 65, then he/she must enroll in Senior Advantage  
• Your eligible dependents continue coverage until age 26 unless disabled and approved by KFHP  
• Your dependents are eligible for COBRA when coverage ends |
| Special Dependent Coverage (KFHP) | • Coverage may continue through direct billing when you retire  
• You may add new, eligible Special Dependent(s) |
| Comprehensive Medical Coverage* | • You are required to elect this coverage if you reside outside of the KFHP service area (California) and wish to have health coverage; otherwise you may waive coverage |
| Kaiser Permanente Multi-Site Plan (KPMP)* | • You are required to elect this coverage if you reside outside of California but within the service area of other Kaiser Permanente participating providers; otherwise you may waive coverage  
• Dependent eligibility varies |
| Supplemental Medical Coverage Plan* | • Coverage continues for you and your spouse/domestic partner if you are enrolled in KFHP or Senior Advantage  
• Coverage continues for your eligible dependents until age 26  
• Dependents eligible for COBRA when coverage ends |
| Medicare Part B Premium Reimbursement Program* | • You are eligible when you turn age 65 and are retired; your eligible spouse/domestic partner who is age 65 or older is eligible for participation in the program  
• You and your eligible spouse/domestic partner will be reimbursed when you enroll in Senior Advantage AND assign your Medicare Part A and B to KFHP |
| Alternate Mental Health Coverage | • Coverage ends upon retirement  
• You, your spouse/domestic partner, and eligible dependents are eligible for COBRA coverage  
• Mental health care is available through KFHP or Senior Advantage |
| Dental Coverage | • Coverage ends upon retirement  
• You, your spouse/domestic partner, and eligible dependents are eligible for COBRA coverage  
• Dental Coverage available through Senior Advantage once you reach age 65 |
| Short-Term Disability (Associate Physicians only) | • Coverage ends upon retirement |
| Compensation Continuance (Partner Physicians only) | • Coverage ends upon retirement |
| Long-Term Disability Insurance | • Coverage ends upon retirement |
| Optional Life Insurance | • Coverage ends upon retirement  
• Conversion/portability available |

* To be eligible, you must be age 55 with 15 years of Qualifying Service, age 65 with 10 years of Qualifying Service; between age 58 and 65 with SCPMG Board of Director’s approval and 10 years of SCPMG Qualifying Service; or age plus years of Qualifying Service must equal at least 75 with 10 or more years of Qualifying Service.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Highlights</th>
</tr>
</thead>
</table>
| Permanente Provided Life Insurance          | • Coverage ends upon retirement  
                                             • Conversion/portability available |
| Disabled Physicians Life Insurance           | • Not eligible                                                             |
| Spouse/Domestic Partner Life Insurance      | • Coverage ends upon retirement  
                                             • Conversion/portability available |
| Tapered Life Insurance*                     | • Coverage begins when Optional Life ends  
                                             • You must have enrolled in Optional Life prior to 1/1/1991 and meet a combined age/service requirement  
                                             • You can have Tapered Life OR Retiree Life, NOT both |
| Retiree Life Insurance*                     | • Coverage of $50,000 begins when all above insurance plans end if you are not eligible for and/or enrolled in Tapered Life  
                                             • You can have Tapered Life OR Retiree Life, NOT both |
| Business Travel Accident Insurance           | • Coverage ends upon retirement                                           |
| Professional Liability Insurance            | • Coverage ends upon retirement or when you cease to perform medical services for KFHP members, whichever is later |
| Vacation Leave                              | • Paid off for accrued balance                                             |
| Educational Leave                           | • Benefit ends upon retirement                                             |
| Sick Leave                                  | • Benefit ends upon retirement                                             |
| Flexible Spending Accounts                  | • Partner Physicians are not eligible  
                                             • Associate Physician contributions cease upon retirement  
                                             • In the year of retirement, an Associate Physician may request reimbursement for eligible expenses incurred  
                                             • Claims for the retirement year must be filed by 3/31 of the following year |
| Long-Term Care Insurance                    | • If enrolled, your policy is portable; not provided by SCPMG  
                                             • Payments are transferred to direct billing  
                                             • If not enrolled, you may purchase coverage if you meet underwriting criteria |

* To be eligible, you must be age 55 with 15 years of Qualifying Service, age 65 with 10 years of Qualifying Service; between age 58 and 65 with SCPMG Board of Director’s approval and 10 years of SCPMG Qualifying Service; or age plus years of Qualifying Service must equal at least 75 with 10 or more years of Qualifying Service. 

Effective March 1, 2014
### DISABILITY

This chart is a summary of benefits available when you retire from SCPMG due to disability. **Details regarding each benefit may be found in this handbook.**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Highlights</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Kaiser Foundation Health Plan (KFHP)</strong></td>
<td>•  If you have at least 5 years of Qualifying Service, coverage continues until age 65</td>
</tr>
<tr>
<td>Required to enroll in <strong>Senior Advantage</strong> at age 65</td>
<td>•  If age 65 you are required to enroll in Senior Advantage</td>
</tr>
<tr>
<td></td>
<td>•  If 5 years’ Qualifying Service requirement is not met, you and your spouse/domestic partner and dependents may be eligible for COBRA or may convert to Personal Advantage</td>
</tr>
<tr>
<td><strong>Special Dependent Coverage (KFHP)</strong></td>
<td>•  You may continue coverage through direct billing</td>
</tr>
<tr>
<td></td>
<td>•  You may add new, eligible Special Dependent(s)</td>
</tr>
<tr>
<td></td>
<td>•  Coverage ends if you are ineligible and Special Dependents may convert to Personal Advantage</td>
</tr>
<tr>
<td><strong>Comprehensive Medical Coverage</strong></td>
<td>•  If you have at least 5 years of Qualifying Service, you may choose this coverage in lieu of KFHP or Senior Advantage</td>
</tr>
<tr>
<td><strong>Kaiser Permanente Multi-Site Plan (KPMP)</strong></td>
<td>•  You are required to elect this coverage if you reside outside of California but within the service area of other Kaiser Permanente participating providers; otherwise you may waive coverage</td>
</tr>
<tr>
<td></td>
<td>•  Dependent eligibility varies</td>
</tr>
<tr>
<td><strong>Supplemental Medical Coverage Plan</strong></td>
<td>•  Coverage continues for you and your spouse/domestic partner if enrolled in KFHP or Senior Advantage</td>
</tr>
<tr>
<td></td>
<td>•  Coverage continues for your eligible dependents until age 26</td>
</tr>
<tr>
<td></td>
<td>•  You, your spouse/domestic partner, and your eligible dependents are eligible for COBRA when coverage ends</td>
</tr>
<tr>
<td><strong>Medicare Part B Premium Reimbursement Program</strong></td>
<td>•  You are eligible when you turn age 65 and are retired; your eligible spouse/domestic partner who is age 65 or older is eligible for participation in the program</td>
</tr>
<tr>
<td></td>
<td>•  You and your eligible spouse/domestic partner will be reimbursed when you enroll in Senior Advantage AND assign your Medicare Part A and B to KFHP, Inc.</td>
</tr>
<tr>
<td><strong>Alternate Mental Health Coverage</strong></td>
<td>•  Coverage ends</td>
</tr>
<tr>
<td></td>
<td>•  You, your spouse/domestic partner, and eligible dependents are eligible for COBRA coverage</td>
</tr>
<tr>
<td></td>
<td>•  Mental health care is available through KFHP or Senior Advantage</td>
</tr>
<tr>
<td><strong>Dental Coverage</strong></td>
<td>•  Coverage ends upon retirement</td>
</tr>
<tr>
<td></td>
<td>•  You, your spouse/domestic partner, and eligible dependents are eligible for COBRA coverage</td>
</tr>
<tr>
<td></td>
<td>•  Dental Coverage available through Senior Advantage once you reach age 65</td>
</tr>
<tr>
<td><strong>Short-Term Disability</strong></td>
<td>•  Coverage for up to five months following disability</td>
</tr>
<tr>
<td>(Associate Physicians only)</td>
<td></td>
</tr>
<tr>
<td><strong>Compensation Continuance</strong></td>
<td>•  Coverage ends</td>
</tr>
<tr>
<td>(Partner Physicians only)</td>
<td></td>
</tr>
<tr>
<td><strong>Long-Term Disability Insurance</strong></td>
<td>•  Coverage up to age 65, if eligible</td>
</tr>
<tr>
<td><strong>Optional Life Insurance</strong></td>
<td>•  Refer to Disabled Physicians Life Insurance</td>
</tr>
<tr>
<td><strong>Permanente Provided Life Insurance</strong></td>
<td>•  Refer to Disabled Physicians Life Insurance</td>
</tr>
</tbody>
</table>

* To be eligible, you must be age 55 with 15 years of Qualifying Service, age 65 with 10 years of Qualifying Service; between age 58 and 65 with SCPMG Board of Director’s approval and 10 years of SCPMG Qualifying Service; or age plus years of Qualifying Service must equal at least 75 with 10 or more years of Qualifying Service.

