

# Partnership Agreement Rules and Regulations



## 2013 Rewrite

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**SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP  
PARTNERSHIP AGREEMENT**

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**ARTICLE 1**

The parties hereto are holders of a physician's and surgeon's certificate issued by the Medical Board of California or the Osteopathic Medical Board of California and hereby enter into a general partnership for the practice of medicine under the name of "Southern California Permanente Medical Group," referred to herein as "Medical Group." Each partner of Medical Group is a co-owner of Medical Group.

**ARTICLE 2**

The partnership will continue until terminated as hereinafter provided.

**ARTICLE 3**

Unless and until hereafter changed, the principal office of the partnership will be in the City of Pasadena, State of California. The partnership may engage in the practice of medicine any place in Southern California as may be determined by the Board of Directors of Medical Group.

**ARTICLE 4: PROFESSIONAL OBLIGATIONS**

All of the partners will devote all, or substantially all, of their professional time, effort and abilities to the partnership business. All billings and collections for professional services, including but not limited to, earnings from teaching and medical research, by any and all partners will be made for the account of the partnership. All earnings by any of the partners from the practice of medicine will belong to the partnership.

The Board of Directors may arrange with any partner to permit professional activities, time or effort outside of the partnership business, subject to such conditions as the Board of Directors deems advisable.

**ARTICLE 5: QUALIFICATIONS FOR PARTNERSHIP**

A physician working not less than eight half days per week may become eligible for partnership after three consecutive years of employment.

There are three categories of partners:

- ◆ Category I Partner — a physician who joins Medical Group, meets all of the requirements of partnership, and is elected to partnership.
- ◆ Category II Partner — a physician who joins Medical Group, meets all of the other requirements of partnership, but because of administrative reasons, is not eligible to be a Category I partner. The benefits for which this partner will be eligible are described in the Rules and Regulations and will be determined by the Board of Directors.
- ◆ Category III Partner — a physician who joins SCPMG as a full time employee or partner upon the acquisition by SCPMG of the physician's former medical group. If the physician was not a shareholder, partner or owner of the acquired medical group, the employee physician may become eligible for Category III partnership only after at least one year as an

SCPMG Full-Time Regular employee. If the physician was a shareholder, partner or owner, they are eligible for Category III partnership. Unless otherwise noted, Category II and Category III rights and responsibilities are identical. A Category III partner is not eligible to become a Category II partner.

The process by which new Category I and Category II partners may be added to this partnership is as follows:

- ◆ After a preliminary approval of at least three-fourths of the entire Board of Directors, an election will be held in which at least three-fourths of the active partners from the Area vote by secret ballot; to be elected, at least three-fourths of those voting must vote in favor of the physician becoming a partner.
- ◆ The results of this election will be submitted to the Board of Directors. Thereafter, upon a three-fourths affirmative vote by the Board of Directors, the physician will be elected to partnership effective on the physician's Anniversary Date and upon written acceptance by the partner. If, for whatever reason, the final review by the Board of Directors occurs after the Anniversary Date on which the physician becomes eligible for partnership, this will result in postponement of the effective date of partnership.
- ◆ In certain circumstances, exceptions with respect to the period required to become eligible for partnership may be made by the Board of Directors, but only for those physicians who were formerly associated with the Southern California Permanente Medical Group or with any of the other Permanente Medical Groups. However, they must be in practice with the Southern California Permanente Medical Group for a minimum of one year, on a full time basis, during the period immediately preceding the date that their partnership would become effective.
- ◆ For those physicians proposed for partnership after the period of employment required to attain partnership, the effective date of partnership will be determined by the Board of Directors.
- ◆ Upon election, each partner will contribute as capital to the partnership an amount determined by the Board of Directors not to exceed \$2,500.

The process by which new Category III partners may be added to this partnership is as follows:

- ◆ Only physicians whose former medical group is acquired by SCPMG are eligible for Category III partnership.
- ◆ A physician can become a Category III partner only after being approved for such by at least three-fourths of the entire Board of Directors.
- ◆ A Category III partner may become eligible for Category I partnership only after three years of regularly working at least eight half days per week as a Full-Time Regular employee of SCPMG or as a Category III partner.
- ◆ In certain circumstances, exceptions with respect to the period required to become eligible for Category I partnership may be made by the Board of Directors, but only for those physicians who were formerly associated with the Southern California Permanente Medical Group or with any of the other Permanente Medical Groups. The Area Medical Director will submit a report identifying the physician involved and the reasons for the request. However, they must be in practice with the Southern California Permanente Medical Group for a

minimum of one year, on a full time basis, during the period immediately preceding the date that their Category I partnership would become effective.

- ◆ Upon election, each partner will contribute as capital to the partnership an amount determined by the Board of Directors not to exceed \$2,500.

#### **ARTICLE 6: AMENDMENT TO PARTNERSHIP AGREEMENT**

Amendments to this Partnership Agreement may be made by one of the two following methods:

- ◆ By a vote of three-fourths of the total Board of Directors followed by an election in which at least three-fourths of the active partners vote and three-fourths of those voting vote in favor of the amendment.
- ◆ Upon the petition (setting forth the text of the proposed amendment) of 50 percent or more of the active partners, an election will be held. Such petition will not be valid unless signatures are obtained within 120 days following commencement of the circulation of the petition. The amendment will be approved if at least three-fourths of the active partners vote and three-fourths of those voting are in favor of the amendment; to be effective, the amendment must be approved by at least three-fourths of the total Board of Directors.

If the amendment is rejected by the Board of Directors, the partnership may override the rejection by holding a subsequent election within 60 days of the rejection; if at least 75% of the total active partners vote in favor of the amendment, it will become effective.

#### **ARTICLE 7: AMENDMENT TO RULES AND REGULATIONS**

Operational Rules and Regulations adopted by the Board of Directors will govern the conduct of the business of the partnership and establish working conditions including, but not limited to, Educational Leave, Vacation time, and Leaves of Absence. Amendments to the Operational Rules and Regulations may be made by one of the two following methods:

- ◆ By the Board of Directors.
- ◆ Upon the petition (setting forth the text of the proposed amendment) of 50 percent or more of the active partners, an election will be held. Such petition will not be valid unless signatures are obtained within 120 days following commencement of the circulation of the petition. The amendment will be approved if, in the election, a majority of the total active partners vote in favor of the amendment.

Such amendments may be rejected by the vote of three-fourths of the total Board of Directors. If the amendment is rejected by the Board of Directors, the partnership may override the rejection by holding a subsequent election within 60 days of the rejection; if at least 75% of the total active partners vote and 75% of those voting are in favor of the amendment, it will become effective.

**ARTICLE 8: DEFINITION, APPOINTMENT AND RESPONSIBILITIES OF THE BOARD OF DIRECTORS**

In order to carry out the business affairs, management, and administration of the partnership, there will be a Board of Directors (“the Board”) consisting of ex-officio members and elected members, all of whom will be partners. The ex-officio members will be the Executive Medical Director, the Medical Directors, and the Area Medical Directors. Each ex-officio member will have a vote on the Board of Directors. When a new Area is proposed, the Executive Medical Director may appoint an Acting Area Medical Director responsible for the development and management of the proposed new Area. The Acting Area Medical Director will be a nonvoting member of the Board of Directors but will otherwise have all the authority of other Area Medical Directors. The term of office of the Acting Area Medical Director will continue until the Area is established. An Area will be established when an acute care hospital and outpatient medical offices staffed by no fewer than 30 partner physicians are located within its geographical boundaries. Partners in the proposed new Area will vote on partnership business at large and locally for physicians eligible for partnership.

The elected Board of Directors members will be elected by the active partners in each Area, and each will have a vote. There will be three elected members from the Los Angeles Area and the San Diego Area and two from each of the other Areas. Except as otherwise provided, the elected members of the Board of Directors will be elected for terms of three years. When a new Area is established, that Area will be entitled to, and will elect, two members to the Board of Directors. Initially one term of office will be for three years and the other term of office will be two years. Should the election precede July 1, each term will commence on January 1 of that year. Should the election be on or follow July 1, the initial terms of office will begin on the election date and will continue for three and two years from January 1 of the following year. Each succeeding term of office will be for three years beginning on a January 1 date.

An elected member of the Board of Directors may be removed by a majority vote of all active partners in the Area from which the member was elected.

The Secretary of the Board of Directors will be appointed from the partnership by the Executive Medical Director, with the approval of three-fourths of the total Board of Directors, and will not have a vote on the Board of Directors, unless the appointee partner is concurrently a voting Board of Directors member. The term of office of the Secretary of the Board of Directors will expire concurrently with the term of the appointing Executive Medical Director. At the discretion of the new Executive Medical Director, the Secretary of the Board of Directors may remain in office for an additional period of time not to exceed six months. An incumbent Secretary of the Board of Directors may be reappointed by the new Executive Medical Director.

The Executive Medical Director will have the authority to appoint Medical Directors from the partnership, with the approval of the Board of Directors. Their functions will be determined by the Executive Medical Director, and their administrative responsibilities may be terminated by the Executive Medical Director at any time. In any event, their terms of office will expire with that of the appointing Executive Medical Director.

The Executive Medical Director, Medical Directors, and Assistant Executive Medical Directors whose administrative responsibilities are terminated, will be granted reasonable time as determined by the Board of Directors, to renew their clinical skills in an approved program. The reasonable period of time will be determined by the Board of Directors and may be up to a maximum of one year, at full pay, provided they remain active partners and return to the partnership in a clinical capacity.

Upon the death, retirement, or removal from office of an ex-officio member of the Board of Directors, a successor will be appointed as indicated in Article 9. Upon the death, retirement, or removal from office of an elected member of the Board of Directors, the active partners in the Area from which the Board of Directors member was elected will elect a successor for the remainder of the term.

The Board of Directors will have the responsibility for establishing policies related to medical care, business affairs, administration, and management of the partnership, including, but without being limited to, the following matters:

- ◆ establishing and executing policies to assure the maintenance of quality medical care rendered by Medical Group;
- ◆ the making of all contracts, including contracts with any person or organization for the rendering of professional services, hospitalization and incidental services, and the hiring and discharging of all employees of the partnership;
- ◆ the lease, purchase, or other acquisition of property from others, or the lease, sale or other disposal of partnership property; and
- ◆ the right to review and revise the amount of the Base Compensation of each partner within the functional classification of assigned professional responsibilities. The maximum amount of any reduction will be to the then Starting Base Salary of a physician in that classification.

The Board of Directors may delegate its responsibilities with respect to any of the foregoing matters to the Executive Medical Director, Medical Directors, Area Medical Directors, or any other partner or employee, limiting their authority in such fashion as it sees fit.

The Board of Directors will meet at least eight times during each year and, if not otherwise herein provided, will adopt procedures for the conduct of its business. Except as otherwise herein provided, decisions will be made by a majority of the entire number of the voting members of the Board of Directors.

In the absence of, or in case of disability of the Executive Medical Director, the Medical Director of Operations, or in his or her absence, the Medical Director of Quality and Clinical Analysis, or in his or her absence, the Medical Director of Business Management, or in his or her absence, the senior Area Medical Director (by length of service as Area Medical Director) may call such meetings of the Board of Directors as are deemed to be necessary.

In the event of the dissolution of the partnership, the Board of Directors holding such office as of the effective date of dissolution, will have possession and control of all partnership assets for the

purpose of concluding the partnership affairs, and will for such purposes have all powers otherwise vested in the entire partnership.

**ARTICLE 9: THE EXECUTIVE MEDICAL DIRECTOR, MEDICAL DIRECTORS, AREA MEDICAL DIRECTORS, CHIEFS OF SERVICE AND PHYSICIANS IN CHARGE**

The Executive Medical Director will officiate as Chairperson of the Board of Directors, and in such position, is empowered to act as Executive Officer for the Board of Directors on all matters falling within the power of the Board of Directors.

The Executive Medical Director will be appointed from the partnership for a six-year term of office by a two-thirds vote of the total Board of Directors and approved by two-thirds of the votes cast by the active partners, provided at least three-fourths of the active partners vote. Each term of office will terminate upon December 31 of the year in which the Executive Medical Director completes six years in office. If the Executive Medical Director attains age 65 before the end of the six-year term, the term will terminate on December 31 of the year he or she attains age 65. An incumbent may be reappointed.

The nominating committee will be made up of all the elected members of the Board of Directors. They will begin deliberations the first quarter of the year preceding the last year of the term of the Executive Medical Director.

The Executive Medical Director may be removed from office by the Board of Directors and a majority vote of the total active partners.

The Medical Directors and Area Medical Directors will appoint an Executive Medical Director Pro Tem with the approval of two-thirds of the total Board of Directors when the Executive Medical Director is disabled and/or deemed temporarily incapable by the Board of Directors of performing the duties of the office.

The Executive Medical Director will appoint from the partnership an Area Medical Director for each Area for a six-year term, with the approval of the Board of Directors and approval by a majority vote of the total active partners in the Area. An incumbent may be reappointed. An Area Medical Director cannot serve in this position beyond December 31, of the year he or she attains age 65.

An Area Medical Director may be removed by the Executive Medical Director with the approval of the Board of Directors, or by the Board of Directors.

A recall procedure against an Area Medical Director may be initiated by any group of partners in that Area through their elected Board of Directors members, or by interview with the Executive Medical Director.

The Executive Medical Director may appoint from the partnership a Medical Director of Operations with the approval of two-thirds of the total Board of Directors, followed by an election in which at least three-fourths of the active partners vote and in which two-thirds of



those voting vote in favor of appointing the partner physician. The Medical Director of Operations cannot serve in this position beyond December 31, of the year he or she attains age 65.

The Executive Medical Director may appoint from the partnership, a Medical Director of Quality and Clinical Analysis with the approval of two-thirds of the total Board of Directors, followed by an election in which at least three-fourths of the active partners vote and in which two-thirds of those voting vote in favor of appointing the partner physician. The Medical Director of Quality and Clinical Analysis cannot serve in this position beyond December 31, of the year he or she attains age 65.

The Executive Medical Director may appoint from the partnership, a Medical Director of Business Management with the approval of two-thirds of the total Board of Directors, followed by an election in which at least three-fourths of the active partners vote and in which two-thirds of those voting vote in favor of appointing the partner physician. The Medical Director of Business Management cannot serve in this position beyond December 31, of the year he or she attains age 65.

The terms of office of the Medical Director of Operations, the Medical Director of Quality and Clinical Analysis, and the Medical Director of Business Management will expire concurrently with the term of the appointing Executive Medical Director. At the discretion of the new Executive Medical Director, the Medical Director of Operations, the Medical Director of Quality and Clinical Analysis, and/or the Medical Director of Business Management may remain in office for an additional period of time, not to exceed six months. The Medical Director of Operations, the Medical Director of Quality and Clinical Analysis, and/or the Medical Director of Business Management may be reappointed as provided in Article 9.

The Medical Director of Operations, the Medical Director of Quality and Clinical Analysis, and/or the Medical Director of Business Management may be removed by the Board of Directors, or by the Executive Medical Director with the concurrence of the Board of Directors.

If a Medical Director is unable to carry out the duties of the office, he or she may be replaced by an Interim Medical Director. The Interim Medical Director will be appointed from the partnership by the Executive Medical Director and must be approved by a majority of the Board of Directors. An Interim Medical Director will be appointed only following appropriate partner input. An Interim Medical Director will serve as long as the Medical Director is incapacitated or until the Medical Director is replaced but in no case longer than nine months. If incapacity is expected to last longer than nine months, the Executive Medical Director will begin the process of replacing the Medical Director within three months of the appointment of the Interim Medical Director. The Executive Medical Director with the approval of a majority of the Board of Directors will determine incapacity and the return to capacity of the Medical Director. The Interim Medical Director will have all the powers and responsibilities of the Medical Director including a vote on the Board of Directors.

Each Chief of Service (“Chief”) or Physician in Charge (“PIC”) of an outlying medical office will be appointed by the Area Medical Director with the approval of the Executive Medical

Director, for a six-year term of office, or to the end of the year in which age 65 is attained, if that interval is shorter than six years. Under all but exceptional circumstances, Physicians in Charge and Chiefs of Service must be partners. Before making such an appointment, the Area Medical Director will consult with such Area partners as deemed appropriate, including, but not restricted to, confidential, individual interviews with, and polling of, each full time permanent member of the department involved. The results of the poll will be advisory, and not binding on the Area Medical Director or the Board of Directors. These appointments must have the approval of the Board of Directors. Incumbents may be reappointed.

A formal report on the performance of each Chief of Service will be submitted by the Area's Medical Director to the Board of Directors every two years.

A Chief of Service or Physician in Charge may be removed by the Area Medical Director with the approval of the Executive Medical Director and the Board of Directors.

#### **ARTICLE 10: WITHDRAWAL OF A PARTNER**

**Voluntary:** A partner may voluntarily retire or withdraw from the partnership at any time. Said notice will be mailed or delivered to the principal office of the partnership. Said notice will specify the date on which the withdrawal will become effective, and the withdrawing partner will be required to perform customary duties until that date. If a partner has given no less than 90 days notice, such partner will be eligible to receive all or a part of the Year-End Performance Draw for the last 90 days worked, but only at the discretion of the Board of Directors. Once given, any notice of withdrawal will be irrevocable and the withdrawing partner will not be entitled to rescind the notice of withdrawal, except upon application to the Board of Directors and approval by a vote of the Board of Directors; the application must be made in writing by the partner prior to the effective date of withdrawal.

**Automatic Termination:** A partner whose license to practice medicine has been revoked by the Medical Board of California or the Osteopathic Medical Board of California (or other agency performing similar licensing functions) and which revocation is not stayed by that Board or agency, will be deemed to have resigned from the partnership as of the effective date of the revocation of the partner's license and will be entitled to no additional compensation except for the distributive share of Year-End Performance Draw earned to the date of revocation and any unpaid amounts owed the partner.

In the event that on appeal such physician re-establishes his or her license to practice medicine, the Board of Directors, in its discretion, taking into account the facts and circumstances involved in the physician's personal situation and the background of the revocation of the physician's license, may re-establish such physician as a partner and may retroactively pay part or all of such physician's compensation and benefits which were not paid during the period that the physician's license was revoked.

**Automatic Suspension:** A partner whose license to practice medicine has been suspended by the Medical Board of California or the Osteopathic Medical Board of California (or other agency performing similar licensing functions) will be automatically suspended from active partnership

status for the period for which the license is suspended. The amount of compensation and benefits, if any, while in such suspended status will be determined by a majority of the Board of Directors in its discretion taking into account the facts and circumstances involved in the partner's personal situation and the background of the suspension of the partner's license.

**Legal Fees:** In the event that a partner is required to appear before the Medical Board of California or the Osteopathic Medical Board of California in a disciplinary proceeding arising out of the partner's medical practice within the partnership that may result in the suspension or revocation of the partner's license to practice medicine, the partnership will provide assistance through the payment of all the partner's legal fees in the proceeding before the Medical Board of California or the Osteopathic Medical Board of California. The Board of Directors has the right in connection with paying such legal fees to select the counsel to represent the partner and to determine the fee arrangement for such representation. Legal fees incurred by the partner following a decision by the Medical Board of California or the Osteopathic Medical Board of California will be paid by the partnership only at the discretion of the Board of Directors.

**Involuntary:** Any partner may be required to withdraw from the partnership at any time and for any reason whatsoever upon the vote of at least three-fourths of the Board of Directors recommending such withdrawal. To be effective, the recommendation must be followed by an election in which three-fourths of the active partners from the physician's Area vote by secret ballot, and in which three-fourths of those voting, are in favor of requiring such withdrawal.

Upon the recommendation to the Board of Directors by the Area Medical Director or an elected member of the Board of Directors from that Area, the Board of Directors may terminate a Category II partner or a Category III partner by a majority vote.

**Retirement:** A partner will automatically be retired from the partnership at the end of the calendar year during which the partner reaches 65 years of age, but the physician may thereafter be continued as an employee of the partnership with compensation arrangements to be determined by the Board of Directors.

#### **ARTICLE 11: PARTNER'S INTEREST AFTER WITHDRAWAL**

**Termination:** The interest in the partnership of any partner who dies, retires, or is terminated by the partnership will terminate as of the day on which death, retirement, or involuntary termination occurs.

**Value of Interest:** The value of the interest in the partnership of any such partner will be determined by the Board of Directors on December 31 (or as soon thereafter as the value can reasonably be ascertained) of the current calendar year from the formal books of record of the partnership. The value of the interest will be liquidated, and the amount paid to such partner (or the partner's representative, if the partner is deceased). The partnership has the right, at its option, to pay such value of the interest in twelve equal monthly installments, commencing from the time of the determination of the value of the interest; however, the current book value of the capital investment will be payable immediately.

Such value of the interest will be conclusively determined by the book value of the partner's proportionate share of the capital of the partnership (which share will be in the same proportion as the amount of capital contributed by the physician bears to the total amount of capital contributed by all partners), plus the proportionate share of undistributed net earnings for the current year as of the day on which the partner died, retired, or was terminated, or as of a date which is 90 days prior to the effective date of withdrawal of a partner who voluntarily withdraws.

Said books will be conclusive evidence thereof, and each partner, heirs, representative and assigns, agree that such payment will be accepted in full satisfaction of any and all claims that he or she, the heirs or estate may have against the partnership, and is in full payment for all of the assets of every kind and description, and that of interests in such assets, except as above provided for, will become the absolute property of the remaining partners upon the death of the partner.

No value will be assigned to goodwill or going value of similar intangibles.

Notwithstanding the foregoing, no value shall be assigned to interests held by the Partnership in the Permanente Federation L.L.C. and any payment to which a Partner may be entitled with respect to such interests shall be determined exclusively under Section 9 of the Rules and Regulations.

Unless otherwise designated by the Board, all capital contributions shall be presumed to be utilized in connection with Permanente Federation L.L.C. investments and repayment of such capital contributions shall be governed exclusively by Section 9 of the Rules and Regulations.

## **ARTICLE 12: LEAVES**

Sick Leave:

- ◆ **Acute Sick Leave:** During each Anniversary Year, each partner will be entitled to Acute Sick Leave totaling one month (22 working days) for periods when he or she is unable to practice due to illness or injury. During such periods, the partner will receive the amount of Base Compensation which he or she is currently receiving and the share of partnership net earnings to which he or she otherwise would be entitled for such period.
- ◆ **Chronic Sick Leave:** In addition to the foregoing annual Acute Sick Leave, partners are entitled to the following Chronic Sick Leave:
  - Six months of Chronic Sick Leave with 25% of Base Compensation.
  - 18 months of Chronic Sick Leave without compensation (partnership status and benefits continue).

See the Partnership Rules and Regulations and the *SCPMG Benefits Handbook for Physicians* for information regarding insured disability benefits.

For the purpose of calculating Chronic Sick Leave pay, a partner is entitled to a percentage of a full working schedule which is the same percentage as the percentage of a full working schedule which the partner has worked during the entire time as a partner. The percentage of a full working schedule which the partner has worked over the entire time as a partner will be

computed as of the end of the calendar year preceding the taking of Chronic Sick Leave. In making such computation, leaves of absence will be omitted. Periods of reduced working time of less than one-half month will not be counted and those in excess of one-half month will be counted as one month. If the percentage of a full working schedule worked is in excess of 95% of a full working schedule during the partner's entire time with the partnership, no reduction will be made in Base Compensation.

A partner will be entitled to the usual share of the Year-End Performance Draw for any period of paid or unpaid Chronic Sick Leave and for six months of unpaid sick leave after the expiration of the two-year Chronic Sick Leave provision; the share of Year-End Performance Draw will be computed in the same fashion as is Base Compensation for purposes of this calculation. Thereafter, a partner who is unable to practice due to illness or injury will no longer participate in any of the earnings or other benefits of the partnership, and will, at the discretion of the Board of Directors, withdraw from the partnership. Such person will, with the concurrence of the Board of Directors and the Area Medical Director, be entitled to resume partnership status with limitation of Chronic Sick Leave at the discretion of the Board of Directors.

A partner who, due to illness or injury, practices on less than a full time basis will be considered to be on reduced working time as defined in the operational Rules and Regulations.

Notwithstanding the foregoing provisions as to sick leave, the Board of Directors, prior to a physician becoming a partner, may limit or eliminate altogether as to such prospective partner the application of the provisions for Chronic Sick Leave. The Chronic Sick Leave to which a partner would otherwise be eligible may be limited with respect to its duration or its application with respect to certain specified illnesses, injuries, or conditions and their complications, or both. If the Board of Directors eliminates Chronic Sick Leave for a prospective partner, notice thereof will be given to the prospective partner in writing prior to election as a partner. If the Board of Directors limits the application of the provisions for Chronic Sick Leave, the nature of the limitation will be specified in writing, which writing will be delivered to the prospective partner prior to the partnership election.

**Military Leave:** Any partner who is required to be absent from work because of military service of greater than four weeks duration is on Military Leave.

A partner returning from Military Leave must indicate to the Board of Directors, in writing within 30 days of discharge, an intention to return to Medical Group and must return to practice within 90 days of discharge.

The Board of Directors may, at its discretion, extend the time during which a physician must return to practice following the termination of this Leave, if at that time the physician is recuperating from a mental or physical disability which prevents the physician from being able to fully perform the required medical practice duties.

A partner who does not return to Medical Group within the prescribed guidelines will be considered to have voluntarily resigned from the partnership.

**Leave of Absence:** A partner of Medical Group may request a Leave of Absence, not to exceed one year which may be granted at the discretion of the Board of Directors, and upon such terms as may be prescribed by them and clarified in the Rules and Regulations.

A partner who does not return to practice with Medical Group at the expiration of this leave, will be considered to have voluntarily resigned from the partnership, will have any capital investment returned, and will not have the privilege of automatically resuming partnership status upon return.

### **ARTICLE 13: TERMINATION OF PARTNERSHIP**

In the event of the death, retirement, termination at the request of the partners, or voluntary withdrawal of a partner, this partnership will not be terminated but will be continued by the remaining partners. This partnership may be terminated by a three-fourths vote of the Board of Directors, and by three-fourths of the votes cast by the active partners, subject to voting by at least three-fourths of the active partners.

### **ARTICLE 14: COMPENSATION**

The Base Compensation of a partner is defined as an amount equal to the Starting Base Salary paid to an Employee Physician as established by the Board of Directors (“Starting Base Salary”), plus increases granted for longevity (including merit longevity), merit, administrative duties, and board certification. The Base Compensation does not include Extra Duty pay.

All of a partner’s compensation is dependent upon the overall financial performance of Southern California Permanente Medical Group. Every other week, each partner receives a check. This check represents an advance against the anticipated earnings of Medical Group. At the end of each year, the net earnings of Medical Group and the total of the year’s advance checks to all partners are reconciled and any surplus (or deficit) net earnings are divided among the partners. Each partner is a part owner of Southern California Permanente Medical Group and shares in its financial performance.

The following limitations on compensation are hereby established:

- ◆ The Base Compensation of any partner other than the Executive Medical Director, less all longevity (including merit longevity) increases granted, will not exceed two times the then current Starting Base Salary for a board certified Internist employed by Medical Group.
- ◆ The Base Compensation for the Executive Medical Director, less all longevity (including merit longevity) increases granted, will not exceed two and one half times the then current Starting Base Salary for a board certified Internist employed by Medical Group.

### **ARTICLE 15: DISTRIBUTION OF PARTNERSHIP NET EARNINGS**

Net earnings of the Partnership will be divided among the partners as follows:

- ◆ Each partner, depending upon board certification status, will receive a Base Compensation in an amount established by the Board of Directors for his or her specialty.

- ◆ There will be added to the foregoing compensation the amounts of any increases granted for longevity (including merit longevity), merit, and pay for administrative duties. The total compensation established in this subsection and the subsection preceding constitutes the Base Compensation.
- ◆ There will be added to Base Compensation any Supplementary Compensation (see Rules and Regulations Section 5.A.2(a)), and any partnership benefits converted into partners' compensation (Imputed Income). The total compensation established in this subsection and the preceding two subsections constitutes the partners' Total Compensation.
- ◆ In the event the partnership earnings are insufficient to pay said Total Compensation, they will be paid proportionately to the extent of the partnership net earnings.
- ◆ Annual net earnings of the partnership in excess of the aggregate Total Compensation of all partners will be divided among the partners as described in the Rules and Regulations.

**ARTICLE 16: ASSIGNMENT OF PARTNERSHIP INTEREST**

No partnership interest, or any part thereof, including any amounts in earnings or capital due a partner, may be assigned without the written consent of the Board of Directors.

**SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP**  
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- B. Educational Leave
  - 1. Partners (Categories I, II and III only; Inactive Partners are ineligible for this Benefit.)
  - 2. Employee Physicians
- C. Holidays
  - 1. Partners
  - 2. Employee Physicians
- D. Miscellaneous Leaves and Expense Reimbursement for Scientific Presentations, Outside Courses, or Specialized Training
  - 1. Leaves and Expense Reimbursement Related to Presentations at Medical Meetings
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    - (c) Credit toward “Common Plan” during Extended Educational Leave:
    - (d) Other Regulations:
  - 2. Extended Medical Service Leave
    - (a) When Extended Medical Service Leave may be taken:
    - (b) Compensation by Medical Group:
    - (c) Credit toward Common Plan during Extended Medical Service Leave:
    - (d) Other Regulations:
  - 3. Extended Military Service Leave
    - (a) When Extended Military Service Leave may be taken:
    - (b) Compensation by Medical Group:
    - (c) Credit toward “Common Plan” during Extended Military Service Leave:
    - (d) Other Regulations:



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    - (a) Special Category
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  - 1. Short Term Disability Insurance (STD) – (Available only to Employee Physicians who enroll within sixty (60) days of hire.)
  - 2. Compensation Continuance Program – (Available only to Partners.)
  - 3. Long Term Disability Insurance
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      - (1) Partners
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- B. Early Separation Program (ESP) - Formerly known as the Full Early Retirement (FER) Plan:
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  - 1. Federation Assessments
  - 2. Funding of Federation Assessments
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**SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP**  
**RULES AND REGULATIONS/PREAMBLE**

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A basic business and service policy of the Southern California Permanente Medical Group is that access to our medical services be the following:

1. If an emergency, come in now.
2. If urgent, come in today or tomorrow.
3. If routine, when would you like the appointment?

**EVERY PHYSICIAN AND EACH DEPARTMENT WILL BE RESPONSIBLE FOR CARRYING OUT THIS POLICY (*SCPMG Partnership Principles*):** A Southern California Permanente Medical Group physician is expected to:

1. care for our members to the best of his/her ability paying heed to both their physical and emotional needs;
2. conform to the standards set forth in the *SCPMG Partnership Agreement and Rules and Regulations*;
3. work within Medical Group for the development and implementation of methods of care which meet the needs of all our members and achieve the most cost-effective use of the medical care resources entrusted to us by our members;
4. keep his/her professional skills current by appropriate continuing medical education activities;
5. participate in a collegial manner in the activities of Medical Group which assist his/her Module, Medical Office, Department, Area, and Region to attain the goals of both Medical Group and the Kaiser Permanente Medical Care System;
6. behave toward his/her co-workers, physicians and non-physicians, with respect, and hold them to the same high levels of care and service that he/she has set for himself/herself;
7. participate in quality improvement and other activities that improve the quality of care and service to Kaiser Permanente patients.
8. vote in SCPMG elections, if eligible to vote.



**SCPMG Message:**

*"Keep your arms on each other's shoulders, and keep your eyes on the stars for innovation and change for the future."*

*-Sidney R Garfield, MD, 1906-84*

**SCPMG Physicians strive to exemplify Permanente Professionalism, Partnership and Values.**

**A Permanente Physician demonstrates Professionalism** by working in a manner that exhibits the highest level of ethics and accountability, humanitarianism and the best interests of the patient, a constant yearning to maintain clinical excellence, and collaboration with colleagues and others on the health care team.

**A Permanente Physician demonstrates the Principles of Partnership** by adopting best practices, keeping current with SCPMG business initiatives, voting in partnership elections when eligible to vote, and actively advocating for the success of SCPMG.

**A Permanente Physician demonstrates the Southern California Kaiser Permanente Values** by exhibiting partnership, accountability and flexibility, embracing innovation, demonstrating integrity, contributing to our diverse workplace, and achieving the highest results in quality and service.

*..."Our Medical Group can accomplish all objectives ultimately, if we have the vision to plan them well and the patience to develop and expand them..."*

*Raymond Kay, MD, Founder of SCPMG*



## **INTRODUCTION**

The Rules and Regulations constitute the operational policies of Medical Group for Partner and Employee Physicians. These policies are subject to change either by decision of the Board of Directors or by Partnership vote (see Partnership Agreement, Article 7).

## **1 PARTNERSHIP**

### **A. Composition**

The Partnership of the Southern California Permanente Medical Group is composed of physicians who are Medical Doctors (M.D.s) or Osteopathic Physicians (D.O.s) licensed to practice medicine in the State of California.

