Benefits for You

Pharmacy Residents

Colorado

April 2017

Summary Plan Description

KAISER PERMANENTE®

This document, called a *Summary Plan Description* or SPD, describes the benefits in effect as of the date on the front cover. The information in this SPD is a summary of important provisions and most common situations associated with your benefits when this SPD went to press. In case of any omission or conflict between what is written in this SPD and in the official plan documents, insurance contracts, or service agreements, the official plan documents, contracts, or agreements always govern.

The benefits and employee benefit plans described in this SPD may be modified or eliminated at your employer's discretion. You will be advised of any significant changes in your benefits programs.

If you are rehired by Kaiser Permanente or if you transfer between Kaiser Permanente employers, you must review the relevant plan document and the national *Inter-Regional Transfer* policy to determine whether your previous employment will be used to determine your eligibility for any specific benefit included in this SPD.

We are pleased to present you with this *Summary Plan Description* (SPD), which provides a general summary of the health and welfare and retirement benefits provided by Kaiser Permanente to eligible employees under various Kaiser Permanente plans. The SPD provides an explanation of the major features of the benefit programs in the following categories, which are governed by the Employee Retirement Income Security Act of 1974 (ERISA):

- medical coverage
- a retirement savings plans
- an employee assistance program (EAP)

This SPD also provides information on eligibility and enrollment rules, claims and appeals processes, and administrative information, including contact information, for each type of benefit plan listed above.

You may also be eligible for benefits that are not governed by ERISA, such as time off programs, which are not addressed in this SPD. Please see below for instructions on how to get more information about all your benefits as a Kaiser Permanente employee.

Please take the time to review the information in this SPD with your spouse or domestic partner/civil union partner, dependents, beneficiaries, and others who need to know about your benefits. Because benefits change from time to time, you will receive an updated SPD every few years. In the meantime, be sure to keep your SPD for future reference when you have a question about your benefits.

This SPD is based on official plan documents. The SPD is not a contract between Kaiser Permanente and any employee or contractor, or a guarantee of employment. The SPD is intended to be an accurate summary of the official plan document, but in the event that there is a discrepancy between this SPD and the official plan documents, the official plan documents will control.

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CONTACT INFORMATION

Department, Organization, or Service	Contact Information
National Human Resources Service Center (NHRSC)	Phone: **1-877-4KP-HRSC (1-877-457-4772)** Fax: **1-877-HRSC-FAX (1-877-477-2329)** Kaiser Permanente National Human Resources Service Center P.O. Box 2074 Oakland, CA 94604-2074 **kp.org/myhr**
Health Care	
Member Services Questions about KFHP medical plans	**Colorado** Denver/Boulder Hours: M-F, 8 a.m. – 5 p.m. **303-338-3800** **303-338-3820 (TTY)** Southern Colorado Hours: M-F, 8 a.m. – 5 p.m. **1-888-681-7878** **1-800-521-4874 (TTY)** Northern Colorado Hours: M-F, 8 a.m. – 5 p.m. **1-800-632-9700** **1-800-521-4874 (TTY)**
Employee Assistance Program (EAP)	Northern California **http://insidekp.kp.org/eap** Southern California **http://insidekp.kp.org/eap** Colorado **1-800-873-7138** Georgia **1-800-869-0276** Hawaii **808-432-4922** Mid-Atlantic States **1-800-227-1060** Northwest **503-813-4703**
HealthPlan Services Questions and claims about the Supplemental Medical Plan	**1-800-216-2166** **www.hpsclaimservices.com**
Retirement Savings Plan	
Vanguard Questions about defined contribution retirement savings plans	**Hours: M-F, 5:30 a.m. – 6 p.m.** **1-800-523-1188** **www.vanguard.com**
Other Benefits	
CONEXIS Questions about the *Consolidated Omnibus Budget Reconciliation Act of 1974* (COBRA)	**1-877-864-9546**

Enrolling in Benefits

Highlights of This Section

Eligibility for Benefits

Who Is Eligible

Generally, you are eligible for health and welfare benefits if you are regularly scheduled to work 20 or more hours per week, in an eligible status. If you are a transferred employee, contact the National Human Resources Service Center (NHRSC) for more information about your eligibility.

When the term "regularly scheduled to work" is used in this *Summary Plan Description*, it refers to the posted hours for the position filled by the employee, not the actual hours worked.

Eligibility for benefits can vary depending upon the benefit. See the beginning of each benefit section for more detailed information on specific eligibility requirements.

Eligible Dependents

Your eligible dependents include the following:

- Your legal spouse or domestic partner (for more information on domestic partner benefits, see "Domestic Partner Benefits"). If you are legally separated, your separated spouse is not an eligible dependent.
- Your, your spouse's, or your domestic partner's children under the age limits. (For age and status requirements, see the chart in "Eligible Children.")

Please note: You are required to provide proof of your dependents' eligibility when you first enroll them and thereafter upon request in order to continue their coverage.

Disabled Dependents

You may be able to extend coverage past the regular age limits for an enrolled dependent child who is incapable of self-support due to a mental or physical disability. However, if you are newly hired, you may add your disabled dependent over the regular age limits when you first enroll if you can show proof that the dependent was covered under your previous plan and that there was no gap in coverage from the time the dependent reached the regular age limits. In both cases, the disability must begin and the child must be enrolled in medical coverage before he or she reaches the age limit.

Please note: You are required to provide proof of your dependent's disability when you enroll them, and are required to provide annual medical certification of continuing disability upon request in order to continue coverage for your disabled dependent over the regular age limits. If you do not provide such proof within 31 days of the request, your dependent may be dropped from coverage.

Eligible Children

Eligible children include:

- Your children
- Your spouse's or domestic partner's children
- Legally adopted children
- Children placed with you for adoption. You will be required to provide proof of your legal right to control the adoptive child's health care. Until the adoption is final, children placed with you pending adoption are eligible for medical and dental coverage only.

- Children who reside in your household for whom you provide chief support and for whom you have been granted authority by a court to make legal decisions for the child's health and/or education
- Children for whom you are required to provide coverage as a result of a Qualified Medical Child Support Order (QMCSO)

Children must also meet the following age and status requirements:

Benefit	Children Must …
Medical	• Be under the age of 26 (Coverage will continue through the end of the month in which your child turns 26, unless they are disabled; see " Disabled Dependents")

Eligible Grandchildren

Your or your spouse's or domestic partner's grandchild is eligible for medical coverage only, if the grandchild's parent (your or your spouse's or domestic partner's child) is under the age of 25, unmarried, and currently covered under your medical coverage —and **both the grandchild and grandchild's parent**:

- Live with you, and
- Are eligible to be claimed as dependents on your federal income tax return

Domestic Partners and Civil Union Partners

Although Kaiser Permanente recognizes domestic partnerships and civil unions, the federal government, which regulates many of our benefit plans, does not. Thus, wherever the terms "married" and "spouse" are used in this SPD, they mean a couple that has entered into a legal marriage. Civil union partners are eligible for the same benefits as domestic partners and are subject to the same restrictions that apply to domestic partners. Therefore, all references in this SPD to domestic partners and domestic partnerships also apply to civil union partners.

Enrolling a Dependent

You must enroll your dependents within 31 days of your date of hire, change to a benefited status, or when they first become eligible (such as date of birth, date of marriage, etc.). If you do not notify the National Human Resources Service Center (NHRSC) that you wish to enroll your new dependents within 31 days of when they become eligible, you must wait until the next annual open enrollment period to do so, unless you have a qualifying family or employment status change (see "Changes During the Plan Year").

When you enroll new dependents, you will be required to provide Kaiser Permanente with the names of all of the dependents you want covered under your plans, as well as proof of their relationship to you and their eligibility. Copies of supporting documents listed in the chart in "Supporting Documentation" must be received by the NHRSC within 31 days of enrolling your dependents in benefits. Make sure you write your name and employee number on each page before sending. If you cannot provide required documentation by the 31-day deadline, the NHRSC may grant you an extension, up to 90 days from the original enrollment date. If you receive an extension from the NHRSC and do not provide the required documentation within 90 days of the original enrollment date, your dependents will not be covered.

You must notify the NHRSC within 31 days of the date an enrolled dependent becomes ineligible based on the previously stated criteria (see "Who Is Eligible").

Falsification of any information regarding dependent eligibility will be investigated and may result in termination of benefits coverage, including recovery of the cost of any benefits provided, and corrective action or disciplinary action, up to termination of employment.

Supporting Documentation

The following chart details what supporting documentation you will need to provide to enroll eligible family members:

Eligible Family Members	Supporting Documentation
Spouse	Copy of a certified marriage certificate
Domestic Partner	Copy of **one** of the following: • Certified local or state government domestic partner registration • Certified local or state government civil union registration • Notarized *Kaiser Permanente Affidavit of Domestic Partnership*
Your natural child, stepchild, or child of your domestic partner	• Copy of a certified birth certificate • Qualified Medical Child Support Order (QMCSO), if applicable
Adopted child or child placed with you for adoption	Copy of **one** of the following certifying the adopted child's date of birth: • Certificate of adoption • Court-issued *Notice of Intent to Adopt;* and *Medical Authorization Form* or *Relinquishment Form* granting you (the employee) the right to control the health care for the adoptive child
Child who resides in your household for whom you provide chief support and you have been granted authority by a court to make legal decisions for the child's health and/or education	Copy of the following: • Court-issued custody/guardianship papers
Disabled natural, step, or adopted child of any age if child was enrolled in coverage and said disability occurred prior to the age limits	Copy of a certified birth certificate or certificate of adoption and *Disabled Dependent Enrollment Application.* You may be required to show proof of your dependent's continuing disability each year
Unmarried grandchild who lives with you and meets the eligibility requirements	Copy of a certified birth certificate (proof of dependency may be required at any time)

Additional Information about Supporting Documentation

- If you enroll a domestic partner, you must also complete and submit the tax portion of the Kaiser Permanente Affidavit of Domestic Partnership. Notarization is not required when submitting this portion of the Kaiser Permanente Affidavit along with your certified domestic partner registration.
- In order to enroll your domestic partner's dependents, you must also submit supporting documentation for your domestic partner.
- If enrolling a newborn, a verification of birth letter from a Kaiser Foundation Health Plan (KFHP) hospital or KFHP-contracted hospital is accepted in lieu of a birth certificate.

- Foster children are not eligible for coverage without the Notice of Intent to Adopt certification.
- Contact Member Services or Customer Service for your region to request a Disabled Dependent Enrollment Application.

Please note: Documents written in a language other than English must be accompanied by a certified and notarized English translation.

When Your Benefits and Coverage Begin

Please refer to each benefit section for information on when your benefits and coverage begin.

When You Can Enroll

You may enroll in your benefits at the following times:

- Within 31 days of your date of hire or transfer into a benefits-eligible position at Kaiser Permanente
- When you move from a health and welfare non-benefited status to a health and welfare benefited status
- During the annual open enrollment period
- If you lose other medical coverage for any reason, you may enroll in medical coverage (see " Special Enrollment Rights")

You are automatically enrolled or participate in certain benefits offered by Kaiser Permanente when you become eligible, such as the Employee Assistance Program, while others allow enrollment at any time, such as your tax-deferred retirement savings plan. Please refer to each benefit section for more information about enrollment in each plan.

Open Enrollment

Each year during open enrollment, you will have the opportunity to review your current benefit choices, if any, and make changes for the upcoming plan year, including adding or removing dependents. Any changes you make during open enrollment become effective January 1 of the next calendar year.

If you do not enroll in benefits by the open enrollment deadline, your benefit elections for the following year will remain the same except for the Flexible Spending Accounts, which must be re-elected each year.

Some benefits are not subject to the annual open enrollment restriction, or are available for enrollment at any time (e.g., your tax-deferred retirement savings plan).

Changes During the Plan Year

Once you have made your benefit election choices as a new hire, as a newly eligible employee, or during open enrollment, they are fixed for the entire plan year. You may make changes to some or all of your benefits during the year only if you experience a qualified change in family or employment status as defined by the Internal Revenue Code (IRC). Any changes in coverage must be consistent with the qualified family or employment status event.

Qualifying Family Status Events

Qualifying changes in family status are based on Section 125 of the IRC and include the following:

- Marriage, legal separation, annulment, or divorce
- Entering or terminating a domestic partner relationship

- Birth or adoption of a child
- Death of a dependent or spouse or domestic partner
- Change in your covered dependent's eligibility status

Qualifying Employment Status Events

Changes in employment status include the following:

- Change from full- to part-time schedule
- Change from part-time to full-time schedule
- Loss of benefit eligibility due to a decrease in work hours, an unpaid leave of absence, or termination of employment for you, your spouse or domestic partner or child
- Gain in benefit eligibility due to a substantial increase in your, your spouse's or domestic partner's work hours, or commencement of your spouse's or domestic partner's or child's employment

In addition, you may be able to enroll in or make changes to certain benefits if you transfer intra- or inter-regionally, or move to another employee group, provided your benefits eligibility requirements change.

Family or Employment Status Changes

Following are the kinds of changes you may be allowed to make if you have a qualifying change in family or employment status (according to the applicable change), and when the change becomes effective:

Type of Change	Effective Date
Add new dependents or change enrollment in medical plans	First of the month following date of event
Remove dependents from existing medical plans	End of the month of date of event

You must inform the NHRSC of any changes in family or employment status within 31 days of the status change, and provide supporting documentation as soon as possible, if documentation is not available at the time of your request (see "Supporting Documentation" for more information). If you cannot provide required documentation by the 31-day deadline, the NHRSC may grant you an extension, up to 90 days from the original enrollment date. If you receive an extension from the NHRSC and do not provide the required documentation within 90 days of the original enrollment date, your dependents will not be covered. If you do not inform the NHRSC of the changes within 31 days of the qualifying event, you must wait until open enrollment to make changes to your benefits, unless a dependent no longer meets the eligibility requirements.

If you are enrolling a newborn or a child who is adopted, or placed with you for adoption, the effective date of coverage will be retroactive to the event date, provided you enroll them in benefits within 31 days of the date of birth, adoption, or placement for adoption.

Any benefit change you make must be consistent with the qualifying event. For information on the benefit changes permitted for each type of employment and family status changes, please review the list available in the Benefits section of My HR.

If a dependent becomes ineligible based on the previously stated criteria (see "Who Is Eligible"), you must notify the NHRSC within 31 days of event. For more information, please contact the NHRSC.

Special Enrollment Rights

If you or your eligible dependent(s) have medical coverage outside of Kaiser Permanente and you or your dependent(s) subsequently lose your other coverage involuntarily, you or your eligible dependent(s) may enroll in a Kaiser Permanente-sponsored medical plan, **provided your enrollment request is received no later than 31 days after the date the other coverage terminated.**

If you or your eligible dependent(s) are enrolled in Medicaid or your state's Children's Health Insurance Program (CHIP) and lose medical coverage under Medicaid or CHIP, then you and/or your eligible dependent(s) may enroll in a Kaiser Permanente-sponsored medical plan, **provided your enrollment request is received no later than 60 days after the date your Medicaid or CHIP coverage terminated.**

Finally, if you or your eligible dependent(s) become eligible for premium assistance under Medicaid or CHIP, and you or your eligible dependent(s) are not already enrolled in a Kaiser Permanente-sponsored medical plan, you and your eligible dependent(s) may enroll in a Kaiser Permanente-sponsored medical plan, **provided your enrollment request is received no later than 60 days after being determined eligible for premium assistance.**

When Coverage Ends

Your benefit coverage ends at the end of the month in which you leave Kaiser Permanente, reclassify to an ineligible status, or go on certain unpaid leaves of absence. Please see each benefit section for specific information on when each coverage ends. For more information on leaves of absence, sign on to My HR.

Your dependents' coverage ends when yours does or when they no longer meet the eligibility requirements.

You may elect to continue some benefits under COBRA. For more information about COBRA, see the **Health Care** section.

How to Enroll

You are able to enroll in or change benefits on My HR when you begin working at Kaiser Permanente, change to a benefit-eligible status, have a qualifying event, or during the annual open enrollment period.

My HR offers a quick, easy, and accurate way to view your current benefit choices and descriptions, as well as to elect or make changes to benefits when you have a qualifying employment event (such as moving from part- to full-time or a non-benefited to benefited status) or a family life event (such as marriage, birth or adoption of a child), or if you transfer within Kaiser Permanente. You can access My HR at any time, from work or home, at **kp.org/myhr**.

Quick Steps for Enrolling in Benefits Online

Enrolling in your benefits online is easy with My HR. Just follow these simple steps:

- Sign on at **kp.org/myhr**.
- Activate your account, if you have not already done so.
- Click **Benefits Enrollment** on the home page to begin the enrollment process.
- Review your benefits options.
- Enroll yourself and your dependents.
    - Click **Edit** next to each benefit. When you elect your medical coverage option, scroll down to the bottom of the page to add and enroll your dependents.
    - **Please note:** After you add dependents, you must click on the **Enroll** box next to their names to enroll them in your benefits.
    - Verify your elections and eligible dependent information.

- Click the **Continue** button at the bottom of the page to go to the **Authorizations** page.
- At the bottom of the **Authorizations** page, click the **Submit Final Choices** button to complete your enrollment. If you do not click **Submit Final Choices**, your elections will not be registered.
- When you see **" Elections Submitted!"** on the **Confirmation** page, you have successfully completed the enrollment process.
- Confirm your elections: You can come back to My HR 48 hours after you submit your elections to review a summary of your elections and ensure they have been captured correctly.

To complete your dependent's enrollments, you must also fax or mail the appropriate supporting documentation (e.g., copy of certified birth certificate, copy of certified marriage certificate, *Kaiser Permanente Affidavit of Domestic Partnership*, etc.) to the NHRSC:

Kaiser Permanente
National Human Resources Service Center
P.O. Box 2074
Oakland, CA 94604-2074
Fax: 1-877-HRSC-FAX (1-877-477-2329)

Please note: Make sure you clearly write your name and employee number on every document you send to the NHRSC and keep copies (including fax transmission confirmations) for your records. In addition, make sure to submit all required forms and/or documents within the required times.

Domestic Partner/Civil Union Partner Benefits

You may extend certain benefits, such as medical and dental benefits, to your same-sex or opposite-sex domestic partner, or civil union partner, and his or her eligible dependents. All references in this section to domestic partners and domestic partnerships also apply to civil union partners.

Who Is Eligible

To be eligible for domestic partner benefits, you must provide documentation of your relationship to the NHRSC. For a list of acceptable documentation, see the " Supporting Documentation" chart. If you file a *Kaiser Permanente Affidavit of Domestic Partnership*, you and your domestic partner must certify that you meet all of the following qualifications:

- You and your domestic partner share a committed personal relationship
- You are each other's sole domestic partner
- You have not been covered by Kaiser Permanente-sponsored benefits with another domestic partner within the last six months
- You are both unmarried
- You and your domestic partner live together and share basic living expenses
- You and your domestic partner are unrelated
- You are both 18 years of age or older
- You and your domestic partner are jointly responsible for each other's common welfare

When you enroll a domestic partner, you will be asked for the tax status of your domestic partner and any of his or her dependents to determine the taxability of the cost of medical and dental benefits provided. If your domestic partner is not a qualified dependent, you will be taxed for the fair-market value (FMV) of his or her medical and dental benefits. For more information, see " Tax Effect of Domestic Partner Coverage."

If you were in a previous domestic partnership, you need to submit the *Termination of Domestic Partnership form #3170* (available on My HR) to the NHRSC before you can add a new domestic partner to your benefits; removing a domestic partner from your benefits coverage during open enrollment does not complete the termination process. You may add a new domestic partner six months after the NHRSC receives your termination form. This requirement is waived if your previous domestic partner died. This requirement applies only if your previous domestic partner was covered as a dependent under your benefits plan.

Covered Benefits

Eligible domestic partners receive the same coverage as spouses, including the following:

- Medical coverage
- Employee Assistance Program (EAP)
- Continuation of medical and EAP coverage through COBRA

Your domestic partner and/or his or her dependents may also be named as beneficiaries for Kaiser Permanente-sponsored retirement savings plans. Your domestic partner may also be eligible for benefits not covered under this *Summary Plan Description*. Please sign on to My HR for more information on domestic partner benefits.

As with spouses and other dependents, domestic partner coverage is contingent on your eligibility for these benefits.

When Domestic Partner Coverage Begins

Your domestic partner's medical benefits become effective on the first of the month following the date that the NHRSC receives your completed enrollment forms and acceptable documentation, or when you become eligible for medical dental benefits, whichever is later.

Adding and Removing a Domestic Partner

You must notify NHRSC to add your domestic partner to your medical benefits within 31 days of the date you become eligible or within 31 days of the date you register your relationship, whichever is later. If you do not add your domestic partner within 31 days, you will have another opportunity during the annual open enrollment period, with coverage effective the following January 1.

You must notify the NHRSC within 31 days of the date your domestic partner becomes ineligible based on the criteria listed above. Falsification of any information regarding domestic partner and dependent eligibility will be investigated and may result in termination of benefits coverage, including recovery of the cost of any benefits provided, and corrective action or disciplinary action, up to termination of employment.

Your domestic partner coverage ends when you are no longer eligible for benefits or if your domestic partner relationship changes. If your domestic partnership changes, you must provide the NHRSC with a notarized *Termination of Domestic Partnership form #3170* (available on My HR) or a copy of a certified *Termination Certificate* filed with a state or local government within 31 days of the change. This qualifies as a family status change, which may allow you to change some of your benefits (see "Changes During the Plan Year").

If you were in a previous domestic partnership and your previous domestic partner was covered as a dependent under your benefits plan, you need to submit the *Termination of Domestic Partnership form #3170* form to the NHRSC before you can add a new domestic partner to your benefits. Removing a domestic partner from your benefits coverage during open enrollment does not complete the termination process. You may add a new domestic partner six months after the NHRSC receives your termination form. This requirement is waived if your previous domestic partner died.

If the change is due to marriage, you must notify the NHRSC within 31 days by completing the change form and providing a copy of your certified marriage certificate. As a result, your registered domestic partner will be re-enrolled as your spouse. This does not qualify as a family status change and you will not be allowed to change your benefits.

If change is due to circumstances where you and/or your domestic partner no longer meet the eligibility criteria, your domestic partner may be eligible to continue health care and dental benefits under the provisions of COBRA or to purchase an individual plan as described in the **Health Care** section.

Tax Effect of Domestic Partner Coverage

The Internal Revenue Service (IRS) requires Kaiser Permanente to withhold federal and Social Security taxes on the Fair Market Value (FMV) of employer-paid medical benefits for your domestic partner and his or her dependents, unless they satisfy the definition of a dependent as described under Internal Revenue Code (IRC) sections for health and welfare benefits. If your domestic partnership is not registered, state income tax laws require Kaiser Permanente to treat the FMV of employer-paid medical benefits for your partner as taxable income.

Please note: In most cases, children of domestic partners do not qualify as tax dependents and the FMV of this coverage may be considered taxable income.

Health Care

Your health care benefits provide you with valuable protection when you become ill or injured. But even more, they work to keep you healthy. This section provides highlights of the health care related benefits available to you.

Highlights of This Section

OVERVIEW OF MEDICAL CARE

Your comprehensive health care program offers the following options for medical coverage:

- You may elect health care coverage through the Kaiser Foundation Health Plan (KFHP).
- You may also receive additional coverage through the Supplemental Medical Plan. Supplemental Medical coverage is automatically provided if you enroll in the KFHP plan.

Who Is Eligible

You are eligible for medical coverage if you are regularly scheduled to work 20 or more hours per week in an eligible status. You may also enroll your eligible dependents.

Eligible Dependents

You may choose to enroll your eligible dependents in medical coverage. If you choose to include your eligible dependents in medical coverage, they will be enrolled in the same plan that you elect for yourself.

For details on dependent eligibility and enrollment, and tax considerations, see the **Enrolling in Benefits** section. For information on Qualified Medical Child Support Orders (QMCSO), please see the **Legal and Administrative Information** section.

When Coverage Begins

You are eligible for medical coverage on the first of the month following your date of hire.

Coverage for your enrolled dependents begins when yours does, provided that the NHRSC receives your completed enrollment materials and supporting documentation.

When Coverage Ends

Your medical coverage ends on the last day of the month in which your employment with Kaiser Permanente ends, you no longer meet the eligibility requirements, or you go on certain unpaid leaves of absence. Coverage for your dependents will end when yours ends or at the end of the month in which they become ineligible for coverage.

You may be eligible for longer employer-paid continuation of medical benefits under certain circumstances. For more information, contact the NHRSC. When coverage ends, you and your dependents may be eligible to continue medical coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). For more information on COBRA, refer to "Continuation of Benefits under COBRA."

Patient Protection Disclosure

Kaiser Foundation Health Plan (KFHP) generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, KFHP designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Member Services.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from KFHP or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Member Services.

Kaiser Foundation Health Plan

Your Kaiser Foundation Health Plan (KFHP) provides health care managed by Kaiser Permanente physicians and other health care providers to ensure that you receive the best services possible. Your KFHP coverage includes a wide range of services such as routine checkups, pediatric checkups, immunizations, mammograms, hospital coverage, laboratory tests, medications, and supplies.

You will receive KFHP membership cards for yourself and your enrolled dependents. You must use Kaiser Permanente providers and plan facilities, except in an emergency or if you obtain special authorization to receive care or services outside the Kaiser Permanente system. You are encouraged to choose a primary care physician who will help you manage your health care needs.

The information in this section is a summary only. It does not fully describe your benefit coverage. For details on your benefit coverage, including a complete list of benefits, services, exclusions, and limitations, refer to your *Evidence of Coverage*, the binding document between KFHP and its members. If you have any questions or problems using your KFHP coverage, or to obtain a copy of the *Evidence of Coverage* brochure, please call Member Services. You can also obtain your *Evidence of Coverage* brochure on **kp.org** (go to the **My health manager** tab, click **My coverage and costs**, then click **My documents** in the left hand navigation).

Your Costs

Kaiser Permanente offers you employer-paid medical coverage. However, you are responsible for copayments as noted in the chart below. When you receive services through Kaiser Foundation Health Plan, you do not need to pay a deductible or submit a claim form. Just pay any applicable charge or copayment at the time you obtain services.

Your Kaiser Foundation Health Plan at a Glance

The following chart summarizes the coverage and costs for the most frequently asked about benefits:

Benefits	You Pay
Annual Copayment Limit[1] Individual Two or more people	 $2,000 $4,500
Outpatient Care Office visits for illness/injury, including specialty care, OB/GYN, Allergy testing	$20 per visit/ No charge for preventive care
Outpatient surgery	$100/ $70 colonoscopy
Lab tests and X-rays MRI, PET, CT Scan, Nuclear Medicine	No charge for diagnostic; $10 for therapeutic $100 per scan
Immunizations (preventive)	No charge
Allergy testing Allergy injections	$10 per test visit $10 per injection visit
Inpatient Care Including room and board, surgical services, nursing care, anesthesia, X-rays, and lab tests	$250 per admission

Benefits	You Pay
Maternity Care	
Prenatal care and first post-partum visit	Office visit copay to confirm pregnancy; no charge thereafter
Labor, delivery, recovery, and inpatient postpartum care	$250 per admission
Well-child care (up to age 17)	No Charge
Infertility Services	
Outpatient, including lab and X-rays (prescriptions not covered)	50% of covered charges
Emergency Department	
Emergency room visits (copay waived if admitted)	$100 per visit
Urgent care visits	$50 per visit
Ambulance (Medically necessary or KP-approved)	20% coinsurance up to $500 per trip
Prescription Drugs[2]	
KP Pharmacy (up to 60-day supply)	$10 generic/$20 brand name
Mail order (up to 90-day supply)	$10 generic/$20 brand name
Mental Health Care	
Outpatient individual (unlimited)	$20 per visit
Outpatient group (unlimited)	$10 per visit
Inpatient	$250 per admission
Alcohol and Drug Dependency Care	
Outpatient individual	$20 per visit
Outpatient group	$10 per visit
Inpatient (detox only)	$250 per admission
Skilled Nursing Facility (up to 100 days per calendar year)	No charge
Physical, Speech, and Occupational Therapy[3] (Up to 20 visits per therapy per calendar year)	$20 per visit
Durable Medical Equipment (DME), Prosthetic, and Orthotic Devices[4]	20% coinsurance
Vision Care	
Office visits for injury/illness	$20 per visit
For adults: eyeglass and contact lenses (every 24 months)	$150 allowance toward one pair of eyeglass lenses & frames or contact lenses
For eligible children up to age 19: one pair of eyeglass frames and lenses OR contact lenses (every 24 months)	No charge

Benefits	You Pay
Home Health Care[5] (Custodial care not covered)	No charge
Hearing Services Hearing exams and tests to determine the need for hearing correction Hearing aids (every 3 years)	$20 per visit $1,000 per ear credit
Hospice Care (custodial care not covered) When prescribed by KP physician and within service area	No charge

[1] *Copayments for prescriptions and vision care do not apply to limits.*

[2] *Prescriptions must fall within KFHP Formulary Guidelines – available at* **kp.org** *on the* **My Health Manager**, **Pharmacy center** *tab – unless specifically prescribed by a Kaiser Permanente physician. All specialty drugs, including self-administered injectables / infusions (excluding prevention immunizations and diagnostic drugs) will be subject to a 20% coinsurance, which will apply towards the Annual Out-of-Pocket Maximum. No charge for FDA-approved contraception.*

[3] *State mandates an additional 20 visits for congenital defects and birth defects from birth to age 5. Autism disorders are not subject to the visit limit.*

[4] *Must be prescribed by a Kaiser Permanente physician in accordance to Health Plan or DME Formulary guidelines.*

[5] *Up to three visits per day, 100 visits per calendar year; Must be prescribed by a Kaiser Permanente physician and authorized by the home health committee.*

Other Covered Services

In addition to the benefits listed above, your medical plans also provide coverage for other medical benefits, including dialysis, health education, and organ transplants.

