Benefits for You

Salaried Employees and Resident Physicians

Hawaii
January 2026 – December 2031

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
- dental coverage
- life and disability insurance plans
- flexible spending accounts
- 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 leave of absences, 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 MyKP at **mykp.kp.org**.

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.

Washington Service Area Residents

If you are a non-executive, nonrepresented Kaiser Foundation Health Plan, Inc. and/or Kaiser Foundation Hospitals (KFHP/KFH) employee who established residency in the Washington Service Area on or after June 1, 2017, this SPD does not apply to you. Please refer to the SPD for Nonrepresented employees in Washington for your benefits.

If you are a former employee of Group Health Cooperative (GHC) or Group Health Options (GHO) or their affiliates before February 1, 2017, who later transferred to another Kaiser Permanente entity (not including Kaiser Foundation Health Plan of Washington), the residency provision above does not apply to you, and you will receive the benefits described in this SPD.

Any non-executive, nonrepresented Kaiser Foundation Health Plan, Inc. and/or Kaiser Foundation Hospitals (KFHP/KFH) employee who reside in the Washington Service Area will refer to the SPD for Nonrepresented employees in Washington for your benefits.

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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 8007 Pleasanton, CA 94588-9801 **mykp.kp.org**
Health Care	
Member Services Questions about KFHP medical plans	**Hawaii** Hours: M-F, 8 a.m. - 5 p.m. Hawaii Standard Time **808-432-5955 (Oahu)** **800-966-5955 (Neighbor islands)** **808-432-7032 (TTY)**
Employee Assistance Program (EAP)	Northern California **kp.org/eap** Southern California **kp.org/eap** Colorado **888-678-0937** **eap.acentra.com*** Georgia **888-678-0937** **eap.acentra.com*** Hawaii **888-678-0937** **eap.acentra.com*** Maui Health System **833-621-2993** **eap.acentra.com**** Mid-Atlantic States **888-678-0937** **eap.acentra.com*** Northwest **503-813-4703** **kp.org/eap** Washington **888-678-0937** **eap.acentra.com*** * password = Kaiser ** password = mauihealth
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**
Cigna Healthcare Questions and claims about the following: • PPO Plus	Hours: 24/7 **855-429-1426** **www.myCigna.com**

Department, Organization, or Service	Contact Information
Health Care (Dental)	
Hawaii Dental Service	**800-232-2533 ext. 248, or 808-529-9248** **www.hawaiidentalservice.com** For a directory of participating dentists in your area, call: **808-521-1431**
Income Protection	
MetLife Questions and claims about the following plans, if applicable for your group: • Life Insurance • Dependent Life Insurance • Long-Term Disability • Accidental Death & Dismemberment • Business Travel Accident	**800-638-6420 or 888-420-1661** **www.metlife.com/mybenefits**
Temporary Disability Insurance (TDI) Questions about the TDI plan:	Hawaii HR Services **808-432-4927**
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 • Legal Services Plus Parents	**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

Department, Organization, or Service	Contact Information
Retirement Programs	
Kaiser Permanente Retirement Center (KPRC) Questions about retiree health and welfare benefits	Hours: M-F, 6 a.m. - 6 p.m. Pacific Time Phone: **866-627-2826** Fax: **888-547-2304** **www.myplansconnect.com/kp**
Fidelity Service Center Questions about pension plans	Hours: M-F, 5:30 a.m. - 6 p.m. Pacific Time Phone: **866-602-0411** Fax: **877-401-0870** **netbenefits.com**
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 Questions and claims about the following plans, as applicable: • Health Care Flexible Spending Account • Dependent Care Flexible Spending Account	Hours: 24/7 **877-924-3967** **healthequity.com**
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**

Flexible Benefits

At Kaiser Permanente, your benefits are designed to meet your changing needs. Through the *Benefits by Design* flexible benefits program, you will receive credits that can be used to purchase the benefits and coverage levels best suited to your needs and those of your family.

Highlights of This Section

Overview of *Benefits by Design*

The *Benefits by Design* flexible benefits program is designed to let you choose the benefits and coverage levels that work best for you and your family.