### **B. Qualifications for Partnership (See Partnership Agreement, Article 5)**

1. Physicians working not less than eight half days per week may become eligible for Partnership after three consecutive years of employment.
  - (a) In addition, to be eligible for consideration for Partnership, the physician who works between 8/10 and 10/10 has an obligation to fulfill a full share of all inpatient and outpatient required department staffing responsibilities (including Extra Duty, After Hours Duty, Call Backs, weekday and weekend rounds, evenings, overnights, Saturday afternoons, Sundays, and holidays).
  - (b) Physicians previously employed by any Permanente Medical Group including SCPMG on a full time basis may have all or part of that time credited toward Partnership eligibility at the discretion of the Board of Directors. The credited time may not exceed two years. Such an Employee Physician, however, will have to work at least 12 consecutive months on a full time basis for SCPMG immediately prior to becoming eligible for Partnership consideration. Any period of employment during that period will not be credited if Extra Duty departmental responsibilities are not fulfilled. Even after one year of full time employment, Partnership in the Southern California Permanente Medical Group is not guaranteed.
2. In order to be considered for Partnership, the physician may not participate in any outside medical practice or professional activity unless approved by the Board of Directors during the time of employment.
3. Physicians to be hired must be evaluated by the Chief of Service and/or Area Medical Director by:
  - (a) personal interviews,
  - (b) reviewing appropriate references covering appropriate time periods between medical school and the time of hiring, and



- (c) verifying reference sources by phone where indicated.
4. The Chief of Service will review the Employee Physician's performance semiannually. These results will be reviewed with the Area Medical Director at least annually, and will include, but not be limited to, evaluation of that physician's:
- (a) quality of work and competence,
  - (b) relationship with patients,
  - (c) relationship with colleagues,
  - (d) relationship with non-physician personnel, and
  - (e) group identification and attitudes.

The Employee Physician will have a performance appraisal within the first six months of employment and at least annually thereafter, by the Chief of Service and/or the Area Medical Director.

5. Time spent in postgraduate studies will not be credited toward Partnership, longevity, benefits, etc. [see Section 3.B.9].
6. All physicians who begin working full time for Medical Group on or after January 1, 1995, must be board certified to be eligible for Category I Partnership. A physician who begins working full time for Medical Group on or after February 2, 2007, and who becomes a Category II Partner but does not become board certified within five years of the date he or she began full time work for Medical Group will be required to withdraw from the Partnership.

Board certification (including Certificates of Added Qualifications and Certificates of Special Qualifications) must be granted by a Board recognized by the American Board of Medical Specialties or any Board authorized by the American Osteopathic Association. Board certifications by organizations outside the United States will be assessed every five years and may be accepted by the Medical Group if found to be comparable to the above Board certifications. For any other board certification to qualify, it must be recommended by the physician's Chief of Service and Area Medical Director, and approved by the collective Medical Directors.

**C. Election of New Category I and II Partners – (See Partnership Agreement, Article 5)**

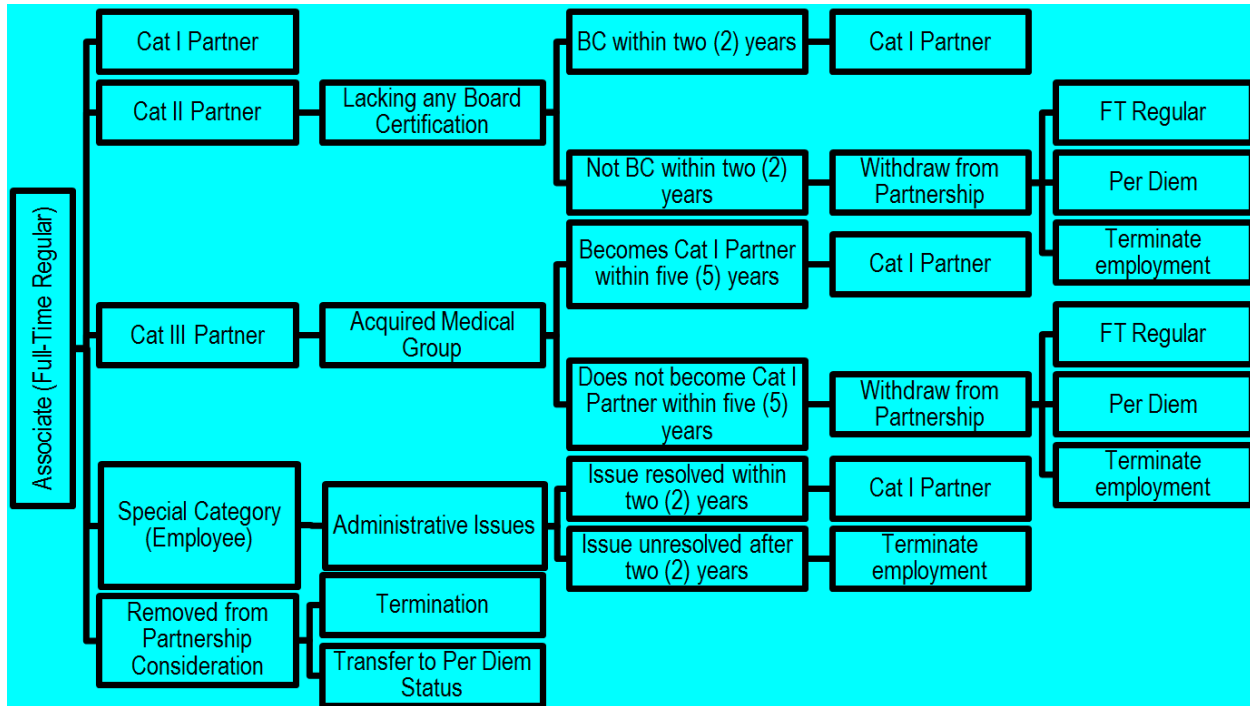
A physician may become eligible for consideration for Category I or II Partnership status only if recommended by the physician's Chief of Service and the physician's Area Medical Director on his or her Anniversary Date following the required years of Credited Service with Medical Group. Eligible physicians include Category III Partners, who are eligible for election into Category I Partnership only. (A Category III partner is not eligible to become a Category II partner.) The procedure is as follows:



1. All Employee Physicians eligible for Partnership will be balloted by secret ballot by department Partners at 12 months after the beginning of full time employment and 6 months prior to the calendar quarter in which a physician may become eligible for Partnership. The ballot should allow for indication of “support” or “do not support” for Partnership and should allow for comments. Results of departmental balloting are only to be shared with a physician’s Chief of Service and Area Medical Director. After the final departmental voting, the Chief of Service and Area Medical Director will determine whether to recommend this physician to the Board of Directors for approval for Partnership balloting. If approved by the Board, physician’s name will be submitted for Area balloting to all Partners.

The process of obtaining departmental approval for Partnership is non-binding.

2. Physicians eligible to be considered will be announced to the Board of Directors three months prior to each calendar quarter.
3. Physicians from the list who are to be considered for Partnership status will be announced in a general notice to all active Partners in the Region for their input.
4. Any response to the general notice and the Area Medical Director’s recommendation will be presented to the Board of Directors two months prior to the quarter. A category designation must be established prior to election to the Partnership. Those who are affirmed by three-quarters of the Board of Directors will be voted on by the Partners in the Area where the prospective Partner practices.
5. At least three-quarters of the active Partners in the Area must return a ballot unambiguously approving or disapproving Partnership and at least three-quarters of those unambiguously expressing a preference must be in favor of Partnership if the candidate is to be considered for Partnership. The results of the election will be submitted to the Board of Directors at the Board of Directors’ meeting held approximately one month in advance of the quarter of Partnership eligibility.
6. Physicians who have been elected by Partners in the physician’s Area will receive final consideration at the Board of Directors’ meeting immediately preceding their Anniversary Date. If three-quarters of the Board of Directors vote affirmatively and the candidate submits a written letter of acceptance, he or she will be elected to the Partnership.
7. Partnership Process Diagram



Note: The title of “Associate” or “Associate Physician” has been commonly used to describe a full time employee physician who is anticipated to become eligible for SCPMG Partnership. Please note that the above diagram is meant to assist readers with understanding rules contained elsewhere in these Rules and Regulations. If there are conflicts between this diagram and the Rules and Regulations, then the Rules are controlling.

**D. Termination of Partners**

1. Voluntary Termination – (See Partnership Agreement, Articles 10 and 11)

When voluntarily withdrawing from the Partnership the Partners must give notice in writing. Said notice will be mailed or delivered to the principal office of the Partnership and a copy sent to the Partner’s Area Medical Director. Said notice will specify the date on which the withdrawal will become effective. The effective date must be a regular work day for the Partner and the last day to be worked or an approved day of Vacation Leave.

2. Involuntary Termination – (See Partnership Agreement, Article 10)

(a) Category I

Immediately upon the first formal action by either the Board of Directors or the Area Partners to terminate a Partner as provided in the Partnership Agreement, and before final action is taken, a notice will be sent to all active Partners informing them of the proposed action so that any Partner who wishes to present any relevant information or opinion to the Board of Directors may do so in person or in writing.

(b) Category II or III

Upon the recommendation to the Board of Directors by the Area Medical Director or an elected member of the Board of Directors from that Area, the Board of Directors may terminate a Category II or III Partner by a majority vote.

**E. Meetings of the General Partnership**

Meetings may be called at the discretion of the Executive Medical Director, the Board of Directors, or by valid petition. To be valid, a petition must specify the purpose(s) of the meeting, be signed by 20% of the Partners, and be verified by the Secretary of the Board of Directors. The Board of Directors will provide a meeting place and time within 30 days of petition verification.

**F. Responsibility and Authority**

1. The Partners delegate policy making authority and responsibility to the Board of Directors, and administrative responsibilities and authority to the Executive Medical Director.
2. Any business that requires a vote of the Partnership must first be considered by the Board of Directors. This does not impair the right of a Partner or Partners to initiate proposals, nor does it require the submission of routine business of the Partnership for a vote by the general Partnership.

Before submitting a proposal for Partnership approval, the Chairperson of the Board of Directors will appoint a committee of Board members to prepare the ballot containing a brief statement explaining background and pros and cons which, following Board of Directors approval, will be distributed to the Partnership with the ballot for the proposal.

3. It is the right of every Partner to request consideration by the Board of Directors of any matter whatsoever, and to request that the matter be placed on the agenda of a Board of Directors' meeting. This may be done in writing, by requesting one of the Area's members of the Board of Directors to place such matters on the agenda of a Board of Directors' meeting.

If any physician opposes any action of the Executive Medical Director, a Medical Director, an Area Medical Director, a Chief of Service, a Physician in Charge, and/or an assistant or appointee of any of the foregoing and that physician wishes to assert a claim against SCPMG because of such action, he or she must follow the Dispute Resolution Procedure (Rules and Regulations, Section 1.I). SCPMG must also follow the Dispute Resolution Procedure should it wish to assert a claim against any physician.

**G. Capital Contribution – (See Partnership Agreement, Article 5)**

All Partners are required to contribute \$2,500 to the capital account of Medical Group. Upon resignation or termination from Partnership, the physician will receive a percentage of the

capital account equal to the amount contributed by the resigning or terminated Partner divided by the total amount contributed by all Partners.

## **H. Administrative Liability**

The Partnership will defend and indemnify any member of the Board of Directors, the Executive Medical Director, and any individual appointed and/or approved by the Board of Directors and/or the Executive Medical Director to act in an administrative capacity, as a party to any proceeding arising from acting in an official capacity. The Partnership will defend and indemnify against expenses, including without limitation, attorney's fees, judgments, fines, settlements, and other amounts actually and reasonably incurred in connection with such proceeding unless the person is found not to have acted in good faith nor in a manner the person reasonably believed to be in the best interest of the Partnership.

## **I. Dispute Resolution Procedure**

### **1. General**

- (a) It is in the interest of SCPMG and its physicians that any dispute between a physician and SCPMG be resolved quickly and fairly. Should any matter remain unresolved after informal efforts have been exhausted, this Dispute Resolution Procedure ("DRP") shall be used as an exclusive means for the resolution of such disputes, except as specified below.
- (b) This DRP applies to any dispute involving a physician and SCPMG that would otherwise be cognizable in a court of law, including, without limitation, any dispute related to a physician's relationship with SCPMG or any alleged termination of that relationship, whether based on contract, tort, state or federal statute, ordinance or regulation. Examples of disputes covered by this DRP include, but are not limited to, claims one party may bring against the other or against the officers, directors, employees, partners, or agents of such party for breach of contract (express or implied), breach of covenant of good faith and fair dealing, theft, damage to property, unfair business practices, unfair competition, false advertising, violation of obligation to preserve trade secrets, interference with contract, interference with prospective economic advantage, wrongful termination or demotion in violation of public policy, retaliation or retaliatory discharge, discrimination (because of race, sex, national origin, religion, age, disability, marital status, or sexual orientation), failure to accommodate, unlawful harassment, denial of leave, intentional and negligent infliction of emotional distress, fraud and deceit, negligent misrepresentation, libel, slander, invasion of privacy, assault, battery, false imprisonment, conversion, malicious prosecution or abuse of process, breach of fiduciary duty, and claims for payment of draws or other forms of Partner compensation, return of capital contribution, or, for non-Partner physicians, claims for wages, commissions, and bonuses.

- (c) Without limiting the breadth of the foregoing, this DRP applies to any dispute between a physician and any other person where SCPMG is sought to be held vicariously or indirectly liable on account of the other person's conduct, and to any dispute between SCPMG and any other person where a physician is sought to be held vicariously liable on account of the other person's conduct.
- (d) This DRP does not apply to certain claims and disputes, as follows: (i) any claim by a non-Partner physician for worker's compensation benefits; (ii) a judicial action by either party for a temporary restraining order or a preliminary injunction to preserve the status quo pending arbitration; (iii) any report to a law enforcement agency regarding conduct believed to be a crime; and (iv) any report to a professional board of the State of California required by law. This DRP also is not meant to prohibit the notification of an administrative agency of the federal or state government by the filing of a charge or complaint which alleges discrimination, failure to pay compensation or other violation of law.
- (e) The claims by more than one physician, or the claims by SCPMG against more than one physician, shall not be consolidated into one proceeding without the express, written consent of all parties.
- (f) The DRP shall not supersede and is not meant to supersede the Dispute Resolution and Arbitration provision within any individual physician's Employee Physician Contract or Per Diem Physician Contract. To the extent the terms of this DRP conflict with the terms of such provision, the individual physician's Employee Physician Contract or Per Diem Physician Contract controls.

## 2. Process I

- (a) The aggrieved party ("Complaining Party") must give written notice of any claim by making a timely written demand for the initiation of the DRP on the other party (the "Responding Party"). In the case of a physician who has a claim against SCPMG, the physician shall send a written demand to SCPMG of the initiation of the DRP to the person(s) (the "Decision Maker(s)") whose act or failure to act ("Act") forms the basis for the physician's claim, with a copy to the General Counsel for SCPMG, at 393 East Walnut Street, Pasadena, CA 91188. Where SCPMG has a claim against a physician, SCPMG shall send a written demand to the physician for the initiation of the DRP to the last address recorded in the physician's file. The written demand must be sent by certified or registered mail, return receipt requested, within the time limitations period for asserting such a claim in a court of law in order to be considered timely. An untimely claim may be rejected on that basis alone.
- (b) The written demand for the initiation of the DRP (the "Complaint") shall be dated and signed by the Complaining Party, and shall describe the nature of all claims asserted and a short and plain statement of facts on which the claims are based, including (i) a list of witnesses to the events underlying the dispute, (ii) the date the dispute arose, (iii) an adequate description (or copy) of the principal documents that

- contain any statement supporting the claims, (iv) the relief requested, and (v) the names of all persons from whom relief is requested. Failure to set forth this information may be grounds for rejection of further consideration of any claim not so supported, and imposes on the Complaining Party a duty to provide such information before the Complaint is further considered.
- (c) If the Act is an administrative decision related to (i) fees for legal services in defense of a legal claim or of a legal process in any forum or, (ii) the payment of any amount that a physician is or may become obligated to pay on account of such legal claim or action, the DRP may proceed only when the underlying claim or action is finally resolved.
  - (d) If the Complaining Party is a physician, the Decision Maker of Responding Party SCPMG must respond in writing to the Complaint within 30 business days after receipt. If the Complaining Party is SCPMG, the Responding Party physician must respond in writing to the Complaint to the General Counsel for SCPMG within 30 business days after receipt. If the Responding Party fails to respond within 30 business days after receiving it, the Complaint shall be deemed denied.
  - (e) If the parties are satisfied with the response in Process I, the dispute will be deemed resolved. If either party is not satisfied with the response in Process I, the dispute may proceed to the next applicable Process.

### 3. Process II

- (a) If either party is not satisfied with the response in Process I, and wishes to further pursue resolution of the dispute, the parties shall next comply with either Process II or III, as applicable. The parties shall bypass Process II and proceed directly to Process III if the Area Medical Director or the Executive Medical Director is the Decision Maker, or if the Area Medical Director or the Executive Medical Director initiated or voted to initiate the filing of a Complaint asserted by SCPMG. Otherwise, the parties shall comply with Process II, as follows:
  - (b) Within 15 business days after receipt of the Process I response, or within 15 business days after the Complaint is deemed denied [see Section 1.I.2(d)], the party dissatisfied with the Process I response shall send to the Area Medical Director for the Area where the physician who is the Complaining Party or Responding Party practices a clear, concise, written statement (the "Process II Statement") of the facts surrounding the Complaint and the reasons why the Process I response is unsatisfactory. The Process II Statement must be signed and dated.
  - (c) After obtaining the Process II Statement, the Area Medical Director may investigate the Complaint or cause the Complaint to be investigated.
  - (d) If the Area Medical Director or designee considers it advisable, a conference may be held with the parties to discuss the Complaint in an effort to reach a mutually satisfactory resolution. The Area Medical Director or designee will provide a written



response to the Complaint within 30 business days of receipt of the Process II Statement. The written response will state whether the Area Medical Director concludes that the Complaint is justified, recommends that the Process I response should be modified, or agrees the Process I response was appropriate, and the reasons for these determinations. If the Area Medical Director fails to respond within 30 business days of receipt of the Process II Statement, it will be deemed that the Area Medical Director agrees that the Process I response was appropriate.

- (e) If the parties are satisfied with the Area Medical Director's response in Process II, the dispute will be deemed resolved. If either party is not satisfied with the Area Medical Director's response in Process II, any dissatisfied party may proceed to the next applicable Process.

#### 4. Process III

- (a) If the parties bypass Process II [see Section 1.I.3(a)], or if the parties have not bypassed Process II but one or more parties are not satisfied with the Area Medical Director's Process II response, and either dissatisfied party wishes to further pursue resolution of the dispute, the parties shall comply with Process III, as follows:
  - (b) Any party invoking Process III must present the Complaint, any Process I response, any Process II response issued by the Area Medical Director, and a written appeal to the Chair of the applicable Area Appeals Committee ("AAC"). The Complaint, any Process I response, any Process II response issued by the Area Medical Director, and the written appeal together shall be referred to as the "Appeal".
  - (c) The Appeal must be presented to the Chair of the applicable AAC within the following time periods:
    - (1) If Process II is bypassed pursuant to Section 1.I.3(a), within 15 business days after the Complaint is denied or deemed denied or an unsatisfactory Process I response is sent to the dissatisfied party;
    - (2) If Process II is not bypassed, within 15 business days of receipt of the Area Medical Director's Process II recommendation; or
    - (3) If Process II is not bypassed, but the Area Medical Director fails to respond within 30 business days of receipt of the Process II Statement, within 15 business days after the Area Medical Director was to have responded under Section 1.I.3(a)(3).
  - (d) The AAC will meet as soon as practical to consider the dispute. The AAC will consider any documentary evidence presented to it in a timely fashion and will hear any witness presented by either of the parties or any other relevant person, provided it feels such testimony is likely to contribute to its determinations.

- (e) Within 30 business days of the above hearing, the AAC Chair will send by United States First Class Mail “Return Receipt” to the Complaining Party and the Responding Party the AAC’s written, non-binding recommendation for how the dispute should be resolved. The Chairperson will send a signed statement to the Secretary of the Board of Directors which will identify the parties, and the date that the AAC’s report was sent to each.
- (f) If the AAC fails to meet within 60 business days after receiving the Appeal, or if it fails to issue its non-binding recommendations within 30 business days after the hearing on the Appeal is completed, the Appeal will be deemed denied by the AAC.
- (g) If the parties are satisfied with the non-binding recommendation from the AAC, the dispute will be deemed resolved. If either party is not satisfied with the non-binding recommendation from the AAC, any dissatisfied party may proceed to the next applicable Process.
- (h) If the parties are not satisfied with the AAC’s non-binding recommendation or if none is forthcoming pursuant to Section 1.I.4(d), and any dissatisfied party wishes to further pursue resolution of the dispute, the parties shall either:
  - (i) Upon mutual assent confirmed in writing, utilize the procedures outlined within this Process IV below for final, binding resolution of their dispute; or
  - (j) If there is no mutual assent to utilize Process IV, proceed directly to Process V – Arbitration.

5. Process IV

- (a) The party seeking appeal shall present a written Notice of Appeal to the Board (“Board Appeal”) to the Secretary of the Board of Directors and to the other party. The Board Appeal must state in a clear, concise manner the basis for the Board Appeal, and must include all materials that constitute the Appeal for Process III. The Board Appeal must be signed and dated by the party presenting it.
- (b) The Secretary of the Board of Directors or designee will forward a copy of the Board Appeal and all documents pertinent to the Appeal to the Chair of the Dispute and Request Committee (“DRC”).
- (c) The Board Appeal must be presented by the party seeking appeal to the Secretary of the Board of Directors within the following time periods: If the AAC issues a Process III non-binding recommendation, within 15 business days after the AAC has sent its Process III recommendation or, if none is forthcoming pursuant to Process III Section 1.I.4(d), within 15 business days after the Appeal is deemed denied.
- (d) The dispute will be heard first by the DRC as soon as practical. The DRC will follow procedures and make determinations as set out in the SCPMG Rules and Regulations (see Section 2.H).

- (e) If either party to the dispute does not accept the actions contained in the final DRC report, either party may request the Board of Directors consider the matter (see Section 2.H). Such request must be written, signed and delivered to the Secretary of the Board of Directors within 15 business days of the final DRC report being mailed to the parties. If neither party delivers such request within this time period, the DRC recommendation will be final and binding upon the parties.
- (f) At any hearing of the DRC or the Board of Directors, the Complaining Party may, but is not required to be represented by a SCPMG Partner. The parties may be advised by lawyers who are not SCPMG Partners, but such lawyers, if present, may speak only to their clients. Any Complaining Party who appears at the meeting of the Board of Directors or the DRC does so on his or her own personal time. The Board of Directors will render its decision in writing within 15 business days after the last meeting at which the Appeal is considered, and a copy of such decision will be mailed to the parties.
- (g) A majority decision of the Board of Directors is final and binding upon the parties. If the Board of Directors does not render a majority decision, the Secretary of the Board of Directors will send by United States First Class Mail notice of same to the parties and either party may then elect to proceed to Process V.

6. Process V — Arbitration

- (a) If the dispute remains unresolved after Process III or if Process IV is utilized and no majority decision is rendered by the Board of Directors, and either party wishes to further pursue resolution of the dispute, the parties shall comply with Process V, as follows:
  - (1) Any party invoking Process V shall deliver a written, signed and dated notice (the “Demand for Arbitration”) to the other party. The party demanding arbitration must deliver the Demand for Arbitration to the other party within the following time periods:
  - (2) If Process IV has been bypassed, and if the AAC has issued a Process III non-binding recommendation, within 15 business days after receipt such Process III recommendation;
  - (3) If Process IV has been bypassed, but the AAC failed to hold a Process III hearing or failed to issue its non-binding recommendation within the time periods specified for such in Section 1.I.4(d), within 15 business days after the Appeal is deemed denied;
  - (4) If Process IV has been utilized, but the Board of Directors declines to hear the matter, or there is no majority decision rendered by the Board of Directors, within 15 business days after notification from the Secretary of the Board of Directors that it has either declined to hear the matter or failed to reach a majority decision.

- (b) Notwithstanding the Processes set forth above, the parties to a dispute may agree between or among themselves at any time to proceed directly to this Process V. If such agreement is made, it shall be in writing signed by all parties, and once fully executed and delivered to all parties, shall be deemed to constitute service of the Demand for Arbitration.
- (c) A Complaint whose resolution requires change to the Partnership Agreement or the Partnership's Rules and Regulations is not subject to arbitration.
- (d) Any arbitration hereunder shall be before a single arbitrator in accordance with the relevant dispute rules of the American Arbitration Association ("AAA") then in effect (which can be found at the website [www.adr.org](http://www.adr.org)), except that in the event of any conflict between those rules and those set forth herein, the rules set forth herein shall control.
- (e) Once the Demand for Arbitration is sent or deemed served, the Responding Party shall within ten (10) business days notify the appropriate office of the AAA that a dispute exists requiring arbitration.
- (f) The single arbitrator shall be selected by the parties as follows. The AAA shall give each party a list of eleven (11) arbitrators drawn from its panel of arbitrators. Each party may strike up to six (6) names on the list. If only one common name remains on the lists of the parties, that individual shall be designated as the arbitrator. If more than one common name remains on the list of all parties, then the parties shall strike names alternately (the party not initiating arbitration going first) until only one remains. If no common name remains on the lists of all parties, then the AAA shall furnish an additional list or lists until an arbitrator is selected. If for any reason the parties fail to agree on an arbitrator, then the AAA may issue additional lists or, at its option, make the appointment from among members of its panel of law arbitrators. Neither party waives the right to seek disqualification of the arbitrator. If a party seeks disqualification due to a potential conflict of interest, then the AAA shall make the final decision as to whether the arbitrator is disqualified.
- (g) Each party shall pay its own legal fees in prosecuting or defending the claims so arbitrated, subject to the authority of the arbitrator to award fees and costs pursuant to statute as set forth in Section 1.I.6(h), below.
- (h) The arbitrator shall have authority to interpret and apply this DRP. The arbitrator shall resolve any controversy as to whether a dispute is arbitrable, construing the scope of this DRP broadly in favor of final and binding arbitration, to the extent permitted by law. The arbitrator may hear and rule on pre-hearing disputes and hold conferences by telephone or in person as the arbitrator deems necessary. The arbitrator shall resolve all discovery disputes, and may permit discovery in addition to that provided for in Section 1.I.6(j) below, upon a showing of good cause for that additional discovery. The arbitrator shall have authority to grant pre-hearing motions, including motions to dismiss and motions for summary judgment, in accordance with

- the rules set forth in the Federal Rules of Civil Procedure and the judicial authorities interpreting those rules. Upon notice of such a motion, the arbitrator will establish a briefing schedule and, if necessary, schedule an opportunity for oral argument prior to considering the motion. The arbitrator shall apply the substantive applicable law including but not limited to the law as it relates to time limitations on when claims must be filed, and may award any remedy authorized by law, including attorney's fees and costs that are authorized by statute. The arbitrator has no authority to (i) add to or modify the terms of any contract between the parties, including but not limited to the Partnership Agreement and these Rules and Regulations, (ii) require SCPMG to adopt new policies or procedures, (iii) hear or decide any matter that was not processed in accordance with this DRP, absent written consent of both parties; or (iv) hear or decide any arbitration as a class action.
- (i) The procedures to be followed are those set forth in the dispute resolution rules of the AAA, except to the extent those rules differ from those set forth in this DRP, in which case this DRP controls. Each party shall have the right to subpoena witnesses and documents for the arbitration hearing. No part of the procedures shall be open to the public or the media. All evidence discovered or submitted at the hearing is confidential and may not be disclosed, except pursuant to court order. Unless the parties otherwise agree, each party may submit a post-hearing brief within thirty (30) days of the close of the hearing. The arbitrator's award shall contain written findings of fact and a finding on each issue necessary to the arbitrator's conclusion, together with conclusions of law sufficient to provide a rationale for the arbitrator's decision with respect to the matters at issue. Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. The award is final and binding on the parties, and may be vacated or modified only on the grounds specified in the U.S. Arbitration Act or applicable law.
- (j) Not less than thirty (30) days prior to any hearing, the parties shall exchange copies of those documents that they anticipate will be used as exhibits and a list of names of persons they anticipate will be called as witnesses at the hearing. Each party shall be entitled to have the following pre-hearing discovery: (i) The right to serve on the other party one set of interrogatories in a form consistent with Rule 33 of the Federal Rules of Civil Procedure, which shall be limited to twenty-five (25) questions (including sub-parts, which shall be counted separately); (ii) The right to serve on the other party one set of document requests in a form consistent with Rule 34 of the Federal Rules of Civil Procedure, which shall be limited to twenty-five (25) requests (including subparts, which shall be counted separately); (iii) The right to conduct up four (4) seven-hour days of depositions in total of witnesses or the parties in accordance with the procedures set forth in Rule 30 of that Federal Rules of Civil Procedure; (iv) in addition to the foregoing deposition(s), the right to conduct the deposition of any expert witness designated by the other party; (v) the right to subpoena the production of documents from third parties; and (vi) the right to seek a physical or mental examination consistent with Rule 35 of that Federal Rules of Civil Procedure. Any discovery beyond that specified above must be approved by the arbitrator upon a showing of good cause by the party seeking such discovery. The

arbitrator will finally resolve any dispute regarding discovery. In so doing, the arbitrator must weigh the delay in resolving the dispute, the weight of any evidence which might be reasonably expected to be discovered, alternative and less costly methods of securing the sought-after information not yet utilized, and the hardship of production.

- (k) Physician's job duties constitute an activity that affects commerce among the states, making physician's agreement with SCPMG a transaction involving commerce among the states. This DRP may be enforced in accordance with the provisions of the Federal Arbitration Act, 9 U.S.C. Sec. 1, *et seq.*, or the provisions of any applicable state arbitration statute. If any provision of this DRP is adjudged to be void or otherwise unenforceable, in whole or in part, that adjudication shall not affect the validity of the remainder of the DRP.

### **J. Area Appeals Committee Procedure**

1. The Area Appeals Committee ("the Committee"), comprised of five members and two alternates, may hear a dispute only after all prior steps required by the DRP have been completed and at least one of the parties requests hearing by the Committee.
2. The Committee will endeavor to meet as soon as practical but in no event later than the time required by the DRP. The alternate member will hear the dispute only if another Committee member is not available to hear the dispute. If for any reason fewer than five Committee members hear any dispute, those Committee members who hear the dispute shall have the full authority and responsibility of the Committee, contingent on approval of all parties. Prior to any hearing, the Committee will select a Chairperson.
3. Each party to a dispute and each Committee member who will hear the dispute must receive notice of the meeting date, time and place and the parties to the dispute must have an opportunity to be heard.
4. Parties may be assisted by counsel but such counsel may only address the counsel's client. Counsel who do not comply completely with this stricture will be excluded from the hearing.
5. Proceedings of the Committee are confidential. No recordation other than hand written notes is permitted.
6. The party requesting Committee review will have the first opportunity to present evidence to the Committee. The other party will next present evidence. Each party, in the above order, will then have an opportunity to present any rebuttal. All testimony, including but not limited to the testimony of the parties, must be presented at a meeting convened according to Section 1.J.3. All witnesses will be interviewed first by the party presenting the witness, then by the opposing party and last by the Committee. Witnesses other than the parties will be interviewed separately and outside of the earshot of other witnesses. Copies of all non-testamentary evidence must be provided to the Committee and the opposing party. The Committee may obtain additional evidence as it sees fit.



Any evidence so obtained must be presented to each Committee member and the parties. Parties must be given an opportunity to comment on such evidence. The Committee will hear all evidence which is possibly relevant and not repetitive of evidence already presented. Any dispute regarding the conduct of the hearing will be finally resolved by the Chairperson.

7. Committee deliberations may not be attended by anyone other than Committee members. The Committee will strive for consensus but may make any decision by majority vote. The substance of the deliberations and any votes are confidential and may not be communicated to the parties or others. Findings must be limited to addressing directly the remedy sought as stated in the Complaint (i.e. the remedy is or is not warranted). Other suggestions for resolving the dispute or avoiding future problems may be informally communicated by any Committee member to both parties.
8. The Committee will make its findings known by means of a written report which shall be mailed by the Chairperson to the parties. The Chairperson will send a signed statement to the Secretary of the Board of Directors which will identify the parties and the date that the report was sent to each.
9. Any Committee member may contact SCPMG Legal Counsel or his or her designee for assistance.

## **2 BOARD OF DIRECTORS – (SEE PARTNERSHIP AGREEMENT, ARTICLE 8)**

### **A. Composition**

1. The Board of Directors consists of ex-officio and elected members, each of whom, with the exception of the Secretary of the Board of Directors and any Acting Area Medical Director, has one vote.

The Secretary of the Board of Directors will have a vote on the Board of Directors if the appointee is concurrently a voting Board of Directors member.

2. Ex-officio membership:
  - (a) The Executive Medical Director is appointed by the Board of Directors and approved by the Partnership.
  - (b) The Medical Director of Business Management, the Medical Director of Operations, and the Medical Director of Quality and Clinical Analysis are appointed by the Executive Medical Director (upon the recommendation of the Executive Medical Director Elect, if applicable), and approved by the Board of Directors and by the Partnership.
  - (c) An Area Medical Director is appointed by the Executive Medical Director (upon the recommendation of the Executive Medical Director Elect, if applicable), approved by the Board of Directors, and ratified by the Partners in the Area.
3. Except as otherwise provided in Article 8 of the Partnership Agreement, the elected members of the Board of Directors are elected for a term of three years. If an elected member of the Board vacates his or her seat, the successor shall serve for the remainder of the term. Reference: Election Manual, Section 9.B.1.