Effective March 1, 2014
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Highlights</th>
</tr>
</thead>
</table>
| Disabled Physicians Life Insurance           | • Coverage ends on the date you are no longer Totally Disabled or turn age 65  
• Conversion/portability available          |
| Spouse/Domestic Partner Life Insurance      | • Coverage ends upon retirement or after 24 months of disability, whichever is first  
• Conversion/portability available          |
| Tapered Life Insurance*                     | • If you participated in Optional Life and are eligible, coverage begins when Disabled Physicians Life Insurance |
| Retiree Life Insurance*                     | • Coverage begins if not eligible for Tapered Life if you meet the eligibility requirements                                                  |
| Business Travel Accident Insurance          | • Coverage ends                                                                                                                                 |
| Professional Liability Insurance            | • Coverage ends upon disability or when you cease to perform medical services for KFHP, Inc. members, whichever is later                       |
| Vacation Leave                              | • Paid off for accrued balance                                                                                                           |
| Educational Leave                           | • Unused balance not compensable                                                                                                          |
| Sick Leave                                  | • Unused balance not compensable                                                                                                          |
| Flexible Spending Accounts                  | • Partner Physicians are not eligible  
• Associate Physician contributions cease at disability  
• In the year of disability, an Associate Physician can request eligible reimbursement for expenses incurred while eligible  
• Claims for the disability year must be filed by 3/31 of the following year |
| Long-Term Care Insurance                    | • If enrolled, your policy is portable; not provided by SCPMG  
• Payments are transferred to direct billing  
• If not enrolled, you may purchase coverage if you meet underwriting criteria |

* To be eligible, you must be age 55 with 15 years of Qualifying Service, age 65 with 10 years of Qualifying Service; between age 58 and 65 with SCPMG Board of Director’s approval and 10 years of SCPMG Qualifying Service; or age plus years of Qualifying Service must equal at least 75 with 10 or more years of Qualifying Service.
**TERMINATION**

This chart is a summary of benefits available when you are terminated from SCPMG. **Details regarding each benefit can be found in the specific section of this handbook.**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Highlights</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser Foundation Health Plan (KFHP)</td>
<td>• Coverage ends</td>
</tr>
<tr>
<td></td>
<td>• Physician, spouse/domestic partner and dependents may be eligible to continue coverage via COBRA or may convert to Personal Advantage</td>
</tr>
<tr>
<td>Special Dependent Coverage (KFHP)</td>
<td>• Coverage ends</td>
</tr>
<tr>
<td></td>
<td>• Special dependents may convert to Personal Advantage</td>
</tr>
<tr>
<td>Supplemental Medical Coverage Plan</td>
<td>• Coverage ends</td>
</tr>
<tr>
<td></td>
<td>• You, your spouse/domestic partner, and dependents may be eligible to continue coverage via COBRA</td>
</tr>
<tr>
<td>Alternate Mental Health Coverage</td>
<td>• Coverage ends</td>
</tr>
<tr>
<td></td>
<td>• You, your spouse/domestic partner, and dependents may be eligible to continue coverage via COBRA</td>
</tr>
<tr>
<td>Dental Coverage</td>
<td>• Coverage ends</td>
</tr>
<tr>
<td></td>
<td>• You, your spouse/domestic partner, and unmarried dependents may be eligible to continue coverage via COBRA</td>
</tr>
<tr>
<td>Short-Term Disability (Associate Physicians only)</td>
<td>• Coverage ends</td>
</tr>
<tr>
<td>Compensation Continuance (Partner Physicians only)</td>
<td>• Coverage ends</td>
</tr>
<tr>
<td>Long-Term Disability Insurance</td>
<td>• Coverage ends</td>
</tr>
<tr>
<td>Optional Life Insurance</td>
<td>• Coverage ends</td>
</tr>
<tr>
<td></td>
<td>• Conversion/portability available</td>
</tr>
<tr>
<td>Permanente Provided Life Insurance</td>
<td>• Coverage ends</td>
</tr>
<tr>
<td></td>
<td>• Conversion/portability available</td>
</tr>
<tr>
<td>Disabled Physicians Life Insurance</td>
<td>• Coverage ends</td>
</tr>
<tr>
<td></td>
<td>• Conversion/portability available</td>
</tr>
<tr>
<td>Spouse/Domestic Partner Life Insurance</td>
<td>• Coverage ends</td>
</tr>
<tr>
<td></td>
<td>• Conversion/portability available</td>
</tr>
<tr>
<td>Business Travel Accident Insurance</td>
<td>• Coverage ends</td>
</tr>
<tr>
<td>Professional Liability Insurance</td>
<td>• Coverage ends</td>
</tr>
<tr>
<td>Vacation Leave</td>
<td>• Paid off for accrued balance</td>
</tr>
<tr>
<td>Educational Leave</td>
<td>• Cannot be used 90 days prior to termination</td>
</tr>
<tr>
<td></td>
<td>• Unused balance not compensable</td>
</tr>
<tr>
<td>Sick Leave</td>
<td>• Unused balance not compensable</td>
</tr>
<tr>
<td>Flexible Spending Accounts</td>
<td>• Partner Physicians are not eligible</td>
</tr>
<tr>
<td>• Dependent Care</td>
<td>• Associate Physician contributions cease at termination may be eligible to continue coverage via COBRA</td>
</tr>
<tr>
<td>• Health Care</td>
<td>• In the year of termination, an Associate Physician may request eligible reimbursement for expenses incurred while eligible</td>
</tr>
<tr>
<td>• Commuter Choice Program</td>
<td>• Claims for the termination year must be filed by 3/31 of the following year</td>
</tr>
<tr>
<td>Long-Term Care Insurance</td>
<td>• If enrolled, your policy is portable; not provided by SCPMG</td>
</tr>
<tr>
<td></td>
<td>• Payments are transferred to direct billing</td>
</tr>
<tr>
<td></td>
<td>• If not enrolled, you may purchase coverage if you meet underwriting criteria</td>
</tr>
</tbody>
</table>

*Effective March 1, 2014*
DEATH
This chart is a summary of benefits available to your survivors when you die while actively employed at SCPMG. Details regarding each benefit can be found in the specific section of this handbook.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Highlights</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser Foundation Health Plan (KFHP)</td>
<td>• Coverage continues for your surviving spouse/domestic partner and eligible dependent children. At age 65, spousal coverage becomes Senior Advantage</td>
</tr>
<tr>
<td>Required to enroll in Senior Advantage at age 65</td>
<td>• Coverage for spouse ends upon remarriage; coverage for dependent children ends at age 26 unless disabled and approved by KFHP; spouse/domestic partner and dependents may be eligible to continue coverage via COBRA</td>
</tr>
<tr>
<td>Special Dependent Coverage (KFHP)</td>
<td>• Special dependents may convert to direct bill or Personal Advantage</td>
</tr>
<tr>
<td>Comprehensive Medical Coverage</td>
<td>• Your surviving spouse/domestic partner and eligible dependents are required to elect this coverage if you reside outside of the KFHP service area (California) and wish to have health coverage, otherwise you may waive coverage</td>
</tr>
<tr>
<td>Supplemental Medical Coverage Plan</td>
<td>• Coverage continues for your surviving spouse/domestic partner and eligible dependent children if you were retirement eligible at time of death</td>
</tr>
<tr>
<td></td>
<td>• Otherwise, your spouse/domestic partner and dependents may be eligible to continue coverage via COBRA</td>
</tr>
<tr>
<td>Medicare Part B Premium Reimbursement Program</td>
<td>• You are eligible when you turn age 65 and are retired; your eligible spouse/domestic partner who is age 65 or older is eligible for participation in the program</td>
</tr>
<tr>
<td></td>
<td>• Your eligible spouse/domestic partner will be reimbursed when they enroll in Senior Advantage AND assign their Medicare Part A and B to KFHP</td>
</tr>
<tr>
<td>Alternate Mental Health Coverage</td>
<td>• Coverage ends</td>
</tr>
<tr>
<td></td>
<td>• Your spouse/domestic partner, and dependents may be eligible to continue coverage via COBRA</td>
</tr>
<tr>
<td>Dental Coverage</td>
<td>• Coverage ends</td>
</tr>
<tr>
<td></td>
<td>• Your spouse/domestic partner, and unmarried dependents may be eligible to continue coverage via COBRA</td>
</tr>
<tr>
<td>Short-Term Disability Insurance</td>
<td>• Coverage ends</td>
</tr>
<tr>
<td>(Associate Physicians only)</td>
<td></td>
</tr>
<tr>
<td>Compensation Continuance</td>
<td>• Coverage ends</td>
</tr>
<tr>
<td>(Partner Physicians only)</td>
<td></td>
</tr>
<tr>
<td>Long-Term Disability Insurance</td>
<td>• Coverage ends</td>
</tr>
<tr>
<td>Optional Life Insurance</td>
<td>• If enrolled, life insurance proceeds paid to beneficiary(ies) on file</td>
</tr>
<tr>
<td>Permanente Provided Life Insurance</td>
<td>• If enrolled, life insurance proceeds paid to beneficiary(ies) on file</td>
</tr>
<tr>
<td>Disabled Physicians Life Insurance</td>
<td>• If enrolled, life insurance proceeds paid to beneficiary(ies) on file</td>
</tr>
<tr>
<td>Spouse/Domestic Partner Life Insurance</td>
<td>• Coverage ends</td>
</tr>
<tr>
<td></td>
<td>• Conversion/portability available</td>
</tr>
<tr>
<td>Business Travel Accident Insurance</td>
<td>• If death while traveling on SCPMG business, insurance proceeds paid to beneficiaries on file for Optional and Permanente Provided Life</td>
</tr>
<tr>
<td>Professional Liability Insurance</td>
<td>• Coverage ends</td>
</tr>
<tr>
<td>Vacation Leave</td>
<td>• Paid off for accrued balance</td>
</tr>
<tr>
<td>Educational Leave</td>
<td>• Unused balance not compensable</td>
</tr>
<tr>
<td>Sick Leave</td>
<td>• Unused balance not compensable</td>
</tr>
<tr>
<td>Benefit</td>
<td>Highlights</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **Flexible Spending Accounts** | • Partner Physicians are not eligible  
• Associate Physician contributions cease at death  
• In the year of your death, your estate can request eligible reimbursement for expenses incurred while eligible  
• Claims for the year you are deceased must be filed by 3/31 of the following year                                                                 |
| **Long-Term Care Insurance**  | • If enrolled, estate may be eligible for Return of Premium Upon Death provision                                                                                                                             |

(continued)
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<th>Section Title</th>
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</table>
HEALTH AND INSURANCE CLAIMS/ADMINISTRATION