Additional Information About Certain Medical Services and Coverage

When You Are Expecting a Baby

In accordance with the Newborn and Mother's Health Protection Act of 1996, under federal law mothers and newborns have the right to stay in the hospital for up to 48 hours following a normal delivery or up to 96 hours following a Cesarean section. However, in consultation with the mother, the attending physician may increase or decrease the length of stay according to the medical needs of the mother.

Mastectomy Benefit

In accordance with the Women's Health and Cancer Rights Act of 1998, KFHP will cover reconstructive surgery, including reconstructive surgery on the non-diseased breast to restore and achieve symmetry, and prosthetic devices after a medically necessary mastectomy. You can request an external prosthetic device from the list of providers available from Member Services. A replacement for a prosthesis that is no longer functional and/or a custom made prosthesis will be provided if necessary. KFHP covers treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same copayments applicable to other medical and surgical benefits provided under this plan.

When You Need Emergency Care

KFHP covers emergency care and urgent care provided at a Kaiser Permanente facility — 24 hours a day, seven days a week. Emergency care is defined as services that are provided by affiliated or non affiliated providers after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in the following conditions:

- Serious jeopardy to the mental or physical health of the individual
- Serious impairment of the individual's bodily functions
- Serious dysfunction of any of the individual's bodily organs
- In the case of a pregnant woman, serious jeopardy to the health of the fetus

Emergency Care at Facilities Not Affiliated With Kaiser Permanente

Although you should try to receive care at Kaiser Permanente facilities, in certain situations described below, benefits are provided for care received at other facilities, with some limitations (see "What Is Not Covered"). If you are admitted for emergency care to a facility not affiliated with Kaiser Permanente, you must notify Member Services within 24 hours of the time you are admitted, or as soon thereafter as practical.

If you do not notify KFHP within 24 hours, you may be responsible for payment of services rendered during your emergency care. KFHP reserves the right to determine what amount it will pay for out of plan emergency care. Reimbursements may be requested by contacting the KFHP Claims Department.

You may be transferred to a Kaiser Permanente facility as soon as it is medically appropriate. KFHP provides full coverage for special transportation to transfer you to another facility if it is approved in advance by a Kaiser Permanente physician.

Within the Service Area: If you are within a Kaiser Permanente service area, you are normally expected to receive emergency care at a Kaiser Permanente facility. However, you are covered at facilities not affiliated with Kaiser Permanente if the treatment would normally be covered by KFHP and extra travel time to reach one of our facilities could result in death, serious disability, or jeopardy to your health.

Outside the Service Area: If you have an unforeseen illness or injury outside the service area, KFHP covers emergency care you receive at facilities not affiliated with Kaiser Permanente. You have the option of using Kaiser Permanente facilities in other regions for emergency care or urgent care, although you are not required to do so.

What Is Not Covered

Your emergency care benefit does not cover the following services at facilities not affiliated with Kaiser Permanente:

- Care you could have received at a Kaiser Permanente facility before leaving the service area
- Childbirth at facilities outside the service area within 31 days before the baby was expected, unless you were outside the service area because of an extreme personal emergency care, or the services were authorized by a KFHP provider
- Follow up visits, even if medically necessary
- Routine or continuing care

Exclusions and Limitations

KFHP excludes and limits certain services. For a complete list and description of exclusions and limitations to your KFHP coverage, please refer to the *Evidence of Coverage*, which is available free of charge by contacting Member Services.

Medical Plan Claims and Appeals

For information about KFHP medical plan claims and appeals procedures, please refer to the **Disputes, Claims, and Appeals** section. You may also obtain detailed information about Medical Claims and Appeals in the *Evidence of Coverage* for your plan.

Supplemental Medical Plan

The Supplemental Medical Plan, administered by HealthPlan Services, provides coverage in addition to the medical benefits provided to you by your KFHP coverage. The Supplemental Medical Plan is not meant to replace your KFHP coverage. In addition, it does not permit you to choose treatment outside KFHP for conditions that are covered under your KFHP benefits.

The Supplemental Medical Plan coverage reimburses you for certain eligible health care expenses for services that are not covered by KFHP or that exceed its limits. You may obtain care from any licensed provider. Unless your provider agrees to bill HealthPlan Services directly, you must pay for your charges and submit a HealthPlan Services claim form to be reimbursed. For a claim form, sign on to My HR at **kp.org/myhr**, or contact HealthPlan Services at **1-800-216-2166** from 8 a.m. to 5 p.m. Pacific time or online 24 hours a day at **www.hpsclaimservices.com**.

Who Is Eligible

You and your eligible dependents are eligible for the Supplemental Medical Plan as long as you are enrolled in the Kaiser Foundation Health Plan (KFHP).

Your Costs

Before you begin to receive benefits under the Supplemental Medical Plan, you must meet an annual deductible. The annual deductible for an individual is the first $100 of covered charges. The annual deductible for family coverage (two or more people) is the first $100 of covered charges per person, up to a maximum of $200.

After you have paid the deductible, you share the cost of covered services by paying coinsurance. HealthPlan Services will authorize payment of a percentage of the reasonable and customary (R&C) charges, which they determine by reviewing the cost of claims in your geographic area. You will be responsible for the remaining percentage. If your health care provider charges more than the usual R&C charge for a particular service, you will be responsible for your percentage — generally 20 percent of R&C charges — and the full amount of any costs above R&C charges.

Authorized Evidence of Exclusion

In most cases you will be required to provide an *Authorized Evidence of Exclusion* from your KFHP medical plan (referred to in the chart as a "denial of service letter"), indicating that your medical plan does not cover a given service or condition, or that you have surpassed the coverage maximum.

If you have reached the maximum medical plan benefit or if a service is excluded from coverage by your medical plan, you may obtain an *Authorized Evidence of Exclusion* from Member Services, either at your local Kaiser Permanente Medical Center or by phone.

Authorized Evidence of Exclusion must state that the patient has KFHP coverage and that any of the following conditions are met:

- Treatment of the medical condition is not available through KFHP
- The service is excluded from coverage under the patient's KFHP plan
- The patient has exceeded plan limits for the service

The *Authorized Evidence of Exclusion* is **not** a letter from KFHP stating that your KFHP claim is denied because you chose to use a non-KFHP provider.

An *Authorized Evidence of Exclusion* is not required for acupuncture or chiropractic services in locations where KFHP does not provide coverage for these services.

Covered Services

The Supplemental Medical Plan covers certain medically necessary services that are not covered under your medical coverage provided by KFHP. In most cases you will be required to provide a letter of denial indicating that a service is excluded from your Kaiser Permanente-sponsored medical plan option or that you have reached the maximum benefits. Please contact Member Services to obtain a denial of service letter. In general, the Supplemental Medical Plan provides coverage for the following services:

Services	You Pay	Maximum/Limits	Restrictions
Acupuncture	20%	N/A	Must be performed by a licensed acupuncturist. Services must be medically appropriate.
Alcohol and Chemical Dependency Inpatient room and board, physician visits and alternative treatment programs Outpatient Individual and group therapy	20%	N/A	Denial of service letter is required.
Biofeedback, Physical, Occupational, Physio, Speech, and Rehabilitation Therapy	20%	N/A	Denial of service letter is required.
Blood, Blood Products, Blood Transfusions and Administration	20%	N/A	Must not be available through your medical plan coverage. Denial of service letter is required.
Chiropractic Services	20%	$1,000 annual maximum	Must be performed by a licensed chiropractor. Chiropractic manipulation, pathology, radiology, and treatment are covered.

Services	You Pay	Maximum/Limits	Restrictions
Custodial Care Services at home or at a skilled nursing facility	50%	N/A	Evidence of total and permanent disability is required. Custodial care at a skilled nursing facility also includes room and board and ill-patient Physician visits
Dental Care for Accidental Injuries	20%	N/A	Only for services related to accidental injury regardless of the prior condition of the tooth. Treatment must be received within 12 months of the accidental injury. Benefits under your employer-sponsored dental plan must be exhausted first. Denial of service letter is required.
Durable Medical Equipment — Rental or Purchase	20%	N/A	Includes wheelchairs, braces, hospital beds, and durable medical supplies. Denial of service letter is required.
Hospice Care Private duty nursing, up to 24 hours a day, by a registered nurse or a licensed practical nurse. Includes room and board, ill patient physician visits and home care	No charge	100 home care visits	Attending physician must certify the need for nursing care, not to exceed an 8-hour shift by the same nurse in one day. Maximum of $50 per visit for a licensed social worker — not to exceed one visit per week. Denial of service letter is required.
Infertility Services	20%	$30,000 lifetime maximum	Denial of service letter is required. Surrogacy services not covered.
Jaw Joint Disorder Treatment	20%	$2,000 lifetime maximum	Denial of service letter is required.
Mental Health Services Inpatient and Outpatient	20%	N/A	Denial of service letter is required

Services	You Pay	Maximum/Limits	Restrictions
Outpatient Home Health Care Services	50%	N/A	Evidence of total and permanent disability is required. Custodial care must be intended to help person meet activities of daily living. Caregiver must be licensed.
Podiatry	20%	N/A	Denial of service letter is required.
Skilled Nursing Facility Non-custodial room and board and ill-patient physician visits	20%	N/A	Denial of service letter is required.

Exclusions and Limitations

The Supplemental Medical plan excludes and limits certain services. If you have questions about whether or not a particular service is covered, contact HealthPlan Services at **1-800-216-2166** from 8 a.m. to 5 p.m. Pacific time or online 24 hours a day at **www.hpsclaimservices.com**.

The following is a listing of services not covered under the Supplemental Medical plan:

- Abortion
- Allergy testing and treatment, including allergy serums
- Ambulance services
- Anesthesia
- Blood, blood products, blood transfusions and their administration, if offered by KFHP
- Chelation therapy
- Chemotherapy
- Contact lenses
- Contraceptives
- Copayments and coinsurance for KFHP
- Corrective eye surgery
- Cosmetic surgery and services
- Cutting, removal, or treatment of corns, calluses, bunions, or toenails are not covered unless needed because of diabetes or other similar disease
- Dental care/treatment not related to an accident
- Dermatology
- Diagnostic laboratory, tests, X-ray services, and other diagnostic tests, including, but not limited to, electrocardiograms, mammograms, and pap smears
- Dialysis and organ transplants

- Education therapy, including, but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, and training or educational therapy for learning disabilities or mental retardation
- Education, training, or instruction
- Electronic voice producing machines
- Emergency room visits and treatments
- Employer's medical clinic visits
- Eye examinations, eyeglass frames and lenses except for eye tests, a pair of eyeglasses or contact lenses due to a cataract operation or diabetic retinopathy if the participant has a denial of service letter from KFHP
- Eye surgery, such as radial keratotomy, solely or primarily for the purpose of correcting refractive defects of the eye
- Experimental or investigational services and supplies and charges for any related services or supplies furnished in connection with experimental or investigational care. A service or supply is experimental or investigational if 1) It is not recognized in accord with generally accepted medical standards as safe and effective for treating the condition in question, whether or not it is authorized by law for use in testing or other studies on human patients; or 2) it requires approval by any governmental authority prior to use and such approval has not been granted before the service or supply is rendered
- General health services not addressed to a specific condition
- Hair prostheses that are not medically necessary, including wigs
- Health club memberships or services
- Health education publications
- Hearing aids or their fitting, and hearing tests
- Hospital services, both inpatient and outpatient, except as specifically provided under " Covered Services"
- Hypnotherapy
- Immunizations in general use
- Immunosuppressive drugs
- Infertility services exclusions include: medical records that do not substantiate the infertility diagnosis, surrogate services, legal fees, travel expenses, financial compensation for purchase of donor egg or sperm, registration fees or storage fees, and any charges that are not FDA-approved, or that are considered experimental or investigational
- Inpatient dressings, casts, durable medical equipment
- Intensive care
- Luxury services or supplies
- Marriage counseling
- Maternity care, including pre-natal care and obstetrical services
- Medical care that is not medically necessary
- Medical care furnished by or paid for by any government or governmental agency, to the extent required by law
- Medical care furnished by a provider who lives in the family member's home or is related to the family member by blood or marriage
- Obesity treatments
- Obstetrical services

- Operating or recovery room
- Organ transplants
- Orthopedic shoes and other supportive devices
- Personal items
- Prenatal care
- Prescription drugs and substances that the Federal Food and Drug Administration has not approved for general use and drugs that bear the label: " Caution-Limited by federal law to investigational use"
- Prescription drugs provided in connection with services normally provided by KFHP, as applicable
- Preventive care, routine physical exams, and gynecological visits
- Private duty nursing care
- Private room in a hospital or other healthcare facility, unless due to a contagious disease
- Radiation therapy and radioactive materials used for therapeutic purposes
- Reconstructive surgery, unless otherwise required under the Women's Health and Cancer Rights Act
- Respiratory therapy
- Room and board charges, except as specifically noted in the " Covered Services" section
- Routine physical examinations
- Second and third medical opinions
- Surgery, surgeon, and assistant surgeon charges
- Ultraviolet light treatment
- Visiting nurse home visits
- Well or sick baby care

In addition to the above exclusions, no benefits will be payable for:

- Charges that are in excess of reasonable and customary (R&C) charges
- Charges due to an on-the-job injury
- Charges due to any sickness which would entitle the covered individual to benefits under a Workers' Compensation Act or similar statute
- Charges for which a terminally ill patient is entitled to as part of the hospice care benefits provided under a KFHP medical plan
- Charges for a physician or other provider acting outside the scope of his or her license
- Sales tax
- Services for which payment is not required
- Treatment for medical conditions resulting from participation in a felonious activity, war or act of war, unless otherwise required under the U.S. Department of Labor's regulations

Filing a Claim

For information on how to file a Supplemental Medical claim, please refer to the **Disputes, Claims, and Appeals** section.

Coordination of Benefits

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- another employer-sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

Determining Which Plan Is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

1. This plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
2. When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
3. A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
4. If you are receiving COBRA continuation coverage under another employer plan, this plan will pay benefits first;
5. Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has covered the parent for a longer period of time. This birthday rule applies only if:
    - the parents are married or living together whether or not they have ever been married and not legally separated; or
    - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
6. If two or more plans cover a dependent child of parents who are divorced, separated, or living apart due to termination of a domestic partnership, and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
    - the parent with custody of the child; then
    - the spouse of the parent with custody of the child; then
    - the parent not having custody of the child; then
    - the spouse of the parent not having custody of the child;
7. Plans for active employees pay before plans covering laid-off or retired employees;
8. If the above do not apply, the plan that has covered the individual claimant the longest will pay first; only expenses normally paid by the plan will be paid under COB; and
9. Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall

be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

The following examples illustrate how the plan determines which plan pays first and which plan pays second:

Determining Primary and Secondary Plan

Example 1: Let us say you and your spouse both have family medical coverage through your respective employers. You are unwell and go to see a physician. Since you are covered as an employee under this plan, and as a dependent under your spouse's plan, this plan will pay benefits for the physician's office visit first.

Example 2: Again, let us say you and your spouse both have family medical coverage through your respective employers. You take your dependent child to see a physician. This plan will look at your birthday and your spouse's birthday to determine which plan pays first. If you were born on June 11 and your spouse was born on May 30, your spouse's plan will pay first.

When This Plan Is Secondary

If this plan is secondary, it determines the amount it will pay for a covered health service by following the steps below.

- The plan determines the amount it would have paid based on the primary plan's allowable expense.
- If this plan would have paid less than the primary plan paid, the plan pays no benefits.
- If this plan would have paid more than the primary plan paid, the plan will pay the difference.

The maximum combined payment you can receive from all plans will never exceed 100 percent of the total allowable expense. If you have funds available, you can use your Health Care Spending Account to pay for eligible expenses not paid by the primary plan or this plan.

Determining the Allowable Expense When This Plan Is Secondary

When this plan is secondary, the allowable expense is the primary plan's in-network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

Allowable Expenses

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When a Covered Person Qualifies for Medicare

Determining Which Plan Is Primary

To the extent permitted by law, this plan will pay benefits second to Medicare when you become eligible for Medicare. There are, however, Medicare-eligible individuals for whom the plan pays benefits first and Medicare pays benefits second based on current Medicare guidelines:

- employees with active current employment status age 65 or older and their spouses age 65 or older
- certain individuals under age 65 who are eligible solely due to a disability, other than end-stage renal disease, and who have coverage under the plan because of their current employment status
- individuals under age 65 with end-stage renal disease, for a limited period of time

If this plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they do not accept Medicare) will be the allowable expense. Medicare payments, combined with plan benefits, will not exceed 100 percent of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this plan is secondary to Medicare, benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

Please note: You must enroll in Medicare when you are first eligible for Social Security disability.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. The Plan Administrator may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits.

The Plan Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give the Plan Administrator any facts needed to apply those rules and determine benefits payable. If you do not provide the Plan Administrator the information needed to apply these rules and determine the benefits payable, your claim for benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that this plan should have paid. If this occurs, the plan may pay the other plan the amount owed.

If the plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, Kaiser Permanente may (if allowed under applicable state law) recover the excess amount in the form of salary, wages, or benefits payable under any company-sponsored benefit plans, including this plan. Kaiser Permanente also reserves the right to recover any overpayment by legal action or offset payments on future eligible expenses.

If the plan overpays a health care provider, it retains the right to recover the excess amount, by legal action if necessary.

Refund of Overpayments

If Kaiser Permanente pays for benefits for expenses incurred on account of a covered person, that covered person, or any other person or organization that was paid, must make a refund to Kaiser Permanente if:

- all or some of the expenses were not paid by the covered person or did not legally have to be paid by the covered person;
- all or some of the payment Kaiser Permanente made exceeded the benefits under the plan; or
- all or some of the payment was made in error.

The refund equals the amount Kaiser Permanente paid in excess of the amount that should have been paid under the plan. If the refund is due from another person or organization, the covered person agrees to help Kaiser Permanente get the refund when requested.

If the covered person, or any other person or organization that was paid, does not promptly refund the full amount, Kaiser Permanente may reduce the amount of any future benefits for the covered person that are payable under the plan. The reductions will equal the amount of the required refund. Kaiser Permanente may have other rights in addition to the right to reduce future benefits.

The COB provisions apply to both your medical and dental plans.

For more information and the complete coordination of benefits provision for your medical plan, please refer to your *Evidence of Coverage* brochure, or call Member Services. If you have any questions about coordination of your dental benefits, please call your dental carrier.

Health Care Continuation

When you leave Kaiser Permanente, go on certain unpaid leaves of absence, or otherwise no longer meet the eligibility requirements, your employer-provided medical coverage continues through the end of the month in which you are terminated or your benefit eligibility ends. Coverage for any enrolled dependents also ends when your coverage ends. You may be eligible for longer employer-provided continuation of medical and/or dental benefits under certain circumstances. For more information, contact the NHRSC.

If you are not eligible for employer-provided continuation, you may still extend your medical benefits —at your own expense —through COBRA.

Continuation of Benefits under COBRA

Under the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your eligible dependents are entitled to continue medical coverage under certain circumstances when coverage would otherwise end —when you elect COBRA, provided you pay the full group rate plus a small administrative fee each month.

The following is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of COBRA. You, your spouse or domestic partner, and your eligible dependents should take the time to read this notice carefully. For more information about your rights and obligations under the plan and under federal law, contact CONEXIS, our third party administrator, at **1-877-864-9546** or Kaiser Permanente, the plan administrator, at the following address and/or phone number:

Kaiser Foundation Health Plan, Inc.
One Kaiser Plaza, 20th Floor
Oakland, CA 94612
Phone: 510-271-5940

You can continue coverage under COBRA for your:

- Medical plan
- Employee Assistance Program

When You Are Eligible

If You Have a Change in Employment Status

You and your dependents, covered under the Kaiser Permanente-sponsored plans, are eligible to continue medical and dental coverage if your employment status changes for one of the reasons described below:

- Your employment ends for any reason (except for termination due to gross misconduct)
- You are no longer scheduled to work the necessary hours in order to meet eligibility

You may also be eligible to continue participating in a Health Care Spending Account.

You may elect to continue coverage for up to 18 months for yourself, your spouse, your domestic partner, and your covered dependent children if your coverage ends. Your coverage under the Kaiser Permanente-sponsored

plans will continue through the end of the month in which any of the above events occur. Your COBRA coverage will become effective on the first day of the following month, provided you make a timely COBRA election and payment.

Please note: Individuals who decline COBRA coverage when first eligible may not enroll for COBRA coverage later based on the same loss of coverage event.

During the period you continue coverage, an open enrollment period will be made available. You will have an opportunity to change or add medical and dental options. You may also drop coverage for a family member or add the following dependents during any open enrollment:

- Any new eligible dependent you acquire
- Any eligible dependents you declined to cover before you elected continued coverage

Special Enrollment Rights

If you decline COBRA coverage for your eligible dependents and they subsequently lose their other coverage for any reason, you may request to enroll your dependent in COBRA no later than 31 days from the date their other coverage terminates.

If You Have a Change in Family Status

Your spouse or domestic partner and covered dependent children can continue coverage for up to a total of 36 months if coverage ends due to one of the following events:

- You divorce, annul your marriage, or legally separate from your spouse, or terminate your domestic partnership
- Your children no longer qualify for dependent coverage under the terms of the plan

If one of these qualifying events occurs after the start of the initial 18-month COBRA coverage period, your spouse or domestic partner and covered dependent children can apply for an additional 18 months of coverage under COBRA. It is your or your dependents' responsibility to notify CONEXIS at **1-877-864-9546** within 60 days of the occurrence of any of these events in order to be eligible for this extended COBRA coverage.

If You Are Called to Military Service

If you are absent from employment for more than 30 days by reason of service in the Uniformed Services, you may elect to continue medical and dental coverage for yourself and your dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or national emergency.

If qualified to continue medical and dental coverage under USERRA, you may elect to continue coverage by notifying the Plan Administrator in advance, and providing payment of any required contribution for your medical and dental coverage. This may include the amount the Plan Administrator normally pays on an employee's behalf. If your Military Service is for a period of time less than 31 days, you may not be required to pay more than the regular contribution amount, if any, for continuation of medical and dental coverage.

You may continue medical and dental plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of your absence from work; or
- the day after the date on which you fail to apply for, or return to, a position of employment

Regardless of whether you continue medical and dental coverage under this policy, if you return to a position of employment, you and your eligible dependents who were enrolled in medical and/or dental coverage before your Military Service will be reinstated under the plan. No exclusions or waiting period may be imposed on you or your eligible dependents in connection with this reinstatement, unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

For more information on policies regarding Military Leaves, contact the NHRSC.

If You Die

Coverage may be continued by your spouse or domestic partner and covered dependent children for up to a total of 36 months.

If You or Your Dependents Are Disabled

If you or your dependents (including domestic partner) are determined to be disabled as defined by the Social Security Act prior to the qualifying event or during the first 60 days of COBRA coverage, COBRA may be extended from 18 months up to a total of 29 months. You must notify CONEXIS at **1-877-864-9546** within 60 days of the receipt of your Social Security award letter, and no later than the expiration of your initial 18-month coverage period. You must also notify CONEXIS within 60 days of the date Social Security determines that you or your dependents are no longer disabled.

COBRA Election Procedures

You and your eligible dependents who lose medical and/or dental coverage due to employment termination or reduction in hours or due to certain unpaid leaves of absence will be notified of COBRA election privileges by CONEXIS. If coverage is lost due to your death, CONEXIS will provide COBRA election notification to your eligible dependents in order to initiate COBRA coverage. If an eligible dependent will lose coverage due to divorce, legal separation, annulment, termination of a domestic partnership, or attainment of the dependent age limits, you must notify the NHRSC within 31 days of the qualifying event. The NHRSC will notify CONEXIS of your eligible dependent's loss of coverage to exercise their COBRA election privileges.

You and your eligible dependents will be provided with a COBRA election form, which **you must fill out and return within 60 days of the notification date shown on the form, or loss of coverage date, if later**. If you do not return the form within 60 days of the notification date or the loss of coverage date, if later, CONEXIS will assume that you have declined coverage.

Consider Your COBRA Decision Carefully

Please examine your options carefully before declining this coverage. If you do not elect COBRA group coverage when eligible, you cannot elect it in the future. You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace.

You have 60 days to make a decision regarding continuation of group medical and/or dental coverage through COBRA. After 60 days you may not change your initial election to continue or not continue coverage through COBRA, although you may stop your COBRA coverage at any time.

Benefits under COBRA

Your benefits while you are enrolled in COBRA coverage will be the same as the coverage for active employees. Therefore, if there are any changes to the plan for active employees, including changes to the cost, your benefits will also change. COBRA premium rates are subject to change on an annual basis.

Under COBRA, you and your dependents have the same enrollment privileges that apply to similarly situated active employees. You may enroll eligible dependent s during the year if there is a qualified change in family status or at open enrollment, and you can change coverage at open enrollment, subject to the same rules that apply to active employees. You may drop COBRA coverage at any time. Once you discontinue COBRA coverage, you may not elect it at a later date or re-enroll.

You will be billed within 31 days of electing COBRA. Your first payment due will include any outstanding premiums retroactive to your initial COBRA eligibility date. Payment for this coverage must be paid in full within 45 days of your election. Partial payments will not be accepted. Subsequent payments will be due the first of the month with a 30-day grace period. If payment is not postmarked within 30 days of the due date, coverage will be terminated retroactive to the first of that month. If for any reason you do not receive a monthly invoice, you are still responsible for a timely payment of the full monthly COBRA premium.

Employee Assistance Program COBRA Continuation

You and your eligible dependents may also continue your Employee Assistance Program through COBRA at no charge, if your qualifying event is termination of employment or loss of benefit eligibility, but not if you retire.

Marketplace Individual Coverage

You may decide to enroll in Marketplace Individual coverage instead of COBRA. You have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. After 60 days you will not be able to enroll. However, you will have an opportunity to enroll in Marketplace coverage during the annual Marketplace open enrollment period.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit **www.HealthCare.gov**.

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event, such as marriage or birth of a child. However, if you terminate your COBRA continuation coverage early without another qualifying event, you will have to wait until the next open enrollment period to enroll in Marketplace coverage. For full details about your COBRA coverage rights, contact the NHRSC.

When Coverage Ends

COBRA coverage stops before the end of the applicable time period if any of the following situations occur:

- You or your dependents become covered under any other group medical or dental plan, unless the other plan has a pre-existing condition exclusion or limitation which will affect coverage for you or your dependents
- You or your dependents become entitled to Medicare benefits
- You fail to pay the required premium on time
- Kaiser Permanente terminates all of its group health plans
- You or your dependents are on a COBRA disability extension and Social Security determines that you or your dependents are no longer disabled

When your COBRA coverage ends, you may be eligible to purchase an individual medical and/or dental plan. In addition, your dependents may be eligible to extend coverage under COBRA for an additional 18 months, or purchase an individual medical and/or dental plan. For full details about your COBRA coverage rights, contact the NHRSC.

COBRA coverage will be provided as required by law. If the law changes, your rights will change accordingly.