Elected members of the Board of Directors who become a Chief of Service, a Physician Director of Business Services, a Service Line Leader, or an Assistant Area Medical Director will be required to stand for a reaffirmation vote if more than a year of their term remains at the time of appointment.

If the Elected member of the Board is not reaffirmed, he/she may remain in office only until a replacement can be elected. The election will be conducted in the same manner as any other election for a Board of Directors member. The Partner who was not reaffirmed may be a candidate in such an election.

- (a) Nominations for election to the Board of Directors are made in each Area. A valid election is one in which at least three-fourths of the active Partners in that Area cast valid ballots (see Election Manual).



(b) When appropriate, ballots will be counted by the method of Preferential Voting.  
Reference: Election Manual, Section 15.

4. During the absence of an Area Medical Director, an Assistant to that Area Medical Director or other designee may be appointed to attend meetings of the Board of Directors as a non-voting member. The Area Medical Director's designation will be valid only if written notice or a personal phone call is received by the Secretary of the Board of Directors.
5. Any Partner in an Area will initiate a recall election of one or more of the Area's elected members of the Board by delivering to the Area Balloting Committee a valid petition for such an election. For the petition to be valid, the petition must state who is the subject of the recall election, the reason or reasons why recall is being sought, and that the signatory supports the recall of the identified elected member(s) of the Board. For the petition to be valid, the petition must evidence valid signatures by 30% of the active Partners in the Area. For a signature to be valid, it must be legible (or the name printed legibly as well as signed), it may not be a photocopy, it must be dated by the signatory at the time of signing, and the signature must have been collected within 30 days of presentation to the Area Balloting Committee, one year after any previous recall election, if any, and no sooner than one year following the last election of the Board member(s). The Area Balloting Committee may verify and finally establish the validity or invalidity of any signature presented.

The recall election must be preceded by a meeting of Partners in the Area during which the allegations contained in the petition are discussed. The identified Board member(s) will have an opportunity to respond to the allegations contained in the petition. On the first business day thirty days following the Area Balloting Committee certification of receipt of a valid recall petition, ballots will be mailed to all active Area Partners. Returned ballots will be accepted for 15 business days after ballots are sent. Ballots will be counted by the Area Balloting Committee within 2 business days of the close of balloting. An elected member of the Board will be recalled if a majority of active Partners in the Area vote to recall the elected member of the Board. A recalled Board member who is otherwise eligible may become a candidate in any Board member election.

## **B. Meetings of the Board of Directors**

Meetings will be held at least eight times a year. All actions require a majority of the entire number of the voting members of the Board of Directors except where otherwise indicated in the Partnership Agreement or the Board of Directors' Operating Rules (Section 2.G). A roll call vote may be requested by any member of the Board of Directors and will be duly recorded.

## **C. Attendance at Board of Directors' Meetings**

The following is the policy for attending Board of Directors' meetings:



1. Incoming Board Members and Permanent Guests

All Partners who have been elected to the Board of Directors but who have not yet taken office, Executive Medical Directors Elect, Medical Directors Elect, Area Medical Directors Elect, the SCPMG Chief Compliance Officer, General Counsel, Chief Operations Officer, Chief Financial Officer, and Assistant Executive Medical Director for Permanente Human Resources (“the Physician Director of Permanente Human Resources”) are allowed to attend and participate in Board of Directors’ meetings as non-voting guests of the Board of Directors.

2. Partners Observing Board Meetings:

- (a) Any Partner who submits a request to the Secretary of the Board of Directors 7 days in advance may observe a meeting of the Board of Directors. All Board Members shall be notified of such a request. A maximum of five seats will be made available for observers. The Secretary of the Board may limit visitor attendance due to limited seating space. If a visitor is unable to attend due to space limitations, that visitor will be offered a seat at a future Board meeting.
- (b) The Chairperson of the Board of Directors may declare any meeting of the Board of Directors or portion thereof an executive session. Observers will be excluded from an executive session. Without Board objection, the Chairperson may recommend ejection of any visitor for unruly behavior. If there is objection, an executive session will be convened for the purpose of voting on the question.

3. Time for Board Attendance by Partners

- (a) A Partner may use Administrative Work, Educational Leave, Vacation Leave, or personal time to attend a Board meeting. Administrative Work may be used only if that Partner is making a Medical Group business presentation to the Board or is otherwise participating in Board work at the Board’s request. For other Board attendance, Educational Leave or Vacation Leave may be used.
- (b) Board attendance in Section 2.C.3(a) above will be for the entire Board meeting, unless other arrangements are made in advance and in writing. The use of Educational Leave for Board attendance requires the Partner’s presence at the meeting. No more than two Educational Leave days per year may be used for this purpose. All physician Leaves require approval of the physician’s Chief of Service or Physician in Charge, based on departmental and patient needs.
- (c) Partners and Employee Physicians who appear for purposes of appeal to any action by the Medical Group or who do not adhere to the above rules will do so on personal time or Vacation Leave, if approved by their Chief of Service or Physician in Charge.

**D. Proxy Voting by Board of Directors Members**



A Board of Directors member may give his or her proxy to any other voting member of the Board of Directors.

The voting proxy may be limited by the giver in any way and for any period of time.

The proxy will be validated by written notice or by a personal phone call or e-mail to the Secretary of the Board of Directors.

#### **E. Executive Medical Director's Annual Report and Performance Evaluation**

1. The Executive Medical Director will present a "State of Medical Group and the Kaiser Permanente Medical Care Program" report to the Board of Directors each year. This is to include a review of the previous year and the objectives for the forthcoming year.
2. A committee of the Board of Directors will review the Executive Medical Director's performance and report to the Board of Directors.

#### **F. The Board of Directors is the Peer Review Body**

For the purpose of California Business and Professions Code §§809 to §§809.9, the Board of Directors is designated as the Peer Review Body.

#### **G. Board of Directors' Operating Rules**

1. All proposals will be initially submitted to the Secretary of the Board of Directors by a member of the Board of Directors.
2. After financial and legal analyses are complete, a Board of Directors' Standing Committee will review the proposal for possible clarification and to make a recommendation to the proposer for further study by a Board of Directors' committee or for consideration by the Board of Directors. If the Board of Directors' Standing Committee recommends further committee study and the proposer wishes the proposal to be heard first by the Board of Directors, the proposer will present to the Board of Directors without discussion. The Board of Directors will then vote whether to proceed immediately to a Hearing Conference.
3. Board of Directors' business will be conducted in the order published in the agenda unless the proposer chooses to have his or her proposal delayed. The setting of the agenda is the sole responsibility of the Secretary of the Board of Directors. Generally, proposals will be placed on the agenda in the order in which they become ready for Board of Directors' consideration.
4. When submitted to the Board of Directors, the proposal's initial presentation and discussion is called the Hearing Conference. The Hearing Conference is for the purpose of discussing and evaluating the proposal. Possible amendments to the proposal may be informally discussed.



5. The Decision Conference will occur at the Board of Directors' meeting following the Hearing Conference or as determined by the Board of Directors. The decision conference will begin with a discussion of any information relevant to the proposal not discussed at the Hearing Conference. After this discussion, amendments may be considered. The Decision Conference will end with a decision on the proposal as amended.
6. The Board of Directors will consider amendments submitted in writing to the Secretary of the Board of Directors prior to the published deadline for submissions to the agenda for the meeting in which the Decision Conference for the proposal is scheduled to occur. An amendment not submitted in the above manner may nonetheless be considered if a request to consider the amendment is seconded and approved by two-thirds of all voting Board of Directors members. An amendment becomes incorporated into the proposal, following discussion, if approved by a majority of all voting Board of Directors members.
7. Except as provided above, only minor amendments will be considered if submitted verbally during the Decision Conference. The Chairperson or the Chairperson's designee will have the exclusive right to determine which amendments are minor. The proposer may accept any minor amendment and in so doing incorporate it into the original proposal. When a proposal comes to the Board of Directors from a Board of Directors' committee, the Board of Directors member chosen by the committee to present the proposal to the Board of Directors may accept or reject any proposed minor amendment unless there is an objection from a committee member. If the proposer does not wish to accept a minor amendment, it will be debated and voted upon by the Board of Directors as any other amendment.
8. A proposer may decide to have the Hearing Conference and the Decision Conference at the same meeting by so notifying the Secretary of the Board of Directors prior to the agenda deadline. This will usually occur with proposals that are straightforward and when no substantial amendments are anticipated. All amendments may be made verbally in this circumstance.
9. Any Board of Directors member recognized by the Chairperson or the Chairperson's designee may request the Decision Conference to immediately follow the Hearing Conference. This request, if seconded, will be voted before other business can continue. If approved by all present voting members of the Board of Directors, the Decision Conference will follow the Hearing Conference and all amendments may be made verbally during the Decision Conference.
10. If the Chairperson of the Board of Directors believes that a verbal amendment is major, then the Chairperson may declare it to be a major amendment and request that the Board of Directors remove the proposed amendment from consideration at that meeting. When the Chairperson makes such a request, the proposer may make a brief presentation concerning why the proposed amendment should be considered as an amendment. Immediately following the Chairperson's request and the proposer's brief presentation,

the Board of Directors will vote whether to further consider the amendment at that meeting.

11. Only one proposal, amendment, or request will be discussed at any given time. Only persons recognized by the Chairperson or the Chairperson's designee will be allowed to speak unless a recognized speaker directly requests an answer to a question from another person present. The Chairperson or the Chairperson's designee will recognize speakers in the order in which they request attention with preference given to the proposer and speakers who have not previously participated in the discussion of the proposal, amendment, or request under consideration.
12. Any Board of Directors member recognized by the Chairperson or the Chairperson's designee may request the current discussion be concluded. Discussion will conclude if all members withdraw their requests for attention or if the request to conclude discussion is seconded and approved by three-fourths of all voting Board of Directors members. When discussion concludes for a Decision Conference, amendment, or request, a vote on that proposal, amendment, or request immediately follows.
13. Any Board of Directors member recognized by the Chairperson or the Chairperson's designee, following the conclusion of discussion on the proposal and any amendments during the Decision Conference, may request that the proposal be postponed for further consideration. The request must include a specific time or specific information to be obtained before the proposal will again be scheduled for a decision conference. The request must be seconded and approved by a majority of all voting Board of Directors members to become effective.
14. Proposals substantially similar (as determined by the Board Function/Offsite Planning/Agenda Committee [BFOPAC]) to those previously considered by the Board of Directors will not be placed on the agenda sooner than one year following the last discussion of the similar proposal unless two-thirds of all Board of Directors members vote to consider the proposal sooner.
15. All proposals, amendments, and requests will be approved by a simple majority of all voting Board of Directors members unless otherwise specified by the Partnership Agreement or as set out above.

#### **H. Dispute and Request Committee**

The Dispute and Request Committee ("Committee") will hear all physician disputes presented to the Board of Directors through the Dispute Resolution Procedure (see Section 1.I), all physician requests for clarification of the Partnership Agreement or of the Rules and Regulations, and all requests for exception to the Rules and Regulations.

The Committee will be composed of four elected members of the Board and one Area Medical Director. None of the Committee members will be from the same Area. There will be three alternate elected members of the Board and two alternate Area Medical Directors. Members and alternates will be selected annually in a drawing conducted by the Secretary of

the Board of Directors. Any Board member who requests not to serve in this capacity will be removed from the drawing. After each name is drawn, the names of the Board members from the same Area will be removed from the drawing. The drawing for Committee membership for the following year will be conducted after each December 15.

Committee members who begin hearing a dispute or request in one year will continue to hear the dispute or request into the following year should that be necessary for the Committee to complete its work. In such a circumstance, the Committee members will bear the same responsibility and authority as they did at the beginning of the dispute or request.

Any Committee member from the Area of either of the parties to a dispute or a requesting physician will be excluded from the Committee when the Committee hears that physician's request or dispute. Any Committee member may excuse himself or herself from hearing any matter. An alternate Area Medical Director will replace the Area Medical Director Committee member should he or she be excluded or excused. An alternate elected member of the Board will replace any elected member of the Board who is excluded or excused. Replacement may occur only before the first hearing for a given dispute or request. Replacement will occur with alternates in the same order of being drawn to become an alternate. If for any reason fewer than five Committee members hear any dispute or request, those Committee members who hear the dispute or request shall have the full authority and responsibility of the Committee.

Medical Group Counsel or a physician-attorney designated by him or her will be staff to the Committee and act as Chairperson but shall not have a vote on the matters heard. All procedural questions will be finally resolved by the Chairperson. The requesting physician will submit to the Chairperson a concise statement of the exception to the Rules and Regulations being sought and the reasons for requesting an exception.

In the case of a dispute, the parties, or, in the case of a request, the requesting physician and the Executive Medical Director or his or her designee, will be informed by the Chairperson of the Committee of the pending dispute or request and the meeting date, time and place at which the Committee will consider the dispute or request. Committee meetings will take place at the principal office of the Partnership or any other location designated by the Chairperson.

Either party to a dispute or the requesting physician may, but is not required to, be represented before the Committee by a Partner. In the case of requests, the Partnership will be represented by the Executive Medical Director or his or her designee. All parties may be advised by lawyers, but such lawyers, if present, may speak only to their client(s).

The Committee will hear the parties and any other relevant testimony they might present. They will review all documentation presented. If deemed necessary by the Committee, the Committee may request additional documents and testimony.

Following deliberation, the Committee will make a report containing all of the following:

- ◆ Undisputed relevant facts,

- ◆ Disputed relevant facts found credible by the Committee, and
- ◆ Recommended actions.

If time permits, the Committee will circulate its proposed report to each of the parties and request comments. Once comments are received, the Committee will finalize its report. If the parties accept the Committee's final report's recommended actions, they will sign off on the recommendations and they will be carried out with the same force and effect as if approved by the Board but without presentation to the Board of Directors. If any party does not accept the final report, that party will so notify the Chairperson and the final report will be presented to the Board of Directors. Any party who does not respond to the Committee's final report within 30 days of its having been mailed to that party or otherwise having been delivered to the party will be conclusively presumed to have accepted the report's recommended actions.

At the end of each calendar year, the Committee will present a summary report to the Board of Directors concerning all disputes and requests which were resolved without presentation to the Board. This report will not identify the parties to the dispute or request.

If a party does not accept the recommended actions contained in the final Committee report, the report will be presented to the Board of Directors. The Board must take as true those facts found by the Committee. Each party will be allowed up to 15 minutes to respond to the Committee's report prior to Board deliberation. Additional response time may be allowed at the discretion of the Chairperson of the Board of Directors. The Board may support Committee action recommendations, may choose to take other actions, or might find the Committee's report deficient and request the Committee reconvene to address specified issues.

## **I. Communication**

Every member of the SCPMG Board of Directors may use all available Kaiser Permanente owned communication tools, including email, to communicate with the physicians they represent. As a courtesy, all members of the Board should share such communications with other Board members in their Area before sending the communication, to elicit input. Communications that concern operations are excluded from this regulation.

Messages sent by Board members must conform to the Social Media Policy.

Any member of the SCPMG Board of Directors who has such authority to communicate, and does so in a manner that violates any part of the Social Media Policy, will have this ability revoked until such time as it shall be reinstated by the Board of Directors. In addition, that physician will be subject to any disciplinary action in the SCPMG Rules and Regulations.



### **3 DEFINITIONS OF PHYSICIAN CATEGORIES**

#### **A. Partners**

1. Category I

A physician who has been duly elected into the Partnership and is eligible for the benefits of Partnership as outlined in the Partnership Agreement and the Rules and Regulations.

2. Category II

A physician who, because of administrative reasons or because of lacking board certification has been recommended for Category II Partnership, has been duly elected into the Partnership and is eligible for the benefits of Partnership as outlined in the Partnership Agreement and the Rules and Regulations.

(a) Category II Partners will be reviewed annually for movement to Category I.

(b) All Category II Partners will automatically be reviewed for movement to Category I when the Partner becomes board certified in the specialty in which he or she practices.

(c) A physician who remains in Category II Partnership for five years will be required to withdraw from the Partnership, if withdrawal is recommended by the physician's Area Medical Director or an Elected Board of Directors member from the physician's Area and is approved by the Board of Directors. A physician hired after February 2, 2007 who remains in Category II Partnership for two years will be required to withdraw from the Partnership.

3. Category III

A physician whose former medical group has been acquired by SCPMG who is eligible for the benefits of Partnership as outlined in the Partnership Agreement and the Rules and Regulations.

(a) Category III Partners will be reviewed at least annually for election into Category I.

(b) A physician who remains in Category III Partnership for five years will be required to withdraw from the Partnership.

4. Inactive

An Inactive Partner is a Partner who is on an approved Leave of Absence. During the period of the Leave, the Inactive Partner may not vote on Partnership matters.

#### **B. Employee Physicians**





Employee Physicians are employed by Medical Group; they are not Partner Physicians. Employee Physician salary and benefits will be reviewed by the Physician Benefits Committee annually, with a report and/or recommendations for any changes included in the annual Benefits Committee Package Presentation Proposal.

Notwithstanding any other provision of these Rules and Regulations, and notwithstanding any document or oral communication, a physician's employment with Medical Group shall have no specified term. Employment may be terminated at the will of either party on notice to the other.

1. Full Time Regular

A physician employed by Medical Group who works a full work week (as defined in Section 4.A.1) and does not participate in an outside medical practice or professional activity unless approved by the Board of Directors. A physician in this category is eligible to receive benefits outlined in the Rules and Regulations.

2. Full Time Special

A physician employed by Medical Group who works on a full time basis, does not participate in an outside practice for monetary gain, and is not eligible for Partnership. The physician may have no obligation to participate in Extra Duty assignments.

An individual may be placed in this category for administrative reasons. It is not expected that a Full Time Special physician will work less than 10/10. However, an 8/10 or 9/10 schedule may be approved by the Chief of Service and Area Medical Director after two years of service. If the schedule is less than 8/10, the status will automatically be changed to Part Time physician. Included in this category are physicians who intend to work for Medical Group for more than three months but less than one year. Benefits are described elsewhere in the Rules and Regulations.

3. Special Category

A physician who has been employed by Medical Group for a minimum of three full years and because of age or administrative reasons is deemed ineligible for Partnership.

A physician may be recommended for this category by the Chief of Service and Area Medical Director, subject to approval by the Board of Directors. If approved, the physician will receive the benefits of a Full Time Regular physician.

A physician who begins working full time for Medical Group on or after February 2, 2007, can be placed in Special Category for no more than one year at a time and can remain in the category for no more than two years from the date he or she was placed in Special Category. Physicians hired on or after February 2, 2007, who are in Special Category for two years and who have not attained Partnership will have their employment terminated. Physicians in this category should be reviewed at least annually by their Area Medical Director to determine if a recommendation should be made to the

Board of Directors to change their status. It is not expected that a Special Category physician will work less than 10/10. However, if the schedule is less than 8/10, the status will automatically be changed to Part Time. Upon election to Special Category, the physician may also accumulate unused Acute Sick Leave as described in Section 7.B.1(a). The physician must fulfill a full share of the Extra Duty obligation of the department.

4. Part Time

A physician who is regularly employed by Medical Group at least half time (5/10 or more). This physician may be permitted to have an outside medical practice. Benefits are described elsewhere in the Rules and Regulations.

5. Partner Emeritus

All former Early Separation or retired Partners employed by Medical Group may be considered Partners Emeritus. This title is bestowed in recognition of a Partner's years of distinguished service to Medical Group and the members it serves.

For Compensation and Benefits purposes, there are two categories of Partner Emeritus: Partner Emeritus A and Partner Emeritus K.

Unless otherwise noted, all references to Per Diems in these Rules and Regulations include Partner Emeritus A and K.

Partner Emeritus A and Partner Emeritus K (PE A&K) are categories established as of January 1, 2013, and require a qualifying physician to:

- (a) Have been a Partner of SCPMG and either Early Separate between ages 58 and 65, or retire from Partnership on the physician's 65<sup>th</sup> birthday through December 31 of the year the physician turns 65 years of age.
- (b) Be board certified unless the physician was not board certified when he or she became a Category I Partner of Medical Group.
- (c) Have no disciplinary or remedial administrative actions or compensation reductions in the 24 months prior to retirement from the Partnership.
- (d) Be willing and able to perform department responsibilities (e.g. Extra Duties, evening, weekend, and overnight call) as requested by the Chief of Service and Area Medical Director based upon the business needs of the department.
- (e) Be willing and able to perform the full spectrum of clinical practice (includes but not limited to performing all duties performed during the majority of time the physician was a Partner, not necessarily the duties just prior to rehiring into this category). Partners working in administrative, research or education roles will be considered for

- Partner Emeritus status subject to the limitations outlined in the SCPMG Rules and Regulations.
- (f) Be subject to the same quality, peer and performance review processes as any other SCPMG physician.
  - (g) Work for an hourly rate, are able to contribute to SCPMG TSR Plan (see below) and receive no other Medical Group benefits:
    - (1) The hourly pay is the physician's Base Compensation immediately preceding retirement from the Partnership minus all Partnership related monthly increases plus a Partner Emeritus monthly increase as approved by the SCPMG Board of Directors converted to an hourly rate of pay.
    - (2) Any increase to the aforementioned rate that would compensate the physician above the physician's specialty Base Compensation rate (minus all Partnership related monthly increases) plus the Partner Emeritus monthly increase must be approved by the collective Medical Directors.
    - (3) Physicians in this category will be reviewed annually by the Chief of Service and Area Medical Director for an increase in their hourly rate based upon any adjustment to the Partner Emeritus monthly Increase and any increase in their specialty/sub-specialty's Base Compensation rate.

In addition to the aforementioned requirements, a Partner Emeritus A & K:

- (a) May participate in the Southern California Permanente Medical Group Physician's Tax Savings Retirement Plan.
- (b) Is eligible to voluntarily participate in the scheduled department Education Half Day at the discretion of the physician's Chief of Service and Area Medical Director without compensation.
- (c) May have an outside practice.

A Partner Emeritus A or K who retires before 12/31 of the year the physician turns 65 years of age should consult with the Permanente Benefits Department to determine how many hours the physician may work.

Early Separation Program: A PE A or PE K who may be receiving benefits from the Early Separation Program will be paid in accordance with the program as outlined in the Early Separation Program Plan Document. For example, a PE A or K is subject to a limited work schedule with the Medical Group (not to exceed 45% of the Final Average Hours (FAH)).

Partner Emeritus K: A PE K is required to begin work no later than six (6) months following separation or retirement from Medical Group, as there can be no break in

service, and must continue to contribute to the Southern California Medical Group Physician's Keogh at the level originally elected (either 25%, 50%, 70%, or 100%).

6. Per Diem

(a) Regular

A physician who works for hourly pay, may have an outside medical practice, and who receives no other Medical Group benefits.

(b) Salaried

A physician who works for a monthly salary for a preset number of hours per month, may have an outside medical practice, and who receives no other Medical Group benefits. Additional hours worked will be compensated at the hourly rate established for the Salaried Per Diem in the department for which the Salaried Per Diem physician works such additional hours.

**C. Physicians who are not employees of the Medical Group**

1. Postgraduate Trainees

Post Graduate Trainees (including interns, residents, and fellows) are employees of Kaiser Foundation Hospitals and not of Medical Group; consequently, time spent as a Postgraduate Trainee is not applicable toward Partnership, nor any Medical Group benefits outlined in these Rules and Regulations.

For crediting of service under The Retirement Plan for Physicians Serving Members of Kaiser Foundation Health Plan, Inc. (Common Plan), refer to the Common Plan Summary Plan Explanation.

2. Partner Retired

A retired Partner no longer actively working for SCPMG.

## **4 DEFINITIONS OF WORK COMPONENTS AND WORK TIME**

### **A. Definition of Components of Work:**

SCPMG physicians are hired into a job category with a Base Compensation predicated upon their ability to perform all the expected work for that specialty and job code, as determined by their Chief of Service and Area Medical Director. References to the term “specialty” include the job code that the physician is assigned.

There are three components of work:

1. Full Specialty Practice:

- (a) Available to perform all patient services requested by the physician’s Chief of Service and Area Medical Director.
- (b) Manages in-box and record keeping as appropriate for the specialty.
- (c) Serves as a specialty consultant in both inpatient and outpatient settings, if required of specialty.
- (d) Available to patients for panel assignment as appropriate for the department.

2. Productivity:

- (a) Approved appointment schedule template for the specialty is followed.
- (b) Procedures are performed according to the approved regional times, if any.
- (c) Manages a full panel, pro-rated to time worked, as appropriate for the department.
- (d) Practices in a way that seeks to meet the productivity measures as determined by the specialty.

3. Call Duties and Extra Duties:

- (a) Available to take a full share of the specialty’s after hours (Call Duties and Extra Duties) patient care responsibilities, including, as appropriate, remotely accessing electronic medical records, providing telephone consultation, and entering notations into Health Connect from a remote site. Provides in-person consultation at the Medical Center whenever it is desirable for a patient to receive such care.
- (b) Participates in the call coverage for specialties that require in-house 7/24 coverage, including availability to cover after hours outside the regular work schedule.

- (c) Participates in the call coverage for after-hours urgent care duties and/or Critical Care Transport (CCT) duties beyond the regular work schedule when needed by the physician's specialty.
- (d) Available to work Extra Duty clinics for access and other acute patient care needs beyond the regular work schedule when needed by the physician's department.

Work responsibilities within a department need not be uniform amongst department members. Work responsibilities may vary by location, by subspecialty and according to other factors determined by the Chief of Service and Area Medical Director. A physician's work responsibilities may vary from time to time. A physician satisfies her/his work responsibilities and is not subject to a compensation reduction if the physician performs all work that is requested by their Chief of Service and Area Medical Director and takes a full share of department work responsibilities, whether during the Regular Work Week or after hours.

## **B. Work Week**

### **1. Regular Work Week**

The Regular Work Week is defined as 11 half days per week, including the morning and afternoon of each weekday and Saturday morning. For full time physicians who work in an outpatient office setting, excluding Extra Duties, inpatient work, and unstructured schedules (e.g. Emergency Department, Urgent Care and Hospitalists), each W includes 210 minutes of patient care time and 30 minutes of Flexible Physician Time used for in basket management, responding to emails, patient messages, or additional patient visits. Each half day equals W-1.

For other physicians, the Regular Work Week is defined as 11 half days per week. Each half day on weekdays extends from 8:00 a.m. - 9:00 a.m. to noon - 1:00 p.m. or from noon - 1:00 p.m. to 5:00 p.m. - 6:00 p.m. Saturday's half-day lasts from 8:00 a.m. - 9:00 a.m. to noon - 1:00 p.m. Each half day equals W-1. The physician's Chief of Service and Area Medical Director will determine the physician's work schedule within the Regular Work Week.

In addition, a physician has responsibility for inpatient and outpatient continuity of care as well as an obligation to share departmental staffing for required Extra Duty, After Hours Duty, Call Backs and hospital staffing.

- (a) For payroll purposes, the work week starts at approximately 11:00 p.m. on Sunday nights, (i.e. with the beginning of the overnight Extra Duty) and ends at 11:00 p.m. the following Sunday night.
- (b) All W's, including overnight, will be used to determine the total number of W's credited to a physician during a pay period. Except as noted in the following sentence, all W's in excess of W-20 in a pay period will be paid at 120% of a physician's Base Compensation (exception: see Holidays, Section 6.C). Physicians

- on a Regular Work Week schedule who work their department overnight Extra Duty (10:00 p.m. to 8 a.m.) will be paid 150% of the physician's Base Compensation for that overnight period. For physicians on Special Schedule, see Section 4.C.
- (c) Minor time adjustments in the definition of the Regular Work Week will be permitted to accommodate different departments in different Areas, as long as this does not result in an artificial demand for extra staffing, there is patient demand for services at the scheduled time, and the schedule is approved by the Area Medical Director and the Executive Medical Director.
  - (d) Where the "Pattern of Practice" equivalent to W-10 plus Extra Duty obligations occurs on a regular basis at times other than the Regular Work Week as defined in Section 4.A.1 (above), it also may be considered as an equivalent full time work week. A Chief of Service who denies a physician request for a pattern of practice which varies from the department's usual schedule will provide the physician and the Area Medical Director with a written report indicating the reasons for the denial, what type of varied work schedule would be appropriate for the department, and when such a schedule might become available.

## 2. Flexible Scheduling Principles of Accountability

- (a) Flexibility in scheduling is a privilege and not a right. Flexible schedules require commitment and good intent on the part of the physician desiring a flexible schedule and the administrative Physician Leader overseeing this flexible arrangement.
- (b) Accountabilities for quality of care, service, patient satisfaction, access, and affordability must be maintained. Flexible schedules are to be approved by the appropriate physician operational leader such as Physician in Charge (if any), Chief of Service, Service Line Leader (if any), and Area Medical Director. It is intended that these schedules should meet the needs of patients, physicians, staff, administrators, and physician administrators. Monitoring adherence to these tenets is the responsibility of the Physician in Charge (if any), Chief of Service, Service Line Leader (if any), and Area Medical Director.
- (c) Flexible schedules are to be discussed and renewed (or not) annually by the involved physician and administrative leaders. A flexible schedule agreement, which is implemented without a specific duration, will be effective for no more than a year. What is learned from implementing these arrangements will be shared with the collective Medical Directors.
- (d) The request to change from a designated flexible schedule back to a regular schedule will require a minimum of three months notice to minimize care delivery disruption and must be approved by the Physician in Charge (if any), Chief of Service, Service Line Leader (if any), and Area Medical Director. This change may be effectuated more rapidly only with the agreement of the Physician in Charge (if any), Chief of Service, Service Line Leader (if any), and Area Medical Director.



- (e) The Physician in Charge (if any), Chief of Service, Service Line Leader (if any) and Area Medical Director may terminate a flexible schedule arrangement due to mitigating factors of adverse impact on quality of care, service/access or affordability.
- (f) The Physician in Charge (if any), Chief of Service, or Service Line Leader (if any) will ascertain that a flexible arrangement is supported by the department prior to implementation. Flexible arrangements for a physician must be structured in a fashion that does not place undue burden on their colleagues and staff.
- (g) If these recommendations are accepted by the Board, these arrangements may be made with approval of the Area Medical Director. Flexible schedule proposals will be reviewed with the Executive Medical Director or designee to ensure that they align with the Rules and Regulations. Such arrangements will be shared with the collective Medical Directors as points of information, but will not require collective Medical Directors' approval to implement.
- (h) Each Medical Center and department has unique differences. Thus the creation of a particular flexible arrangement in any one Area or specialty does not guarantee that the same arrangement will be available to physicians in another Area or specialty as the factors of location, affordability, space constraints, patient satisfaction, colleague support, etc. may vary from Area to Area.
- (i) A document describing an agreed upon flexible arrangement will be signed by the involved physician(s), Physician in Charge (if any), Chief of Service, Service Line Leader (if any), and Area Medical Director ensuring understanding of the above principles of accountability. This signed document will describe the mutual accountabilities of the arrangement.

### 3. Flexible Scheduling Within the Regular Work Week

Recurring bookable in-office patient time that is pre-booked and pre-approved may be booked and exchanged in one-quarter W (1-hr.) increments. "Exchanged" means that a one-quarter W (or more) may be moved from one part of a physician's to another part of the physician's schedule, subject to the conditions below. Bookable in-office patient time is defined by each department's specific booking guidelines (e.g. patient appointments every 15 minutes, every 20 minutes, etc.). There is no restriction as to start and stop times as long as quality of care, affordability, access, and service needs are met. It is recommended that appropriate break time be scheduled anytime a physician works more than four consecutive bookable hours. The total number of W's worked must still add up in a pay period to that physician's defined work schedule (e.g. 9/10 or 10/10) and additionally must provide for the department's After-Hours and Extra Duty coverage.

Office hours may begin as early as 7:00 a.m. and may end as late as 8:00 p.m. Based on patient demand and department need, a physician, with the approval of the physician's Chief of Service and Area Medical Director, may request his or her W's be scheduled any time between 7:00 a.m. and 8:00 p.m.



(a) Physician Eligibility:

The responsibility to determine physician eligibility and to maintain coverage for the schedules lies with the Physician in Charge, Chiefs of Service, and Area Medical Director. The qualifications listed below are recommendations which can be taken into consideration and should be viewed as guidelines:

- ◆ The prior year's Regional Access Goals for the physician's department
- ◆ Regional and Local guidelines for chart closure and In Basket management
- ◆ Willingly contributes to the needs of the department
- ◆ Communicates well with patients, staff, and colleagues
- ◆ No performance counseling in the past 12 months
- ◆ Completes administrative tasks in a timely manner (i.e. self-assessment, compliance training, etc.)
- ◆ Attains MAPPS and Clinical Strategic Goals (CSG) targets

When on Compensatory Time, physician is willing to be available by phone or pager when not in the office (this does not apply to vacation time) to address non-urgent patient concerns or staff questions.

(b) Department Considerations:

The responsibility to maintain coverage for the schedules lies with the Physician in Charge, Chief of Service and Area Medical Director. The qualifications listed below are recommendations which can be taken into consideration and should be viewed as guidelines:

- ◆ Flexible schedule must meet access demands in the department In the event that one member of a physician pair (dyad) or a replacement is unable, or no longer willing, to perform his or her duties the remaining Partner may be required to resume a full schedule.
- ◆ Dyads with complimentary schedules cover effectively for each other.
- ◆ The physician's Chief of Service will arrange with the Physician in Charge and Department Administrator, whenever practical and at no significant expense, for appropriate staffing to support flexibility. This may mean the same staff may not be with the same physician throughout the course of the day or week.
- ◆ Schedules will be subject to review.

