Benefits for You

Pharmacy Residents

Colorado
January 2023

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
- retirement plans
- Employee Assistance Program

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, and leaves of absence, which are not addressed in this SPD. The **Contact Information** section of this SPD provides details on whom to contact for more information on all your benefits. You may also sign on to HRconnect at **kp.org/HRconnect**.

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 documents, but in the event that there is a discrepancy between this SPD and the official plan documents, the official plan documents will control.

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 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 health and welfare plans (medical, life insurance, disability, etc.) and all retirement savings plans	See specific information in the **Disputes, Claims and Appeals** section for 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

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Department, Organization, or Service	Contact Information
National Human Resources Service Center (NHRSC)	Phone: **877-4KP-HRSC (877-457-4772)** Fax: **877-HRSC-FAX (877-477-2329)** Kaiser Permanente National Human Resources Service Center P.O. Box 2074 Oakland, CA 94604-2074 **kp.org/HRconnect**
Health Care	
Member Services Questions about KFHP or KEMHP medical plans (as applicable)	**One KP Colorado** Hours: M-F, 8 a.m. - 6 p.m. **303-338-3800** **711** (TTY)
Employee Assistance Program (EAP)	Northern California **kp.org/eap** Southern California **kp.org/eap** Colorado **888-678-0937** **espyr.com*** Georgia **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*** * espyr.com password = Kaiser
HealthPlan Services Questions and claims about the following: • Supplemental Medical	Hours: M-F, 6 a.m. - 6 p.m. PT **800-216-2166** **www.hpsclaimservices.com**

Department, Organization, or Service	Contact Information
Income Protection (Voluntary Programs)	
Benefits by Design Voluntary Programs General questions about the voluntary programs	Hours: M-F, 5 a.m. – 6 p.m. Pacific Time **866-486-1949** **kp.org/voluntaryprograms**
Aflac Questions and claims about the following programs, as applicable: • Accident Insurance • Critical Illness	**800-433-3036** cscmail@aflac.com **Aflacgroupinsurance.com**
MetLife Questions and claims about Voluntary Term Life insurance	**888-420-1661** or **800-638-6420** **www.metlife.com/mybenefits**
MetLife Legal Plans Questions and claims about Legal Services	**800-821-6400** **www.legalplans.com**
Trustmark Insurance Company Questions and claims about Life Insurance with Long-Term Care Coverage	Beneficiary updates: **800-918-8877** Claims: **877-201-9373** **customercare@trustmarkbenefits.com**
Retirement Programs	
Kaiser Permanente Retirement Center (KPRC) Questions about retirement benefits	Hours: M-F, 6 a.m. – 6 p.m. Pacific Time Phone: **866-627-2826** Fax: **888-547-2304** **www.myplansconnect.com/kp**
Vanguard Questions about defined contribution retirement savings plans	Hours: M-F, 5:30 a.m. – 6 p.m. Pacific Time **800-523-1188** **www.vanguard.com**
Other Benefits	
HealthEquity/WageWorks Questions about the *Consolidated Omnibus Budget Reconciliation Act of 1985* (COBRA)	Hours: M-F, 5 a.m. – 5 p.m. Pacific Time **877-722-2667**

Enrolling in Benefits

Kaiser Permanente is proud to offer you a comprehensive benefits package designed to support you and your family both at work and at home. Take the time to read this section carefully and ensure that you make the most of the benefits you are offered.

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 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 limit. (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 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.

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.

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 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 Dependent Children Over the Age Limit")

Eligible Grandchildren

Your or your spouse's or domestic partner's grandchild is eligible for medical coverage only if the grandchild's parent (your child or the child of your spouse or domestic partner) 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 required documents listed in the "Required Documentation for Benefits" chart 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").

If there is a report or other suspicion of any falsification of any information regarding dependent eligibility, this will be investigated and may result in termination of benefits coverage, including recovery of the cost of any benefits provided and disciplinary action, up to termination of employment.

Enrolling a Newborn

Your newborn baby is covered under your coverage through the end of the month of birth, but you must inform the NHRSC and enroll the newborn in coverage within 31 days of the date of birth. Otherwise, you will have to wait until the following open enrollment period to enroll your baby in coverage, unless you have a qualifying employment or family status change. If you are enrolling a newborn or a child who is adopted, or placed with you for adoptions, 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.

Required Documentation for Benefits

The following information details the required documentation you will need to provide to enroll eligible family members:

Eligible Family Members	Required Documentation
Spouse	Copy of a certified marriage certificate
Common Law Spouse	Copy of a certified *Common Law Marriage Affidavit*
Domestic Partner	Copy of **one** of the following: • Notarized *Kaiser Permanente Affidavit of Domestic Partnership* (Form 3192 – available on HRconnect), or • Certified local or state government domestic partner registration and *Kaiser Permanente Affidavit of Domestic Partnership (notarization not required)*
Civil Union Partner	Copy of certified civil union license/registration from local or state government
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, or • 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

Eligible Family Members	Required Documentation
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 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 limit	Copy of a certified birth certificate or certificate of adoption and enrollment application, as applicable. You may be required to show proof of your dependent's continuing disability upon request.
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 Required Documentation for Benefits

- If you enroll a domestic partner, along with your certified domestic partner registration, you must also complete and submit the tax portion of the *Kaiser Permanente Affidavit of Domestic Partnership* (Form 3192 – available on HRconnect). Notarization is not required when submitting the tax portion of the affidavit.
- In order to enroll your domestic partner's dependents, you must also submit the required documentation for your domestic partner.
- If you are enrolling a newborn, and you do not yet have a birth certificate, a verification of birth letter from a Kaiser Foundation Health Plan (KFHP) hospital, KFHP-contracted hospital, or any other hospital is accepted.
- Foster children are not eligible for coverage without the *Notice of Intent to Adopt* certification.
- Contact Member Services to request an enrollment application for your disabled dependent, if one is required.

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 certain reasons, you may enroll in medical coverage (see "Special Enrollment Rights" for more information)

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 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.

Some benefits are not subject to the annual open enrollment restriction or are available for enrollment at any time (e.g., your 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 qualifying 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-time 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, once you are eligible for the benefit), 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
Add a newborn or adopted child to medical plans	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 the required documentation as soon as possible, if documentation is not available at the time of your request (see "Required Documentation for Benefits" 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 more 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 HRconnect.

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

Tax Considerations

Internal Revenue Service (IRS) regulations require certain benefits to be paid on an after-tax basis.

Your **after-tax** benefits are as follows:

- Benefits by Design Voluntary Programs

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 HRconnect.

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 HRconnect when you begin working at Kaiser Permanente, change to an eligible status, have a qualifying event, or during the annual open enrollment period.

HRconnect 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 HRconnect at any time, from work or home, at **kp.org/HRconnect**.

Enrolling in Benefits Online

Click on the **Benefits enrollment** link to:

- **Enroll in or change** your benefits or coverage levels
- **Add or remove dependents** from your coverage

For help, look for the orange **Guide Me** button on the right side of each enrollment screen. This button can give you guidance specific to the actions you can take each step of the way. You also can use it to search for answers to questions regarding the enrollment process.

Please note: Make sure you finish enrolling in one session; if you start your enrollment and decide to exit and come back later, your progress will not be saved. When you have finished, choose the **Submit** button to register your choices. Your elections will be saved and confirmed immediately.

Once you have submitted your enrollment, click the **Print** button to save your enrollment summary as a confirmation statement.

To complete your dependent's enrollment, you must also provide required documentation (e.g., copy of certified birth certificate, copy of certified marriage certificate, *Kaiser Permanente Affidavit of Domestic Partnership*, etc.) to NHRSC (see the "Required Documents for Benefits" section). You may upload these documents directly to your case on **My Cases** on HRconnect (preferred), fax, or mail to:

Kaiser Permanente
National Human Resources Service Center
P.O. Box 2074
Oakland, CA 94604-2074
Fax: 877-HRSC-FAX (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. If you need additional help with your enrollments, contact the NHRSC.

Domestic Partner/Civil Union Partner Benefits

You may extend certain benefits, such as medical 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 "Required Documentation for Benefits" chart. If you file a *Kaiser Permanente Affidavit of Domestic Partnership* (Form 3192 – available on HRconnect), 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 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 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 HRconnect), 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
- Parent Medical Coverage

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 HRconnect 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 benefits, whichever is later.

Adding and Removing a Domestic Partner

You must notify the 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 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 HRconnect) 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 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 medical 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. You will be responsible for the FMV on the cost of benefits from the start of enrollment. Imputed income may not start immediately.

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.

Please note: If your eligible dependents engage in violent gross misconduct against any Kaiser Permanente employee at the workplace and/or any Kaiser Permanente physician at a Kaiser Permanente facility, your dependents will be excluded from medical coverage.

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

If you choose to enroll 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.

Your Costs

To find applicable premium information and any required employee cost share, visit **kp.org/HRconnect** and type “health plan cost” in the search field. Premium rates are subject to change annually. You will pay any required cost share through automatic payroll deductions on the first two pay statements of each month. 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.

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.

Coverage for your enrolled dependents begins when yours does, provided that the NHRSC receives your completed enrollment materials and the required documentation (see “Required Documentation for Benefits” chart).

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 the “Continuation of Benefits under COBRA” section.

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. 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 contact Member Services.

Your KFHP Medical Plan at a Glance

The following chart summarizes the most frequently asked questions about benefits and their respective coverage and costs. For a complete description of benefits and costs, please refer to the *Evidence of Coverage* brochure.

Benefits	You Pay
Annual Out-of-Pocket Maximum	
Individual	$2,000
Two or more people	$4,500
Outpatient Care	
Office visits for illness/injury, including specialty care and OB/GYN	$20 per visit
Outpatient surgery	$100 per visit

Benefits	You Pay
Affordable Care Act (ACA) Preventive Services, as defined by each region	No charge
Routine physical exams	No charge
Lab tests and X-rays	No charge for diagnostic; $10 for therapeutic
Immunizations (preventive)	No charge
Allergy testing	$10 per visit
Allergy injections	$10 per visit
Inpatient Care	
Including room and board, surgical services, nursing care, anesthesia, X-rays, and lab tests	$250 per admission
Maternity Care	
Prenatal care	No charge
Labor, delivery, and recovery	$250 per admission
Routine postpartum visit	No charge
Well-child care	No charge (through age 17)
Family Planning	
Outpatient	No charge for ACA Preventive Services, otherwise $20 per visit
Inpatient	$250 per admission
Fertility Services	
Office visit	Same as for other covered care (see “Office visits”)
Outpatient surgery (includes services for IVF up to 3 retrievals)	Same as for other covered care (see “Outpatient surgery”)
Inpatient care	Same as for other covered care (see “Inpatient Care”)
Prescription drugs	Same as for other drugs (see “Prescription Drugs”)
Outpatient	50% of covered charges
Inpatient	$250 per admission
Emergency Department	
Emergency room visits	$100 per visit (waived if admitted)
Urgent care visits	$50 per visit
Ambulance	
Medically necessary or Kaiser Permanente-approved	20% coinsurance up to $500 per trip

Benefits	You Pay
Prescription Drugs	
Note: Prescriptions must fall within KFHP Formulary guidelines, unless specifically prescribed by a Kaiser Permanente physician.	
KP Pharmacy (up to 60-day supply) (First time prescriptions may be filled at any network or KP Medical Office Pharmacy. Any refills must be filled at KP Medical Office pharmacies or through KP Mail Order)	$10 generic / $20 brand name
Mail order (up to 60-day supply non-maintenance / up to 100-day supply maintenance)	$20 generic / $20 brand name
ACA-mandated medications	No charge
Mental Health Care	
Outpatient Individual	$20 per visit
Outpatient Group	$10 per visit
Inpatient	$250 per admission
Substance Use Disorder	
Outpatient Individual	$20 per visit
Outpatient Group	$10 per visit
Inpatient	$250 per admission (detox only)
Residential Treatment	$250 per admission
Skilled Nursing Facility	
Up to 100 days per calendar year	No charge
Physical, Speech, and Occupational Therapy	
Outpatient (Must be prescribed by a Kaiser Permanente provider. Up to 20 visits per therapy per calendar year. Separate visit limits apply to habilitative and rehabilitative therapies.)	$20 per visit
Inpatient	$250 per admission
Durable Medical Equipment (DME), Prosthetic, and Orthotic Devices	
Must be prescribed by a Kaiser Permanente physician in accordance with Health Plan and DME Formulary guidelines	No charge
Vision Care	
Routine eye exams	$20 per visit
Eyeglasses and contact lenses, adults **Note:** Charges in excess of the allowance do not apply to out-of-pocket limits.	$150 credit toward one pair of eyeglass lenses and frames OR contact lenses (every 24 months)

Benefits	You Pay
Eyeglasses and contact lenses, children up to age 19	No charge for one pair of eyeglass lenses and frames OR contact lenses (every 24 months)
Home Health Care	
Must be prescribed by a Kaiser Permanente physician and authorized by the Home Health committee. Custodial care not covered.	No charge
Hearing Care	
Hearing exams	No charge if part of preventive exam; otherwise, $20 per visit
Hearing aids, adults	$1,000 per ear credit every 3 years
Hearing aids, children up to age 18 with verified hearing loss	No charge for initial and replacement hearing aids once every 5 years
Hospice Care	
Available within service area only	No charge

Telemedicine Services

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.

There is no cost for telemedicine services. Prescription costs will apply.

COVID-19 Services

Special Note on COVID-19 Services

Under the Coronavirus Aid, Relief, and Economic Security (CARES) Act and related guidance from the federal government, the following items are available at no charge through the end of the COVID-19 public health emergency (as declared by the U.S. Secretary of Health and Human Services):

- COVID-19 vaccines
- COVID-19 testing

Home tests. Coverage for testing includes up to eight FDA-approved COVID-19 rapid antigen over-the-counter (OTC) home tests per calendar month for yourself and for each of your eligible covered dependents. This benefit is for tests obtained or purchased on or after January 15, 2022.

You do not need a doctor's order or prescription or prior authorization for the over-the-counter tests. The tests must be administered by and the results read by you and/or your eligible dependents. In addition, the tests must be for personal use (not for employment purposes or resale) and cannot be reimbursed elsewhere.

For information on the home test options available to you under your plan, call Member Services or Customer Service for your plan or visit your plan's website.

If you have a Health Care Flexible Spending Account (Health Care FSA), you may use your Health Care FSA to reimburse yourself for home test costs not covered by your plan (for example, for tests beyond the eight per month).

Other Covered Services

In addition to the benefits listed above, your medical plans also provide coverage for other medical benefits, including dialysis, health education, gender-affirming services, and organ transplants. For details about these benefits, please refer to your *Evidence of Coverage* or call Member Services.

Additional Information About Certain Medical Services and Coverage

When You Are Expecting a Baby

In accordance with the Newborns' and Mothers' 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, such that you reasonably believed that the absence of immediate medical attention would result in any of the following:

- Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment of the individual's bodily functions
- Serious dysfunction of any bodily organ or part

A mental health condition is an Emergency Medical Condition when it meets the requirements above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to himself or herself or to others
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to mental disorder

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. 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.

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.