Employee Assistance Program

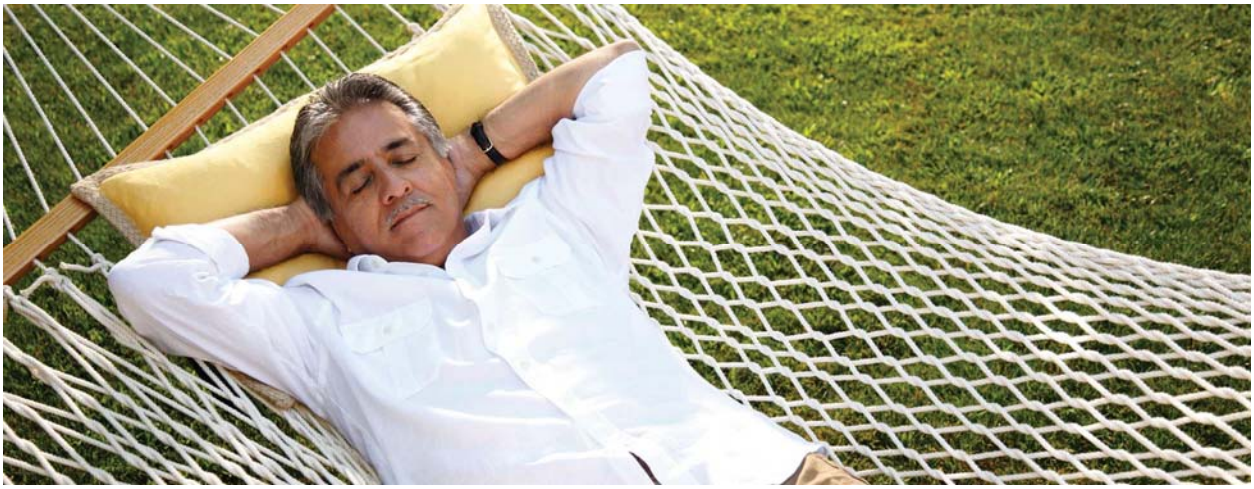
The Employee Assistance Program (EAP) provides a free and confidential service for all Kaiser Permanente employees and their dependent family members. EAP professionals are available for short-term problem solving and referral on a wide range of issues at no charge four sessions per household member per year. EAP is not part of your medical coverage — it is a separate employee benefit and not recorded in your medical record. Your decision to use the program is entirely voluntary and strictly confidential.

EAP professionals are licensed, trained clinicians who have years of experience working with a variety of work-related and personal issues, including the following:

- Work, personal, or financial stress
- Alcohol or drug use
- Loneliness, depression or anxiety
- Marital, family, or relationship difficulties
- Childcare referral assistance
- Care giving for family members
- Financial or legal referrals
- Domestic violence or other abuse
- Loss and grief
- Health and wellness issues
- Job performance problems
- Eating problems
- Work relationship issues

For scheduling convenience, consultations can be scheduled face-to-face or by phone and can be held during regular business hours: Monday through Friday, 8:30 a.m. to 5 p.m. For more information, family member eligibility, or to contact a local EAP professional, sign on to **http://insidekp.kp.org/eap** and click on your region.

Retirement Programs



Highlights of This Section

Kaiser Permanente Tax-Sheltered Annuity Plan

The Kaiser Permanente Tax-Sheltered Annuity Plan (TSA) is a defined contribution retirement savings plan.

Who Is Eligible

You are eligible to enroll in the plan as soon as you are hired.

How to Enroll

If you are newly hired or transferred, Vanguard will automatically send you an eligibility notice when you become eligible for the plan. You may enroll at any time online at http://kpenroll.vanguard-education.com. You will receive a Personal Identification Number (PIN) from Vanguard for the automated VOICE network. Access your account through the Vanguard website at **www.vanguard.com**, the VOICE network, or a Participant Services Associate at **1-800-523-1188**. Your plan number is **090998**. You can make your payroll deferral election and investment elections online at any time. You will be prompted to name beneficiaries when you activate your online account access.

To name beneficiaries at a later time, or to update your beneficiary information, follow these simple steps:

- Sign in to **www.vanguard.com**
- Click **Go to the Personal Investor Site**
- Click **My Profile** (if you have multiple accounts at Vanguard, you may need to select **Employer Plans** first)
- Click **Beneficiaries** under " Do It Yourself"

Making Contributions to Your Account

Pre-Tax Employee Contributions

Based on your election, contributions are deducted from your paycheck each pay period, and your gross pay will be reduced by the amount of your contributions. Your contributions are deducted from your pay before federal and state taxes are withheld. As a result, your taxable income — the amount on which you pay taxes — is reduced, saving you tax dollars. Your actual tax savings will depend on your income level, exemptions, marital status, deductions, and the current tax rates.

The minimum amount you can contribute to your plan account is 1 percent of your salary.

The maximum amount you can contribute to your plan account each year cannot exceed the legal limit, which is the least of the following:

- The maximum contribution dollar limit allowed by the Internal Revenue Code (IRC) — which is $18,000 in 2017
- 75 percent of your annual compensation

Unless you elect otherwise, after you reach the automatic increase limit, your contribution rate will continue from year to year or until you reach a legal limit.

Your total contributions will be monitored on an ongoing basis and reviewed at the end of the year. If you exceed your total contribution limit, you will be notified and refunded any excess contributions.

If You Are Age 50 or Older

If you are age 50 or older, or if you will reach age 50 by December 31 of a given year, you are eligible to make an additional pre-tax catch-up contribution to your plan for that year and in subsequent years. The maximum allowable catch-up contribution in 2017 is $6,000. Your annual contribution limit and catch-up contribution limit may change from year to year.

You are eligible to make catch-up contributions only after you have reached your applicable annual contribution limit. The following chart outlines the annual contribution limit in 2017:

Pre-Tax Contribution Limit	Catch-Up Contribution Limit	Combined Contribution Limit
$18,000	$6,000	$24,000

If you wish to make catch-up contributions, you should review your current deferral rate to determine if you need to increase it to take advantage of the combined contribution limit.

If you have any questions about the catch-up contributions, contact Vanguard, our third-party administrator, at **1-800-523-1188**.

Maximum Compensation Limit

The maximum annual eligible pay under the Internal Revenue Code (IRC) that may be considered for benefit purposes for 2017 is $270,000. This amount may be indexed periodically for cost-of-living increases. In addition, your annual maximum contribution may be limited by the IRC.

Vesting

Vesting refers to your entitlement to a benefit. Once you are vested, you are entitled to a distribution of your account when you leave Kaiser Permanente.

You are immediately 100 percent vested in your pre-tax employee contributions to your plan account. This means that you are entitled to the total value of your contributions and any investment earnings in your account when you leave Kaiser Permanente.

Choosing Your Beneficiary

When you become a participant, you will be asked to name a beneficiary to receive payment of your account if you die. Under the plan your spouse is legally entitled to 50 percent of your account upon your death, unless certain requirements are satisfied. If you are married, age 35 or older, and you want someone other than your spouse to receive more than 50 percent of your account, your beneficiary designation must be accompanied by a written, notarized statement of your spouse's consent to be valid. If you are married and younger than age 35, you may not designate anyone other than your spouse to receive more than 50 percent of the value of your account, regardless of whether or not your spouse agrees to the designation. You may change your designated beneficiary at any time, except as described for your spouse.

Domestic Partners and Civil Union Partners

Although Kaiser Permanente recognizes domestic partnerships and civil unions, the federal government, which regulates many of our benefit plans, does not. Thus, wherever the terms "married" and "spouse" are used in this SPD, they mean a couple that has entered into a legal marriage. Civil union partners are eligible for the same benefits as domestic partners and are subject to the same restrictions that apply to domestic partners. Therefore, all references in this SPD to domestic partners and domestic partnerships also apply to civil union partners.

Choosing Your Investments

You can invest your account among a diversified lineup of investment options. In addition, you are eligible to invest your account through the Vanguard Brokerage Option. You can invest up to 50 percent of your fully vested account in Vanguard Brokerage Option. Investment funds are reviewed by the Investment Committee on an ongoing basis, and the actual funds offered through the plan are subject to change. A complete list of funds and more information about the Vanguard Brokerage Option is available online at **www.vanguard.com** or by calling Vanguard's VOICE network at **1-800-523-1188**.

Upon becoming a participant, any contributions to your account will be invested in the Qualified Default Investment Alternative (QDIA) until you select an investment option. The QDIA is the KP Retirement Path Fund with the target date closest to the year in which you will reach age 65. The KP Retirement Path Funds are invested in several broadly diversified funds and are subject to the risks of their underlying funds. The year in the fund name refers to the approximate year (the target date) when an investor in the fund would attain age 65. The fund will gradually shift its emphasis from more aggressive investments to more conservative ones based on its target date. Contact Vanguard to learn about your QDIA fund.

The plan is intended to satisfy the requirements of Section 404(c) of the Employee Retirement Income Security Act (ERISA) and Department of Labor Regulation Section 2550.404c-1. In general, this means that you are solely responsible for any investment losses caused by your investment decisions. Kaiser Permanente, its directors, officers, employees, subsidiaries, plan fiduciaries, and the trustee do not guarantee or insure the performance of any of the investment funds offered by the plan, and will not be liable for those losses.

Since you alone will be responsible for the losses or gains that result from your investment decisions, it is very important that you carefully consider the investment options available to you.

You should note that in the event that a proxy voting decision is required regarding shares of the investment funds, the investment fund shares will be voted on by the fiduciary for the plan in accordance with the investment guidelines for the plan.

The plan administrator is the plan fiduciary responsible for providing participants and beneficiaries with the information necessary for making informed decisions under the plan. To request additional information from the plan administrator, please see the contact information provided in this *Summary Plan Description*. In addition, the Plan provides a variety of tools and services available to help you make your investment decisions, like the Vanguard Managed Account Program (VMAP) and Personal Online Advisor. More information is available online at **www.vanguard.com** or by calling Vanguard's VOICE network at **1-800-523-1188**.

Changing Your Investments

You can change the investment of your account online at **www.vanguard.com** or by calling Vanguard's VOICE network or on your mobile device using the Vanguard app. You can redirect all future contributions to new investment options (a contribution allocation change) as well as reinvest your balance — including your past contributions — among options (an exchange).

Receiving Information About Your Investments

You may obtain information and make changes to your account online at **www.vanguard.com**. The Vanguard website provides you with an easy way to monitor the activity in your plan accounts as well as initiate transactions.

You may obtain information and make changes to your account on your mobile device. Go to **vanguard.com/bemobile** to download the Vanguard app so you can access your account on the go.

You may also access information by calling the Vanguard VOICE network, an automated toll-free telephone service that enables you to request account information and execute transactions via a touch-tone telephone.

With the touch of a few buttons, you can obtain your account balance, confirm your investment allocations for future contributions, or request a transaction. Updated information about account transactions is available at approximately 8 a.m. Eastern time on the day after the transaction is processed.

Borrowing From Your Account

If you have at least $2,000 in your plan account as of your loan application date, you can borrow up to 50 percent of your vested account balance or $50,000, whichever is less. At no time can you borrow more than $50,000 from your combined defined contribution plans, if you participate in more than one plan. The minimum loan amount is $1,000. Only one loan per plan is permitted at a time.

You pay the principal and interest back to your own account through regular payroll deductions. The interest rate applied to loans is the prime rate quoted in the Reuters on the first business day of the month, plus 1 percent.

As described below, you can borrow on a short-term or long-term basis:

- If you borrow on a short-term basis, you must repay the loan within 12 to 60 months from the loan issue date.
- If you borrow on a long-term basis, you must repay the loan within 61 to 180 months. Long-term loans are available only when you are purchasing your primary residence.

There is a $50 loan application fee applied to all loans.

Your loan repayments are made on an after-tax basis. You must repay the entire loan before you can borrow from your account again or if your employment ends.

Your loan is not subject to taxes or penalties unless the loan defaults. A loan defaults if it is not repaid on a timely basis or if it is not repaid in full when your employment ends.

You can find out how much you can borrow from your plan account or calculate different loan repayment amounts and schedules by logging on to **www.vanguard.com** or by calling VOICE to speak to a Vanguard Participant Services associate.

If you are married, federal law requires that your spouse consent to all loans. As a result, your application for a loan must be accompanied by a written, notarized statement of your spouse's consent.

If You Go on an Unpaid Leave of Absence

If you go on an unpaid leave of absence, payroll deductions for your plan loan automatically stop. You have the option to make manual payments directly to Vanguard, or to suspend your loan payments for up to 12 months or when you return from your leave, whichever is earlier. However, the loan period does not increase, so you must make up any missed payments by the original due date for the loan.

When you return from an unpaid leave of absence your loan payments will automatically restart. Once you return to work, you will have the option to either pay all missed payments in a lump sum, or you may reamortize the loan. If you decide to reamortize the loan, your loan payments are recalculated at a higher payroll deduction amount so that the loan is paid by the end of the original agreed term of the loan.

If you are on an unpaid leave of absence for more than 12 months, and you do not arrange to make up missed payments on a manual basis, the balance owing on your loan is deemed to be distributed to you. The distribution is considered taxable income in the year you receive it, and you may also be subject to tax penalties, depending on your age and employment status. Special rules apply if you are on a military leave of absence.

If You Transfer to Another Employee Group or Terminate Employment

If you transfer to another employee group or terminate employment before your loan is repaid, please contact Vanguard in advance (if possible) to determine how this will affect your loan.

When You Can Receive a Distribution

Normally, you are entitled to receive your plan account balance when your employment with Kaiser Permanente ends. You can defer receiving payment until April 1 of the year following your termination or the year you reach 70½, whichever is later, if you have more than $1,000 in your account as of your termination date.

When Vanguard receives notice of your termination date, you will receive account distribution information and forms. You will receive payment as soon as administratively possible, once Vanguard receives your forms.

If you plan to re-invest your distribution or roll over your distribution into another employer's qualified plan or an IRA, you should compare the investment options and plan administrative and investment fees for both your current plan as well as the new plan or IRA to determine your best financial option.

You may not take a distribution while employed by Kaiser Permanente, except as noted below. Thus, if you terminate from one Kaiser Permanente Entity and transfer to or are re-employed by another Kaiser Permanente Entity, you may not take a distribution from this plan during your employment with your new Entity.

In-Service Withdrawal

Age 59½ Withdrawal

If you are at least 59½ and still employed at Kaiser Permanente, you can withdraw your pre-tax employee contributions, rollover contributions, and applicable investment earnings from your plan account.

Hardship Withdrawal

Based on federal requirements, while you are employed at Kaiser Permanente, you can withdraw pre-tax employee contributions from the plan before you reach age 59½ only in case of financial hardship. Investment earnings, employer contributions, and rollover contributions from another retirement plan are not eligible to be withdrawn for financial hardship.

Financial hardship includes money needed for the following:

- College tuition for yourself, your spouse or domestic partner, or your dependents
- Medical expenses for yourself, your spouse or domestic partner, or your dependents
- Purchasing your primary residence or avoiding eviction from or foreclosure on your home
- Certain expenses relating to the repair of damage to your principal residence that qualifies as a casualty deduction
- Payments for burial or funeral expenses for your deceased parent, spouse, domestic partner, or dependent For a complete list of hardship circumstances, contact Vanguard at **1-800-523-1188**.

Please note: Domestic partners and dependents must satisfy the requirements of the plan before a distribution can be taken on their behalf.

To qualify for a financial hardship withdrawal, it must be clear that you cannot obtain the money you need from any other source, such as an eligible loan from your retirement account.

You must complete a hardship withdrawal application. If your application is approved, you will receive your withdrawal as soon as administratively possible. It is taxable as ordinary income, and you may also owe federal and state tax penalties for early withdrawal.

If you are married, federal law requires that your spouse consent to all withdrawals. As a result, your application for a withdrawal must be accompanied by a written, notarized consent from your spouse.

Disability Withdrawal

In addition, you may receive a distribution from your vested account due to a disability, as defined under the plan, while you are employed. Generally, this requires that you are totally disabled.

How Benefits Are Paid

If you have $1,000 or less in your account when you retire or leave Kaiser Permanente, you will receive a Lump Sum payment. If the value of your account is more than $1,000, you can select any of the following available forms of payment:

- **Lump Sum:** The total value of your account is paid to you in a single payment.
- **Single Life Annuity:** The total value of your account is used to purchase a non-transferable single life annuity that provides monthly income to you for your lifetime only. This is the normal form of payment of your benefits if you are not married.
- **50 percent, $66^{2/3}$ percent, 75 percent, and 100 percent Joint and Survivor Annuity:** You may elect to have an adjusted benefit paid to you for the joint lives of you and another person (your Joint Annuitant). You may choose to receive an adjusted monthly income while you are both alive, and then 100 percent, 75 percent, $66^{2/3}$ percent, or 50 percent of that amount will be paid to the survivor after either of you dies. The amount of adjustment for a Joint and Survivor Annuity is based upon your age and the age of your Joint Annuitant when benefits begin. If your Joint Annuitant is not your spouse, an additional adjustment may be needed to meet the minimum distribution requirement. The 50 percent Joint and Survivor Annuity is the normal form of payment if you are married.
- **Installments:** The value of your account is paid to you in monthly, quarterly, or annual installments over a period of two to 25 years. In no event shall the payment extend beyond your life expectancy, nor shall any payment, except the last, be less than $100. You continue to direct the investment of your account until the installment payments are completed. You may request a total or partial distribution of your remaining account at any time.
  Your installment options include declining balance, fixed dollar, or fixed percentage payments. Declining balance payments allow you to take regular installments over a specific number of years, based on the remaining number of payments and your balance at the time of each payment. Fixed dollar payments allow you to specify the dollar amounts you would like to withdraw at intervals you choose (monthly, quarterly, annually). Fixed percentage payments allow you to specify the percentage of your balance you would like to withdraw at intervals you choose (monthly, quarterly, annually).

If you select an annuity option, you are responsible for arranging the purchase. Except for installment payments, once a distribution is made you cannot change your form of payment. Your distribution cannot be reversed back to the plan.

If no election is made and you are single, the normal form of payment is the Single Life Annuity. Your spouse is entitled by federal law to receive benefits in the form of a 50 percent Joint and Survivor Annuity, which is the normal form of payment if you are married. Therefore, you are legally required to obtain your spouse's consent to any other type of distribution before it can be paid to you. This consent must be in writing and notarized no more than 90 days before the benefits begin.

If You Die

Here is what happens if you die before you commence your vested benefits from the plan or if you have a vested benefit remaining in your account:

- If you have a valid beneficiary designation on file, payment will be made to your beneficiary (or beneficiaries).
- If you do not have a valid designated beneficiary on file at the time of your death or if your designated beneficiary dies and you have not named another beneficiary before your death, payment of your account will be made in the following order:
  - To your surviving legal spouse
  - If none, to your surviving children (natural or adopted) on an equal share basis
  - If none, to your surviving parents on an equal share basis
  - If none, then to your estate
- If the remaining balance is more than $1,000, your spouse may elect any form of payment and may defer receiving payment until April 1 of the year following the year in which you would have reached age 70½. Your spouse may elect a tax-free rollover to an IRA.

Your remaining balance to a non-spouse beneficiary will be paid in a lump sum. Payment to a non-spouse beneficiary must be made no later than December 31 of the year following your death. Non-spouse beneficiaries may elect tax-free rollovers to an "inherited" IRA set up to specifically receive survivor benefits from the plan.

Tax Considerations

Your plan has been designed to provide you with significant tax advantages as long as your contributions remain in your account. When you receive your account balance, however, it will be considered taxable income for the year in which you receive it. In some cases, favorable tax treatment may be available.

The federal government also requires that 20 percent of the taxable portion of most distributions be automatically withheld unless you directly transfer your distribution to a tax-deferred Individual Retirement Account (IRA), to another Kaiser Permanente-sponsored defined contribution plan, or another employer's qualified plan.

If you are under age 55 when you terminate and you receive a distribution before age 59½, the taxable portion may be subject to significant tax penalties, unless you roll your distribution over to an IRA or another qualified plan.

If you turn age 55 or older in the year you terminate, any subsequent distribution you take in that year or later is exempt from the penalty tax.

Benefit payments that are part of a series of payments over a lifetime are not eligible to be rolled over. Because the tax laws regarding plan distributions are complicated, you may want to consult a tax advisor before you choose a distribution from the plan.

Rollovers to Another Plan or Tax-Deferred IRA

Taxable distributions from your plan may be rolled over into another employer's qualified plan or a tax-deferred IRA. If an eligible distribution is rolled over, income taxes will be deferred until you later withdraw the funds. Remember that you may leave your account in your current plan until you are required to take a minimum distribution (see "Minimum Distribution Requirement"). Before choosing to roll over your distributions into another employer's qualified plan or an IRA, you should compare the investment options and plan administrative and investment fees for both your current plan as well as the new plan or IRA to determine your best financial option.

Please note: Hardship withdrawals may not be rolled over to another employer's qualified plan or to an IRA.

Non-Spouse Beneficiary Rollovers

Non-spouse beneficiaries, such as domestic partners, children, parents and siblings may elect to roll over eligible survivor benefit distributions from the plan to an "inherited" IRA that is set up specifically to receive such contributions.

Rollovers to a Roth IRA

You, your spouse, and non-spouse beneficiaries may roll over qualified amounts of plan distributions directly into a Roth IRA. Income taxes on the taxable portion of your distribution will not be deferred if you elect to roll over to a Roth IRA. Because tax laws regarding rollovers to a Roth IRA are complex, you may want to consult a tax advisor before you elect any distribution from the plan.

Minimum Distribution Requirement

You will be required by law to take a minimum distribution of your account by April 1 of the calendar year following the year in which you reach age 70½ or retire, whichever is later. All of the plan's forms of payment meet the minimum distribution requirement. Minimum distributions are not eligible to be rolled over into an IRA or another tax-qualified retirement plan. If you do not make a timely election, you will be paid in the normal form of payment.

Unclaimed Benefits Process

You are responsible for maintaining your most current address on file with Vanguard if you keep an account with them. If you cannot be located within 180 days of the latest date your benefit is required to be paid (for example, the date your account balance drops below $1,000 after you have left Kaiser Permanente), your benefit will be forfeited and used by the Plan. If you later return to claim your benefit, it will be deemed payable as of the required payment date.

Assignment of Benefits

Generally, your benefits under the plan cannot be assigned, given away, transferred, or pledged in any way. However, there are some exceptions, such as a Qualified Domestic Relations Order (QDRO). For details of this provision, see the **Legal and Administrative Information** section.

Disputes, Claims, and Appeals

This section of the SPD describes the health and welfare dispute process and how to file a claim for your health and welfare retirement benefits. In addition, you will find information on how to appeal a benefit claim determination.

Highlights of This Section

Health and Welfare Eligibility and Enrollment Disputes

If you have a question relating to you or your dependent's eligibility for health and welfare benefits, including enrollment disputes, you must contact the National Human Resources Service Center. If you disagree with the NHRSC's response, you may ask for a Request for an Administrative Review Form and submit a written dispute. Your request for an administrative review must be received by the NHRSC within six months of the event that gives rise to your initial question. The NHRSC will make a final determination regarding your inquiry within 90 days after the request for an administrative review is received.

General Information About ERISA Claims and Appeals

This section provides some general information that applies to claims for benefits under various types of plans. It also provides additional information about filing claims and appeals for the following categories of plans and types of coverage:

- Health plans (i.e., medical plans, dental plans, and the Health Care Spending Account)
- Disability plans and other plans where benefits depend on whether you are disabled
- Retirement plans and retiree medical eligibility determinations
- Other plans subject to ERISA (e.g., life insurance plans, accidental death and dismemberment insurance plans, etc.)

Before you can file a civil action under ERISA section 502(a)(1)(B), you must meet any deadlines and exhaust the claims and appeals procedures set forth in this section. No legal action for benefits under the plan may be brought until the claimant has submitted a written claim for benefits in accordance with the procedures described below, has been notified by the plan administrator that the claim is denied, has filed a written appeal in accordance with the appeal procedures described below, and has been notified that all administrative remedies have been exhausted. If you miss a deadline for filing a claim or appeal, the claims administrator may decline to review it.

Use of an Authorized Representative

You may authorize a representative to help you pursue a claim or appeal on your behalf. Your representative need not be an attorney. Your representative may be asked to provide evidence that you have authorized him or her to represent you. The fact that you assign your right to receive benefits to a health care provider does not, by itself, mean that you have designated that health care provider as your representative. If your claim or appeal involves health benefits, then you (or the affected family member) may be asked to provide a written authorization that permits the health plan to provide personal health information to your representative. However, a licensed health care professional familiar with your medical condition may act as your representative with respect to a claim (or appeal) for urgent care without providing any further evidence that he or she is your representative. Please let the claims administrator know if you would like responses to your claim or appeal to be sent directly to you instead of your authorized representative.

What Is a Claim for Benefits

Federal law requires that a plan follow specific procedures when you make a claim for benefits or appeal a denial of your claim for benefits. A "claim" for benefits is a formal request by you (or your beneficiary) for the payment of benefits you believe are due under the terms of an employee benefit plan covered by the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The procedures apply to the benefits described in this **Disputes, Claims, and Appeals** section of the *Summary Plan Description* (SPD). However, these procedures do not apply to claims filed with respect to the Dependent Care Spending Account or salary continuance benefits. Similarly, these procedures do not apply to other company programs, unless otherwise stated.

Except in the case of claims or appeals under a health plan involving urgent care, you must submit in writing your claim for benefits or your appeal of a denial of a claim. You must submit your claim to the relevant person specified in the "Claims and Appeals" section for each particular plan in this SPD. For example, it would not be a formal claim for benefits if you submitted your request for a benefit to your supervisor. Similarly, see the "Claims and Appeals" section for each plan in this SPD (that follows this "General Information" section) to find out if a particular form is required to submit a claim with respect to a specific plan.

This section refers to "you" (i.e., the current or former employee) making a claim or appeal. For plans that provide benefits to family members or beneficiaries, generally claims may be made by those family members or beneficiaries and the same procedures will be followed as with a claim submitted by an employee.

The claims and appeals procedures described here do not apply to inquiries or requests that you might make about your plan benefits that are not formal claims for benefits. This means information provided in response to anything that fails to satisfy the requirements of a formal claim for benefits is not binding on the applicable plan and cannot be relied upon as the plan fiduciary's response to your claim. Your employer (and not the plan fiduciary) may also have a separate administrative review process for resolving issues that are not formal claims for benefits.

For example, the following are not formal claims for benefits:

- Questions you ask the National Human Resources Service Center or any Human Resources staff member.
- Questions you ask the Kaiser Permanente Retirement Center or Vanguard.
- Questions you ask a claims administrator's call center.
- Your application to enroll in an employee benefit plan and other enrollment disputes. If you are denied the opportunity to enroll in a plan because your employer believes that you are not eligible to participate in that plan at that time, then your employer need not follow these claims and appeal procedures when responding to your challenge to that denial of coverage. However, if you believe that you are entitled to a benefit under one of the plans and you submit a formal claim for benefits, the applicable procedures in this section will be followed, even if one of the issues is whether you are eligible to participate in the plan or whether you properly enrolled in the plan.
- Inquiries before a service is performed or a product is purchased as to whether a health plan will cover that service or product.
- Your objections to a pharmacy about a problem when you attempt to fill your prescription at Kaiser Permanente or an outside pharmacy. If the pharmacy fails to provide you the medicine that you believe you are entitled to under the plan or charges you more than you believe is due under the terms of the plan, then you may file a claim for benefits and you will receive a response. The claim is filed with the person who handles claims for the medical or dental, plan that will pay for the prescription, and not with the pharmacist.

Information Provided by the Plan If Your Claim Is Denied

If the claims administrator denies your claim, then you will receive a written response from the claims administrator explaining the reasons for the denial. (The deadlines for the claims administrator to inform you of a claim denial are summarized later in this section.) If your health plan claim for benefits is denied, then your Explanation of Benefits may serve as the written claim response. However, when responding to a health plan claim for urgent care, sometimes the claims administrator will communicate its decision orally so that you receive a faster response. The oral response will be followed up by a written response within three days after the oral response. A denial of a claim includes any of the following responses: a failure to provide advance approval for a service (applies only when the plan requires pre-approval for the service); a failure to provide, in whole or in part, a particular service; a failure to pay, in whole or in part, for services that were performed; a reduction or termination of previously-approved benefits; or a failure to provide, in whole or in part, a requested benefit pursuant to the terms of a specific plan (e.g., a long-term disability benefit or an early retirement benefit under the defined benefit plan).

The denial may be made for a variety of reasons such as the fact that the benefit is not covered by the plan, the amount claimed is excessive, or the fact that you are not covered by the plan.

Your Right to Appeal a Denied Claim

Please refer to the information for each particular plan in this section for the deadline to file your appeal. If your appeal is not received by this deadline, then you may lose your right to the appeal and the benefit that you are seeking.

In connection with your appeal, you may make a written request for additional information and you will be provided, at no cost, reasonable access to and copies of all documents, records, and other information (other than legally or medically privileged documents or information about other persons) relevant to your claim. In some cases, you may be requested to obtain relevant records from your health care provider that the plan does not have. As part of your appeal, you may submit written comments, documents, records, and other information relating to your claim for benefits, even if you did not submit this information in connection with your initial claim. Please address the concerns that were specified in the denial of your claim. Be sure to include any information and documents requested in the response to your claim. The plan will review the appeal, taking into account all comments, documents, records, and other information submitted relating to the appeal, without regard to whether that information was submitted or considered in the initial review of your claim.

If the claims administrator denies your appeal, then you will be provided with a written response explaining the reasons for the denial.

If your appeal is denied and the claims administrator informs you that you have exhausted your administrative remedies, you can bring a civil action in federal court under Section 502(a)(1)(B) of ERISA. Unless otherwise provided in the appropriate plan document, any legal action must be brought in the U.S. District Court of the Northern District of California and no legal action may be commenced or maintained against the plan or the plan administrator more than 12 months from the date all administrative remedies under the plan have been exhausted.