(c) Medical Offices:

In order for a physician to be eligible for a flexible schedule that extends medical office hours, there must be enough patient demand and enough physicians willing to work the extended hours to justify any additional expense.

Flexible schedules must be approved by the scheduled physician, appropriate operational Physician Leader such as the Physician in Charge (if any), Chief of Service, Service Line Leader (if any), and Area Medical Director. Note: All such arrangements must adhere to the Flexible Scheduling Principles of Accountability, outlined in Section 4.A.2 (a-i), above. Examples of some possible flexible schedules can be found on the physician portal.

4. Job Sharing

Job sharing is a kind of flexible schedule and subject to Flexible Scheduling Principles of Accountability [see Section 4.B.2 (a-i), above]. The SCPMG definition of job sharing is a situation where two physicians whose total work commitment equals 8/10 or more and who function as if they were one physician. Two job sharing physicians agree to cover all the responsibilities of coverage, Extra Duty, Holidays, weekends, night duties, etc. as if they were one physician. They agree to be scheduled in the office at different times, thereby maximizing their availability to their patients. They agree to cover all patient related information for their job share partner including messages, lab review, etc. They will share one panel. They are also to communicate to their patients that they have a primary practice partner. They will share one office and one computer. Their pay and benefits will be prorated to their work schedule as currently provided for in the SCPMG Rules and Regulations. In particular these physicians will not receive the Education Half Day as is currently described in the Rules and Regulations. An arrangement that would regularly trigger Leave of Absence will not be accepted. If the arrangement is deemed not viable by either involved job share partner or the Physician Leader, it may be terminated with sufficient notice to ensure continuity and quality of patient care, access, and affordability. A physician who job shares may be required to work full time if the physician's job share partner is no longer available to job share and a replacement is not available.

5. Education Half Day

The Education Half Day (also known as Education Time or ET) each week is a vital and important part of our practice.

(a) Partners

- (1) When a Partner regularly works an 8/10 to 10/10 work schedule, a half day may be scheduled each week for educational purposes. The time devoted to this activity and the educational program must be approved by the Chief of Service.

- (2) Any Partner physician working less than an 8/10 schedule will not be scheduled for a weekly Education Half Day.
- (3) The Education Half Day is a paid work session. There cannot be double remuneration for a physician who substitutes regular medical office duties or hospital duties in lieu of the Education Half Day. The Chief of Service may require this substitution (without additional compensation) of physicians in the department because of patient care needs. The substitution of more than five half days in a given calendar year may not be required for any physician for the purpose of improving access, without approval by the Board of Directors. The Education Half Day is not cumulative. If it coincides with a physician's Sick Leave, holiday or any other Leave, there will be no additional compensation.
- (4) The physician should follow a regular pattern of planned educational programs (exception: ET Bank [see description in Section 4.B.5(a)(13) below]). If patient care responsibilities of the department interfere on a regular or frequent basis with the regularly scheduled educational programs, the physician may be allowed to substitute another program. These changes must be requested of, and approved by, the Chief of Service with sufficient advance notice to avoid cancellation of appointments.
- (5) Regular departmental meetings take precedence over other educational activities in determining the utilization of the weekly Education Half Day. It is the responsibility of the Chief of Service and the Area Medical Director to assure that the educational program is worthwhile. All outside educational programs must meet the approval of the Chief of Service.

Guidelines for approved programs should be developed in each specialty and all should be at least two hours duration.

- (6) Assessment of the utilization of the Education Half Day with respect to quality and quantity should be an ongoing departmental and group activity. This is desirable for Medical Group as well as being a requirement of accreditation agencies and commissions.

The following method of documentation and reporting is to be used:

- ◆ a semiannual physician report to the Chief of Service, and a semiannual Chief of Service report to the Area Medical Director; and
  - ◆ an annual Area report to the Executive Medical Director.
- (7) It is recognized by the Board of Directors that university teaching appointments and medical research may require additional time commitments by a physician. The first half day of university teaching or medical research in a week must count as the regularly scheduled weekly Education Half Day. If a second half day in a week is required, this may be taken as Educational Leave, Vacation

Leave or Non-Scheduled. If additional time is required to maintain a teaching appointment or do medical research, additional half days of indirect work up to a maximum of twelve half days per year may be approved. Approval for additional half days for university teaching or medical research which has been approved under Rules and Regulation Section 10.G require approval by the Chief of Service and the Area Medical Director. The Chief of Service and Area Medical Director should deny the request if necessary to maintain or improve patient access. Absences from the office in any one week will not exceed three half days.

Half days of indirect work approved to maintain a teaching appointment or to do medical research will be reported to the Board of Directors at the end of each calendar year by each Area Medical Director.

- (8) Medical Group supports regular, ongoing departmental medical education programs by providing a weekly Education Half Day for eligible physicians.

If neither a departmental nor acceptable community program is available, a physician may request approval from his or her Chief of Service, Area Medical Director, and the Executive Medical Director to substitute the weekly Education Half Day during a full Anniversary Year for an additional two weeks of Educational Leave. The request must be in advance and in writing. If granted, the additional two weeks must be taken during the approved or subsequent Anniversary Year or it will be forfeited. Once granted, this substitution will continue from Anniversary Year to Anniversary Year unless the physician requests in writing the reinstatement of his or her Education Half Day. Once requested, reinstatement of the Education Half Day will commence on the physician's next Anniversary Date.

- (9) All departments must have meetings to fulfill their hospital and Medical Group obligations. If the department does not have its own educational program, these obligations must be fulfilled during non-work hours.
- (10) A physician attending his or her own departmental symposium will use the Education Half Day that week and may use the Education Half Day from the other week in the same pay period. Any time needed beyond that will be personal time. A Partner may distribute or combine half days within the same pay period for an educational activity other than the physician's departmental symposia only if the rescheduled Education Half Day is pre-approved by the physician's Chief of Service and Area Medical Director in advance of the pay period. The Education Half Day may not be moved within the pay period from a week that contains any scheduled leave. The Board will receive an annual report and annual review of this proposal and its impact on access, its administrative effect, as well as the financial impact upon SCPMG.

- (11) Ordinarily, departments should schedule the Education Half Day during the Regular Work Week. When Department scheduling and efficient use of resources require, the Area Medical Director and Chief of Service may approve regularly scheduled Education Half Days outside of the Regular Work Week. In order for a physician to be compensated for an Education Half Day outside the Regular Work Week, the Education Half Day must be regularly scheduled, be in-house and at least 3 hours in duration, and the physician must sign-in and sign-out. If a physician takes any Leave (except Holiday Leave) on the day of his or her department's evening Education Half Day and does not attend the department's evening educational meeting, the evening session will be counted as the same Leave. If the evening Education Half Day would normally immediately follow Holiday Leave, the Education Half Day will not be scheduled that week and the department will schedule an additional work session during the same week. Nothing in this section should be construed to alter Section 4.F.
- (12) With approval of the Chief of Service and the Area Medical Director, the Education Half Day may be utilized for medically-oriented uncompensated community service projects and programs. No more than one half day per week, or twelve half days per calendar year, may be used for medically-oriented uncompensated community service projects and programs.
- (13) Educational Half Day (EHD) may be used to retrain physicians when they are asked to return to overnight in-hospital duty. The exact training need and eligibility will be determined by the Chief of Service and the Area Medical Director.

EHD may be combined with Education Leave and Indirect work time (IW) to accomplish required retraining that will enable the physician to return to overnight in-hospital duty. The total time allowed will not exceed 30 days per year.

Half days of indirect work approved to accomplish required retraining will be reported to the Board of Directors at the end of each calendar year by each Area Medical Director.

The exact training need and eligibility must be concordant with the current departmentally required credentials and privileges. The total time allowed will not exceed 30 days, and requires the approval of a majority of the Medical Directors.

- (14) Patient Care Education Half Day (PET)/Banked Education Half Day (BET) Program: When a department is out of access in any quarter, the Area Medical Director will notify the respective Chief of Service that the department may work their Education Half Day for patient care purposes (PET). After working five (5) PET's, a physician may begin to bank subsequently worked ET's for

future educational use. There will be no more than five (5) ET's banked (BET's) for use in any one calendar year. (Note: banked time could result in more than one ET being taken in a given week if approved by the Chief of Service).

Physician preference as well as acute and chronic access needs and budgetary considerations will be used to guide decisions on the utilization of the BET's.

BET's can only be used/accrued after five (5) ET's for access annually have been worked, as defined in the Rules and Regulations 4.B.5(a)(3).

The PET/BET Program requires an annual review and report to the Board of Directors regarding the program's status.

(b) Employee Physicians

Employee Physicians will receive the same Education Half Day benefit as partners with the following exceptions:

- (1) Only Employee Physicians working a 10/10 schedule may be considered for one Education Half Day per week. Granting the Education Half Day per week is at the discretion of the Chief of Service and the Area Medical Director.

Physicians regularly working 8/10 or 9/10 per week may be considered for no more than one Education Half Day in each calendar month.

- (2) Part Time and Per Diem physicians are not entitled to an Education Half Day.

6. Non-Scheduled Half Day

Within a five and one half day week [see Section 4.B.1], each 10/10 physician will be given a half day off (Non-Scheduled Half Day or N.S.). This will be scheduled with the approval of the Chief of Service consistent with the requirements of the department. Any time taken off voluntarily during the week (which excludes Sick Leave, Educational Leave or Vacation, but would include religious days or holidays during which the medical offices are open) would count as this Non-Scheduled Half Day. If the physician works this 11th half day (N.S.), he or she will be compensated as defined elsewhere in the Rules and Regulations. In order for a physician to work this half day, except in emergency situations, approval must be received from the Chief of Service.

**C. Special Schedule**

A physician who works an equivalent permanent Special Schedule (e.g. Emergency Medicine) may be considered full time and be eligible for Partnership.



An average of half of the hours worked must be worked outside of the Regular Work Week [see Section 4.B.1]. Each qualified applicant must be approved by the Chief of Service, Area Medical Director and the Executive Medical Director.

The physician must consider the Special Schedule and location of a practice as a permanent commitment before and after Partnership. The Special Schedule is subject to future modifications and/or elimination. The physician will continue in the Special Schedule as originally designated or as modified for as long as called upon to do so. The physician may also be assigned to other work responsibilities.

1. For payroll purposes, the work week starts at approximately 11:00 p.m. on Sunday night and ends at 11:00 p.m. the following Sunday night.
2. Special Schedule physicians will be paid according to the hours worked in increments of W-1/2 for completing each full two hours worked.
3. All W's in excess of W-20 in a pay period will be paid at 120% of the Special Schedule physician's Base Compensation. All W's during the overnight period will be compensated at 120% of the Special Schedule physician's Base Compensation [Exception: See Holidays, Section 6.C].
4. Special Schedule physicians and physicians in a job category that routinely requires after hours coverage as part of their regularly scheduled work duties (e.g. Hospitalists and Emergency Medicine), will continue to provide overnight in-hospital duty regardless of age (see Section 4.F.3.(b)).

#### **D. Month**

A Month, as used to define the extent and limitations of certain benefits, means the equivalent of 22 working days for a physician on a full (10/10) work week schedule, (e.g. one month Sick Leave equals 22 working days).

#### **E. Anniversary Date and Anniversary Year**

A physician's Anniversary Date is usually identified as the date the physician started working for Medical Group. For each full time physician, appropriate longevity benefits will accrue on that date in each subsequent year. The year between Anniversary Dates constitutes an Anniversary Year. The Anniversary Date will be adjusted as provided elsewhere in the Rules and Regulations.

#### **F. Extra Duty, After Hours Duty (including Night Clinic Time) and Call Backs**

##### **1. Physician Obligation**

Every department has an obligation to provide staffing for inpatient and outpatient care after the usual medical office hours defined in Section 4.A.1. Each department member who works 8/10 or more must fulfill a full share of all department responsibilities. Any



physician working less than 8/10 must work at least the proportionate share of duties, unless in a physician category not requiring Extra Duty obligations. The type of obligation may vary from duties in the medical center to being on call at home. No benefits except increased income will accrue for Extra Duty, After Hours Duty, or Call Backs.

2. Extra Duty Pay

For those obligations requiring the presence of the physician in the medical center, the equivalent pay is as follows:

W-1 = 1 unit (half day)

Each day is divided into 5 “W” units for pay purposes:

Morning — 8:00 a.m. - 9:00 a.m. to 12:00 noon - 1:00 p.m. = W-1

Afternoon — 12:00 noon - 1:00 p.m. to 5:00 p.m. - 6:00 p.m. = W-1

Evening — 5:00 p.m. - 6:00 p.m. to 10:00 p.m. - 11:00 p.m. = W-1

Overnight — 10:00 p.m. - 11:00 p.m. to 8:00 a.m. - 9:00 a.m. = W-2

3. Exceptions to Extra Duty Requirements

(a) If, for medical reasons, a physician recuperating from a serious illness or injury should not take Extra Duty, that physician, upon the recommendation of the Chief of Service and the approval of the Area Medical Director, will be excused from the responsibility for Extra Duty for a period of up to six months. If, after a period of six months, medical reasons continue which warrant the excuse from Extra Duty, the physician’s compensation will be reduced [see Section 5.D.2(a)].

(b) A physician in an Area that requires routine overnight in-hospital duty, who attains the age of 55 and who has worked full time with Medical Group a minimum of 15 years, may request to be approved to go off overnight in-hospital duty requirements (10:00 p.m. - 11:00 p.m. to 8:00 a.m. - 9:00 a.m.). This includes Physicians whose regular schedule is during the standard work week and have extra duties that might include overnight in-house hospital duty. If a physician is approved to go off overnight call, the physician will not thereby incur a reduction in Base Compensation.

This provision does not alter the requirement to fulfill a share of other Extra Duty responsibilities. In exceptional circumstances, if there are not adequate numbers of physicians to cover the overnight in-hospital duties without undue burden on the remaining members in that specialty, the Chief of Service and Area Medical Director may require a physician to perform such duties. The Chief of Service and Area Medical Director may also require any physician who is capable of providing the necessary services overnight to perform such duties if, under unusual circumstances,



patient care would otherwise be adversely impacted. If a physician requests to go off the overnight call schedule and the Chief of Service and Area Medical Director wish to deny the request, the denial may not occur without the approval of the collective Medical Directors. A physician has a right to appeal denial of a request through the Dispute Resolution Procedure (see Section 1.I).

Any request to extend the provision to resume overnight call will be subject to review every six months and require approval by the majority of the collective Medical Directors.

- (c) A physician who attains the age of 55 who has worked full time with Medical Group less than 15 years may go off overnight in-hospital duty but this will mean an automatic non-disciplinary reduction in Base Compensation of 10%. In exceptional circumstances, if there are not adequate numbers of physicians to cover the overnight in-hospital duties without undue burden on the remaining members in that specialty, the Chief of Service and Area Medical Director may require a physician to perform such duties. The Chief of Service and Area Medical Director may also require any physician who is capable of providing the necessary services overnight to perform such duties if, under unusual circumstances, patient care would otherwise be adversely impacted. A physician has a right to appeal denial of a request through the Dispute Resolution Procedure (see Section 1.I).

Any request to extend the provision to resume overnight call will be subject to review every six months and require approval by the majority of the collective Medical Directors.

This provision does not alter the requirement to fulfill a share of other Extra Duty responsibilities.

- (d) A general surgeon who works in the hospital until 10:00 p.m. and takes an overnight call from home, and who reaches the age of 55 and has been with Medical Group for 15 years, will receive a W-1 for taking overnight call and is permitted to have the afternoon (1:00 p.m. - 1:30 p.m. to 5:00 p.m.) off without pay on the day following the overnight on call duty (Sunday through Thursday) at no reduction in Base Compensation. In the above circumstance, Call Backs may be earned during an overnight call [see Section 4.F.5]. Work for the afternoon after an overnight call (always with approval of the Chief of Service and the Area Medical Director) will be credited as W-1. This option is not transferable to any time other than the afternoon immediately following the overnight call.

A general surgeon who is 55 but has been with Medical Group less than 15 years may receive the above benefits, but this will mean an automatic 10% reduction in Base Compensation.

- (e) Routine overnight in-hospital duty is defined as the regular scheduled and printed overnight hospital coverage. It does not include Backup, Standby, Call Back, or any

other name used by a department to handle the inability of the scheduled person to render services, nor does it include standby duty necessitated by increased volumes. It does not include medical office time and it has no arbitrary cut-off time. In-hospital is defined as covering in-hospital patients and/or being required to stay in the hospital physically all night.

4. Work Pattern by Departments

- (a) Internal Medicine, Family Medicine, OB/Gyn, Pediatrics: For physicians in these departments or others required to be in the Medical Center, compensation will be based on the “W” system as previously outlined. The overnight call (W-2) is compensated by a day off within the same pay period, pay, or a combination of pay and time off [see Section 6.F].
- (b) Surgery: The surgeon is required to be in the hospital until 10:00 p.m. - 11:00 p.m. and will be compensated accordingly. After 10:00 p.m. - 11:00 p.m. the surgeon is on call from home.

5. Call Backs

- (a) A physician who is called back to the physician’s Medical Center by another physician or nurse, and who works between 7:00 p.m. and 6:00 a.m. Monday through Friday, will be paid a Call Back. A physician will earn a Call Back two hours before or after regularly scheduled work only if at least one of the following occur:
  - ◆ the physician has a Non-scheduled half day immediately prior to the Call Back;
  - ◆ the physician is called back on a Saturday, Sunday or Holiday;
  - ◆ the physician is called back to a Medical Center other than the physician’s Medical Center;
  - ◆ the time worked is at least 2 hours.

A physician will earn a Call Back between 6:00 a.m. and 7:00 a.m. only if at least one of the following occur:

- ◆ called back on a Sunday or Holiday;
- ◆ called back prior to a Non-Scheduled Half Day;
- ◆ called back to a Medical Center other than where the physician is scheduled to work that morning; or,
- ◆ the time worked is at least two hours.

If at least one of the following occur, a physician will earn a Call Back if called back:

- ◆ between 1:00 p.m. Saturday and 6:00 a.m. Monday;
- ◆ on a Holiday; or,
- ◆ on a Non-Scheduled Half Day.

Call Back time begins as of the time a physician arrives at the Medical Center. All Call Backs will be documented on the Call Back Request (i.e. the appropriate information and reasons for the call so the Chief of Service, Assistant Area Medical Director, and Area Medical Director can properly review for approval for payroll purposes, if appropriate). The manner of compensation for a Call Back is based on when each W-1/2 of the Call Back begins. It is the physician's responsibility to complete the Call Back reporting within 48 hours of the work reported.

- (1) Except as noted above, Call Backs will be paid at the rate of W-1/2 if two hours or less are worked. The physician will earn an additional W-1/2 if he or she works one hour beyond any completed two hour increment (within the limits noted in Section 4.F.5(a)(2) below). No more than one Call Back (W-1/2) will be earned in any two hour period.
  - (2) Maximum Call Back compensation may not exceed that permitted by Sections 4.A.1(b) and 4.E.2.
  - (3) All Call Back W's will be compensated at a physician's Base Compensation rate when the aggregate W count in a pay period is 20 or less. Call Back W's may be used to reach the basic work schedule W-20 count for purposes of premium calculations only. Call Backs may not be used to meet work schedule requirements.
- (b) Physicians will not be paid extra for making rounds regardless of when or how frequently they make them.
- (c) There is no extra compensation for being on call except as noted in Section 4.E.3(d).

#### 6. Night Clinic Extra Duty

No benefit except increased income will accrue for Night Clinic extra duty. Night Clinics (pre-approved and pre-scheduled W consisting of a minimum of 210 bookable in-office patient time (defined by each department's specific booking guidelines)) may be initiated by a Chief of Service subject to approval by the Area Medical Director. Physicians providing On Call services who work Night Clinics are expected to see urgent patient referrals from the Emergency Room during the scheduled hours of the Night Clinics (similar to departmental practice during the Regular Work Week). A Night Clinic is duty in addition to regularly scheduled work time; it is not a substitute for a regularly scheduled work session. Each department member who works 8/10 or more must fulfill a full share of all department responsibilities. Any physician working less than 8/10 must work at least the proportionate share of duties.

7. Permanente Extra Duty Rate

Compensation for primary discipline After Hours or Extra Duty work that is not a part of a subspecialty physician's core work responsibilities will be in the form of Permanente Extra Duty Rate (PED). This work may occur anywhere in the region. Physicians must be approved to participate in PED work by their Chief of Service and Area Medical Director.

The PED Compensation rate is the approved rate for the primary discipline (e.g. Family Medicine, General Internal Medicine, General Pediatrics, General Surgery, etc.). The PED rate is calculated based on the participating physician's years of service to include the primary discipline's Starting Base Compensation, Specialty Longevity, Standard Longevity, Merit Longevity, Specialty Merit Longevity, Access, Value of Partnership MAPPs and board certification equivalent to the physician's category (Partner/Employee Physician) and years of service. A physician who receives advance longevities upon hire will receive a PED rate that similarly advances longevities in specialty/subspecialty worked, as determined by the Area Medical Director. A physician's PED rate will increase with the physician's longevity in the Group. PED does not include any Merit Increase, Administrative Stipend Increase, Partnership Equity Longevity Merit or other individual physician specific base rate increase. The PED will be paid in hourly increments or .25 sessions. The PED will count toward the regular W count and will promote to premium pay (120% if more than 20Ws in the pay period). Any PED work performed in the overnight, as defined in Section 4.E.2, that occurs between midnight and 6:00 a.m. (Partial Overnight) will be paid at 150%.

8. Miscellaneous Rules

- (a) With the premise that every department is responsible for covering its hospital and emergency room services as defined above, any substitution on the Extra Duty roster or any non-Medical Group physician hired to provide coverage must be approved by the Chief of Service. There will be no additional compensation to the replaced physician for being called back during this shift, nor any compensation to the replaced physician for being on call.
- (b) If one of our staff is substituting on the general surgeon's Extra Duty roster, a general surgeon called in by the substitute will receive Call Back pay.
- (c) Minor time adjustments of the Extra Duty shifts will be permitted to accommodate different departments in different Areas, as long as this does not result in an artificial demand for extra staffing.
- (d) Any scheduling of a physician beyond the morning after a regularly scheduled overnight call in the hospital should be on an exception basis at the request of the Chief of Service and with the approval of the Area Medical Director. The exception should clearly be based on a specific staffing need and handled as an exception and should rarely, if ever, include the entire day (afternoon as well as morning). Under no

circumstances should a physician working the day after an overnight be permitted to also work the successive evening or overnight. If an in-house regularly scheduled educational program approved by the physician's Chief of Service is available on the morning or afternoon following a scheduled overnight call, a physician may use the Education Half Day to attend such a program.

- (e) The Executive Medical Director or Medical Director who performs in a clinical role after hours will be compensated as any other physician in the physician's clinical specialty with the same longevity in Medical Group.
- (f) A physician who is required to render direct patient care at least 2 hours beyond the close of a scheduled work session is eligible for compensation. The physician will earn a W-1/2 for each completed 2 hours of work beyond the close of a scheduled work session. Any such W 1/2s will be compensated at 150% of the physician's Base Compensation if it occurs between midnight and 6:00 a.m. (Partial Overnight). Maximum compensation for work beyond a scheduled work session may not exceed that permitted by Sections 4.A.1(b) and 4.E.2.

#### 9. Use of Per Diem Physicians

Per Diem physicians will not be employed for After Hours Duty until each staff member of that department has fulfilled an average of one Extra Duty per week. This will include a minimum of one overnight or weekend shift per month. This requirement of one Extra Duty per week applies to all staff members who are on an 8/10 or more schedule.

### **G. Additional Clinic Time**

No benefit except increased income will accrue for Additional Clinic Time. When requested by the Chief of Service, the individual physician has the option to work or decline to work the Non-Scheduled Half Day. Similarly, the Chief of Service has the option of starting or stopping this Additional Clinic Time scheduling to fit conditions and needs at any particular time. Only Partners and Employee Physicians are eligible for Additional Clinic Time.

#### 1. Departmental

The Chief of Service may request Additional Clinic Time scheduling when the situation warrants such action. This Additional Clinic Time scheduling must have the approval of the Area Medical Director. It will be the responsibility of the Chief of Service to recommend discontinuance of Additional Clinic Time scheduling as soon as the departmental situation changes.

#### 2. Individual

The individual physician in a department may elect to work or not to work this Additional Clinic Time when the department has approval for such scheduling. Any physician choosing to work should not discontinue the Additional Clinic Time as long as

the need exists without providing sufficient notice satisfactory to the Chief of Service in order to permit the orderly readjustment of schedules.

**3. Limited Need**

If a department's need for Additional Clinic Time is limited, the Chief of Service will make the selection from those desiring extra work.

**4. Leaves of Absence and Other Absences**

Individuals on the Additional Clinic Time schedule who are absent for part of any week due to Vacation, Sick Leave, or Educational Leave will have the period of absence charged to the appropriate category, and will be paid for working the Additional Clinic Time during this week.

**H. Reduced Work Schedule**

If a physician works a Reduced Work Schedule with the approval of the Chief of Service and the Area Medical Director, the Base Compensation will be reduced proportionately. A Partner working a Reduced Work Schedule will have Year-End Performance Draw reduced proportionately. In addition, the number of days earned for Vacation, Sick Leave, and Educational Leave will be proportionate to the physician's work schedule. Physicians working a reduced schedule must have their Chief of Service approve an increase in the work schedule. A Chief of Service who grants a physician's request for a Reduced Work Schedule will provide the physician and the Area Medical Director with a written statement of the projected time limitations, if any, of the Reduced Work Schedule. A Chief of Service who denies a physician's request for a Reduced Work Schedule will provide the physician and the Area Medical Director with a written report indicating the reasons for the denial, steps to be taken to allow the request to be honored, and a time when the Chief of Service expects to be able to honor the request.

**I. Regional Meetings**

Requests for Regional Meetings or administrative-educational conferences require the approval of the Executive Medical Director, who will determine the frequency, the attendees, and the time and duration of these meetings.

**J. Administrative Work**

Administrative Work is time within the Regular Work Week during which a physician, with the approval of the Executive Medical Director, a Medical Director, or one of their designees, undertakes activities to conduct the business of the Medical Group which are other than specialty/subspecialty based duties. Compensation for Administrative Work is at the physician's current rate of compensation as determined according to the Partnership Agreement and these Rules and Regulations.

## **5 PHYSICIANS' COMPENSATION**

For compensation purposes, Southern California Permanente Medical Group has two physician categories: Partners and Employee Physicians.

### **A. Partners**

A Partner's Total Annual Compensation is composed of several components that are defined in this section. All of a Partner's compensation is dependent upon the overall financial performance of Southern California Permanente Medical Group. Every other week, each Partner receives a check. This check represents an advance against the anticipated earnings of Medical Group. Except as otherwise provided in Section 9 of the Rules and Regulations, at the end of each year, the net earnings of Medical Group and the total of the year's advance checks to all Partners are reconciled and any surplus (or deficit) net earnings are divided among the Partners. Each Partner is a part owner of Southern California Permanente Medical Group and shares in its financial performance.

#### **Compensation Overview**

Annual Base Compensation for Partners is defined as the sum of the annual Starting Base Salary paid to Employee Physicians that is established by the Board of Directors for the physician's specialty, plus increases granted for longevity, merit, administrative duties, board certification, the attainment of Partnership status, any starting Base Salary Compensation Adjustment paid to Employee Physicians in the physician specialty, and General Compensation Adjustments. The term longevity includes Standard Longevity, Merit Longevity, Specialty Merit Longevity, and Subspecialty Merit Longevity. Base Compensation is prorated to the physician's work schedule.

Only Base Compensation is used to determine the amount of group life insurance, travel accident insurance, Sick Leave, disability benefits, and "Common Plan" retirement benefits.

Each year the Board of Directors reviews the compensation program to be sure it meets current competitive and economic factors; included in this review are all facets of Total Annual Compensation.

Supplementary Compensation is earned for clinical service performed that exceeds the regularly scheduled 20 half days during a two week pay period; it is not a part of Base Compensation.

Based on a 10/10 schedule, the amount received in a Partner's biweekly check is the sum of his or her Annual Base Compensation divided by 26 plus any Supplementary Compensation earned during the two week pay period minus any authorized deductions.

A Partner's Total Annual Compensation also includes the Partner's share of Medical Group's Year-End Performance Draw plus the value of group benefits (insurance, Sick Leave, etc.) in

the form of Imputed Income. In the case of certain Partners, it may also include a bonus paid for that year's performance and/or the previous year's performance.

The compensation components are explained in the following section.

### **Compensation Details**

#### **1. Base Compensation**

Base Compensation includes the items explained in the following section.

##### **(a) Starting Base Salary**

The Starting Base Salary paid to Employee Physicians is the amount of money established by the Board of Directors as the starting pay for the physician's specialty. For Partners, an amount equal to Starting Base Salary paid to Employee Physicians is one of the defined components that make up the advance check paid every other week against anticipated Medical Group net earnings. Since these amounts are the same, the term Starting Base Salary may be applied both to the Starting Base Salary paid to Employee Physicians and the defined component that makes up part of the advance check against anticipated Medical Group net earnings.

##### **(b) Starting Base Salary Compensation Adjustment**

An amount determined by the Board of Directors which represents the equivalent of an adjustment to the Starting Base Salary paid to Employee Physicians. All physicians who are on paid or unpaid Chronic Sick Leave will receive said adjustment. This will not include any monies designated as Specialty Merit Longevity in the first year.

##### **(c) Standard Longevity Increases**

Standard Longevity Increases are automatically given to all Partners, Special Category and Full Time Regular physicians on certain Anniversary Dates (or Adjusted Anniversary Dates).

##### **(d) Merit Longevity and Specialty/Subspecialty Merit Longevity Increases**

Merit Longevity and Specialty/Subspecialty Merit Longevity Increases are added to a physician's Base Compensation at periodic longevity intervals for meritorious Medical Group practice.

Merit Longevity or Specialty/Subspecialty Merit Longevity Increases require approval by the Board of Directors upon the recommendation of the Chief of Service and the Area Medical Director.



The Board of Directors has delegated discretionary authority to the Executive Medical Director to advance any or all of the Standard Longevity, Merit Longevity, and Specialty/Subspecialty Merit Longevity compensation steps to a physician's compensation as circumstances and special needs of Medical Group require.

A Merit Longevity or a Specialty/Subspecialty Merit Longevity Increase may be withheld or partially awarded. An Increase that is withheld or partially awarded on a physician's Anniversary Date is reviewed no later than one year following that action. A physician who wishes to dispute the decision to withhold a Merit Longevity or Specialty/Subspecialty Merit Longevity Increase may do so [see Sections 1.I and 1.J].

(1) Merit Longevity Increases

A Merit Longevity schedule has been established so a physician's Base Compensation may be increased at scheduled intervals based on meritorious performance. The Merit Longevity schedule and the amount of each Increase are subject to adjustment periodically by the Board of Directors.

Prior to a physician's eligibility for a Merit Longevity Increase, the Chief of Service and Area Medical Director will obtain input from departmental and other Area physicians as well as Area Chiefs of Service. The general criteria for the evaluation review will include:

- ◆ quality of work and competence;
- ◆ relationship with patients;
- ◆ relationship with colleagues;
- ◆ relationship with non-physician personnel; and
- ◆ group identification and attitudes.

The increases approved by the Board of Directors will be considered ongoing; however, the Board of Directors has the authority to revise the compensation of any physician, inclusive of these Merit Longevity Increases.

(2) Specialty/Subspecialty Merit Longevity Increases

Physicians in selected specialties and subspecialties meeting defined criteria and practice requirements are eligible to be considered for Specialty/Subspecialty Merit Longevity Increases. The Specialty/ Subspecialty Merit Longevity Increase schedule, the amount of the increase, and the eligibility criteria are defined for each specialty and subspecialty and are subject to adjustment by the Board of Directors to meet the needs of the Partnership. The amount and timing of the increases varies by specialty.

Each specialist/subspecialist will be evaluated according to the following criteria to determine eligibility and level of participation:

- ◆ training;
- ◆ Board eligibility (if applicable);
- ◆ conditions of hire; and
- ◆ competence recognized by the physician's Chief of Service and the physician's colleagues relating to requests for consultations, referrals, special call schedules for a subspecialty skill, and teaching responsibilities.

The maximum number of subspecialists required in an Area to provide coverage for that service will be determined by the Executive Medical Director after consultation with the Regional Chiefs of Service of that specialty and the Area Medical Directors. If the number of participating subspecialists exceeds this maximum, the increases may be divided among them.

Qualified specialists/subspecialists will also be evaluated according to the general criteria applicable to Merit Longevity Increases.

An Area Medical Director may reduce or eliminate a physician's Specialty/Subspecialty Merit Longevity Increases as the physician's practice responsibilities change or the physician no longer fulfills some or all of the qualifying criteria.

(3) Partnership Equity Longevity Merit (PELM) Increase

A Merit Longevity Increase in recognition of a Partner's years of service with the Medical Group and to show appreciation of his/her participation in working Extra Duties. In order to be eligible, a physician must meet three criteria:

- (i) Active Partner
- (ii) At least age 55
- (iii) At least 20 years Credited Service with Medical Group.

