Exhibit C

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Northern California Region

A nonprofit corporation

Kaiser Permanente Traditional Plan Evidence of Coverage for GOOGLE INC.

Purchaser ID: 39717 Contract: 1 Version: 12 *EOC* Number: 2

July 1, 2004 through June 30, 2005

Member Service Call Center
7 a.m. to 7 p.m.
Seven days a week (except holidays)
1-800-464-4000
Hearing and speech impaired
TTY line 1-800-777-1370
www.kaiserpermanente.org

Introduction

This *Evidence of Coverage (EOC)* describes the health care coverage of "Kaiser Permanente Traditional Plan" provided under the *Agreement* between Kaiser Foundation Health Plan, Inc., and your Group. For benefits provided under any other Health Plan program, refer to that plan's *Evidence of Coverage*. In this *EOC*, Kaiser Foundation Health Plan, Inc., is sometimes referred to as "Health Plan," "we," or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this *EOC*; please see the "Definitions" section for terms you should know.

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

Term of this *EOC*

This *EOC* is for the period July 1, 2004 through June 30, 2005 unless amended. Your Group's benefits administrator can tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has expired or been amended.

About Kaiser Permanente

Kaiser Permanente provides Services directly to our Members through an integrated medical care program. Our Health Plan, Plan Hospitals, and Medical Group work together to provide our Members with quality care. Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital care, laboratory and pharmacy Services, and other benefits described in the "Benefits" section.

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

- Getting a referral, in the "How to Obtain Services" section
- Our Visiting Member Program, in the "How to Obtain Services" section
- Emergency Care, Out-of-Area Urgent Care, and Post-stabilization Care received from non–Plan Providers, in the "Emergency, Urgent, and Routine Care" section

Dues, Eligibility, and Enrollment

Dues

Your Group is responsible for paying Dues. If you are responsible for any contribution to the Dues, your Group will tell you the amount and how to pay your Group (through payroll deduction, for example).

Who Is Eligible

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

Group eligibility requirements

You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of its eligibility requirements, such as the minimum number of hours that employees must work to be eligible for coverage. Please note that your Group might not allow enrollment to some persons who meet the requirements under "Service Area eligibility requirements" and "Additional eligibility requirements."

Service Area eligibility requirements

The Subscriber must live or work in our Service Area at the time he or she enrolls. The "Definitions" section describes our Service Area and how it may change. You cannot enroll or continue enrollment as a Subscriber or Dependent if you live in or move to a Region outside California except as described below. If you move anywhere else outside our Service Area after enrollment, you can continue your membership as long as you meet all other eligibility requirements. However, you must receive covered Services from Plan Providers inside our Service Area, except for Emergency Care, Out-of-Area Urgent Care, and Post-stabilization Care received from non–Plan Providers described in the "Emergency, Urgent, and Routine Care" section and "Our Visiting Member Program" described in the "How to Obtain Services" section.

Regions outside California. If you live in or move to the service area of a Region outside California, you are not eligible for membership under this *EOC* (unless one of the exceptions listed below applies to you). Please contact your Group's benefits administrator to learn about your Group health care options. You may be able to enroll in the new service area if there is an agreement between your Group and the Region, but the coverage, dues, and eligibility requirements might not be the same in the other service area.

Exceptions — This restriction does not apply to the following persons (see "Our Visiting Member Program" in the "How to Obtain Services" section for information about benefits when you are in another service area):

- A Subscriber who works inside our Service Area
- The Subscriber's or the Subscriber's Spouse's children
- Members who are eligible under this *EOC* because of COBRA, Cal-COBRA, or USERRA coverage (please refer to the "Continuation of Membership" section for information about COBRA, Cal-COBRA, or USERRA coverage)

For the purposes of this eligibility rule, the service areas of these non-California Regions may change on January 1 of each year and are currently the District of Columbia, Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington. For more information, please call our Member Service Call Center.

Southern California Region's service area. If you live in or are moving to our Southern California Region's service area, please contact your Group's benefits administrator to learn about your Group health care options. Your Group may have an arrangement with us that permits membership in the Southern California Region, but the coverage, dues, and eligibility requirements might not be the same as under this *EOC*.