Health Plan Claims and Appeals

There are special rules that apply to claims and appeals for benefits under a health plan such as a medical plan, a dental plan, or the health care spending account.

Types of Claims

The deadline for the claims administrator to respond to your claim or appeal depends on the type of claim you are making. Government regulations distinguish four different types of health plan claims and establish different rules for responding to these types of claims:

Urgent Care Claim: This is a claim in which you are seeking advance approval for urgent care. Urgent care is medical care or treatment for which a faster than normal decision on your claim or appeal is required to avoid seriously jeopardizing your life, health, or ability to regain maximum function. Urgent care is also care that, in the opinion of your physician who is familiar with your medical condition, is needed to prevent you from suffering severe pain that otherwise cannot be adequately managed without the care you are seeking. If a physician with knowledge of your medical condition determines that the care you are seeking to have paid under the plan is urgent care, then the plan must treat the claim as an urgent care claim. Otherwise, the health plan's claims administrator will determine whether you are seeking urgent care. If you submit an urgent care claim and you later decide to receive the urgent care before a decision is made on your claim or appeal, then your claim or appeal will no longer be treated as an urgent care claim and instead will be treated as a post-service claim.

Pre-Service Claim: This is a claim you are required to submit before you receive the care or treatment you are seeking because the plan will not provide or pay for at least some of the care unless the claims administrator

approves the care before it has been provided. Pre-service claims are generally service specific. Review the Health Care section of this SPD or contact the claims administrator for your health plan to determine whether you need to file a pre-service claim for a specific service. If you are seeking pre-approval for urgent care, then the claim will be an urgent care claim, not a pre-service claim.

Post-Service Claim: This is a claim for care that does not need to be approved in advance of the treatment. You are asking the plan to pay for treatment that has already been provided. This is the most common type of claim.

Concurrent Care Claim: Concurrent care is an ongoing course of treatment for a specified period or a specified number of treatments (e.g., a specified number of physical therapy sessions). A concurrent care claim occurs when you wish to challenge the plan's decision to reduce or terminate concurrent care before the end of the previously approved period or before you have received the previously-approved number of treatments. A concurrent care claim also occurs when you wish to extend concurrent care beyond the previously-approved period or number of treatments.

Deadlines for Responding to Each of the Four Types of Health Care Claims

The claims administrator must make a decision on the four types of health care claims by the following deadlines:

Urgent Care Claims

If your claim includes all information required for the claims administrator to decide whether the plan provides the benefits that you are seeking, then the claims administrator will notify you of its decision on your claim as soon as possible, taking into account the medical exigencies, but **not later than 72 hours after the claims administrator receives the initial claim.** If you believe that a faster response is required, please describe in your claim the medical circumstances that require an expedited response. You will receive a response even if the claims administrator fully approves your claim for urgent care.

If you do not provide enough information with your initial claim for the claims administrator to determine whether the plan provides the benefits you are seeking, then the claims administrator will notify you, within 24 hours of receipt of your claim, of the additional information that is needed. You will be provided a reasonable period of at least 48 additional hours to provide the requested information. If you provide all of the requested information by the claims administrator's deadline, then the claims administrator will provide you with a decision on your claim within 48 hours after you provide all of the additional information. If you do not provide all of the requested information by the claim administrator's deadline, then the claims administrator will provide you with a decision within 48 hours after its deadline for you to provide the additional information.

If you file a claim with the wrong person or in an incorrect manner, then, in some cases, you will be notified of that error as soon as possible and not later than 24 hours after you incorrectly filed the claim. You will be informed of the correct way to submit your claim. In some cases, you will be notified orally, but you may request a written confirmation of the correct way to file the claim. The health plan is not required to notify you of your error in filing your claim unless your claim names the person making the claim, the specific medical condition or symptom, and the specific treatment, service, or product that is being sought. Also, the claim must be received by a person who normally handles health benefit matters. For example, if you submitted your urgent care claim to your supervisor or to a third-party administrator for a retirement plan, then you may not receive a response alerting you to the proper procedure for filing your urgent care claim.

Pre-Service Claims

If your claim includes all information required for the claims administrator to approve the benefits you are seeking, then the claims administrator will notify you of its decision as to whether the plan will provide or pay for the care you are seeking within a reasonable period, in light of the medical circumstances, but **not later than 15 days after the claims administrator receives the initial claim.** If you believe that a faster response is required,

please describe in your claim the medical circumstances that require an expedited response. You will receive a response even if the claims administrator fully approves your pre-service claim so that you know that the claim has been approved.

In some cases, the claims administrator will notify you, before the end of the normal maximum 15-day deadline for responding to your claim, that additional time is required to process your claim for reasons beyond the control of the claims administrator. The notice of the extension will inform you of the reasons for the extension and the date by which the claims administrator expects to make a decision. The claims administrator may take up to an additional 15 days to respond to your claim. If the claims administrator requests the extension because you did not submit all information that the claims administrator needs to decide on your claim, then the notice of the extension will inform you of the additional information needed by the claims administrator. You will be provided at least 45 days to provide the additional information. If you respond, by the deadline established by the claims administrator, to the request for additional information, then the claims administrator will make a decision on your claim within 15 days after your response. If you do not respond to the request for additional information by the claim administrator's deadline, then the claims administrator will provide you with a decision within 15 days after its deadline for you to provide the additional information.

If you file a claim with the wrong person or in an incorrect manner, then, in some cases, the plan will notify you of that error as soon as possible and not later than 5 days after you incorrectly filed the claim. You will be informed of the correct way to submit your claim. In some cases, you will be notified orally, but you may request a written confirmation of the correct way to file the claim. The health plan is not required to notify you of your error in filing your claim unless your claim names the person making the claim, the specific medical condition or symptom, and the specific treatment, service, or product that is being sought. Also, the claim must be received by a person who normally handles health benefit matters. For example, if you submitted your health plan pre-service claim to your supervisor or to a third-party administrator for a retirement plan, then you may not receive a response alerting you to the proper procedure for filing your pre-service claim.

Post-Service Claims

If your claim includes all information required for the claims administrator to decide whether the plan covers the care that you received, then the claims administrator will notify you if the plan denies your claim. The notice will be provided within a reasonable period, but **not later than 30 days after the claims administrator receives the initial claim.**

In some cases, the claims administrator will notify you, before the end of the normal 30-day maximum deadline for responding to your claim, that additional time is required to process your claim for reasons beyond the control of the claims administrator. The notice of the extension will inform you of the reasons for the extension and the date by which the claims administrator expects to make a decision. The claims administrator may take up to an additional 15 days to respond to your claim. If the claims administrator requests the extension because you did not submit all information that the claims administrator needs to decide on your claim, then the notice of the extension will inform you of the additional information needed by the claims administrator. You will be provided at least 45 days to provide the additional information. If you respond, by the deadline established by the claims administrator, to the request for additional information, then the claims administrator will make a decision on your claim within 15 days after your response. If you do not respond to the request for additional information by the claim administrator's deadline, then the claims administrator will provide you with a decision within 15 days after its deadline for you to provide the additional information.

Concurrent Care Claims

Special rules apply for a concurrent care claim if the claims administrator decides to restrict the concurrent care benefits that it previously approved (e.g., terminate your physical therapy before the previously-approved sessions are completed) or if you seek to extend the period of concurrent care (e.g., you seek to continue physical therapy beyond the sessions previously approved).

Premature End to Previously-Approved Concurrent Care

If the claims administrator decides to reduce or stop the treatments that it previously approved, then this decision will be treated as a denial of the previous claim to approve these benefits. (If the treatments are reduced on account of a plan amendment or the termination of the plan, then these special rules do not apply.) You will be notified of this decision before the change goes into effect. Instead of the normal deadline for appealing a denial, you will be provided a reasonable period to appeal this decision so that you may receive a response to your appeal before the change goes into effect. Please follow the appeals procedure described in this section that applies to the denial of an urgent care claim (if the concurrent care is urgent care) or a pre-service claim (if the concurrent care is not urgent care).

Extension of Previously-Approved Concurrent Care

If you wish to extend the previously-approved period or increase the previously-approved number of treatments, then you should notify the claims administrator in writing. Your request will be treated as a claim for benefits.

If you are seeking to extend concurrent care that is urgent care, then your request will be handled as follows. If you request an increase in the period of treatment or the number of treatments at least 24 hours in advance of the expiration of the previously-approved course of treatment, then the claims administrator will notify you of its decision as to whether the plan will provide or pay for the care you are seeking as soon as possible, taking into account the medical exigencies, but not later than 24 hours after the claims administrator receives your request for an extension. If you request an increase less than 24 hours in advance of the expiration of the previously-approved course of treatment, then a decision on your request will be made in accordance with the rules that normally apply for urgent care claims. In either case, the decision will be communicated as described above for urgent care claims (e.g., the initial response may be oral).

If you are seeking to extend concurrent care that is not urgent care, then your request will be treated as a normal pre-service claim (if pre-approval is required) or post-service claim (if no pre-approval is required) and handled as described above.

If your claim for extended concurrent care is denied, then you may file an appeal of that denial and the appeal will be decided within the appropriate time frame, based on the nature of your request (i.e., an urgent care claim, a pre-service claim, or a post-service claim).

How to Appeal if Your Claim for Health Benefits Is Denied

If your claim for health benefits is denied, then you may appeal that denial. When you appeal, please follow the specific procedures outlined for your plan later in this section. Except in the case of an urgent care claim, you must submit your appeal in writing. If your appeal is seeking urgent care, then you may make your appeal orally and submit necessary information by telephone, fax, email, or some other expedited method. The claims administrator may provide an oral response to your appeal.

With one exception, you must submit your appeal to the claims administrator within 180 days after your claim has been denied. If you are appealing a denial of your claim objecting to a reduction in previously-approved concurrent care that is urgent care, then the claims administrator will provide you with a reasonable period to submit your appeal, but that period will likely be significantly shorter than 180 days.

Deadlines for Responding to Your Appeal for Each of the Four Types of Health Care Claims

The claims administrator must make a decision on your appeal of a denial of one of the four types of health care claims by the following deadlines.

Urgent Care Claims

If the health plan provides only one regular appeal, then the claims administrator will notify you of its decision as to whether the plan will provide or pay for the care you are seeking as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the claims administrator receives the appeal. If you believe that a faster response is required, please describe in your claim the medical circumstances that require an expedited response.

Pre-Service Claims

If the health plan provides only one regular appeal, then the claims administrator will notify you of its decision as to whether the plan will provide or pay for the care you are seeking within a reasonable period, in light of the medical circumstances, but not later than 30 days after the claims administrator receives the appeal.

If you believe that a faster response is required for any appeal, please describe in your appeal the medical circumstances that require an expedited response.

Post-Service Claims

If the health plan provides only one regular appeal, then the claims administrator will notify you if the plan will not pay for some or all of the care you received. The notice will be provided within a reasonable period, but not later than 60 days after the claims administrator receives the appeal.

Concurrent-Care Claims

As noted above, if the claims administrator decides to reduce or stop previously-approved treatments, then its decision will be treated as a denial of your original claim and your objection will be treated as an appeal. As noted in the discussion of concurrent care claims, sometimes there may be faster deadlines for filing and responding to the claims administrator's decision to reduce or stop your previously-approved treatments.

If your claim seeking to extend previously-approved concurrent care is denied, then you may file an appeal of that denial and the appeal will be decided within the appropriate time frame, based on the nature of your request (i.e., an urgent care claim, a pre-service claim, or a post-service claim).

Medical Plans

Kaiser Foundation Health Plan

If you wish to submit a claim for benefits under your Kaiser Foundation Health Plan (KFHP) policy, contact Member Services.

Emergency Claims

Depending on where you receive emergency care, you may be responsible for paying for emergency services at a facility not affiliated with Kaiser Permanente and submitting your claim to Kaiser Permanente Claims and Referrals. Once you submit a claim, KFHP will reimburse you — if the emergency treatment would normally

have been covered by KFHP and if delaying treatment would have resulted in death, serious disability, or jeopardy to your health. KFHP will pay reasonable charges, excluding your emergency copayment, any other copayments that would have applied at Kaiser Permanente, or any amounts payable under insurance and government programs other than Medicaid. Claims must be submitted within 12 months of treatment.

Where to File Your KFHP (including Emergency) Claims

Submit your completed claim forms to:

Kaiser Foundation Health Plan, Inc.
Claims Department
Waterpark One
2500 So. Havana Street
Aurora, CO 80014

Medicare members are subject to a slightly different provision. Please refer to the *Evidence of Coverage* booklet for your health plan.

Appeals

This appeal procedure applies to claims for out-of-plan emergency or urgent care services, and to in-plan pre-service, post-service, and urgent care situations in which Kaiser Permanente has denied a claim to provide or pay for a service covered by Kaiser Permanente to which you believe you are entitled. Please refer to the *Evidence of Coverage* for your plan for details on the applicable time frames and procedures to file your appeals.

KFHP appeals should be sent to:

Kaiser Foundation Health Plan, Inc.
Claims Department
Waterpark One
2500 So. Havana Street
Aurora, CO 80014

Medicare members are subject to a slightly different provision. Please refer to the *Evidence of Coverage* booklet for your health plan.

Arbitration Agreement

Except for Small Claims Court cases; claims subject to Section 502(a)(1)(B) of the Employee Retirement Income Security Act (ERISA); claims subject to the Colorado Health Care Availability Act, Section 13-64-403, Colorado Revised Statutes; claims subject to the provisions of Colorado Revised Statutes 10-3-1116(1); claims reviewed through independent external review as set out in Colorado Revised Statutes 10-16-113.5; and claims subject to Medicare appeals procedures ; any dispute between you, your spouse, your heirs, or other associated parties on the one hand and Kaiser Foundation Health Plan of Colorado, its contracted health care providers (including the Colorado Permanente Medical Group), or their agents, employees, or shareholders on the other hand, for alleged violation of any duty arising from your membership in Health Plan, must be decided through binding arbitration before a single neutral arbiter. This includes claims for premises liability, or relating to the coverage for, or the delivery of, services or items, irrespective of the legal theories upon which the claim is asserted. Both sides give up your and their rights to a jury or court trial, and both sides are responsible for certain costs associated with binding arbitration. You must use Health Plan procedures to request arbitration. This provision shall not limit your access to procedures for review of utilization management determinations as set out in Colorado Revised Statutes and Division of Insurance Regulation.

The full arbitration provision is contained in the *Evidence of Coverage*. You can obtain a copy of the *Evidence of Coverage* brochure by calling Member Services at **1-800-464-4000** or by visiting **kp.org** (go to the **My health manager** tab, click **My coverage and costs**, then click **My documents** in the left hand navigation).

Claims and Appeals for the Supplemental Medical Plan

Claims

Claim forms are available online from My HR. Contact the NHRSC if you have difficulty locating the appropriate claim form. A separate claim form should be completed for each patient, and your HealthPlan Services Member ID number is required on all forms. The HealthPlan Services Member ID number begins with "Q9" and can be found on your plan identification card (if provided), or by calling HealthPlan Services at the number listed below. Complete the employee and patient information sections, sign and date the form. Ask your physician or health care provider to complete the physician or supplier information section. The physician or health care provider's signature and credentials must be included to process the claim. The authorization for release of the information section of the form should be completed and signed by the patient. If the patient is a minor or incapacitated, you (the employee) should sign the release.

When submitting your claim form, attach your itemized bills for services received. Properly itemized bills are required as evidence to support your claim for payment of covered services. Your itemized bill should contain the physician or health care provider's identification number, the patient's full name, dates of treatment or service, services provided, charges, and information about the illness or injury. If you have prescription drug charges, submit itemized receipts which include the patient's name, prescription number, type, dosage, quantity, and cost. The actual bills are required; copies and handwritten bills are not acceptable.

Some claims will need a valid *Kaiser Permanente Authorized Evidence of Exclusion* (also referred to as a denial of service letter) in order to be processed.

In addition, you will be required to provide coordination of benefits information in some cases. Review the "Coordination of Benefits" section in this SPD and the coordination of benefits notice attached to each claim form for additional information. Failure to provide coordination of benefits information may delay the processing of your claim or cause your claim to be denied.

If you would like HealthPlan Services to pay the physician or health care provider directly, you may authorize payment directly to the provider of service on the claim form.

You must submit your completed claim form and supporting documentation within 12 months from the day services were received. In most cases, your claim will be processed within one month from the date HealthPlan Services receives it, if no additional information is necessary. Missing, incomplete, or unclear information will cause your claim to be denied.

Mail or fax your claims directly to HealthPlan Services at the following address or fax number:

HealthPlan Services
P.O. Box 30537
Salt Lake City, UT 84130-0547
Phone: 1-800-216-2166
Fax: 1-877-779-9873

In the case of an urgent care claim, a request for an expedited review may be submitted orally by calling HealthPlan Services at **1-800-216-2166**. All necessary information, including the claim determination, may be transmitted between the plan and the covered person (or authorized representative) via telephone, facsimile, or other available similarly expeditious methods.

Continuing Claims

One original claim form per injury or illness is required each calendar year. Therefore, if you received services during a calendar year for an injury or illness where the diagnosis and health care provider remains the same, you or your provider do not need to submit a new claim form each time. You may submit the original itemized bill with your Social Security or HealthPlan Services member number written on it or include a copy of the original claim form.

Appeals

Your appeal rights are repeated at the bottom of every HealthPlan Services Explanation of Benefits. In the case of an urgent care claim appeal, a request for an expedited review may be submitted orally by calling HealthPlan Services at **1-800-216-2166**. All necessary information, including the appeal determination, may be transmitted between the plan and the covered person (or authorized representative) via telephone, facsimile, or other available similarly expeditious methods.

Appeals of non-urgent care claims should be sent to:

Appeals & Reconsideration Unit
HealthPlan Services
3701 Boardman-Canfield Road, Building B
Canfield, OH 44406

Retirement Benefits Claims and Appeals

Defined Contribution Plan Claims

If you are a participant in a defined contribution plan and wish to receive a distribution of any account balance you have in the plan, contact Vanguard online at **www.vanguard.com** or by calling the VOICE network at **1-800-523-1188**.

Vanguard will mail you the appropriate distribution application forms upon request and will process your request for a distribution from the plan.

If you wish to contest the amount to be distributed to you, you may discuss it with a Vanguard representative. If the problem is not resolved after discussing it with a Vanguard representative, Vanguard will provide you with a *Claim Initiation Form* for the appropriate plan. You must follow the instructions on the *Claim Initiation Form* to engage the plan's formal claims process. Beneficiaries can follow this procedure as well.

Statute of Limitations

Any legal action must be brought in the U.S. District Court of the Northern District of California.

Any claim regarding your form of payment or the failure to timely pay, in whole or in part, your account as of your benefit starting date must be filed within one year of your benefit starting date. In addition, any claim for benefits under the appropriate plan must be filed by the later of December 2016 or two years following the date you knew or should have known that a contribution should have been made to your account.

Deadlines for Responding to Your Claims

The claims administrator will make a decision on your claim within a reasonable period but not later than 90 days after it receives your *Claim Initiation Form*. In some cases, the claims administrator will notify you, before the end of the normal 90-day maximum period for responding to your claim, that additional time is required to process your claim on account of special circumstances. In that event, the claims administrator may take up to an

additional 90 days to respond to your claim. When the claims administrator requests the 90-day extension, it will indicate the special circumstances and the date by which it expects to make a decision on your claim.

Appeal

Within 90 days from the date of the claim denial letter, you or your authorized representative may file an appeal by writing to the Kaiser Permanente Administrative Committee's Appeals Sub-Committee (" Appeals Sub-Committee") at the address below and request a review of the denial:

Kaiser Permanente Administrative Committee
c/o Kaiser Foundation Health Plan, Inc.
One Kaiser Plaza, 20th Floor
Oakland, CA 94612

Deadlines for Responding to Your Appeal

The Appeals Sub-Committee will review your appeal at the next regularly scheduled meeting following receipt of an appeal. If the appeal is not received at least 30 days prior to the next scheduled meeting, it may be heard at the following regularly scheduled meeting. Meetings are held quarterly. If special circumstances require a further extension of time for processing, a determination shall be rendered not later than the third regularly scheduled meeting after the receipt of the appeal. The Appeals Sub-Committee will advise you in writing within 5 days of its decision, citing the specific reasons for its decision, and will identify those terms of the plan on which the decision is based.

Decision on Review

If the Appeals Sub-Committee denies your appeal, you will have exhausted your administrative remedies and you can bring a civil action in federal court under Section 502(a)(1)(B) of ERISA regarding the final denial of your claim for a benefit.

No legal action (whether in law, in equity, or otherwise) may be commenced or maintained against the plan, the plan administrator, the Kaiser Permanente Administrative Committee, or its Appeals Sub-Committee more than one year after the later of the date of the initial claim denial, or if a timely request for appeal of the denial has been made, the date of the Appeals Sub-Committee's appeal denial.

Legal and Administrative Information

This section of the SPD contains required legal information that applies to your benefit plans, including your rights under the Employee Retirement Income Security Act (ERISA) of 1974. The information in this section may not apply to all plans.

Highlights of This Section

Administration of the Plans

Entity	Plan Sponsor	Plan Administrator
Kaiser Foundation Health Plan, Inc./Kaiser Foundation Hospitals	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza, 20th Floor Oakland, CA 94612 510-271-5940 EIN # 94-1340523	**For Health and Welfare Plans** Kaiser Permanente Administrative Committee (KPAC) One Kaiser Plaza Oakland, CA 94612 510-271-5940 **For Defined Contribution Plans** Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612

Service of Legal Process

Service of legal process may be made upon a plan trustee or plan administrator. For the plan administrator, please direct all legal documents for service of legal process to the following agent:

Corporation Service Company
ATTN: Officer of the Corporation
2710 Gateway Oaks Dr., Suite
150N Sacramento, CA 95833

Administrative Powers and Responsibilities

The plan administrator and named fiduciary for purposes of the Employee Retirement Income Security Act of 1974 (ERISA) administers each employee benefit plan described in the *Summary Plan Description* (SPD), unless otherwise noted in this SPD.

The plan administrator has the authority to administer each of its employee benefit plans and may delegate this authority in writing to third parties such as insurers or Administrative Committees. The plan administrator also may delegate its authority to approve or deny claims for benefits to a claims administrator. The plan administrator or, to the extent delegated to a third party, has the exclusive and full discretionary authority to control and manage the administration and operation of each employee benefit plan described in your SPD, including but not limited to the following:

- The discretionary authority to make and enforce rules for the administration of each employee benefit plan, including the designation of forms to be used in such administration
- The discretionary authority to construe and interpret each and every document setting forth the applicable terms of a plan, including official plan documents, SPDs, and insurance contracts
- The discretionary authority to decide questions regarding the eligibility of any person to participate in any employee benefit plan

- The discretionary authority to approve or deny claims for benefits under each employee benefit plan unless discretionary authority has been delegated in writing to a third party, such as an insurer, claims administrator, or Administrative Committee
- The discretionary authority to appoint or employ agents, including but not limited to, counsel, accountants, consultants, and other persons to assist in the administration of each employee benefit plan

Welfare and Retirement Plans

The following are the plan names, identification numbers, and other relevant information on the welfare and retirement plans available to you. You may or may not be eligible to participate in all of these plans. For all plans, the plan year ends December 31.

Plan Name/Plan Options	Plan Sponsor EIN #	ID No.	Type of Plan	Claims Administrator	Type of Adminis-tration	Plan Trustee	Funding Medium	Contributing Source
HEALTH AND WELFARE PROGRAMS								
Kaiser Foundation Health Plan, Inc. Health and Welfare Plan	94-1340523	560	Health and Welfare Programs					
Kaiser Foundation Health Plan			Insured	Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612	Insured	N/A	Insured agreement premiums paid from general assets	Employer and employee
Kaiser Permanente Supplemental Medical Plan			Insured	Appeals & Reconsideration Unit HealthPlan Services 3701 Boardman-Canfield Road Bldg. B Canfield, OH 44406	Insured	N/A	Insured agreement premiums paid from general assets	Employer and employee
RETIREMENT PLANS								
Kaiser Permanente Tax-Sheltered Annuity Plan	94-1340523	033	KP 403(b) Defined Contribution Plan	The Vanguard Group P.O. Box 2600 Valley Forge, PA 19482	Third-Party/Record Keeper	The Vanguard Group P.O. Box 2600 Valley Forge, PA 19482	Trust	Employee and employer pre-tax contribution

Third Party Responsibility

The Plan has first rights of subrogation and reimbursement. As a condition of receiving plan benefits, eligible employees and/or their covered dependents grant specific and first rights of subrogation, reimbursement, and restitution to the Plan with respect to benefits they receive from the Plan that either relate to an injury, illness or condition which results from the act or omission of a third party or are, otherwise, subject to any reimbursement provision of a no fault automobile insurance policy. Such rights shall come first and shall not be adversely impacted in any way by:

- The " make whole doctrine" (i.e., the eligible employee's or covered dependent's recovery of his full damages or attorney's fees), contributory or comparative negligence, the common fund doctrine, or any other defense or doctrine which may limit the Plan's rights (equitable or otherwise); or
- The manner in which any recovery by an eligible employee or covered dependent is characterized or structured (e.g., as lost wages, damages, attorney's fees rather than as for medical expenses).

The Plan's rights of subrogation, reimbursement, and restitution shall extend to any property (including money), without regard to the type of property or the source of the recovery, including any recovery from the payment or compromise of a claim (including an insurance claim), a judgment or settlement of a lawsuit, resolution through any alternative dispute resolution process (including arbitration), or any insurance (including insurance on the employee and/or covered dependent, no-fault coverage, uninsured and/or underinsured motorist coverage).

The Plan is entitled to an equitable lien by contract and creation of a constructive trust. At the time the Plan pays benefits which may be subject to the Plan's right of reimbursement, subrogation, or restitution, the eligible employee and/or covered dependent shall at that time grant to the Plan (as a condition of such payment) an equitable lien by contract in any property described above, without regard to the identity of the property's source or holder at any particular time; or whether property at the time the property exists, is segregated, or whether the eligible employee and/or covered dependent has any rights to it. Until the time such equitable lien by contract is completely satisfied, the eligible employee and/or covered dependent or other holder of the property that is subject to such equitable lien by contract (e.g., an account or trust established for the benefit of the eligible employee and/or covered dependent, an insurer, etc.) shall hold such property as the Plan's constructive trustee. Such constructive trustee shall immediately deliver such property to the Plan upon the direction of the Plan to satisfy the equitable lien by contract.

Obligations of the Eligible Employee and/or Covered Dependent

The eligible employee and/or covered dependent shall:

- Not assign any rights or causes of action he or she may have against others (including under insurance policies) which may implicate the Plan's right to reimbursement, subrogation or restitution without the express written consent of the Plan;
- Cooperate with the Plan and take any action that may be necessary to protect the Plan's interests as described in this SPD.
- Immediately take or regain possession of any property subject to the Plan's equitable lien by contract in his or her own name, place it in a segregated account within his or her control at least in the amount of the equitable lien, and not alienate it or otherwise take any action so that such property is not in his or her possession prior to the satisfaction of such equitable lien by contract; and
- Promptly notify the Plan of the possibility that the circumstances regarding the payment of benefits by the Plan may be subject to the Plan's right of reimbursement, subrogation or restitution, or of the submission any claim or demand letter, the filing of any legal action or request for any alternative dispute resolution process, or of the commencement of any trial or alternative dispute resolution process (at least 30 days prior notice), or of any

agreement (relating to any claim, legal action or alternative dispute resolution), that relates to any property that may be subject to the Plan's rights of subrogation, reimbursement, restitution, to an equitable lien by contract, or as beneficiary of a constructive trust.

No Duty to Independently Sue or Intervene

While the Plan's right of subrogation includes the right to file an independent legal action or alternative dispute resolution proceeding against such third party (or to intervene in one brought by or on behalf of the eligible employee and/or covered dependent), it has no obligation to do so.

Recovery of Overpayments

To the extent that the Plan makes a payment to any eligible employee or dependent or beneficiary in excess of the amount payable under the Plan to such eligible employee or dependent or beneficiary, the Plan shall have a first right of reimbursement and restitution with an equitable lien by contract in the amount of such overpayment. The holder of any such overpayment shall hold such property as the Plan's constructive trustee. The Plan's rights of reimbursement and restitution shall in no way be affected, reduced, compromised, or eliminated by any doctrines limiting its rights (equitable or otherwise) such as the make-whole doctrine, contributory or comparative negligence, the common fund doctrine, or any other defense. The Plan's rights against the eligible employee's or dependent's or beneficiary's obligation to the Plan shall also not be affected if the overpayment was made to another person or entity on behalf of the eligible employee or covered dependent or beneficiary.