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.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

Definition of "Balance Billing" (also referred to as "Surprise Billing")

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or must pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

"Out-of-network" describes providers and facilities that have not signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

Surprise Billing

"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care — like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

Balance Billing Protection

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility without prior authorization, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **cannot** be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology,

assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

Additional Protection When Balance Billing Is Not Allowed

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your *Explanation of Benefits*.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed, or to obtain a copy of your *Evidence of Coverage*, call Member Services or Customer Service (see the **Contact Information** section).

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 HRconnect or contact HealthPlan Services (see **Contact Information** section).

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).

How Supplemental Medical Works

Before you begin to receive benefits for most services 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, to a maximum of $200.

Exceptions to this requirement are made for the following:

- Hospice care: The eligible hospice care services described in the Supplemental Medical Covered Services chart will be reimbursed at 100% regardless of whether the annual deductible has been met.
- (*If applicable*) Services for which you pay a copayment: You pay only the dollar amount specified as the copayment. Amounts paid as copayments do not count toward the annual deductible.

After you have met the deductible, you share the cost of the covered services that are subject to it by paying coinsurance. HealthPlan Services will authorize payment of a percentage of the reasonable and customary (R&C) charges, which it determines 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% 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.

An *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 the KFHP plan
- The service is excluded from coverage under the patient's KFHP plan
- The patient has exceeded plan limits for the service through the KFHP plan

An *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 the KFHP plan 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 the KFHP plan. 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 before you can receive reimbursement for covered services from Supplemental Medical. 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.

Services	You Pay	Maximum/Limits	Restrictions
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. Treatment plan may be required. Limited definition of speech therapy.
Blood, Blood Products, Blood Transfusions and their 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.
Custodial Care Services At home or at a skilled nursing facility	50%	N/A	Evidence of total and permanent disability is required. Custodial care must be intended to help person meet activities of daily living.
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.

Services	You Pay	Maximum/Limits	Restrictions
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
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.

Telemedicine Services

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. Certain providers may not offer telemedicine appointments. Please check with your provider.

Copayment and/or cost share will apply for telemedicine services.

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.

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
- 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 intellectual disabilities
- Education, training, or instruction
- Electronic voice producing machines
- Emergency room visits and treatments
- Employer's medical clinic visits and treatments
- 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
- Immunosuppressive drugs
- Infertility services where patient’s medical records 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
- Injectable contraceptives
- 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 participant's or dependent's spouse, parent, child, grandparent, brother, sister, or parent/brother/sister-in-law
- 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 visit
- 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 (called "dual coverage");
- 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:
    a. the parents are married or living together, whether or not they have ever been married, and are not legally separated; or
    b. 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:
    a. the parent with custody of the child; then
    b. the spouse of the parent with custody of the child; then
    c. the parent not having custody of the child; then
    d. 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.

Determining Primary and Secondary Plan

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

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% of the total allowable expense.

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% 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 your medical plan.

For more information and the complete coordination of benefits provision for your KFHP medical plan, please refer to your *Evidence of Coverage* brochure, or call Member Services.

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 benefits under certain circumstances. For more information, contact the National Human Resources Service Center.

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 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. For more information about your rights and obligations under the plan and under federal law, contact HealthEquity/WageWorks, our third-party administrator (see the **Contact Information** section), or Kaiser Permanente, the plan administrator (see the **Legal and Administrative Information** section).

You can continue coverage under COBRA for the following plans:

- Medical plans
- Employee Assistance Program

When You Are Eligible

If You Have a Change in Employment Status

You and your eligible dependents covered under the Kaiser Permanente-sponsored plans, are eligible to continue medical 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 elect to continue coverage for up to 18 months for yourself and your eligible dependents 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 do not elect COBRA within the 60-day election period cannot later enroll based on the same loss of coverage event.

During the period you continue coverage, an open enrollment period may be available, during which time you may add medical 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 do not elect COBRA coverage for your eligible dependents, and they subsequently lose their other coverage because of marriage, birth, adoption, placement for adoption, or 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 eligible dependents 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 eligible dependents can apply for an additional 18 months of coverage under COBRA. It is your or your dependents' responsibility to notify HealthEquity/WageWorks 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 coverage for yourself and your eligible 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 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 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 coverage.

You may continue medical 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 coverage under this policy, if you return to a position of employment, you and your eligible dependents who were enrolled in medical 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, refer to the national HR Policies library, available on HRconnect, or contact the NHRSC.

If You Die

Coverage may be continued by your covered eligible dependents for up to a total of 36 months.

If You or Your Dependents Are Disabled

If you and/or your eligible dependents 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 HealthEquity/WageWorks 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 HealthEquity/WageWorks within 60 days of the date Social Security determines that you and/or your eligible dependents are no longer disabled.

COBRA Election Procedures

You and your eligible dependents who lose medical coverage due to employment termination or reduction in hours or due to certain unpaid leaves of absence will be provided with a COBRA election notice by HealthEquity/WageWorks. If coverage is lost due to your death, HealthEquity/WageWorks 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 limit, you or your dependent must notify the NHRSC within 60 days of the qualifying event. The NHRSC will notify HealthEquity/WageWorks of your eligible dependent's loss of coverage to exercise his or her right to elect COBRA.

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, HealthEquity/WageWorks will assume that you have declined coverage.

When adding a new eligible dependent as a result of a family status change that does not involve loss of coverage, you must notify HealthEquity/WageWorks within 31 days of the qualifying event.

Consider Your COBRA Decision Carefully

Please examine your options carefully before declining this coverage. If you do not elect COBRA group coverage during the 60-day election period, 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 and your eligible dependents have the same enrollment rights 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.

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 HealthEquity/WageWorks.

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.

When Coverage Ends

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

- You and/or your eligible dependents become covered under any other group medical plan
- You and/or your eligible dependents 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 and/or your eligible dependents are on a COBRA disability extension and Social Security determines that you and/or your eligible dependents are no longer disabled

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

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 issue per year. EAP is a standalone 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 **kp.org/eap** and click on your region.

When you terminate employment from Kaiser Permanente, you and your dependents may continue your EAP through COBRA at no charge, if your qualifying event is termination of employment or loss of benefit eligibility, but not retirement. For more information, refer to the "Continuation of Benefits under COBRA" section.

Parent Medical Coverage

You may have the opportunity to enroll parents, parents-in-law, or parents of a domestic partner who also qualify for Medicare in Kaiser Permanente medical plan coverage at group rates. Because this is a group plan offered through Kaiser Permanente, no medical review is necessary.

Who Is Eligible

Eligible Employees

In order for your parents to qualify for Parent Medical Coverage (PMC), you must be an active employee in an eligible status, whether or not you are enrolled in medical coverage.

Eligible Parents

To be eligible, your parents must be enrolled in Medicare Parts A and B, meet eligibility requirements for Kaiser Permanente Senior Advantage, and assign their Medicare benefits to Kaiser Permanente. Additionally, you and your eligible parents must reside within the same Kaiser Permanente region, and your parents must live in a Kaiser Permanente Medicare service area. Dependents of parents are not eligible for this coverage. The following are considered eligible parents for this plan:

- Your natural parents
- Your stepparents, if still married to or widowed from your natural parents (a widowed stepparent who remarries is not eligible for coverage)
- A domestic partner of your parents
- Your spouse's or domestic partner's natural parents
- Your spouse's or domestic partner's stepparents, if still married to or widowed from your spouse's natural parents (a widowed stepparent who remarries is not eligible for coverage)
- A domestic partner of your spouse's or domestic partner's parents

Medicare Eligibility and Coverage

Parents must be enrolled in Medicare Parts A and B and enroll in Kaiser Permanente Senior Advantage to be eligible for Parent Medical Coverage. Kaiser Permanente Senior Advantage is subject to additional eligibility requirements, as described on the *Kaiser Permanente Senior Advantage Election Form* enclosed with the enrollment kit.

When Your Eligible Parents May Enroll

Your eligible parents may enroll in this benefit only during the following designated enrollment periods:

- Within 31 days of your date of hire
- During the annual open enrollment period (you will be notified in advance of the dates)
- Outside of the open enrollment period within 31 days of the following qualifying events:

- When an eligible parent first moves into a Kaiser Permanente Medicare service area in your region
- When an eligible parent first becomes eligible for and enrolls in Parts A and B of Medicare

If you have a change in eligibility status (for example, if you move from a non-benefited to a benefited status, if you or your parent marries or enters into a domestic partnership, or if you or your parent divorces) you will have 31 days to enroll or disenroll your parents from coverage.

How to Enroll

To enroll a parent:

1. Sign on to HRconnect and access the Benefits Enrollment page. The PMC enrollment information is at the end of the enrollment page.
2. Complete the online request to have PMC enrollment forms emailed to you.
3. Once you receive the email, complete pages 1 and 2 of the *Parent Medical Coverage Enrollment Application* (4130) for each parent; **both you and your parent must complete and sign this form**.
4. Submit a notarized *Kaiser Permanente Affidavit of Domestic Partnership* (Form 3192 – available on HRconnect) or submit a copy of a certified domestic partnership registration filed with a local or state government if your or your spouse's parent's domestic partner is applying for coverage.
5. Each eligible parent you wish to enroll must complete the *Kaiser Permanente Senior Advantage Election Form.*
6. Please include your 8-digit employee number on the top of each form.
7. Mail or fax all completed forms to the NHRSC within 31 days of the date you and/or your parent(s) become eligible, or before the end of the annual open enrollment period.

Each eligible parent must enroll separately.

Coverage Premiums

Parents who enroll in this coverage will be responsible for the entire amount of the premium for their coverage, as well as for any applicable copayments and administrative fees. Premium payments for coverage must be made directly to HealthEquity, the third-party administrator of this plan. HealthEquity will bill your enrolled parents directly. This is a pre-paid health plan, so payments must be received in advance of the effective date of coverage.

Premiums are subject to change from year to year. Your enrolled parents will be notified in advance of any change in premiums. For more information on premiums, visit HRconnect.

Medical Coverage Under This Plan

Parent Medical Coverage includes comprehensive medical care coordinated with Medicare and features a $5 office visit copayment.

A complete list of benefits, services, and copayments will be included in the enrollment kit.

When Coverage Is Effective

If your parents enroll during the annual open enrollment period, coverage is effective on January 1 of the following year.

If you are a newly hired employee, or if your parents enrolled during the benefit year as a result of a qualifying event, coverage is effective on the first of the month following the date that the NHRSC receives the completed and signed *Kaiser Permanente Parent Medical Coverage Enrollment Application* and the *Kaiser Permanente Senior Advantage Election Form*, or the Medicare-eligible date, whichever is later.

For example: If completed paperwork is received on May 15, coverage is effective June 1, as long as your parent is enrolled in Medicare on June 1.

Enrollment is contingent upon eligibility for Medicare Parts A and B. If there is a delay in confirming your parents' eligibility for enrollment in Medicare, the effective date of coverage may be delayed accordingly.

Your parent may continue PMC coverage as long as you remain actively employed in an eligible status, or are on an approved, long-term disability leave.

When Parents Lose Coverage

Your eligible parents will lose coverage when one of the following occurs:

- You terminate employment prior to retirement or are no longer eligible per the eligibility requirements above. If you lose eligibility, your parents' coverage will end on the last day of the calendar quarter in which your status change occurred.
- Your parents no longer meet the eligibility requirements stated in the "Eligible Parents" section above.
- You and/or your covered parents no longer reside in the same Kaiser Permanente region and/or your parents no longer reside in a Kaiser Permanente Medicare service area.
- Premiums for medical coverage are not paid. Parents who lose coverage due to nonpayment will be converted to an individual plan. Disenrollment for nonpayment will be processed in accordance with Medicare guidelines.

Parents who disenroll for any reason must wait until the next open enrollment period to re-enroll. If your parents are disenrolled from the Parent Medical Coverage plan, they will be offered conversion to an individual plan. Continuation of coverage is not available through COBRA.

When You Retire

If you have parents enrolled in the plan when you retire, they may continue the coverage in your retirement. However, if your parents disenroll, their coverage will cease, and they will not be eligible to re-enroll.

Likewise, parents will not be eligible to enroll in the Parent Medical Coverage plan after you retire.

For more information about this plan, visit HRconnect or contact the NHRSC.

Income Protection

Kaiser Permanente offers you a variety of insurance plans to provide financial assistance for you and those who rely on you. In the event of an illness or injury, the disability insurance plans can provide continuing income. The life insurance programs give your beneficiaries added financial assistance in the event of your death.

Highlights of This Section

Survivor Assistance

In addition to life insurance, you may be entitled to the Survivor Assistance benefit. This benefit provides your beneficiary with a more immediate means of financial assistance in the event of your death. The Survivor Assistance benefit is not part of your life insurance coverage — it is a separate employee benefit fully funded by Kaiser Permanente.

Who Is Eligible

You are eligible for the Survivor Assistance benefit if you are regularly scheduled to work 20 or more hours per week in an eligible status.

When Coverage Begins

If eligible, you are automatically covered on your date of hire.

How Survivor Assistance Works

The Survivor Assistance benefit amount is equal to one times your monthly base salary (prorated for part-time employees). In the event of your death, your beneficiaries will receive the proceeds of your Survivor Assistance benefit, generally within four to six weeks from the date a death certificate is received by the NHRSC. This benefit amount may be subject to taxes.

If your death occurs while you are on a leave of absence of less than one year, your beneficiary is still eligible to receive the Survivor Assistance benefit.

You can designate a beneficiary online by signing on to **kp.org/HRconnect**. If you do not have access to a computer, contact the NHRSC.

Benefits by Design Voluntary Programs

Overview of Benefits by Design Voluntary Programs

Benefits by Design Voluntary Programs provide eligible employees with the opportunity to participate in programs such as accident insurance, critical illness insurance, legal services, life insurance with long-term care coverage, and voluntary term life insurance, which are governed by the Employee Retirement Income Security Act (ERISA) of 1974. Participation in these programs is voluntary and does not affect any of the existing benefits provided through Kaiser Permanente.

Accident Insurance

Benefits by Design Voluntary Programs give you the opportunity to purchase accident insurance at group rates through Aflac.

Accident insurance pays cash directly to you, unless otherwise assigned, to help with medical costs, your rent or mortgage, or any other bills in the event of a covered accident. These payments are independent of and in addition to any medical, disability, and workers' compensation benefits you receive.

Who Is Eligible

You are eligible to purchase accident insurance if you are regularly scheduled to work 20 or more hours per week.

You may purchase insurance for yourself only or also for your spouse or civil union/domestic partner and/or your eligible children under age 26. Dependent coverage is available only with employee coverage.

Coverage may be extended beyond age 26 for a dependent child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. You or your spouse or civil union/domestic partner must furnish proof of this incapacity and dependency to Aflac within 31 days following the dependent child's 26th birthday.

When Coverage Begins

You may enroll only during the spring enrollment period each year. Coverage begins the first of the second month following the end of the enrollment period. For example, if the enrollment period ends on April 30, your coverage will begin on June 1. Your coverage continues unless you cancel your coverage. You may cancel coverage at any time.

If you do not enroll in accident insurance during the spring enrollment period, you will have to wait until the following year to enroll. You will be notified when the enrollment period will occur each year.

Your Cost

The cost of your coverage will depend on the coverage you elect – Employee only, Employee + Spouse/Civil Union/Domestic Partner, Employee + Children, or Family coverage. Your payments are made through payroll deductions on an after-tax basis from the first two paychecks of each month.

Please sign on to **kp.org/voluntaryprograms** or call Benefits by Design Voluntary Programs for information on the current rates (see the **Contact Information** section).