Additional eligibility requirements

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

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

If you are a Subscriber, the following persons may be eligible to enroll as your Dependents:

- Your Spouse. For the purposes of this *EOC*, the term "Spouse" includes your domestic partner, in accord with your Group's requirements that we approve in writing
- Your or your Spouse's unmarried children (including adopted children or children placed with you for adoption) who are under age 19, or under age 25 if a student as defined by your Group
- Other unmarried dependent persons (but not including foster children) who meet all of the following requirements:
  - they are under age 19, or under age 25 if a student as defined by your Group
  - they receive all of their support and maintenance from you or your Spouse
  - they permanently reside with you (the Subscriber)
  - you or your Spouse is the court-appointed guardian (or was before the person reached age 18) or the person's parent is an enrolled Dependent under your family coverage
- Dependents who meet the Dependent eligibility requirements except for the age limit may be eligible if they meet all the following requirements:
  - they are incapable of self-sustaining employment because of mental retardation or physical handicap that occurred prior to reaching the age limit for Dependents
  - they receive substantially all of their support and maintenance from you or your Spouse
  - you give us proof of their incapacity and dependency within 31 days after we request it

Persons barred from enrolling in Health Plan

- Persons who have had their entitlement to receive Services through Health Plan either rescinded or terminated for cause cannot enroll
- Persons who have had entitlement to receive Services through Health Plan terminated for failure to pay individual (nongroup) plan dues or failure to pay any amounts owed to Health Plan or a Plan Provider cannot enroll, unless we agree to allow you to enroll after you pay all amounts owed by you and your dependents

Members with Medicare and retirees

This plan is not intended for most Medicare beneficiaries and some Groups do not offer coverage to retirees. If, during the term of this *EOC*, you are or become eligible for Medicare or you retire, please ask your Group's benefits administrator about your membership options as follows:

- If a Subscriber retires who is entitled to Medicare Parts A and B, and the Subscriber's Group has a Kaiser Permanente Senior Advantage plan for retirees, the Subscriber should enroll in the plan if eligible
- If the Subscriber retires and your Group does not offer coverage to retirees, you may be eligible to continue membership as described in the "Continuation of Membership" section of this *EOC*
- If federal law requires that your Group's health care plan be primary and Medicare coverage be secondary, your coverage under this *EOC* will be the same as it would be if you had not become eligible for Medicare. However, you may be eligible to enroll in Kaiser Permanente Senior Advantage through your Group if you are entitled to Medicare Parts A and B
- If you are or become eligible for Medicare and are in a class of beneficiaries for which your Group's health care plan is secondary to Medicare, you should enroll in Kaiser Permanente Senior Advantage through your Group if you are eligible
- If none of the above applies to you and you are eligible for Medicare or you retire, please ask your Group's benefits administrator about your membership options

When Medicare is primary. If you are or become eligible for Medicare Part A or Part B (or both), as primary coverage, and you are not enrolled through your Group in Kaiser Permanente Senior Advantage for any reason (even if you are not eligible to enroll or the plan is not available to you), your Group's Dues may increase. If your Group fails to pay the entire Dues required for your Family Unit, your membership will be terminated in accord with "Partial payment of Dues for a Family Unit" under "Termination for Nonpayment" in the "Termination of Membership" section.

When Medicare is secondary. Medicare is the primary coverage except when federal law requires that your Group's health care plan be primary and Medicare coverage be secondary. Members eligible for Medicare as their secondary coverage are subject to the same Dues and receive the same benefits as Members who are not eligible for Medicare. However, any such Members who meet the eligibility requirements for our Kaiser Permanente Senior Advantage plan may enroll in Senior Advantage if the plan is available to you. These Members receive the benefits and coverage described in the Kaiser Permanente Senior Advantage (MSP) *EOC*.

Note: You may be ineligible to enroll in Kaiser Permanente Senior Advantage if that plan has reached a capacity limit that the Centers for Medicare & Medicaid Services has approved. This limitation does not apply to existing Members who are eligible for Medicare (for example, when you turn age 65).

When You Can Enroll and When Coverage Begins

Your Group is required to inform you when you are eligible to enroll and your effective date of coverage. If you are eligible to enroll as described under "Who Is Eligible" in this "Dues, Eligibility, and Enrollment" section, enrollment is permitted as follows and membership begins at the very beginning (12:00 a.m.) of the effective date of coverage indicated below (your Group may have additional requirements that we have approved, which allow enrollment in other situations).