If any eligible employee or covered dependent or beneficiary has cause to reasonably believe that an overpayment may have been made, the eligible employee or covered dependent or beneficiary shall promptly notify the Plan Administrator of the relevant facts, shall not alienate any property that may be subject to the Plan's right of reimbursement or restitution, and shall cooperate with the Plan and take any action that may be necessary to protect the Plan's interests as described in this SPD. If the Plan Administrator determines (on the basis of any relevant facts) that an overpayment was made to any eligible employee or covered dependent or beneficiary (or any other person), any amounts subsequently payable as benefits under this Plan with respect to the eligible employee or covered dependent or beneficiary may be reduced by the amount of the outstanding overpayment or the Plan Administrator may recover such overpayment by any other appropriate method that the Plan Administrator shall determine.

Qualified Domestic Relations Order

In the event of a separation or dissolution of marriage, a court may issue an order directing one or more of your retirement plans to pay some or all of your benefits for alimony, child support, or divided community property. Within a reasonable period after the plan receives the order, it will determine whether the order is a Qualified Domestic Relations Order (QDRO) and will advise you in writing of its determination, or it will ask a court to decide the question.

Until validity of the Domestic Relations Order is resolved, your interest in the plan which is subject to the Domestic Relations Order will be segregated and may not be distributed. If a decision is made within 18 months, the account will be paid out in accordance with the QDRO. If the status of the Domestic Relations Order is unresolved, your benefit will no longer be segregated and distributions may be permitted. If the order is later determined to be qualified, the order will apply prospectively.

QDRO Fees

If the Plan receives a Domestic Relations Order regarding one or more of your Kaiser Permanente defined contribution retirement plans, you will be charged a review and processing fee that will be deducted from your

account. The current fee for reviewing and processing a Domestic Relations Order applicable to one Kaiser Permanente defined contribution plan is $475. The fee for two or more plans is an additional $275, with a maximum of $750 for all applicable defined contribution plans. There is no review and processing fee for a Domestic Relations Order applicable to a Kaiser Permanente defined benefit pension plan.

For additional information about a QDRO for your defined benefit plan, contact the Kaiser Permanente Retirement Center (KPRC) at **1-866-627-2826** Monday through Friday from 6 a.m. to 6 p.m. Pacific time, or online by clicking the **My Pension** button on the **Retirement** page of My HR at **kp.org/myhr**.

For additional information about a QDRO for your defined contribution retirement plan(s), contact Vanguard at **www.vanguard.com** or **1-800-523-1188**.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) creates or recognizes the rights of a child or other dependent of a participant who, by virtue of a Domestic Relations Order, is entitled to receive medical benefits through the participant's coverage. You will be contacted by the National Human Resources Service Center (NHRSC) in the event a QMCSO is received by the plan administrator.

Such an order cannot require Kaiser Permanente to provide any type or form of benefit or any option that is not otherwise provided to the participant under the provisions of the plan.

If the plan receives a medical child support order for your child that instructs the plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If the Administrator determines that it does, your child will be enrolled in the plan as your dependent, and the plan will be required to provide benefits as directed by the order. Coverage will continue for as long as specified in the order, or until coverage would otherwise end according to the terms of the plan.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Statement of ERISA Rights

As a participant in any employee benefit plan sponsored by your employer, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all pension and welfare plan participants shall be entitled to:

- Examine, without charge, at the plan administrator's office, copies of all documents filed by the plan with the
- U.S. Department of Labor, such as detailed annual reports and plan descriptions.
- Obtain copies of all the plan documents and other plan information upon written request to the plan administrator through the NHRSC. The plan administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required to furnish each participant with a copy of the Summary Annual Report/annual funding notice free of charge.
- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to be entitled to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The plan must provide the statement free of charge.
- Continue group health plan coverage for yourself, spouse or dependents through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) if there is a loss of coverage under the plan as a result of a

qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- A reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.
- Prudent actions by plan fiduciaries. In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called " fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.
- If your claim for a (pension, welfare) benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

Not all of the plans described in this SPD are subject to ERISA provisions. If you have any questions about your plans, you should contact the National Human Resources Service Center. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, contact the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-EBSA (1-866-444-3272)**, or the Division of Technical Assistance and Inquiries at the address below:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Ave. NW
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

THE RIGHT TO AMEND OR TERMINATE THE PLANS

The plan sponsors reserve the right to amend or terminate any or all of the employee benefit plans described in this *Summary Plan Description* in any way and at any time. Such changes will be made in accordance with the procedures contained in the official plan documents for the plan. You will be notified if the plan sponsors change or terminate any of your employee benefits.

KAISER PERMANENTE®

Help in your Language for Medical Benefits

English: You have the right to get help in your language at no cost. If you have questions about your benefits, or you are required to take action by a specific date, call the number provided for your state or region to talk to an interpreter.

አማርኛ (Amharic): ያለምንም ክፍያ በቋንቋዎ እርዳታ የማግኘት መብት አለዎ። ስለ ጥቅማጥቅሞችዎ ጥያቄዎች ካሉዎት፣ ወይም በተወሰነ ቀን እንዲያከናውኑ የሚጠበቅዎ ድርጊት ካለ፣ ስቴትዎ ወይም ክልልዎ ከተርጓሚ ጋር እንዲነጋገር በተሰጠዎ ስልክ ቁጥር ይደውሉ።

العربية (Arabic): لك الحق في الحصول على المساعدة بلغتك دون تحمل أي تكاليف. إذا كانت لديك استفسارات بشأن المزايا الخاصة بك أو قد طُلب منك اتخاذ إجراء خلال تاريخ محدد، يُرجى الاتصال بالرقم المخصص لولايتك أو منطقتك للتحدث إلى مترجم فوري.

Հայերեն (Armenian): Դուք ունեք Ձեր լեզվով անվճար օգնություն ստանալու իրավունք: Եթե Դուք հարցեր ունեք Ձեր նպաստների, կամ Դուք պարտադրված եք գործողություններ ձեռնարկել մինչև որոշակի ամսաթիվ, ապա զանգահարե՛ք Ձեր նահանգի կամ շրջանի համար տրամադրված հեռախոսահամարով՝ թարգմանչի հետ խոսելու համար:

Ɓǎsɔ́ɔ̀ - wùdù (Bassa): Ɔ mɔ̀ nì kpé ɓɛ́ m̀ ké gbo-kpá-kpá dyé dɛ́ m̀ mìɔùn nììn ɓídí-wùdù mú pídyi. Ɔ jǔ ké m̀ dyi dyi-diè-dɛ̀ ɓě ɓédé ɓá kpáná ɓě m̀ kɔ̃̀ m̀ ké dyéɛ jè dyí, mɔɔ ɔ jǔ ké wa dyi níin m̀ mɛ nyu dɛ dɛ́ ɓě ɓó wé jɛ̀ɛ́ dɔ̀ kɔ̃ɛɛ ní, nìí, m̀ mɛ dá nɔ̀ɓà ɓɛ́ wa tòà ɓó nì ɓódɔ́ɔ̀ mɔɔ ɓó nì gbɛ̌ɛ̀ɔ̀ bìlɛ, ɓɛ́ m̀ ké nyɔ-wudúún-zà-nyɔ̀ dɔ̀ gbo wùdù.

বাংলা (Bengali): বিনা খরচে আপনার নিজের ভাষায় সাহায্য পাওয়ার অধিকার আপনার আছে। আপনার সুবিধাগুলির সম্পর্কে আপনার যদি কোন প্রশ্ন থাকে, অথবা একটি নির্ধারিত দিনের মধ্যে যদি আপনার কোন পদক্ষেপ গ্রহণ করার প্রয়োজন হয়, তাহলে দোভাষীর সঙ্গে কথা বলতে আপনার রাজ্য বা অঞ্চলের জন্য প্রদত্ত নম্বরটিতে ফোন করুন।

For Self-funded plans:

Northern California Region	1-800-663-1771
Southern California Region	1-800-533-1833
Colorado Region	1-877-883-6698
Mid-Atlantic States Region	1-877-740-4117
Northwest Region	1-866-800-3402
Georgia Region	1-866-800-1486
TTY	711

For Fully-insured plans:

California	1-800-464-4000
Colorado	1-800-632-9700
District of Columbia	1-800-777-7902
Georgia	1-888-865-5813
Hawaii	1-800-966-5955
Maryland	1-800-777-7902
Oregon	1-800-813-2000
Virginia	1-800-777-7902
Washington	1-800-813-2000
TTY	711

For Plans adminstered by HealthPlan Services:

All Regions	1-800-216-2166
TTY	711

Cebuano (Bisaya): Anaa moy katungod nga mangayo og tabang sa inyo pinulongan ug kini walay bayad. Kung naa mo pangutana bahin sa inyo benepisyo o may mga butang nga nanginahanglan sa inyo paglihok sa dili pa usa ka piho nga petsa, palihug lang pagtawag sa mga numero sa telepono nga gihatag sa imong estado ("state") o rehiyon ("region") para makigstorya sa usa ka interpreter.

中文 (Chinese): 您有權免費以您的語言獲得幫助。如果您對您的福利有任何疑問，或者您被要求在具體日期之前採取措施，請致電您所在的州或地區的電話，與口譯員進行溝通。

Chuuk (Chuukese): Mei wor omw pwuung omw kopwe neuneu aninis non kapasen fonuomw (Chuukese), ese kamo. Ika mei wor omw kapas eis usun omw pekin insurance, are ika a men auchea omw kopwe fori pwan ekoch fofor mei namot ngeni omw plan, ke tongeni kori ewe nampa ren omw state ika neni (asan) pwe eman chon awewe epwe anisuk non kapasen fonuomw.

Français (French): Une assistance gratuite dans votre langue est à votre disposition. Si vous avez des questions à propos de vos avantages ou si vous devez prendre des mesure à une date précise, appelez le numéro indiqué pour votre Etat ou votre région pour parler à un interprète.

Deutsch (German): Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Falls Sie Fragen bezüglich Ihres Leistungsanspruchs haben oder Sie bis zu bestimmten Stichtagen handeln müssen, rufen Sie die für Ihren Bundesstaat oder Ihre Region aufgeführte Nummer an, um mit einem Dolmetscher zu sprechen.

ગુજરાતી (Gujarati): તમને કોઇ પણ ખર્ચ વગર તમારી ભાષામાં મદદ મેળવવાનો અધિકાર છે. જો તમને તમારા લાભો વિશે પ્રશ્નો હોય, અથવા કોઈ ચોક્કસ તારીખથી તમને પગલાં લેવાની જરૂર હોય, તો દુભાષિયા સાથે વાત કરવા તમારા સ્ટેટ અથવા રીજીયન માટે પુરો પાડવામાં આવેલ નબંર પર ફોન કરો.

Kreyòl Ayisyen (Haitian Creole): Ou gen dwa pou jwenn èd nan lang ou gratis. Si ou gen nenpòt kesyon sou aplikasyon ou an oswa asirans ou ak Kaiser Permanente, oswa si nan avi sa a gen bagay ou sipoze fè avan yon sèten dat, rele nimewo nou mete pou Eta oswa rejyon ou a pou w ka pale ak yon entèprèt.

ʻōlelo Hawaiʻi (Hawaiian): He pono a ua loaʻa no kekahi kōkua me kāu ʻōlelo inā makemake a he manuahi no hoʻi. Inā he mau nīnau kāu e pili ana i kāu pono keu i ka polokalamu ola kino, a i ʻole inā ke haʻi nei iāʻoe e hana koke aku i kēia ma mua o kekahi lā i waiho ʻia, e kelepona aku i ka helu i loaʻa nei no kāu mokuʻāina a i ʻole panaʻāina no ka walaʻau ʻana me kekahi kanaka unuhi ʻōlelo.

हिन्दी (Hindi): आपको बिना कोई कीमत चुकाए आपकी भाषा में मदद पाने का अधिकार है। यदि आप आपके लाभ के बारे में कोई सवाल पूछना चाहते हैं या आपको किसी निश्चित तारीख तक कोई कारवाई करने की आवश्यकता है,तो आप आपके राज्य या क्षेत्र के लिए दिये गए नंबर पर फोन करके किसी दुभाषिए से बात करें।

Hmoob (Hmong): Koj muaj cai tau txais kev pab txhais ua koj hom lus pub dawb. Yog koj muaj lus nug txog koj cov txiaj ntsig, lossis koj yuav tsum tau ua raws li hnub hais tseg ntawd, hu rau tus nab npawb xovtooj ntawm lub xeev lossis hauv ib cheeb tsam uas tau muab rau koj mus tham nrog ib tug kws txhais lus.

Igbo (Igbo): Ị nwere ikike ịnweta enyemaka n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ọ bụrụ na ị nwere ajụjụ gbasara elele gị, ma ọ bụ na achọrọ ka ị mee ihe tupu otu ụbọchị, kpọọ nọmba enyere maka steeti ma ọ bụ mpaghara gị i ji kwukọrịta okwu n'etiti onye ọkọwa okwu.

Iloko (Ilocano): Adda dda ti karbenganyo a dumawat iti tulong iti pagsasaoyo nga awan ti bayadanyo. No addaankayo kadagiti saludsod maipanggep kadagiti benepisioyo wenno, mangkalikagum kadakayo a rumbeng nga aramidenyo ti addang iti espesipiko a petsa, tawagan ti numero nga inpaay para ti estado wenno rehion tapno makipatang ti maysa mangipatarus iti pagsasao.

Italiano (Italian): Hai il diritto di ricevere assistenza nella tua lingua gratuitamente.In caso di domande riguardanti le tue agevolazioni o se devi intervenire entro una data specifica, chiama il numero fornito per il tuo stato o la tua regione per parlare con un interprete.

日本語 (Japanese): あなたは、費用負担なしでご使用の言語で支援を受ける権利を保持しています。給付に関してご質問があるか、または、あなたが特定の日付までに行動を起こすよう依頼されている場合、お住まいの州または地域に対して提供された電話番号に電話して、通訳とお話ください。

ខ្មែរ (Khmer): អ្នកមានសិទ្ធិទទួលបានជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ បើសិនអ្នកមានសំណួរណាមួយអំពីអត្ថប្រយោជន៍របស់លោកអ្នក ឬត្រូវបានតម្រូវឲ្យអ្នក ចាត់វិធានការត្រឹមកាលបរិច្ឆេទជាក់លាក់ សូមទូរស័ព្ទទៅលេខដែលបានផ្តល់ជូនសម្រាប់រដ្ឋឬតំបន់របស់អ្នកដើម្បីនិយាយទៅកាន់អ្នកបកប្រែ ។

한국어 (Korean): 귀하에게는 한국어 통역서비스를 무료로 받으실 수 있는 권리가 있습니다. 귀하의 보험 혜택이나 이 통지서의 요구대로 어느 날짜까지 조취를 취해야만 하는 경우, 제공된 귀하의 주 및 지역 전화번호로 연락해 통역사와 통화하십시오.

ลาว (Laotian): ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສັງຄ່າ. ຖ້າວ່າ ທ່ານມີຄຳຖາມກ່ຽວກັບຜົນປະໂຫຍດຂອງທ່ານ, ຫຼື ທ່ານຈຳເປັນຕ້ອງດຳເນີນການພາຍໃນວັນທີທີ່ເຈາະຈົງໃດໜຶ່ງ, ໃຫ້ໂທຕາມໝາຍເລກທີ່ໃຫ້ໄວ້ສຳລັບລັດ ຫຼື ເຂດຂອງທ່ານເພື່ອຂໍລົມກັບນາຍພາສາ.

Kajin Majōļ (Marshallese): Ewōr jimwe eo aṃ in bōk jipañ ilo kajin eo aṃ ejjeļọk wōṇāān. Ñe ewōr aṃ kajjitōk kōn jibañ ko aṃ, ak ñe kwoj aikuuj in ṃakūtkūt ṃokta jān juon raan eo emōj an kallikkar, kaļọk nōṃba eo ej leļọk ñan state eo aṃ ak jikūṃ bwe kwōn maroñ kōnono ippān juon ri-ukōt.

Naabeehó (Navajo): Doo bik'é asíníłáágo ata' hane' bee níká i'doolwoł. Bee naa áháyánígíí dóó bee níká aná'álwo'ígíí bína'ídíłkidgo, éí doodago náás yoołkááłgi hait'éegoda í'díílíił ni'di'nígo, bik'ehgo béésh bee hane'í naaltsoos bikáá'íjį' hodíílnih nitsaa hahoodzojį' éí doodago aadi nahós'a'di áko ata' halne'í bich'į' hadíídzih.

नेपाली (Nepali): तपाईंले कुनै खर्च बिना आफ्नो भाषामा सहायता पाउने अधिकार छ। यदि सुविधाहरूका बारेमा तपाईंको कुनै प्रश्नहरू भए, अथवा कुनै निर्धारित मिति भित्र तपाईंले कुनै कारबाही गर्न आवश्यक भए, कुनै दोभाषेसँग कुरा गर्न तपाईंको राज्य वा क्षेत्रका लागि उपलब्ध नम्बरमा फोन गर्नुहोस्।

Afaan Oromoo (Oromo): Baasii malee afaan keetiin gargaarsa argachuudhaaf mirga qabda. Waa'ee tajaajila keetii ilaalchisee gaaffii yoo qabaatte, yookaan yoo guyyaa murtaa'e irratti tarkaanfii akka fudhattu gaafatamte, lakkoofsa bilbilaa naannoo yookaan goodina keetiif kenname bilbiluudhaan turjumaana haasofsiisi.

فارسی (Persian): شما حق دارید که بدون هیچ هزینه ای به زبان خود کمک دریافت کنید. اگر درباره مزایای خود سؤالی داشته یا لازم است تا تاریخ مشخصی اقدامی بعمل آورید، برای صحبت با یک مترجم شفاهی با شماره تلفن ارائه شده برای ایالت یا منطقه خود تماس بگیرید.

lokaiahn Pohnpei (Pohnpeian): Komw anehki pwung en rapahki sounkawehwe en omw palien lokaia ni sohte isaihs. Ma mie iren owmi kalelapak ohng kosoandi me pid kamwau pe kan, de anahne komwi en mwekid ohng rahn me kileledi, ah komw anahne koahl nempe me sansalehr (insert number here) ohng owmi palien wehi pwe komwi en lokaiaieng owmi tungoal soun kawehwe.

Português (Portuguese): Você tem o direito de obter ajuda em seu idioma sem nenhum custo. Se você tiver dúvidas sobre seus benefícios, ou caso seja necessário que você tome alguma medida até uma data específica, ligue para o número fornecido para seu estado ou região para falar com um intérprete.

ਪੰਜਾਬੀ (Punjabi): ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਸ਼ੁਲਕ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਮਦਦ ਪਾਉਣ ਦਾ ਹੱਕ ਹੈ. ਜੇਕਰ ਤੁਹਾਡੇ ਆਪਣੇ ਫਾਇਦਿਆਂ ਬਾਰੇ ਸਵਾਲ ਹਨ, ਜਾਂ ਤੁਹਾਨੂੰ ਕਿਸੇ ਨਿਸ਼ਚਿਤ ਮਿਤੀ ਤੱਕ ਕਾਰਵਾਈ ਕਰਨ ਦੀ ਲੋੜ ਪਵੇ, ਤਾਂ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ ਆਪਣੇ ਰਾਜ ਜਾਂ ਇਲਾਕੇ ਲਈ ਮੁਹੱਈਆ ਕਰਵਾਏ ਗਏ ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰੋ.

Română (Romanian): Aveți dreptul de a solicita ajutor care să vă fie oferit în mod gratuit în limba dumneavoastră. Dacă aveți întrebări legate de beneficiile dumneavoastră sau vi se solicită să luați măsuri până la o anumită dată, sunați la numărul de telefon furnizat pentru statul sau regiunea dumneavoastră pentru a sta de vorbă cu un interpret.

Русский (Russian): У вас есть право получить бесплатную помощь на своем языке. Если у вас имеются вопросы относительно ваших преимуществ либо необходимо выполнение каких-либо действий к определенной дате, позвоните по номеру телефона для своего штата или региона, чтобы поговорить с переводчиком.

Faa-Samoa (Samoan): E iai lou 'aia e maua fua se fesoasoani i lou lava gagana. Afai e iai ni fesili e uiga i ou penefiti, pe e manaomia onae gaioioi a o le'i oo i se aso filifilia, vili le numera ua saunia atu mo lou setete po o vaipanoa e talanoa i se faaliliu.

Español (Spanish): Usted tiene derecho a obtener ayuda en su idioma sin costo alguno. Si tiene preguntas acerca de sus beneficios o si se le solicita que tome alguna medida antes de una fecha determinada, llame al número de teléfono que se proporciona para su estado o región para hablar con un intérprete.

Tagalog (Tagalog): Mayroon kang karapatang humingi ng tulong sa iyong wika nang walang bayad. Kung mayroon kang mga katanungan tungkol sa iyong mga benepisyo o kinakailangan mong magsagawa ng aksyon sa tiyak na petsa, tumawag sa numerong ibinigay para sa iyong estado o rehiyon para makipag-usap sa isang interpreter.

ไทย (Thai): ท่านมีสิทธิที่จะได้รับความช่วยเหลือในภาษาของท่านโดยไม่เสียค่าใช้จ่าย หากท่านมีคำถามเกี่ยวกับสิทธิประโยชน์ของท่าน หรือท่านจำเป็นต้องดำเนินการภายในวันที่ที่กำหนดไว้ โปรดติดต่อหมายเลขที่ให้ไว้สำหรับรัฐหรือเขตพื้นที่ของท่านเพื่อคุยกับล่าม

Lea Faka-Tonga (Tongan): 'Oku 'i ai ho totonu ke ma'u ha fakatonulea ta'etotongi. Kapau 'oku 'i ai ha'o fehu'i 'o fekau'aki mo ho ngaahi penefiti, pe ko ha me'a na'e fiema'u ke fai ki ha 'aho na'e tukupau atu ke fakahoko ia, taa ki he fika kuo 'oatu ki ho siteiti pe ko e vahefonua ke talanoa mo ha fakatonulea.

Українська (Ukrainian): У Вас є право на отримання допомоги на Вашій рідній мові безкоштовно. Якщо Ви маєте питання стосовно Ваших переваг, чи якщо Вам необхідно здійснити певну дію до конкретної дати, подзвоніть по номеру телефону, що відповідає Вашій країні чи регіону, щоб поговорити з перекладачем.

اُردو (Urdu): آپ کو کوئی بھی قیمت ادا کئے بغیر اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ اگر آپ کے ذہن میں اپنے فوائد کے متعلق کوئی سوالات ہیں، یا آپ کو ایک مخصوص تاریخ تک عمل انجام دینے کی ضرورت ہے تو، کسی مترجم سے بات چیت کرنے کے لئے آپ کی ریاست یا علاقہ کے لئے فراہم کئے گئے نمبر پر کال کریں۔

Tiếng Việt (Vietnamese): Quý vị có quyền được nhận trợ giúp miễn phí bằng ngôn ngữ của mình. Nếu quý vị có các câu hỏi về các lợi ích của mình, hoặc quý vị được yêu cầu thực hiện vào một ngày cụ thể, hãy gọi đến số điện thoại được cung cấp cho bang hoặc khu vực của quý vị để trò chuyện với phiên dịch viên.

Yorùbá (Yoruba): O ní ẹ̀tọ́ láti gba ìrànwọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Tí o bá ní ìbéèrè nípa àwọn ànfàní rẹ tàbí o ní láti gbé ìgbésẹ̀ kan ní ọjọ́ kan pàtó, pe nọ́mbà tí a pèsè fún ìpínlẹ̀ rẹ tàbí agbègbè láti bá òṣìṣẹ́ kan sọ̀rọ̀.

KAISER PERMANENTE®

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

Kaiser Permanente complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in alternative formats
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call the number provided below for your region.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance at the address provided below for your region, to the attention of the Kaiser Civil Rights Coordinator.

Region	Phone #	Address to File a Grievance
Colorado	1-800-632-9700 711 (TTY)	2500 South Havana Aurora, CO 80014
Georgia	1-888-865-5813 711 (TTY)	Nine Piedmont Center 3495 Piedmont Road, NE Atlanta, GA 30305-1736
Hawaii	1-800-966-5955 711 (TTY)	711 Kapiolani Blvd Honolulu, HI 96813
Mid-Atlantic States	1-800-777-7902 711 (TTY)	2101 East Jefferson Street Rockville, MD 20852
Northwest	1-800-813-2000 711 (TTY)	500 NE Multnomah St. Ste 100 Portland, OR 97232

You can file a grievance by mail or phone. If you need help filing a grievance, the Kaiser Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-868-1019
1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Benefits for You

Pharmacy Residents

Summaries of Material Modification through September 2021

Colorado

Summary Plan Description

KAISER PERMANENTE®

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September 2021

To: All Kaiser Permanente employees participating in or eligible for the health plans listed on page 2

Re: COVID-19 testing and vaccines

Overview

As part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, COVID-19 testing and vaccines are available at no charge under certain health care plans through the end of the COVID-19 National Emergency Period. The current National Emergency period is the period from March 1, 2020 until 60 days after the federal government announces the end of the National Emergency. Please read the *Summary of Material Modification* below for updates to your *Summary Plan Description* (SPD).

SUMMARY OF MATERIAL MODIFICATION

This document updates the **Health Care** section of your *Summary Plan Description* (SPD). Please read this document carefully and keep it with your SPD for future reference.

Update to Your SPD

Cost share information related to COVID-19 health care services is hereby added as a "Special Note" to the **Health Care** sections of your SPD. All other information in this section remains unchanged.

HEALTH CARE

Medical Plan *(as applicable)* *(see list of plans on page 2)*

COVID-19 Services

Special Note

Under the Coronavirus Aid, Relief, and Economic Security (CARES) Act, effective through the end of the COVID-19 National Emergency Period, COVID-19 testing and vaccines are available at no charge.

For More Information

For more information about your benefits, you may refer to the **Benefits & Wellness** tab at **kp.org/HRconnect** and click on the **Benefits documents** link to access your SPD.

Plans affected by changes in this SMM:

Health Plans

- Alternate Comprehensive Medical Plan
- Alternate Medical Plan
- Comprehensive Medical Plan
- Comprehensive Medical Plan with vision benefits
- Hawaii Medical Service Association Preferred Provider Organization Plan
- Kaiser Foundation Health Plan
- Kaiser Employee Medical Health Plan
- Preferred Provider Organization Plan
- Preferred Provider Organization Plus Plan
- Retiree Out-of-Area Plan
- Base Plus Major Medical Plan (for select grandfathered retirees only)

The information described herein is an update to your *Summary Plan Description*.
In case of any omission or conflict between what is written in this document and what is written in the plan documents, contracts, or agreements, the plan documents, contracts, or agreements always govern.

The Plan Sponsor reserves the right to modify, amend, change, replace, or terminate the benefit plans described in this *Summary of Material Modification* at any time. Benefits may be modified or eliminated through the negotiation process as well. You will be advised of any significant changes in your benefit program.

KAISER PERMANENTE®

September 2021

To: All Kaiser Permanente employees

Re: COVID-19 National Emergency deadline extension

Overview

Due to the COVID-19 National Emergency, the deadlines for taking certain actions under your benefit plans have been extended if the original deadline was on or after March 1, 2020. The new extended deadlines end on the earlier of:

1. One year from the date of your original deadline, or
2. 60 days from the end of the National Emergency period plus the usual time period given to take action

Please note: As of the date of this communication, there has not been a declared end date to the COVID-19 National Emergency period.

Please read the *Summary of Material Modification* (SMM) below for details on how these changes update your *Summary Plan Description* (SPD).

SUMMARY OF MATERIAL MODIFICATION

This document updates your *Summary Plan Description* (SPD). Please read this document carefully and keep it with your SPD for future reference.

Update to Your SPD

Information about the COVID-19 National Emergency deadline is hereby added as a "Special Note" in the **Front** section of your SPD. All other information in this section remains unchanged.

COVID-19 National Emergency Deadline Extensions

Special Note

The time period to complete the action items listed below has been extended due to the COVID-19 National Emergency if the original deadline was on or after March 1, 2020. Once the end of the National Emergency is announced by the federal government, you will have 60 days plus the usual time period to complete any applicable action items. However, the deadline will not extend by more than one year from the date of the original deadline, even if the National Emergency is still ongoing at that time.