The PELM Increase is calculated by using the average percentage by which a physician's gross earnings (which includes all sessions paid and all cash awards) exceeds their 10/10 Base Compensation. This average percent is multiplied by an amount established by the Board of Directors, up to a maximum as established by the Board of Directors, to determine the monthly increase amount. The PELM is calculated one-time using the ten years preceding the first year that a physician is eligible. Once approved, the amount is added to the physician's monthly Base Compensation.

To maintain the Increase, the physician must share fully in departmental responsibilities (e.g. Extra Duties, evening, weekend, and, if required, overnight call) as well as continue to participate in the full spectrum of clinical practice. Eligibility for the PELM Increase will be reviewed annually.

(e) General Compensation Adjustments

General Compensation Adjustments, if approved by the Board of Directors, are effective for all physicians who are Partners on the date of the adjustment. The granting of this adjustment is based on an individual review of each physician's performance and the amount granted may range up to the full amount of that year's adjustment. The adjustment remains in each Partner's Base Compensation but it does not become a longevity step. Physicians who become Partners during the year will be awarded the adjustment on the date of the adjustment or on their Partnership Anniversary Date, whichever is later.

(f) Merit Increases

Merit Increases are a monthly increase in a physician's compensation which may continue from year to year. In 1996, the Board of Directors moved to a compensation strategy that no longer included Merit Increases.

(g) Board Certification Stipend(s)

A board certification stipend is awarded upon receipt by Medical Group of the official notification of board certification. This stipend is granted at the time of hire for a physician who is already board certified.

The board certification stipend(s) may only be received when the physician is board certified by a body recognized by SCPMG. No additional board certification stipend(s) are allowed for becoming recertified. The board certification stipend(s) will be rescinded when a physician allows his/her board certification to lapse. Physicians are encouraged to be Board certified in the specialty or, where applicable, subspecialty in which they practice. A Partner who wishes to be considered for employment as a clinician following retirement from the Partnership is encouraged to maintain board certification.

Only board certifications (including Certificates of Added Qualifications and Certificates of Special Qualifications) recognized by the American Board of Medical Specialties (ABMS), or authorized by the American Osteopathic Association (AOA) allow a physician to qualify for the board certification stipends. Allowing any other board certification to qualify a physician for the board certification stipends must be recommended by the physician's Chief of Service and Area Medical Director, and approved by the collective Medical Directors.

Effective January 1, 2004, any physician who has allowed his/her board certification to lapse as a result of failing to recertify where recertification is periodically required

will have up to two (2) years to become board certified. During 2004 and 2005, the physician will continue to receive any board certification stipend received in 2003 but will not be eligible for any other board certification stipend unless he/she becomes board certified. After 2005, if the physician has not become board certified, his/her board certification stipend will be rescinded.

(h) Partnership Status Increase

Upon attaining Partnership status, an increase is awarded.

(i) Value of Partnership (VOP) Increases

Increases are awarded in recognition of Partnership for eligible Partners as follows:

- (1) Board certification acceptable to SCPMG
- (2) Member Appraisal of Physician and Provider Services (MAPPS) dependent on attaining and maintaining acceptable MAPPS scores, as determined by the Board of Directors.

To receive a VOP Increase, a Partner is required to:

- ◆ Sign a letter acknowledging the SCPMG Partnership Principles, which is based on the Preamble to the SCPMG Partnership Rules and Regulations, if the physician has not done this previously;
- ◆ Be in good standing (no disciplinary compensation reduction) at the time of the Partnership Increase; and
- ◆ Be recommended by his/her Chief of Service and Area Medical Director and approved by the Board of Directors.

(j) Base Compensation Award Programs (Award amounts will be determined annually):

Access Performance Base Compensation Adjustment: Each year, if budgeted by the Board of Directors, physicians are eligible to receive an Access Performance Base Compensation Adjustment. To be eligible, qualifying physicians must meet established access targets approved by the Board of Directors.

(k) Pay-For-Performance Programs:

A small percentage of a physician's total compensation is attached to performance recognition compensation, and is designed to focus attention on key Medical Group business initiatives to improve patient care. These specialty-specific performance recognition programs are implemented as approved by either the Quality of Care Committee (for pilot compensation-related programs with projected costs of less than or equal to one million dollars and a duration of less than eighteen months), or the

Board of Directors. Remuneration may be in the form of bonus compensation or a Base Compensation Increase.

(1) Executive Compensation:

This section identifies the compensation for Executives, those Physician Leaders whose administrative duties are regularly 8/10<sup>th</sup> or more. The Administrative Appointment and review process is described in Article 9 of the Partnership Agreement.

(1) Executive Medical Director

The Executive Medical Director will have a Starting Base Compensation that is two and one-half times the Starting Base Salary of a board certified Internist Employee Physician.

This new Starting Base Compensation will replace the Executive Medical Director's previous Starting Base Compensation and all previously granted Merit and Administrative Increases.

To this new Starting Base Compensation will be added the Partnership Status Increase, all granted Longevity and Merit Longevity Increases, General Compensation Adjustments, and any Administrative Specialty Merit Longevity Increase (Administrative Increase) for which he or she is eligible and approved by the Board of Directors to receive.

When an Executive Medical Director completes a term of office, is fully retrained and qualified, and returns to clinical practice, the Starting Base Compensation will be that of an Employee Physician of the department to which he or she returns. The Administrative Specialty Merit Longevity Increase available to the Executive Medical Director will be removed when the individual no longer holds the position of Executive Medical Director. To this will be added:

- ◆ All Longevity, Merit Longevity Increases and General Compensation Adjustments that were granted plus any Specialty or Subspecialty Increase for which he or she is qualified upon completion of the retraining period (see below). Continued Partnership status is required to receive any Merit Longevity Increases.
- ◆ All Merit Increases and board certification stipends granted prior to becoming Executive Medical Director.

If an Executive Medical Director does not complete a full six year term of office, the Executive Medical Director will return to clinical practice with the Starting Base Compensation of an Employee Physician of the department to which he or she returns. To this will be added the applicable increases

discussed immediately above. The circumstances that resulted in not completing the term will be considered by the Board of Directors in determining how much of the Base Compensation earned by the Executive Medical Director during the last year in office is to be added to his or her new Starting Base Compensation.

The Executive Medical Director who returns to clinical practice with Medical Group is entitled to an opportunity to be retrained in his or her specialty. The time allocated for this purpose will not exceed one year and the retraining program and estimated expenses must be prospectively approved by the Chief of Service, the Area Medical Director and the Executive Medical Director Elect. Expenses incurred during the retraining period will be reimbursed and may include such items as tuition, reasonable living expenses (if required to live away from one's usual residence to obtain training), etc. The Starting Base Compensation during this period will be the Starting Base Salary of an Employee Physician in his or her current clinical specialty. The physician is not eligible for any Specialty or Subspecialty Merit Longevity Increase(s) until the retraining period is complete and he or she is again fully qualified. By accepting this period of retraining, the physician agrees to undertake a period of clinical practice equal to the length of time of the retraining. This responsibility will be excused on death, disability established to the satisfaction of the Board of Directors, or determination by the Board of Directors that the services of the physician are no longer required.

(2) Executive Medical Director Pro Tem

The Starting Base Compensation of the Executive Medical Director Pro Tem will be derived in the same way as the Starting Base Compensation of the Executive Medical Director.

(3) Executive Medical Director Elect

The Starting Base Compensation of the Executive Medical Director Elect will be derived in the same way as the Starting Base Compensation of a Medical Director as described in Section 5.A.1(I)(4) below.

Effective on the date of approval of the position, an Executive Medical Director Elect may choose to be compensated at the rate otherwise established for an Executive Medical Director Elect or at the physician's rate of compensation prior to assuming this position. An Executive Medical Director Elect is not eligible for an Administrative Specialty Merit Longevity Increase if the first alternative above is chosen. This choice must be made at the time of assuming the position.

(4) Medical Directors (Regional and Area)

A Medical Director will have a Starting Base Compensation that is two times the Starting Base Salary of a board certified Internist Employee Physician. This Starting Base Compensation will replace a Medical Director's previous Starting Base Compensation and all previously granted Merit and Administrative Increases.

To this new Starting Base Compensation will be added the Partnership Status Increase, all granted Longevity and Merit Longevity Increases, General Compensation Adjustments, and any Administrative Specialty Merit Longevity Increase (Administrative Increase) for which he or she is eligible and approved.

When a Medical Director completes a term of office, is fully retrained and qualified, and returns to clinical practice, the Starting Base Compensation will be that of an Employee Physician of the department to which he or she returns. The Administrative Specialty Merit Longevity Increase available to the Medical Directors will be removed when the physician no longer holds the position of Medical Director. To this will be added:

- ◆ All Longevity, Merit Longevity Increases, and/or General Compensation Adjustments that were granted, plus any Specialty or Subspecialty Increase for which he or she is qualified upon completion of the retraining period (see below);
- ◆ All Merit and board certification stipends previously granted prior to becoming Medical Director; and
- ◆ In addition to the above, subject to the Board of Directors approval, the Executive Medical Director may grant and add to the Medical Director's Compensation up to 10% of the Starting Base Compensation of the Medical Director at the time of completion of the Medical Director's last term of office or the Starting Base Compensation of the Medical Director as of December 31 of the last full calendar year in office. In the event the Medical Director serves more than one term, up to 20% may be granted. Past compensation history as well as performance will be taken into consideration in determining the amount granted. In no event may the total exceed the Partner's compensation ceiling limitation. Physicians whose term of office began on or after January 1, 1997 are not eligible to receive the additional 10% or 20% increase described immediately above.

A Medical Director who returns to clinical practice with Medical Group is entitled to an opportunity to be retrained in his or her specialty. The time allocated for this purpose will not exceed one year, and the retraining program and estimated expenses must be prospectively approved by the Chief of Service, the Area Medical Director and the Executive Medical Director. Expenses incurred during the retraining period will be reimbursed and may include such items as tuition, reasonable living expenses (if required to live away from one's

usual residence to obtain training), etc. The Starting Base Compensation during this period will be the Starting Base Salary of an Employee Physician in his or her current clinical specialty. The physician is not eligible for any Specialty or Subspecialty Merit Longevity Increase(s) until the retraining period is complete and he or she is again fully qualified. By accepting this period of retraining, the physician agrees to undertake a period of clinical practice equal to the length of time of retraining. This responsibility will be excused on death, disability established to the satisfaction of the Board of Directors, or determination by the Board of Directors that the services of the physician are no longer required.

(5) Acting Medical Directors

The Starting Base Compensation of an Acting Medical Director will be derived in the same way as the Starting Base Compensation for a Medical Director [see Section 5.A.1(I)(4) above/Reference Partnership Agreement Article 8)].

(6) Medical Directors Elect

A Medical Director Elect's Starting Base Compensation will be derived in the same way as a Medical Director's [see Section 5.A.1(I)(4) above] except one-and-one half times the Starting Base Salary of a board certified Internist Employee Physician will be used and the Medical Director Elect will not be eligible for any Administrative Specialty Merit Longevity Increase.

Effective the date of approval of the position, a Medical Director Elect may choose to be compensated at the rate otherwise established for a Medical Director Elect or at the physician's rate of compensation prior to assuming this position. A Medical Director Elect is not eligible for an Administrative Specialty Merit Longevity Increase if he/she chooses the first alternative above. This choice must be made at the time of assuming the position. An Interim Medical Director will have the same compensation as a Medical Director Elect.

(7) Assistant Executive Medical Directors

An Assistant Executive Medical Director at the executive level (working 8/10 or more administrative W's per week) will have a Starting Base Compensation that is one and one-half times the Starting Base Salary paid to a board certified Internist Employee Physician. This Starting Base Compensation will replace an Assistant Executive Medical Director's previous Starting Base Compensation and all previously granted Merit and Administrative Increases.

To this new Starting Base Compensation will be added the Partnership Status Increase, all granted Longevity and Merit Longevity Increases, General Compensation Adjustment, and any Administrative Specialty Merit Longevity Increase (Administrative Increase) for which he or she is eligible and approved by the Board of Directors to receive.



(8) Assistant Medical Directors

An Assistant Medical Director will have a Starting Base Compensation that is one and one-half times the Starting Base Salary of a board certified Internist Employee Physician. In addition, the Assistant Medical Director will be eligible for an Administrative Specialty Merit Longevity Increase. This Starting Base Compensation will replace an Assistant Medical Director's previous Starting Base Compensation and all previously granted Merit and Administrative Increases. To this new Starting Base Compensation will be added the Partnership Status Increase, all granted Longevity and Merit Longevity Increases, General Compensation Adjustments, and any Administrative Specialty Merit Longevity Increase (Administrative Increase) for which he or she is eligible and approved to receive. The Board of Directors must approve the appointment and Administrative Increase of each Assistant Medical Director working 8/10 or greater.

**MONTHLY ADMINISTRATIVE SPECIALTY MERIT LONGEVITY INCREASES  
 AND ADMINISTRATIVE STIPENDS FOR  
 ADMINISTRATIVE LEADERSHIP POSITIONS**

**ALL DOLLAR AMOUNTS LISTED BELOW ARE PER MONTH:**

*Executive Compensation:*

Title/Category	Start Base	Administrative Specialty Merit Longevity	Merit Bonus Derived as a Percentage of Base <sup>1</sup>
Executive Medical Director	2 ½ x BC Gen IM	\$17,000	35%
Medical Director of Business Management, Medical Director of Operations and Medical Director of Quality and Clinical Analysis	2 x BC Gen IM	\$11,500	30%
Area Medical Director	2 x BC Gen IM	\$7,000	15%
Assistant Executive Medical Director	1 ½ x BC Gen IM	\$3,500 <sup>2</sup>	10%
Assistant Area Medical Director, Assistant Medical Director of Business Management, Assistant Medical Director of Operations, Assistant Medical Director of Quality and Clinical Analysis ( $\geq 8/10$ )	1 ½ x BC Gen IM	\$3,500 <sup>2</sup>	10%

<sup>1</sup> The Merit Bonus will be derived as a percentage of Base Compensation as defined in Section 5.A.1.

<sup>2</sup> Discretion is allowed when determining appropriate administrative stipend for the Assistant Executive Medical Director, Assistant Medical Director, or the Assistant Area Medical Director positions. Physicians appointed to these roles should not experience a compensation decrease. As with all other appointments, the position and stipend must be presented to the Board of Directors for approval.



(9) Retained Administrative Stipends

At the end of the physician administrator's tenure, he or she will be eligible, upon recommendation by the Area Medical Director and approval by the Board of Directors, to retain up to 10% of his or her stipend for service of at least one term of office and up to 20% for service of two or more terms of office (rounded to the next higher \$100).

Only former physician administrators appointed on or before December 31, 1995 who are in full time clinical practice are eligible for Retained Administrative Stipends. If a physician receives an Administrative Stipend, the physician may not receive a Retained Administrative Stipend while he or she is an administrator. A physician may receive only the one highest Retained Administrative Stipend awarded. This paragraph applies to Assistant Area Medical Directors, Assistant Medical Directors, and the Secretary of the Board of Directors.

For Retained Administrative Stipends for the Medical Directors see Section 5.A.1(I)(4).

(10) Merit Increases

Merit Increases awarded during administrative tenure may be retained on return to clinical practice.

(m) Non-Executive, Physician Leader Compensation:

This section identifies the approved positions and associated Physician Leader stipends for Non-Executive Physician Leaders, those Physician Leaders whose administrative duties are regularly 7/10 or less.

Physician Leaders may be appointed provided that a) the total stipends do not exceed the Area or Region's Administrative Stipend Budget, and b) the Board of Directors approves the appointment.

Any proposed new administrative position must first be submitted to and approved by the collective Medical Directors, then approved by the Administrative Stipend Committee and finally approved by the Board of Directors.

A Medical Director should consider the following minimum criteria for any leadership position prior to submitting an appointment recommendation. The leadership position will be:

- ◆ Accountable for performance of a group of physicians, providers, and/or staff in a defined work unit; and/or

- ◆ Accountable for one or more SCPMG strategic goals, e.g. quality, service, access, finance, people, community benefit, regulatory, technology, policy, etc.; and
- ◆ Accountable for predefined performance targets or outcomes.

Physician Leaders will be eligible for the Administrative Stipend indicated on the applicable tables that follow. Criteria for stipends may include Physician Budgeted FTEs. When determining the total Physician Budgeted FTEs the following non-physician FTEs are added at a 2:1 to the number of full time budgeted physicians:

Audiologists, Certified Nurse Midwives, Certified Registered Nurse Anesthetists, Genetic Counselors, Nurse Practitioners, Occupational Therapists, Optometrists, Oral Surgeons, Physical Therapists, Physician Assistants, Podiatrists, Psychiatric Social Workers, Psychologists, Residents (not including PGY1), Speech Pathologists.

In addition, the Physician Leader will be eligible for any applicable Administrative Merit Bonus established by the Board of Directors. The actual award depends on the evaluation of the Physician Leader's performance during the previous calendar year.

Each of the following described Physician Leader positions will have a term of six years. Performance will be reviewed annually to determine Merit Bonus award and reported to the SCPMG every two years per Article 9 of the Partnership Agreement. The elected members of the Board and Area Partners should have input into the performance review process.

Physician Leaders proposed to be reappointed for a third or subsequent term will be evaluated by the Administrative Stipend Committee, which will report its approval or non-approval to the Board of Directors. If approved by the Administrative Stipend Committee, such reappointments may be approved as part of the Board's Routine Business.

Physician Leaders appointed prior to July 1, 2010 will not have their stipends reduced solely because of the restructuring of stipends effective on that date.

The following describes each Non-Executive Physician Leader position:

(1) Assistant Medical Director

This position may directly report to the Executive Medical Director, the Medical Director of Business Management, the Medical Director of Operations or the Medical Director of Quality and Clinical Analysis. The maximum stipend for an Assistant Medical Director is \$2,500 per month. The Board of Directors will approve the appointment and stipend of the Assistant Medical Director.

(2) Assistant Area Medical Director

The maximum stipend for the Assistant Area Medical Director is \$2,000 per month. The Board of Directors will approve the appointment and stipend of each Assistant Area Medical Director.

(3) Regional Chief of Service

A Regional Chief of Service may be appointed by the Executive Medical Director for any of the recognized specialties as defined in Section 5.A.1(m)(4), Chiefs of Service. The qualifications for the position of Regional Chief of Service are:

- (i) The candidate must be an active SCPMG Partner.
- (ii) The candidate must be a current Chief of Service in their Specialty or must have previously served as a Chief of Service.
- (iii) The candidate must be respected by his/her peers as a practicing physician in that specialty.

The process for appointing a Regional Chief is:

- (i) An active Chief of Service must be supported by the other active Chiefs of Service within the specialty.
- (ii) Once nominated, a past (non-active) Chief of Service candidate must obtain a simple majority vote of support from the active Chiefs of Service within the specialty, to be appointed.
- (iii) If a Regional Chief of Service's local Chief of Service term ends, then the physician may complete his/her term as Regional Chief without a vote from the active Chiefs of Service within the specialty.
- (iv) Each Regional Chief of Service term will be for six years.

A reappointment beyond a second term for Regional Chiefs of Service must be reviewed by the Administrative Stipend Committee and discussed with the Executive Medical Director prior to the appointment. This is the same vetting process as proposed for other Physician Leader appointments.

The Administrative stipend for this position will be the same as the highest amount received by an active Chief of Service in that specialty who does not receive any other stipend for other administrative work. A physician who holds more than one administrative position will receive only one Administrative Stipend. He or she will be eligible for the single largest stipend of the held positions.

The annual administrative Merit Bonus for this position is \$10,000 and may be in addition to any other administrative Merit Bonus received up to a maximum of \$20,000 per year. The Regional Chief of Service administrative Merit Bonus of \$10,000 is based equally on the five objective criteria below:

<p><b>GOALS</b></p> <p>Successful completion of goal setting by target date</p> <p>Successful completion of Quality goal*</p> <p>Successful completion of Service goal*</p> <p>Successful completion of Access goal*</p> <p>Annual Review with peer input</p>
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\* Goal will be prorated based on the number of medical centers achieving these goals. Performance-Based Compensation Program is subject to change.

(4) Chiefs of Service

A Chief of Service only may be appointed for the following recognized specialties. Any new specialty must be approved by the Board of Directors.

*Recognized Specialties for Chief of Service Positions:*

Addiction Medicine	Occupational Medicine
Allergy	Ophthalmology
Anesthesiology	Orthopedics
Cardiac Surgery	Otolaryngology/Head and Neck Surgery
Dermatology	Pediatrics
Emergency Medicine	Physical Medicine and Rehabilitation
Family Medicine	Plastic Surgery
Internal Medicine	Psychiatry
Medical Genetics	Pathology [see stipends referenced in Section 5.A.1(l)(6)]
Neurosurgery	Radiation Oncology
Neurology	Radiology [see stipends referenced in Section 5.A.1(l)(6)]
Nuclear Medicine	Surgery
OB/Gynecology	Urology

The maximum stipend a Chief of Service is eligible for depends on the size of the department.

*Chief of Service Table:*

Level	Physician Budgeted FTEs	Maximum Monthly Stipend
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I	90+	\$2,000
II	60.0-89.9	\$1,700
III	31.0-59.9	\$1,400
IV	16.0-30.9	\$1,100
V	6.0-15.9	\$800
VI	1.0-5.9	\$500

Chiefs of a Service with responsibility for more than one Medical Center may be eligible for the next higher Chief of Service stipend level, if recommended by the Area Medical Directors of the Areas being served and approved by the Board of Directors. Each Area must have its own department for which the Chief of Service is responsible.

Chiefs of a Service with responsibility for more than one service within an Area may be eligible for the next higher Chief of Service stipend level, if recommended by the Area Medical Director and approved by the Board of Directors.

(5) Regional Physician Coordinator Other Clinical Services

A Regional Physician Coordinator of Other Clinical Services may be appointed by the Executive Medical Director for any established subspecialty as approved by the Board of Directors. The qualifications for the position of Regional Physician Coordinator of Other Clinical Services are:

- (i) The candidate must be an active SCPMG Partner.
- (ii) The candidate must be a current Physician in Charge of Other Clinical Services or must have previously served as Physician in Charge of Other Clinical Services.
- (iii) The candidate must be respected by his/her peers as a practicing physician in that subspecialty.

The process for appointing Regional Physician Coordinator of Other Clinical Services is:

- (i) An active Physician in Charge of Other Clinical Services must be supported by the other active Physicians in Charge of Other Clinical Services within the subspecialty.
- (ii) Once nominated, a past (non-active) Physician in Charge of Other Clinical Services must obtain a simple majority vote of support from the active

Physicians in Charge of Other Clinical Services within the subspecialty, to be appointed.

- (iii) If a Regional Physician Coordinator of Other Clinical Services' local Physician in Charge of Other Clinical Services term ends, then the physician may complete his/her term as Regional Physician Coordinator without a vote from the active Physicians in Charge of Other Clinical Services within the subspecialty.
- (iv) Each Regional Physician Coordinator term will be for six years.

A reappointment beyond a second term for Regional Physician Coordinator must be reviewed by the Administrative Stipend Committee and discussed with the Executive Medical Director prior to the appointment. This is the same vetting process as proposed for other Physician Leader appointments.

The Administrative stipend for this position will be the same as the highest amount received by an active Physician in Charge in that subspecialty who does not receive any other stipend for other administrative work. A physician who holds more than one administrative position will receive only one Administrative Stipend. He or she will be eligible for the single largest stipend of the held positions.

The annual eligible administrative Merit Bonus is \$5,000 and may be in addition to any other administrative Merit Bonus received up to a maximum of \$15,000 per year.

(6) Chiefs of Service of Pathology or Radiology

The stipend range depends on the number of physicians served and is determined based on the FTE count of the Area.

*Chief of Service of Pathology or Radiology Table:*

Level	Area Physician FTE Count	Maximum Monthly Stipend
I	400+	\$1,100
II	1-399	\$800

(7) Assistant Chiefs of Service

The stipend level for an Assistant Chief of Service depends on the size of the department. To determine the stipend level for multiple Assistant Chiefs of Service in a department, divide the total FTE count by the number of Assistant Chiefs of Service.

*Assistant Chief of Service Table:*



Level	Physician Budgeted FTEs	Maximum Monthly Stipend
I	31.0+	\$1,100
II	16.0-30.9	\$800
III	5-15.9	\$500

(8) Assistant Chiefs of Service of Pathology/Radiology

The stipend range depends on the number of physicians served and is determined based on the FTE count of the Area. To determine the stipend for multiple Assistant Chiefs of Service in the department of Pathology or Radiology divide the total FTE count by the number of Assistant Chiefs of Service.

*Assistant Chiefs of Service of Pathology/Radiology Table:*

Level	Area Physician FTE Count	Maximum Monthly Stipend
I	400+	\$800
II	1-399	\$500

(9) Physician in Charge of Medical Office Buildings

The stipend level for a Physician in Charge of Medical Office Buildings depends on the size of the MOB.

*Physician in Charge of Medical Office Buildings Table:*

Level	MOB Budgeted Physician FTEs	Maximum Monthly Stipend
I	31+	\$1,100
II	16-30.9	\$800
III	1-15.9	\$500

(10) Assistant Physician in Charge of Medical Office Buildings

The stipend level for an Assistant Physician in Charge of a Medical Office Building depends on the size of the MOB. To determine the stipend level for multiple Assistant Physicians in Charge of a MOB, divide the total FTE count in the MOB by the number of Assistant Physicians in Charge of MOB.

*Assistant Physician In Charge of MOB Table:*

Level	MOB Budgeted Physician FTEs	Maximum Monthly Stipend
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Level	MOB Budgeted Physician FTEs	Maximum Monthly Stipend
I	31+	\$800
II	16-30.9	\$500
III	5-15.9	\$250

(11) Physician in Charge of Other Clinical Services and Residency Director

The stipend level for a Physician in Charge of Other Clinical Services and Residency Director depends on the size of the department. Examples include but are not limited to: Continuing Care, Neonatology and Internal Medicine Subspecialties such as, Cardiology, Gastroenterology, Oncology, and Pulmonary Disease.

*Physician In Charge of Other Clinical Services And Residency Director Table:*

Level	Physician Budgeted FTEs	Maximum Monthly Stipend
I	16+	\$800
II	5-15.9	\$500
III	1-4.9	\$250

(12) Physician Director of Business Services

This position is responsible for specific business needs of an Area and is tied to the FTE count of the Medical Center. A business need relates to oversight of an imperative or strategy that fulfills the KP Promise. Examples include but are not limited to:

- ◆ Quality
- ◆ Utilization Management
- ◆ Geographical Area (North County, South County): oversight of delivery of services including contracting and OSM expenses.
- ◆ Marketing
- ◆ Coding
- ◆ Access, Service, and the Patient Care Experience
- ◆ Service

◆ Population Care Management

*Physician Director of Business Services Table:*

Level	Area Physician FTE Count	Maximum Monthly Stipend
I	500+	\$1,100
II	250-499	\$800
III	1-249	\$500

(13) Service Line Leader

The Service Line Leader position is responsible for the clinical operations of the departments within the Service Line, including the quality, access, service, and budgetary performance of the clinical departments. The Service Line Leader works closely with the Chiefs of Service and Department Administrators within his/her Service Line to ensure that performance targets are met. They ensure that the departments operate in a collaborative, efficient, and synergistic fashion. The Service Line Leaders are members of the Area's leadership team and participate in strategy, operations, and problem solving for the Service Line. The Service Line Leader reports directly to the Area Medical Director.

This position is tied to the FTE count of the departments within their Service Line.

*Service Line Leader Table:*

Level	Physician Budgeted FTEs	Maximum Monthly Stipend
I	100+	\$2,000
II	50-99.9	\$1,700
III	1.0-49.9	\$1,100

(14) Assistant Service Line Leader

The Assistant Service Line Leader reports directly to the Service Line Leader. The Assistant Service Line Leader supports the Service Line Leader in carrying out his/her duties and functions. This position is tied to the FTE count of the departments within the Service Line. To determine the stipend level for multiple Assistant Service Line Leaders, divide the total FTE count in the Service Line by the number of Assistant Service Line Leaders.

*Assistant Service Line Leader Table:*

Level	Physician Budgeted FTEs	Maximum Monthly Stipend
I	50+	\$1,100

II	5-49	\$800
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(15) Physician Director, Fresenius

The position and associated stipend require Board of Directors' approval. This stipend is paid as a lump sum at year end and depends on how many beds are in the unit.

*Physician Director, Fresenius Table:*

Level	Number of Beds	Maximum Annual Lump Sum Stipend
I	21+	\$6,000
II	1-20	\$5,000

(16) Cardiologist in Charge

The maximum stipend for the Cardiologist in Charge (CIC) is \$2,000 per month. The responsibilities of Cardiologists in Charge include, but are not limited to, the following:

- ◆ Maintaining quality and efficiency of Sub-Regional Program, e.g. maintaining appropriate policies and procedures, training of personnel (M.D. and non-M.D.), ensuring adequate equipment and facilities.
- ◆ Assuring appropriateness of procedures: Screening and approval of referrals from SCPMG and non-SCPMG cardiologists for invasive procedures (cardiac cath, PTCA's etc.) based on regionally accepted guidelines.
- ◆ Managing of referral cases not being followed by an in-house cardiologist.
- ◆ Communicating with non-SCPMG cardiologists regarding diagnosis, treatment, transfer and follow-up of patients.

If additional sub-regions are needed, additional CIC's will be designated. The collective Medical Directors will determine when any sub-regional program has been fully implemented, and also whether and how a stipend is to be awarded (i.e.. full or shared).

(17) Secretary of the Board of Directors

The maximum stipend for the Secretary of the Board of Directors is \$1,400 per month.

(18) More Than One Administrative Position

A physician who holds more than one administrative position will receive only one Administrative Stipend. He or she will be eligible for the single largest stipend of the held positions.

(19) Administrative Physicians Maintaining Board Certification

All SCPMG administrative physicians who administer a clinical service and who are not board certified are required to become certified or resign from their administrative position on June 1, 2006. After June 1, 2006, any such physician administrator who allows their board certification to lapse will be considered to have resigned from their administrative position two years from the date that they are no longer board certified. If the physician becomes recertified before resignation is effective, the resignation may be rescinded with the approval of the Board of Directors. This applies only to physicians hired full time on or after January 1, 1995, the date new hires were required to be board certified in order to be eligible for Category I Partnership. An exception for an individual physician without current board certification can be approved by the collective Medical Directors, making the physician eligible to serve in any administrative position.

(20) Physician Administrator Transfers

When an Area Medical Director requests that a physician administrator transfer to assume an administrative position in another Area, the physician will be eligible to begin the new administrative position at his or her former stipend, but the physician administrator must receive an Administrative Stipend within the range permitted for the new position.

(21) Retained Administrative Stipends

At the end of the physician administrators' tenure, he or she will be eligible, upon recommendation by the Area Medical Director and approval by the Board of Directors, to retain up to 10% of his or her stipend for service of at least one term of office, and up to 20% for service of two or more terms of office (rounded to the next higher \$100).

Only former physician administrators appointed on or before December 31, 1995 who are in full time clinical practice are eligible for Retained Administrative Stipends. If a physician receives an Administrative Stipend, the physician may not receive a Retained Administrative Stipend while he or she is an administrator. A physician may receive only the one highest Retained Administrative Stipend awarded. This paragraph applies to all Chiefs of Service, Assistant Chiefs of Service, Physician Directors, Service Line Leaders, Assistant Service Leaders, Cardiologists in Charge, Physicians in Charge, Assistant Physicians in Charge, and the Secretary of the Board of Directors.

(22) Merit Increases

Merit Increases awarded during administrative tenure may be retained on return to clinical practice.

2. Total Annual Compensation

Total Annual Compensation includes Base Compensation as described above, plus Supplementary Compensation, Imputed Income, and other lump sum awards or bonuses as described below.

(a) Supplementary Compensation

A full time (10/10) physician's normal work week is considered to be 10 scheduled half days. For patient service provided beyond the regularly scheduled 20 half days during a two week pay period, a physician receives premium pay; this may be for Extra Duty, After Hours Duty, Call Back, Additional Clinic Time, or Night Medical Office. The following Leaves may be used to reach the basic work schedule W-20 count: Vacation Leave, Educational Leave, Jury Leave, Emergency Leave, Compassionate Leave, Military Leave, Sick Leave, and Extended Educational Leave. The premium rates vary based on the physician's Base Compensation and when the service is provided. A fixed fee schedule is used to determine Supplementary Compensation for After Hours House Calls. The Permanente Extra Duty Rate is used to determine Supplementary Compensation when a staff physician substitutes for Extra Duty in a specialty or subspecialty other than his/her specialty or subspecialty anywhere in the Region. If the physician substitutes for a full time physician employee or Partner within his or her department, the physician will earn his or her usual rate of compensation. Full time physicians may substitute for a Per Diem physician so long as quality of care is not compromised and the substitution is approved by the Chief of Service.