New employees

When your Group informs you that you are eligible to enroll as a Subscriber, you may enroll yourself and any eligible Dependents by submitting a Health Plan–approved enrollment application to your Group within 31 days.

Effective date of coverage. The effective date of coverage for new employees and their eligible family Dependents is the date of hire.

Newly acquired Dependents

To enroll a Dependent who becomes eligible to enroll after you became a Subscriber (such as a new Spouse, a newborn child, or a newly adopted child), you must submit a Health Plan–approved change of enrollment form to your Group within 31 days after the Dependent becomes eligible. Also, refer to "Special enrollment due to new Dependents" below.

Effective date of coverage. Other than a newborn or a newly adopted child (including a child placed with you for adoption), the effective date of coverage for newly acquired Dependents is the date of acquisition. For a newborn or a newly adopted child, the effective date of coverage is as follows:

- A newborn child is covered from the moment of birth if the Subscriber enrolls the child within 31 days after birth. Any Dues required for the newborn will be effective the first of the month following birth
- If the newborn child is not enrolled within 31 days, the newborn is covered only through the calendar month of birth, or the mother's hospitalization if she is a Member, whichever is later
- A newly adopted child's (including a child placed with you for adoption) membership will begin on the date when the adopting parent gains the legal right to control the child's health care if the Subscriber enrolls the child within 31 days of that date

Special enrollment due to new Dependents

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, within 30 days of marriage, birth, adoption, or placement for adoption by submitting to your Group an enrollment or change of enrollment application in a form agreed upon by your Group and Health Plan.

Effective date of coverage. The effective date of an enrollment resulting from marriage is no later than the first day of the month following the date that the Subscriber signs an enrollment or change of enrollment application. Enrollments due to birth, adoption, or placement for adoption are effective on the date of birth, adoption, or placement for adoption.

Special enrollment due to loss of other coverage

An employee and the employee's eligible Dependents may enroll within 30 days of losing other coverage by submitting to your Group an enrollment or change of enrollment application in a form agreed upon by your Group and Health Plan. The employee who is requesting enrollment must have previously waived coverage for self or family Dependents when originally eligible because of the other coverage. In addition, the loss of the other coverage must be due to ineligibility to continue the other coverage, Group continuation of coverage has expired, or the other employer has ceased making contributions toward the other coverage and the loss of coverage is not due to nonpayment or cause. The employee must enroll or be enrolled in order to enroll a family Dependent.

Effective date of coverage. The effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date that the Subscriber signs an enrollment or change of enrollment application.

Special enrollment due to court or administrative order

Within 31 days after the date of a court or administrative order requiring a Subscriber to provide health coverage for a child who meets the eligibility requirements as a Dependent, the Subscriber may add the child as a Dependent by submitting to Group an enrollment or change of enrollment application in a form agreed upon by Group and Health Plan.

Effective date of coverage. The effective date of an enrollment resulting from a court or administrative order is the date of the court order.

Open enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan–approved enrollment application to your Group during the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the effective date of coverage.

You or your physician must request an expedited decision in one of the following ways and you must specifically state that you want an "expedited decision":

- Call toll free 1-888-987-7247
- Send your written request to Kaiser Foundation Health Plan, Inc., Advocacy Program, P.O. Box 12983, Oakland, CA 94604-2983, Attention: Expedited Review
- Fax your written request to 1-888-987-2252
- Deliver your request in person to your local Member Services Department at a Plan Facility

If we deny your request for an expedited decision, we will notify you and we will respond to your request for coverage as described under "Standard decision." If we deny your request for coverage in whole or in part, our written decision will fully explain why we denied it and how you can file a grievance.

Note: If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the DMHC directly at any time without first filing a grievance with us.

Dispute Resolution

Grievances

We are committed to providing you with quality care and with a timely response to your concerns if an issue arises. Our Member Service representatives are available to discuss your concerns at most Plan Facilities or you can call our Member Service Call Center.