Refer to the chart below for a list of applicable actions and information on how the extension is applied:

Action	Regular Deadline	Extended Deadline
Enroll newly eligible dependents in medical coverage (due to marriage, birth, adoption or placement for adoption)	31 days from date of event	The earlier of: ▪ 1 year from the date of event + 31 days, OR ▪ 60 days after the end of the declared National Emergency period + 31 days

Action	Regular Deadline	Extended Deadline
Enroll in medical coverage due to: (a) certain losses of coverage such as Medicaid or a state Children's Health Insurance Program or (b) becoming eligible for a state premium assistance program such as Medicaid or a state Children's Health Insurance Program	60 days from date of event	The earlier of: ▪ 1 year from the date of event + 60 days, OR ▪ 60 days after the end of the declared National Emergency period + 60 days
Enroll in COBRA coverage	60 days from the loss of coverage	The earlier of: ▪ 1 year from the date of event + 60 days, OR ▪ 60 days after the end of the declared National Emergency period + 60 days
Notify Kaiser Permanente of a COBRA qualifying event	60 days from the event	The earlier of: ▪ 1 year from the date of event + 60 days, OR ▪ 60 days after the end of the declared National Emergency period + 60 days
Pay monthly COBRA premiums	45 days from election date	The earlier of: ▪ 1 year from the date of COBRA election + 45 days, OR ▪ 60 days after the end of the declared National Emergency period + 45 days
Request an external review of medical claims and submit additional information for a request	See the **Medical Plans Claims and Appeals** section for the specific plan deadline	The earlier of: ▪ 1 year from the date of original deadline, OR ▪ 60 days after the end of the declared National Emergency period + the specific plan deadline to take action
File benefit claims and appeals for all health and welfare plans (medical, life insurance, disability, etc.) and all retirement savings plans	See specific sections in the **Disputes, Claims and Appeals** section for the specific plan deadline	The earlier of: ▪ 1 year from the date of original deadline, OR ▪ 60 days after the end of the declared National Emergency period + the specific plan deadline to take action

For More Information

For more information about your benefits, you may refer to the **Benefits & Wellness** tab at **kp.org/HRconnect** and click on the **Benefits documents** link to access your SPD.

The information described herein is an update to your *Summary Plan Description*. In case of any omission or conflict between what is written in this document and what is written in the plan documents, contracts, or agreements, the plan documents, contracts, or agreements always govern.

The Plan Sponsor reserves the right to modify, amend, change, replace, or terminate the benefit plans described in this *Summary of Material Modification* at any time. Benefits may be modified or eliminated through the negotiation process as well, if applicable. You will be advised of any significant changes in your benefit program.

KAISER PERMANENTE®

September 2021

To: All executives and nonrepresented employees in the following regions:

- Colorado
- Georgia
- Hawaii
- Mid-Atlantic States
- National Functions
- Northern California (KFH/KFHP)
- Northwest
- Southern California (KFH/KFHP)

Re: Preventive care services covered under the Affordable Care Act

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Overview

Effective January 1, 2022, Kaiser Foundation Health Plan (KFHP) and Kaiser Employee Medical Health Plans (KEMHP) medical plans for the nonrepresented employees listed above will no longer be grandfathered under the Affordable Care Act (ACA). As a result, certain preventive services, as defined by the region, will be covered at $0 cost share.

SUMMARY OF MATERIAL MODIFICATION

This document updates the **Health Care** section of your *Summary Plan Description* (SPD) or your *Benefits Booklet*, as applicable for your region or employee group. Please read this document carefully and keep it with your SPD or *Benefits Booklet* for future reference.

Update to Your SPD

HEALTH CARE

The **Grandfathered Health Plan** section is hereby removed from the SPD and replaced with the **Patient Protection Disclosure section**. In addition, the following KFHP rows are added to the Covered Services chart, as applicable.

Patient Protection Disclosure

Kaiser Foundation Health Plan (KFHP) generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, KFHP designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Member Services.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from KFHP or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Member Services.

Kaiser Foundation Health Plan

Your Medical Plan Options at a Glance

Benefits	Plan Option, as applicable You Pay
Outpatient Care	
Affordable Care Act (ACA) Preventive Services, as defined by each region	No charge
Prescription Drugs	
ACA-mandated medications	No charge

Update to Your Kaiser Employee Medical Health Plan (KEMHP) *Benefits Booklet*

The **Grandfathered Health Plan** section is hereby removed from the *Benefits Booklet*.

In addition, the Affordable Care Act (ACA) Preventive Services as defined by each region and as shown in the **Schedule of Benefits** chart will be provided at no charge.

For More Information

For more information about your benefits, you may refer to the **Benefits & Wellness** tab at **kp.org/HRconnect** and click on the **Benefits documents** link to access your SPD or *Benefits Booklet*, as applicable.

Note: You may request a paper copy of this *Summary of Material Modification* (SMM) at no charge by calling the National Human Resources Service Center (NHRSC) at **877-4KP-HRSC** (**877-457-4772**).

The information described herein is a summary of benefit changes effective on January 1, 2022.
In case of any omission or conflict between what is written in this document and what is written in the plan documents, contracts, or agreements, the plan documents, contracts, or agreements always govern.

The Plan Sponsor reserves the right to modify, amend, change, replace, or terminate the benefit plans described in this *Summary of Material Modification* at any time. You will be advised of any significant changes in your benefit program.

KAISER PERMANENTE®

September 2021

To: All Kaiser Permanente employees who are eligible for Employee Life and/or Voluntary Term Life insurance through MetLife

Re: Choosing Your Beneficiary

Overview

The *Summary of Material Modification* (SMM) below updates the **Choosing Your Beneficiary** language in your *Summary Plan Description* (SPD). Please read the SMM below for more information.

SUMMARY OF MATERIAL MODIFICATION

This document updates the **Income Protection section** of your *Summary Plan Description* (SPD). Please read this document carefully and keep it with your SPD for future reference.

Update to Your SPD

This SMM replaces the language for **Choosing Your Beneficiary** in its entirety in the Income Protection section for your Employee Life insurance and/or Voluntary Term Life insurance, as applicable. All other information in the section remains unchanged.

INCOME PROTECTION

Employee Life Insurance

Choosing Your Beneficiary

You must choose a beneficiary or beneficiaries when you enroll in life insurance coverage, designating the person(s) to receive benefits in the event of your death. You may designate primary and contingent beneficiaries. If, upon your death, there is no beneficiary or surviving designated beneficiary, MetLife will determine the beneficiary to be one or more of the following who survive you:

- Spouse or Domestic Partner
- Child(ren)
- Parent(s)
- Sibling(s)

Instead of making payments to any of the above, MetLife may pay your estate. Any payment made in good faith will discharge MetLife's liability to the extent of such payment. If a beneficiary or payee is a minor or incompetent to receive payment, MetLife will pay that person's guardian.

To name a beneficiary, access MetLife online through HRconnect. Sign on to **kp.org/HRconnect** and select the **Benefits & Wellness tab**. Under the **Enroll & Change** column, choose **My beneficiaries**. From there, select **Life Insurance** and click on the blue button labeled **Update Beneficiary**. You will be taken to MetLife's online **My Accounts** portal.

If you do not have access to a computer, you can designate your beneficiary by calling MetLife at **888-420-1661**, **prompt 5**.

Benefits by Design Voluntary Programs

Voluntary Term Life

Choosing Your Beneficiary

You must choose a beneficiary or beneficiaries when you enroll in life insurance coverage, designating the person(s) to receive benefits in the event of your death. You may designate primary and contingent beneficiaries. If, upon your death, there is no beneficiary or surviving designated beneficiary, MetLife will determine the beneficiary to be one or more of the following who survive you:

- Spouse or Domestic Partner
- Child(ren)
- Parent(s)
- Sibling(s)

Instead of making payments to any of the above, MetLife may pay your estate. Any payment made in good faith will discharge MetLife's liability to the extent of such payment. If a beneficiary or payee is a minor or incompetent to receive payment, MetLife will pay that person's guardian.

To name a beneficiary, access MetLife online through HRconnect. Sign on to **kp.org/HRconnect** and select the **Benefits & Wellness tab**. From there, under the **Benefits & Coverage tab**, click on **"My insurance benefits,"** scroll down, and click on "Learn more about Benefits by Design Voluntary Programs." Under the **Insurance tab,** click on "View Information & Enroll." Then navigate to "Voluntary Term Life Insurance" and click on "Enroll Now," which will take you to MetLife's online **My Account** portal to name and/or update your beneficiaries.

If you do not have access to a computer, you can designate your KP Life Insurance beneficiary by calling MetLife at **888-420-1661, prompt 5**.

For More Information

For more information about your benefits, you may refer to the **Benefits & Wellness** tab at **kp.org/HRconnect** and click on the **Benefits documents** link to access your SPD or Benefits Booklet (as applicable).

KAISER PERMANENTE®

September 2021

To: Employees eligible for Voluntary Program Benefits

Re: Long-Term Care insurance closure to new enrollees

Overview

Effective July 1, 2021, Long-Term Care (LTC) insurance under the Benefits by Design Voluntary Programs will no longer be available to new enrollees. All LTC provisions, requirements, and restrictions remain unchanged for employees already enrolled in LTC insurance prior to July 1, 2021.

Please read the *Summary of Material Modification* below for more information.

SUMMARY OF MATERIAL MODIFICATION

This document updates the **Income Protection** section of your *Summary Plan Description* (SPD). Please read this document carefully and keep it with your SPD for future reference.

Update to Your SPD

A note has been added to the introduction of the **Long-Term Care insurance** section of your current *Summary Plan Description* (SPD) to indicate that no new LTC enrollments will be accepted, effective July 1, 2021. In addition, the "Who Is Eligible" LTC content is hereby removed. All other information in this section remains unchanged.

Income Protection

Benefits by Design Voluntary Programs

Long-Term Care Insurance

Effective July 1, 2021, Transamerica is no longer accepting new applications for long-term care insurance. If you enrolled prior to July 1, 2021, your long-term care insurance coverage will continue as long as you continue to pay the premiums.

Long-Term Care (LTC) insurance is designed to assist you and your eligible dependents with the activities of daily living at home, at an assisted-living care facility, or at a nursing home. The LTC insurance program is called Home Care Plus[sm], distributed by ACSIA Partners and underwritten by Transamerica Life Insurance Company (Transamerica). LTC insurance premiums are employee-paid.

For More Information

For more information about your benefits, you may refer to the **Benefits & Wellness** tab at **kp.org/HRconnect** and click on the **Benefits documents** link to access your SPD.

The information described herein is a summary of benefit changes effective on July 1, 2021.
In case of any omission or conflict between what is written in this document and what is written in the plan documents, contracts, or agreements, the plan documents, contracts, or agreements always govern.

The Plan Sponsor reserves the right to modify, amend, change, replace, or terminate the benefit plans described in this *Summary of Material Modification* at any time. Benefits may be modified or eliminated through the negotiation process as well. You will be advised of any significant changes in your benefit program.

KAISER PERMANENTE®

September 2021

To: Employees eligible for or participating in a Kaiser Permanente defined contribution retirement savings plan (*see list of affected plans on page 4)*

Re: Defined Contribution Plan updates

Overview

The following provisions are updated for certain defined contribution (DC) plans. Refer to the table below for the list of updates, the affected plans, and where to find the updated language in your *Summary Plan Description* (SPD).

Please read the information carefully and keep this *Summary of Material Modification* (SMM) with your SPD for future reference.

DC Plans	Updates
• Kaiser Permanente 401(k) Retirement Plan	Consolidate rollover contributions from previous 401(k) or 403(b) accounts, see Rollover Contributions
• Kaiser Permanente 401(k) Retirement Plan • Kaiser Permanente Tax Sheltered Annuity Plan (I, II, III)	1. Add FEMA declared disasters to the safe harbor for hardship withdrawals, see Hardship Withdrawals 2. Remove Qualified Joint and Survivor Annuity (QJSA) requirement, see How Benefits Are Paid
• Kaiser Permanente 401(k) Retirement Plan • Kaiser Permanente Northwest Supplemental Retirement Plan • Kaiser Permanente Supplemental Savings and Retirement Plan • Kaiser Permanente Supplemental Savings and Retirement Plan for Union Groups • Kaiser Permanente Tax Sheltered Annuity Plan (I, II, III) • Oregon Federation of Nurses and Health Professionals – Kaiser Foundation Health Plan Retirement Plan & Trust	1. Update beneficiary hierarchy in the event of your death, see If You Die 2. Update the required minimum distribution age from $70^1/_2$ to 72, see When You Can Receive a Distribution and Minimum Distribution Requirement 3. Update Vanguard's mailing address, see Welfare and Retirement Plan

SUMMARY OF MATERIAL MODIFICATION

For employees eligible for or participating in a Kaiser Permanente defined contribution retirement savings plan. See list of affected plans on page 4.

This document updates the **Retirement Programs** and **Legal and Administrative Information sections** of your *Summary Plan Description* (SPD). Please read this document carefully and keep it with your SPD for future reference.

Update to Your SPD

This SMM updates the information in the **Retirement Programs** and **Legal and Administrative** sections of your SPD, as applicable. All other information in the sections indicated below continue to apply.

RETIREMENT PROGRAMS

Defined Contribution Plan (*as applicable*) (*see the table in the Overview for affected plan names*)

Rollover Contributions

You may consolidate your retirement savings by rolling over pre-tax or after-tax contributions from qualifying IRAs and vested balances from 403(b) or 401(k) plans that you have with previous employers into your plan account. You must complete a rollover contribution form and submit it to Vanguard. More information is available online at **www.vanguard.com** or by calling Vanguard.

When You Can Receive a Distribution

Normally, you are entitled to receive your plan account balance when your employment with Kaiser Permanente ends. You can defer receiving payment until April 1 of the year following your termination or the year you reach 72, whichever is later, if you have more than $5,000 in your account.

Please note: If you have a Roth[1] account, you can avoid IRS-required age 72 minimum distributions on your Roth after-tax contributions by rolling them over to a Roth IRA account after you terminate employment and before you reach age 72. You may need to wait five years after the rollover to take a tax-free distribution of earnings from your Roth IRA. However, your beneficiaries will be required to take minimum distributions after your death. For more information on Roth IRAs, sign on to **www.vanguard.com**.

Hardship Withdrawal

Based on federal requirements, while you are employed at Kaiser Permanente, in most cases, you can withdraw pre-tax employee contributions from the plan before you reach age 59½ only in case of financial hardship. Investment earnings, employer contributions, and rollover contributions from another retirement plan are not eligible to be withdrawn for financial hardship.

Financial hardship includes money needed for the following:

- College tuition for yourself, your spouse or domestic partner, or your dependents
- Medical expenses for yourself, your spouse or domestic partner, or your dependents
- Purchasing your primary residence or avoiding eviction from or foreclosure on your home
- Certain expenses relating to the repair of damage to your principal residence that generally qualifies as a casualty deduction

[1] *The Roth IRA information applies only if your plan offers this option. Please refer to your Summary Plan Description to determine whether your employee group has the Roth IRA option.*

- Payments for burial or funeral expenses for your deceased parent, spouse, domestic partner, or dependents
- Money needed for specified expenses and losses you incur on account of a disaster declared by the Federal Emergency Management Agency (FEMA)

There are also other situations that may qualify you for a hardship distribution. Contact Vanguard for a complete list of hardship circumstances.

Please note: Domestic partners and dependents must satisfy the requirements of the plan before a distribution can be taken on their behalf.

To qualify for a financial hardship withdrawal, you must complete a hardship application, in which you must represent that you cannot obtain the money you need from certain other sources. If your application is approved, you will receive your withdrawal as soon as administratively possible.

How Benefits Are Paid

If the value of your account is more than $5,000, you can select any of the following available forms of payment:

- **Lump Sum:** The total value of your account is paid to you in a single payment. This is the normal form of payment of your benefits if you are not married.
- **Single Life Annuity:** The total value of your account is used to purchase a non-transferable single life annuity that provides monthly income to you for your lifetime only. If you are married and select a Single Life Annuity, you are legally required to obtain your spouse's consent. This consent must be in writing and notarized no more than 180 days before the benefits begin.
- **50 percent, 662/3 percent, 75 percent, and 100 percent Joint and Survivor Annuity:** You may elect to have an adjusted benefit paid to you for the joint lives of you and another person (your Joint Annuitant). You may choose to receive an adjusted monthly income while you are both alive, and then 100 percent, 75 percent, 662/3 percent, or 50 percent of that amount will be paid to the survivor after either of you dies. The amount of adjustment for a Joint and Survivor Annuity is based upon your age and the age of your Joint Annuitant when benefits begin. If your Joint Annuitant is not your spouse, an additional adjustment may be needed to meet the minimum distribution and you are legally required to obtain your spouse's consent. This consent must be in writing and notarized no more than 180 days before the benefits begin.

If no election is made, the normal form of payment is the Lump Sum.

If You Die

If you die before you commence your vested benefits from the plan or if you have a vested benefit remaining in your account the following occurs:

- If you have a valid beneficiary designation on file, payment will be made to your beneficiary (or beneficiaries).
- If you die and have Roth[1] after-tax contributions in your plan, the five-year period carries over to your beneficiary. Once the five-year period is satisfied, distributions of your account, including any earnings, to your beneficiary are tax-free.
- If your beneficiary is a minor, the following are eligible representatives who may act on behalf of that minor:
  - the court-appointed guardian or conservator
  - the person whom you name as the minor's representative in your last will and testament as admitted to probate
  - a person deemed by the Plan sponsor to be authorized to act for the minor
- If you do not have a valid designated beneficiary on file at the time of your death or if your designated beneficiary dies and you have not named another beneficiary before your death, payment of your account will be made in the following order:
  - To your surviving legal spouse
  - If none, then to your estate

Minimum Distribution Requirement

You will be required by law to take a minimum distribution of your account by April 1 of the calendar year following the year in which you reach age 72 or retire, whichever is later. All of the plan's forms of payment meet the minimum distribution requirement. Minimum distributions are not eligible to be rolled over into an IRA or another tax-qualified retirement plan. If you do not make a timely election, you will be paid in the normal form of payment.

LEGAL AND ADMINISTRATIVE INFORMATION

Welfare and Retirement Plan

Plan Name/Plan Options	Plan Sponsor EIN #	ID No.	Type of Plan	Claims Administrator	Type of Administration	Plan Trustee	Funding Medium	Contributing Source
RETIREMENT PLANS								
Kaiser Permanente Defined Contribution Plan name, as applicable*				Vanguard Attn: DC Plan P.O. Box 982902 El Paso, TX 79998-2902		Vanguard Attn: DC Plan P.O. Box 982902 El Paso, TX 79998-2902		

For More Information

For more information about your benefits, you may refer to your SPD available on HRconnect. To access your SPD, sign on to **kp.org/HRconnect**. Then go to the "Benefits & Wellness" tab and click on "Benefits documents."

* Defined Contribution Plans Affected by This SMM

- Kaiser Permanente 401(k) Retirement Plan (Plan Number 090310)
- Kaiser Permanente Northwest Supplemental Retirement Plan (Plan Number 093356)
- Kaiser Permanente Supplemental Savings and Retirement Plan (Plan Number 092528)
- Kaiser Permanente Supplemental Savings and Retirement Plan for Union Groups (Plan Number 093150)
- Kaiser Permanente Tax Sheltered Annuity Plan (Plan Number 090998)
- Kaiser Permanente Tax Sheltered Annuity Plan II (Plan Number 094998)
- Kaiser Permanente Tax Sheltered Annuity Plan III (Plan Number 094174)
- Oregon Federation of Nurses and Health Professionals – Kaiser Foundation Health Plan Retirement Plan & Trust (Plan Number 090349)

The information described herein is an update to your *Summary Plan Description*. In case of any omission or conflict between what is written in this document and what is written in the plan documents, contracts, or agreements, the plan documents, contracts, or agreements always govern.

The Plan Sponsor reserves the right to modify, amend, change, replace, or terminate the benefit plans described in this *Summary of Material Modification* at any time. Benefits may be modified or eliminated through the negotiation process as well, as applicable. You will be advised of any significant changes in your benefit program.

KAISER PERMANENTE®

September 2021

To: All Kaiser Permanente employees participating in or eligible for a defined contribution retirement savings plan

Re: Change in Qualified Default Investment Alternative funds

Overview

The *Summary of Material Modification* (SMM) below provides information regarding changes to the investment funds for the Qualified Default Investment Alternative (QDIA) under your defined contribution plan, effective December 2020. In addition, proxy voting for decisions regarding shares of the investment funds has been clarified. Please read the SMM for updates to your *Summary Plan Description* (SPD).

SUMMARY OF MATERIAL MODIFICATION

This document updates the **Retirement Programs** sections of your *Summary Plan Description* (SPD). Please read this document carefully and keep it with your SPD for future reference.

Update to Your SPD

The "Choosing Your Investments" content under **Vesting** for all applicable defined contribution sections of your SPD is hereby replaced in its entirety with the following language. All other information in this section remains unchanged.

RETIREMENT PROGRAMS

Vesting

Choosing Your Investments

You can invest your account among a diversified lineup of investment options. In addition, you are eligible to invest your account through the Vanguard Brokerage Option. You can invest up to 50 percent of your fully vested account in the Vanguard Brokerage Option. Investment funds are reviewed by the Investment Committee on an ongoing basis, and the actual funds offered through the plan are subject to change. A complete list of funds and more information about the Vanguard Brokerage Option is available online at **www.vanguard.com** or by calling Vanguard's VOICE network at **800-523-1188**. You may also obtain information and make changes to your account on your mobile device. Go to **vanguard.com/bemobile** to download the Vanguard app so you can access your account on the go.

Upon becoming a participant, any contributions to your account will be invested in the Qualified Default Investment Alternative (QDIA) until you select an investment option. The QDIA is the JPMorgan SmartRetirement Fund with the target date closest to the year in which you will reach age 65. Each JPMorgan SmartRetirement Fund is a well-diversified, professionally managed, automatic investment option designed to care

for all of the assets within your employer retirement plan. The fund will gradually shift its emphasis from more aggressive investments to more conservative ones based on the approximate year (the target date) when an investor in the fund would attain age 65. Contact Vanguard to learn about your QDIA fund.

The plan is intended to satisfy the requirements of Section 404(c) of the Employee Retirement Income Security Act (ERISA) and Department of Labor Regulation Section 2550.404c-1. In general, this means that you are solely responsible for any investment losses caused by your investment decisions. Kaiser Permanente, its directors, officers, employees, subsidiaries, plan fiduciaries, and the trustee do not guarantee or ensure the performance of any of the investment funds offered by the plan and will not be liable for those losses.

Since you alone will be responsible for the losses or gains that result from your investment decisions, it is very important that you carefully consider the investment options available to you.

Generally, in the event that a proxy voting decision is required regarding shares of the investment funds, the investment fund shares will be voted on by the fiduciary for the plan in accordance with the investment guidelines for the plan. For 403(b) plans, the proxies are voted by the participants. Additionally, proxies are voted by participants for any investments held in brokerage, regardless of plan type.

The plan administrator is the plan fiduciary responsible for providing participants and beneficiaries with the information necessary for making informed decisions under the plan. To request additional information from the plan administrator, please see the contact information provided in this *Summary Plan Description*. In addition, the Plan provides a variety of tools and services available to help you make your investment decisions, like the Vanguard Managed Account Program (VMAP) and Personal Online Advisor.

For More Information

For more information about your benefits, you may refer to the **Benefits & Wellness** tab at **kp.org/HRconnect** and click on the **Benefits documents** link to access your SPD.

The information described herein is an update to your *Summary Plan Description*.
In case of any omission or conflict between what is written in this document and what is written in the plan documents, contracts, or agreements, the plan documents, contracts, or agreements always govern.

The Plan Sponsor reserves the right to modify, amend, change, replace, or terminate the benefit plans described in this *Summary of Material Modification* at any time. Benefits may be modified or eliminated through the negotiation process as well. You will be advised of any significant changes in your benefit program.

KAISER PERMANENTE®

September 2021

To: Participants in plans with claims administration performed by HealthPlan Services (*see page 3 for list of plans*)

Re: HealthPlan Services offering online claims submission

Overview

Participants in plans with claims administration performed by HealthPlan Services may now submit claims online.

SUMMARY OF MATERIAL MODIFICATION

This document updates the **Disputes, Claims and Appeals** section of your *Summary Plan Description* (SPD). Please read this document carefully and keep it with your SPD for future reference.

Update to Your SPD

Medical Plans Claims and Appeals

The following language replaces the "Claims" paragraph for the Alternative Medical Plan, Alternate Mental Health Plan, Comprehensive Alternate Medical Plan, Kaiser Permanente Flexible Choice Plan, KFHP Point-of-Service Plan, PPO Plus Plan and/or Supplemental Medical Plan section of your SPD. All other content in the section continues to apply.

Claims and Appeals

Claims

A separate claim form (or online claim submission) should be completed for each patient, and your HealthPlan Services Member ID number is required on all forms/submissions. The HealthPlan Services Member ID number begins with "Q9" and can be found on your plan identification card (if provided), or by calling HealthPlan Services at the number listed below. If using the form, complete the employee and patient information sections, sign, and date the form. Ask your physician or health care provider to complete the physician or supplier information section. The physician or health care provider's signature and credentials must be included to process the claim. The authorization for release of the information section of the form should be completed and signed by the patient. If the patient is a minor or incapacitated, you (the employee) should sign the release. If submitting online, complete the employee and patient information sections and upload your supporting documentation.

When submitting your claim form, attach your itemized bills for services received. Properly itemized bills are required as evidence to support your claim for payment of covered services. Your itemized bill should contain the physician or health care provider's identification number, the patient's full name, dates of treatment or service, services provided, charges, and information about the illness or injury. If you have prescription drug charges, submit itemized receipts which include the patient's name, prescription number, type, dosage, quantity, and cost. The actual bills are required; copies and handwritten bills are not acceptable.

Some claims will need a valid Kaiser Permanente *Authorized Evidence of Exclusion* (also referred to as a denial of service letter) in order to be processed.

In addition, you will be required to provide coordination of benefits information in some cases. Review the "Coordination of Benefits" section in this SPD and the coordination of benefits notice attached to each claim form for additional information. Failure to provide coordination of benefits information may delay the processing of your claim or cause your claim to be denied.

If you would like HealthPlan Services to pay the physician or health care provider directly, you may authorize payment directly to the provider of service on the claim form.

You must submit your completed claim form and required documentation within 12 months from the day services were received. In most cases, your claim will be processed within one month from the date HealthPlan Services receives it, if no additional information is necessary. Missing, incomplete, or unclear information will cause your claim to be denied.

For a claim form or to file a claim online, call HealthPlan Services or sign on to their website at **www.hpsclaimservices.com**. Claim forms also are available on the HRconnect portal.

If you choose to mail or fax your claim to HealthPlan Services, you may send it to the following address or fax number:

HealthPlan Services
P.O. Box 30537
Salt Lake City, UT 84130-0547
Phone: 800-216-2166
Fax: 877-779-9873

In the case of an urgent care claim, a request for an expedited review may be submitted orally by calling HealthPlan Services at **800-216-2166**. All necessary information, including the claim determination, may be transmitted between the plan and the covered person (or authorized representative) via telephone, facsimile, or other available similarly expeditious methods.

For More Information

For more information about your benefits, you may refer to the **Benefits & Wellness** tab at **kp.org/HRconnect** and click on the **Benefits documents** link to access your SPD.

Plans Affected by This SMM

- Alternate Medical Plan
- Alternate Mental Health Plan
- Comprehensive Alternate Medical Plan
- Kaiser Permanente Flexible Choice Plan
- KFPH Point-of-Service Plan
- Preferred Provider Organization Plus Plan
- Supplemental Medical Plan

The information described herein is an update to your *Summary Plan Description*. In case of any omission or conflict between what is written in this document and what is written in the plan documents, contracts, or agreements, the plan documents, contracts, or agreements always govern.

The Plan Sponsor reserves the right to modify, amend, change, replace, or terminate the benefit plans described in this *Summary of Material Modification* at any time. Benefits may be modified or eliminated through the negotiation process as well. You will be advised of any significant changes in your benefit program.

KAISER PERMANENTE®

October 2020

To: All Kaiser Permanente employees

Re: Clarification of age limits for covering disabled dependent children

Overview

This *Summary of Material Modification* (SMM) clarifies the requirements for continuing coverage for a disabled dependent child past the regular age limits. Please read the SMM below for more information.

SUMMARY OF MATERIAL MODIFICATION

This document updates the **ENROLLING IN BENEFITS / FLEXIBLE BENEFITS** section of your *Summary Plan Description* (SPD). Please read this document carefully and keep it with your SPD for future reference.

Update to Your SPD

The following updates the "Disabled Dependents" content in the **Enrolling in Benefits / Flexible Benefits** section of your SPD, as applicable. All other information in this section remains unchanged.

ENROLLING IN BENEFITS / FLEXIBLE BENEFITS (as applicable)

Who Is Eligible

Disabled Dependent Children Over the Age Limit

You may be able to extend coverage past the regular age limit for a dependent child who is incapable of self-support due to a mental or physical disability, provided the following conditions are met:

For an enrolled dependent child:

- The disability must have begun before the dependent child reached age 26.
- The dependent child must be currently enrolled in the coverage you are requesting to continue beyond age 26.
- You are able to provide proof of your dependent child's disability when you request to extend coverage and agree to provide continued certification of disability upon request from the plan administrators.

For a disabled dependent child of a newly hired employee:

- The disability must have begun before the dependent child reached age 26.
- Your disabled dependent child must have been covered under your previous medical plan.
- You are able to provide proof of your dependent child's disability when you first enroll him or her and agree to provide continued certification of disability upon request from the plan administrators.
- A disabled dependent child past the regular age limits is not eligible for Dependent Life insurance and/or Accidental Death and Dismemberment coverage.