How Accident Insurance Works

Accident insurance pays cash benefits directly to you (unless otherwise assigned) for various expenses you might have in the event of a covered accident.

For example: You are injured in a car accident and transported to an emergency room by ambulance. The emergency room doctor X-rays, diagnoses a fracture, and treats you. You leave the hospital on crutches.

In this case, accident insurance would pay you set dollar amounts for the fracture, the ambulance, the emergency room treatment, one follow-up treatment, and the crutches.

Benefits are paid regardless of what types of other insurance you may have such as medical, disability and workers' compensation.

Covered Services, Injuries, and Conditions

Benefit amounts are based on medical services or treated injuries or conditions. These amounts are set by the plan and do not depend on what you are charged or pay. General categories are listed below. For more details, including the dollar amounts, frequency of coverage, and conditions of payment, please sign on to HRconnect or contact Aflac (see the **Contact Information** section).

- Accident follow-up treatment
- Ambulance
- Appliances (within 6 months after accident)
- Blood/plasma/platelets
- Burns (2nd and 3rd degree)
- Chiropractic or alternative therapy

- Concussion
- Dislocations
- Emergency dental work
- Emergency room observation
- Eye injuries
- Facilities fee for outpatient surgery
- Family member lodging
- Fractures
- Hospitalization
- Initial treatment (at hospital emergency room, urgent care facility, or doctor's office or facility)
- Inpatient surgery and anesthesia
- Lacerations
- Major diagnostic testing
- Outpatient surgery and anesthesia
- Pain management
- Paralysis
- Post-traumatic stress disorder
- Prescriptions
- Prosthesis
- Rehabilitation unit
- Residence/vehicle modification
- Surgery and anesthesia
- Therapy
- Traumatic brain injury
- Wellness benefit tests (once per calendar year)

Organized Athletic Activity Benefit

Accident insurance also includes an organized athletic activity benefit – an additional percentage of the benefit amount for covered accidental injuries sustained during participation in an organized athletic event. This benefit is paid in addition to benefits paid under the plan.

The organized athletic activity benefit is not payable for accidental injuries that are caused by or occur as a result of physical education classes or participation in any sport or sporting activity for wage, compensation, or profit, including officiating, coaching, or racing any type of vehicle in an organized event.

Exclusions

Exclusions apply to benefits for accidental injuries, disability, or death contributed to, caused by, or resulting from the following:

- Cosmetic surgery
- Felony
- Illegal occupation

- Racing
- Suicide
- Sickness
- Self-inflicted injuries
- Sports
- War

Choosing Your Beneficiary

You must choose a beneficiary or beneficiaries at the time you enroll in accident insurance. You will be guided through the necessary steps to designate your beneficiary or beneficiaries when you enroll online.

If you need assistance or want to update or change your beneficiaries, call Benefits by Design Voluntary Programs (see the **Contact Information** section).

When Coverage Ends

Your accident insurance may terminate if you do not pay the premium or if you transfer to a position where this benefit is not offered and you do not elect to continue the coverage on a direct-payment basis.

This coverage is portable, and you may continue your insurance if you terminate employment or retire. For details about continuing your coverage and applicable rates, please call Aflac or visit its website (see the **Contact Information** section) within 31 days of termination of employment.

You may contact Aflac to cancel your coverage at any time.

If you die while covered by this plan and your dependents are also covered under this plan at the time of your death and are interested in continuing coverage, your surviving spouse or civil union/domestic partner should call Benefits by Design Voluntary Programs or Aflac for information (see the **Contact Information** section).

Critical Illness Insurance

Benefits by Design Voluntary Programs give you the opportunity to purchase critical illness insurance at group rates through Aflac.

Critical illness insurance pays cash directly to you, unless otherwise assigned, to use any way you choose in the event of a covered critical illness. These payments are independent of and in addition to any medical, disability, and workers' compensation benefits you receive.

Who Is Eligible

You are eligible to purchase critical illness insurance if you are actively at work and regularly scheduled to work 20 or more hours per week.

You may purchase insurance for yourself only or also for your spouse or civil union/domestic partner and eligible children under age 26. Dependent coverage is available only with employee coverage.

Coverage may be extended beyond age 26 for a dependent child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. You or your spouse or civil union/domestic partner must furnish proof of this incapacity and dependency to Aflac within 31 days following the dependent child's 26th birthday.

When Coverage Begins

You may enroll only during the spring enrollment period each year. Coverage begins the first of the second month following the end of the enrollment period. For example, if the enrollment period ends on April 30, your coverage will begin on June 1. Your coverage continues unless you cancel your coverage. You may cancel coverage at any time.

If you do not enroll in critical illness insurance during the spring enrollment period, you will have to wait until the following year to enroll. You will be notified when the enrollment period will occur each year.

Your Cost

The cost for critical illness insurance is based on the benefit amount you elect, your age, whether you use tobacco products, and whether you include coverage for your spouse or civil union/domestic partner (there is no additional charge to cover children).

Your payments are made through payroll deductions on an after-tax basis from the first two paychecks of each month.

Please sign on to **kp.org/voluntaryprograms** or call Benefits by Design Voluntary Programs for cost information (see the **Contact Information** section).

Waiver of premium: If you are under age 65 and become totally disabled due to a covered critical illness, premiums for you and any of your covered dependents will be waived for up to 24 months, subject to the terms of the plan, after 90 continuous days of total disability, as long as you remain totally disabled.

Totally disabled means you are not working at any job for pay or benefits, you are under the care of a doctor/qualified medical professional for the treatment of a covered critical illness, and you are unable to work

- at the occupation you were performing when your total disability began during the first 365 days and
- at any gainful occupation for which you are suited by education, training, or experience after the first 365 days.

Proof of total disability must be provided at least once every 12 months. Premiums that were paid for the first 90 days of total disability will be refunded after your claim for this benefit is approved.

How Critical Illness Insurance Works

You choose from the following coverage options:

Critical Illness Coverage Option 1	Benefit Amounts
Employee Only	$10,000
Employee and Spouse or Civil Union/Domestic Partner	$10,000 / $10,000
Employee and Children	$10,000 / $5,000
Family (Employee, Spouse or Civil Union/Domestic Partner, and Children)	$10,000 / $10,000 / $5,000

Critical Illness Coverage Option 2	Benefit Amounts
Employee Only	$20,000
Employee and Spouse or Civil Union/Domestic Partner	$20,000 / $20,000
Employee and Children	$20,000 / $10,000
Family (Employee, Spouse or Civil Union/Domestic Partner, and Children)	$20,000 / $20,000 / $10,000

Critical illness insurance pays benefits according to a schedule for a covered illness diagnosed in you or a covered dependent.

For example: You are enrolled in the $20,000 coverage option. You experience chest pains and numbness in the left arm. You visit the emergency room. A physician determines that you have suffered a heart attack.

The plan pays 100% of the benefit amount for a heart attack, so in this case your critical illness insurance would pay you $20,000. You can use the $20,000 however you choose (for example, to help pay medical expenses or for daily living expenses, caregiving assistance, or alternative transportation needs during your recovery).

Covered Critical Illnesses

Covered illnesses and conditions include those listed below. For more details, including the percentage of the benefit amount payable for each illness, definitions of illnesses, and conditions of payment, please sign on to HRconnect or contact Aflac (see the **Contact Information** section).

- Alzheimer's disease (advanced)
- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease)
- Benign brain tumor (limited benefit)
- Bone marrow transplant (stem cell transplant) not resulting from a covered critical illness for which a benefit has been paid under the plan
- Burn (severe) due to, caused by, and attributed to a covered accident
- Cancer (internal, invasive, non-invasive, or skin) (certain limitations apply)
- Cardiac arrest (sudden)
- Coma due to a covered underlying disease or a covered accident (limited benefit)
- Coronary artery bypass surgery
- Heart attack (myocardial infarction)
- Kidney failure (end-stage renal failure)
- Loss of speech/sight/hearing due to a covered underlying disease or a covered accident (limited benefit)
- Major organ transplant (limited benefit)
- Paralysis due to a covered underlying disease or a covered accident (limited benefit)
- Parkinson's disease (advanced)
- Stroke (ischemic or hemorrhagic)
- Sustained multiple sclerosis

Additional Covered Conditions and Specified Diseases

Childhood Conditions

- Autism
- Cerebral palsy
- Cystic fibrosis
- Cleft lip or cleft palate
- Diabetes – type 1
- Down syndrome
- Phenylalanine hydroxylase deficiency disease (PKU)
- Spina bifida

Tier I Specified Diseases

- Addison's disease
- Cerebrospinal meningitis
- Diphtheria
- Huntington's chorea
- Legionnaire's disease
- Malaria
- Muscular dystrophy
- Myasthenia gravis
- Necrotizing fasciitis
- Osteomyelitis
- Poliomyelitis (polio)
- Rabies
- Sickle cell anemia
- Systemic lupus
- Systemic sclerosis (scleroderma)
- Tetanus
- Tuberculosis

Tier II Specified Disease

- Human coronavirus resulting in confinement in a hospital or hospital intensive care unit (if this condition recurs, benefits will be payable again only if at least 180 days separate the date you last qualified for this benefit and the new diagnosis)

The plan also includes additional payments for items such as mammography tests, preventive health screening tests, diagnosis of skin cancer, and diagnosis of autism spectrum disorder in a covered child.

Exclusions and Limitations

No benefits will be paid for losses due to the following:

- Illegal occupation
- Intoxicants and controlled substances
- Participation in aggressive conflict of any kind, including war (declared or undeclared) or military conflicts and insurrection or riot
- Self-inflicted injuries
- Suicide

Limitations – Cancer diagnosis: Benefits are payable for cancer and/or non-invasive cancer as long as the insured is:

- treatment-free from cancer for at least 12 months before the diagnosis date and
- in complete remission prior to the date of a subsequent diagnosis, as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the cancer.

Choosing Your Beneficiary

You must choose a beneficiary or beneficiaries when you enroll in the critical illness insurance coverage. You will be guided through the necessary steps to designate your beneficiary or beneficiaries when you enroll online.

If you need assistance or want to change your beneficiaries, call Benefits by Design Voluntary Programs (see the **Contact Information** section).

When Coverage Ends

Your critical illness insurance may terminate if you do not pay the premium or if you transfer to a position where this benefit is not offered and you do not elect to continue the coverage on a direct-payment basis.

This coverage is portable, and you may continue your insurance if you terminate employment or retire. For details about continuing your coverage and applicable rates, please call Aflac or visit its website (see the **Contact Information** section) within 31 days of termination of employment.

You may contact Aflac to cancel your coverage at any time.

If you die while covered by this plan and your dependents are also covered under this plan at the time of your death and are interested in continuing coverage, your surviving spouse or civil union/domestic partner should call Benefits by Design Voluntary Programs or Aflac for information (see the **Contact Information** section).

Legal Services

The legal services plan provides you access to a nationwide network of attorneys. The plan, underwritten by MetLife Legal Plans, is available to you and your entire family for a monthly premium paid through payroll deductions.

Who Is Eligible

You are eligible to purchase the legal services plan if you are regularly scheduled to work 20 or more hours per week.

When Coverage Begins

You are able to purchase legal services during the Voluntary Programs legal services enrollment period each year. Once you make an election during this enrollment period, your coverage will begin the first of the second month following the end of the election period. For example, if the enrollment period ends on April 30, your coverage will begin on June 1.

Your enrollment will continue unless you disenroll during the enrollment period. If you do not enroll in legal services during this enrollment period, you will have to wait until the following year to enroll. You will be notified when the enrollment period will occur each year.

Your Cost

Deductions for the cost of this coverage will be taken on an after-tax basis from your first two paychecks of each month.

The cost is subject to change annually. Information on the current cost is available on HRconnect. Go to the **Benefits and Wellness** tab, click on **Benefits by Design Voluntary Benefits** under the **Ways to Save** column, and then select **Legal Services**.

How Legal Services Work

To use your legal services, visit the MetLife Legal Plans website at **www.legalplans.com** or call their Client Service Center at **800-821-6400**, Monday through Friday, 8 a.m. to 7 p.m. Eastern time.

If you call the Client Service Center, the Client Service Representative who answers your call will:

- verify your eligibility for services
- make an initial determination of whether and to what extent your case is covered (the Plan Attorney will make the final determination of coverage)
- give you a case number that is similar to a claim number (you will need a new case number for each new case you have)
- give you the telephone number of the Plan Attorney most convenient to you; and
- answer any questions you have about your Legal Plan.

When calling the Plan Attorney, identify yourself as a legal plan member referred by MetLife Legal Plans. You should request an appointment for a consultation. Evening and Saturday appointments may be available. Be prepared to give your case number, the name of the legal plan you belong to, and the type of legal matter you would like to address. If you wish, you may choose an out-of-network attorney. In a few areas, where there are no participating law firms, you will be asked to select your own attorney. In both circumstances, MetLife Legal Plans will reimburse you for these non-plan attorneys' fees based on a set fee schedule.

Covered Services

You and your eligible dependents are entitled to receive certain personal legal services such as:

- Adoption, guardianship or conservatorship
- Civil litigation defense, including administrative hearings and incompetency defense
- Consumer protection and personal property matters
- Debt collection defense
- Divorce (first 10 hours)
- Elder-law matters and review of personal legal documents

- Identity theft defense
- Immigration assistance
- Name change
- Purchase, sale and refinancing of primary, secondary and vacation homes
- Personal bankruptcy and IRS tax audits
- Premarital agreement
- Preparation of powers of attorney, affidavits, deeds, demand letters, promissory notes, home equity loans and mortgages
- Preparation of wills, living wills and trusts
- Protection from domestic violence
- Restoration of driving privileges, juvenile court proceedings and traffic ticket defense (no DUI)
- Security deposit assistance, zoning applications, property tax assessments and boundary/title disputes
- Small-claims assistance
- Tenant negotiations and eviction defense (tenant only)

Kaiser Permanente cannot guarantee the legal outcomes of the services provided. Contact MetLife Legal Plans directly with any concerns you have about the legal services you receive.

Exclusions

Excluded services are those legal services that are not provided under the plan. No services, not even a consultation, can be provided for the following matters:

- Appeals and class actions
- Costs or fines
- Employment-related matters, including company or statutory benefits
- Farm matters, business or investment matters, matters involving property held for investment or rental, or issues when the Participant is the landlord
- Frivolous or unethical matters
- Matters for which an attorney-client relationship exists prior to the Participant becoming eligible for plan benefits
- Matters in which there is a conflict of interest between the employee and spouse/domestic partner or dependents in which case services are excluded for the spouse/domestic partner and dependents
- Matters involving Kaiser Permanente, MetLife and affiliates, and Plan Attorneys
- Patent, trademark and copyright matters

For details about covered services and exclusions, please visit MetLife Legal Plans' website at **www.legalplans.com** or call **800-821-6400.**

Life Insurance with Long-Term Care Coverage

Benefits by Design Voluntary Programs give you the opportunity to purchase life insurance with long-term care (LTC) coverage through Trustmark Insurance Company (Trustmark).

In addition to a death benefit payout for life insurance, this program can pay benefits for LTC services while you are still living if you require assistance to perform two or more activities of daily living or have a cognitive impairment.