You can file a grievance for any issue. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about Services you received. You may submit your grievance orally or in writing as follows:

- To a Member Service representative at your local Member Services Department at a Plan Facility (please refer to *Your Guidebook* for locations)
- Through our Web site at *www.members.kp.org*
- To the following location for claims described under "Non–Plan Emergency Care, Out-of-Area Urgent Care, or Post-stabilization Care" in the "Requests for Payment or Services" section:

  Kaiser Permanente
  Special Services Unit
  P.O. Box 23280
  Oakland, CA 94623

We will send you a confirming letter within five days of our receipt of your grievance. We will send you our written decision within 30 days. If we deny your grievance in whole or in part, our written decision will fully explain why we denied it and additional dispute resolution options.

Expedited grievance

You or your physician may make an oral or written request that we expedite our decision about your grievance if it involves imminent and serious threat to your health, such as severe pain or potential loss of life, limb, or major bodily function. We will inform you of our decision within 72 hours (orally or in writing).

We will also expedite our decision if the request is for a continuation of an expiring course of treatment.

You or your physician must request an expedited decision in one of the following ways and you must specifically state that you want an "expedited decision":

- Call toll free 1-888-987-7247
- Send your written request to Kaiser Foundation Health Plan, Inc., Advocacy Program, P.O. Box 12983, Oakland, CA 94604-2983, Attention: Expedited Review
- Fax your written request to 1-888-987-2252
- Deliver your request in person to your local Member Services Department at a Plan Facility

If we deny your request for an expedited decision, we will notify you and we will respond to your grievance within 30 days. If we deny your grievance in whole or in part, our written decision will fully explain why we denied it and additional dispute resolution options.

Note: If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the DMHC directly at any time without first filing a grievance with us.

Providing Supporting Documents for Your Request

It is helpful for you to include any information that clarifies or supports your position. You may want to include with your grievance supporting information, such as medical records or physician opinions in support of your request. When appropriate, we will request medical records from Plan Providers on your behalf. If you have consulted with a non–Plan Provider, and are unable to provide copies of relevant medical records, we will contact the provider to request a copy of your medical records. We will ask you to send or fax us a written authorization so that we can request your records. If we do not receive the information we request in a timely fashion, we will make a decision based on the information we have.

Who May File

The following persons may file a grievance:

- You may file for yourself
- You may appoint someone as your authorized representative by completing our authorization form. Authorization forms are available from your local Member Services Department at a Plan Facility or by calling our Member Service Call Center. Your completed authorization form must accompany the grievance
- You may file for your Dependent children, except that they must appoint you as their authorized representative if they have the legal right to control release of information that is relevant to the grievance
- You may file for your ward if you are a court-appointed guardian
- You may file for your conservatee if you are a court-appointed conservator
- You may file for your principal if you are an agent under a health care proxy, to the extent provided under state law
- Your physician may request an expedited grievance as described under "Expedited grievance" above

DMHC Complaints

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(1-800-464-4000)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department' s Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

Independent Medical Review (IMR)

If you qualify, you or your authorized representative may have your issue reviewed through the Independent Medical Review (IMR) process managed by the California Department of Managed Health Care (DMHC). The DMHC determines which cases qualify for IMR. This review is at no cost to you. If you decide not to request an IMR, you may give up the right to pursue some legal actions against us.

You may qualify for IMR if all of the following are true:

- One of these situations applies to you: (1) you have a recommendation from a provider requesting Medically Necessary Services, (2) you have received Emergency Care or urgent care from a provider who determined the Services to be Medically Necessary, or (3) you have been seen by a Plan Provider for the diagnosis or treatment of your medical condition
- Your request for payment of a Service has been denied, modified, or delayed based in whole or in part on a decision that the Service is not Medically Necessary
- You have filed a grievance and we have denied it or we haven't made a decision about your grievance within 30 days (or three days for expedited grievances). The DMHC may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function

You may also qualify for IMR if the Service you requested has been denied on the basis that it is experimental or investigational as described under "Experimental or Investigational denials."

If DMHC determines that your case is eligible for IMR, it will ask us to send your case to the DMHC's Independent Medical Review organization. The DMHC will promptly notify you of its decision after it receives the Independent Medical Review organization's determination. If the decision is in your favor, we will contact you to arrange for the Service or payment.