An Executive Medical Director or Area Medical Director who provides or is responsible for direct patient care in an Extra Duty or Call Back capacity will be compensated at a rate of pay equivalent to that of the Compensation program of the physician's specialty. The Permanente Extra Duty Rate is used to determine Supplementary Compensation when an Executive Medical Director or Area Medical Director substitutes for Extra Duty in a department other than his/her specialty or subspecialty anywhere in the Region.

(b) Imputed Income

Although the monetary value of benefits (life insurance, medical benefits, etc.) does not appear on the biweekly paychecks, it is a part of Total Annual Compensation, and the Imputed Income for the benefits is reflected on the Partner's Statement of Earnings each year. The Statement of Earnings provides income information for tax purposes; it is the Partner's equivalent of an employee's W-2 form and is targeted for distribution in early March.

The annual cost of the benefits for each Partner is calculated, and the value of the benefits is indicated, on the Partner's Statement of Earnings. The monetary value of the benefits is called Imputed Income.

(c) Planned Year-End Performance Draw and 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.

All Partners will receive a full share of Year-End Performance Draw except as provided below. During the first year in the Partnership and during the year of termination from the Partnership, a physician's share of Year-End Performance Draw will be prorated to the portion of the year during which he or she was a Partner. A Partner who gives less than 90 days notice of voluntary withdrawal from Medical Group will not be eligible for Year-End Performance Draw for the last 90 days worked. In all years, the share of Year-End Performance Draw will be proportional to the work schedule of the Partner. Effective January 1, 2010, a Partner whose compensation is reduced as a result of a disciplinary action will receive a 10% reduction in his or her share of YEPD for each 1% of compensation reduction. A Partner whose compensation is reduced as a result of a non-disciplinary action (i.e. not performing all duties of his/her departmental colleagues) will receive a 1% reduction in his or her share of YEPD for each 1% of compensation reduction (the Chief of Service or Area Medical Director may require the physician to undergo an independent medical exam to support ongoing work restriction). The reduction in share of Year-End Performance Draw will be prorated to the number of full months the compensation reduction is in effect. Year-End Performance Draw may be reduced for physicians who take Leave of Absence [see Section 6.F.1(j)] or Chronic Sick Leave [see Section 7.B.4)].

(d) Merit Bonuses

Each year, if budgeted by the Board of Directors, each Area is allotted a portion of the Merit Bonus Pool. Merit Bonuses are a one-time payment. The portion of Merit Bonus funds received by an Area is determined by the number of physicians in the Area in relation to the physicians in the Region. Each Area determines its own process for awarding its Merit Bonuses. Merit Bonuses are intended only for physicians who have demonstrated excellence through clinical achievements and/or who have shown exceptional dedication to furthering the overall goals of the organization. Physicians who are Partner Emeritus, who are merit worthy, and meet all of the merit criteria applied to other physicians in their Area, may be considered

for a Merit Bonus from that Area's Merit Bonus pool. A Merit Bonus may not exceed \$5,000.

(e) Administrative Merit Bonuses

Each year, if budgeted by the Board of Directors, each Area is allotted a portion of the Administrative Merit Bonus Pool. Administrative Merit Bonuses are one-time payments awarded to Physician Leaders who have demonstrated excellence in leadership and/or who have shown exceptional dedication to furthering the achievement of the overall goals of the organization. Physician Leader Merit Bonuses may not exceed the limits set forth in the Rules and Regulations.

(f) Lump Sum Award Programs (award amounts will be determined annually)

A small percentage of a physician's total compensation is attached to performance recognition compensation, and is designed to focus attention on key Medical Group business initiatives to improve patient care.

Clinical Quality of Care Award Programs:

(1) Medical Record Documentation, Patient Safety and Quality Merit Award Program:

Each year, and if approved by the Board of Directors, an annual lump sum is granted eligible physicians who meet the measurable performance criteria approved by the Board of Directors for this award.

(2) Clinical Quality of Care Award Program:

Each year, and if approved by the Board of Directors, qualifying participants are eligible to receive an award for meeting measurable performance criteria approved by the Board of Directors for this award. An annual to Base Compensation adjustment for Partner physicians who plan to retire at age 65 is available during the last 36 months preceding retirement.

**B. Employee Physicians**

Employee Physicians of Medical Group are paid a salary in return for the services they perform. As long as an Employee Physician is employed by the Partnership, his or her salary is considered an expense and financial obligation of the Partnership.

An Employee Physician, excluding Per Diem, is eligible for any of the increases described in the Partners section except for the Partnership Status Increase, all increases in recognition of the Value of Partnership (VOP), e.g. the additional board certification and MAPPS Base Compensation Increases. All increases after the fifth year and all yearly increases above the basic Standard Longevity Schedule are considered Merit Longevity Increases and are subject



to administrative review and approval by the physician's Chief of Service, Area Medical Director and the Board of Directors.

A general increase similar to the General Compensation for Partners may also be available for Employee Physicians (other than Per Diem).

The granting of this increase is based on an individual review of each physician's performance and the amount granted may range up to the full amount of that year's General Compensation Adjustment. Once granted, any increases become an additional part of his or her salary. An Employee Physician's Annual Base Compensation is the Starting Base Salary for his or her specialty, plus any increases that have been granted and added to it. Administrative review is required for the Standard Longevity Increases for Per Diem, Part Time and Full Time Special physicians and for Merit Longevity Increases for all Employee Physicians.

Per Diem physicians are paid an hourly wage that is determined by Medical Group Board of Directors for each specialty. Per Diem physicians are eligible for Standard Longevity Increases based on their years of service with Medical Group. In addition:

- ◆ Each year, and if approved by the Board of Directors, Per Diem physicians who attain and maintain acceptable MAPPs scores as established and approved by the Board of Directors are eligible for a Lump Sum Bonus.
- ◆ A Partner Emeritus physician working an average of 8/10 or greater is eligible for the Clinical Quality of Care Award Programs, providing the physician meets the criteria established for each award program.

Supplementary Compensation, as described in Section 5.A.2(a), is also earned by Employee Physicians for services provided in excess of the regularly scheduled 20 half days during a two week pay period.

Except for any amounts of life insurance in excess of \$50,000 that are provided by Medical Group, the value of Imputed Income for benefits [see Section 5.A.2(b)] is not added to an Employee Physician's W-2 and is not taxed.

Employee Physicians do not participate in Year-End Performance Draw. No Bonus similar to the Year-End Performance Draw will be awarded to SCPMG Employee Physicians.

### **C. Unique Need Compensation:**

Unique Need Compensation is a mechanism introduced in 2009 to provide the Executive Medical Director and a subcommittee of the SCPMG Physicians Benefits Committee discretion to set compensation for unique physicians to allow for the timely setting of compensation for a physician recruitment/retention to meet an operational or strategic need in which the usual Compensation/Benefits Committees schedule and process could compromise the hiring. This need has been typically to recruit or retain a physician in a specialty in a

particular geographical Area of expansion; or a unique subspecialty skill needed to provide Regional coverage.

After discussion with the ad hoc committee, the Executive Medical Director will inform the Board of Directors at the next regularly scheduled meeting of the Board of the hire and contract details.

The Medical Director of Operations, on a yearly basis, will perform an analysis and report the value of the services provided by the unique hired physicians by job code, i.e. number of consults, productivity assessment, Relative Value Units or other measures to allow for comparison with the financial analysis provided prior to hire.

#### **D. Reduction of Compensation**

##### **1. Disciplinary:**

A physician's income may be reduced by up to 10% of current Base Compensation for disciplinary reasons. This action must be recommended by the Chief of Service (unless the Chief of Service is the individual subject to the reduction) and the Area Medical Director, approved by the Executive Medical Director and discussed with the physician involved. This action will be reported to the Board of Directors without identifying the physician involved in order to protect the individual.

If the reduction is to continue beyond six months or is greater than 10% of Base Compensation, the Area Medical Director must obtain the approval of the Board of Directors and submit a report identifying the physician involved and the reasons for the action.

A physician may dispute any proposed or actual reduction in the physician's compensation. If a physician is disputing a proposed or actual reduction in that physician's compensation, the matter will be resolved through the Dispute Resolution Procedure [see Section 1.I].

At any time, the Board of Directors has the right to review and revise the amount of the Base Compensation of any Partner within the functional classification of assigned professional responsibilities. If the compensation is to be reduced, the maximum reduction will be to the then Starting Base Salary of an Employee Physician in that classification.

##### **2. Non-Disciplinary:**

Work responsibilities within a department need not be uniform amongst department members. Work responsibilities may vary by location, by subspecialty and/or according to other factors determined by the Chief of Service and Area Medical Director. A physician's work responsibilities may vary from time to time. A physician satisfies her/his work responsibilities and is not subject to a compensation reduction if the physician performs all work as requested by their Chief of Service and Area Medical

Director and takes a full share of department work responsibilities, whether during the Regular Work Week or afterhours. If a physician does not perform all the duties of his or her specialty/subspecialty as requested by their Chief of Service and Area Medical Director, Base Compensation will be reduced.

(a) Compensation Adjustment for non-disciplinary workload issues:

- (1) Physicians who no longer practice a significant part of their specialty job category such that the department or its patients are negatively impacted will be considered for one of the following:
  - ◆ Assignment to a job category that reflects work actually performed. The physician must meet the qualifications and competency to do the job. The physician will be paid according to the reclassified job category compensation structure.
  - ◆ 20% reduction in Base Compensation.
- (2) A physician whose productivity is reduced will first be considered for part-time status commensurate with their reduced productivity. If the physician requires full time status to accomplish the reduced productivity, the physician's Base Compensation will be reduced commensurate with the reduced productivity. The physician may be required to provide patient care during the time ordinarily scheduled for the Education Half Day, to help mitigate the reduced productivity.
- (3) Physicians who are approved to not participate in Extra Duty or other work responsibilities outside of the Regular Work Week ordinarily required by their specialty job code and their department will have their compensation reduced by 20%. A physician who works a portion of the physician's Extra Duty and/or Call responsibilities will have her/his compensation reduction prorated.

(b) Exceptions to Extra Duty Requirements

If, for medical reasons, a physician recuperating from a serious illness or injury should not take Extra Duty, that physician, upon the recommendation of the Chief of Service and the approval of the Area Medical Director, will be excused from the responsibility for Extra Duty for a period of up to six months. If, after a period of six months, medical reasons continue which warrant the excuse from Extra Duty, the physician's compensation will be reduced [see Section 4.F.3(a)].

3. Impact on Year-End Performance Draw:

A Partner whose compensation is reduced will receive less than a full share of Year-End Performance Draw [see Section 5.A.2(c)].

4. Impact on Bonuses and Future Merit Longevity Increases:

A Partner whose compensation is reduced will have Bonuses and future Merit Longevity Increases reduced commensurate with the compensation adjustment.

5. Impact on Partner Equity Longevity Merit (PELM):

A Partner who does not participate in the call duties expected of the physician or does not perform the specialty duties requested by the Partner's Chief of Service is not eligible for PELM consideration.

## 6 SCHEDULED TIME OFF — LEAVES

### A. Vacation Leave

1. Partners (Categories I, II and III only; Inactive Partners are ineligible for this benefit.)
  - (a) Partners earn Vacation Leave during the first year of Partnership (fourth anniversary year) at the rate of 23 days per year. During the fifth through ninth anniversary years, Vacation Leave is earned at the rate of 28 days per year. During the tenth and subsequent years, Vacation Leave is earned at the rate of 33 days per year. All Vacation Leave is accrued bi-weekly. Vacation Leave will be prorated for those working less than a 10/10 schedule.
  - (b) Ordinarily, Vacation Leave should be taken in the year following the year in which the Vacation Leave was earned. If a Partner terminates association with the Partnership, that Partner will be paid for the Vacation Leave which has accrued, but has not been taken.
  - (c) Physicians will receive compensation in lieu of Vacation Leave in the following circumstances:
    - (1) Vacation Leave will accumulate to a maximum of 90 days. Only at the conclusion of an Anniversary Year will any Vacation Leave accumulated in excess of 90 days be automatically paid at the physician's then current Base Compensation and the physician's Vacation Leave balance reduced to 90 days.
    - (2) A physician who has accumulated 20 days or more of Vacation Leave may request and receive compensation in lieu of Vacation Leave earned in the calendar year following the request. To be effective, such a request must be received during the enrollment period just prior to the calendar year in which compensation is to be received in lieu of Vacation Leave. Such a request is effective for one year and irrevocable.

A physician may request compensation in lieu of Vacation Leave due to severe financial hardship. Severe financial hardship is defined as an unforeseeable emergency resulting from an illness or accident, loss of property due to casualty, or other similar extraordinary circumstances occurring as a result of events beyond the physician's control. This request must be approved in advance by the physician's Area Medical Director and the Executive Medical Director after receiving a recommendation from the Permanente Human Resources Department.
  - (d) Vacation Leave is to be scheduled in advance and approved by the Chief of Service.
  - (e) Inactive Partners and Partners on Extended Educational, Extended Medical Service, and Extended Military Service Leaves will not earn Vacation Leave.

- (f) Physicians may borrow up to one year's Vacation Leave for Parenting Leave or for an unforeseeable health emergency of the physician's spouse, domestic partner, child, or parent. If Sick Leave benefits may be taken for the absence, these must be exhausted before Vacation Leave may be borrowed. All borrowing of Vacation Leave requires the approval of the physician's Area Medical Director and the Executive Medical Director, or their designees.

For those physicians with a negative vacation balance as of December 31, 2007, a new Debit Vacation Account will be established and their negative vacation balance will be transferred to that account. Effective January 1, 2008, those physicians will begin to accrue Vacation Leave bi-weekly according to their accrual schedule. Effective July 1, 2008, 75% of the bi-weekly accrual will continue to go into the physician's Vacation Leave account and 25% of the physician's bi-weekly accrual will be credited to his/her Debit Vacation Account. This will continue until the Debit Vacation Account is eliminated.

2. Employee Physicians

- (a) Full Time Regular, Full Time Special, Special Category and Part Time physicians are eligible for Vacation Leave. Vacation Leave is earned during each of the first four years of association with Medical Group at the rate of 18 days per year. During the fifth through ninth years, Vacation Leave is earned at the rate of 23 days per year. During the tenth and subsequent years, Vacation is earned at the rate of 28 days per year. Vacation will be prorated for those working less than 10/10. Employees are subject to the same limitations and restrictions as Partners with respect to receiving compensation in lieu of Vacation Leave and borrowing Vacation Leave.

- (b) Per Diem physicians are not eligible for Vacation Leave.

3. Former Kaiser Foundation Hospital (KFH) Residents and Fellows

Former KFH Residents and Fellows may transfer up to 10 days of Vacation Leave to Medical Group. In order to be eligible for this transfer of Vacation Leave, the physician must join Medical Group within 90 days of termination from KFH and must elect to transfer the Vacation Leave balance prior to terminating from KFH. The Vacation Leave will be credited to the physician at his or her new rate of pay as a Medical Group physician. The physician may not take this Vacation Leave under Medical Group pay rate until he or she has actually joined Medical Group and completed at least one month of service.

**B. Educational Leave**

1. Partners (Categories I, II and III only; Inactive Partners are ineligible for this Benefit.)

- (a) Active Partners are eligible for one week of Educational Leave per year prorated according to their work schedule. Educational Leave is a privilege granted by the Partnership to sustain the highest level of professional development for the mutual

benefit of the individual and Medical Group. It must be used to acquire professional knowledge, maintain educational requirements for licensure and board certification, or participate in university medical teaching. With approval of the Chief of Service and the Area Medical Director, Educational Leave may be utilized for medically-oriented uncompensated community service projects and programs. With approval from that physician's Chief of Service or Physician in Charge, Educational Leave may be utilized to attend SCPMG Board of Directors meetings.

Educational Leave may be taken as:

- (1) In lieu of regularly scheduled work. In this case, the Educational Leave is to be scheduled in advance with the approval of the Chief of Service, or
  - (2) Non-work hours, i.e. not during regularly scheduled work. Educational Leave taken during non-work hours will be compensated at the physician's regular W rate upon filing of accredited CME certificate with the physician's Area's Education Coordinator. A W will be paid for each 4 hours of accredited Continuing Medical Education (CME). CME activities of less than 4 hours may be accumulated. Fewer than 4 hours will not be paid. This program begins in 2009. No physician may earn more than 2 W's per calendar year in this manner. Educational Leave W's earned in this manner will not count toward the regular W count and will not promote to premium pay.
- (b) Educational Leave to study for specialty or subspecialty board examinations is permitted. Time to take the specialty, subspecialty, or recertification board examination plus appropriate time for travel will be considered work time, and is coded as indirect work (IW).
- (c) Unused Educational Leave is not compensable. Educational Leave is not earned on a proportionate basis for a portion of an Anniversary Year.
- (d) No Educational Leave will be granted to physicians during the 90 day period immediately preceding resignation or termination. Physicians retiring from Medical Group may be granted Educational Leave up to 30 days prior to retirement. If Educational Leave is taken during the above periods, it will be considered Vacation Leave.
- (e) If a physician does not use earned Educational Leave, it may accumulate to a maximum of 20 days. At the conclusion of each subsequent Anniversary Year, any unused Educational Leave in excess of 20 days will be lost.
- (f) A maximum of five days may be borrowed from the next Anniversary Year. Any Educational Leave taken in excess of the above will be charged to Leave of Absence. A physician may choose to utilize any accumulated Vacation Leave rather than Leave of Absence in this circumstance.

- (g) If a Partner has used “borrowed” Educational Leave and terminates, any unearned but used Educational Leave must be repaid at the time of termination.
- (h) Educational Leave (EL) may be used to retrain physicians when they are asked to return to overnight in-hospital duty. The exact training need and eligibility will be determined by the Chief of Service and the Area Medical Director, but the total time allowed will not exceed 30 days.

2. Employee Physicians

Employee Physicians will receive the same benefits as in the section above with the following exceptions:

- (a) Educational Leave is not earned in the first year of full time employment with Medical Group. Ordinarily, Educational Leave is to be taken in the year in which it is earned. The rest of the guidelines are the same as for Partners.
- (b) Full Time Special physicians may be granted Educational Leave at the discretion of the Chief of Service and the Area Medical Director.
- (c) Part Time and Per Diem physicians are not eligible for Educational Leave.

**C. Holidays**

1. Partners

- (a) Partners will receive paid time off for the approved Holidays. Those working less than an 8/10 schedule will be paid for all Holidays on a prorated basis. When Holidays occur during Vacation Leave, that day will be credited as a Holiday rather than Vacation. Physicians who work on a Holiday will receive additional compensation. When a recognized Holiday occurs on a Saturday, premium pay will be paid for sessions in excess of W-21 for that pay period.
- (b) Inactive Partners are not eligible for holiday pay.

2. Employee Physicians

Employee Physicians, except Per Diem physicians, will receive the same Holiday benefits as Partners, except physicians working less than a 10/10 schedule will be paid for Holidays on a prorated basis.

**D. Miscellaneous Leaves and Expense Reimbursement for Scientific Presentations, Outside Courses, or Specialized Training**

Under special circumstances, if staffing permits, time off to participate in meetings of major professional medical organizations or institutions, attend outside courses, or take specialized





training may be granted with the approval of the Chief of Service, Area Medical Director, and Executive Medical Director (or the Executive Medical Director's designee).

Physicians who serve as officers or committee members in professional societies, or surveyors for accrediting or regulatory agencies will not be granted special Leave expense reimbursement to fulfill these outside responsibilities unless they are requested to do so by the Executive Medical Director as part of their administrative responsibility or for the special benefit of Medical Group.

Area Medical Directors may provide Administrative Work and expense reimbursement from operating funds, following organizational guidelines, for physicians to visit other medical centers or institutions in order to observe aspects of health care delivery or facilities for the benefit of the Kaiser Permanente Medical Care Program.

The following guidelines and procedures are to be followed in making requests:

1. Leaves and Expense Reimbursement Related to Presentations at Medical Meetings

The guidelines and procedures outlined below are for requests by physicians for Leave and reimbursement for travel and other expenses relating to education and research activities. These requests are not funded through research funds but by Medical Group.

(a) Types of presentations and activities relating to major United States or international medical professional organizations or institutions that are eligible for consideration for Leave and expense reimbursement include:

- (1) a presentation of original research (either as a talk or poster), which has been published or submitted for publication as a paper or abstract;
- (2) serving as a faculty member at an academic medical center;
- (3) serving as a member of, or examiner for, a national specialty or sub-specialty board; or
- (4) exceptional formal scientific presentations approved by the collective Medical Directors.

(b) Criteria for reimbursement:

- (1) A written invitation to participate in one of the types of presentations listed in Section 6.D.1(a) above is required.
- (2) The invitation must be from a major United States or international professional medical organization or institution.
- (3) Research activities must be performed and presentations given while the physician is working full time with Medical Group. A research project may be

performed at a local teaching institution and in collaboration with others at that institution.

- (4) A maximum of two Leaves (not to exceed a total of six working days per calendar year) per applicant may be authorized.
- (5) Only one physician will be subsidized for any type of presentation.
- (6) For one presentation at a distant meeting, there will be a maximum Leave allowance of three days and two nights (one day to get to the meeting, one day to present the paper and one day to return). Where distances and time enable the physician to travel to and from the meeting and make the presentation in one day, only one day of Leave will be authorized.

Additional time off for the purpose of attending the remainder of the meeting is to be taken as Educational Leave or Vacation Leave.

For multiple presentations at a distant meeting, there will be a maximum of four days for presentations plus two days for travel. For exhibits, Leave will be granted for the total required exhibit time plus two days for travel.

- (7) Exceptions may be considered by the Executive Medical Director for the special benefit of the Kaiser Permanente Medical Care Program.

(c) Reimbursement:

- (1) If not otherwise available, there will be reimbursement for round trip coach airfare (or mileage where appropriate) to be arranged by our own travel department except under exceptional circumstances approved in advance by the Medical Director of Quality and Clinical Analysis. When the meeting is in a foreign country (except Canada), the reimbursed fare will be the lesser of the coach fare to either the nearest port of exit from the United States or to the site of the meeting.
- (2) If not otherwise available and upon submission of receipts for incurred expenses, there will be a maximum per diem reimbursement for expenses for each day authorized at the meeting (not to exceed three days). There will be no additional payment during the trip for travel, hotel, meals or other expenses beyond the maximum.
- (3) Registration fees, if not paid for by the outside organization, will be reimbursed in addition to the per diem allowance. There must be a written timely request to have the registration fees waived and a rejection from the outside organization in order for Medical Group to reimburse registration fees.

(d) Procedure to be followed in obtaining reimbursement:

- (1) An application form is to be obtained from the Academic Affairs Department.
- (2) The completed form, with approvals by the Chief of Service and Area Medical Director, is attached to the invitation document and sent to the Medical Director of Quality and Clinical Analysis.
- (3) All requests must be approved by the Executive Medical Director or the Executive Medical Director's designee prior to the trip.
- (4) Original expense receipts must be submitted with a standard Request for Reimbursement Form to the Medical Director of Quality and Clinical Analysis.

Presentations funded for travel expense reimbursement by non-Kaiser Permanente sources must have the same type of approval as described above if the physician is representing the Kaiser Permanente Medical Care Program.

## 2. Outside Courses

Medical Group will not pay for courses for any physician unless taken for the specific benefit of Medical Group at the request of the Executive Medical Director. No time in addition to Educational Leave will be allowed for courses without authorization. The Executive Medical Director will keep a record of all such approvals and report on this activity yearly to the Board of Directors.

## 3. Specialized Additional Training

A physician requested by the Executive Medical Director and approved for a specific training program or course at the expense of the Partnership shall sign an agreement to continue practice with Medical Group for a specified period of time, depending upon the cost to the Partnership. The Base Compensation of the physician while away obtaining such training should be considered as part of the expense to the Partnership. This time will be considered work time.

## **E. Extended Educational, Extended Medical Service and Extended Military Service Leaves**

For each five years of service with Medical Group, a Partner will accumulate three months Leave to be used for either an Extended Educational Leave, Extended Medical Service Leave, or Extended Military Service Leave. Eligibility for Leave will be based on full five year periods and no fractions of five year periods will increase the eligible Leave period, nor will it be possible to draw on unearned Leave time. The maximum cumulative amount of all these Leaves that can be taken by any Partner at any one time will not exceed one year.

Extended Educational and Medical Service Leaves may only be approved if the physician requesting the Leave works in a department that is meeting all established access standards for the department at the time of approval of the Leave. If a department is not in access, a plan will be implemented to address access during the physician's absence from the



department. The access plan will be developed between the Chief of Service and Area Medical Director in the respective Area. Exceptions require approval by the collective Medical Directors.

1. Extended Educational Leave

(a) When Extended Educational Leave may be taken:

This Leave is a privilege and not a right; it is granted at the convenience and discretion of Medical Group, and is not automatic. Extended Educational Leave requires approval of the Partner's Chief of Service, Area Medical Director, and the Executive Medical Director and depends on funding by the Board of Directors. 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 Leave may also be used for research if the research will require at least three weeks of full time work. The Research Executive Committee must approve any research that utilizes the Extended Educational Leave benefit. The Research Executive Committee will only approve research which is likely to result in publication in a peer review journal or which will significantly enhance medical knowledge and our reputation.

Any physician who is granted Extended Educational Leave to carry out research must submit an executive summary describing his/her research to the Research Executive Committee. A physician will be eligible for Extended Educational Leave for research only if the physician has submitted to the Research Executive Committee an executive summary resulting from any research previously approved for such Leave by the Committee for that physician. With the exception of approved language immersion training, Extended Educational Leave cannot be used for any activity of less than three weeks' duration.

(b) Compensation by Medical Group:

With the exception of approved language immersion training, when a Partner is on Extended Educational Leave, the Partner will receive one-half of Base Compensation except as noted in the next paragraph. Base Compensation at the time of applying for Leave will reflect the work pattern of the physician's previous five years of service.

For every ten years of service, one month of Leave may be paid at 100% of Base Compensation. To qualify for 100% payment, the Leave must be taken within ten years of being earned. Only the last month of a Leave of three or more months' duration may be paid at 100% of Base Compensation. A physician will receive less compensation from Medical Group, if necessary to comply with Section 6.E.1(d)(3).

Physicians using Extended Educational Leave for approved language immersion training will be paid at full Base Compensation for the duration of that training. The physician will use 4 W's of Extended Educational Leave for each day of language



immersion training. The lifetime maximum of this benefit is four weeks, or 20 working days. The training need not occur in consecutive weeks.

A Partner on Extended Educational Leave will receive an applicable share of Year-End Performance Draw. The working status with regard to the physician's Year-End Performance Draw at the time of applying for Leave will reflect the working pattern of the physician's previous five years of service. The physician will be considered as though working his or her usual pattern so as to receive all benefits of Partnership except Holidays and accumulation of credit toward Vacation Leave, and Educational Leave.

(c) Credit toward "Common Plan" during Extended Educational Leave:

Credit toward the Retirement Plan for Physicians Serving Members of Kaiser Foundation Health Plan ("Common Plan") will be full Qualifying Service and up to 90 days Credited Service for each Leave.

(d) Other Regulations:

- (1) If transportation specifically is paid for, this may be accepted by the Partner.
- (2) If housing specifically is furnished, this may be accepted by the Partner.
- (3) If a stipend is specifically furnished in conjunction with the purpose for which the Leave is granted, the physician will be permitted to receive and retain it. However, total physician income is not to exceed the physician's Base Compensation.
- (4) A Partner may not work at, nor receive compensation for, any activities other than those for which the Leave is granted.
- (5) A Partner who becomes seriously disabled during an approved Leave will be permitted, upon request and subject to approval by the Board of Directors, to revert from Leave status to active status and thereupon to draw on unused Acute and Chronic Sick Leave. The Extended Educational Leave must have been used only for the purpose for which it was granted. Following recovery, a Partner may not return to Extended Educational Leave status.

2. Extended Medical Service Leave

(a) When Extended Medical Service Leave may be taken:

This Leave is a privilege and not a right; it is granted at the convenience and discretion of Medical Group, and is not automatic. Extended Medical Service Leave requires approval of the Partner's Chief of Service, Area Medical Director, and the Executive Medical Director. This Leave is to be used 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 the Southern California Permanente Medical Group would sponsor independently. The Extended Medical Service Leave Program is a volunteer medical service activity and requires a determination of malpractice coverage. A voluntary activity report form is available from each physician's Area Medical Director's office.

(b) Compensation by Medical Group:

When a Partner is on Medical Service Leave, the physician will receive one-half of Base Compensation plus an applicable share of Year-End Performance Draw. The working status with regard to the physician's Base Compensation and Year-End Performance Draw at the time of applying for Leave will reflect the working pattern of the physician's previous five years of service. The Partner will be considered as though working his or her usual pattern so as to receive all benefits of Partnership except Holidays and credit toward Vacation Leave, and Educational Leave.

(c) Credit toward Common Plan during Extended Medical Service Leave:

Credit toward the Retirement Plan for Physicians Serving Members of Kaiser Foundation Health Plan (Common Plan) will be 50% Qualifying Service and 50% Credited Service for the entire period of the Leave.

(d) Other Regulations:

- (1) If transportation specifically is paid for, this may be accepted by the Partner.
- (2) If housing specifically is furnished, this may be accepted by the Partner.
- (3) If a stipend is specifically furnished in conjunction with the purpose for which the Leave is granted, the physician will be permitted to receive and retain it. However, total physician income is not to exceed the physician's Base Compensation.
- (4) A Partner may not work at, nor receive compensation for, any activities other than those for which the Leave is granted.
- (5) A Partner who becomes seriously disabled during an approved Leave will be permitted, upon request and subject to approval by the Board of Directors, to revert from Leave status to active status and thereupon to draw on unused Acute and Chronic Sick Leave. The Extended Medical Service Leave must have been used only for the purpose for which it was granted. Following recovery, a Partner may not return to Extended Medical Service Leave status.

3. Extended Military Service Leave

(a) When Extended Military Service Leave may be taken:

This Leave is a privilege and not a right; it is granted at the convenience and discretion of Medical Group, and is not automatic. Extended Military Service Leave requires approval of the Partner's Chief of Service, Area Medical Director, and the Executive Medical Director and depends on funding by the Board of Directors. Extended Military Service Leave is to be used only for involuntary full time active duty service as clinicians in the United States Military, during a time of armed conflict, for a period not less than one month and no more than 12 months.

(b) Compensation by Medical Group:

When a Partner is on Extended Military Service Leave, the Partner will receive one-half of Base Compensation. Base Compensation at the time of applying for Leave will reflect the work pattern of the physician's previous five years of service.

A Partner on Extended Military Service Leave will receive an applicable share of Year-End Performance Draw. The working status with regard to the physician's Year-End Performance Draw at the time of applying for Leave will reflect the working pattern of the physician's previous five years of service. The physician will be considered as though working his or her usual pattern so as to receive all benefits of Partnership except Holidays and accumulation of credit toward Vacation Leave, and Educational Leave.

(c) Credit toward "Common Plan" during Extended Military Service Leave:

Credit toward the Retirement Plan for Physicians Serving Members of Kaiser Foundation Health Plan ("Common Plan") will be full Qualifying Service and Credited Service for each Leave.

(d) Other Regulations:

- (1) The physician will be permitted to receive and retain pay from the United States Military. However, total physician income is not to exceed the physician's Base Compensation.
- (2) A Partner may not work at, nor receive compensation for, any work other than military service.

4. Inactive Partners and Employee Physicians

Inactive Partners and Employee Physicians are not eligible for Extended Educational, Extended Medical Service, or Extended Military Service Leave.

**F. Leave of Absence**

1. Partners



- (a) Leaves of Absence and compensatory time off are not to be considered a right, and may only be granted with the approval of the Chief of Service and the Area Medical Director or the Executive Medical Director. The standard of service in each department is the paramount consideration, so that if a Leave of Absence or compensatory time off should interfere with this standard of care, it may not and should not be granted. Compensatory time off may be approved only on an episodic basis.
- (b) Any physician requesting a Leave of Absence of more than ten days must have the Leave approved by the Chief of Service, Area Medical Director, and the Executive Medical Director in advance of the Leave of Absence.
- (c) A Leave of Absence of up to one year may be approved for Partners.
- (d) Unless approved by the Board of Directors, physicians on Leave of Absence may not engage in the practice of medicine for monetary gain except for a stipend received during a Residency or Fellowship approved by Medical Group or pay for working for a Permanente Medical Group, The Permanente Federation, LLC, or The Permanente Company, LLC. Physicians on Extended Educational Leave or Medical Service Leave may receive a stipend [see Sections 6.E.1(d)(3) and 6.E.2(d)(3)].
- (e) A Partner who receives from the government a Final Nonconfirmation (FNC), indicating that he/she may not work in the United States, will automatically be placed on Leave of Absence for three months, effective the date of the FNC. The Board of Directors may approve an extension of Leave of Absence, up to one year.
- (f) A physician who does not return to active practice in Medical Group on the expiration of the Leave of Absence will be deemed to have resigned from the Partnership, effective on the last day worked.
- (g) A Partner who becomes seriously disabled during an approved Leave of Absence will be permitted, upon request and subject to approval by the Board of Directors, to revert from Leave of Absence status to active status and thereupon to draw on unused Acute and Chronic Sick Leave. The Leave of Absence must have been used only for the purpose for which it was granted. Following recovery, a Partner may not return to Leave of Absence status.
- (h) Each physician's Anniversary Date will be adjusted on a day for day basis when the combined Leaves of Absence exceed ten days in an Anniversary Year.
- (i) Each physician is allowed a lifetime total of 60 working days of Leaves of Absence beyond which all additional Leaves of Absence will result in an Anniversary Date adjustment on a day-for-day basis.
- (j) Each Partner will not have Year-End Performance Draw reduced for the first ten days of a Leave of Absence in any calendar year provided the total accumulation of Leave of Absence while practicing with Medical Group does not exceed 60 days. Year-End





Performance Draw will be reduced proportionately for Leave of Absence in excess of ten days in a calendar year or for Leave of Absence in excess of 60 days during the physician's career with Medical Group.