Who Is Eligible

To enroll in life insurance with LTC coverage, you must be regularly scheduled to work 20 or more hours per week, have at least 6 months of employment, and be age 18 - 70. Eligible employees who are age 71 - 75 may apply only for life insurance without the LTC coverage.

If you enroll in coverage for yourself, you may also apply for coverage for your eligible dependents, which include the following:

- Your spouse or civil union/domestic partner,
- Your eligible children under age 26, and
- Your eligible grandchildren under age 19.

Coverage may be extended beyond age 26 for dependent children who are both incapable of self-sustaining employment by reason of an intellectual disability or physical handicap and chiefly dependent on you for support and maintenance.

When Coverage Begins

A long-term care consultant will assist you with the enrollment process and will provide information on the effective date of your coverage.

Your Cost

You pay 100% of the premiums. Your cost is based on several factors, including, but not limited to, the state you live in, your age on the effective date of your coverage, and whether you include coverage for your dependents. The long-term care consultant who assists you with enrollment will also provide information on your premium based on the coverage elected.

Your payments are made through payroll deductions on an after-tax basis from the first two paychecks of each month.

Waiver of premium: If you or your spouse/civil union/domestic partner becomes totally disabled, as defined by the certificate, prior to age 70, premiums for you and any of your covered dependents will be waived after the disability has continued for 6 months and payment of LTC benefits has started. If the total disability begins after age 60, premiums will be waived up to age 65. The waiver of premium will end if the condition of total disability ends.

How Life Insurance with Long-Term Care Coverage Works

This plan offering provides dual benefits for life insurance and LTC coverage. The benefit amount you select during the enrollment process will be the same for both your life insurance and your LTC coverage.

As a newly eligible employee, or if you are in an employee group that is being offered these programs for the first time, you may enroll for employee-only coverage of up to $150,000 without answering any medical questions, provided you are under age 65.

If you do not enroll when you are first eligible or if you are age 65 or older, want to apply for more than $150,000 in coverage, or want to add coverage for your dependents, answering some medical questions will be required. As noted above, if you are age 71 – 75, you may apply only for life insurance without the LTC coverage.

Life Insurance

The life insurance component of this program pays a death benefit if you or a covered dependent should die while enrolled in the plan. It also allows for an accelerated benefit in the case of terminal illness: up to 75% of

the death benefit can be paid while you are still living, if life expectancy is 24 months or less. Payment of this accelerated benefit reduces the death benefit payable to beneficiaries.

Long-Term Care

The long-term care (LTC) component pays a monthly benefit equal to 4% of the death benefit for up to 25 months when you or a covered dependent:

- is confined to a long-term care or assisted living facility or receiving home health care, adult day care, or hospice services,
- has been confined or receiving such services for 90 days, and
- needs assistance with two of seven activities of daily living or has cognitive impairment:
  - The seven activities of daily living are bathing, dressing, transferring, eating, toileting, continence, and ambulating.
  - Cognitive impairment means deterioration or loss of functional capacity due to organic mental disease, including Alzheimer's disease or related illnesses that require continual supervision to protect oneself or others.

LTC benefits can be paid only for long-term care services received after the 90 days referenced above (these 90 days are called the "elimination period.")

Amounts paid for LTC are subsequently restored to the death benefit amount, so the full death benefit can be paid to your beneficiaries. **For example:** You have enrolled in $100,000 of life insurance. If 4% of that benefit is paid for LTC for 25 months, you would have received $100,000 of LTC benefits. That $100,000 would be restored to the death benefit amount, returning it to $100,000.

To enroll or for additional information, please contact a long-term care consultant using one of the following methods:

1. Call **844-228-9192** or
2. Visit **https://kp.yourcare360.com**.

You should also consult your financial adviser to discuss whether life insurance with long-term care coverage makes sense for you and your family.

Exclusions and Limitations

Exclusions and limitation include those shown below. If you have questions about what is covered, contact Trustmark (see the **Contact Information** section).

Exclusions Under Life Insurance

If you or a covered dependent commits suicide within two years from the certificate date, the death benefit will be limited to the premiums paid less any loans and less any partial surrenders paid.

If you or a covered dependent commits suicide within two years after the effective date of any increase in the coverage or any reinstatement, the death benefit will be the costs of insurance associated with each increase or the reinstatement.

Exclusions Under LTC Coverage

The plan does not pay LTC benefits for loss:

- Incurred while the insured person is residing or confined outside the United States and Canada
- Due to alcoholism or drug addiction, unless the addiction results from administration of drugs for treatment prescribed by a physician

- For treatment provided in a government facility, unless otherwise required by law, services for which benefits are available under Medicare or other governmental programs (except Medi-Cal or Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no fault law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance
- Services provided by a member of the insured person's immediate family
- Due to illness, treatment, or medical conditions arising out of
  - War or act of war (whether declared or undeclared)
  - Participation in a felony, riot, or insurrection
  - Service in the armed forces or units auxiliary thereto
  - Suicide, whether or not the person had mental capacity to control what he or she was doing, attempted suicide, or intentionally self-inflicted injury

Pre-existing Condition Limitation

The plan does not pay LTC benefits for loss due to a pre-existing condition that begins within the first six months after the effective date.

Choosing Your Beneficiary

You will be required to choose a beneficiary or beneficiaries when you enroll with a long-term care consultant. If you later want to change or update your beneficiary information, please call Trustmark (see the **Contact Information** section).

When Coverage Ends

Contact Trustmark for information on how nonpayment of premiums or other conditions could cause your life insurance with long-term care coverage to lapse.

This coverage is portable, and you may continue your coverage on a direct-payment basis if you terminate employment or retire or transfer to a position where this benefit is not offered. For details about continuing your coverage and applicable rates, please call Trustmark (see the **Contact Information** section) when one of these events occurs.

You may contact Trustmark to cancel your coverage at any time.

If you die while covered by this plan and your covered dependents are also covered under this plan at the time of your death, they may elect to continue their coverage.

Voluntary Term Life Insurance

As part of the Benefits by Design Voluntary Program, you have the opportunity to purchase voluntary term life insurance coverage at group rates through MetLife. Voluntary term life insurance is in addition to and separate from any life insurance for which you may be eligible. The coverage amount you choose under the voluntary term life insurance does not count toward the maximum coverage amount allowed under your benefits program.

Who Is Eligible

You are eligible to purchase voluntary term life insurance for yourself, your spouse, or civil union/domestic partner and children under age 26 if you are regularly scheduled to work 20 or more hours per week.

When Coverage Begins

You may elect to purchase voluntary term life insurance coverage as long as you meet the eligibility requirements. You can enroll at any time throughout the year. Your coverage becomes effective on the first of the month following the date MetLife approves your application.

In order for your coverage to become effective, you must be actively at work. In addition, you and your dependents (if applicable) should not be confined to a hospital on the enrollment date, at home for any medical reason, or entitled to receive disability income for any medical reason on the date your coverage is scheduled to become effective.

To enroll in Voluntary Term Life, access MetLife online through HRconnect. Go to the **Benefits & Wellness** tab, click on **Benefits by Design Voluntary Benefits** under the **Ways to Save** column, and then select **View Information and Enroll** under **Insurance**. Select **Voluntary Term Life Insurance** and click on **Enroll Now**. You will then be routed to MetLife's online **My Accounts** portal.

Your Cost

The cost for voluntary term life insurance is based on the amount of coverage you elect and your age.

Coverage for your spouse or civil union/domestic partner is based on his or her age. Your cost may increase with age effective January 1 of each year. Your payments are made through payroll deductions on an after-tax basis on the first two paychecks of each month.

Please sign on to **kp.org/voluntaryprograms** or you may call Benefits by Design Voluntary Programs for information on the current rates.

How Voluntary Term Life Insurance Works

You may elect up to eight times your base annual earnings rounded up to the next higher $1,000, for a maximum of $1 million of coverage. You may also request to enroll your spouse/civil union/domestic partner in voluntary term life insurance of up to $150,000 in increments of $10,000, not to exceed the elected coverage amount for yourself. Each eligible child may also be enrolled in $10,000 of coverage.

You must first elect employee voluntary term life insurance coverage in order to elect coverage for your spouse/civil union/domestic partner or children.

Voluntary term life insurance also provides access to a variety of additional features such as Accelerated Benefit Option, Will Preparation Services, Estate Resolution Services, and Portability. For details about these additional features, please call Benefits by Design Voluntary Programs for costs and complete details of exclusions and limitations.

Evidence of Insurability

If you request to enroll in voluntary term life insurance when you are first eligible, or within 31 days of marriage for spouse or civil union/domestic partner coverage, you may enroll in up to three times your base annual earnings or $300,000 of coverage (whichever is less) without *Evidence of Insurability* (EOI), which is proof of good health. Your spouse/civil union/domestic partner may also enroll in up to $50,000 of coverage without EOI.

If you enroll during any other time, you will need to go through EOI and be approved by MetLife before coverage can begin. Your eligible children are not required to provide proof of good health.

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 of 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.

You can name a beneficiary online by signing on to **kp.org/HRconnect**. If you do not have access to a computer, you can designate your beneficiary by calling MetLife at **888-420-1661, prompt 5.**

When Coverage Ends

In the event you terminate employment with Kaiser Permanente or if you are on a leave of absence, your voluntary term life insurance coverage ends unless you choose to continue your coverage as an individual policy. You will be billed directly by MetLife based on their individual policy rates at the time of your termination.

For details about continuing your coverage and applicable rates at the time of termination, or to cancel your existing coverage, please call the Benefits by Design Voluntary Programs.

Consult your financial adviser to discuss whether long-term care insurance makes sense for you and your family. For details about your costs and coverage levels under the LTC insurance, please contact a long-term care insurance specialist at **866-486-1949**.

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. For questions about your coverage, please call Benefits by Design Voluntary Programs at ***866-486-1949****.*

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.

Your Cost

You pay 100% of the premiums. Your cost, deducted from your pay on an after-tax basis, is based on several factors, including, but not limited to, the state you live in, your occupation, your marital status, and your age.

How Long-Term Care Insurance Works

LTC insurance provides coverage for out-of-pocket expenses for qualified long-term care services.

You may elect a pool amount and monthly benefit. You also can elect an optional offer that increases the pool amount by 3% a year to keep up with inflation. The pool amounts and monthly benefits are:

- Bronze — $36,000/$1,500
- Silver — $73,000/$3,000
- Gold — $109,500/$4,500
- Platinum — customized with an agent

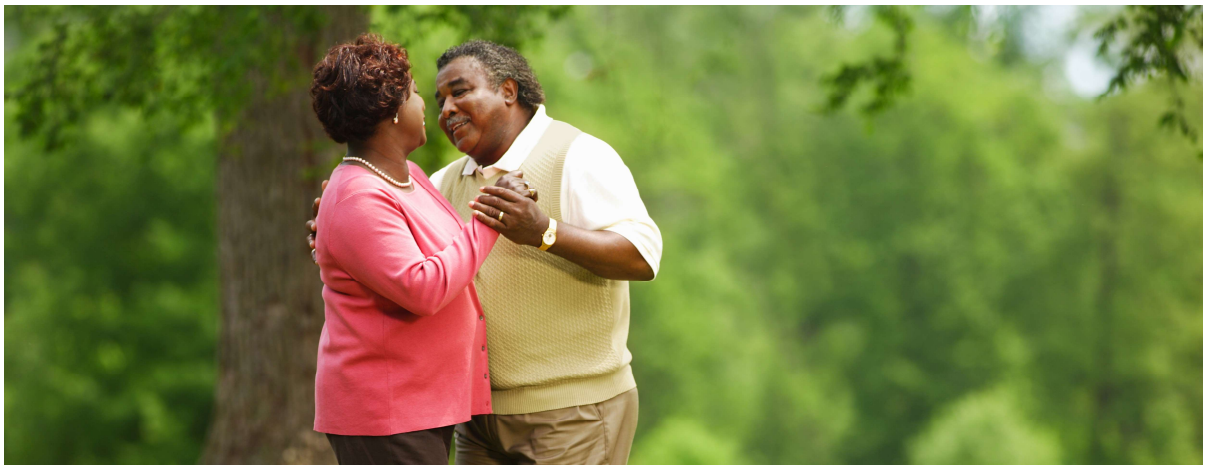
For details about your costs and coverage levels under the LTC insurance, please contact a long-term care insurance specialist at 866-486-1949.

When Coverage Ends

Your LTC insurance coverage will end on the earliest of the following:

- the date your policy lapses
- the date of your death
- the date the policy maximum amount has been exhausted; or
- your written request to Transamerica to cancel the policy. If you do not specify a date to cancel the policy, it will end on the next policy monthly anniversary following Transamerica's receipt of the request. If you name a date, it will end on your requested future cancellation date. To submit a cancellation request to Transamerica, please contact your long-term care specialist, who will provide you with a form cancellation letter that will require your wet signature, and your long-term care specialist will submit to Transamerica on your behalf.

Retirement Programs



Preparing for a financially secure future during your working years is just as important as funding your lifestyle today. Kaiser Permanente offers retirement programs especially designed to help provide you with financial assistance down the road. If you work a full career at Kaiser Permanente and take advantage of the retirement savings plans, your Kaiser Permanente retirement programs can be an important source of your retirement income.

Highlights of This Section

Kaiser Permanente Tax-Sheltered Annuity Plan II

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

Who Is Eligible

You are eligible to participate in the plan regardless of your work schedule. You are eligible to enroll in the plan as soon as you are hired.

Automatic Enrollment in Pre-Tax Employee Contributions

If you are a newly hired or newly eligible employee, you are automatically enrolled in the plan at a payroll deferral rate of 2% of eligible pay. Your contributions will automatically be deducted from each paycheck on a pre-tax basis, and you will be 100% vested in your contributions and any associated earnings. Your contributions will be invested in the Qualified Default Investment Alternative (QDIA), the plan's default investment option. You may move money between funds at any time.

Automatic Increases

Each year after your first year of participation, your pre-tax employee contribution rate will be increased by 1% until you reach the plan's designated automatic savings limit of 6%. This automatic annual contribution rate increase will generally occur as soon as possible after the first day of April each year, unless you choose to change the month of the annual increase. You can always contribute more than 6% as long as your contribution rate does not exceed the plan's annual limit (which is 75% of eligible pay) or the IRS annual contribution limit, whichever is less. You may also change your contribution rate at any time.

Actions You Can Take

You have a 45-day window starting on your date of hire in which to opt out of participation in the plan. You have the right not to contribute to the plan. You also always have the right to contribute a pre-tax employee contribution amount different than the automatic contribution amount, or to invest in funds other than your plan's default fund.

You may contact Vanguard, our recordkeeper, to take any of the following actions during the 45-day window:

- Enroll in the plan before the end of the 45-day period
- Enroll in the plan at a different contribution level
- Opt out of enrolling in the plan
- Opt out of Automatic Increases
- Make a Roth after-tax contribution election

If you do not opt out of automatic enrollment within the 45-day window, you will be enrolled and pre-tax employee contributions will be deducted from your paycheck starting on the first pay period following the close of the window. If you change your mind about participating in the plan after contributions have started, you will have 90 days from the date of your first payroll deduction to cancel participation and have your contributions attributable to automatic enrollment returned to you.

If you want to make any of the changes described above, contact Vanguard at **www.vanguard.com** or **800-523-1188** Monday through Friday from 5:30 a.m. to 6 p.m. Pacific time.