Benefits by Design offers you the following options:

- Choose from a selection of benefits
- Decline the optional benefits you do not want
- Choose the plan and coverage levels that best meet your and your family's needs (i.e., coverage for yourself only or for your eligible dependents as well)

The chart below shows the benefits available through *Benefits by Design*:

Flexible Benefits	Choices
Medical Benefits	3 option(s)
Dental Benefits	2 option(s)
Optional Life Insurance	Variable coverage options
Dependent Life Insurance	Variable coverage options for your family
Accidental Death and Dismemberment Insurance	Variable coverage options for you and your family
Long-Term Disability Insurance	2 levels
Health Care Flexible Spending Account	Up to $3,300 annually
Dependent Care Flexible Spending Account	Up to $5,000 annually

Who Is Eligible

You are eligible to participate in *Benefits by Design* if you are regularly scheduled to work 20 or more hours per week in a benefits-eligible status.

If you are a transferred employee, contact the NHRSC for more information about your eligibility.

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

Eligible Dependents

Your eligible dependents include the following:

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

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 limits for a dependent child who is incapable of self-support due to a mental or physical disability, provided the following conditions are met:

For an enrolled dependent child:

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

For a disabled dependent child of a newly hired employee:

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

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

Eligible Children

Eligible children include:

- Your children
- Your spouse's or domestic partner's children
- Legally adopted children
- Children placed with you for adoption. You will be required to provide proof of your legal right to control the adoptive child's health care. Until the adoption is final, children placed with you pending adoption are eligible for medical and dental coverage only.
- Children who reside in your household for whom you provide chief support and for whom you have been granted authority by a court to make legal decisions for the child's health and/or education
- Children for whom you are required to provide coverage as a result of a Qualified Medical Child Support Order (QMCSO)

Coverage will continue through the end of the month in which your child turns 26, unless your child is disabled (see "Disabled Dependent Children Over the Age Limit") or no longer meets the plan's eligibility requirements.

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 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, 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.

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 corrective action.

Enrolling a Newborn

You must inform the NHRSC and enroll your newborn in coverage within 31 days of the date of birth. If you do not enroll your newborn within 31 days of the date of birth, you will have to wait until the following open enrollment period to enroll your baby in coverage, unless you have another qualifying employment or family status change. 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.

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

Eligible Family Members	Required Documentation
Domestic Partner	Copy of **one** of the following: • Notarized affidavit of domestic partnership*, or* • Certified local or state government domestic partner registration and Kaiser Permanente Affidavit of Domestic Partnership and Legally Recognized Partners form 3191 (notarization not required)
Civil Union Partner	• Copy of certified civil union license/registration from local or state government and • *Kaiser Permanente Affidavit of Domestic Partnership and Legally Recognized Partners form 3191*
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
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 limits	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.

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 and Legally Recognized Partners form 3191*. 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 or Customer Services, as applicable 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 *Benefits by Design* Coverage Begins

Refer to the following chart to determine the effective date of your *Benefits by Design* coverage (coverage for your enrolled dependents begins at the same time your coverage begins):

Employment Status	When Coverage Begins	
	Medical, Life Insurance, AD&D, Flexible Spending Account	Dental, Long-Term Disability
New hire, benefits-eligible	First of the month following your date of hire*	First of the month after three months of employment
Rehired within 6 months	First of the month following rehire date	First of the month after three months of employment
Benefits-ineligible to benefits-eligible	First of the month following change in a benefits-eligible status	First of the month following change in a benefits-eligible status**
Non-flex-eligible to flex-eligible	First of the month following change in status	First of the month following change in an eligible status**
Inter- or intra-regional transfer	First of the month following transfer	First of the month following transfer**

* If you are hired on the first of the month, you are eligible on your date of hire.

** Provided you already have three months of employment.

Please note: Previously elected *Benefits by Design* benefits apply if you are rehired within the same calendar year.

How Flexible Benefits Work

Kaiser Permanente gives you credits to purchase your benefits from *Benefits by Design*. A specified number of credits are issued to you and reflected on the first two pay statements of each month. Your credits and costs do not reflect the full cost of your benefits. Kaiser Permanente pays the majority of your benefit costs.

Under *Benefits by Design*, you choose the following:

- The benefits you want from the options available
- The level of coverage

- Whether you will be covering yourself only, or yourself and one or more of your eligible dependents

If the benefits you choose cost more than your credits, you pay the difference through pre-tax or after-tax payroll deductions.

If the benefits you choose cost less than your credits, you receive the excess credits as taxable income in the first two pay statements of each month. Deductions are taken from the first two pay statements of each month, totaling 24 deductions annually.

If you are regularly scheduled to work less than 32 hours per week, your credits will be prorated based on your scheduled hours.