Please note: If you do not provide proof of your dependent child's disability by the deadline stated in the plan administrator's certification request, your dependent child may be dropped from coverage.

For More Information

For more information about your benefits, you may refer to your SPD available on My HR. To access your SPD, sign on to **kp.org/myhr**. Click on "My Profile" and scroll down to the "Benefits & Wellness" section. From there, click on "Benefits Resources," then on "Benefit Guides and Summary Plan Descriptions (SPD)."

The information described herein is an update to your *Summary Plan Description*. In case of any omission or conflict between what is written in this document and what is written in the plan documents, contracts, or agreements, the plan documents, contracts, or agreements always govern.

The Plan Sponsor reserves the right to modify, amend, change, replace, or terminate the benefit plans described in this *Summary of Material Modification* at any time. Benefits may be modified or eliminated through the negotiation process as well, if applicable. You will be advised of any significant changes in your benefit program.

KAISER PERMANENTE®

October 2020

To: Kaiser Permanente Employees in the Colorado Region, including Executives, Program Offices and Information Technology Employees in the Colorado Region

Re: OneKP Colorado and pharmacy first fill updates

Overview

Effective January 1, 2021, the Colorado Region will unify its Denver, Colorado Springs, Northern Colorado and Pueblo Service Areas to create one single One KP Colorado Service Area. The purpose of this change is to promote a more consistent and simplified experience for all members. As a result, you will be able to access care across all of the unified service areas. The current Member Services Department phone numbers will be consolidated into a single phone number. Also, you will receive new member ID cards. Otherwise, the medical benefits you receive under your Kaiser Foundation Health Plan or Kaiser Employee Medical Health Plan (as applicable) will not be affected.

Effective January 1, 2021, you will be able to fill your first pharmacy prescription at any network pharmacy in addition to a Kaiser Permanente Medical Office Pharmacy, or KP Mail Order Pharmacy. After the first fill, you must use a Kaiser Permanente Medical Office Pharmacy, or KP Mail Order Pharmacy.

Please read the *Summary of Material Modification* below for updates to your *Summary Plan Description* (SPD) and the *KEMHP/EPO Benefits Booklets*, as applicable.

SUMMARY OF MATERIAL MODIFICATION

This document updates the **Contacts** and **Health Care** sections of your *Summary Plan Description* (SPD). Please read this document carefully and keep it with your SPD for future reference. This information also updates the **Schedule of Benefits** in the *KEMHP/EPO Benefits Booklets*, as applicable.

Update to Your SPD or Benefits Booklet, as applicable

The following updates the **Contacts** and **Health Care** and sections of your SPD. All existing content in these sections continue to apply.

CONTACTS

Department, Organization, or Service	Contact Information
Health Care	
Member Services Questions about KFHP or KEMHP (as applicable) medical plans	**One KP Colorado** Hours: M-F 8 a.m. – 6 p.m. **303-338-3800** **711 (TTY)**

HEALTH CARE

Benefits	High Plan You Pay	Mid Plan You Pay	Basic Plan You Pay
Prescription Drugs			
Note: Prescriptions must fall within KFHP Formulary guidelines, unless specifically prescribed by a Kaiser Permanente physician.			
KP Pharmacy *(up to the number of days supply indicated in your employee group's SPD)* (First time prescriptions may be filled at any network or KP Medical Office Pharmacy in ALL KP Service Areas. Any refills must be filled at KP Medical Office pharmacies or through KP Mail Order)	*(your employee group's copay applies)*	*(your employee group's copay applies)*	*(your employee group's copay applies)*

The above updates also apply to the "Schedule of Benefits" section in the *KEMHP/EPO Benefits Booklets*, as applicable. All existing content in these sections continue to apply.

For More Information

For more information about your benefits, please sign on to **kp.org/myhr**. Click on "My Profile" and scroll down to the "Benefits & Wellness" section. From there, click on "Benefits Resources," then on "Benefit Guides and Summary Plan Descriptions (SPD)."

The information described herein is an update to your *Summary Plan Description*. In case of any omission or conflict between what is written in this document and what is written in the plan documents, contracts, or agreements, the plan documents, contracts, or agreements always govern.

The Plan Sponsor reserves the right to modify, amend, change, replace, or terminate the benefit plans described in this *Summary of Material Modification* at any time. Benefits may be modified or eliminated through the negotiations process, as applicable. You will be advised of any significant changes in your benefit program.

KAISER PERMANENTE®

October 2020

To: All Kaiser Permanente employees participating in or eligible for the plans listed on page 5

Re: Updates to your health care and retirement benefits

Overview

As part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, the following enhancements have been made to your healthcare coverage, as applicable:

Effective January 1, 2020

- You may be reimbursed for over-the-counter medications and menstrual care products purchased after December 31, 2019, using contributions from the Health Care Flexible Spending Account, Sick Leave Health Reimbursement Account (HRA), or Retiree Medical Health Reimbursement Account.

Effective March 1, 2020

- Telemedicine services are provided under the Kaiser Foundation Health Plan, the Kaiser Employee Medical Health Plan, and health plans administered by HealthPlan Services.

In addition, effective immediately, WageWorks, Kaiser Permanente's third-party administrator for Flexible Spending Accounts, is rebranded as HealthEquity.

Please read the *Summary of Material Modification* below for updates to your *Summary Plan Description* (SPD).

SUMMARY OF MATERIAL MODIFICATION

This document updates the **Health Care** and **Retirement Programs** sections of your *Summary Plan Description* (SPD). Please read this document carefully and keep it with your SPD for future reference.

Update to Your SPD

The information below updates the identified sections in your SPD. All other information in these sections continue to apply.

In addition, all references to WageWorks throughout the SPD are hereby changed to HealthEquity. Their new website will be **healthequity.com**. As part of this rebranding, you will receive a new "HealthEquity Visa Health Account Card" when your WageWorks card expires, if you need a replacement card, or for new enrollments. This rebranding does not affect your benefits.

HEALTH CARE

The "Telemedicine" content below is hereby added under each health plan listed on page 5, as applicable. All other content for these applicable plans in your SPD continues to apply.

Telemedicine

Interactive visits between you and your physician using phone, interactive video, internet messaging applications, and email, when available, are intended to make it more convenient for you to receive medically appropriate Covered Services. You may request telemedicine services when scheduling an appointment.

For KFHP/KEMHP Plans: There is no cost for telemedicine services. Prescription costs will apply.

For Plans administered by HealthPlan Services: Copayment and/or cost share will apply for telemedicine services. You may submit a *Health Benefit Claim* form #0600 to get reimbursed. Certain HealthPlan Services plan providers may not offer telemedicine appointments. Please check with your provider.

Health Care Flexible Spending Account

Eligible Expenses

- Menstrual care products
- Over-the-counter (OTC) drugs or medications including but not limited to the following: cold and flu medicine; cough suppressants, allergy and sinus medicine; eye drops; pain relievers; toothache remedies; and topical products (e.g., Bengay, Neosporin)

RETIREMENT PROGRAMS

Sick Leave Health Reimbursement Account

Eligible Expenses

Eligible expenses include:

- Menstrual care products
- Over-the-counter (OTC) drugs or medications including but not limited to the following: cold and flu medicine; cough suppressants, allergy and sinus medicine; eye drops; pain relievers; toothache remedies; and topical products (e.g., Bengay, Neosporin)

Expenses Not Covered

The following are some of the expenses not eligible for reimbursement through the Sick Leave HRA.

- Babysitting expenses due to doctor visits
- Baldness treatments or hair transplants
- Cosmetic surgery, procedures, services, and products (non-medically necessary)
- Dental veneers or bonding (non-medically necessary)
- Dietary, nutritional, and herbal supplements used to maintain general health
- Diet foods
- Electrolysis
- Exercise equipment or programs to promote general health
- Family and marriage counseling
- Funeral services
- Marijuana or other controlled substances (even for medical purposes)
- Medical insurance premiums paid for a non-Kaiser Permanente medical plan. However, if a Kaiser Permanente medical plan is not available in your area, your medical plan premiums may be reimbursable.

- Recreational lessons, such as swimming or dancing
- Vacation expenses (even if recommended by a doctor)
- Varicose vein cosmetic procedure

Retiree Medical Health Reimbursement Account

Eligible Medical Expenses

In order for expenses to be eligible for reimbursement, you must incur them while you are actively participating in the Retiree Medical HRA.

If you live in a Kaiser Permanente Senior Advantage service area, you may use the Retiree Medical HRA to be reimbursed for expenses that are approved under Internal Revenue Code Section 213(d) for Medicare-eligible services connected with a Kaiser Permanente medical plan offered through the retiree medical benefit. This includes expenses such as Kaiser Permanente Senior Advantage[1] copayments and deductibles (including copayments and deductibles related to prescription drugs for Medicare-eligible services), over-the-counter medications, menstrual care products, Kaiser Permanente Senior Advantage[1] premiums not covered by the subsidy, and copayments and deductibles for your Medicare-eligible spouse or tax-dependent domestic partner[2]. To confirm whether an expense is for a Medicare-eligible service, visit **https://www.medicare.gov/coverage** and search for the test, item, or service.

If your Kaiser Permanente health care provider refers you to a non-Kaiser Permanente provider or refers you to obtain services outside of Kaiser Permanente, you may still be able to be reimbursed for expenses related to the referral, but must also include proof of the referral and an Explanation of Benefits (EOB) showing the services were covered by your Kaiser Permanente Senior Advantage[1] plan with your request for reimbursement.

If you live outside of a Kaiser Permanente Senior Advantage service area, you may use the Retiree Medical HRA to be reimbursed for expenses that are approved under Internal Revenue Code Section 213(d) for Medicare-eligible services under any Medicare supplement or Medicare Advantage plan. This includes expenses such as copayments and deductibles (including copayments and deductibles related to prescription drugs for Medicare-eligible services), over-the-counter medications, menstrual care products, Medicare supplement or Medicare Advantage plan premiums not covered by the subsidy, and copayments and deductibles for your Medicare-eligible spouse or tax-dependent domestic partner[2]. To confirm whether an expense is for a Medicare-eligible service, visit **https://www.medicare.gov/coverage** and search for the test, item, or service.

To obtain reimbursement for expenses associated with a non-Kaiser Permanente Medicare supplement or Medicare Advantage plan, you must submit an Explanation of Benefits (EOB) showing proof of coverage of the underlying services by the Medicare supplement or Medicare Advantage plan with your request for reimbursement.

Expenses Not Covered

You cannot be reimbursed from the Retiree Medical HRA for expenses associated with any non-Kaiser Permanente health plan, unless there is no Kaiser Permanente Senior Advantage plan available where you live as described above.

In addition, you cannot be reimbursed from the Retiree Medical HRA for:

- Expenses in excess of the Retiree Medical HRA account balance
- Expenses incurred before you were eligible to access the Retiree Medical HRA or while you are employed at Kaiser Permanente
- Expenses for someone that does not qualify as your dependent under the Internal Revenue Code[2]

[1] Or Kaiser Permanente Medicare Advantage for employees in the Mid-Atlantic States Region

[2] For retirees of the International Union of Operating Engineers, Local 99-99A, in the Mid-Atlantic States Region, copayments/expenses are included for yourself only.

- Reimbursement for your children's health care expenses
- Babysitting expenses due to doctor visits
- Baldness treatments or hair transplants
- Cosmetic surgery, procedures, services, and products (non-medically necessary)
- Dental veneers or bonding (non-medically necessary)
- Dietary, nutritional and herbal supplements used to maintain general health
- Diet foods
- Electrolysis
- Exercise equipment or programs to promote general health
- Family and marriage counseling
- Funeral services
- Marijuana or other Schedule 1 controlled substances (even for medical purposes)
- Medical insurance premiums paid for a non-Kaiser Permanente medical plan, except as noted above, or for another employer's plan
- Medicare Part B or Part D premiums
- Medicare Part B or Part D surcharges, such as late enrollment surcharges and the income-related monthly adjustment amount
- Recreational lessons, such as swimming or dancing
- Vacation expenses (even if recommended by a doctor)
- Varicose vein cosmetic procedure

For More Information

For more information about your benefits, you may refer to your SPD available on My HR. To access your SPD, sign on to **kp.org/myhr**. Click on “My Profile” and scroll down to the "Benefits & Wellness" section. From there, click on “Benefits Resources,” then on “Benefit Guides and Summary Plan Descriptions (SPD).”

Plans Affected by the changes in this SMM:

Health Plans

- Alternate Comprehensive Medical Plan
- Alternate Medical Plan
- Alternate Mental Health
- Comprehensive Medical Plan
- Kaiser Foundation Health Plan
- Kaiser Employee Medical Health Plan
- Preferred Provider Organization Plan
- Preferred Provider Organization Plus Plan
- Supplemental Medical Plan

Flexible Spending Account

- Health Care Flexible Spending Account

Retiree Medical Plans

- Retiree Medical Health Reimbursement Account
- Sick Leave Health Reimbursement Account

The information described herein is a summary of benefit changes effective on the dates as indicated in this SMM. In case of any omission or conflict between what is written in this document and what is written in the plan documents, contracts, or agreements, the plan documents, contracts, or agreements always govern.

The Plan Sponsor reserves the right to modify, amend, change, replace, or terminate the benefit plans described in this *Summary of Material Modification* at any time. Benefits may be modified or eliminated through the negotiation process as well. You will be advised of any significant changes in your benefit program.

KAISER PERMANENTE®

MAUI HEALTH SYSTEM
Community hospitals affiliated with KAISER PERMANENTE®

October 2020

To: Nonrepresented employees who transitioned from Maui Regional Healthcare System

Re: Prior service with Maui Regional Health System

Overview

If, on July 1, 2017, you transitioned from Maui Regional Health System (MRHS) and became an eligible employee of Maui Health System (MHS), your prior service with MRHS will be used to calculate your Years of Service requirement for the Kaiser Permanente Supplemental Savings and Retirement Plan and The Modified Retiree Medical Benefit, as applicable. Your prior MRHS service will also be used to calculate your vesting service under your defined benefit plan, as applicable.

Please read the *Summary of Material Modification* below for more information.

SUMMARY OF MATERIAL MODIFICATION

This document updates the **RETIREMENT PROGRAMS** section of your *Summary Plan Description* (SPD). Please read this document carefully and keep it with your SPD for future reference.

Update to Your SPD

The following information is hereby added to the "Vesting in Your Benefit" content under the "Kaiser Permanente Retirement Plan" section, "When You Are Eligible" under the "Kaiser Permanente Supplemental Savings and Retirement Plan" section, and the "Definition of a Year of Service for Retiree Medical Benefits" content under the "The Modified Retiree Medical Benefit" section of your SPD, as applicable. All other information in these sections continues to apply.

RETIREMENT PROGRAMS

Defined Benefit Plan in your SPD, as applicable
Supplement to the Kaiser Permanente Retirement Plan

Vesting in Your Benefit

Please Note: If you transitioned from Maui Regional Health System (MRHS) to Maui Health System (MHS) on July 1, 2017, your prior service with MRHS will count toward the Years of Service vesting requirements for this plan. You will need to provide sufficient evidence if you believe that your previous MRHS service is greater than what Kaiser Permanente shows.

Kaiser Permanente Supplemental Savings and Retirement Plan

Who Is Eligible

When You Are Eligible

If you transitioned from Maui Regional Health System (MRHS) to Maui Health System (MHS) on July 1, 2017, your prior service with MRHS will count toward the Years of Service eligibility requirements for this plan, as applicable. You will need to provide sufficient evidence if you believe that your previous MRHS service is greater than what Kaiser Permanente shows.

The Modified Retiree Medical Benefit, as applicable

Who Is Eligible

Definition of a Year of Service for Retiree Medical Benefits

Please Note: If you transitioned from Maui Regional Health System (MRHS) to Maui Health System (MHS) on July 1, 2017, your prior service with MRHS will count toward the Years of Service requirements for Retiree Medical eligibility, but not toward the Retiree Medical HRA. You will need to provide sufficient evidence if you believe that your previous MRHS service is greater than what Kaiser Permanente shows.

For More Information

For more information about your benefits, you may refer to your SPD available on My HR. To access your SPD, sign on to **kp.org/myhr**. Click on “My Profile” and scroll down to the "Benefits & Wellness" section. From there, click on “Benefits Resources,” then on “Benefit Guides and Summary Plan Descriptions (SPD).”

The information described herein is an update to your Summary Plan Description. In case of any omission or conflict between what is written in this document and what is written in the plan documents, contracts, or agreements, the plan documents, contracts, or agreements always govern.

The Plan Sponsor reserves the right to modify, amend, change, replace, or terminate the benefit plans described in this Summary of Material Modification at any time. You will be advised of any significant changes in your benefit program.

KAISER PERMANENTE®

October 2020

To: All Kaiser Permanente employees

Re: Contact information for the Kaiser Permanente Retirement Center

Overview

Contact information for the KPRC has changed.

The *Summary of Material Modification* below updates your *Summary Plan Description* with the new information.

SUMMARY OF MATERIAL MODIFICATION

This document updates your *Summary Plan Description* (SPD). Please read this document carefully and keep it with your SPD for future reference.

Update to Your SPD

The KPRC contact information is updated throughout your SPD. All other information in the SPD remains unchanged.

For General Questions about Pension Plans and Retirement Benefits:

Kaiser Permanente Retirement Center
P.O. Box 9922
Providence, RI 02940-4022

Phone: **866-627-2826**
Fax: **888-547-2304**
myplansconnect.com/kp

For Retiree Health and Welfare Eligibility Claims:

Kaiser Permanente Retirement Center
P.O. Box 9923
Providence, RI 02940-4023

For More Information

For more information about your benefits, you may refer to your SPD available on My HR. To access your SPD, sign on to **kp.org/myhr**. Click on "My Profile" and scroll down to the "Benefits & Wellness" section. From there, click on "Benefits Resources," then on "Benefit Guides and Summary Plan Descriptions (SPD)."

The information described herein is an update to your *Summary Plan Description*. In case of any omission or conflict between what is written in this document and what is written in the plan documents, contracts, or agreements, the plan documents, contracts, or agreements always govern.

The Plan Sponsor reserves the right to modify, amend, change, replace, or terminate the benefit plans described in this *Summary of Material Modification* at any time. Benefits may be modified or eliminated through the negotiation process as well, if applicable. You will be advised of any significant changes in your benefit program.

KAISER PERMANENTE®

October 2020

To: Employees and Executives eligible for the *Benefits by Design* Voluntary Programs (*excluding the Mid-Atlantic States Region*)

Re: New name for Legal Services third-party administrator

Overview

Your *Summary Plan Description* (SPD) refers to Hyatt Legal Plans as Kaiser Permanente's vendor for Legal Services offered through the *Benefits by Design* Voluntary Programs. Going forward, the name of the Legal Services vendor has changed to MetLife Legal Plans.

Please see the *Summary of Material Modification* below for more information.

SUMMARY OF MATERIAL MODIFICATION

This document updates the **CONTACTS, INCOME PROTECTION, DISPUTES, CLAIMS and APPEALS,** and **LEGAL and ADMINISTRATIVE** sections of your *Summary Plan Description* (SPD). Please read this document carefully and keep it with your SPD for future reference.

Update to Your SPD

Benefits by Design Voluntary Programs

Legal Services

All references to Hyatt Legal Plans in the **CONTACTS**, **INCOME PROTECTION**, **DISPUTES, CLAIMS and APPEALS**, and **LEGAL and ADMINISTRATIVE** sections of your *Summary Plan Description* (SPD) are hereby changed to MetLife Legal Plans. Contact information including their website address remain the same.

For More Information

For more information about your benefits, you may refer to your SPD available on My HR. To access your SPD, sign on to **kp.org/myhr**. Click on "My Profile" and scroll down to the "Benefits & Wellness" section. From there, click on "Benefits Resources," then on "Benefit Guides and Summary Plan Descriptions (SPD)."

The information described herein is an update to your *Summary Plan Description*. In case of any omission or conflict between what is written in this document and what is written in the plan documents, contracts, or agreements, the plan documents, contracts, or agreements always govern.

The Plan Sponsor reserves the right to modify, amend, change, replace, or terminate the benefit plans described in this *Summary of Material Modification* at any time. Benefits may be modified or eliminated through the negotiation process as well, if applicable. You will be advised of any significant changes in your benefit program.

KAISER PERMANENTE®

October 2019

To: Employees in the Colorado Region
(including Executives, Program Offices and Information Technology employees in the Colorado Region)

Re: KFHP and KEMHP arbitration process elimination

Overview

We have been informed that the arbitration process for Kaiser Foundation Health Plan (KFHP) and Kaiser Employee Medical Health Plan/Exclusive Provider Organization (KEMHP) (as applicable) has been eliminated for the Colorado Region. As a result, the Arbitration Agreement language in your *Summary Plan Description*s (SPDs) does not apply. The *Summary of Material Modification*, below, updated your SPDs, as applicable.

SUMMARY OF MATERIAL MODIFICATION

This document updates the **HEALTH CARE** section of your *Summary Plan Description* (SPD) and the **Claims and Appeals** section of the KEMHP SPD, as applicable. Please read this document carefully and keep it with your SPDs for future reference.

Update to Your SPDs *(as applicable)*

HEALTH CARE *(Applies to employees in the Colorado Region)*

Kaiser Foundation Health Plan

The "Arbitration Agreement" language in the above section is hereby removed. All other information in the SPD remains the same.

KEMHP *(Applies to Executives, Program Offices and Information Technology employees in the Colorado Region)*

Claims and Appeals

The "**Arbitration Agreement for Participants and Dependents Assigned to the Kaiser Permanente Colorado Region"** section and any reference to arbitration throughout the KEMHP SPD are hereby removed. All other information in the SPD remains the same.

For More Information

For more information about your benefits, you may refer to your SPD available on My HR. To access your SPD, sign on to **kp.org/myhr**. Click on "My Profile" and scroll down to the "Benefits & Wellness" section. From there, click on "Benefits Resources," then on "Benefit Guides and Summary Plan Descriptions (SPD)."

The information described herein is an update to your *Summary Plan Description*.
In case of any omission or conflict between what is written in this document and what is written in the plan documents, contracts, or agreements, the plan documents, contracts, or agreements always govern.

The Plan Sponsor reserves the right to modify, amend, change, replace, or terminate the benefit plans described in this *Summary of Material Modification* at any time. Benefits may be modified or eliminated through the negotiation process as well. You will be advised of any significant changes in your benefit program.

KAISER PERMANENTE®

June 2019

To: All Kaiser Permanente employees

Re: Employee Assistance Program Contacts

Overview

Contact information for the Employee Assistance Program has been updated. The language in the *Summary of Material Modification* below updates the EAP phone numbers and websites listed in your *Summary Plan Description* (SPD).

SUMMARY OF MATERIAL MODIFICATION

This document updates the **CONTACT INFORMATION** section of your *Summary Plan Description* (SPD). Please read this document carefully and keep it with your SPD for future reference.

Update to Your SPD

The following content is hereby updated under the **CONTACT INFORMATION** section of your SPD. All other contact information remains the same.

CONTACT INFORMATION

Health Care		
Employee Assistance Program (EAP)	Northern California	**kp.org/eap**
	Southern California	**kp.org/eap**
	Georgia	**888-678-0937** **espyr.com**
	Colorado	**888-678-0937** **espyr.com**
	Hawaii	**808-432-4922** **kp.org/eap**
	Mid-Atlantic States	**888-678-0937** **espyr.com**
	Northwest	**503-813-4703** **kp.org/eap**
	Washington	**888-678-0937** **espyr.com**

For More Information

For more information about your benefits, you may refer to your SPD available on My HR. To access your SPD, sign on to **kp.org/myhr**. Click on “My Profile” and scroll down to the "Benefits & Wellness" section. From there, click on “Benefits Resources,” then on “Benefit Guides and Summary Plan Descriptions (SPD).”

The information described herein is an update to your *Summary Plan Description*.
In case of any omission or conflict between what is written in this document and what is written in the plan documents, contracts, or agreements, the plan documents, contracts, or agreements always govern.

The Plan Sponsor reserves the right to modify, amend, change, replace, or terminate the benefit plans described in this *Summary of Material Modification* at any time. Benefits may be modified or eliminated through the negotiation process as well. You will be advised of any significant changes in your benefit program.

KAISER PERMANENTE®

June 2019

To: Employees eligible to participate in a Kaiser Permanente a defined contribution plan *(see page 2 for list of plans)*

Re: Defined contribution plan balance cash-out rule change for terminated and retired participants

Overview

Effective January 14, 2019, when you terminate or retire from Kaiser Permanente with a defined contribution account balance of $5,000 or less, your account will be closed, and the balance rolled into an individual retirement account in your name. You may defer receiving a distribution only if your defined contribution account balance is more than $5,000. Your beneficiary may elect to defer receiving a distribution and choose how the distribution will be paid only if your account balance is more than $5,000.

Please read the below *Summary of Material Modification* for the updates in your *Summary Plan Description* (SPD).

SUMMARY OF MATERIAL MODIFICATION

This document updates the **Retirement Programs** section of your *Summary Plan Description* (SPD). Please read this document carefully and keep it with your SPD for future reference.

Update to Your SPD

This *Summary of Material Modification* updates the information in the **Retirement Programs** section of your SPD that are affected by this change. All other information in your SPD regarding your defined contribution plans remains unchanged.

RETIREMENT PROGRAMS

Defined Contribution Plan *(see list of plan names on page 2)*

When You Can Receive a Distribution

Normally, you are entitled to receive your plan account balance when your employment with Kaiser Permanente ends. You can defer receiving payment until April 1 of the year following your termination or the year you reach 70 ½, whichever is later, if you have more than $5,000 in your account as of your termination date.

How Benefits Are Paid

You can elect to receive a distribution of your full account balance, or, if the value of your account is more than $5,000, you can elect to receive a portion of your account and designate the specific type of contributions within your account to be distributed. If you elect a partial distribution and your account is invested in multiple investments, your distribution will be withdrawn proportionally from all of your investments.

Please note: If you request a partial distribution, you must continue to maintain an account balance greater than $5,000. When you retire or terminate your employment with Kaiser Permanente, and the value of your account is $5,000 or less, your account will be closed, and the amount will be rolled over into an Individual Retirement Account (IRA) in your name.

Required Distribution of Small Accounts

If, following the termination of your employment with Kaiser Permanente, the value of your account is $5,000 or less and you do not request distribution of your benefits, your benefit will be rolled over into an Individual Retirement Account (IRA) in your name. This automatic distribution may take place as early as the end of the first quarter following your termination of employment with Kaiser Permanente. Vanguard will contact you if this applies to you. Once the IRA is established, you will receive additional information. If you participate in more than one defined contribution plan, your plan balances will not be aggregated for purposes of the $5,000 threshold.

If You Die

Here is what happens if you die before you commence your vested benefits from the plan or if you have a vested benefit remaining in your account:

- If the remaining balance is more than $5,000, your beneficiary may elect any form of payment and may defer receiving payment until April 1 of the year following the year in which you would have reached age 70½. Your beneficiary may elect a tax-free rollover to an IRA.

For More Information

For information on the defined contribution plan(s) for which you are eligible, or your benefits in general, please refer to your SPD, available on My HR. To access your SPD, sign on to **kp.org/myhr**. Click on "My Profile" and scroll down to the "Benefits & Wellness" section. From there, click on "Benefits Resources," then on "Benefit Guides and Summary Plan Descriptions (SPD)."

Defined Contribution Retirement Savings Plans Affected by this SMM

- Health Care Management Solutions, LLC 401(k) Plan
- Kaiser Permanente 401(k) Retirement Plan
- Kaiser Permanente Northwest Supplemental Retirement Plan
- Kaiser Permanente Supplemental Savings and Retirement Plan
- Kaiser Permanente Supplemental Savings and Retirement Plan
- Kaiser Permanente Supplemental Savings and Retirement Plan for Union Groups
- Kaiser Permanente Tax-Sheltered Annuity Plan (I, II, and III)
- Kaiser Permanente Washington 403(b) Plan
- Kaiser Permanente Washington Defined Contribution Plan
- Kaiser Permanente Washington Options 401(k) Plan
- Oregon Federation of Nurses and Health Professionals – Kaiser Foundation Health Plan Retirement Plan and Trust
- The Permanente 401(K) Retirement Plan
- The Permanente Medical Group, Inc. Salary Deferral Retirement Plan (for union-represented employees)

The information described herein is a summary of benefit changes effective on January 14, 2019 (December 6, 2018, for TPMG). In case of any omission or conflict between what is written in this document and what is written in the plan documents, contracts, or agreements, the plan documents, contracts, or agreements always govern.

The Plan Sponsor reserves the right to modify, amend, change, replace, or terminate the benefit plans described in this *Summary of Material Modification* at any time. Benefits may be modified or eliminated through the negotiation process as well. You will be advised of any significant changes in your benefit program.