Confirming Your Enrollment

You will receive a confirmation notice once your automatic enrollment is complete or you have chosen one of the alternatives listed above.

How to Enroll

If you are newly hired or transferred, Vanguard will automatically enroll you in pre-tax contributions to the plan (see "Automatic Enrollment in Pre-Tax Employee Contributions") and send you a confirmation notice. You have the option to make after-tax contributions through the plan's Roth feature. 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 **800-523-1188**. Your TSA plan number is **094998**.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

You have the option to make pre-tax and/or Roth after-tax contributions to your plan. Pre-tax contributions and earnings are taxed when you take a distribution. Roth after-tax contributions are taxed when your contributions are made. Your pre-tax and Roth after-tax contributions are invested proportionately in the same mutual funds you elect in your plan.

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 income 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.

You can contribute between 1% and 75% of your eligible compensation each period, in whole percentage increments. However, the maximum amount you can contribute to your plan account each year cannot exceed the maximum contribution dollar limit allowed by the Internal Revenue Code (IRC) — which is $22,500 in 2023.

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. For the most up-to-date IRS limits, visit **irs.gov** and search for "contribution limits."

Roth After-Tax Employee Contributions

The Roth after-tax feature allows you to make after-tax employee contributions to your plan. Any after-tax Roth contributions you make — along with any earnings on those contributions — may be withdrawn tax-free if:

- It has been at least five years since your first after-tax contribution or in-plan conversion, whichever is earlier; and

- You are at least age 59½ at the time you make a withdrawal, or
- You are totally and permanently disabled, or you die

Please note: Roth after-tax contributions apply toward the annual contribution limits.

The five-year period begins on January 1 of the year you first make a Roth after-tax contribution to the plan. It ends when five consecutive years have passed. In the event of your death, the five-year period carries over to your beneficiary. To learn more about Roth after-tax contributions, sign on to **vanguard.com/rothfeature** or call Vanguard at **800-523-1188**, Monday through Friday, from 5:30 a.m. to 6 p.m. Pacific time.

Roth In-Plan Conversions

Roth in-plan conversions allow you to convert your current pre-tax retirement savings plan account (or a portion of your account) to a Roth after-tax account within the plan. If you elect a Roth in-plan conversion, the pre-tax amount that is converted to Roth becomes taxable income in the year of conversion. In some instances, this could move you to a higher tax rate and/or may cause other adverse tax consequences.

You should consider the following before electing an in-plan conversion:

- There is no tax withholding from your plan for the conversion, so you must pay those taxes from another source
- You will pay taxes on the amount of a Roth in-plan conversion for the year of conversion
- You should consider that state and local income taxes may apply in addition to federal taxes
- You cannot reverse a Roth in-plan conversion once it is made

Any Roth in-plan conversion amount — along with any earnings on the converted amount — can be withdrawn tax-free if you are at least age 59½ and it has been at least five years since the conversion. Each Roth in-plan conversion is subject to a separate five-year period. If you withdraw Roth in-plan conversion assets within five years of the conversion, you will owe a 10% federal penalty tax on the portion of the withdrawal that represents converted assets, unless an exception applies. Early distribution exceptions include:

- Direct rollover to a Roth Individual Retirement Account (IRA) or another qualified plan that accepts Roth rollovers
- Severance from employment at age 55 or later
- You are age 59½ or older

For more information about Roth in-plan conversions, sign on to **vanguard.com/inplanconversion** or call Vanguard at **800-523-1188**, Monday through Friday, from 5:30 a.m. to 6 p.m. Pacific time.

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 this year, you are eligible to make additional catch-up contributions to your plan for this year and in subsequent years. The maximum allowable catch-up contribution in 2023 is $7,500. Your regular 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 limit for regular contributions. The following chart outlines the annual contribution limits (pre-tax and Roth combined, as applicable) in 2023:

Pre-Tax Contribution Limit	Catch-Up Contribution Limit	Combined Contribution Limit
$22,500	$7,500	$30,000

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

If you have any questions about catch-up contributions, call Vanguard at **800-523-1188**. For the most up-to-date IRS limits, visit **irs.gov** and search for “contribution limits.”

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 w**ww.vanguard.com** or by calling Vanguard’s VOICE network at **800-523-1188**.

Maximum Compensation Limit

The maximum compensation limit is the annual eligible pay under the Internal Revenue Code (IRC) that may be considered for benefit purposes. The maximum compensation limit for 2023 is $330,000. This amount may be indexed periodically for cost-of-living increases. In addition, your annual maximum contribution may be limited by the IRC. For the most up-to-date IRS limits, visit **irs.gov** and search for “contribution limits.”

Non-Discrimination Test

The contributions to the defined contribution plan are subject to a federally required discrimination test. This complex test compares the contributions of the “highly compensated” to the contributions of the “non-highly compensated” participants under all applicable plans provided by Kaiser Permanente and may require a reduction in contributions made by 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.

Vesting

Vesting refers to your entitlement to a benefit. You are immediately 100% vested in your pre-tax and Roth after-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 at the time you take a distribution.

Choosing Your Beneficiary

When you become a participant, you should name a beneficiary to receive payment of your account if you die. Under the plan your spouse is legally entitled to 50% 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% 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% 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.

Please see the "If You Die" section for more information.

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% 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 are 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.

Changing Your Investments

You can change the investment of your account on Vanguard's website, 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 by signing on to Vanguard's website, by calling Vanguard's VOICE network, or on your mobile device using the Vanguard app. You may monitor the

activity in your plan accounts as well as initiate transactions. You may also 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% of your vested account balance or $50,000, whichever is less, in any 12-month period. 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 by Reuters on the first business day of the month, plus 1%.

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 each loan.

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 the VOICE network to speak to a Vanguard Participant Services associate.

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 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, the balance owing on your loan is deemed to be distributed to you. The distribution (other than any portion made up of Roth contributions and earnings that qualify for tax-free treatment, if applicable) 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 age 72, whichever is later, if you have more than $5,000 in your account.

Please note: If you have a Roth 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 **vanguard.com**.

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 consult with a financial planner to 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 and/or Roth after-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, in most cases, you can withdraw your 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 qualify as a casualty deduction
- Payments for burial or funeral expenses for your deceased parent, spouse, domestic partner, or dependent
- 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 withdrawal 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. Aside from any Roth contributions (if applicable), it is taxable as ordinary income, and you may also owe federal and state tax penalties for early withdrawal.

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

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.

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%, 66⅔%, 75%, and 100% 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%, 75%, 66⅔%, or 50% 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 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. The 50% 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, the normal form of payment is the Lump Sum. Your spouse is entitled by federal law to receive benefits in the form of a 50% 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 180 days before the benefits begin.

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

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 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
- If the remaining balance is more than $5,000, 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 72. Your beneficiary 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.

Pre-tax contributions

In general, as long as your pre-tax contributions remain in your plan, you are not required to pay taxes on your contributions or earnings. When you receive a distribution from your account balance, however, any amount you receive 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% 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.

Roth after-tax contributions

When you take a distribution from your Roth after-tax account, your contributions and earnings will be tax-free if you are at least age 59½ and made your first Roth after-tax contribution to the plan at least five years earlier.

If you receive a distribution of your Roth after-tax account before age 59½ or less than five years after your first Roth after-tax contribution, then the special Roth rules will not apply and the earnings you receive will be subject to ordinary income tax. In addition, you will be subject to the 10% federal penalty tax unless an early distribution exception applies. Early distribution exceptions include:

- Direct rollover to a Roth Individual Retirement Account (IRA) or another qualified plan that accepts Roth rollovers
- Severance from employment at age 55 or later
- A distribution that is made on or after the date you reach age 59½, attributable to your being disabled, or made after your death

Special rules apply for Roth in-plan conversions. For more information, refer to the "Roth In-Plan Conversions" section.

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 consult with a tax or financial advisor to 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 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.

Unclaimed Benefit Process

You are required to keep 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, 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.

Service for Leased Employees

If you provided services to Kaiser Permanente as an employee of a leasing company (that is, a third-party provider of employee services) for at least 12 months before or after working as a regular employee, Kaiser Permanente's retirement plans may recognize additional service (for the limited purposes described below) for time you worked at Kaiser Permanente through the leasing company. To qualify for this additional service, you must submit sufficient evidence that you performed work at Kaiser Permanente for at least 1,500 hours during a 12-month period, and that while employed by the leasing company during this period, your services were subject to Kaiser Permanente's direction and control.

Service granted on the basis of employment with a leasing company **can count** toward:

- Pension plan participation eligibility
- Pension plan vesting
- Pension plan Early Retirement eligibility
- Pension plan eligibility for Disability Retirement (if applicable)

- Defined contribution plan vesting (if applicable)
- Eligibility for employer contributions under defined contribution plans such as Plan B, TPMG's Plan 2 or the Kaiser Permanente Supplemental Savings and Retirement Plan for Union Groups (KPSSRPUG) (if applicable)
- Eligibility for participation in employer matching contributions (if applicable) to a tax-deferred retirement savings plan, such as KP401K or the Tax-Sheltered Annuity (TSA) plan
- Eligibility for a Sick Leave Health Reimbursement Account (Sick Leave HRA) (if applicable)

Any service granted under this program will **NOT count** toward:

- Retiree Medical, Retiree Life Insurance, and any other retiree health and welfare plan eligibility
- Eligibility for the Retiree Medical Health Reimbursement Account associated with the modified retiree medical benefit
- Credited Service for benefit accrual purposes under any Kaiser Permanente defined benefit plan
- Other Kaiser Permanente programs (such as vacation)

For information about how to make a request to recognize such service, please contact the Kaiser Permanente Retirement Center (KPRC).

Disputes, Claims, and Appeals

This section of the SPD describes the dispute process and how to file a claim for your health and welfare retirement benefits, retirement savings benefits, and/or retirement health 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 *Benefits Request for Administrative Review Form* (Form 3460 – available on HRconnect) 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. A final determination will be made by the NHRSC 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 (if applicable, as you may not participate in all of these types of benefit 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 FSA)
- Disability plans and other plans where benefits depend on whether you are disabled
- Retirement plans eligibility determinations
- Other plans subject to ERISA (e.g., life insurance plans)

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*. These procedures do not apply to claims filed with respect to benefits not covered under ERISA, or 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

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 FSA.

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 Claims and Appeals

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 KFHP has denied a claim to provide or pay for a service covered by KFHP 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.

Supplemental Medical Plan 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.

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 **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 **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.

No legal action can be brought more than one year after the later of (i) the date of the initial denial of your claim, or (ii) if a timely request for appeal of the denial had been made, the date of the denial of your appeal.

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 Subcommittee") at the address below and request a review of the denial:

For first-class mail sent through the U.S. Postal Service:

Vanguard / IIG Full-Service
Attn: DC (Defined Contribution Plan – KPAC Appeals Subcommittee)
P.O. Box 982902
El Paso, TX 79998-2902

For trackable mail sent Registered, Certified, Priority, or Overnight:

Vanguard / IIG Full-Service
Attn: DC (Defined Contribution Plan – KPAC Appeals Subcommittee)
5951 Luckett Court, Suite A2
El Paso, TX 79932

Deadlines for Responding to Your Appeal

The Appeals Subcommittee 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 Subcommittee 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 Subcommittee 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 Subcommittee 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 Subcommittee's appeal denial.

Leased Employee Service Claims

If you believe you may be entitled to service as a leased employee, please contact the Kaiser Permanente Retirement Center (KPRC).

The KPRC will provide you with a questionnaire to complete, along with an opportunity to submit evidence of your eligibility for such additional service. Examples of such evidence include:

- W-2s for the years you worked for the leasing company for work performed at Kaiser Permanente.
- An accounting report, your time card or an invoice from the leasing company reflecting the dates and total hours of work performed at Kaiser Permanente.

Please note, your completed questionnaire may be subject to verification by Kaiser Permanente personnel, including any supervisor you may have reported to while working for the leasing company.

Additional evidence or clarification of your responses to the questionnaire may be required. The determination of whether you are entitled to service for periods of leased employment will be determined on a facts and circumstances basis.

You will receive a response, generally within 120 days, from the KPRC with a determination of your eligibility for additional service for all applicable benefit purposes. You will be notified if additional time is needed. If you disagree with the determination, you may file a claim. To file a claim, contact the KPRC and request a *Claim Initiation Form*. You must follow the instructions on the *Claim Initiation Form* to engage the formal claims process.

Important Note: If you intend to pursue a claim for benefits by filing a *Claim Initiation Form,* you must file the *Claim Initiation Form* within two years following the earlier of either:

1. The date you received a *Summary of Material Modification* with this information, or
2. The date you received this SPD.

Remember, first you need to seek a determination of your eligibility for additional service by submitting your completed questionnaire and evidence of your eligibility.

If your claim for additional service as a leased employee is denied, you will have a chance to appeal the decision. In such cases, the KPRC will provide you with information and timelines on filing an appeal.

General Information About Other Types of Claims and Appeals

The following rules relate to claims and appeals that are not made under health plans or retirement plans and that are not subject to the special rules for disability benefits.

MetLife is the insurer and third-party administrator for the insurance plans, as applicable.

Accident and Critical Illness Insurance Claims

You must give Aflac written notice of a claim within 20 days after the occurrence or commencement of any loss covered by this insurance or as soon thereafter as is reasonably possible. You must provide Aflac with written proof of loss within 90 days of the loss or as soon thereafter as is reasonably possible and no later than 1 year from the time proof is otherwise required (except in the absence of legal capacity on your part).

You can file a claim with Aflac online as follows:

- Visit **Aflacgroupinsurance.com** and click on **Customer Service** and then **File a Claim**.
- Choose from accident, critical illness, or wellness and follow the instructions.
- Complete and upload your HIPAA authorization, claim details and documents, and direct deposit information.

You can also submit claims by mail, fax, or email (instructions and forms for these methods can be found online at **Aflacgroupinsurance.com**):

Mail: **Aflac**
Attn: Claims
P.O. Box 84075
Columbus, GA 31993-9103

Fax: **866-849-2970**

Email: **groupclaimfiling@aflac.com**

Deadlines for Responding to your Claim

If a claim form has not been completed in its entirety or is not signed, you will be notified within 7 to 10 business days. Incomplete or unsigned forms will delay claim processing.

Aflac will make a decision on your claim within a reasonable period but not later than 90 days after it receives your claim form. In some cases, Aflac 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, Aflac may take up to an additional 90 days to respond to your claim. When Aflac 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.

How to Appeal a Denial of Your Initial Claim

If your claim is denied, you will be given written notice of the reason for the denial and the plan provision that supports the denial.

If you wish to appeal a claim decision, the appeal must be submitted in writing to Aflac no later than 180 days after notice of denial of a claim. You have the right to submit new information with your request. You may request copies of records relevant to your claim.

The appeal must be mailed to the following address:

Aflac – Continental American Insurance Company
P.O. Box 84075
Columbus, GA 31993

If you have any questions, you may call the customer service department (see the Contact Information section).

Please note that before filing any lawsuit (see “What to Do About a Denial After Final Review” below)—and no later than 60 days after notice of denial of a claim—you, the claimant, or an authorized representative of either of you must appeal any denial of benefits under the plan by sending a written request for review of the denial to Aflac’s Home Office.

Deadlines for Responding to Your Appeal

You will be notified of Aflac's final decision on the appeal within 60 days after receipt of your request for review. An extension of up to 60 days is permitted if special circumstances require an extension of time to process the appeal.