Experimental or Investigational denials

If we deny a Service because it is experimental or investigational, we will send you our written explanation within five days of making our decision. We will explain why we denied the Service and provide additional dispute resolution options. Also, we will provide information about your right to request Independent Medical Review if we had the following information when we made our decision:

- Your treating physician provided us a written statement that you have a life-threatening or seriously debilitating condition and that standard therapies have not been effective in improving your condition, or that standard therapies would not be appropriate, or that there is no more beneficial standard therapy we cover than the therapy being requested
  - "life-threatening" means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival
  - "seriously debilitating" means diseases or conditions that cause major irreversible morbidity
- If your treating physician is a Plan Physician, he or she recommended a treatment, drug, device, procedure, or other therapy and certified that the requested therapy is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Plan Physician in certifying his or her recommendation
- You (or your non–Plan Physician who is a licensed, and either a board-certified or board-eligible, physician qualified in the area of practice appropriate to treat your condition) requested a therapy that, based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy. The physician's certification included a statement of the evidence relied upon by the physician in certifying his or her recommendation. We do not cover the Services of the non–Plan Provider

Note: You can request IMR for experimental or investigational denials at any time without first filing a grievance with us.

Binding Arbitration

For all claims subject to this "Binding Arbitration" section both Claimants and Respondents give up the right to a jury or court trial, and accept the use of binding arbitration. Insofar as this "Binding Arbitration" section applies to claims asserted by Kaiser Permanente Parties, it shall apply retroactively to all unresolved claims that accrued before the effective date of this *EOC*. Such retroactive application shall be binding only on the Kaiser Permanente Parties.

Scope of Arbitration

Any dispute shall be submitted to binding arbitration if all of the following requirements are met:

1. The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *EOC* or a Member Party's relationship to Kaiser Foundation Health Plan, Inc., (Health Plan), including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, Services, irrespective of the legal theories upon which the claim is asserted
2. The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties
3. The claim is *not* within the jurisdiction of the Small Claims Court
4. If the Member's Group must comply with the Employee Retirement Income Security Act (ERISA) requirements, the claim is *not* a benefit-related request that constitutes a "benefit claim" in Section 502(a)(1)(B) of ERISA. Note: Benefit claims under this Section of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor regulation prohibiting mandatory binding arbitration of this category of claim (29 CFR 2560.503-1(c)(4)) is modified, amended, repealed, superseded, or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without further notice

As referred to in this "Binding Arbitration" section,

1. "Member Parties" include:
   a. A Member,
   b. A Member's heir or personal representative, or
   c. Any person claiming that a duty to him or her arises from a Member's relationship to one or more Kaiser Permanente Parties.
2. "Kaiser Permanente Parties" include:
   a. Kaiser Foundation Health Plan, Inc. (Health Plan),
   b. Kaiser Foundation Hospitals (KFH),
   c. The Permanente Medical Group, Inc. (TPMG),
   d. Southern California Permanente Medical Group (SCPMG),
   e. The Permanente Federation, LLC,
   f. The Permanente Company, LLC,
   g. Any KFH, TPMG, or SCPMG physician,
   h. Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Member Parties, or
   i. Any employee or agent of any of the foregoing.
3. "Claimant" refers to a Member Party or a Kaiser Permanente Party who asserts a claim as described above.
4. "Respondent" refers to a Member Party or a Kaiser Permanente Party against whom a claim is asserted.

Arbitration Oversight Board and Independent Administrator

In 1997, Health Plan assembled a Blue Ribbon Panel to evaluate the arbitration system and recommend improvements. The Panel's recommendations included the establishment of an Independent Administrator to oversee the arbitration process and an Advisory Committee with broad representation to assist in the independent administration. The Independent Administrator and the Advisory Committee established Rules of Procedure applicable to Health Plan's arbitration system. In 2002, the Advisory Committee was replaced by an Arbitration Oversight Board.

Initiating Arbitration

Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the claim against the Respondents; the amount of damages the Claimants seek in the arbitration; the names, addresses, and telephone numbers of the Claimants and their attorney, if any; and the names of all Respondents. Claimants shall include all claims against Respondents that are based on the same incident, transaction, or related circumstances in the Demand for Arbitration.

Serving Demand for Arbitration

Health Plan, KFH, TPMG, SCPMG, The Permanente Federation, LLC, and The Permanente Company, LLC shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of:

Kaiser Foundation Health Plan, Inc.
Legal Department
1950 Franklin Street, 17th Floor
Oakland, CA 94612

Service on that Respondent shall be deemed completed when received.