KAISER PERMANENTE®

June 2019

To: Kaiser Permanente Retirement Plan participants who transitioned from Kaiser Foundation Health Plan of Washington

Re: Group Health Cooperative Service and Credited Service

Overview

If, on February 1, 2017, you were a transition employee as part of the acquisition of Group Health Cooperative and its affiliates, and subsequently you transferred to or were rehired by Kaiser Foundation Hospitals, or Kaiser Foundation Health Plan Inc., your employment with Group Health Cooperative, and its affiliates will count toward eligibility and vesting calculations for Service and Credited Service for your defined benefit plan.

Please read the below *Summary of Material Modification* for more information.

SUMMARY OF MATERIAL MODIFICATION

This document updates the **Retirement Programs** section of your *Summary Plan Description* (SPD). Please read this document carefully and keep it with your SPD for future reference.

Update to Your SPD

The following information is hereby added to the "How Your Benefit Is Calculated" under **Retirement Programs** of the "Kaiser Permanente Retirement Plan" section of your SPD.

All other information remains the same.

RETIREMENT PROGRAMS

Defined Benefit Plan in your SPD, as applicable

Supplement to the Kaiser Permanente Retirement Plan

How Your Benefit Is Calculated

Important note for transition employees of the Washington Region: If, on February 1, 2017, you were a transition employee as part of the acquisition of Group Health Cooperative and its affiliates, and subsequently transferred to or were rehired by Kaiser Foundation Hospitals, or Kaiser Foundation Health Plan Inc., in another Kaiser Permanente region, your eligible employment with Group Health Cooperative and its affiliates will count when calculating your Service and Credited Service for your Kaiser Permanente Retirement Plan benefits in your new region. Any benefit offset rules will continue to apply.

Pension Offset Rules

For Washington Region transition employees who transfer to or are rehired in another Kaiser Permanente region: If you were a transition employee as part of the acquisition of Group Health Cooperative (GHC) and its affiliates, and then you transferred to or were rehired by Kaiser Foundation Hospitals or Kaiser Foundation Health Plan, Inc., (KFH/KFHP) in another region, any pension benefit you may be eligible for under your new position, will be offset by the sum of:

a) Any vested accrued benefit you are eligible for under a Kaiser Permanente Washington defined benefit plans as of the date of your transfer or rehire, and
b) The actuarial equivalent of your balance as of January 31, 2017, in any defined contribution plans sponsored by GHC and its affiliates.

For More Information

For more information about your benefits, you may refer to your SPD available on My HR. To access your SPD, sign on to **kp.org/myhr**. Click on "My Profile" and scroll down to the "Benefits & Wellness" section. From there, click on "Benefits Resources," then on "Benefit Guides and Summary Plan Descriptions (SPD)."

The information described herein is a summary of benefit changes. In case of any omission or conflict between what is written in this document and what is written in the plan documents, contracts, or agreements, the plan documents, contracts, or agreements always govern.

The Plan Sponsor reserves the right to modify, amend, change, replace, or terminate the benefit plans described in this *Summary of Material Modification* at any time. Benefits may be modified or eliminated through the negotiation process as well. You will be advised of any significant changes in your benefit program.

KAISER PERMANENTE®

June 2019

To: Employees eligible to participate in a defined contribution plan *(see page 2 for list of plans)*

Re: Defined Contribution Plans Non-Discrimination Test

Overview

The Internal Revenue Service (IRS) requires that defined contribution plans perform various nondiscrimination tests. This *Summary of Material Modification* (SMM) incorporates language into your *Summary Plan Description* (SPD) relating to the annual non-discrimination test. This test is federally required.

Please read the SMM below for more information.

SUMMARY OF MATERIAL MODIFICATION

This document updates the **RETIREMENT PROGRAMS** of your *Summary Plan Description* (SPD). Please read this document carefully and keep it with your SPD for future reference.

Update to Your SPD

The following language is hereby added at the end of the Defined Contribution Plan section under the **Retirement Programs** section of your SPD. All other information about your Defined Contribution Plan remains the same.

RETIREMENT PROGRAMS

Defined Contribution Plan *(see list of plan names on page 2)*

Non-Discrimination Test

The benefits you may receive to the defined contribution plan may be subject to federally required discrimination tests. This complex test compares the benefits of the "highly compensated" to the benefits of the "non-highly compensated" participants under all applicable plans provided by Kaiser Permanente and may require a reduction in benefits for the "highly compensated" participants.

Because of this test, if you are highly compensated (as defined by statute), the amount of your contributions may be reduced below the annual maximums to comply with the rules. You will be notified during the year if this reduction applies to you.

For More Information

For more information about your benefits, you may refer to your SPD available on My HR. To access your SPD, sign on to **kp.org/myhr**. Click on "My Profile" and scroll down to the "Benefits & Wellness" section. From there, click on "Benefits Resources," then on "Benefit Guides and Summary Plan Descriptions (SPD)."

Defined Contribution Retirement Savings Plans Affected by this SMM

- Health Care Management Solutions, LLC 401(k) Plan
- Kaiser Permanente 401(k) Retirement Plan (SCPMG, KFH, and KFHP)
- Kaiser Permanente Northwest Supplemental Retirement Plan
- Kaiser Permanente Supplemental Savings and Retirement Plan (SCPMG, KFH, and KFHP)
- Kaiser Permanente Supplemental Savings and Retirement Plan for Union Groups
- Kaiser Permanente Tax-Sheltered Annuity Plan (I, II, and III)
- Kaiser Permanente Washington 403(b) Plan
- Kaiser Permanente Washington Defined Contribution Plan
- Kaiser Permanente Washington Options 401(k) Plan
- Oregon Federation of Nurses and Health Professionals – Kaiser Foundation Health Plan Retirement Plan and Trust
- Southern California Permanente Medical Group Tax-Savings Retirement Plan
- The Permanente 401(k) Retirement Plan
- The Permanente Medical Group, Inc., Salary Deferral Retirement Plan
- The Permanente Money Purchase Pension Plan

The information described herein is an update to your *Summary Plan Description*.
In case of any omission or conflict between what is written in this document and what is written in the plan documents, contracts, or agreements, the plan documents, contracts, or agreements always govern.

The Plan Sponsor reserves the right to modify, amend, change, replace, or terminate the benefit plans described in this *Summary of Material Modification* at any time. Benefits may be modified or eliminated through the negotiation process as well. You will be advised of any significant changes in your benefit program.

KAISER PERMANENTE®

October 2018

To: Employees eligible to participate in Kaiser Permanente defined contribution retirement savings plans
(see page 2 for list of plans)

Re: Revised processing fees for Qualified Domestic Relations Orders

Overview

We would like to inform you that there has been a revision to the Qualified Domestic Relations Order (QDRO) review and processing fee. The new fee is $350 per Kaiser Permanente defined contribution retirement savings plan. Your account will be charged $350 per plan even if multiple plans are included in one QDRO.

SUMMARY OF MATERIAL MODIFICATION

For employees eligible to participate in Kaiser Permanente defined contribution retirement savings plans
(see page 2 for list of plans)

This document updates the **Legal and Administrative Information** section of your *Summary Plan Description* (SPD). Please read this document carefully and keep it with your SPD for future reference.

Update to Your SPD

The following language updates the "QDRO fees" paragraph in the "Qualified Domestic Relations Order" section of the **Legal and Administrative Information** section of your SPD. The remaining information is unchanged.

LEGAL AND ADMINISTRATIVE INFORMATION

Qualified Domestic Relations Order

QDRO Fees

If the Plan receives a Domestic Relations Order regarding one or more of your Kaiser Permanente defined contribution retirement savings plans, you will be charged a review and processing fee that will be deducted from your account. The current fee for reviewing and processing a Qualified Domestic Relations Order (QDRO) applicable to your Kaiser Permanente defined contribution retirement savings plans is $350 for each plan, even if multiple plans are included in one QDRO.

There is no review and processing fee for a Domestic Relations Order applicable to a Kaiser Permanente defined benefit pension plan.

For additional information about a QDRO for your defined benefit plan, if applicable, contact the Kaiser Permanente Retirement Center (KPRC) at **1-866-627-2826** Monday through Friday from 6 a.m. to 6 p.m. Pacific time, or online by clicking the **My Pension** button on the **Retirement** page of My HR at **kp.org/myhr**.

For additional information about a QDRO for your defined contribution retirement savings plan(s), contact Vanguard at **www.vanguard.com** or **1-800-523-1188**.

For More Information

For more information about your benefits, you may refer to your SPD available on My HR at **kp.org/myhr**.

Defined Contribution Retirement Savings Plans Covered under this Change

- Kaiser Permanente 401(k) Retirement Plan (KP401K)
- Kaiser Permanente Northwest Supplemental Retirement Plan
- Kaiser Permanente Supplemental Savings and Retirement Plan (Plan B)
- Kaiser Permanente Supplemental Savings and Retirement Plan for SCPMG (Plan B SCPMG)
- Kaiser Permanente Supplemental Savings and Retirement Plan for Union Groups
- Kaiser Permanente Washington 403(b) Plan
- Kaiser Permanente Washington Defined Contribution Plan
- Kaiser Permanente Washington Options 401(k) Plan
- Oregon Federation of Nurses and Health Professionals — Kaiser Foundation Health Plan Retirement Plan & Trust
- Tax-Sheltered Annuity Plans (I, II, and III)
- Tax-Savings Retirement Plan (TSR)
- TPMG Salaried Deferral Retirement Plan (SDR)

The information described herein is an update to your *Summary Plan Description*. In case of any omission or conflict between what is written in this document and what is written in the plan documents, contracts, or agreements, the plan documents, contracts, or agreements always govern.

The Plan Sponsor reserves the right to modify, amend, change, replace, or terminate the benefit plans described in this *Summary of Material Modification* at any time. Benefits may be modified or eliminated through the negotiation process as well. You will be advised of any significant changes in your benefit program.

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SUMMARY OF MATERIAL MODIFICATION

June 2018

To: Employees eligible to participate in Kaiser Permanente defined contribution retirement savings plans (see page 2 for list of plans)

Re: Change in processing fees for Qualified Domestic Relations Orders

This document updates the **Legal and Administrative Information** section of your *Summary Plan Description* (SPD). Please read this document carefully and keep it with your SPD for future reference.

Overview

When a Qualified Domestic Relations Order (QDRO) is filed with respect to your defined contribution retirement savings plan account(s), a QDRO review and processing fee is taken from your account balance. Kaiser Permanente has negotiated a reduction in the QDRO fee. The previous fee was $475 for the first plan, and $275 for any additional plans, up to a maximum of $750 per QDRO. Effective February 1, 2018, the new QDRO review and processing fee is a flat $350 per QDRO, regardless of the number of Kaiser Permanente defined contribution plans included in the QDRO. If multiple QDROs are filed, your account will be charged $350 per QDRO.

Update to Your SPD

The following updates the QDRO fees information in the Qualified Domestic Relations Order paragraph under the **Legal and Administrative Information** section of your SPD.

LEGAL AND ADMINISTRATIVE INFORMATION

Qualified Domestic Relations Order

QDRO Fees

If the Plan receives a Domestic Relations Order regarding one or more of your Kaiser Permanente defined contribution retirement plans, you will be charged a review and processing fee that will be deducted from your account. The current fee for reviewing and processing a Domestic Relations Order applicable to your Kaiser Permanente defined contribution plans is $350 for each QDRO, regardless of the number of Kaiser Permanente defined contribution plans included in the QDRO. If multiple QDROs are filed, your account will be charged $350 per QDRO.

There is no review and processing fee for a Domestic Relations Order applicable to a Kaiser Permanente defined benefit pension plan.

For additional information about a QDRO for your defined benefit plan, if applicable, contact the Kaiser Permanente Retirement Center (KPRC) at **1-866-627-2826** Monday through Friday from 6 a.m. to 6 p.m. Pacific time, or online by clicking the **My Pension** button on the **Retirement** page of My HR at **kp.org/myhr**.

For additional information about a QDRO for your defined contribution retirement plan(s), contact Vanguard at **www.vanguard.com** or **1-800-523-1188**.

For More Information

For more information about your benefits, you may refer to your SPD available on My HR at **kp.org/myhr**.

Defined Contribution Retirement Savings Plans Covered under this Change

- Kaiser Permanente 401(k) Retirement Plan (KP401K)
- Kaiser Permanente Supplemental Savings and Retirement Plan (Plan B)
- Kaiser Permanente Supplemental Savings and Retirement Plan for SCPMG (Plan B SCPMG)
- Kaiser Permanente Supplemental Savings and Retirement Plan for Union Groups
- Tax-Sheltered Annuity Plans (I, II, and III)
- Tax Savings Retirement Plan (TSR)
- TPMG Salaried Deferral Retirement Plan (SDR)
- Oregon Federation of Nurses and Health Professionals — Kaiser Foundation Health Plan Retirement Plan & Trust
- Kaiser Permanente Northwest Supplemental Retirement Plan

The information described herein is a summary of benefit changes effective as of February 1, 2018.
In case of any omission or conflict between what is written in this document and what is written in the plan documents, contracts, or agreements, the plan documents, contracts, or agreements always govern.

The Plan Sponsor reserves the right to modify, amend, change, replace, or terminate the benefit plans described in this *Summary of Material Modification* at any time. Benefits may be modified or eliminated through the negotiation process as well, if applicable. You will be advised of any significant changes in your benefit program.

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SUMMARY OF MATERIAL MODIFICATION

March 2018

To: Pharmacy Residents in the Colorado Region

Re: Change to Medical Benefits Effective Date

This document updates the **Health Care** section of your *Summary Plan Description* (SPD). Please read this document carefully and keep it with your SPD for future reference.

Overview

Currently, medical coverage for Pharmacy Residents in the Colorado Region begins on the first of the month following date of hire. Effective **April 1, 2018**, if you are hired on the first of the month, your medical coverage begins on your date of hire.

Update to Your SPD

The content below replaces the corresponding section in your *Summary Plan Description* (SPD) dated April 2017. The remaining information in this section remains unchanged.

HEALTH CARE

OVERVIEW OF MEDICAL CARE

When Coverage Begins

You are eligible for medical coverage on the first day of the month following your date of hire.

Please note: If you are hired on the first of the month, your coverage begins on your date of hire.

For More Information

For more information about your benefits, you may refer to your SPD available on My HR at **kp.org/myhr**.

Note: You may request a paper copy of this *Summary of Material Modification* at no charge by calling the National Human Resources Service Center at **1-877-4KP-HRSC (1-877-457-4772)**.

The information described herein is a summary of benefit changes effective on April 1, 2018.
In case of any omission or conflict between what is written in this document and what is written in the plan documents, contracts, or agreements, the plan documents, contracts, or agreements always govern.
Kaiser Permanente reserves the right to modify, amend, change, replace, or terminate the benefit plans described in this *Summary of Material Modification* at any time. You will be advised of any significant changes in your benefit program.

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SUMMARY OF MATERIAL MODIFICATION

October 2017

To: All Kaiser Permanente employees

Re: Change in Third-Party Administrator Name

This document updates the **Health Care** section of your *Summary Plan Description* (SPD). Please read this document carefully and keep it with your SPD for future reference.

Overview

CONEXIS, the third-party administrator for COBRA and Parent Medical Coverage, has been acquired by WageWorks. Effective immediately, all references to CONEXIS in the *Summary Plan Description* (SPD) will change to WageWorks. All contact information and the website for questions related to COBRA and Parent Medical Coverage remain the same.

Update to Your SPD

HEALTH CARE

All references to CONEXIS in your current SPD are hereby replaced with WageWorks. The contact information remains unchanged.

For More Information

For more information about your benefits, you may refer to your SPD available on My HR at **kp.org/myhr**.

The information described herein is an update to your *Summary Plan Description*. In case of any omission or conflict between what is written in this document and what is written in the plan documents, contracts, or agreements, the plan documents, contracts, or agreements always govern.

Kaiser Permanente reserves the right to modify, amend, change, replace, or terminate the benefit plans described in this *Summary of Material Modification* at any time. Benefits may be modified or eliminated through the negotiation process as well. You will be advised of any significant changes in your benefit program.

KAISER PERMANENTE®

SUMMARY OF MATERIAL MODIFICATION

May 2017

To: All Kaiser Permanente employees

Re: COBRA language changes

This document updates the **Health Care** section of your *Summary Plan Description* (SPD). Please read this document carefully and keep it with your SPD for future reference.

Overview

This *Summary of Material Modification* (SMM) provides updates to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) language currently in your *Summary Plan Description* (SPD). The updates provide additional information about COBRA coverage for retiree benefits. You may not be eligible for certain benefits mentioned in the SMM. Please refer to your employee group's SPD for information on benefits eligibility.

Update to Your SPD

The language below updates the "Continuation of Benefits under COBRA" information in the **Health Care** section of your SPD.

HEALTH CARE

Continuation of Benefits under COBRA

Under the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you, your spouse or domestic partner, and your eligible children are entitled to continue group health coverage under certain circumstances when coverage would otherwise end when you elect COBRA, provided you pay the full group rate plus a small administrative fee each month.

The following is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of COBRA. You, your spouse or domestic partner, and your eligible children should take the time to read this notice carefully. For more information about your rights and obligations under the plan and under federal law, contact CONEXIS, our third-party administrator, at **1-877-864-9546** or Kaiser Permanente, the plan administrator, at the following address and/or phone number:

Kaiser Foundation Health Plan, Inc.
One Kaiser Plaza, 20th Floor
Oakland, CA 94612
Phone: 510-271-5940

You can continue coverage under COBRA for the following plans, *if eligible*:

- Medical plans
- Dental plan
- Health Care Spending Account
- Employee Assistance Program

California law extends the self-payment coverage period to you and your dependents for the full period permitted under federal COBRA law. The state-extended coverage, known as CalCOBRA, becomes available only after you have exhausted federal COBRA and extends self-paid medical coverage only, for up to an additional 18 months not including Supplemental Medical for a combined maximum coverage period of 36 months from the date of your initial qualifying event. The state-extended coverage applies if you, your spouse or domestic partner, and your eligible children lose group health plan coverage as a result of a termination of employment or reduction of hours.

Please note: You may refer to the "COBRA Continuation for Retiree Health Benefits" section below for the different rules that apply to COBRA coverage for retirees. If you have any questions relating to retiree coverage, including COBRA for retiree health benefits, you may contact the KPRC.

When You Are Eligible

If You Have a Change in Employment Status

You, your spouse or domestic partner, and your eligible children, covered under the Kaiser Permanente-sponsored plans, are eligible to continue medical and dental coverage if your employment status changes for one of the reasons described below:

- Your employment ends for any reason (except for termination due to gross misconduct)
- You are no longer scheduled to work the necessary hours in order to meet eligibility

You may also be eligible to continue your participation in a Health Care Spending Account.

You may elect to continue coverage for up to 18 months for yourself, your covered spouse or your domestic partner, and your eligible children if your coverage ends. Your coverage under the Kaiser Permanente-sponsored plans will continue through the end of the month in which any of the above events occur. Your COBRA coverage will become effective on the first day of the following month, provided you make a timely COBRA election and payment.

Please note: Individuals who decline COBRA coverage when first eligible may not enroll for COBRA coverage later based on the same loss of coverage event.

During the period you continue coverage, an open enrollment period will be made available. You will have an opportunity to change or add medical and dental options. You may also drop coverage for a family member or add the following dependents during any open enrollment:

- Any new eligible dependents you acquire
- Any eligible dependents you declined to cover before you elected continued coverage

Special Enrollment Rights

If you decline COBRA coverage for your spouse, your domestic partner, and your eligible children and they subsequently lose their other coverage for any reason, you may request to enroll them in COBRA no later than 31 days from the date their other coverage terminates.

If You Have a Change in Family Status

Your spouse, your domestic partner, and your eligible children can continue coverage for up to a total of 36 months if coverage ends due to one of the following events:

- You divorce, annul your marriage, or legally separate from your spouse, or terminate your domestic partnership
- Your children no longer qualify for dependent coverage under the terms of the plan

If one of these qualifying events occurs after the start of the initial 18-month COBRA coverage period, your spouse or your domestic partner and eligible children can apply for an additional 18 months of coverage under COBRA. It is your or your dependents' responsibility to notify CONEXIS within 60 days of the occurrence of any of these events in order to be eligible for this extended COBRA coverage.

If You Are Called to Military Service

If you are absent from employment for more than 30 days by reason of service in the Uniformed Services, you may elect to continue medical and dental coverage for yourself, your spouse or your domestic partner and your eligible children in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or national emergency.

If qualified to continue medical and dental coverage under USERRA, you may elect to continue coverage by notifying the Plan Administrator in advance, and providing payment of any required contribution for your medical and dental coverage. This may include the amount the Plan Administrator normally pays on an employee's behalf. If your Military Service is for a period of time less than 31 days, you may not be required to pay more than the regular contribution amount, if any, for continuation of medical and dental coverage.

You may continue medical and dental plan coverage under USERRA for up to the lesser of:

- The 24-month period beginning on the date of your absence from work; or
- The day after the date on which you fail to apply for, or return to, a position of employment

Regardless of whether you continue medical and dental coverage under this policy, if you return to a position of employment, you and your eligible dependents who were enrolled in medical and/or dental coverage before your Military Service will be reinstated under the plan. No exclusions or waiting period may be imposed on you or your eligible dependents in connection with this reinstatement, unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

For more information on policies regarding Military Leaves, contact the National Human Resources Service Center (NHRSC).

If You Die

Coverage may be continued by your covered spouse or domestic partner and eligible children for up to a total of 36 months.

If You or Your Dependents Are Disabled

If you, your spouse or domestic partner, and eligible children are determined to be disabled as defined by the Social Security Act prior to the qualifying event or during the first 60 days of COBRA coverage, COBRA may be extended from 18 months up to a total of 29 months at a higher premium. You must notify CONEXIS within 60 days of the receipt of your Social Security award letter, and no later than the expiration of your initial 18-month coverage period. You must also notify CONEXIS within 60 days of the date Social Security determines that you, your spouse or domestic partner and your eligible children are no longer disabled.

COBRA Election Procedures

You, your spouse or domestic partner, and your eligible children who lose medical and/or dental coverage due to employment termination or reduction in hours or due to certain unpaid leaves of absence will be notified of COBRA election privileges by CONEXIS. If coverage is lost due to your death, CONEXIS will provide COBRA election notification to your eligible dependents in order to initiate COBRA coverage. If an eligible dependent will lose coverage due to divorce, legal separation, annulment, termination of a domestic partnership, or attainment of the dependent age limits, you must notify the NHRSC, within 31 days of the qualifying event. The NHRSC will notify CONEXIS of your eligible dependent's loss of coverage to exercise their COBRA election privileges.

You, your spouse or domestic partner, and your eligible children will be provided with a COBRA election form, which you must fill out and return within 60 days **of** the notification date shown on the form, or loss of coverage

date, if later. If you do not return the form within 60 days of the notification date or the loss of coverage date, if later, CONEXIS will assume that you have declined coverage.

Consider Your COBRA Decision Carefully

Please examine your options carefully before declining this coverage. If you do not elect COBRA coverage when eligible, you cannot elect it in the future. You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace.

You have 60 days to make a decision regarding continuation of group coverage through COBRA. After 60 days you may not change your initial election to continue or not continue coverage through COBRA, although you may stop your COBRA coverage at any time.

Benefits under COBRA

If the COBRA qualifying event occurred while you were an active employee, your benefits while you are enrolled in COBRA coverage will be the same as the coverage for active employees. Therefore, if there are any changes to the plan for active employees, including changes to the cost, your benefits will also change. COBRA premium rates are subject to change on an annual basis.

Under COBRA, you, your spouse or domestic partner and your eligible children, have the same enrollment privileges that apply to similarly situated active employees. You may enroll eligible dependents during the year if there is a qualified change in family status or at open enrollment, and you can change coverage at open enrollment, subject to the same rules that apply to active employees. You may drop COBRA coverage at any time. Once you discontinue COBRA coverage, you may not elect it at a later date, or re-enroll.

For information about COBRA continuation as a retiree, please refer to the "COBRA Continuation for Retiree Health Benefits" section below.

You will be billed within 31 days of electing COBRA. Your first payment due will include any outstanding premiums retroactive to your initial COBRA eligibility date. Payment for this coverage must be paid in full within 45 days of your election. Partial payments will not be accepted. Subsequent payments will be due the first of the month with a 30-day grace period. If payment is not postmarked within 30 days of the due date, coverage will be terminated retroactive to the first of that month. If for any reason you do not receive a monthly invoice, you are still responsible for a timely payment of the full monthly COBRA premium.

Marketplace Individual Coverage

You may decide to enroll in Marketplace Individual coverage instead of COBRA. You have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. After 60 days you will not be able to enroll. However, you will have an opportunity to enroll in Marketplace coverage during the annual Marketplace open enrollment period.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit **www.HealthCare.gov**.

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event, such as marriage or birth of a child. However, if you terminate your COBRA continuation coverage early without another qualifying event, you will have to wait until the next open enrollment period to enroll in Marketplace coverage. For full details about your COBRA coverage rights, contact the NHRSC.

When Coverage Ends

COBRA coverage stops before the end of the applicable time period if any of the following situations occur:

- You, your spouse or domestic partner, and your eligible children become covered under any other group medical or dental plan
- You, your spouse or domestic partner, and your eligible children become entitled to Medicare benefits after the qualifying event
- You fail to pay the required premium on time
- Kaiser Permanente terminates all of its group health plans
- You, your spouse or domestic partner, and your eligible children are on a COBRA disability extension and Social Security determines that you, your spouse or domestic partner, and your eligible children are no longer disabled

When your COBRA coverage ends, you may be eligible to convert to an individual medical and/or dental plan. In addition, your spouse or domestic partner, and your eligible children may be eligible to extend coverage under COBRA for an additional 18 months, or convert to an individual medical and/or dental plan. For full details about your COBRA coverage rights, contact the NHRSC.

COBRA coverage will be provided as required by law. If the law changes, your rights will change accordingly.

Employee Assistance Program COBRA Continuation

You and your spouse or your domestic partner and eligible children may also continue your Employee Assistance Program through COBRA at no charge, if your qualifying event is termination of employment or loss of benefit eligibility, but not if you retire.

COBRA Continuation for Retiree Health Benefits

Your covered spouse or domestic partner and eligible children may continue retiree health benefits under COBRA for the following plans:

- Retiree medical plans
- Retiree dental plans

Your covered spouse and eligible children may continue retiree health benefits under COBRA for the following plans:

- Sick Leave Health Reimbursement Account (Sick Leave HRA)
- Retiree Medical Health Reimbursement Account (Retiree Medical HRA) benefits

When You Are Eligible

Your covered spouse or domestic partner and eligible children may elect to continue coverage for up to 36 months, if the retiree health benefits end for one of the following qualifying events:

- You divorce, annul your marriage, or legally separate from your spouse, or terminate your domestic partnership, or
- Your children no longer qualify for dependent coverage under the terms of the plan,
- Your death, unless there are survivor benefits (and coverage would not end) under the terms of the plan, or
- Commencement of bankruptcy proceedings by Kaiser Permanente.

If the Sick Leave HRA or Retiree Medical HRA have a zero balance at the time of the qualifying event, COBRA coverage for these accounts will not be available. In addition, COBRA coverage will end before the 36-month maximum period if these accounts have a zero balance.

Benefits for your covered spouse or domestic partner and eligible children while enrolled in COBRA coverage will be the same retiree health benefits you had immediately prior to the qualifying event, except the Sick Leave HRA balance and the Retiree Medical HRA balance is prorated for divorce, annulment and legal separation.

If any changes are made to the retiree health benefits for non-COBRA participants, including changes to copayments or benefits, those changes will apply to you and your dependents.

COBRA Election Procedure

To elect to continue retiree health benefits through COBRA, you, your covered spouse or domestic partner, and eligible children must contact the KPRC to provide notice of a qualifying event. Notice of a qualifying event must be provided to the KPRC within 31 days of the qualifying event date. The KPRC will, in return, notify CONEXIS.

Your covered spouse or domestic partner, and your eligible children will be provided with a COBRA election form, which they must fill out and return within 60 days of the notification date shown on the form, or loss of coverage date, if later. If they do not return the form within 60 days of the notification date or the loss of coverage date, if later, CONEXIS will assume that coverage has been declined.

When Coverage Ends

COBRA coverage for the retiree health benefits will stop before the end of the 36-month maximum period if any of the following situations occur:

- Your spouse or domestic partner, or your eligible children become covered under any other group health plan,
- You fail to pay the required premium on time
- Kaiser Permanente terminates all of its retiree health benefits
- For the Sick Leave HRA and Retiree Medical HRA, when the accounts have a zero balance

For More Information

For more information about your benefits, you may refer to your SPD available on My HR at **kp.org/myhr**.

The information described herein is a summary of COBRA language changes. In case of any omission or conflict between what is written in this document and what is written in the plan documents, contracts, or agreements, the plan documents, contracts, or agreements always govern.

Kaiser Permanente reserves the right to modify, amend, change, replace, or terminate the benefit plans described in this *Summary of Material Modification* at any time. Benefits may be modified or eliminated through the negotiation process as well (if applicable). You will be advised of any significant changes in your benefit program.

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