What to Do About a Denial After Final Review

If your appeal is denied and you disagree with the final decision, you may file a lawsuit under ERISA 502(a). Legal action on a claim may be brought no earlier than 60 days after the date you have furnished written proof of loss and no later than 3 years after the date furnishing of such proof is required by Aflac. If you wish, you may take the matter up with the Department of Insurance in your state.

Legal Services Claims and Appeals

Contact MetLife Legal Plans at **800-821-6400** to initiate a claim. MetLife Legal Plans will provide you with instructions on how to complete the claim process.

Send completed claims to the address below:

MetLife Legal Plans Director of Administration
1111 Superior Ave. E, Suite 800
Cleveland, OH 44114-2507
Fax: 216-694-4309
Phone: 800-821-6400

Deadlines for Responding to Your Claims

MetLife Legal Plans will make a decision on your claim within a reasonable period but not later than 90 days after it receives your claim form. In some cases, MetLife Legal Plans 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, MetLife Legal Plans may take up to an additional 90 days to respond to your claim. When MetLife Legal Plans 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.

How to Appeal a Denial of Your Initial Claim

If your claim is denied, MetLife Legal Plans will provide you with a written explanation of the denial and you will have the right to request a review of your claim by writing to MetLife Legal Plans. Please include in your appeal letter the reason(s) you believe the claim was improperly denied, and submit any additional comments, documents, records or other information relating to your claim that you deem appropriate to enable MetLife Legal Plans to give your appeal proper consideration. Upon your written request, MetLife Legal Plans will provide you with a copy of the records and/or reports that are relevant to your claim. Your appeal can be sent to the following address within 60 days of the claim denial:

MetLife Legal Plans Director of Administration
1111 Superior Ave. E, Suite 800
Cleveland, OH 44114-2507
Fax: 216-694-4309
Phone: 800-821-6400

Deadlines for Responding to Your Appeal

If MetLife Legal Plans denies your appeal, MetLife Legal Plans must notify you of its decision on your appeal within a reasonable period, but not later than 60 days after it receives your appeal. In some cases, MetLife Legal Plans will notify you, before the end of the normal 60-day maximum deadline for responding to your

appeal, that additional time is required to process your appeal on account of special circumstances. In that event, MetLife Legal Plans may take up to an additional 60 days to respond to your appeal. When MetLife Legal Plans requests the 60-day extension, it will indicate the special circumstances in writing. If MetLife Legal Plans needs additional information from you to resolve your appeal, then MetLife Legal Plans may decide not to count the time between when you are requested to send the additional information and the time when you furnish that information towards the additional 60 days that MetLife Legal Plans has to decide your appeal.

What to Do About a Denial After Final Review

If your appeal is denied and you disagree with the final decision, you may file a lawsuit under ERISA 502(a). If you wish, you may take the matter up with the Department of Insurance in your state.

Life Insurance and Voluntary Term Life Claims

You or your beneficiary must contact MetLife to initiate a claim. MetLife will provide the claimant with a customized claim packet with instructions on how to complete the claim process. A copy of the death certificate is required to process a claim for death benefits. In addition, each beneficiary will need to provide a claimant statement. Send completed claims to the address below:

MetLife - Group Life Claims
P.O. Box 6100
Scranton, PA 18505
Fax: 570-558-8645
Phone: 800-638-6420

Deadlines for Responding to Your Claims

MetLife will make a decision on your claim within a reasonable period but not later than 90 days after it receives your claim form. In some cases, MetLife 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, MetLife may take up to an additional 90 days to respond to your claim. When MetLife 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.

How to Appeal a Denial of Your Initial Claim

If your claim is denied, MetLife will provide you with a written explanation of the denial and you will have the right to request a review of your claim by writing to MetLife. Please include in your appeal letter the reason(s) you believe the claim was improperly denied, and submit any additional comments, documents, records or other information relating to your claim that you deem appropriate to enable MetLife to give your appeal proper consideration. Upon your written request, MetLife will provide you with a copy of the records and/or reports that are relevant to your claim.

Your appeal can be sent to the following address within 60 days of the claim denial:

MetLife - Group Life Claims
P.O. Box 6100
Scranton, PA 18505
Fax: 570-558-8645
Phone: 800-638-6420

You may send mail requiring signature or overnight mail to:

MetLife - Group Life Claims
123 Wyoming Ave.
Scranton, PA 18503

Deadlines for Responding to Your Appeal

If MetLife denies your appeal, MetLife must notify you of its decision on your appeal within a reasonable period, but not later than 60 days after it receives your appeal. In some cases, MetLife will notify you, before the end of the normal 60-day maximum deadline for responding to your appeal, that additional time is required to process your appeal on account of special circumstances. In that event, MetLife may take up to an additional 60 days to respond to your appeal. When MetLife requests the 60-day extension, it will indicate the special circumstances and the date by which it expects to make a decision on your claim. If MetLife needs additional information from you to resolve your appeal, then MetLife may decide not to count the time between when you are requested to send the additional information and the time when you furnish that information towards the additional 60 days that MetLife has to decide your appeal.

What to Do About a Denial After Final Review

If your appeal is denied and you disagree with the final decision, you may file a lawsuit under ERISA 502(a) within one year of the date of your appeal determination. If you wish, you may take the matter up with the Department of Insurance in your state.

Life Insurance with Long-Term Care (LTC) Coverage Claims

The beneficiary should submit a claim for the death benefit as soon as possible after the death occurs. Written notice of claim for LTC benefits is required to be submitted within 30 days after a covered loss begins or as soon as reasonably possible after that.

You can file a claim online at **https://www.trustmarkbenefits.com/claims**. If you need assistance, please call claims customer service at **877-201-9373 ext. 45750** or send an email to **ClaimContactVB@trustmarkbenefits.com**.

You can also call claims customer service for claim forms (or download forms from the website) and then submit your claim with supporting documentation by mail, fax, or email:

Mail: **Trustmark Insurance**
P.O. Box 2906
Clinton, IA 52733

Fax: **508-853-0310**

Email: **LifeClaimsVB@trustmarkbenefits.com**

A copy of the death certificate is required for a death benefit claim. In addition, each beneficiary will need to complete the Statement of Beneficiary portion of the claim form.

In the case of an LTC claim, proof of satisfaction of the 90-day elimination period and monthly billing statements will need to be provided to Trustmark documenting ongoing care. Periodically, Trustmark will require additional information documenting the level of care received and the status of the claimant. This can be in the form of quarterly, semi-annual, or annual medical records.

Deadlines for Responding to your Claim

Trustmark will make a determination on your claim within 45 calendar days of receipt of your proof of loss. If more time is required to make a claim determination, within the same 45 calendar days, Trustmark will provide

the claimant with written notice of the need for additional time. The notice will specify any additional information required to make a determination.

How to Appeal a Denial of Your Initial Claim

If your claim is denied and you disagree with the claim determination, you may appeal the decision by submitting a request for review to Trustmark. The appeal must be submitted within 180 days from your receipt of the claim determination letter and must be in writing.

You can submit your appeal request and associated documentation to Trustmark by mail, fax, or email:

Mail: **Trustmark Insurance**
P.O. Box 2906
Clinton, IA 52733

Fax: **508-853-0310**

Email: **LifeClaimsVB@trustmarkbenefits.com**

You should include any additional information that you feel has a bearing on the claim decision.

You have the right to obtain access to or copies of information, documents, or records relevant to your claim for benefits as well as a copy of any internal rule, guideline, protocol, or similar criterion relied upon in Trustmark's decision. Such information, documents, or records will be provided free of charge upon your written request.

Deadlines for Responding to Your Appeal

Trustmark will make a determination on your appeal within 45 days of receipt of your appeal. The 45-day time period will start when the appeal is filed without regard to whether all of the information necessary to decide your claim accompanies the filing. If Trustmark is not able to decide your appeal within 45 days, it may extend the appeal decision for as many as 45 additional days.

What to Do About a Denial After Final Review

If your appeal is denied and you disagree with the final decision, you may file a lawsuit under ERISA 502(a).

Please note: You and the plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency.

Long-Term Care Claims and Appeals

Contact Transamerica LTC at **800-821-6400** to initiate a claim. You must submit a written request for any claim determination. Send completed claims to:

Transamerica Life Insurance Company
P.O. Box 869093
Plano, TX 75086
Fax: 866-630-7502
Phone: 866-745-3545

Deadlines for Responding to Your Claims

Transamerica LTC will make a decision on your claim within a reasonable period, usually within 10 business days, but not later than 90 days after it receives your claim form. In some cases, Transamerica LTC 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, Transamerica LTC may take

up to an additional 90 days to respond to your claim. When Transamerica LTC 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.

How to Appeal a Denial of Your Initial Claim

If your claim is denied, Transamerica LTC will provide you with a written explanation of the denial and you will have the right to request a review of your claim by writing to Transamerica LTC. Please include in your appeal letter the reason(s) you believe the claim was improperly denied, and submit any additional comments, documents, records or other information relating to your claim that you deem appropriate to enable Transamerica LTC to give your appeal proper consideration. Upon your written request, Transamerica LTC will provide you with a copy of the records and/or reports that are relevant to your claim. Your appeal can be sent to the following address within 60 days of the claim denial:

Transamerica Life Insurance Company
P.O. Box 869093
Plano, TX 75086
Fax: 866-630-7502
Phone: 866-745-3545

Deadlines for Responding to Your Appeal

Once your appeal is submitted in writing, the information received will be reviewed by a team of Consumer Affairs analysts that are independent of the team that made the initial determination. The analysts will review the appeal submitted and any additional information that may have been received. A written response will be sent to you or your representative advising of the decision to overturn or uphold the original determination or advising if additional information is needed to complete the review.

If Transamerica LTC denies your appeal, Transamerica LTC must notify you of its decision on your appeal within a reasonable period, but not later than 60 days after it receives your appeal. In some cases, Transamerica LTC will notify you, before the end of the normal 60-day maximum deadline for responding to your appeal, that additional time is required to process your appeal on account of special circumstances. In that event, Transamerica LTC may take up to an additional 60 days to respond to your appeal. When Transamerica LTC requests the 60-day extension, it will indicate the special circumstances in writing. If Transamerica LTC needs additional information from you to resolve your appeal, then Transamerica LTC may decide not to count the time between when you are requested to send the additional information and the time when you furnish that information towards the additional 60 days that Transamerica LTC has to decide your appeal.

What to Do About a Denial After Final Review

If your appeal is denied and you disagree with the final decision, you may file a lawsuit under ERISA 502(a). If you wish, you may take the matter up with the Department of Insurance in your state.

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. 1 Kaiser Plaza, 20th Floor Bayside Oakland, CA 94612 510-271-5940 EIN # 94-1340523	**For Health and Welfare Plans** **Kaiser Permanente Administrative Committee (KPAC)** 1 Kaiser Plaza, 20th Floor Bayside Oakland, CA 94612 510-271-5940 **For Defined Contribution Plans** Kaiser Foundation Health Plan, Inc. 1 Kaiser Plaza, 20th Floor Bayside 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*, 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. Claims Department Waterpark One 2500 So. Havana Street Aurora, CO 80014	Insured	N/A	Insured agreement premiums paid from general assets	Employer and employee
Kaiser Permanente Supplemental Medical Plan			Self-Funded	Appeals and Reconsideration Unit HealthPlan Services 3701 Broadman-Canfield Road, Building B Canfield, OH 44406	Self-Funded	N/A	Self-funded; paid from general assets	Employer and employee
Accident Insurance			Insured	Continental American Insurance Company P.O. Box 84075 Columbus, GA 31993	Insured	N/A	N/A	Employee
Critical Illness Insurance			Insured	Continental American Insurance Company P.O. Box 84075 Columbus, GA 31993	Insured	N/A	N/A	Employee

Plan Name/Plan Options	Plan Sponsor EIN #	ID No.	Type of Plan	Claims Administrator	Type of Administration	Plan Trustee	Funding Medium	Contributing Source
Legal Services			Legal Services	MetLife Legal Plans, Director of Administration 1111 Superior Avenue E, Suite 800 Cleveland, OH 44114-2507	Third-Party	N/A	N/A	Employee
Life Insurance with Long-Term Care Coverage			Insured	Trustmark Insurance Company 400 Field Drive Lake Forest, IL 60045	Insured	N/A	N/A	Employee
Long-Term Care Insurance			Insured	Transamerica Life Insurance Company P.O. Box 869093 Plano, TX 75086	Insured	N/A	N/A	Employee
Voluntary Term Life Insurance			Insured	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100	Insured	N/A	N/A	Employee
Employee Assistance Program			Self-Funded	Kaiser Permanente Employee and Physician Assistance Program 1950 Franklin St., 15th Floor Oakland, CA 94112	Self-Funded	N/A	Self-funded; paid from general assets	Employer
RETIREMENT PLANS								
Kaiser Permanente Tax-Sheltered Annuity Plan II	94-1340523	037	Pension-403(b) Defined Contribution Plan	Vanguard Attn: DC Plan P.O. Box 982902 El Paso, TX 79998-2902	Third- Party / Record Keeper	Vanguard Attn: DC Plan P.O. Box 982902 El Paso, TX 79998-2902	Custodial account	Employee pre-tax and/or Roth contributions

Separation From Service

Your Kaiser Permanente retirement plans and the Internal Revenue Code (IRC) require that there be a bona fide separation from service before there can be a distribution of retirement benefits. This means that there can be no intent at the time of your separation (when you leave and retire from Kaiser Permanente) on either your part or that of your supervisor or other Kaiser Permanente personnel to re-employ you after you have taken a distribution of benefits. This bona fide separation from service requirement means you may not leave with the intent to return as an employee or in such other capacities as consultant or contractor. This does not mean you

may never return to Kaiser Permanente. You may return at some time in the future if you are applying for a bona fide open position. However, if you return, it must be because of changed circumstances after you terminate and retire, and not because of an agreement made prior to termination and retirement. If you are under age 65 when you terminate, a move to a different legal entity does not constitute a Separation From Service, and you cannot take a distribution.

Age 65 Exception

If you are working after age 65 for Kaiser Permanente and you have retirement plan benefits from both (1) a Permanente Medical Group and (2) KFHP/H, you may elect to begin your retirement plan benefit provided by the Kaiser Permanente legal entity where you are not working. KFHP and KFH are legally related, but they are separate legal entities from the Permanente Medical Groups.

Retirement Plan Termination Insurance

Your pension benefits under this plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers: (1) normal and early retirement benefits; (2) disability benefits if you become disabled before the plan terminates; and (3) certain benefits for your survivors.

The PBGC guarantee generally does not cover: (1) benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates; (2) some or all of benefit increases and new benefits based on plan provisions that have been in place for less than five years at the time the plan terminates; (3) benefits that are not vested because you have not worked long enough for the company; (4) benefits for which you have not met all of the requirements at the time the plan terminates; (5) certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age; (6) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay; (7) defined contribution plans; and (8) retiree medical benefits.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money your plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, ask your plan administrator or contact the PBGC's Technical Assistance Division. Inquiries should be addressed to the location below:

Technical Assistance Division, PBGC
445 12th Street SW
Washington, D.C. 20024-2101
Phone: 202-326-4000

Note: TTY/TDD users may call the federal relay service toll-free at **800-877-8339** and ask to be connected to **202-326-4000**.