Health and Insurance Plan Names and Numbers

The official names of the health and insurance plans, the names and addresses of the plan insurers or administrators, the type of administration of each plan, and the plan identification numbers are as follows:

<table>
<thead>
<tr>
<th>Health Care Plans</th>
<th>Provider/Claims Administrator</th>
<th>Type of Administration</th>
<th>Plan ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Kaiser Foundation Health Plan (KFHP) Coverage</strong></td>
<td>Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 7004 Downey, CA 90242-7004 1-800-390-3510 <a href="http://www.kp.org">www.kp.org</a> Southern California Permanente Medical Group 393 East Walnut Street 3rd floor Pasadena, CA 91188 1-877-608-0044</td>
<td>Fully insured Claims and appeals administration through provider</td>
<td>502</td>
</tr>
<tr>
<td><strong>Senior Advantage</strong></td>
<td>Meritain Health <a href="mailto:SCPMG.Claims@meritain.com">SCPMG.Claims@meritain.com</a> 1-888-711-7876 1-763-852-5016 (fax) <a href="http://www.meritain.com">www.meritain.com</a></td>
<td>Self-insured Claims administration through provider</td>
<td>510</td>
</tr>
<tr>
<td><strong>Supplemental Medical Care Insurance</strong></td>
<td>Meritain Health <a href="mailto:SCPMG.Claims@meritain.com">SCPMG.Claims@meritain.com</a> 1-888-711-7876 1-763-852-5016 (fax) <a href="http://www.meritain.com">www.meritain.com</a></td>
<td>Self-insured Claims administration through provider</td>
<td>511</td>
</tr>
<tr>
<td><strong>Comprehensive Medical Plan</strong></td>
<td>Meritain Health P.O. Box 27267 Minneapolis, MN 55427-0267 1-888-711-7876 <a href="http://www.meritain.com">www.meritain.com</a></td>
<td>Self-insured Claims administration through provider</td>
<td>515</td>
</tr>
<tr>
<td><strong>Express Scripts Prescription Drug Plan</strong></td>
<td>Meritain Health <a href="mailto:SCPMG.Claims@meritain.com">SCPMG.Claims@meritain.com</a> 1-888-711-7876 1-763-852-5016 (fax) <a href="http://www.meritain.com">www.meritain.com</a></td>
<td>Self-insured Claims administration through provider</td>
<td>515</td>
</tr>
<tr>
<td><strong>Alternate Mental Health Insurance</strong></td>
<td>Meritain Health <a href="mailto:SCPMG.Claims@meritain.com">SCPMG.Claims@meritain.com</a> 1-888-711-7876 1-763-852-5016 (fax) <a href="http://www.meritain.com">www.meritain.com</a></td>
<td>Self-insured Claims administration through provider</td>
<td>515</td>
</tr>
<tr>
<td><strong>Dental Care Program</strong></td>
<td>Delta Dental (PPO) 12898 Towne Center Drive Cerritos, CA 90703 1-888-335-8227 <a href="http://www.deltadentalins.com">www.deltadentalins.com</a> DeltaCare U.S.A. 12898 Towne Center Drive Cerritos, CA 90703 1-800-422-4234 <a href="http://www.deltadentalins.com">www.deltadentalins.com</a></td>
<td>Fully insured Claims and appeals administration through provider</td>
<td>550</td>
</tr>
<tr>
<td></td>
<td>United Concordia 4401 Deer Path Road Harrisburg, PA 17110 1-866-357-3304 <a href="http://www.ucci.com">www.ucci.com</a></td>
<td>Fully insured Claims and appeals administration through provider</td>
<td>550</td>
</tr>
</tbody>
</table>
### Disability Plans

<table>
<thead>
<tr>
<th>Disability Plans</th>
<th>Provider/Claims Administrator</th>
<th>Type of Administration</th>
<th>Plan ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Short-Term Disability Insurance</strong></td>
<td>Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192 1-800-732-1603</td>
<td>Fully insured Claims and appeals administration through provider</td>
<td>508</td>
</tr>
<tr>
<td><strong>Long-Term Disability Insurance</strong></td>
<td>Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192 1-800-732-1603</td>
<td>Fully insured Claims and appeals administration through provider</td>
<td>509</td>
</tr>
<tr>
<td><strong>Long-Term Care Insurance (for policies purchased before November 2012)</strong></td>
<td>New York Life Life Insurance Company Long-Term Care Division 98 San Jacinto Boulevard Suite 800 Austin, TX 78701 1-888-414-0821</td>
<td>Fully insured Claims and appeals administration through provider</td>
<td>516</td>
</tr>
<tr>
<td><strong>Long-Term Care Insurance (for policies purchased on or after March 2014)</strong></td>
<td>Genworth Life Insurance Company Group Processing Center — Southern California Permanente Medical Group P.O. Box 64010 St. Paul, MN 55164-0010 1-800-416-3624</td>
<td>Fully insured Claims and appeals administration through provider</td>
<td>516</td>
</tr>
</tbody>
</table>

### Life and Accident Insurance Plans

<table>
<thead>
<tr>
<th>Life and Accident Insurance Plans</th>
<th>Provider/Claims Administrator</th>
<th>Type of Administration</th>
<th>Plan ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Life Insurance Options</strong></td>
<td>Life Insurance Company of North America — a CIGNA Company 1601 Chestnut Street Philadelphia, PA 19192 1-800-552-5744</td>
<td>Fully insured Claims and appeals administration through provider</td>
<td>507</td>
</tr>
<tr>
<td><strong>Business Travel Accident Insurance</strong></td>
<td>AIG Life Insurance Co. One Alico Plaza Wilmington, DE 19801 1-302-594-2000</td>
<td>Fully insured Claims and appeals administration through provider</td>
<td>507</td>
</tr>
</tbody>
</table>

### Other Benefit Plans

<table>
<thead>
<tr>
<th>Other Benefit Plans</th>
<th>Provider/Claims Administrator</th>
<th>Type of Administration</th>
<th>Plan ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Special Dependent Coverage</strong></td>
<td>Conexis P.O. Box 223646 Dallas, TX 75222-3646 1-877-442-6204 <a href="https://mybenefits.conexis.com">https://mybenefits.conexis.com</a></td>
<td>Premium billing and collection services</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>COBRA</strong></td>
<td>Conexis P.O. Box 223646 Dallas, TX 75222-3646 1-877-442-6204 <a href="https://mybenefits.conexis.com">https://mybenefits.conexis.com</a></td>
<td>Premium billing and collection services</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Commuter Choice Program</strong></td>
<td>Ceridian P.O. Box 534002 St. Peters burg, FL 33747-4002 1-877-548-7788 <a href="http://www.ceridian-benefits.com">www.ceridian-benefits.com</a></td>
<td>Claims administration through provider</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Health Care Flexible Spending Account</strong></td>
<td>Ceridian P.O. Box 534055 St. Petersburg, FL 33747-4055 1-877-799-8820 <a href="http://www.ceridian-benefits.com">www.ceridian-benefits.com</a></td>
<td>Self-insured Claims administration through provider</td>
<td>542</td>
</tr>
</tbody>
</table>
Plan Year
The plan year for all plans extends from January 1 through December 31.

Plan Sponsor
The plans are sponsored by the Southern California Permanente Medical Group for its physicians. The address of the Partnership is:

    Southern California Permanente Medical Group
    393 East Walnut Street, 3rd Floor
    Pasadena, CA 91188-8018

Plan Types
All plans referred to in this section are classified as Welfare Plans.

Plan Administration and Service of Legal Process
The Health and Insurance Plans are administered by the office of the Southern California Permanente Medical Group’s Business Administrator. In the event of any legal action involving the plan, the Business Administrator would receive legal notices. The address for service of legal process is:

    Business Administrator
    Southern California Permanente Medical Group
    393 East Walnut Street
    Pasadena, CA 91188-8018
    Phone: 1-626-405-5715

Identification Number
The Employer Identification Number (EIN) assigned to the Plan Sponsor by the Internal Revenue Service is 95-1750445.

Contribution Sources
Contributions for the purchase of health and insurance benefits are made by you, the individual physician, for the contributory benefits you elect. All other benefits are paid for by SCPMG. The individual sections of this handbook also include information about who pays for each of the benefits.

How to Claim Benefits
Health Plan Claims — Normally, you do not need to submit claims for
services under Kaiser Foundation Health Plan coverage. However, if you wish to submit claims for coverage for emergency hospital, surgical or medical expenses, or if you wish to submit claims for other benefits described in the KFHP Coverage brochure (see the Health Care Benefits section in this handbook), you must use the claims procedure described below:

Claims must be submitted on the appropriate forms. Forms are available from the Member Services Office in your local area. Claims must be submitted to the Member Service Office within 60 days after the service was first rendered. As stated in the description of your Health Plan coverage, you also must notify Health Plan within 48 hours after emergency care begins in a non-Kaiser Permanente facility. You can reach Member Services by calling 1-800-464-4000.

All claims are acted upon within 45 days after they are received unless additional information is required. If additional information is required, you will be advised in writing of what is needed. Your claim will then be acted upon within 45 days after Health Plan has received the additional information. Your claims may be denied or granted. You will be notified of the decision in writing. A notice of denial will include the specific reasons for the denial, a specific reference to pertinent plan provisions, a description of any additional material or information needed to perfect the claim, and the steps for appealing the denial.

**Claims for Damages** — Any claim for damages for personal injury or wrongful death arising out of rendering or the failure to render services under Kaiser Foundation Health Plan must be submitted to binding arbitration.

**Dental Claims** — If you use dental care benefits through Delta Dental Services, your dentist will normally complete the claim forms and forward them to Delta Dental, however, if you have already paid for services you may obtain the necessary claim forms from your dentist or from Member Services at Delta Dental. Your dentist can assist you in filling out your portion of the form and he or she will file your claim for you.

PMI and United Concordia do not require claim forms.