If you are an employee regularly scheduled to work 26 to 31 hours per week, your credits are funded at 80%. If you are an employee regularly scheduled to work 20 to 25 hours per week, your credits are funded at 60%.

What Your Credits Will Purchase

If you are regularly scheduled to work at least 32 hours per week, you will receive enough credits to purchase the following coverage:

- **Medical coverage:** Kaiser Foundation Health Plan Basic — including Supplemental Medical — for yourself only
- **Dental coverage:** Hawaii Dental Service (HDS) Basic for you and your eligible dependents
- **Life insurance coverage:** Approximately one times your annual base salary
- **Long-Term Disability insurance:** 50% of your base salary

Please note: You may be eligible for additional benefits provided outside of *Benefits by Design*. Please refer to each section of this SPD for more information.

Plan Year

Your elections will remain in effect for the plan year — from January 1 through December 31.

When You Can Enroll

You may enroll in the *Benefits by Design* flexible benefits program at the following times:

- When you begin working in a benefits-eligible status 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”)

You are automatically enrolled 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.

Important note: You must make a medical plan election for your enrollment to be considered complete — even if you wish to waive medical coverage. If you do not make a medical plan election, or if you waive medical coverage and do not provide the NHRSC with proof of other medical coverage, you will receive Default coverage (please see "Default Coverage" for more information).

When You Begin Working at Kaiser Permanente

You must enroll in *Benefits by Design* coverage within 31 days of your date of hire. Complete your benefits enrollment on MyKP at **mykp.kp.org** by the deadline. **If the NHRSC does not receive your completed enrollment by the deadline, you will receive default coverage**, and you will have to wait until the next annual open enrollment period to enroll in *Benefits by Design*, unless you have a qualifying change in family or employment status. Any elections that you make during open enrollment will not become effective until January 1 of the following calendar year.

Open Enrollment

Each year during open enrollment, you will have the opportunity to review your current *Benefits by Design* elections, 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 Design* by the open enrollment deadline, your benefit elections for the following year will remain the same except for the flexible spending accounts, which must be re-elected every year.

Some benefits are not subject to the annual open enrollment restrictions 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 qualified change in family or employment status as defined by the Internal Revenue Code (IRC). Any changes in coverage must be consistent with the qualified family or employment status event.

Qualifying Family Status Events

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

- Marriage, legal separation, annulment, or divorce
- Entering or terminating a domestic partner relationship
- Birth or adoption of a child
- Death of a dependent or spouse or domestic partner
- Change in your covered dependent's eligibility status

Note: For the Dependent Care Flexible Spending Account only, you may make a mid-year enrollment change if you experience a significant change in your dependent care expenses, provided the change is imposed by a dependent care provider who is not your relative.

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 an 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
Add new dependents or change enrollment in dental plans	First of the month following date of event
Remove dependents from existing medical and/or dental plans	End of the month of date of event
Start, stop, increase or decrease your contributions to a Flexible Spending Account (as allowed by IRS regulations)	First of the month following date the change was processed by NHRSC
Add dependents or change enrollment in Dependent Life and/or Accidental Death & Dismemberment Insurance (only in the case of marriage, entering a domestic partner relationship, or birth or adoption of a child)	First of the month following date of event (provided you are actively at work)
Remove dependents from Dependent Life and/or Accidental Death & Dismemberment Insurance (only in the case of divorce, termination of a domestic partner relationship, death, or if a dependent loses eligibility)	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 the 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 example, if you get a divorce, you must remove your former spouse from your benefits coverage, but you may not start contributing to a Health Care Flexible Spending Account. For more information on the benefit changes permitted for each type of employment and family status changes, sign on to MyKP.

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.**

Default Coverage

Kaiser Permanente believes it is important for you to have a minimum level of certain benefits, known as default coverage, to protect you in case of unexpected illness or catastrophe. If you do not complete your enrollment in *Benefits by Design* during your initial enrollment period, or if you enroll but do not make a medical plan election, you will receive default coverage. This coverage will stay in effect until the end of the plan year. During the next open enrollment period, you may make changes to your coverage, which will take effect on January 1 of the following plan year. If you do not make changes during open enrollment, you will remain in default coverage.

Default coverage includes the following:

- Kaiser Foundation Health Plan Basic (including Supplemental Medical) for yourself only
- Employee Life Insurance coverage in the amount of one times your annual salary, up to $50,000 (outside of Benefits by Design)

Default coverage does not include dental benefits or any coverage for your dependents. In addition, when you have default coverage, you do not receive any *Benefits by Design* credits.