Additional information about the PBGC's pension insurance program is available through the PBGC's website at **www.pbgc.gov**.

Benefits under defined contribution plans are not insured by the PBGC. This is because the plan termination insurance provisions of the Employee Retirement Income Security Act of 1974 (ERISA) do not apply to defined contribution plans.

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 of 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 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 Domestic Relations Order applicable to your Kaiser Permanente defined contribution retirement savings plans is $350 for each plan, even if multiple plans are included in one Domestic Relations Order.

For additional information about a Qualified Domestic Relations Order (QDRO) for your defined contribution retirement savings plan(s), contact Vanguard at **www.vanguard.com** or **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 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 pre-existing 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

866-444-EBSA (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.

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Benefits Compliance Communications
Total Rewards
January 2023

KAISER PERMANENTE®

SPD-CO-RES 1/2023

Benefits for You

Pharmacy Residents

Summaries of Material Modification through October 2024

Colorado

Summary Plan Description

KAISER PERMANENTE®

KAISER PERMANENTE®

October 2024

To: Benefits-eligible employees in the Colorado, Northern California, Northwest, and Southern California Regions

Re: Parental age requirement for grandchild benefits

Overview

In order for grandchildren to be eligible to receive medical and dental benefits under your benefit plan, their parent (your child or the child of your spouse or domestic partner) must meet certain requirements, including, but not limited to, being under the age of 26, unmarried, and covered under your medical coverage.

Please read the entire *Summary of Material Modification* (SMM) below for more information regarding updated language for your SPD.

SUMMARY OF MATERIAL MODIFICATION

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

Update to Your SPD

The parental age requirement within the "Eligible Grandchildren" section of your SPD is hereby updated from "under age 25" to "under age 26." All other information in the **Enrolling in Benefits** or **Flexible Benefits** section, as applicable, continues to apply (unless modified by another *Summary of Material Modification*).

ENROLLING IN BENEFITS / FLEXIBLE BENEFITS *(as applicable)*

Eligibility for Benefits / Overview of *Benefits by Design (as applicable)*

Who Is Eligible

Eligible Grandchildren

Your or your spouse's or domestic partner's grandchild is eligible for medical and dental coverage only, if the grandchild's parent (your child or the child of your spouse or domestic partner) is under age 26, 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

For More Information

For more information about your benefits, please sign on to **kp.org/HRconnect**.

The information described herein is an update to your *Summary Plan Description*, as indicated in this *Summary of Material Modification*. 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 2024

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

Re: New MetLife Legal Services Plus Parents Plan Benefit

Overview

Employees who elect Benefits by Design Voluntary Programs Legal Services benefit for themselves and their immediate family outside the Mid-Atlantic States region have a new option to extend certain legal services, for an extra cost, to up to eight additional family members including parents, parent-in-law, stepparents, and grandparents.

Please read the entire *Summary of Material Modification* (SMM) below for more information regarding updated language for your *Summary Plan Description* (SPD).

SUMMARY OF MATERIAL MODIFICATION

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

Updates to Your SPD

The following content is hereby modified under the **Benefits by Design Voluntary Programs** and **General Information About Other Types of Claims and Appeals** sections of your SPD. The section "Legal Services" is replaced with "Legal Services and Plus Parents Legal Services." The section "Legal Services Claims and Appeals" is replaced with "Legal Services and Legal Services Plus Parents Claims and Appeals." All other content in these sections continue to apply, unless modified by another SMM.

INCOME PROTECTION

Benefits by Design Voluntary Programs

Legal Services and Plus Parents Legal Services

The legal services plan provides you access to a nationwide network of attorneys. The plan, underwritten by MetLife Legal Plans, is available to you and your family for a monthly premium paid through payroll deductions. You have the option to sign up for Legal Services for you and your immediate family or Plus Parents Legal Services for you, your immediate family, and your parents, parents-in-law, stepparents, and grandparents up to eight additional family members at an extra cost.

Who is Eligible

You are eligible to purchase a legal services plan if you are regularly scheduled to work 20 or more hours per week.

When Coverage Begins

You are able to purchase legal services during the Voluntary Programs legal services enrollment period each year. Once you make an election during this enrollment period, your coverage will begin the first of the second month following the end of the election period. For example, if the enrollment period ends on April 30, your coverage will begin on June 1.

Your enrollment will continue unless you disenroll during the enrollment period. If you do not enroll in legal services during this enrollment period, you will have to wait until the following year to enroll. You will be notified when the enrollment period will occur each year.

Your Cost

Deductions for the cost of this coverage will be taken on an after-tax basis from your first two paychecks of each month. The cost for Legal Services Plus Parents plan is higher than the regular Legal Services plan. The cost is subject to change annually. Please sign on to **kp.org/voluntaryprograms** or call Benefits by Design Voluntary Programs for information on the current rates (see the **Contact Information** section).

How Legal Services Work

To use your legal services, visit MetLife Legal Plans website at **www.legalplans.com** or call their Client Service Center at **800-821-6400**, Monday through Friday, 8 a.m. to 7 p.m. Eastern time.

If you call the Client Service Center, the Client Service Representative who answers your call will:

- verify your eligibility for services
- make an initial determination of whether and to what extent your case is covered (the Plan Attorney will make the final determination of coverage)
- give you a case number that is similar to a claim number (you will need a new case number for each new case you have)
- give you the telephone number of the Plan Attorney most convenient to you; and
- answer any questions you have about your Legal Plan.

When calling the Plan Attorney, identify yourself as a legal plan member referred by MetLife Legal Plans or MetLife Legal Plans Plus Parents. You should request an appointment for a consultation. Evening and Saturday appointments may be available. Be prepared to give your case number, the name of the legal plan you belong to, and the type of legal matter you would like to address. If you wish, you may choose an out-of-network attorney. In a few areas, where there are no participating law firms, you will be asked to select your own attorney. In both circumstances, MetLife Legal Plans will reimburse you for these non-plan attorneys' fees based on a set fee schedule.

Covered Services

You and your eligible dependents are entitled to receive certain personal legal services listed below. Only services highlighted in **bold** are available to parents, parents-in-law, stepparents, and grandparents through Plus Parents, which allows you to extend coverage to up to eight family members at an additional cost.

- Adoption, guardianship, parental responsibility matters, school hearings, and conservatorship
- Civil litigation defense, including administrative hearings and incompetency defense
- Consumer protection and personal property matters
- Debt collection, garnishment, and tax collection defense
- Divorce (first 10 hours)
- **Elder-law matters including Medicare, Medicaid, nursing home agreements, and prescription plans**
- Identity theft defense
- Immigration assistance
- Name change
- Negotiations with creditors and repossession, personal bankruptcy, and IRS tax audits
- Pet liabilities

- Premarital agreement
- Preparation of **powers of attorney, affidavits, deeds, demand letters, promissory notes**, home equity loans, and **mortgages**
- **Preparation of simple and complex wills, living wills, codicils, healthcare proxies,** and trusts
- Protection from domestic violence
- Purchase, sale, and refinancing of primary, secondary, and vacation homes
- Restoration of driving privileges, juvenile court proceedings, DUI defense, and traffic ticket defense
- **Review of any personal legal document**
- Security deposit assistance, zoning applications, property tax assessments, and boundary/title disputes
- Small claims assistance
- Tenant negotiations, foreclosure, and eviction defense (tenant only)

Kaiser Permanente cannot guarantee the legal outcomes of the services provided. Contact MetLife Legal Plans directly with any concerns you have about the legal services you receive.

Exclusions

Excluded services are those legal services that are not provided under the plan. No services, not even a consultation, can be provided for the following matters:

- Appeals and class actions
- Costs or fines
- Employment-related matters, including company or statutory benefits
- Farm matters, business or investment matters, matters involving property held for investment or rental, or issues when the Participant is the landlord
- Frivolous or unethical matters
- Matters for which an attorney-client relationship exists prior to the Participant becoming eligible for plan benefits
- Matters in which there is a conflict of interest between the employee and spouse/domestic partner or dependents in which case services are excluded for the spouse/domestic partner and dependents
- Matters involving Kaiser Permanente, MetLife and affiliates, and Plan Attorneys
- Patent, trademark, and copyright matters

For details about covered services and exclusions, please visit MetLife Legal Plans' website at **www.legalplans.com** or call **800-821-6400.**

DISPUTES, CLAIMS, AND APPEALS

General Information About Other Types of Claims and Appeals

Legal Services and Legal Services Plus Parents Claims and Appeals

Contact MetLife Legal Plans at **800-821-6400** to initiate a claim. MetLife Legal Plans will provide you with instructions on how to complete the claims process. Send completed claims to the address below:

MetLife Legal Plans Director of Administration
1111 Superior Ave. E, Suite 800
Cleveland, OH 44114-2507
Fax: 216-694-4309
Phone: 800-821-6400

Deadlines for Responding to Your Claims

MetLife Legal Plans will make a decision on your claim within a reasonable period but not later than 90 days after it receives your claim form. In some cases, MetLife Legal Plans 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, MetLife Legal Plans may take up to an additional 90 days to respond to your claim. When MetLife Legal Plans 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.

How to Appeal a Denial of Your Initial Claim

If your claim is denied, MetLife Legal Plans will provide you with a written explanation of the denial and you will have the right to request a review of your claim by writing to MetLife Legal Plans. Please include in your appeal letter the reason(s) you believe the claim was improperly denied, and submit any additional comments, documents, records or other information relating to your claim that you deem appropriate to enable MetLife Legal Plans to give your appeal proper consideration. Upon your written request, MetLife Legal Plans will provide you with a copy of the records and/or reports that are relevant to your claim. Your appeal can be sent to the following address within 60 days of the claim denial:

MetLife Legal Plans Director of Administration
1111 Superior Ave. E, Suite 800
Cleveland, OH 44114-2507
Fax: 216-694-4309
Phone: 800-821-6400

Deadlines for Responding to Your Appeal

If MetLife Legal Plans denies your appeal, MetLife Legal Plans must notify you of its decision on your appeal within a reasonable period, but not later than 60 days after it receives your appeal. In some cases, MetLife Legal Plans will notify you, before the end of the normal 60-day maximum deadline for responding to your appeal, that additional time is required to process your appeal on account of special circumstances. In that event, MetLife Legal Plans may take up to an additional 60 days to respond to your appeal. When MetLife Legal Plans requests the 60-day extension, it will indicate the special circumstances in writing. If MetLife Legal Plans needs additional information from you to resolve your appeal, then MetLife Legal Plans may decide not to count the time between when you are requested to send the additional information and the time when you furnish that information towards the additional 60 days that MetLife Legal Plans has to decide your appeal.

What to Do About a Denial After Final Review

If your appeal is denied and you disagree with the final decision, you may file a lawsuit under ERISA 502(a). If you wish, you may take the matter up with the Department of Insurance in your state.

For More Information

For more information about your benefits, please sign on to **kp.org/HRconnect**.

The information described herein is a summary of benefit changes as indicated in this *Summary of Material Modification*. 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®

July 2024

To: Executives and employees eligible for the Kaiser Permanente Tax Sheltered Annuity Plan II

Re: Information regarding your new retirement defined contribution plan

Overview

In late December 2023, the following Kaiser Permanente retirement savings plans were merged into the Kaiser Permanente Tax Sheltered Annuity Plan III (TSA III) (094174):

- Kaiser Permanente Tax Sheltered Annuity Plan (TSA) (090998)
- Kaiser Permanente Tax Sheltered Annuity Plan (TSA II) (094998)
- Kaiser Permanente Washington 403(b) Plan (095690)

Effective January 1, 2024, your new plan name and plan number is the Kaiser Permanente Tax Sheltered Annuity Plan (TSA) (**094174**). The fund options and plan features were not affected by this merger; only the plan name and plan number changed.

In addition, effective January 1, 2024:

- Your TSA contribution limits for 2024 have increased.
- If you are in active duty military service and meet certain requirements, you may be eligible to make a penalty-free withdrawal or receive a distribution from your TSA retirement savings plan accounts.

Please read the entire *Summary of Material Modification* (SMM) below for more information regarding updated language for your 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.

Updates to Your SPD

The information below updates the following "Kaiser Permanente Tax-Sheltered Annuity Plan" sections under the **Retirement Programs** section of your current SPD. All other "Kaiser Permanente Tax-Sheltered Annuity Plan" and **Retirement Programs** section information in your SPD continues to apply (unless modified by another *Summary of Material Modification*).

RETIREMENT PROGRAMS

Kaiser Permanente Tax-Sheltered Annuity Plan

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

How to Enroll

If you are newly hired or transferred, Vanguard will automatically enroll you in pre-tax contributions to the plan (see "Automatic Enrollment in Pre-Tax Employee Contributions") and send you a confirmation notice. 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 **800-523-1188**. Your **Kaiser Permanente Tax-Sheltered Annuity Plan** plan number is **094174**. 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

You have the option to make pre-tax and/or Roth after-tax contributions to your plan. Pre-tax contributions and earnings are taxed when you take a distribution. Roth after-tax contributions are taxed when your contributions are made. Your pre-tax and Roth after-tax contributions are invested proportionately in the same mutual funds you elect in your plan.

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 income 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.

You can contribute between 1% and 75% of your eligible compensation each period, in whole age increments. However, the maximum amount you can contribute to your plan account each year cannot exceed the maximum contribution dollar limit allowed by the Internal Revenue Code (IRC) — which is $23,000 in 2024.

Unless you elect otherwise, 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. For the most up-to-date IRS limits, visit **irs.gov** and search for "contribution limits."

Roth After-Tax Employee Contributions

The Roth after-tax feature allows you to make after-tax employee contributions to your plan. Any after-tax Roth contributions you make — along with any earnings on those contributions — may be withdrawn tax-free if:

- it has been at least five years since your first after-tax contribution or in-plan conversion, whichever is earlier; and
- you are at least age 59½ at the time you make a withdrawal, or
- you are totally and permanently disabled, or you die

Please note: Roth after-tax contributions apply toward the annual contribution limits.

The five-year period begins on January 1 of the year you first make a Roth after-tax contribution to the plan. It ends when five consecutive years have passed. In the event of your death, the five-year period carries over to your beneficiary. To learn more about Roth after-tax contributions, sign on to **vanguard.com/rothfeature** or call Vanguard at **800-523-1188**, Monday through Friday from 5:30 a.m. to 6 p.m. Pacific time.

Roth In-Plan Conversions

Roth in-plan conversions allow you to convert your current pre-tax retirement savings plan account (or a portion of your account) to a Roth after-tax account within the plan. If you elect a Roth in-plan conversion, the pre-tax amount that is converted to Roth becomes taxable income in the year of conversion. In some instances, this could move you to a higher tax rate and/or may cause other adverse tax consequences.

You should consider the following before electing an in-plan conversion:

- There is no tax withholding from your plan for the conversion, so you must pay those taxes from another source
- You will pay taxes on the amount of a Roth in-plan conversion for the year of conversion

You should consider that state and local income taxes may apply in addition to federal taxes

- You cannot reverse a Roth in-plan conversion once it is made

Any Roth in-plan conversion amount — along with any earnings on the converted amount — can be withdrawn tax-free if you are at least age 59½ and it has been at least five years since the conversion. Each Roth in-plan conversion is subject to a separate five-year period. If you withdraw Roth in-plan conversion assets within five years of the conversion, you will owe a 10% federal penalty tax on the portion of the withdrawal that represents converted assets, unless an exception applies. Early distribution exceptions include:

- Direct rollover to a Roth Individual Retirement Account (IRA) or another qualified plan that accepts Roth rollovers
- Severance from employment at age 55 or later
- You are age 59½ or older

For more information about Roth in-plan conversions, sign on to **vanguard.com/inplanconversion** or call Vanguard at **800-523-1188**, Monday through Friday from 5:30 a.m. to 6 p.m. Pacific time.