All other Respondents, including individuals, must be served as required by the California Code of Civil Procedure for a civil action.

Filing Fee

The Claimants shall pay a single, non-refundable, filing fee of $150 per arbitration payable to "Arbitration Account" regardless of the number of claims asserted in the Demand for Arbitration or the number of Claimants or Respondents named in the Demand for Arbitration.

Any Claimant who claims extreme hardship may request that the Independent Administrator waive the filing fee and the Neutral Arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling the Kaiser Permanente Member Service Call Center.

Number of Arbitrators

The number of Arbitrators may affect the Claimant's responsibility for paying the Neutral Arbitrator's fees and expenses.

If the Demand for Arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one Neutral Arbitrator, unless the parties otherwise agree in writing that the arbitration shall be heard by two Party Arbitrators and a Neutral Arbitrator. The Neutral Arbitrator shall not have authority to award monetary damages that are greater than $200,000.

If the Demand for Arbitration seeks total damages of more than $200,000, the dispute shall be heard and determined by one Neutral Arbitrator and two Party Arbitrators, one jointly appointed by all Claimants and one jointly appointed by all Respondents. Parties who are entitled to select a Party Arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a Single Neutral Arbitrator.

Payment of Arbitrator Fees and Expenses

Health Plan will pay the fees and expenses of the Neutral Arbitrator under certain conditions as set forth in the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* (Rules of Procedure). In all other arbitrations, the fees and expenses of the Neutral Arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

If the parties select Party Arbitrators, Claimants shall be responsible for paying the fees and expenses of their Party Arbitrator and Respondents shall be responsible for paying the fees and expenses of their Party Arbitrator.

Costs

Except for the aforementioned fees and expenses of the Neutral Arbitrator, and except as otherwise mandated by laws that apply to arbitrations under this "Binding Arbitration" section, each party shall bear the party's own attorneys' fees, witness fees, and other expenses incurred in prosecuting or defending against a claim regardless of the nature of the claim or outcome of the arbitration.

Rules of Procedure

Arbitrations shall be conducted according to Rules of Procedure developed by the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from the Member Service Call Center.

General Provisions

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondents served by the applicable statute of limitations, or (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (i) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (ii) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the Neutral Arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the Neutral Arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for noneconomic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any claims for professional negligence or any other claims as permitted by law.

Arbitrations shall be governed by this "Binding Arbitration" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this section.

Termination of Membership

Your Group is required to inform the Subscriber of the date your membership terminates. Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2004, your last minute of coverage was at 11:59 p.m. on December 31, 2003). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further liability or responsibility under this *EOC* after your membership terminates, except as provided under "Payments after Termination" in this "Termination of Membership" section.

Termination Due to Loss of Eligibility

If you meet the eligibility requirements described under "Who Is Eligible" in the "Dues, Eligibility, and Enrollment" section on the first day of a month, but later in that month you no longer meet those eligibility requirements, your membership will end at 11:59 p.m. on the last day of that month. For example, if you become ineligible on December 5, 2003, your termination date is January 1, 2004 and your last minute of coverage is at 11:59 p.m. on December 31, 2003.

Termination of *Group Agreement*

If your Group's *Agreement* with us terminates for any reason, your membership ends on the same date. Your Group is required to notify Subscribers in writing if its *Agreement* with us terminates.

Termination for Cause

If you commit one of the following acts, we may terminate your membership immediately by sending written notice to the Subscriber; termination will be effective on the date we send the notice:

- Your behavior threatens the safety of Plan personnel, or of any person or property at a Plan Facility
- You commit theft from Health Plan, from a Plan Provider, or at a Plan Facility

Nondiscrimination
We do not discriminate in our employment practices or in the delivery of Services on the basis of age, race, color, national origin, cultural background, religion, sex, sexual orientation, or physical or mental disability.

Notices
Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call our Member Service Call Center, as soon as possible to give us their new address. If a Member does not reside with the Subscriber, he or she should contact our Member Service Call Center to discuss alternate delivery options.

Overpayment recovery
We may recover any overpayment we make for Services from anyone who receives such an overpayment or from any person or organization obligated to pay for the Services.