Please note: If you work in an area in which Kaiser Permanente-sponsored medical coverage is not offered, you will receive the Preferred Provider Organization (PPO Plus) Plan.

Tax Considerations

Internal Revenue Service (IRS) regulations only allow certain benefits to be paid on a pre-tax basis. That is why you pay for some benefits with pre-tax dollars and others with after-tax dollars.

Pre-Tax: Your costs are deducted from your paycheck before federal and state income taxes are determined. *Benefits by Design* credits may be used only to pay for pre-tax benefits.

Your pre-tax benefits are as follows:

- Medical benefits (including Supplemental Medical)
- Dental benefits
- Optional Life insurance
- Accidental Death and Dismemberment insurance, employee coverage only
- Contributions to a Health Care Flexible Spending Account
- Contributions to a Dependent Care Flexible Spending Account

After-Tax: Your costs are deducted from your paycheck after federal and state income taxes are determined.

Your after-tax benefits are as follows:

- Dependent Life insurance
- Dependent Accidental Death and Dismemberment insurance
- Benefits by Design Voluntary Programs

You can elect to pay for Long-Term Disability insurance with either pre-tax or after-tax dollars. For more information, see the **Income Protection** section.

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 MyKP at **mykp.kp.org**.

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

You may elect to continue certain coverage 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 MyKP when you begin working at Kaiser Permanente, change to a benefit-eligible status, have a qualifying event, or during the annual open enrollment period.

MyKP 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 MyKP at any time, from work or home, at **mykp.kp.org**.

To complete your dependents' 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 and Legally Recognized Partners form 3191*, etc.) to the NHRSC (see the "Required Documentation for Benefits" section). You may upload these documents directly to your case on **My Cases** on MyKP (preferred), fax, or mail to:

Kaiser Permanente
National Human Resources Service Center
P.O. Box 8007
Pleasanton, CA 94588-9801
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 case there is an issue. 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.

You must make a medical plan election to complete your enrollment — even if you are eligible to waive medical coverage. If you do not make a medical plan election, or if you waive medical coverage and do not provide the NHRSC with proof of other medical coverage, you will receive Default coverage (please see "Default Coverage" for more information).

Domestic Partner/Civil Union Partner Benefits

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

Who Is Eligible

To be eligible for domestic partner benefits, you must provide documentation of your relationship to the NHRSC. For a list of acceptable documentation, see the "Required Documentation for Benefits" chart. If you file a *Kaiser Permanente Affidavit of Domestic Partnership and Legally Recognized Partners form 3191* (available on MyKP), you and your domestic partner must certify that you meet all of the following qualifications:

- You and your domestic partner share a committed personal relationship
- You are each other's sole domestic partner
- You have not been covered by Kaiser Permanente-sponsored benefits with another domestic partner within the last six months
- You are both unmarried
- You and your domestic partner live together and share basic living expenses
- You and your domestic partner are unrelated

- You are both 18 years of age or older
- You and your domestic partner are jointly responsible for each other's common welfare

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

If you were in a previous domestic partnership, you need to submit the *Termination of Domestic Partnership form (Form 3170* – available on MyKP) 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
- Dental coverage
- Dependent Life insurance
- Employee Assistance Program (EAP)
- Continuation of medical, dental, and EAP coverage through COBRA
- Flexible Spending Accounts, only if your domestic partner and/or your domestic partner's child is your tax dependent
- Retiree Medical benefits
- Survivor pension benefits from your pension plan (in accordance with federal regulations)

Your domestic partner and/or his or her dependents may also be named as beneficiaries for life insurance and 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 MyKP 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 and dental 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 and/or dental benefits, whichever is later.

Adding and Removing a Domestic Partner

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

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

Your domestic partner coverage ends when you are no longer eligible for benefits or if your domestic partner relationship changes. If your domestic partnership changes, you must provide the NHRSC with a notarized *Termination of Domestic Partnership/Legally Recognized Partners (Form 3171* – available on MyKP) 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/Legally Recognized Partners 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 the 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 and dental benefits under the provisions of COBRA or to purchase an individual plan as described in the **Health Care** section.