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 this year, you are eligible to make an additional catch-up contribution to your plan for this year and in subsequent years. The maximum allowable catch-up contribution in 2024 is $7,500. Your regular 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 limit for regular contributions. The following chart outlines the annual contribution limits (pre-tax and Roth combined, as applicable) in 2024:

Regular Contribution Limit	Catch-Up Contribution Limit	Combined Contribution Limit
$23,000	$7,500	$30,500

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

If you have any questions about catch-up contributions, call Vanguard at **800-523-1188**. For the most up-to-date IRS limits, visit **irs.gov** and search for "contribution limits."

Military Personnel Distributions

If you are in active duty military service for at least 30 days, you can elect to receive a distribution of your pre-tax contributions (as adjusted for investment gains or losses). If you receive such a distribution, your right to make contributions to the plan will be suspended for six months after the date of the distribution.

If you were ordered or called to active duty for at least 180 days or for an indefinite period as provided in Section 72(t)(2)(G) of the Internal Revenue Code, you can make a penalty-free withdrawal from your plan account while on active duty. If you make such a withdrawal, you may, at any time within the two-year period beginning on the day after the end of your active duty period, make one or more contributions to an individual retirement account in an aggregate amount not exceeding the amount of your penalty-free withdrawal(s) from the plan.

For More Information

For more information about your benefits, please sign on to **kp.org/HRconnect**.

Executives: You may request a paper copy of this *Summary of Material Modification* (SMM) at no charge by calling the Executive Benefits Helpline at **(510) 271-6667.**

Program Offices, IT and Regional non-represented employees: You may request a paper copy of this Summary of Material Modification (SMM) at no charge by calling the National Human Resources Service Center at **1-877-4KP-HRSC (1-877-457-4772).**

KAISER PERMANENTE®

October 2023

To: Employees eligible to participate in any of the defined contribution retirement savings plans listed on page 2

Re: Age 35 retirement account requirement when designating a non-spouse beneficiary

Overview

If you are married and name a non-spouse beneficiary to your retirement savings plan before the year in which you reach age 35, your beneficiary will automatically revert back to your spouse on January 1 of that year. To re-designate a non-spouse beneficiary, you must complete a new beneficiary form, again with your spouse's written consent.

Please read the entire *Summary of Material Modification* (SMM) below for more information regarding updated language for your 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

The following content is hereby modified under the "Choosing Your Beneficiary" section of your SPD. All other information in this section continues to apply (unless modified by another *Summary of Material Modification*).

RETIREMENT PROGRAMS

Defined Contribution Plan (as applicable) (*see page 2 for affected plan names*)

Choosing Your Beneficiary

When you become a participant, you should 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 name a non-spouse beneficiary before the year in which you reach age 35, your beneficiary will automatically revert back to your spouse on January 1 of that year. To re-designate a non-spouse beneficiary, you must complete a new beneficiary form, again with your spouse's written consent.

Please see the "If You Die" section for more information.

For More Information

For more information about your benefits, please sign on to **kp.org/HRconnect**.

Employee Plans Affected by This SMM

- Kaiser Permanente Employees Pension Plan – Supplemental Retirement Income Plan (SRIP) (Plan Number 093210)
- Kaiser Permanente Employees Pension Plan – Supplemental Retirement Income Plan for The Permanente Medical Group, Inc. (SRIP-TPMG) (Plan Number 093638)
- Kaiser Permanente Northwest Supplemental Retirement Plan (Plan Number 093356)
- Kaiser Permanente Supplemental Savings and Retirement Plan (Plan B) (Plan Number 092528)
- Kaiser Permanente Supplemental Savings and Retirement Plan for Union Groups (KPSSRPUG) (Plan Number 093150)
- Kaiser Permanente Washington Defined Contribution Plan (Plan Number 092833)
- The Permanente 401(k) Retirement Plan (P401K) (Plan Number 092625)
- The Permanente Medical Group, Inc., Salary Deferral Retirement Plan (SDR) (Plan Number 093143)
- The Southern California Permanente Medical Group Tax Savings Retirement Plan (TSR) (Plan Number 090480)

The information described herein is an update to your current *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. If applicable, 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 2023

To: Employees eligible to participate in any of the retirement savings plans listed on page 2

Re: Military Leave of Absence Make Up Contributions to Kaiser Permanente retirement savings plans

Overview

Employees participating in Kaiser Permanente retirement savings plans may make up missed elective contributions due a military leave of absence.

Please read the entire *Summary of Material Modification* (SMM) below for more information regarding updated language for your 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.

Updates to Your SPD

The following content is added to the "Making Contributions to Your Account" section of your SPD. All other "Making Contributions to Your Account" content continues to apply (unless modified by another *Summary of Material Modification*).

RETIREMENT PROGRAMS

Kaiser Permanente Retirement Savings Plans (*see page 2)*

Making Contributions to Your Account

Military Leave of Absence Make Up Contributions

You are eligible to make up any employee contributions you missed during your military leave of absence (MLOA). The deadline to do this is the lesser of five years or three times the length of your MLOA, beginning on the date of your return from leave.

Your make up contributions are subject to the annual IRS limits in effect during your MLOA and will be adjusted for any elective deferrals made during the MLOA period.

To make up your missed contributions, contact Vanguard.

For More Information

For more information about your benefits, please sign on to **kp.org/HRconnect**.

Employee Plans Affected by This SMM

- Kaiser Permanente Employees Pension Plan – Supplemental Retirement Income Plan (SRIP) (Plan Number 093210)
- Kaiser Permanente Employees Pension Plan – Supplemental Retirement Income Plan for The Permanente Medical Group, Inc. (SRIP-TPMG) (Plan Number 093638)
- Kaiser Permanente Northwest Supplemental Retirement Plan (Plan Number 093356)
- Kaiser Permanente Supplemental Savings and Retirement Plan (Plan B) (Plan Number 092528)
- Kaiser Permanente Supplemental Savings and Retirement Plan for Union Groups (KPSSRPUG) (Plan Number 093150)
- Kaiser Permanente Washington 403(b) Plan (Plan Number 095690)
- Kaiser Permanente Washington Defined Contribution Plan (Plan Number 092833)
- Kaiser Permanente 401(k) Retirement Plan (Plan Number 090310)
- Kaiser Permanente of Washington Options 401(k) Retirement Plan (Plan Number 094552)
- Kaiser Permanente Tax Sheltered Annuity Plan (Plan Number 090998)
- Kaiser Permanente Tax Sheltered Annuity Plan II (Plan Number 094174)
- Kaiser Permanente Tax Sheltered Annuity Plan II (Plan Number 094998)
- The Permanente 401(k) Retirement Plan (P401K) (Plan Number 092625)
- The Permanente Medical Group, Inc., Salary Deferral Retirement Plan (SDR) (Plan Number 093143)
- The Southern California Permanente Medical Group Tax Savings Retirement Plan (TSR) (Plan Number 090480)

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KAISER PERMANENTE®

June 2023

To: All Kaiser Permanente Employees and Former Employees Participating in or Eligible for Medical Plan Coverage

Re: End of COVID-19 National Emergency Extended Plan Deadlines and of Coverage for COVID-19 Vaccines and Testing with the End of the Public Health Emergency Declarations

Overview

During the first quarter of 2023, the federal government announced that the COVID-19 National Emergency and Public Health Emergency (PHE) would expire on May 11, 2023. California law extended the end of the PHE an additional six months to November 11, 2023.

End of COVID-19 National Emergency Extended Plan Deadlines

As previously communicated, certain deadlines for your benefit plans were extended due to the COVID-19 National Emergency starting March 1, 2020. With the COVID-19 National Emergency ending on May 11, 2023 (and the related Outbreak Period on July 10, 2023), the impacted deadlines will return to the regular timeframes. Please refer to the chart below for how this change will affect you and your benefit plans.

Actions	Deadline if Event is On or Before July 10, 2023	Deadline if Event is After July 10, 2023
You want to enroll a new dependent in medical coverage due to marriage, birth, adoption, or placement for adoption	The earlier of: • 1 year from the date of event + 31 days, OR • August 10, 2023	31 days from date of event
You want to enroll in medical coverage because • You lost coverage in a program like Medicaid or CHIP, OR • You became eligible for a program like Medicaid or CHIP	The earlier of: • 1 year from the date of event + 60 days, OR • September 8, 2023	60 days from date of event
You want to enroll in COBRA coverage	The earlier of: • 1 year from the date of "qualifying event" (or the date your election notice was sent to you, if later) + 60 days, OR • September 8, 2023	60 days from the "qualifying event" or the date your election notice is sent to you, whichever is later

Actions	Deadline if Event is On or Before July 10, 2023	Deadline if Event is After July 10, 2023
You are notifying Kaiser Permanente of one of the following COBRA-qualifying events: • divorce/legal separation, • loss of dependent status, OR • notification of an extension of COBRA because of a Social Security Administration disability determination	The earlier of: • 1 year from the date of event + 60 days, OR • September 8, 2023	60 days from date of event
You want to make your initial payment for COBRA premiums	The earlier of: • 1 year from the date of COBRA election + 45 days, OR • August 24, 2023	45 days from COBRA election date
You want to make your monthly COBRA premium payment (after the initial payment)	The earlier of: • 1 year from the date initially due + 30 days, OR • August 9, 2023	30 days from initial due date
You want to request an external review of medical claims and submit additional information to perfect the request of external review	The earlier of: • 1 year from the date of original deadline, OR • July 10, 2023 + any specific plan deadline to take action	See the **Disputes, Claims, and Appeals** section in your *Summary Plan Description* for your plan deadline
You want to make a benefit claim or appeal for your health or retirement plan, or a benefit like life insurance or disability insurance	The earlier of: • 1 year from the date of original deadline, OR • July 10, 2023 + any specific plan deadline to take action	See specific sections in the **Disputes, Claims, and Appeals** in your *Summary Plan Description* for your plan deadline

Examples for Deadline Extensions Ending

Example 1: COBRA Election

Facts: Ahmed works for Kaiser Permanente (KP) and participates in KP's group health plan. Ahmed experiences a qualifying event on April 21, 2023 and is no longer covered as of May 1, 2023. Ahmed is eligible to elect COBRA coverage under KP's health plan and is provided a COBRA election notice on May 15, 2023. What is the deadline for Ahmed to elect COBRA?

Conclusion: Because Ahmed's qualifying event occurred on April 21, 2023, the deadline extensions still apply. The last day of Ahmed's COBRA election period is September 8, 2023, 60 days after July 10, 2023 (the end of the Outbreak Period).

Example 2: New Dependent Enrollment

Facts: Mia works for Kaiser Permanente (KP). Mia is eligible for KP's group health plan, but previously waived coverage. On July 12, 2023, Mia gives birth (a HIPAA special enrollment event) and wants to enroll

herself and her newborn in KP's health plan. However, open enrollment doesn't begin until October 23, 2023. Can Mia enroll herself and her newborn in the middle of the year?

Conclusion: Yes, Mia and her newborn may enroll in a KP health plan in the middle of the year. Since the birth of her child occurred after the National Emergency Deadline Extensions expired, her enrollment period will fall within the health plan's regular timeframe. Mia will have until August 12, 2023, or 31 days after July 12, 2023, to enroll herself and her newborn in a KP health plan.

Example 3: Health Care Flexible Spending Account (Health Care FSA) Reimbursement

Facts: Xavier works for Kaiser Permanente (KP) and was a participant in the Health Care FSA in 2022. Xavier bought a blood pressure monitor in 2022 and wants to make a claim to get reimbursed for the purchase from his KP Health Care FSA. What is the deadline for Xavier to submit his 2022 Health Care FSA claim for reimbursement?

Conclusion: The Health Care FSA usually requires that benefit claims incurred in 2022 must be submitted by March 31, 2023. However, because of the extended deadlines, Xavier has until October 8, 2023, or 90 days after July 10, 2023, to submit his 2022 claim to the KP Health Care FSA.

End of COVID-19 Public Health Emergency

In addition, when the federal government initially declared the PHE on January 31, 2020, applicable federal law mandated no-cost COVID-19 testing and vaccines. While the federal PHE ended May 11, 2023, California extended the no-cost COVID-19 testing and vaccine requirements until November 11, 2023.

This means, for all KP regions except California, health plans are no longer required to provide special coverage for COVID-19 testing and vaccines beginning May 12, 2023. For California, the mandate will end effective November 12, 2023. Ending the special coverage mandate means COVID-19 testing and vaccines will be treated the same way as testing and vaccines that help prevent other illnesses.

Also, COVID-19 over-the-counter home tests will no longer be covered as of May 12, 2023 for all regions and, as of November 12, 2023, for California. *Please note*: If you are a California health plan member whose COVID-19 home tests remain covered until November 11, 2023, you may be asked to pay for the home tests, but you can submit a claim for reimbursement. If you have questions about this process, please log on to kp.org. You may also refer to your Evidence Of Coverage (EOC)/Benefits Booklet or call Member Services/Customer Service, as applicable.

Please read the entire *Summary of Material Modification* (SMM) below for more information regarding updated language for your *Summary Plan Description* (SPD).

SUMMARY OF MATERIAL MODIFICATION

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

Updates to Your SPD

Information about the COVID-19 National Emergency deadline as a "Special Note" in the **Front** section of your SPD or added to that section by an SMM issued in September 2021 is hereby removed.

In addition, the "COVID-19 Services" in the **Health Care** section of your SPD or added to that section by an SMM issued in October 2022 regarding "Special Note on COVID-19 Services" is hereby replaced with the below.

All other content in these sections continue to apply (unless modified by a different *Summary of Material Modification*).

HEALTH CARE

Medical Plan *(as applicable)* *(see list of plans on page 4)*

COVID-19 Items and Services (*Effective May 12, 2023 for all regions except California; Effective November 12, 2023 for California*)

With the declaration of the end of the Public Health Emergency, the following COVID-19 items and services are covered as follows:

- COVID-19 Vaccines – Covered under preventive benefits at no cost
- COVID-19 PCR Testing – Covered under outpatient diagnostic lab at applicable cost share
- COVID-19 Treatment – Covered as any other medical condition with applicable cost share
- COVID-19 Out-Of-Network (OON) Items and Services – Covered as any other emergency/urgent care medical condition with applicable cost share
- COVID-19 Over-The-Counter (OTC) Rapid Antigen Home Tests – **Not covered**. If you have a Health Care Flexible Spending Account (Health Care FSA), you may use your Health Care FSA to seek reimbursement for home test costs not covered by your plan.

For details about your coverage, please refer to your EOC/Benefits Booklet or call Member Services/Customer Service, as applicable.

For More Information

For more information about your benefits, please sign on to **kp.org/HRconnect**.

Plans Affected by This SMM

Medical Plans

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

The information described herein is a summary of benefit changes effective as indicated in this *Summary of Material Modification*. 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.