**Other Group Insurance Claims** — If you wish to submit a claim for benefits under any of your group insurance policies, contact PHR Shared Services at Walnut Center, Pasadena or your local SCPMG Administration Office.

**Claims Appeals** — If your claim for benefits under a Welfare Plan is denied, you may have the right to file an appeal. Refer to General Information in this section for details.

**Beneficiaries for Retirement Benefits, Life, and Accident Insurance**

In order to designate a beneficiary under your life and accident insurance...
you must file the necessary forms with the Plan Administrator. You may change your beneficiary at any time (provided you have not assigned the ownership of the insurance) by completing the necessary change of beneficiary forms and filing them with PHR Shared Services. Your beneficiary is the last person you designate in writing. If you have no beneficiary, the death benefit will be paid to your estate.

To obtain forms for the designation or to change your beneficiary, contact PHR Shared Services at 1-877-608-0044 or visit the SCPMG Physician Portal at http://scpmgphysician.kp.org.

**TSR and Keogh Plans** — In order to change your beneficiary or designate a beneficiary for your Retirement benefits, please contact Schwab Retirement Plan Services Company, Participant Services at 1-888-256-8830 or go online at www.401kaccess.com/scpmg.

**Common Plan** — Call Kaiser Permanente Retirement Center at 1-800-721-3647.

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**Limited Continuation of Health Benefits Available (COBRA)**

As a result of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended, continuation for health and dental benefit plans is available to all physicians, excluding Per Diem, who leave SCPMG or who might become ineligible for benefits. Plans eligible for COBRA continuation coverage are KFHP Coverage (but not Special Dependent Coverage), Supplemental Medical Coverage, Comprehensive Medical Plan Coverage, Alternate Mental Health Plan Coverage, Dental Care Program Coverage, and the Health Care Flexible Spending Account Plan.

Continuation also is available to eligible family members (including domestic partners and their eligible dependents) who were covered at the time of the loss of coverage due to:

- your death,
- divorce, or
- dependent child exceeding the age limit.

In addition, a child born to, adopted by, or placed for adoption with you during the COBRA coverage period will be eligible for COBRA coverage in his/her own right.

The continuation is at the individual’s own expense and may last for up to 18, 29, or 36 months following a qualifying event. See the chart at the end of this section regarding the coverage periods applicable to different qualifying events. Coverage will cease before the end of the 18-, 29-, or 36-month period if one of the following events occurs:

- the health benefit program for SCPMG is terminated,
- the required premium is not paid when due,
- after the date of the COBRA election, an individual becomes entitled.
to Medicare benefits, or

- after the date of the COBRA election, an individual becomes covered under another group health plan which does not contain any limitation with respect to any pre-existing condition. However, if the new group health plan’s pre-existing condition limitation does not affect the individual because of the Health Insurance Portability and Accountability Act (HIPAA), the individual’s COBRA coverage may be terminated.

The full cost of the plan must be paid by the COBRA participant in monthly installments. The full cost of the coverage plus a 2% administrative fee will be determined and the rate will be provided when needed. Professional courtesy will not be reflected in the health care rates.

Upon your death, termination/retirement, disability or transfer to an ineligible category, you and/or your eligible family member(s), as applicable, will be notified of the availability of benefit continuation. In the event of divorce or cessation of a child’s dependent status, you or your qualified beneficiary must notify PHR Shared Services within 60 days of the date of the qualifying event.

You and/or your eligible family member(s) have 60 days from the later of notification or the date coverage would otherwise terminate to elect coverage continuation. Unless coverage is waived, the existing health care coverage must continue during this election period at the insured’s expense, payable at the time of election. However, federal law requires a 45-day grace period for this initial payment. No further extension is allowed. If you would like further information, contact PHR Shared Services at 1-877-608-0044.

If you become entitled to Medicare before your termination or change in eligibility status, you will be entitled to up to 18 months of COBRA coverage upon the termination or change. Your spouse/domestic partner and dependent children, if any, however, may receive COBRA continuation for up to the greater of: (a) 18 months from the date of your qualifying event or (b) 36 months from the date of your Medicare entitlement.

If you become entitled to Medicare after your termination or reduction in hours, your COBRA coverage will cease, but your spouse/domestic partner and dependents, if any, may receive up to an additional 18 months of COBRA continuation coverage for a maximum coverage period of 36 months from the initial qualifying event. Please note that the results differ if a person other than you becomes entitled to Medicare. If your spouse/domestic partner or dependent child (or former dependent) becomes entitled to Medicare after COBRA coverage begins, such person’s COBRA continuation coverage will cease. (Medicare entitlement means actually being covered for either Part A or Part B of Medicare, not just eligibility for Medicare.)
<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Who May Continue</th>
<th>Continuation Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your termination/ retirement for reasons other than gross misconduct</td>
<td>You and your eligible family members</td>
<td>Up to 18 months</td>
</tr>
<tr>
<td>Loss of health plan eligibility due to transfer to an ineligible category</td>
<td>You and your eligible family members</td>
<td>Up to 18 months</td>
</tr>
<tr>
<td>Your death</td>
<td>Eligible family members</td>
<td>Up to 36 months</td>
</tr>
<tr>
<td>Divorce or legal separation</td>
<td>Eligible family members</td>
<td>Up to 36 months</td>
</tr>
<tr>
<td>Child reaches the age limit under the plan</td>
<td>Child</td>
<td>Up to 36 months</td>
</tr>
</tbody>
</table>

When several qualifying events occur, the continuation period for coverage may be extended, but in no event to more than 36 months from the original qualifying event. For example, if you are terminated in June of 1999, continuation coverage is available for up to 18 months until the end of November, 2000. If you and your spouse obtain a divorce in December of 1999, coverage is available for the ex-spouse and qualified dependents until the end of June, 2002 (36 months from the original qualifying event). However, a termination of employment following a transfer to an ineligible category will not constitute a second qualifying event extending the 18-month continuation coverage period. A second qualifying event will result in an extension of the maximum Continuation Coverage period only if the second qualifying event would have resulted in a loss of coverage for your covered spouse or dependent under the plan had the initial qualifying event not occurred.

**COBRA Coverage for Disabilities**

In situations involving termination of service or transfer to an ineligible category, COBRA coverage can be extended beyond the initial 18 months for a disability.

COBRA coverage can continue for an additional 11 months if a person is totally disabled when he or she becomes eligible for COBRA coverage or becomes disabled during the first 60 days of COBRA coverage. All individuals covered by the original qualifying event are eligible for this extension, not just the disabled individual. You could be required to pay 150% of the cost for continuing your coverage during this 11-month extension.

To be eligible for extended coverage due to Social Security disability, you must notify PHR Shared Services at 1-877-608-0044 of the disability determination before the end of the initial 18 months of COBRA continuation coverage and within 60 days after the later of:

- the date you or a covered dependent is determined to be disabled by

**Effective March 1, 2014**
the social security administration;

- the date of the qualifying event;

- the date on which you or your covered dependent loses (or would lose) coverage under the plan as a result of the qualifying event; and

- the date on which you or your covered dependent is informed of the obligation to provide the disability notice (including receipt of the Benefits Handbook, which constitutes notice).

If the disabled individual should no longer be considered to be disabled by the Social Security Administration, you must notify PHR Shared Services at 1-877-608-0044 within 30 days following the end of the disability. Coverage that has exceeded the original 18-month continuation period will end when the individual is no longer considered to be disabled by the Social Security Administration.

**COBRA Coverage for Health Care Flexible Spending Account Plan (HCFSA)**

To avoid forfeiting any unused balance you may have in your HCFSA when your participation in the HCFSA would otherwise end, you may continue participating in the HCFSA by making after-tax contributions through COBRA for the remainder of the year. When you elect COBRA, you may continue to submit expenses for reimbursement and use the balance in your HCFSA until the end of the benefit plan year in which your COBRA qualifying event occurs. Under no circumstances will you be able to continue your participation in the HCFSA through COBRA after the year in which your COBRA qualifying event occurs.

**COBRA Coverage for Domestic Partners and Same-Sex Spouse**

COBRA is generally not available to domestic partners and same-sex spouses under COBRA’s eligibility rules. Due to SCPMG’s commitment to its physicians, SCPMG will make continuation coverage available to domestic partners and same-sex spouses on substantially the same terms as the COBRA continuation coverage described in this handbook. The continuation coverage offered to domestic partners and same-sex spouses is not covered by COBRA but may be covered by state or other federal law, where applicable.

If you have any questions regarding this continuation coverage, contact PHR Shared Services at 1-877-608-0044.

**Cal-COBRA**

For certain medical plans that are fully insured (see the description of Type of Administration in the Health and Insurance Plan Names and Numbers section above for a list of those plans that are fully insured), you may have
additional continuation rights pursuant to California insurance law under Cal-COBRA after your COBRA continuation coverage ends. For more information on Cal-COBRA, contact the California Department of Insurance at 1-800-927-4357.

COBRA and Cal-COBRA (or any other state continuation coverage rights) will run concurrently, if applicable. You may also contact PHR Shared Services at 1-877-608-0044 for more information.