- (k) A Leave of Absence will be recorded for each half day not worked or otherwise accounted for in a physician's regular schedule. The exception is a compensatory half day off for each "W" worked outside of the physician's regular work schedule. The compensatory half day may be taken only during the same pay period and only when requested by the physician.

When requested by a physician, the compensatory day immediately following an overnight call must always be approved.

- (l) All full time physicians (10/10) are given credit for retirement for any Leave of Absence of ten days or less. Credit may not exceed ten days in any calendar year or 60 days lifetime. Physicians on less than a full time schedule (10/10) will receive proportional credit.
- (m) Medical Group will continue to pay premiums for Health Plan, Major Medical Insurance, Dental Care Insurance, Alternate Mental Health Insurance, Short and Long Term Disability through the first full month following the month in which the Leave of Absence begins. Continuation of these benefits is optional, and at the physician's expense after this time. Permanente Provided Life Insurance premiums will continue to be paid by Medical Group throughout the Leave of Absence.

## 2. Employee Physicians

### (a) Special Category

The rules regarding Leaves of Absence for Partners also apply, where appropriate, to physicians in this category.

### (b) Full Time Regular, Full Time Special, and Part Time

- (1) Physicians will be considered for short Leaves of Absence only. All of the rules that apply to Partners apply to these Employee Physicians except they cannot convert Leave of Absence to Sick Leave.
- (2) The Anniversary Date adjustment and the definition of Leave of Absence as well as limitations are the same as for Partners.
- (3) Medical Group will continue to pay premiums for Health Plan, Major Medical Insurance, Dental Care Insurance, Alternate Mental Health Insurance, Short and Long Term Disability Insurance through the end of the month in which the Leave of Absence begins. Continuation of these benefits is optional, at the physician's expense, after this time. Permanente Provided Life Insurance

premiums will continue to be paid by Medical Group throughout the Leave of Absence.

- (4) While on Parenting Leave, the provisions of Section 6.J apply.

Employee Physicians may not take Leave of Absence for part of a work day, unless permitted by the Family Medical Leave Act (FMLA).

**G. Military Leave** — (All physicians, excluding Full Time Special, Part Time and Per Diem physicians, are eligible for this Benefit.)

Physicians returning from required Military Leave will be eligible for the same longevity pay increases they would have been eligible for had they not gone on Military Leave. They will be granted credit toward increasing benefits for time in military service. Credit will not be granted for accruing Vacation, Educational Leave, nor Partnership eligibility.

Returning Employee Physicians must fulfill the time requirements for Partnership as employees of Medical Group to become eligible for Partnership. Also see Partnership Agreement, Article 12.

**H. Leaves for Military Active Reserve**

All physicians, except Per Diem, who are members of the Military Active Reserve of a branch of the United States Armed Forces and who are ordered for up to four weeks of active service may elect to take this time as Leave of Absence or as Vacation Leave. If taken as Leave of Absence, it will not count against the ten day per year or 60 day lifetime allowances as it affects the Anniversary Date [Sections 6.F.1(h) and 6.F.1(i)]. A Partner's Anniversary Date will be adjusted for Leave of Absence for active reserve service greater than four weeks per year according to the provisions of Sections 6.F.1(h) and 6.F.1(i).

**I. Compassionate Leave**

Up to five working days of Compassionate Leave may be extended to any physician (except Per Diem) with the approval of the Chief of Service and Area Medical Director, for the death of the physician's spouse, children, parents, brothers, sisters, grandparents, grandchildren, step-parents, step-children, legal wards, parents-in-law, brothers-in-law, sisters-in-law, a significant other who meets the administrative criteria for a Domestic Partner (see health care eligibility in the *SCPMG Benefits Handbook for Physicians*), and the parents, children, brothers, and sisters of a significant other who meets the administrative criteria for a Domestic Partner. The amount of Compassionate Leave will be prorated to the physician's work schedule.

**J. Parenting Leave**

A physician who has become the parent of a live birth or adopts a child less than two years of age may take a Leave of up to 120 calendar days. For the purpose of Parenting Leave, a physician may use, without possibility of denial, accrued Vacation Leave, Leave of Absence



or Sick Leave subject to the other restrictions of these Leaves and as set out below. Sick Leave may be used only by physicians who are physically impaired. If the physician's Chief of Service or Area Medical Director requests, a physician must show evidence of becoming the parent of a live birth or of having adopted a child less than two years of age to be eligible for Parenting Leave. Medical Group will continue to pay for health care benefits, Short and Long Term Disability Insurance, and Permanente Provided Life Insurance during Parenting Leave.

An Employee Physician, other than Per Diem, who has been delivered of a live birth, following 30 days of Sick Leave, will be eligible for Short Term Disability. A Partner Physician who has been delivered of a live birth, following 30 days of Sick Leave, will be eligible for the Compensation Continuance Program. Leave may be taken up to 30 days prior to birth. Once the post-partum disability period ends, the physician may use any available Vacation Leave or Leave of Absence for the remainder of Parenting Leave. For benefits with a complicated pregnancy or complicated delivery see Section 7 (Sick Leave).

#### **K. Emergency Personal Leave**

Every physician working not less than an 8/10 schedule is eligible to take up to 5 days in any Anniversary Year as Emergency Personal Leave. Emergency Personal Leave may be taken at short notice in circumstances of personal hardship. If the physician has accrued Vacation Leave, Emergency Personal Leave will be compensated as Vacation Leave and the physician's Vacation Leave balance will be reduced accordingly. If the physician does not have sufficient accrued Vacation Leave, Emergency Personal Leave will be uncompensated and otherwise similar to Leave of Absence except as provided above. Whenever possible, absences should be planned and other Leaves used.

#### **L. When Leaves May Be Taken**

All Leaves may only be taken in lieu of regularly scheduled work time (maximum of 20 W's in a biweekly period based on a 10/10 work schedule). The only exception is Educational Leave taken pursuant to Section 6.B.1(a)(2). Leaves may not be taken in lieu of Extra Duties.

#### **M. Constructive Resignation From Partnership**

A Partner who has Unapproved Absence for a total of 60 days will, upon a majority vote of the Board of Directors, be deemed to have resigned from the Partnership. Such resignation may be rescinded if any Partner applies for rescission in writing and the Board of Directors approves rescission. If a Partner resigns under the provisions of this paragraph, compensation and benefits will be owed to the physician only through the last day worked or on approved Leave, or as determined by the Board of Directors.

#### **N. Jury Duty Leave**

Each physician may receive a maximum of 10 days of Jury Duty Leave in any five consecutive calendar years. Any additional Jury Duty time must be taken as Vacation Leave

or Leave of Absence. Effective January 1, 2003, Jury Duty Leave will be prorated for those working less than 10/10. Additional required jury service of less than a full work week must be taken by eligible Employee Physicians as Jury Duty Leave borrowed against future Jury Duty Leave accruals. Additional required jury service of a full work week must be taken by eligible Employee Physicians as Vacation Leave or Leave of Absence.

**O. Administrative Leave with Compensation**

A physician may be placed on Administrative Leave with Compensation with the approval of the Area Medical Director or the Executive Medical Director or his/her designee.

**P. Unapproved Absence**

A physician who is absent from assigned duties without an approved Leave has an Unapproved Absence. Employee Physicians absent for part of a day will not be charged Unapproved Absence. Unapproved Absence will not be compensated monetarily or with benefits. The cost of benefits received during Unapproved Absence will be paid by the physician. The physician's anniversary date will be adjusted for all Unapproved Absences. Unapproved Absence may be replaced with a Leave, if a Leave is subsequently requested and approved.

## **7 SICK LEAVE**

Granting of all Sick Leave is by the recommendation of the attending physician, approved by the Chief of Service, the Area Medical Director and, when deemed necessary, reviewed by the Board of Directors.

### **A. Acute Sick Leave**

#### 1. All Physicians

- (a) Hired on or before June 30, 2014: During their first year with Medical Group, physicians accrue Acute Sick Leave at the rate of approximately two days per month to a maximum of 22 working days per year. On the second and each subsequent Anniversary Date, each eligible physician receives 22 days of Acute Sick Leave for the coming year. Those physicians working less than 10/10 will have their benefit prorated. Acute Sick Leave cannot be accumulated except as noted in Sections 7.A.2(a) and 7.A.2(b). Per Diem physicians are not entitled to Sick Leave benefits. Former Kaiser Foundation Hospital Residents will receive up to 22 days of Sick Leave at the beginning of the physician's start year. Former Kaiser Foundation Hospital Residents will not accrue additional days of Sick Leave during their first year of service.
- (b) Hired on or after July 1, 2014: During their first year with Medical Group, physicians accrue Acute Sick Leave at the rate of ten (10) days per year, accrued by the end of the first six (6) months of employment. Ten (10) days will be front-loaded each anniversary year thereafter. Those physicians working less than 10/10 schedule will have their Acute Sick Leave benefit prorated. Acute Sick Leave cannot be accumulated except as noted in Sections 7.A.2.(a) and 7.A.2.(b). Per Diem physicians are not entitled to Sick Leave benefits. Former Kaiser Foundation Hospital Residents will receive up to ten (10) days of Sick Leave at the beginning of their start year. Former Kaiser Foundation Hospital Residents will not accrue additional days of Sick Leave during their first year of service.
  - \* Where all subsequent sections reference 22 days for Associates physicians' Sick Leave, 10 days should be referenced for all physicians hired on or after July 1, 2014.
- (c) If a physician develops a serious illness or is hospitalized while on Vacation Leave, the physician may request counting the time for the illness as Sick Leave, thereby converting a portion of the Vacation Leave to Acute Sick Leave. To be effective, the request must be approved by the physician's Area Medical Director.
- (d) Upon the recommendation of the Chief of Service, and with the approval of the Area Medical Director, a physician may return to practice on a part time schedule for a maximum of six weeks while convalescing from an acute illness of at least one

- week's duration. The time not worked will be compensated as, and deducted from, Acute Sick Leave.
- (e) If a physician uses one month (22\* working days) or less of Sick Leave during any one Anniversary Year, all credit for benefits will continue to accrue and there will be no Anniversary Date adjustment.
  - (f) During Sick Leave exceeding one month (22\* working days) in an Anniversary Year, the Anniversary Date will be adjusted on a day for day basis according to the rules for Leave of Absence [see Section 6.F]. Partners who use their Accumulated Acute Sick Leave as described in Section 7.A.2 represent an exception to this rule. A physician's Anniversary Date will be adjusted on a day for day basis after exhaustion of all Acute and/or Accumulated Acute Sick Leave.
  - (g) Employee Physicians (excluding those who are on a qualifying Leave under the Family and Medical Leave Act [FMLA]) who are too ill to work and whose Sick Leave account is exhausted may take Leave of Absence for full day absences. For partial day absences only, such Employee Physicians may borrow from future Sick Leave accruals.
  - (h) Leave for Pregnancy and Pregnancy Related Illness: All pregnant physicians are eligible to begin their period of disability for pregnancy as soon as they are certified as disabled by their attending physician.

Regardless of the day the physician stops working due to pregnancy disability, the Short Term Disability Program (STD) for Employee Physicians and the Compensation Continuance Program for Partners will pay benefits for a post-partum period of no more than six weeks for a normal delivery or eight weeks for cesarean delivery. During the 30 calendar-day STD waiting period for benefits (for those hired on or before June 30, 2014), or 14 calendar-day waiting period for benefits (for those hired on or after July 1, 2014), the physician must use Acute Sick Leave. When Acute Sick Leave is exhausted, the Partner physician may use Accumulated Acute Sick Leave or Leave of Absence and the Employee Physician may use Leave of Absence. Once the six- or eight-week post-partum period of disability ends, the physician may use any accrued Vacation Leave or Leave of Absence for the remainder of Parenting Leave [see Section 6.J].

- (i) Physicians who are drawing Acute Sick Leave or Accumulated Acute Sick Leave benefits are eligible for Standard Longevity, Merit Longevity, and Specialty and/or Subspecialty Merit Longevity Increases on applicable Anniversary Dates. All increases other than the Standard Longevity Increases are subject to review and approval.
- (j) A physician may use up to one half of the physician's annual allotment of Acute Sick Leave (eleven [11] days for those hired on or before June 30, 2014, and five [5] days

for those hired on or after July 1, 2014) to care for the physician's child, spouse, or parent who is ill, or a Domestic Partner or the Domestic Partner's child who is ill.

- (k) **Permanente Medicine for Permanente Physicians:** It is the policy of SCPMG that every Permanente physician is encouraged to designate a personal physician and to see that physician on a regular basis. All SCPMG physicians should be registered on kp.org.

Physicians are encouraged to schedule their own preventive care in a way that honors the central importance of patient access. As indicated by age and/or health status, physicians are encouraged to schedule up to one day, or 2W, of Sick Leave per year - in increments as small as 1/2W - for preventive care visits to their personal physician or dentist, or screening procedures ordered by their personal physician. Full-day (2W) preventive care coded as Sick Leave should be reserved for procedures such as Colonoscopy that normally require a full day off. Chiefs of Service and Physicians in Charge may request that physicians provide documentation of preventive care visits or procedures. Special circumstances requiring more extensive use of Sick Leave for preventive care must be approved in advance by the Chief of Service or Physician in Charge, and the Area Medical Director.

## 2. Partners

- (a) Partner physicians will accumulate 20% of their unused Acute Sick Leave to a maximum of 44 working days. This can be used after the initial 22 working days of Acute Sick Leave have been exhausted. Usage of Acute Sick Leave will not change a physician's Anniversary Date. Unlike Chronic Sick Leave, which cannot be restored once it has been used, the 20% accumulation of unused Acute Sick Leave may again be accrued prospectively to the 44-day maximum accumulation following return to work.
- (b) Accumulated Acute Sick Leave time may be used in 25%, 40%, 50%, or 100% increments and integrated with either the Compensation Continuance Program or Medical Group disability insurance payments. In no case, can the Accumulated Acute Sick Leave benefit exceed 40% of the Base Compensation when combined with the Compensation Continuance Program.
- (c) If a Partner physician develops a serious illness or is hospitalized while on approved Leave of Absence, Extended Educational Leave, or Medical Service Leave, the Board of Directors may consider counting this illness as Sick Leave. A Partner's longevity and work history will be taken into consideration by the Board of Directors in its decision. If approved, the physician's other Leave will be terminated, and the physician placed on Sick Leave. The physician will return to active practice upon recovery, and may not resume the previously granted Leave.
- (d) If a Partner who has notified the Executive Medical Director and the Board of Directors of an intent to retire/terminate from the Partnership as of a certain date

becomes ill during the interim period, the Partner will be entitled to Acute Sick Leave and all benefits of the Chronic Sick Leave and disability programs up to the end of the year in which the Partner reaches age 65. A Partner on disability is not eligible for the Early Separation program.

## **B. Chronic Sick Leave**

A physician's Anniversary Date will be adjusted proportionate to the time out of the work schedule while on Chronic Sick Leave, whether the payment is 50%, 25%, or 0% of Base Compensation.

In addition to Acute Sick Leave and Accumulated Acute Sick Leave, Partners are entitled to an amount of Chronic Sick Leave compensation during their entire period of Partnership as follows:

- ◆ Six months with 25% of their Base Compensation. Partnership status then continues for an additional 18 months of Chronic Sick Leave without compensation. In addition, they will receive their share of Year-End Performance Draw.
- ◆ A combination of all Sick Leave programs may not exceed 40% of Base Compensation and 60% of gross compensation when combined with the Compensation Continuance Program.

### 1. Employee Physicians

#### (a) Special Category

Only those physicians approved for Special Category will be allowed to accumulate unused Acute Sick Leave to apply toward Chronic Sick Leave benefits. Chronic Sick Leave will be paid at 50% of Base Compensation.

#### (b) All other Employee Physicians

Other Employee Physicians are not entitled to Chronic Sick Leave.

### 2. Reduced Work Schedule

Physicians who are or have been on a Reduced Work Schedule at any time during their work history will be paid for Chronic Sick Leave on the following basis:

- (a) The percentage of a full working schedule that the physician has worked with Medical Group will be computed as of the end of the calendar year preceding the taking of any Chronic Sick Leave. For periods of Chronic Sick Leave, the physician will be paid that same percentage of current full time Base Compensation subject to the following conditions:





- (1) In making such computations, all unpaid Leaves of Absence will be omitted i.e. will not affect the percentage of time worked.
  - (2) If the percentage of time worked is in excess of 95% of a full working schedule during the physician's work history, no reduction will be made from the current full time Base Compensation.
  - (3) Periods of Reduced Work Schedule will be rounded to the nearest full month period, for example, periods of less than one-half month will be dropped and periods in excess of one-half month will be counted as a full month.
- (b) If a Partner physician must work a reduced work schedule following a major illness or disability lasting at least 30 calendar days, the Partner physician may supplement the temporary pay reduction with Accumulated Acute or partial Chronic Sick Leave and Compensation Continuance or Disability Insurance benefits. The reduced work schedule must be recommended by the attending physician and approved by the Chief of Service and the Area Medical Director.
  - (c) If a physician is approved for part time practice while recuperating, the physician will be paid for the time worked, and the difference between the amount earned and full disability benefits will be paid from Medical Group Sick Leave programs, if available, and either the Compensation Continuance Program (Partners) or the Disability Insurance Program (Full Time Employee Physicians). The physician's Anniversary Date will be adjusted based on the actual amount of Chronic Sick Leave used. The maximum compensation may not exceed the benefits available for full disability.
  - (d) The objectives of the policies are to encourage physicians to return to their practices as early as possible and to conserve as much of their Chronic Sick Leave benefit as possible for the future.
  - (e) At the end of 6 months, or sooner at the request of the physician and with the approval of the Chief of Service and the Area Medical Director, the physician's work schedule will be indefinitely changed to the physician's level of practice. There will be no further adjustment of the Anniversary Date but benefits will be adjusted to reflect the new work pattern.
3. Compensation Adjustments/Increases

Physicians who are on the paid or unpaid Chronic Sick Leave Program are eligible for any Starting Base Salary Compensation Adjustments and/or any General Compensation Adjustments to Base Compensation. Such physicians are not eligible for Standard Longevity, Merit Longevity, Specialty and/or Subspecialty Merit Longevity Increases.

Existing group life and disability insurance amounts will be adjusted for any increase that is effective within six months of a disabled physician's last day worked.

4. Year-End Performance Draw and Withdrawal from the Partnership

A Partner's average work history while a Partner will be used to determine the amount of Year-End Performance Draw the Partner will receive while on Chronic Sick Leave.

A Partner shall be entitled to a share of the Year-End Performance Draw for any period of Acute or Chronic Sick Leave plus six additional months. Thereafter, a Partner who is unable to practice due to illness or injury shall no longer participate in any of the earnings or benefits of the Partnership and shall, at the discretion of the Board of Directors, withdraw from the Partnership. Such Partner, upon recommendation of the Area Medical Director and with approval of the Board of Directors, may resume Partnership status without further Chronic Sick Leave benefits.

5. Retirement Plan Benefits During Chronic Sick Leave

Credit toward retirement under the Retirement Plan for Physicians Serving Members of Kaiser Foundation Health Plan ("Common Plan") will be granted for periods of absence due to illness or temporary disability. The amount of credit is:

(a) up to two years of Qualifying Service for any one condition, or

(b) up to 90 days of Credited Service provided the absence is immediately preceded by a period of other Credited Service.

**C. Other Disability Benefits**

1. Short Term Disability Insurance (STD) – (Available only to Employee Physicians who enroll within sixty (60) days of hire.)

Employee Physicians are eligible for Short Term Disability (STD) Insurance upon written application and payment of the premium. A physician has a one-time opportunity to enroll in the STD plan, and must do so within 60 days of joining Medical Group.

After a 30 calendar-day waiting period (for those hired on or after June 30, 2014), and a 14 calendar day waiting period (for those hired on or after July 1, 2014), the Short Term Disability Insurance will pay 50% of a physician's Base Salary prorated to the work schedule up to a maximum of \$3,462 per week. The Short Term Disability Insurance will continue to pay benefits for up to five months while the physician is certified disabled by the insurance carrier.

2. Compensation Continuance Program – (Available only to Partners.)

All Partners are eligible for Compensation Continuance beginning on the 31st day of disability. Disability will be determined by the attending physician subject to "advice to pay" by the carrier of the Long Term Disability program. The benefit is payable for a maximum of 5 months as long as the Partner remains disabled.

The benefit payable is the greater of:

- ◆ 60% of the Base Compensation in effect at the onset of disability, or
- ◆ 60% of the average monthly gross compensation for the 12 month period ending December 31 or June 30 and immediately preceding the onset of disability.

The Compensation Continuance Program is paid in addition to any Medical Group Sick Leave benefits for which a disabled physician may be entitled. In no case can Medical Group Sick Leave benefits exceed 40% of the Base Compensation when combined with the 60% Compensation Continuance program.

### 3. Long Term Disability Insurance

All physicians, except Per Diem, are eligible for Long Term Disability Insurance upon written application and payment of the premium. This benefit must be applied for within 60 days of joining Medical Group. A physician who does not apply within 60 days of joining Medical Group will not be eligible for this insurance plan until the physician becomes a Partner. A physician must pay for this benefit; upon becoming a Partner, it is paid for by Medical Group.

A physician qualifies for benefits after he or she has been disabled for 6 calendar months and is unable to perform all the material duties of his or her regular occupation, or unable to earn more than 80% of Indexed Covered Earnings (*see the SCPMG Benefits Handbook for Physicians*) for the first 60 months of disability.

After 60 months, the physician qualifies for benefits if unable to perform all the material duties of any occupation for which the physician may reasonably become qualified based on education, training, or experience, or if unable to earn more than 80% of indexed covered earnings. Long Term Disability Insurance benefits continue while so disabled up to age 65 and pays the greater of:

- ◆ 50% of the Base Compensation in effect at the onset of disability, or
- ◆ 50% of the average monthly gross compensation for the 12 month period ending December 31, or June 30, immediately preceding the onset of disability.

Long Term Disability Insurance benefits will not exceed the maximum specified in the policy.

### 4. Benefits Continuation While Disabled

(a) Kaiser Foundation Health Plan Coverage, Alternate Mental Health, Dental Care Program and Major Medical Insurance:

- (1) Partners

These benefits will continue and will be paid for by Medical Group until the end of the month of the Partner's Partnership termination date (upon the expiration of all paid and unpaid Sick Leave).

(2) Employee Physicians

These benefits will continue and will be paid for by Medical Group for three months beyond the exhaustion of the physician's paid Sick Leave (Acute and any Accumulated Chronic Sick Leave).

Per Diem physicians are not eligible for these benefits.

Part Time Physicians are eligible for Kaiser Foundation Health Plan coverage only and must pay 50% of the cost. If they were enrolled prior to disability, they may continue the coverage as indicated above by continuing to pay 50% of the cost.

(b) Permanente Provided Life Insurance

If enrolled prior to disability, if approved under the Waiver of Premium provision of the disability policy, and if the disability occurs before age 60 and continues for six (6) consecutive months, these benefits will continue to be provided for Partners and eligible Employee Physicians until the waiver period expires. If the physician elects his or her "Common Plan" option prior to becoming eligible for Waiver of Premium, these benefits cease upon the election of the "Common Plan" option.

(c) Optional Life Insurance

If enrolled prior to disability, Partners and eligible Employee Physicians may continue this insurance at their own expense. If the disability occurs before age 60 and continues for six (6) consecutive months, this coverage will continue under the Waiver of Premium provision of the disability policy.

(d) Long Term Disability Insurance

While receiving Long Term Disability benefits, the premiums for this benefit are waived.

## 8 PHYSICIAN BENEFITS

### A. The SCPMG Benefits Handbook for Physicians

The *SCPMG Benefits Handbook for Physicians* which is hereby incorporated by reference provides a detailed explanation of all benefits. Please refer to the Handbook for information regarding benefits.

### B. Early Separation Program (ESP) - Formerly known as the Full Early Retirement (FER) Plan:

The Southern California Permanente Medical Group maintains an Early Separation Program. The intent of this program is to provide Partners between the ages of 58 and 65, who meet the qualifications, with an opportunity for complete early retirement. Benefits are available under this program only with the Board of Directors' approval.

#### **Application to Retire Under the Early Separation Program:**

A Partner must apply to retire under the Early Separation Program one year before the effective date of benefits. The effective date selected may be any date subsequent to the physician's 58th birthday as long as the effective date is a regular work day for the Partner and the last day to be worked or an approved day of Vacation Leave. However, the Board of Directors may waive all or part of the one-year notice period. Thus, a Partner may apply for retirement under the Early Separation Program as early as age 57, but benefits never begin before age 58. Also, as stated above, benefits are available under the Early Separation Program only if approved by the Board of Directors. The Board of Directors may approve, deny or delay an Early Separation. If Early Separation is approved, then the Board of Directors may set conditions related to such approval. If the Board of Directors delays An Early Separation, then it cannot do so for more than one year. Once the notice of Early Separation is given, the notice is irrevocable (except upon a written application by the Partner to the Board of Directors, and approval by the Board of Directors). As a condition of approval by the Board of Directors for Early Separation, every SCPMG physician shall be required to execute a release of all claims based directly or indirectly upon employment or Partnership with SCPMG, or the termination of employment or Partnership with SCPMG. Excluded from the release will be all claims that the physician as a patient has received negligent medical care from another SCPMG physician. Physicians approved for Early Separation on October 25, 2007, or later who do not sign such a release within 45 days of eligibility to commence benefits will forfeit all Early Separation benefits, except as may be directed by the Board of Directors on a case-by-case basis.

Benefits are paid from the Partnership's current operating funds. If the Partnership is terminated, Early Separation benefits stop. If, due to economic circumstances, the Base Compensation of active Partners is reduced, the Board of Directors may reduce the Early Separation payments in the same proportion.

### C. Former Kaiser Foundation Hospitals (KFH) Residents

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A former KFH Resident will be eligible for reimbursement of any dues paid by the physician for Health Plan coverage for the physician and eligible dependents provided the physician joins Medical Group in a category other than Per Diem no later than 90 days after the completion of the residency.

**9 PROCEDURES RELATING TO FEDERATION FUNDING, PAYMENTS TO TERMINATING PARTNERS AND FEDERATION DISTRIBUTIONS**

These Procedures are effective as of January 1, 1998 and are for the purpose of establishing rules and procedures relating to (i) the funding of assessments imposed by The Permanente Federation, L.L.C. (the “Federation”) on its Members (including SCPMG), (ii) the payment of bonuses to Partners who terminate from SCPMG in order to reflect their pro rata share in the value of SCPMG’s interest in the Federation, and (iii) the allocation among Partners of amounts distributed by the Federation to SCPMG.

**A. Definitions**

Whenever the following words and phrases are used in this section of the Rules and Regulations with the first letter capitalized, they shall have the meanings specified below.

“Assessment” shall mean an amount which is imposed periodically by the Federation on its Members in order to fund certain activities of the Federation as described more fully in the Operating Agreement.

“Medical Director” shall mean the Medical Director of Business Management of Southern California Permanente Medical Group.

“Beneficiary” or “Beneficiaries” shall mean the person or persons, including a trustee, personal representative or other fiduciary, last designated in writing by a Partner in accordance with procedures established by the Executive Medical Director or his or her delegate to receive the amounts specified hereunder in the event of the Partner’s death. The Beneficiary shall be the person last designated as the beneficiary for Permanente Provided Life Insurance. If the Partner does not have Permanente Provided Life Insurance or wishes to designate a different Beneficiary, the Partner may do so in writing in accordance with procedures established by the Executive Medical Director or his or her delegate. If the Partner is married, no beneficiary designation of someone other than the Partner’s spouse shall be effective unless such designation is consented to by the Partner’s spouse on a form provided by and in accordance with the procedures established by the Executive Medical Director or his or her delegate. If there is no Beneficiary designation in effect, or if there is no surviving designated Beneficiary, then the Partner’s surviving spouse shall be the Beneficiary. If there is no surviving spouse to receive any benefits payable in accordance with the preceding sentence, the duly appointed and currently acting personal representative of the Partner’s estate (which shall include either the Partner’s probate estate or living trust) shall be the Beneficiary. In any case where there is no such personal representative of the Partner’s estate duly appointed and acting in that capacity within 90 days after the Partner’s death (or such extended period as the Executive Medical Director or his or her delegate determines is reasonably necessary to allow such personal representative to be appointed, but not to exceed 180 days after the Partner’s death), then Beneficiary shall mean the person or persons who can verify by affidavit or court order to the satisfaction of the Executive Medical Director that they are legally entitled to receive the payments specified hereunder. In the event any amount is payable under these Procedures to a minor, payment shall not be made to the minor, but instead be paid (a) to that person’s living parent(s) to act as custodian,

(b) if that person's parents are then divorced, and one parent is the sole custodial parent, to such custodial parent, or (c) if no parent of that person is then living, to a custodian selected by the Executive Medical Director to hold the funds for the minor under the Uniform Transfers or Gifts to Minors Act in effect in the jurisdiction in which the minor resides. If no parent is living and the Executive Medical Director decides not to select another custodian to hold the funds for the minor, then payment shall be made to the duly appointed and currently acting guardian of the estate for the minor or, if no guardian of the estate for the minor is duly appointed and currently acting with 60 days after the date the amount becomes payable, payment shall be deposited with the court having jurisdiction over the estate of the minor.

“Bonus Payment” shall mean that payment due a retiring physician as determined under Section 9.E.

“Capital Contribution” shall mean an amount determined by the Board of Directors contributed by every Partner to SCPMG that shall be repaid in accordance with this Section 9.

“Exhibit” shall mean the bookkeeping record maintained by SCPMG for each Fiscal Year that identifies the Loans and/or Capital Contributions made by Partners to SCPMG pursuant to these Procedures.

“Federation” shall mean The Permanente Federation L.L.C.

“Federation Distribution” shall mean an amount distributed by the Federation to SCPMG pursuant to the Operating Agreement; provided, however, that such term shall not include distributions by the Federation designed to enable the SCPMG Partners to pay their taxes on Federation income.

“Federation Value” shall mean the value of SCPMG's interest in the Federation plus the value of SCPMG's interest in Optimal Renal Care.

“Fiscal Year” shall mean the 12 consecutive month period beginning January 1 and ending December 31.

“Health Plan” shall mean Kaiser Foundation Health Plan, Inc.

“Interest” shall mean accrued earnings on capital held in the Investment Reserve Fund.

“Investment Reserve Fund” shall mean the fund established and maintained by SCPMG pursuant to Section 9.D.

“Loan” shall mean an amount deemed to be loaned by a Partner to SCPMG on a recourse basis pursuant to Sections 9.B.2(b), 9.B.3(b), and 9.E.3(c).

“Executive Medical Director” shall mean the Executive Medical Director of the Southern California Permanente Medical Group.



“Medical Services Agreement” shall mean the agreement between SCPMG and Health Plan which describes the terms and conditions relating to SCPMG’s provision of medical services to enrollees of Health Plan.

“Members” shall mean those entities which are members of the Federation, including SCPMG.

“Operating Agreement” shall mean the Operating Agreement of The Permanente Federation L.L.C.

“Payment Eligibility Date” shall mean the date as soon as administratively feasible following the date a Partner terminates from SCPMG.

“Procedures” shall mean these Procedures Relating to Federation Funding, Payments to Terminating Partners and Federation Distributions.

“SCPMG” shall mean Southern California Permanente Medical Group.

“Share Unit” shall mean a non-voting unit of measurement which is deemed solely for bookkeeping purposes under these Procedures to have a value derived as set forth at Section 9.E.3(b).

“Share Unit Account” shall mean a bookkeeping account maintained by SCPMG for each Partner that is credited with any Share Units, whether vested or unvested.

“Valuation Date” shall mean the December 31 of each Fiscal Year or such other dates as may be selected by the Executive Medical Director or his or her delegate.

“Year of Partnership Service” shall mean the twelve-month period commencing with the date that an individual becomes a Partner of SCPMG or any anniversaries thereof, provided that in either case the individual is in service as a Partner on the last day of such twelve-month period. A Partner shall receive credit for full Years of Partnership Service completed prior to the date of adoption of these Procedures.

## **B. Funding of Federation Assessments**

### 1. Federation Assessments

The Federation may periodically impose Assessments on SCPMG. Each Assessment shall be considered to be a liability of SCPMG that may only be paid in accordance with these Procedures. If the Federation imposes an Assessment on SCPMG during the Fiscal Year, SCPMG may require each Partner, in the manner and under the circumstances described in Section 9.B.2, to contribute a pro rata amount toward payment of the Assessment.

### 2. Funding of Federation Assessments

(a) Funding of Federation Assessments.