Privacy practices
Kaiser Permanente will protect the privacy of your Protected Health Information (PHI). We also require contracting providers to protect your PHI. PHI is health information that includes your name, Social Security number, or other information that reveals who you are. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment, and health care operations purposes, including health research and measuring the quality of care and Services. We are sometimes required by law to give PHI to government agencies or in judicial actions. In addition, Member-identifiable medical information is shared with employers only with your authorization or as otherwise permitted by law. We will not use or disclose your PHI for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* describing our policies and procedures for preserving the confidentiality of medical records and other PHI is available and will be furnished to you upon request. To request a copy, please call our Member Service Call Center. You can also find the notice at your local Plan Facility or on our Web site at *www.members.kp.org*.

Definitions

The following terms, when capitalized and used in any part of this *EOC*, mean:

Charges: Charges means the following:
- For Services for which the provider is compensated on a capitation basis, the charges in the provider's schedule of charges for Services provided to the general public (or, for Members, the provider's schedule of charges for Services provided to Members, if different)
- For items covered under "Drugs, Supplies, and Supplements" and obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan)
- For all other Services, the payments that Kaiser Permanente made for the Services

Clinically Stable: You are considered Clinically Stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service as listed in the "Copayments and Coinsurance" section.

Copayment: A specific dollar amount that you must pay when you receive a covered Service as listed in the "Copayments and Coinsurance" section.

Dependent: A Member who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements, see "Who Is Eligible").

Dues: Periodic membership charges paid by Group.

Emergency Care: Emergency Care is:
- Evaluation by a physician (or other appropriate personnel under the supervision of a physician to the extent provided by law)
- Medically Necessary Services required to make you Clinically Stable within the capabilities of the facility
- Emergency ambulance Services covered under "Ambulance Services" in the "Benefits" section

Emergency Medical Condition: An Emergency Medical Condition is:
- A medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in any of the following:
  - serious jeopardy to your health
  - serious impairment to your bodily functions
  - serious dysfunction of any bodily organ or part
- "Active labor," which means a labor when there is inadequate time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to the health and safety of the Member or unborn child

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

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

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

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

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

Medicare: A federal health insurance program for people age 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

Member: A person who is eligible and enrolled under this *EOC*, and for whom we have received applicable Dues. This *EOC* sometimes refers to a Member as "you."

Out-of-Area Urgent Care: An urgent care need requires prompt medical attention, but is not an Emergency Medical Condition. Out-of-Area Urgent Care is Medically Necessary Services you receive from a non-Plan Provider for an unforeseen illness or injury if all of the following are true:
- You are temporarily outside of our Service Area
- The Services are necessary to prevent serious deterioration of your health
- Treatment cannot be delayed until you return to our Service Area

Plan: Kaiser Permanente.

Plan Facility: Any facility listed in the "Plan Facilities" section or in one of the *Guidebooks* for our Service Area, except that Plan Facilities are subject to change at any time without notice. If you have any questions about the current locations of Plan Facilities, please call our Member Service Call Center.

Plan Hospital: Any hospital listed in the "Plan Facilities" section or in one of the *Guidebooks* for our Service Area, except that Plan Hospitals are subject to change at any time without notice. If you have any questions about the current locations of Plan Hospitals, please call our Member Service Call Center.

Plan Medical Office: Any medical office listed in the "Plan Facilities" section or in one of the *Guidebooks* for our Service Area, except that Plan Medical Offices are subject to change at any time without notice. If you have any questions about the current locations of Plan Medical Offices, please call our Member Service Call Center.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Please refer to *Your Guidebook* for a list of Plan Pharmacies in your area, except that Plan Pharmacies are subject to change at any time without notice. If you have any questions about the current locations of Plan Pharmacies, please call our Member Service Call Center.

Plan Physician: Any licensed physician who is an employee of Medical Group, or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider: A Plan Hospital, Plan Physician, Medical Group, Plan Pharmacy, or other health care provider that we designate as a Plan Provider.

Post-stabilization Care: Post-stabilization Care is the Services (including transportation) you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable, or after you obtain covered Out-of-Area Urgent Care. Post-stabilization Care can be provided while you are still in a hospital Emergency Department, after you have been admitted to a hospital, or in another setting.