RETIREMENT PLANS CLAIMS/ADMINISTRATION

Retirement Plan Names and Numbers
The official names of the retirement plans or programs, their trustees and administrators, and plan numbers are as follows:

<table>
<thead>
<tr>
<th>Retirement Plan or Program</th>
<th>Trustee, Recordkeeper and/or Administrator</th>
<th>Plan Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern California Permanente Medical Group Retirement Plan (Keogh)</td>
<td>The Charles Schwab Trust Company, Trustee Schwab Retirement Plan Services Company, Recordkeeper</td>
<td>008</td>
</tr>
<tr>
<td>Southern California Permanente Medical Group Physicians’ Tax Savings Retirement Plan (TSR)</td>
<td>The Charles Schwab Trust Company, Trustee Schwab Retirement Plan Services Company, Recordkeeper</td>
<td>009</td>
</tr>
<tr>
<td>Early Separation Program</td>
<td>Permanente Human Resources, Administrator</td>
<td>None</td>
</tr>
<tr>
<td>Retirement Plan for Physicians Serving Members of Kaiser Foundation Health Plan (Common Plan)</td>
<td>Refer to Summary Explanation material</td>
<td>None</td>
</tr>
</tbody>
</table>

The addresses of the trustees, administrators, and recordkeepers are as follows:

**Keogh and TSR Plan — Trustee**
The Charles Schwab Trust Company  
211 Main Street, 14th Floor  
San Francisco, CA 94105  
1-512-344-3000

**Recordkeeper**
The Schwab Retirement Plan Services Company  
c/o Participant Services  
Southern California Permanente Medical Group Retirement Plan  
P.O. Box 202710  
Austin, TX 78720-2710  
www.401kaccess.com/scpmg  
1-888-256-8830

Effective March 1, 2014
The Employer Identification Number (EIN) for the plan is 95-1750445.

SCPMG Retirement Committee
c/o Permanente Human Resources
Southern California Permanente Medical Group
393 East Walnut Street, 3rd Floor
Pasadena, CA 91188-8018
1-877-608-0044

Plan Year

The plan year for all retirement plans extends from January 1 through December 31.

Plan Types

The Keogh Plan and Tax Savings Retirement Plans are defined contribution retirement plans. Technically, the Keogh Plan and the TSR Plan qualify as “profit-sharing plans” as defined by the Internal Revenue Code.

The Early Separation Program is an unfunded, non-qualified deferred compensation plan sponsored by Southern California Permanente Medical Group.

The Common Plan is a non-qualified defined-benefit retirement plan sponsored by Kaiser Foundation Health Plan, Inc.

Plan Sponsors

Keogh Plan — The Southern California Permanente Medical Group Retirement Plan (Keogh) is sponsored by Southern California Permanente Medical Group. The address is:

    Retirement Committee
c/o Southern California Permanente Medical Group
    393 East Walnut Street, 3rd Floor
    Pasadena, CA 91188-8018

Service of legal process for this plan may be made on the Secretary of the Retirement Committee or any Committee member at the above address, or upon the Recordkeeper listed on the previous page.

The Employer Identification Number (EIN) for the Plan Sponsor is 95-1750445.

Southern California Permanente Medical Group Physicians’ Tax Savings Retirement Plan (TSR) — The Southern California Permanente Medical Group Physicians’ Tax Savings Retirement Plan is sponsored by the Southern California Permanente Medical Group. The address is:
Retirement Committee
c/o Southern California Permanente Medical Group
393 East Walnut Street, 3rd Floor
Pasadena, CA 91188-8018

Service of legal process for this plan may be made on the Secretary of the Retirement Committee or any Committee member at the above address, or upon the recordkeeper at the address on the previous page.

Common Plan — The Common Plan is sponsored by Kaiser Foundation Health Plan Inc. ("Health Plan"). The address is:

Kaiser Foundation Health Plan, Inc.
Attention: Administrative Committee for the Common Plan
P.O. Box 2074
Oakland, CA 94604-2074

The Employer Identification Number (EIN) for the Plan Sponsor is 94-1340523.

Service of legal process for this plan may be made on any member of the Committee.

Contribution Source
Contributions to the Keogh Plan and the Tax Savings Retirement Plan (TSR) are made by the participants or by the partnership on their behalf to the participants' own segregated trust accounts. The Early Separation Program is funded from the current operating income of the Southern California Permanente Medical Group.

Common Plan benefits are paid for by Kaiser Foundation Health Plan, Inc.

How to Claim Benefits

Keogh Plan (a qualified defined contribution plan) — You are eligible for a distribution of your post-1993 account balance when you meet any of the following retirement criteria and have terminated your service with the Southern California Permanente Medical Group:

- age 55 with at least 15 years of Qualifying Service,
- age plus years of Qualifying Service equals at least 75,
- age 65, or
- your death.

You are eligible for distribution of your pre-1994 Keogh Plan account balance upon termination from SCPMG or retirement from the partnership, disability, or your death.

Your beneficiary is eligible for a distribution of your benefit upon your death. To obtain information regarding distributions contact Schwab Retirement Plan Services Company, Participant Services at 1-888-256-8830
or go online at www.401kaccess.com/scpmg.

**Tax Savings Retirement Plan** (a qualified defined contribution plan) — You are eligible for distribution of your Tax Savings Retirement (TSR) as a result of permanent disability, termination of your services with SCPMG, or upon attaining 59½. To obtain information regarding distributions contact Schwab Retirement Plan Services Company, Participant Services at 1-888-256-8830 or go online at www.401kaccess.com/scpmg.

**Early Separation Program** — If you are a Partner who qualifies for Early Separation benefits, you may apply for benefits by submitting your written application to your Chief or Area Medical Director, who will then submit it to the Board of Directors, at least one year before your planned retirement date. The Board may waive all or part of the one-year notification requirement or may delay retirement for up to one additional year. Your application for Early Separation is also your notice of withdrawal from the partnership. Once given, any notice of withdrawal (Early Separation) will be irrevocable. You will not be entitled to rescind or change the date of your Early Separation (notice of withdrawal) except upon written application to, and approval by, the Board of Directors prior to the effective date of retirement (withdrawal). Participants should refer to their copy of the *Early Separation Program Summary Plan Explanation*.

**Common Plan** (a non-qualified defined benefit plan) — As a Plan participant, you may be entitled to retirement benefits if you meet the eligibility requirements of the plan and retire or leave Southern California Medical Group after vesting. To receive any type of retirement benefits under the Common Plan, you must contact the Kaiser Permanente Retirement Center (KPRC) at 1-800-721-3647. Refer to your separate Common Plan Summary Explanation material for information, or contact the KPRC. The KPRC will assist you with the various notification requirements. If you fail to provide sufficient notice to the KPRC, it will result in delay or forfeiture of your benefits. Notice to SCPMG of a pending retirement or termination does not constitute notice to Common Plan. Participants should refer to their copy of the Common Plan Summary Explanation guide or contact the Kaiser Permanente Retirement Center at 800-721-3647 for rules of the Plan.

**Claims Appeals** — If your claim is denied, you have the right to file an appeal. Refer to *General Information* in this section for details.

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**Retirement Plan Termination Insurance**

**Keogh Plan and Tax Savings Retirement Plan** — Benefits under defined contribution plans are not insured by the Pension Benefit Guaranty Corporation (PBGC) if the plans terminate.

**Early Separation Program** — The Early Separation Program is not covered by the Employee Retirement Income Security Act of 1974 (ERISA), and the Pension Benefit Guaranty Corporation (PBGC) insurance
does not apply to it.

**Common Plan** — The Common Plan is not a qualified plan and therefore is not covered by the Employee Retirement Income Security Act of 1974 (ERISA) or the Pension Benefit Guaranty Corporation (PBGC). Participants in this plan become unsecured creditors of Kaiser Foundation Health Plan, Inc. in instances of default or bankruptcy.

**Beneficiaries**

You must designate a beneficiary to receive your Keogh Plan or TSR Plan benefits in the event of your death. Contact Schwab Participant Services at www.401kaccess.com/scpmq or 1-888-256-8830. You may change your beneficiary at any time. Your beneficiary is the last person you designate under this procedure.

If you die while a participant in the Keogh or TSR plans, without a beneficiary, or if your beneficiary dies before receiving payment (to which he is entitled), then the amount in your account will be paid to the following individual(s) in this order:

- your surviving spouse,
- the personal representative of your estate, then
- the person(s) who can verify by affidavit or court order to the satisfaction of the Committee that they are legally entitled to receive plan benefits.

In the case of a dissolution of marriage, if you do not change your beneficiary, any designation of your former spouse as beneficiary will be treated as though your former spouse had predeceased you. Exceptions to this are:

- you complete another beneficiary change form that clearly names your former spouse as beneficiary, or
- a court order meeting the requirements of a Qualified Domestic Relations Order (QDRO) is received by the Plan Administrator prior to the time of the distribution.

To designate or change beneficiaries for either your Keogh Plan or TSR Plan, contact Participant Services at Schwab Retirement Plan Services Company at 1-888-256-8830 or log on to www.401kaccess.com/scpmq.

**GENERAL INFORMATION**

This handbook provides summary highlights of your Southern California Permanente Medical Group benefits program. Complete details can be found in the insurance contracts and official plan documents that govern the plans. If there is a conflict between the official contracts and documents and this handbook, the official contracts and documents will govern.

*Effective March 1, 2014*
Claim Appeal Information

Information on how to appeal a denial of your claim for benefits under the welfare plans described under Health and Insurance Plan Names and Numbers section of this handbook is provided below. Please note, there are no claim appeal rights under the Commuter Choice Program benefit.

Claims Appeal Process for Fully Insured Welfare Plans

For welfare plans identified as fully insured (see Type of Administration in the Health and Insurance Plan Names and Numbers table earlier in this section), the claim appeal process is administered entirely by the designated provider. Welfare plans that are fully insured include KFHP Coverage, Dental Care Program Coverage, Disability Plan Coverage, and Life and Accident Plan Coverage.

A description of your claim appeal rights for fully insured plans may be found in the applicable booklet, certificate, or policy of insurance provided for the respective plan. You may contact Member Services at 1-800-464-4000 for more information or a copy of the booklet, certificate, or policy of insurance describing your rights.

Claim Appeal Process for Self-Insured Welfare Plans

SCPMG maintains a claim appeal process for welfare plans identified as self-insured. (See Type of Administration in the Health and Insurance Plan Names and Numbers table featured earlier in this section.) The claim appeal process for self-insured welfare plans is described below.