If the Federation imposes an Assessment on SCPMG during the Fiscal Year, and if the Assessment cannot otherwise be satisfied by (i) payments made by Health Plan to SCPMG during the Fiscal Year pursuant to the Medical Services Agreement, (ii) Federation Distributions received by SCPMG during the Fiscal Year, or (iii) amounts held in the Investment Reserve Fund, or any combination thereof, SCPMG shall require each Partner to make a pro rata loan toward the payment of such Assessment. The determination of the amount to be contributed by each Partner shall be made by the Board of Directors or its designee.

(b) Partner Loans.

The amount that each Partner is required to loan pursuant to Sections 9.B.2(a), 9.B.3(b), and 9.E.3(c) shall represent a separate Loan made by the Partner to SCPMG. If a Partner is required to make a Loan to SCPMG, such amount shall be withheld by SCPMG from amounts otherwise distributable to the Partner. SCPMG shall establish and maintain a separate Exhibit for each Fiscal Year which identifies Loans made by Partners during such Fiscal Year. A Partner's Loan balance set forth on an Exhibit shall be treated as a debt of the Partnership.

(c) Capital Contributions.

The amount that each Partner is required to contribute pursuant to Sections 1.G, 9.B.2(a), 9.B.3(b), and 9.E.3(c) [see Partnership Agreement, Article 5]. If a Partner is required by the Board of Directors to make a Capital Contribution to SCPMG, such amount shall be withheld by SCPMG from amounts otherwise distributable to the Partner. If a Partner's pro rata share of distributions does not cover the full capital contribution, the monies will be withheld from the physician's draw checks over 5 consecutive pay periods. SCPMG shall establish and maintain a separate Exhibit for each Fiscal Year which identifies Capital Contributions made by Partners during such Fiscal Year.

3. Repayment of Loans/Capital Contributions

(a) Repayment of Loans and/or Capital Contributions Prior to Termination.

Except to the extent otherwise required by Sections 1.G and 9.C.1, SCPMG shall repay outstanding Loans (plus accrued interest) to Partners as soon as administratively practical following SCPMG's receipt of a Federation Distribution. SCPMG shall repay Loans in chronological order, i.e. the oldest Loans shall be repaid first. SCPMG may repay Capital Contributions from Federation Distributions prior to Termination at the discretion of the Board of Directors.

(b) Repayment of Loans or Capital Contributions and Terminating Partners; Source of Payments to Terminating Partners.

Notwithstanding Section 9.B.3(a), in the event that a Partner terminates from SCPMG, the terminating Partner shall be repaid his or her outstanding Loan and Capital Contribution balances (including accrued interest) as set forth in the Exhibits,

as of the Partner's Payment Eligibility Date. SCPMG may repay a terminating Partner his or her outstanding Loan and Capital Contribution balances from one or any combination of the following sources of funds:

- (1) Subject to Section 9.C.1, Federation Distributions which are received by SCPMG during the Fiscal Year; or
- (2) Amounts credited to the Investment Reserve Fund.

In the event the amounts in (i) and (ii) above are insufficient to repay Loans and Capital Contributions to terminating Partners, such Loans and Capital Contributions shall be repaid from new loan assessments or Capital Contributions on remaining Partners. Such new loans and/or Capital Contributions shall be treated as additional Loans and Capital Contributions made pursuant to and accounted for in accordance with Section 9.B.2(b). Such additional Loans and/or Capital Contributions shall be repaid in accordance with this Section 9.B.3.

### **C. Federation Distributions**

#### 1. Allocation of Federation Distributions

The Federation may periodically make Federation Distributions to SCPMG in connection with its activities. Federation Distributions received by SCPMG during the Fiscal Year shall be utilized in the following order:

- (a) First, Federation Distributions shall be used by SCPMG to satisfy any Partner Loans which would otherwise be imposed during such Fiscal Year pursuant to Sections 1.G, 9.B.2(b), 9.B.3(b), or 9.E.3(c);
- (b) Second, any remaining portion of the Federation Distribution shall be used to repay Loans or Capital Contributions owed to terminating Partners in accordance with Section 9.B.3(b);
- (c) Third, any remaining portion of the Federation Distribution shall be used to make bonus payments to terminating Partners in accordance with Section 9.E;
- (d) Fourth, at the discretion of the Board any remaining portion may be used to make a distribution to active Partners to enable them to pay some or all of the taxes which may be due for a particular year on account of undistributed taxable income from the Federation or the Investment Reserve Fund;
- (e) Fifth, any remaining portion of the Federation Distribution shall be used to repay Loans to non-terminating Partners in accordance with Section 9.B.3(a);
- (f) Sixth, at the discretion of the Board any remaining portion may be used to repay Capital Contributions to non-terminating Partners in accordance with Section 9.B.3(a); and



- (g) Finally, any remaining balance of the Federation Distribution shall be contributed to the Investment Reserve Fund in accordance with Section 9.D.1.

**D. Investment Reserve Fund**

1. Establishment of Investment Reserve Fund

SCPMG shall establish and maintain an Investment Reserve Fund for the purpose of funding its obligations hereunder. The Investment Reserve Fund shall be maintained in a separate account and shall be credited with any Capital Contributions not currently needed to fund Federation assessments to pay terminating Partners and with that portion of each Federation Distribution, if any, that is allocated to the Investment Reserve Fund pursuant to Section 9.C.1(e). The amounts in the Investment Reserve Fund shall be invested as directed by the Executive Medical Director or his or her designee and gains and losses from such investments shall be debited or credited to the Investment Reserve Fund. The Board of Directors shall receive quarterly statements as to the status of the investments. No Partner shall be treated as having any interest or claim to any of the assets allocated to the Investment Reserve Fund.

2. Distributions from Investment Reserve Fund

The Investment Reserve Fund shall be distributed in the following order:

- (a) First, the Investment Reserve Fund shall be used to satisfy any Assessments which would otherwise be imposed on Partners during a Fiscal Year pursuant to Section 9.B.2(b);
- (b) Second, the Investment Reserve Fund may be used to pay Loans or Capital Contributions to terminating Partners in accordance with Section 9.B.3(b);
- (c) Third, the Investment Reserve Fund shall be used to satisfy any bonus payments to terminating Partners required to be made by SCPMG during the Fiscal Year in accordance under Section 9.E;
- (d) Fourth, at the discretion of the Board any remaining portion may be used to make a distribution to active Partners to enable them to pay some or all of the taxes which may be due for a particular year on account of undistributed taxable income from the Federation or the Investment Reserve Fund;
- (e) Fifth, the Investment Reserve Fund shall be used to repay Loans; and
- (f) Finally, at the discretion of the Board, the Investment Reserve Fund may be used to repay Capital Contributions to non-terminating Partners in accordance with Section 9.B.3(a).

**E. Bonus Payments**

1. Share Unit Account

- (a) SCPMG shall establish and maintain a Share Unit Account for each Partner. A Partner's Share Unit Account shall be a memorandum account on the books of SCPMG. The Share Units credited to a Partner's Share Unit Account shall be used solely as a device for the determination of the amount to be eventually distributed to a terminating Partner in accordance with this Section 9.E. The Share Units shall not be treated as property or as a trust fund of any kind. No Partner shall be entitled to voting or other rights with respect to Share Units granted under this Section 9.E.1.
- (b) Each Partner's Share Unit Account shall be credited with one Share Unit for each full Year of Partnership Service completed by the Partner after January 1, 1998. Share Units shall be credited as of the last day of the relevant Year of Partnership Service for the Partner.

2. Vesting

- (a) A Partner's Share Unit Account shall become vested as follows:

Total Years of Partnership Service	Percentage Vested
Less than five	0%
Five or more	100%

- (b) Additional vesting rules relating to Partners who terminate from SCPMG are set forth in Section 9.E.5.

3. Bonus Payment to Terminating Partner

- (a) If a Partner terminates from SCPMG for any reason, on the Partner's Payment Eligibility Date, the Partner (or, in the case of his or her death, Beneficiary) shall be paid the fair market value of the vested Share Units credited to his or her Share Unit Account in the form of a cash lump sum. The fair market value of Share Units shall be determined as of the Valuation Date immediately preceding the Partner's termination from SCPMG and in accordance with Section 9.E.3(b). Non-vested Share Units shall be forfeited as of the date of the Partner's termination.
- (b) As of each Valuation Date, the Executive Medical Director of SCPMG or his or her delegate shall determine the value of Share Units in the manner described below. First, the Executive Medical Director or his or her delegate shall confirm the value ("Federation Value") of SCPMG's interest in the Federation as of the Valuation Date as determined by the Executive Committee of the Federation pursuant to the Operating Agreement. Next, the value per Share Unit shall be computed by dividing (i) by (ii), where (i) is an amount equal to the sum of the Federation Value plus the Investment Reserve Fund, less the aggregate outstanding Loan and Capital Contribution balances of all Partners set forth on the exhibits, and (ii) is the total number of Share Units (vested and unvested share units) credited to Partners' Share Unit Accounts.

- (c) In the event there are insufficient funds available to pay a Bonus Payment from either (i) current Federation distributions, or (ii) the Investment Reserve Fund, each non-terminating Partner shall be required to make a pro rata loan or Capital Contribution, at the discretion of the Board of Directors and within the limits of the Partnership Agreement, toward the payment of such bonus payment. The amount that each Partner is required to loan or contribute in accordance with the preceding sentence shall be deemed to be an additional Loan and/or Capital Contribution made pursuant to and accounted for in accordance with Section 9.B.2(b). Such additional Loans and/or Capital Contributions shall be repaid in accordance with Section 9.B.3.

4. Tax Treatment of Bonus Payments

For tax purposes, the Bonus Payment to each Terminating Partner shall be treated as follows:

- (a) First, as a payment made in liquidation of such Partner's interest in the SCPMG Partnership to the extent of such Partner's positive tax basis; and
- (b) The balance, if any, as a guaranteed payment described in Section 707(c) of the Internal Revenue Code of 1986, as amended.

5. Termination followed by Return to Service

- (a) If a Partner terminates from SCPMG and is paid the fair market value of the vested Share Units credited to his or her Share Unit Account in accordance with Section 9.E.3, and if such Partner rejoins the Partnership, any Share Units credited to the Partner's Share Unit Account following his or her return to service shall be fully vested. The Share Units previously paid to such Partner at termination shall not be reinstated upon his or her return to the Partnership.
- (b) If a Partner terminates from SCPMG and forfeits the non-vested Share Units credited to his or her Share Unit Account in accordance with Section 9.E.3, and if such Partner rejoins the Partnership, the Partner's previously forfeited Shares Units shall be reinstated to his or her Share Unit Account subject to the vesting requirements of Section 9.E.2. For purposes of determining the Partner's vested interest in his or her Share Unit Account following a return to service with the Partnership, the Partner shall receive prior service credit for Years of Partnership Service completed prior to his or her termination.

**F. Miscellaneous**

1. Administration

The Executive Medical Director or his or her delegate, on behalf of the Partners and their Beneficiaries, shall be charged with the general administration of the Procedures, and shall have all powers necessary to accomplish the purposes of the Procedures, including, but not by way of limitation, the following:

- (a) To construe and interpret the terms and provisions of these Procedures;
- (b) To compute and certify to SCPMG the amount payable to Partners and their Beneficiaries;
- (c) To maintain all records that may be necessary for the administration of these Procedures;
- (d) To make and publish such rules for the administration of the Procedures as are not inconsistent with the terms hereof; and
- (e) To authorize all disbursements by SCPMG pursuant to these Procedures.

2. Construction and Interpretation

The Executive Medical Director or his or her delegate shall have full discretion to construe and interpret the terms and provisions of these Procedures, which interpretation or construction shall be final and binding on all parties, including but not limited to SCPMG and any Partner or Beneficiary.

3. Expenses and Indemnity

- (a) The Executive Medical Director is authorized at the expense of SCPMG to employ such legal counsel as it may deem advisable to assist in the performance of its duties hereunder. Expenses and fees in connection with the administration of these Procedures shall be paid by SCPMG.
- (b) To the extent permitted by applicable state law, SCPMG shall indemnify and save harmless the officers and directors of SCPMG against any and all expenses, liabilities, and claims (including legal fees) arising out of their discharge in good faith of responsibilities under or incident to these Procedures, other than expenses and liabilities arising out of willful misconduct. This indemnity shall not preclude such further indemnities as may be available under insurance purchased by SCPMG or provided by SCPMG under any agreement or otherwise, as such indemnities are permitted under state law.

4. Unsecured General Creditor

Partners and their Beneficiaries, heirs, successors, and assigns shall have no legal or equitable rights, claims, or interest in any specific property or assets of SCPMG. No assets of SCPMG shall be held under any trust, or held in any way as collateral security for the fulfilling of the obligations of SCPMG under these Procedures. Any and all of SCPMG's assets shall be, and remain, the general unpledged, unrestricted assets of SCPMG. SCPMG's obligation under Section 9.E. of these Procedures shall be merely that of an unfunded and unsecured promise of SCPMG to pay money in the future, and the rights of the Partners and Beneficiaries shall be no greater than those of unsecured general creditors.

5. Restriction Against Assignment

SCPMG shall pay all amounts payable hereunder only to the person or persons designated by these Procedures and not to any other person or corporation. No part of a Partner's interest under these Procedures shall be liable for the debts, contracts, or engagements of any Partner, his or her Beneficiary, or successors in interest, nor shall a Partner's interest under these Procedures be subject to execution by levy, attachment, or garnishment or by any other legal or equitable proceeding, nor shall any such person have any right to alienate, anticipate, commute, pledge, encumber, or assign any benefits or payments hereunder in any manner whatsoever. If any Partner, Beneficiary, or successor in interest is adjudicated bankrupt or purports to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge any distribution or payment from these Procedures, voluntarily or involuntarily, the Executive Medical Director or his or her delegate, in his or her discretion, may cancel such distribution or payment (or any part thereof) to or for the benefit of such Partner, Beneficiary, or successor in interest in such manner as the Executive Medical Director shall determine.

6. Amendment, Modification, Suspension or Termination

SCPMG may amend, modify, suspend, or terminate these Procedures in whole or in part at any time in writing.

7. Governing Law, Severability

These Procedures shall be construed, governed, and administered in accordance with the laws of the State of California. If any provisions of this instrument shall be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

8. Receipt or Release

Any payment to a Partner or the Partner's Beneficiary in accordance with the provisions of these Procedures shall, to the extent thereof, be in full satisfaction of all claims against the Executive Medical Director and SCPMG. The Executive Medical Director may require such Partner or Beneficiary, as a condition precedent to such payment, to execute a receipt and release to such effect.

9. Payments on Behalf of Persons Under Incapacity

In the event that any amount becomes payable under these Procedures to a person who, in the sole judgment of the Executive Medical Director or his or her delegate, is considered by reason of physical or mental condition to be unable to give a valid receipt therefore, the Executive Medical Director or his or her delegate may direct that such payment be made to any person found by the Executive Medical Director or his or her delegate, in his or her sole judgment, to have assumed the care of such person. Any payment made pursuant to such determination shall constitute a full release and discharge of the Executive Medical Director, his or her delegate, and SCPMG.



10. No Right to Service

These Procedures shall not give any person the right to continued service or any rights or interests other than as herein provided. No Partner shall have any right to any payment or benefit hereunder except to the extent provided in these Procedures.

11. Headings, etc. Not Part of Agreement

Headings and subheadings in these Procedures are inserted for convenience of reference only and are not to be considered in the construction of the provisions hereof.

12. Gender

Concerning the words used in these Procedures, the feminine gender shall include the masculine or neuter gender, and vice versa, as the context requires.

## **10 MISCELLANEOUS**

### **A. Reimbursement for Expenses**

As a matter of policy, Medical Group does not reimburse physicians for professional expenses such as automobiles, travel, meals, professional education, professional journals, professional dues, professional licenses, etc. A physician will only be entitled to reimbursement of professional expenses when it meets the eligibility requirements of an Affirmative Policy (see “Reimbursement for Courses, Certification, or Recertification” below):

#### **1. Reimbursement for Courses, Certification or Recertification**

In the event a Medical Center sponsored program is offered, physicians are encouraged to obtain the necessary training / certification through these venues. However, in the event a physician must participate in an outside program, the physician will be reimbursed for the course fee and / or certification fee that is necessary or desirable for performing specific functions for SCPMG.

In order for SCPMG to reimburse these fees, SCPMG must request in writing that the physician take the course and/or become certified or recertified and receive authorization for reimbursement prior to enrolling in, or applying for, the course or certification.

Some examples include Basic Life Support (BLS), Advance Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), Neonatal Resuscitation Provider (NRP) Certification, Society for Healthcare Epidemiology of America (SHEA) certification, Human Immunodeficiency Virus (HIV) certification, Fluoroscopy, and Densitometry courses and certifications.

Fees for professional licenses that are required to practice in the State are not reimbursed by SCPMG. This includes licensing by the Medical Board of California, the Osteopathic Medical Board of California and the Drug Enforcement Agency. Continuing Medical Education fees for courses required to maintain these licenses are not reimbursed by SCPMG.

Specialty board certifications and recertifications and certificates of added qualification fees are not reimbursed since appropriate adjustments are reflected in the Base Compensation for each physician’s specialty.

Exceptions or new requests must be approved by the collective Medical Directors.

#### **2. Reimbursement Process**

Physicians will submit a request for reimbursement on the appropriate expense report. The Chief of Service and Area Medical Director will review and approve the expense, if appropriate. A medical center may pay for a vendor or others to present the course to their physicians on campus. Time taken for courses and certification tests will be taken as Education Half Day (ET), Educational Leave (EL), Vacation Leave (VL), or Leave of

Absence (LOA), except as noted in Section 6.B.1(b) (above). Exceptions must be approved by the collective Medical Directors.

## **B. Conflict of Interest**

All physicians, except Part Time and Per Diem, whether employees or Partners of Medical Group, are required to refrain from investing in or performing services for any organization or entity which provides medical care services to patients in those areas of Southern California serviced by Medical Group. Such services include not only physician services but also such support activities as laboratory, diagnostic imaging, and physiotherapy services as well as the sale of pharmaceutical, optical, and medical appliances. Additionally, physicians are required to refrain from referral of KP members to a product or service in which the referring physician or the physician's family member has a financial interest.

A potential conflict of interest is also created whenever a physician can influence a purchase from a Kaiser Permanente Medical Care Program supplier and the physician has any interest in that supplier. In addition to the foregoing, it will be considered a conflict of interest of a Partner of Medical Group to be a member of any organization which has or seeks any business relationship with Medical Group or with the Kaiser Permanente Medical Care Program.

A physician who finds himself or herself in violation of the prohibitions set forth in this rule must take immediate action to sever the relationship with such outside entities and/or organizations.

A physician, other than Part Time or Per Diem, prior to being hired by Medical Group, must bring any conflict of interest to the attention of the physician's Area Medical Director. The Area Medical Director and the Executive Medical Director will determine what action, if any, is to be taken by Medical Group and will maintain documentation of any potential conflict. Any potential conflict will be divested as soon as practical as determined by the Executive Medical Director.

Examples of activities which will not be considered a "conflict of interest" are:

1. Investment in:
  - (a) manufacturing companies;
  - (b) drug manufacturing and wholesale pharmaceutical firms;
  - (c) an organization or company outside the Southern California service area which provides medical care services to patients; or
  - (d) any publicly held stock.
2. Performance of services for the Armed Service, active or reserve, or California National Guard, on non-Medical Group time, upon approval by the Board of Directors.

## **C. Income from Outside Sources**



All income obtained by Partner or Employee Physicians (other than Part Time and Per Diem) from professional sources outside of Medical Group including private patients, research, teaching, or related assignments will be Medical Group income, and such income will be turned over to the Partnership. When such income is earned during work time, the income will be credited to the budget of the earning physician's Area.

Any physician who is required to join another medical group in order to teach at a medical school or residency program may do so if no services are provided by the physician other than those associated with such teaching. Participation in such a medical group is subject to review and approval by the physician's Chief of Service, the Area Medical Director, and Medical Director of Quality and Clinical Analysis. If approved, any income earned which is attributable to the physician's teaching activities may be assigned to the faculty medical group.

Physicians, other than Per Diems, may not engage in any activity outside of SCPMG assigned duties that requires a medical license or medical expertise unless approved by the SCPMG Board of Directors, with the following exceptions: Physicians may author, on their personal time, books, chapters, or articles, and retain any royalties, so long as the physician's association with Medical Group or Kaiser Permanente is not used to promote the publication and no Kaiser Permanente proprietary or confidential information is used in the publication. Physicians may develop, promote, and sell intellectual property, so long as absolutely no Kaiser Permanente resources are used in the process. Such Kaiser Permanente resources include, but are not limited to, Kaiser Permanente facilities, computers, computer software, email, equipment, work space, storage space, work time, telephones, faxes, work processes, intellectual property (whether patented, copyrighted, trademarked, or not), patients/members, physicians and other workers, the names of the Kaiser Permanente Medical Care Program, the names of the entities that comprise the Kaiser Permanente Medical Care Program and similar names, and anything of value belonging to any of the legal entities comprising the Kaiser Permanente Health Care Program. Physicians may volunteer their personal time and efforts at a not-for-profit entity, so long as such activities do not conflict with SCPMG assigned duties and no Kaiser Permanente resources are used in the activity, unless separately approved. Physicians who wish to be insured against professional liability claims while working for a not-for-profit entity must apply for and receive approval from SCPMG prior to engaging in that activity.

All legal and expert witness fees and fees for completion of insurance forms are Medical Group income and will be turned over to the Partnership.

Honoraria received by physicians for teaching and lectures, reviewing Kaiser Permanente Institutional Review Board (IRB) research proposals at the request of the IRB Committee, or compensation for participating in Medical Board of California, the Osteopathic Medical Board of California or Peer Review Organization activities, if not performed on Medical Group time (i.e. Educational Leave, Vacation Leave, or personal time) and if performed at no expense to Medical Group, may be retained by the physician subject to approval of the physician's Area Medical Director and the Executive Medical Director. An honorarium is a token amount paid to honor a person engaged in an activity that is inherently rewarding and of general benefit. An honorarium is never hourly compensation.

All honoraria and reimbursement for expenses which are to be retained by the physician must be approved in advance by the physician's Area Medical Director and the Medical Director of Quality and Clinical Analysis or their designees. The Area Medical Director's assessment will include, but not necessarily be limited to, evaluating whether the activity will be performed on personal time, whether the physician will represent the Group well, and whether the physician is providing excellent care to the physician's patients and contributing adequately to the care responsibilities of the physician's department. The Medical Director of Quality and Clinical Analysis's assessment will include, but not necessarily be limited to, evaluating whether the activity seeks to promote a clinical practice that has been judged by the Group to be beneficial for our patients, or represents a conflict of interests or is otherwise contrary to the best interests of the Group or its patients. Honoraria may be received for educational activities only if the event has been approved for physician Continuing Medical Education (CME). Non-CME activities must be sponsored by a nonprofit entity that is not a vendor or competitor.

All payment of honoraria and reimbursement for expenses must be to Medical Group. Payment to the physician will be from Medical Group. A physician may not receive from Medical Group a payment in excess of the rate of compensation the physician receives for clinical duties calculated on an hourly basis for time spent on the activity and any required preparation time, plus reimbursement for reasonable expenses. Paid preparation time may not exceed the time of the activity or one W. The collective Medical Directors may make exceptions to the above limitations, but in no case will the compensation received by a physician exceed the physician's regular W rate, plus reasonable expenses (as determined by the collective Medical Directors). All exceptions will be reported annually to the Board of Directors.

Effective in 2011, physicians who deliver a one hour or longer presentation to an SCPMG symposia or an SCPMG maintenance of certificate program will be eligible to receive up to \$500. The collective Medical Directors may modify the amount of this payment. A report of presentation payments will be provided annually to the Board of Directors.

Physicians may not accept offers from outside vendors to pay the cost of travel and/or attendance at product demonstrations, educational programs, conventions, or conferences unless approval is obtained in advance from the Area Medical Director. The request for approval must state in detail the reason why acceptance of vendor sponsorship is being proposed rather than sponsorship by Kaiser Permanente and the approximate value of the vendor sponsorship.

Physicians may be approved to attend meetings as described above if:

1. it is not performed on Medical Group time (i.e. on the physician's Educational Leave, Vacation Leave, or personal time),
2. the physician could not be influenced by this company to make an organizational decision,
3. nothing of substantial value is received by the physician from a vendor,
4. the activity has a clinical educational basis, and



5. these trips are available to all physicians who use the product, in and out of our Program, regardless of their ability to influence the purchase of the product by any organization.

The Area Medical Director must determine whether the meeting qualifies and whether or not to approve attendance by the physician(s). In addition, the Medical Director of Quality and Clinical Analysis may approve a clinical investigator conducting Kaiser Permanente IRB research to attend meetings necessary for that research. Travel expenses related to attending these meetings may be directly arranged and paid by the sponsor of the trial for the physician or reimbursed by the sponsor directly to the physician with full disclosure and transparency to the physician's Area Medical Director and the Director of Clinical Trials.

Physicians selected by an Area Medical Director to serve as a quality improvement organization (QIO) reviewer for Medicare in California may serve one half day per week. The physician will be paid his or her usual rate of pay plus Medical Group mileage, and the income and mileage paid by QIO will be Medical Group income. Medical Group physicians may volunteer as QIO reviewers on their Non-Scheduled Half Day or after regular hours and retain both QIO hourly payment and the mileage reimbursement paid to reviewers.

#### **D. Patient Gifts to Physicians**

Gifts and bequests from patients to SCPMG physicians will not be considered income from outside sources for the purposes of Section 10.C. and will not be considered Partnership earnings for the purpose of Partnership Agreement Article 4 with the following exception.

If a SCPMG physician feels that a particular gift or bequest to any SCPMG physician represents a conflict of interest or gives the appearance of patient preference, he or she may request an evaluation by the Dispute and Request Committee (DRC). If the DRC finds a conflict of interest or any appearance of patient preference, the DRC may declare such gift or bequest to be Partnership income and the physician will transfer the gift or bequest to Medical Group. Alternatively, if the DRC finds a conflict of interest or any appearance of patient preference, the DRC may direct that the gift will be retained by the donor person, trust or estate and the physician may not retain the gift. The physician recipient may appeal the decision of the DRC according to the Dispute Resolution Procedure (Section 1.I).

#### **E. Salary Advances and Bank Loans**

1. All Partners and other physicians working full time may obtain a salary advance of up to \$1,200 on the approval of the Area Medical Director. The advance will be repaid through payroll deductions over the following four months. This may not be approved more often than once each year.
2. Mortgage programs may be available to physicians who qualify. Information about qualification and how to apply is available in each physician's Area Medical Director's office or the Area Permanente Human Resources (PHR) office.
3. Full-time partner and associate physicians may request a personal loan at prevailing interest rates countersigned by Medical Group subject to the individual and aggregate loan limits if



they meet one of the following circumstances and with the approval of their Area Medical Director:

- Additional moving expenses not covered under existing Physician Moving Expense Reimbursement program(s)
- Malpractice tail insurance premiums
- Primary residence purchase
- Emergency home repair - must be unanticipated, i.e. home not safe to inhabit without repair
- Unanticipated tax burden – not for routine annual/ quarterly income tax expenses
- Medical expenses not covered by Medical Coverage for self or immediate family members
- Other reasons of financial hardship. A detailed explanation must be submitted and approved by the Physician Director of Permanente Human Resources.

Exceptions may be approved by the Physician Director of Permanente Human Resources and the Executive Medical Director or designee.

The loan is to be repaid in biweekly payroll deductions and is not renewable except under unusual circumstances with approval by the Physician Director of Permanente Human Resources.

In the event of default, if the Medical Group is required to pay any part of the loan, the compensation of the physician may be withheld until the amount of the default plus interest is repaid. If arrangements are made to repay the Medical Group over a period of time, interest will accrue from the date of default at the rate then charged by the Federal Reserve Bank to member banks plus 3%.

#### **F. Physician Transfers**

In the event that a medical office location is changed or eliminated, the physician will be relocated within the same Area. As a policy, Medical Group does not encourage transfers of physicians within the Region. A Partner or Employee Physician desiring a transfer must obtain the approval of the Chief of Service and Area Medical Director in both Areas. The timing of such a transfer will be determined by all parties concerned.

#### **G. Research**

All proposed research projects, including research on drugs and devices, must be submitted to and require approval of the Chief of Service, the Area Medical Director, the Regional Research Committee, and the Regional Institutional Review Board. Research grants are available semiannually from Kaiser Foundation Hospitals, the apportionment of which is under the supervision of the Regional Research Committee.

#### **H. Publications**



All original publications emanating from Medical Group must be approved by the Regional Research Committee. All printed materials including educational material distributed by Medical Group to members of Kaiser Foundation Health Plan Inc. should have the prior approval of the Department of Clinical Services.

**I. Kaiser Permanente Stationery**

Kaiser Permanente Medical Care Program stationery will be used only for business related correspondence. Kaiser Permanente Medical Care Program stationery will not be used by physicians to represent their personal points of view on medical or other issues in any correspondence external to the organization.

**J. Inter-Region Physician Transfers**

Any Southern California Permanente Medical Group Partner physician who will be transferred directly to another Permanente Medical Group, The Permanente Federation, LLC, or The Permanente Company, LLC may, prior to resignation from the Southern California Permanente Medical Group, receive an assurance of re-employment under the following circumstances. The assurance must be recommended by the Executive Medical Director and approved by the Board of Directors. The physician may return to the Southern California Permanente Medical Group under such an assurance only if, at the time of the physician's return to the Southern California Permanente Medical Group, the Executive Medical Director determines that the physician is capable of performing the work sought at the Southern California Permanente Medical Group and determines that the physician is leaving the other Permanente Medical Group, The Permanente Federation, LLC or the Permanente Company in good standing. The physician must return to the Southern California Permanente Medical Group within five years of departure and return directly to the Southern California Permanente Medical Group on completion of the aforementioned service. Upon return, the physician will be employed for a probationary period of up to one year. The Executive Medical Director will determine what, if any, additional training will be required. Credit toward compensation and all benefits will be calculated based on the physician's first date of joining the Southern California Permanente Medical Group with the exception that "Common Plan" Qualifying and Credited Service will be only for periods of service with the Southern California Permanente Medical Group. The physician will become eligible for Partnership consideration following one year of service as an employee of the Southern California Permanente Medical Group.

**K. Legal Representation and the Payment of Legal Fees**

The Board of Directors delegates to SCPMG Counsel the selection of legal counsel and the compensation of such counsel when a physician is required to appear before the Medical Board of California or the Osteopathic Medical Board of California in a proceeding arising out of the physician's medical practice within the Partnership that may result in the suspension or revocation of the physician's license to practice medicine.

Legal representation for proceedings not involving the Medical Board of California or the Osteopathic Medical Board of California may be provided or paid for by SCPMG only if preauthorized by SCPMG Counsel. If SCPMG will provide legal services to a physician,



SCPMG Counsel has the right to select the legal representative and the compensation of such counsel.

If Counsel denies a request for legal representation, or denies a request to pay legal fees, the physician seeking representation or payment of legal fees may submit his/her request to the Board's Dispute and Request Committee. SCPMG Counsel will be replaced as Chairperson of the Dispute and Request Committee when hearing these matters by a Chairperson selected by the Committee from amongst the members hearing the request. The requesting physician or Partner chosen by the requesting physician will first present to the Committee his/her reasons for the request. Next, SCPMG Counsel or his/her designee will present to the Committee the reasons for denial of the request. If the requesting physician or SCPMG Counsel are unwilling to accept the Dispute and Request Committee decision, the decision may only be appealed to the Board of Directors according to the rules for appealing decisions of the Dispute and Request Committee [see Section 2.H].

#### **L. Partner Disclosure**

A Partner seeking election to an SCPMG office must sign a complete disclosure of any Merit Longevity Increase denied the Partner, any litigation or arbitration instigated by the Partner related to SCPMG, or any reduction in the Partner's compensation within 5 years of the close of nominations. The Partner must disclose such actions to the Partners who will be voting in such an election. To facilitate this, a Partner Disclosure form must be completed by all Partners seeking election and sent to the Board Election Administrator. Partners with actions requiring disclosure will have their forms made available for review to all Partners who are eligible to vote in the election no later than two business days following the close of nominations for the position sought, e.g. through email for Area elections or on the SCPMG Physician Portal for Regional elections. For each successful Partner, the Secretary of the Board of Directors will be the final arbiter as to whether the disclosure made by the above deadline was complete. If the Partner is from the same Area as the Secretary of the Board of Directors, then the General Counsel will be the final arbiter in determining complete disclosure. A Partner who does not make a timely and complete disclosure will be removed from the ballot and will be disqualified from holding office. If an incomplete disclosure is discovered after the election is completed, the first runner up will be declared the election winner. In the event that multiple positions and/or candidates are involved in a single election, and provided the Partner was successfully elected to one of the positions, the election will be declared invalid and a second election would commence with the remaining candidates.

#### **M. Election Manual**

As is the Benefits Handbook, the SCPMG Election Manual is an extension of the Rules and Regulations of the SCPMG Partnership.

The Secretary of the Board of Directors, along with Permanente Board Support, will continue to update the SCPMG Election Manual as needed, in order to comply with any relevant changes at the direction of the Board (i.e. proposals, etc.). In the future, revised versions of the SCPMG Election Manual will be noted and referenced in the biennial Rules and Regulations Rewrite Proposal to the Board.