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

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

- Amador: 95640, 95669
- El Dorado: 95613-14, 95619, 95623, 95633-35, 95651, 95664, 95667, 95672, 95682, 95762
- Fresno: 93242, 93602, 93606-07, 93609, 93611-13, 93616, 93618, 93624-27, 93630-31, 93646, 93648-52, 93654, 93656-57, 93660, 93662, 93667-68, 93675, 93701-12, 93714-18, 93720-22, 93724-29, 93740-41, 93744-45, 93747, 93750, 93755, 93760-62, 93764-65, 93771-80, 93784, 93786, 93790-94, 93844, 93888
- Kings: 93230, 93232, 93242, 93631, 93656
- Madera: 93601-02, 93604, 93614, 93623, 93626, 93637-39, 93643-45, 93653, 93669, 93720
- Mariposa: 93601, 93623, 93653
- Napa: 94503, 94508, 94515, 94558-59, 94562, 94567*, 94573-74, 94576, 94581, 94589-90, 94599, 95476
- Placer: 95602-04, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677-78, 95681, 95692, 95703, 95722, 95736, 95746-47, 95765
- Santa Clara: 94022-24, 94035, 94039-43, 94085-90, 94301-06, 94309-10, 94550, 95002, 95008-09, 95011, 95013-15, 95020*-21, 95026, 95030-33, 95035-38, 95042, 95044, 95046, 95050-56, 95070-71, 95101-03, 95106, 95108-42, 95148, 95150-61, 95164, 95170-73, 95190-94, 95196
- Sonoma: 94515, 94922-23, 94926-28, 94931, 94951-55, 94972, 94975, 94999, 95401-09, 95416, 95419, 95421, 95425, 95430-31, 95433, 95436, 95439, 95441-42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471-73, 95476, 95486-87, 95492
- Sutter: 95645, 95659, 95668, 95674, 95676, 95692, 95837
- Tulare: 93238, 93261, 93618, 93646, 93654, 93666, 93673
- Yolo: 95605, 95607, 95612, 95616-18, 95645, 95691, 95694-95, 95697-98, 95776, 95798-99
- Yuba: 95692, 95903, 95961

*Exception: The communities of Bells Station and Knoxville are not in our Service Area.

Note: We may expand our Service Area at any time by giving written notice to your Group. ZIP codes are subject to change by the U.S. Post Office.

Services: Health care services or items.

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services and is licensed by the state of California and approved by Health Plan. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility, or facility for the aged that furnishes primarily custodial care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section within another facility (for example, a Plan Hospital) as long as it continues to meet the definition above.

Spouse: Your legal husband or wife. For the purposes of this *EOC*, the term "Spouse" includes your domestic partner, in accord with your Group's requirements that we approve in writing.

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

Copayments and Coinsurance

This section discusses Copayments and Coinsurance only. This section does not describe benefits. To learn what is covered for each benefit (including any visit and day limits), please refer to the identical heading in the "Benefits" section (also refer to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section, which applies to all benefits).

Copayments or Coinsurance are due when you receive the Service, but for items ordered in advance, you pay the Copayment or Coinsurance in effect on the order date (though we will not cover the item unless you still have coverage for it on the date you receive it). In some cases, we may agree to bill you for your Copayment or Coinsurance. If we agree to bill you, we will increase the amount by $13.50 and mail you a bill for the entire amount. However, before you can schedule an elective infertility procedure, you must pay the Copayment or Coinsurance for the procedure along with any past-due, infertility-related Copayments and Coinsurance.

Outpatient Services	You Pay
Primary and specialty care visits (includes routine and urgent care appointments)	$10 per visit
Well-child preventive care visits (23 months or younger)	$5 per visit
Scheduled prenatal care and first postpartum visit	$5 per visit
Outpatient surgery	$10 per procedure
Allergy testing visits	$10 per visit
Allergy injection visits	$5 per visit
Physical, occupational, and speech therapy	$10 per visit
Multidisciplinary rehabilitation program	$10 per day
Emergency Department visits	$50 per visit (waived if admitted directly to the hospital)
Blood, blood products, and their administration	No charge

Hospital Inpatient Care	You Pay
Hospital inpatient care, including physician Services	No charge
Multidisciplinary rehabilitation program in an acute rehabilitation facility	No charge

Ambulance Services	You Pay
Ambulance Services	No charge