Tax Effect of Domestic Partner Coverage

The Internal Revenue Service (IRS) requires Kaiser Permanente to withhold federal and Social Security taxes on the Fair Market Value (FMV) of employer-paid medical and dental 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 and dental 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 coverage through the Kaiser Foundation Health Plan (KFHP). You may choose from three medical plan options, each of which offers different coverage levels.
- You may also receive additional coverage through the Supplemental Medical Plan. Supplemental Medical coverage is automatically provided if you enroll in any of the KFHP plans.
- You may elect coverage under the Preferred Provider Organization (PPO) Plus plan. This plan is available to Out-of-Area employees only.
- If you are a call-in or part-time employee regularly scheduled to work less than 20 hours per week, but you work 20 hours or more per week for four full consecutive weeks, you may be eligible to receive Call-In Health Plan coverage available through the state of Hawaii. For information about the Call-In Health Plan please call the NHRSC.
- You may also choose to waive medical coverage provided you show proof of coverage in another medical 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 and dental 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 **Flexible 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 **mykp.kp.org**. 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.

You must enroll in *Benefits by Design* coverage within 31 days from your date of hire. See the **Flexible Benefits** section for more details.

When Coverage Ends

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

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

Patient Protection Disclosure

Kaiser Permanente 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, Kaiser Permanente 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 Kaiser Permanente 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.

Please note: Your KFHP visiting member coverage provides you medical care in a Kaiser Permanente service area outside the Hawaii region. In addition, your eligible dependent children who reside outside of a KP service area (within the U.S.A.) may continue to receive urgent care, emergency care, and limited routine medical care. For information about available services and visiting member coverage, please sign on to **kp.org** and/or refer to the *Evidence of Coverage.*

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*, please contact Member Services.

Your Medical Plan Options at a Glance

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

Kaiser Foundation Health Plan Comparison Chart

Benefits	High Plan You Pay	Mid Plan You Pay	Basic Plan You Pay
Annual Out-of-Pocket Maximum			
Individual	$2,000	$2,000	$2,000
Three or more people	$6,000	$6,000	$6,000
Outpatient Care			
Office visits for illness/injury, including specialty care and OB/GYN	$5 per visit	$10 per visit	$15 per visit
Affordable Care Act (ACA) Preventive Services, as defined by each region	No charge	No charge	No charge
Outpatient surgery	$5 per visit	$10 per visit	$15 per visit
Routine physical exams	$5 per visit	$10 per visit	$15 per visit
Lab tests and X-rays	No charge	No charge	No charge
Immunizations (preventive)	No charge	No charge	No charge
Allergy testing	$5 per visit	$10 per visit	$15 per visit
Allergy injections	No charge	No charge	No charge
Inpatient Care			
Including room and board, surgical services, nursing care, anesthesia, X-rays, and lab tests	No charge	$50 per day	$75 per day
Maternity Care			
Prenatal care	No charge	No charge	No charge
Labor, delivery, and recovery	No charge	No charge	No charge
Routine postpartum visit	No charge	No charge	No charge
Well-child care	No charge (up to age 5)	No charge (up to age 5)	No charge (up to age 5)

Benefits	High Plan You Pay	Mid Plan You Pay	Basic Plan You Pay
Family Planning			
Outpatient	$5 per visit	$10 per visit	$15 per visit
Inpatient	No charge	$50 per day	$75 per day
Fertility Services			
Outpatient	$5 per visit	$10 per visit	$15 per visit
Inpatient	No charge	$50 per day	$75 per day
In vitro fertilization (IVF) (one time benefit per lifetime)	20% coinsurance	20% coinsurance	20% coinsurance
Emergency Department			
Emergency room visits	$50 per visit; (waived if admitted)	$50 per visit; (waived if admitted)	$75 per visit; (waived if admitted)
Urgent care visits			
At a KP-facility within the Hawaii service area	$5 per visit	$10 per visit	$15 per visit
At a Non-KP-facility / outside of Hawaii service area	20% coinsurance	20% coinsurance	20% coinsurance
Ambulance			
Medically necessary or Kaiser Permanente-approved	20% coinsurance	20% coinsurance	20% coinsurance
Prescription Drugs			
Note: Prescriptions must fall within KFHP Formulary guidelines, unless specifically prescribed by a Kaiser Permanente physician			
KP Pharmacy (up to 30-day supply)	$10	$12	$15
Mail Order (up to 90-day supply)	$20	$24	$30
ACA-mandated medications	No charge	No charge	No charge
Mental Health Care			
Outpatient Individual	$5 per visit	$10 per visit	$15 per visit
Outpatient Group	$5 per visit	$10 per visit	$15 per visit
Inpatient	No charge	$50 per day	$75 per day
Substance Use Disorder			
Outpatient Individual	$5 per visit	$10 per visit	$15 per visit
Outpatient Group	$5 per visit	$10 per visit	$15 per visit
Inpatient	No charge	$50 per day	$75 per day