Either you or your authorized representative may file claims for plan benefits. An “authorized representative” means a person you authorize, in writing, to act on your behalf. The plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an Urgent Care Claim, a health care professional with knowledge of your condition may act as your authorized representative. All communications from the plan will be directed to your authorized representative unless your written designation provides otherwise.

Your initial claim should be filed with the applicable provider listed under Health and Insurance Plan Names and Numbers earlier in this section of the handbook. All claims are treated and filed on the date they are received. If your claim is denied in whole or in part, you will receive a written notice of the denial directly from the provider (also known as the Claims Administrator for the purposes of claim appeals). The notice will explain the reason for the denial and the review procedures. If you have any questions about your claim, please contact the Member Service Call Center at 1-800-464-4000.
Urgent Care Claims

If the plan requires advance approval of a service, supply, or procedure before a benefit will be payable, and if the plan or your physician determines that it is an Urgent Care Claim, you will be notified whether the service, supply, or procedure is payable under the plan no later than 72 hours after the claim is received, either orally or in writing.

“Urgent Care Claim” means a claim for services received for an illness, injury, or condition that could seriously jeopardize your life or health or your ability to regain maximum function, or a condition that, in your treating physician’s opinion, could subject you to severe pain that cannot adequately be managed without such care or treatment.

For Urgent Care Claims that name a specific claimant, medical condition, or service or supply for which approval is required, and that are submitted to the plan representative responsible for handling benefit matters, but otherwise fail to follow the plan’s procedures, you will be notified of the failure within 24 hours of receipt of the claim. You also will be informed of the proper procedures to be followed. The notice may be oral unless you or your authorized representative requests written notification. For the purposes of Urgent Care Claims, your physician will be considered your authorized representative unless you designate another individual in writing to the applicable Claims Administrator listed under Health and Insurance Plan Names and Numbers listed earlier in this section of the handbook.

If there is not sufficient information to decide the claim, you or your physician will be notified of the specific information necessary to complete the claim as soon as possible, but no later than 24 hours after receipt of the claim. You or your physician will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information. You or your physician will be notified of the decision no later than 48 hours after the end of the additional time period (or after receipt of the information, if earlier). If the decision is provided to you or your physician orally (unless you or your physician requests a written notification), you will be provided with a written or electronic notification no later than three days after you or your physician receives the oral notification.

Pre-Service and Post-Service Claims

If the plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, such a claim will be considered a Pre-Service Claim. You will be notified of the decision no later than 15 days after receipt of the Pre-Service Claim. All other claims will be deemed to be Post-Service Claims. You will be notified of a Post-Service Claim decision no later than 30 days after receipt of such claim.

For Pre-Service Claims that name a specific claimant, medical condition, and service or supply for which approval is required, and that are submitted to the plan representative responsible for handling benefit matters, but
which otherwise fail to follow the plan’s procedures, you will be notified of the failure within five days for Pre-Service Claims. You also will be informed of the proper procedures to be followed. The notice may be provided to you orally unless you or your representative request written notification.

For either a Pre-Service or a Post-Service Claim, the time period in which the decision must be made may be extended up to an additional 15 days due to circumstances beyond the plan’s control. In that case, you will be notified of the extension before the end of the initial 15- or 30-day period.

If there is not sufficient information to decide the claim, the notice of extension will specifically describe the information necessary to complete the claim. You will have at least 45 days from the date you receive the notice to provide the specified information. The Claims Administrator’s period for making the determination will exclude the period of time from the date the notification of the extension is sent to you until the date you respond to the request for additional information. If you fail to supply the requested information within the 45-day period, your claim will be denied.

**Ongoing Course of Treatment**

If you are receiving an ongoing course of treatment, you will be notified in advance if the plan intends to terminate or reduce previously authorized benefits for the course of treatment so that you will have the opportunity to appeal the decision before the termination or reduction takes effect. If the course of treatment involves an Urgent Care Claim, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

**Filing an Appeal of an Adverse Benefits Determination**

If your Urgent Care, Pre-Service, Post-Service, or Ongoing Course of Treatment claim is denied, you will receive a written notice which will include:

- the specific reasons for the denial;
- reference to the specific plan provisions upon which the denial is based;
- a description of any additional information you might be required to provide with an explanation of why it is needed;
- an explanation of the plan’s claims review and appeal procedures, including your right to bring a civil action in federal court following a denial of your appeal;
- a description of any internal rules, guidelines, protocols, or other similar criteria that were relied upon in the decision-making process, or a statement that explains your right to receive a copy of such information free of charge upon request;
• if the denial was based on medical necessity, experimental treatment, or other similar exclusion or limit, the notice shall contain either (a) an explanation of the clinical or scientific judgment for making such a decision, applying the terms of the plan to the medical condition; or (b) a statement that such explanation is available free of charge upon request; and

• in the case of an Urgent Care Claim, a description of the expedited appeals process available.

With the exception of Urgent Care Claims, you will have 180 days following receipt of an adverse benefit decision to appeal the decision. Your appeal must be in writing and submitted to Kaiser Foundation Health Plan, Inc., Special Services Unit, P.O. Box 7136, Pasadena, CA 91109. You will be notified of the decision no later than 30 days (for Pre-Service Claims) or 60 days (for Post-Service Claims) after the appeal is received. Along with your claim for benefits, you may submit written comments, documents, records and other information related to your claim, whether or not the comments, documents, records or information were submitted in connection with the initial claim. You also may request that the plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

The review will be made by a person different from the person who made the initial determination, and no deference will be afforded to the initial determination. The individual making the appeal determination will not be a subordinate of the original decision maker. In the case of a claim denied on the grounds of a medical judgment, a health professional with appropriate training and experience will be consulted. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate to such person. If the advice of a medical expert was obtained in connection with the denial of your claim, the names of each such expert will be provided to you upon request, regardless of whether the advice was relied upon.

If your claim involves an Urgent Care Claim, an expedited appeal may be initiated by a telephone call to the Expedited Review Unit at 1-888-987-7247. You or your physician may appeal Urgent Care Claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your physician and the plan by telephone, facsimile (fax), or other similar method. If the appeal decision is communicated to you or your physician orally, you will receive a written determination within three days following the oral determination. You will be notified of the decision no later than 36 hours after the appeal is received.

If your Urgent Care, Pre-Service, Post-Service or Ongoing Course of Treatment appeal is denied, you will receive a written notice which will include:
the specific reasons for the denial;

reference to the specific plan provisions upon which the denial is based;

your right to request access to or copies of all information relevant to your appeal;

your right to bring a civil action in federal court;

a description of any internal rules, guidelines, protocols, or other similar criteria that were relied upon in the decision-making process, or a statement that explains your right to receive a copy of such information free of charge upon request; and

if the denial was based on medical necessity, experimental treatment, or other similar exclusion or limit, the notice shall contain either (a) an explanation of the clinical or scientific judgment for making such a decision, applying the terms of the plan to the medical condition; or (b) a statement that such explanation is available free of charge upon request.

After receiving such a determination, you will have exhausted your administrative remedies under the plan, and you will have a right to bring an action for benefits in federal court under ERISA Section 502(a)(1)(B). You may also have the right to other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.

Benefits will be paid under the plan only if the appropriate Claims Administrator determines in its discretion that you are entitled to them.

**Claims Procedures for All Other Plans**

If you or your beneficiary apply for benefits under any self-insured welfare plan other than those discussed above (such as the Dependent Care Flexible Spending Account) and the application is denied by Ceridian, the Claims Administrator will notify the claimant of such denial in writing within 90 days, or within 180 days if the Claims Administrator notifies the claimant in writing that special circumstances require additional time for processing the claim. The notice will:

- explain the reason for the denial,
- refer to the specific plan provisions on which the denial is based,
- describe any additional material necessary to perfect the claim and explain why such material is necessary, and
- explain the steps to be taken if you wish to submit the claim for review and a statement of your right to bring a civil action in federal court if your claim is denied upon appeal.

Ceridian Flex Spending Customer Service can be reached at 1-877-799-8820.

Effective March 1, 2014
A claimant (or his or her duly authorized representative) may appeal the
Claims Administrator's denial of a claim by filing a written appeal with
the Claims Administrator within 60 days of the original denial. The appeal
must contain:

- the date on which the original application was filed,
- the specific portions of the denial the claimant wishes the Claims
  Administrator to review,
- a statement setting forth the reasons the denial should be reversed, and
- any written material the claimant wishes the Claims Administrator to
  examine when reconsidering the claim.

The Claims Administrator will permit the claimant to examine any
documents that are relevant to his or her claim. The Claims Administrator
will notify the claimant of its decision on the appeal in writing within
60 days, or within 120 days if the Claims Administrator notifies the claimant
in writing that special circumstances require additional time for reviewing
the appeal. If your appeal is denied, the notice will:

- explain the reason for the denial,
- refer to the specific plan provisions on which the denial is based,
- explain your right to request access to or copies of all information
  relevant to your appeal,
- explain any voluntary appeal procedures available and your right
  to obtain this information upon request free of charge; and
- your right to bring a civil action in federal court.

The Claims Administrator’s decision will be final and binding on all parties.
After receiving such a decision, the claimant will have exhausted his or her
administrative remedies under the plan, and will have a right to bring an
action for benefits in federal court under ERISA Section 502(a)(1)(B). You
may also have the right to other voluntary alternative dispute resolution
options, such as mediation. One way to find out what may be available
is to contact your local U.S. Department of Labor Office and your state
insurance regulatory agency.

Benefits will be paid under the plan only if the appropriate Claims
Administrator determines in its discretion that you are entitled to them.

Claims Procedures for Retirement Plans

Generally, the Southern California Permanente Medical Group Retirement
Plan (Keogh Plan) and the Southern California Permanente Medical Group
Physician’s Tax Savings Retirement Plan (TSR Plan) benefits begin in
accordance with the terms of the pertinent Retirement Plans. This typically
requires that you complete various forms before you begin receiving the
benefits you are entitled to under these Plans. However, in the event that
your Retirement Plan benefits do not begin timely, or if you believe that the
amount of your benefit may be incorrect or if you have any other dispute concerning your Retirement Plan benefits, you must file a formal written claim for benefits under the Retirement Plans’ benefit claim procedures. These benefit claim procedures apply to the SCPMG Keogh and TSR Plans.

In general, a claim for Retirement Plan benefits is a formal written request by a Claimant for the payment of a benefit due under the terms of the pertinent Retirement Plan. The following generally are not treated as formal claims for benefits:

- a request for determination of eligibility, enrollment or participation under the pertinent Retirement Plan without an accompanying written claim for benefits
- any casual or verbal inquiry relating to the pertinent Retirement Plan, including an inquiry regarding benefits or the circumstances under which benefits might be paid
- any claim or inquiry made to any employee or agent of SCPMG, or any other third-party administrator, which may include Schwab Retirement Plan Services or Kaiser Permanente Retirement Center
- a claim that is defective or otherwise fails to follow the benefit claims procedures for the Retirement Plans
- an application or request for benefits under the pertinent Retirement Plan.

**Filing a Claim**

SCPMG is responsible for ruling on your formal claim for benefits. All formal claims for benefits must be submitted by the Claimant in writing to: SCPMG Retirement Committee, c/o Permanente Human Resources, Southern California Permanente Medical Group, 393 E. Walnut Street, 3rd Floor, Pasadena, CA 91188-8018. The submission should indicate that you are filing a claim for benefits under the Retirement Plans.

**Initial Claim Determination**

If a claim for benefits is wholly or partially denied, SCPMG will, no later than 90 days after receipt of the claim (or 45 days after receipt of the claim in the case of a Disability claim), notify the Claimant of the denial of benefits.

**Extension of Time for Making the Initial Claim Determination**

In the case of a claim other than a Disability claim, if special circumstances justify extending the period up to an additional 90 days, the Claimant will be given written notice of this extension within the initial 90-day period, and the notice will set forth the special circumstances and the date on which a decision is expected.

In the case of a Disability claim, SCPMG will give the Claimant written notice before the end of the initial 45-day period that it needs an additional
30 days to review the claim, provided that the notice will set forth the circumstances beyond SCPMG’s control justifying the extension of the period and the date on which a decision is expected. If special circumstances beyond SCPMG’s control justify extending the claim review period for a Disability claim for an additional 30 days, then the Claimant will be provided written notice of this extension within the first 30-day period.

If a Claim Is Denied
If the claim is denied, in whole or in part, a notice of denial will be provided to the Claimant, and the denial will be written in a manner calculated to be understood by the Claimant. The notice of denial will contain all of the following:

- the specific reason for the denial of the claim
- specific reference to the pertinent Plan provisions on which the denial is based
- a description of any additional material or information necessary for the claimant to perfect the claim, along with an explanation as to why the material or information is necessary
- an explanation of the pertinent Plan’s benefit claims procedures and the time limits applicable to the procedures
- a statement regarding the Claimant’s right to bring a civil action under ERISA Section 502(a) following a denial of a claim

In the case of a Disability claim, the notice of denial will also include the following, if applicable:

- the specific internal rule, guideline, protocol or criteria relied upon in making the adverse determination and the right to receive a copy of the same, free of charge
- if the denial is based on a particular medical exclusion or limit, an explanation of the scientific or clinical judgment relied upon for the denial or the right to a copy of the same, free of charge

Review on Appeal
Within 60 days of receipt by the Claimant of the written denial (or within 180 days of receipt in the case of a Disability claim), the Claimant may file a written request with the Committee that it conduct a full review of the denial of the claim. The request for review must be submitted to: SCPMG Retirement Committee, c/o Permanente Human Resources, Southern California Permanente Medical Group, 393 E. Walnut Street, 3rd Floor, Pasadena, CA 91188-8018.

In connection with the Claimant’s appeal, upon request, the Claimant may review and obtain copies of all documents, records and other information relevant to the Claimant’s claim for benefits (but not including any document, record or information that is subject to any attorney-client or

Effective March 1, 2014
work-product privilege or whose disclosure would violate the privacy rights or expectations of any person other than the Claimant). The Claimant may submit written comments, documents, records and other information relating to the claim for benefits. All comments, documents, records and other information submitted by the Claimant will be taken into account in the appeal without regard to whether the information was submitted or considered in the initial claim determination.

Response to an Appeal

Generally, the Committee will provide the Claimant with a written response within 60 days after the receipt of the appeal. If special circumstances exist that justify extending this period, the Committee may consider the appeal for up to an additional 60 days (or 45 days in the case of a Disability claim). If the period is extended, the Claimant will be given written notice of this extension during the initial 60-day period (or 45-day period in the case of a Disability claim), and the notice will set forth the special circumstances and the date that a decision is expected.

If an Appeal Is Denied

If the claim is denied on review, in whole or in part, a notice of denial will be provided to the Claimant, and the denial will be written in a manner calculated to be understood by the Claimant. The notice of denial will contain the following:

- the specific reason for the decision
- specific references to the pertinent Plan provisions on which the decision is based
- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to other information relevant to the Claimant’s claim for benefits
- a statement regarding the Claimant’s right to bring a civil action under ERISA Section 502(a) following an adverse determination

In the case of a Disability claim, the decision on review will also include the following, if applicable:

- the specific internal rule, guideline, protocol or criteria relied upon in making the adverse determination and the right to receive a copy of the same, free of charge
- if the denial on review of the claim is based on a particular medical exclusion or limit, an explanation of the scientific or clinical judgment relied upon for the denial or the right to a copy of the same, free of charge
- the following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department
of Labor Office and your State insurance regulatory agency.”

Before proceeding to any legal remedy, including without limitation a suit for any benefit claims under the Plan, a Claimant must use all claims review procedures until all are completely exhausted and an adverse final benefit determination has been communicated in writing.

**HIPAA Privacy Notice**

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in our HIPAA privacy notice, which was distributed to you and is available upon request from the Member Service Call Center at 1-800-464-4000.

Neither SCPMG or the Kaiser Foundation Health Plan will use or further disclose information that is protected by HIPAA (“protected health information” or PHI) except as necessary for treatment, payment, health plan operations and plan administration, or as otherwise permitted or required by law. By law, SCPMG and Kaiser Foundation Health Plan have required all of its business associates to also observe HIPAA’s privacy rules. In particular, SCPMG and Kaiser Foundation Health Plan will not, without authorization, use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of SCPMG.

Under HIPAA, you have certain rights with respect to your PHI, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and, in certain circumstances, amend the information. You also have the right to file a complaint with SCPMG or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

The Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA’s privacy rules. For a copy of the notice, or if you have any questions about the privacy of your health information, or if you wish to file a complaint under HIPAA, contact the Member Service Call Center at 1-800-464-4000.

**Qualified Medical Child Support Order Procedures**

In accordance with federal law, SCPMG provides medical coverage to certain dependent children (called alternate recipients) if SCPMG is directed to do so by a Qualified Medical Child Support Order (QMCSO). This is an order or judgment from a court, or produced as a result of a state-authorized administrative process directing SCPMG to include a child in the physician’s coverage.

In addition to requiring you to provide coverage for the child, the law
authorizes SCPMG to make applicable payroll deductions, if any.

A medical child support order is qualified and enforceable if it specifies:

- your name and last known address,
- each alternate recipient’s name and address,
- a reasonable description of the coverage to which the alternate recipient is entitled,
- the coverage effective date,
- how long the child is entitled to coverage,
- each plan subject to the order.

When SCPMG receives a medical child support order, it will promptly notify both you and the alternate recipient that the order has been received and what procedures SCPMG will use to determine if the order is qualified. Then SCPMG will decide, on the basis of the plan’s written procedures and within a reasonable time, whether the order is qualified. Once the decision is made, SCPMG will notify you and the alternate recipient(s) by mail.

You can get more information on QMCSO procedures by contacting PHR Shared Services at 1-877-608-0044.

YOUR ERISA RIGHTS

As a participant in an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), you are entitled to certain rights and protections. ERISA provides that all qualified pension plan and welfare benefit plan participants shall be entitled to:

- Examine copies of all Plan documents including documents filed with the U.S. Department of Labor such as detailed annual reports and plan descriptions. This may be done at the Plan Administrator’s office without charge.
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator or the designee. The Administrator or the designee may make a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required to furnish each participant with a copy of this summary annual report, without charge.
- Obtain, free of charge, a statement telling you what benefits have accrued based on your years of service to date, and whether you have a nonforfeitable right to receive these benefits at normal retirement age (age 65) if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how much longer you have to work to be entitled to a pension. This statement must be requested in writing and is not required to be given more than once a year.
In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the benefit Plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one may fire you or otherwise discriminate against you in any way for the purpose of preventing you from obtaining a pension or welfare benefit or from exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan Committee review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim frivolous).

If you have any questions about your Plan you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Effective March 1, 2014
GLOSSARY OF TERMS
Terms related specifically to benefits are detailed here. However, there are many other terms used in describing each benefit, which are defined in the specific section of this handbook devoted to each of those benefits.

**Actively at Work**

Certain benefits require that you be actively at work for the coverage to take effect. Those benefits include Supplemental Medical Coverage, Alternate Mental Health Coverage, Disability Coverage and Life Insurance. Actively at work is defined as your being:

- actively working full-time at your place of business or other location to which you are required to travel to perform your regular duties,
- physically able to perform all such duties, and
- regularly working the required number of scheduled hours per week.

**Alcohol or Chemical Dependency**

Physical or psychological dependency, or both, on a controlled substance or alcohol agent. Does not include conditions not attributable to a mental disorder that are focus of attention or treatment; an addiction to nicotine products, food or caffeine intoxication.

**Activities of Daily Living (ADL)**

Basic activities of daily living consists of these self-care tasks: bathing, dressing/undressing, feeding, ambulating, maintaining continence, able to use toilet, and walking.

**Anniversary Date/Year**

The Anniversary Date is your benefits anniversary date for purposes of this Benefits Handbook and is your date of hire with any adjustments made for certain leave statuses and prior service credit. Your Anniversary Year is based on the Anniversary Date. Both affect service defined later in this section. The Anniversary Date is the date you first became an associate with any adjustment made due to leaves.

**Appropriate Care**

Appropriate care means the determination made by a doctor of an accurate and medically supported diagnosis of the cause of your disability that conforms to generally accepted medical standards, including frequency of treatment and care.

**Associate Physician**

Refers to an employee physician.
**Base Compensation**
The term Base Compensation is used for life insurance, disability and Common Plan benefits. Base Compensation includes:

- Starting base salary,
- Start base salary compensation adjustment,
- Base Compensation award programs,
- Standard longevity increases,
- Merit longevity and specialty/subspecialty merit longevity increases,
- General compensation adjustments,
- Merit increases,
- Board certification stipend,
- Partnership status increase, and
- Administrative stipend.

Each of these components of Base Compensation is defined in detail in the Partnership Agreement/Rules and Regulations [Section 5A.1.(a) – (l) and (l)]. Additional pay for extra duty, Year-End Performance Draw, or other special compensation is not included in Base Compensation.

Base Compensation is prorated to the work schedule. The work schedule in effect at the time of disability or death is used to determine any benefit amounts, except that salary increases received within the first six months of disability may increase benefits.

**Consumer Price Index (CPI-W)**
The Consumer Price Index for Urban Wage Earners is published by the U.S. Department of Labor. If the index is discontinued or changed, another nationally published index similar to the CPI-W will be used.

**Conversion Coverage**
Conversion coverage is a type of health care (within 63 days) or life insurance coverage (within 90 days) offered to an individual who was previously covered. Policies that offer conversion coverage may not offer the identical benefits to those the individual had previously and may be more expensive than the individual’s group coverage with SCPMG. However, policies that offer conversion coverage do not generally require any medical evidence of insurability if the conversion application is made within the required amount of time.

**Covered Earnings**
Covered earnings means the greater of:

- 50 percent of your monthly Base Compensation as of the onset
of disability prorated to your work schedule at that time (including compensation increases during the first six months of disability), or

- 50 percent of your average monthly gross compensation for the 12 months ending the June 30 or December 31 immediately preceding the onset of disability.

**Credited Service**

Credited Service is time counted to determine the amount of your retirement income. Credited Service generally is computed the same as Qualifying Service but is counted on a proportional basis. For example, if you work an 8/10 schedule for 10 years, you earn 10 years of Qualifying Service, but only eight years of Credited Service. The first year of postgraduate training while an employee of Kaiser Foundation Hospitals does not count as Credited Service; however, any subsequent years do count as Credited Service.

**Dependent Children**

Dependent children are your children or the children of your spouse or domestic partner by birth, legal adoption, placement for adoption, or legal guardianship. In addition, dependent children include any child that is the subject of a Qualified Medical Child Support Order.

**Domestic Partner**

A domestic partner is an individual who you, as an unmarried physician, enroll for Health Plan benefits. Both you and your domestic partner must sign the Affidavit in Support of Eligibility for Health Care Coverage for Domestic Partners of All Physicians of Southern California Permanente Medical Group in order to be covered.

In addition, your domestic partner:

- must live with you, and
- cannot be related to or employed by you (such as a housekeeper).

You may enroll only one domestic partner at a time for health plan benefits. At least twelve months must elapse between the enrollment date of one domestic partner and the enrollment date of a subsequent domestic partner. Dependent children of a domestic partner may also enroll.

**Eligible Dependents**

Eligible dependents are individuals who may be eligible for coverage under the Kaiser Foundation Health Plan, Supplemental Medical Plan, Alternate Mental Health Plan, and Dental Care benefits. They are your:
• spouse or domestic partner, and
• dependent children.

The age at which dependent children become ineligible for health care benefits depends on the benefit. Kaiser Foundation Health Plan coverage, Supplemental Medical coverage, and Alternate Mental Health coverage stops for dependent children at age 26 regardless of student status. Dental coverage stops for dependent children at age 26 regardless of student status.

All health care continues for disabled dependent children for their lifetimes if they are incapable of self-support due to a mental or physical handicap that has been approved by Kaiser Foundation Health Plan, and their disability occurred prior to a loss of eligibility under the respective plan(s) due to age. Proof may be required annually.

**Gross Compensation**

Gross compensation is your monthly Base Compensation plus overnight and extra duty pay, but excludes amounts received as bonuses, awards, Imputed Income, or year-end performance draw.

**Health Plan**

Health Plan refers to Kaiser Foundation Health Plan, Inc.

**Imputed Income**

The cost of medical, dental, disability, and life insurance benefits paid for by the Medical Group on behalf of each Partner. It’s taxable compensation to the physician.

**Indexed Covered Earnings**

For the first 12 months, monthly benefits are payable, Indexed Covered Earnings will be equal to Covered Earnings. After 12 monthly benefits are payable, Indexed Covered Earnings will be a Physician’s Covered Earnings plus an increase applied on each anniversary of the date monthly benefits become payable. The amount of each increase will be the lesser of: 10% of the Physician’s Indexed Covered Earnings during the preceding year of Disability; or the rate of increase in the Consumer Price Index during the preceding calendar year.

Indexed Covered Earnings does not increase the disability benefit amount, however, it is designed to protect the physician’s eligibility under the 80% rule from being eroded by inflation.

**In-Service Death**

Your death while still working and considered “active status.”

*Effective March 1, 2014*
**Kaiser Permanente Multi-Site Plan**

The Kaiser Permanente Multi-Site Plan is an alternative to Kaiser Foundation Health Plan, Senior Advantage and the Comprehensive Medical Plan for eligible retirees. The Kaiser Permanente Multi-Site Plan provides health care benefits. Any physician eligible for health care benefits in retirement who moves out of a Kaiser Permanente service area is required to elect the Comprehensive Medical or Multi-Site Plan in place of KFHP.

**Mental Illness**

Any condition or disorder that carries with it a psycho-pathological diagnosis contained in the Diagnostic and Statistical Manual of Mental Disorders (Third Edition - Revised, or any subsequent edition or revision thereof) by the American Psychiatric Association, irrespective of whether the condition or disorder has an identifiable congenital, hereditary, biochemical or other physiological cause.

**Medicare Reimbursement**

Available to retirees and their spouse or domestic partner who are Medicare-eligible (age 65) and enrolled in the Kaiser Foundation Health Plan. Retirees must meet the retirement criteria to qualify for this benefit, and Medicare must be assigned to Kaiser Foundation Health Plan. If eligible, SCPMG will reimburse for the Medicare Part B Premium to the retired physician and spouse or domestic partner.

**Qualifying Service**

Qualifying Service is time counted to determine if you are eligible for benefits. Qualifying Service includes both full-time and part-time (half-time or more) service, and can include periods devoted to certain other activities such as medical research and advanced study approved by the Plan’s Administrative Committee. Time spent in postgraduate training as an employee of Kaiser Foundation Hospitals does not count as Qualifying Service.

**R & C**

Reasonable and customary.

**Same-Sex Spouse**

If you have a same-sex spouse recognized under California law, the same-sex spouse will be treated as a spouse for the purposes of eligibility and enrollment. You may enroll your same-sex spouse and your dependent children, if any, normally with a valid marriage certificate.
Senior Advantage

Senior Advantage refers to the Medicare Risk Contract between Kaiser Foundation Health Plan, Inc. and the Health Care Finance Administration (HCFA), and is the health care coverage available for you and your spouse/domestic partner generally upon reaching age 65 (if you are no longer working and are eligible for benefits).

Special Dependents

Special dependents are individuals who are covered for Health Plan benefits. They are your:

- parents, spouse’s parents, or domestic partner’s parents, and
- over age children and their eligible dependents.

Spouse

Your legally recognized spouse. This definition does not include your legally separated or divorced spouse, even if the separation agreement or divorce states that coverage must be provided.

Southern California Permanente Medical Group (SCPMG)

SCPMG is the plan sponsor of benefits described in this handbook and employs the eligible classes of physicians defined in the first section of this handbook. It is also referred to as Medical Group.

Totally Disabled

For life insurance continuation purposes, you are considered totally disabled if, because of injury or sickness, you are unable to perform all material duties of your occupation. This is different from the definition of total disability as described in the Disability Income Protection section of this handbook.

Year-End Performance Draw

Partner earnings represent the net income of Medical Group (i.e., the amount remaining after expenses are deducted from revenues). The paychecks that Partners receive every two weeks are considered an advance against Medical Group’s anticipated net earnings and do not include Year-End Performance Draw. Planned Year-End Performance Draw is the amount budgeted for distribution to the Partners following year end. Year-End Performance Draw is the amount that is actually available for distribution at the end of the year. Your individual share of Year-End Performance Draw will be prorated to the portion of the year for which you are a Partner, and will be proportional to your work schedule. Other factors may reduce your Year-End Performance Draw. (Formerly known as At-Risk Compensation.)
Grandfathered Health Plan Notice

For Kaiser Permanente employees eligible for employer-provided grandfathered medical plans

Grandfathered Health Plans

A reminder about your health plans

Kaiser Permanente believes that your employer-provided major medical plans are “grandfathered health plans” under the Patient Protection and Affordable Care Act ("the Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your health plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, such as the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to grandfathered health plans, and what might cause a plan to lose grandfathered health plan status can be directed to the plan administrator:

Kaiser Foundation Health Plan, Inc.,
One Kaiser Plaza, 20th floor
Oakland, CA 94612
(510) 271-5940

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.