Benefits	High Plan You Pay	Mid Plan You Pay	Basic Plan You Pay
Skilled Nursing Facility			
Up to 120 days per calendar year	No charge	No charge	No charge
Physical, Speech, and Occupational Therapy			
Outpatient (must be prescribed by a Kaiser Permanente provider)	$5 per visit	$10 per visit	$15 per visit
Inpatient	No charge	$50 per day	$75 per day
Durable Medical Equipment (DME) and Prosthetics			
Must be prescribed by a Kaiser Permanente physician in accordance with Health Plan and DME Formulary guidelines	No charge	No charge	No charge
Vision Care			
Routine eye exams, adults	$5 per visit (limit one exam per calendar year); No charge if covered as part of a preventive exam	$10 per visit (limit one exam per calendar year); No charge if covered as part of a preventive exam	$15 per visit (limit one exam per calendar year); No charge if covered as part of a preventive exam
Routine eye exams, children up to age 19	No charge	No charge	No charge
Eyeglasses and contact lenses, adults. Note: Charges in excess of the allowance do not apply to copayment limits.	$150 allowance per calendar year toward one pair of eyeglass lenses and frames or contact lenses	$150 allowance per calendar year toward one pair of eyeglass lenses and frames or contact lenses	$150 allowance per calendar year toward one pair of eyeglass lenses and frames or contact lenses
Eyeglasses and contact lenses, children under age 19.	No charge for one pair of eyeglasses (from pre-selected collection) and lenses or contact lenses every calendar year.	No charge for one pair of eyeglasses (from pre-selected collection) and lenses or contact lenses every calendar year.	No charge for one pair of eyeglasses (from pre-selected collection) and lenses or contact lenses every calendar year.
Home Health Care			
Must be prescribed by a Kaiser Permanente physician and authorized by the Home Health committee. Custodial care not covered.	No charge	No charge	No charge

Benefits	High Plan You Pay	Mid Plan You Pay	Basic Plan You Pay
Hearing Care			
Hearing exams	$5 per visit; No charge if covered as part of a preventive exam	$10 per visit; No charge if covered as part of a preventive exam	$15 per visit; No charge if covered as part of a preventive exam
Hearing aids (Adults and children)	Up to 60% of charges (limit to two standard model aids every three years, one aid per ear)	Up to 60% of charges (limit to two standard model aids every three years, one aid per ear)	Up to 60% of charges (limit to two standard model aids every three years, one aid per ear)
Hospice Care			
Available within service area only	No charge	No charge	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.

COVID-19 Items and Services

For details about your coverage, please refer to your *Evidence of Coverage* or call Member Services.

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 EOC or call Member Services.

Additional Information About Certain Medical Services and Coverage

When You Are Expecting a Baby

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

Mastectomy Benefit

In accordance with the Women's Health and Cancer Rights Act of 1998, KFHP will cover reconstructive surgery, including reconstructive surgery on the non-diseased breast to restore and achieve symmetry, and prosthetic devices after a medically necessary mastectomy. You can request an external prosthetic device from the list of providers available from Member Services. A replacement for a prosthesis that is no longer

functional and/or a custom made prosthesis will be provided if necessary. KFHP covers treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same copayments applicable to other medical and surgical benefits provided under this plan.

When You Need Emergency Care

KFHP covers emergency care and urgent care provided at a Kaiser Permanente facility — 24 hours a day, seven days a week. Emergency care is defined as services that are provided by affiliated or non-affiliated providers after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, such that you reasonably believed that the absence of immediate medical attention could 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 and arbitration requirement, please refer to the **Disputes, Claims, and Appeals** section. You may also obtain detailed information about Medical Claims and Appeals in the *Evidence of Coverage* for your plan.

Supplemental Medical Plan

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

The Supplemental Medical Plan coverage reimburses you for certain eligible health care expenses for services that are not covered by KFHP or that exceed its limits. You may obtain care from any licensed provider. Unless your provider agrees to bill HealthPlan Services directly, you must pay for your charges and submit a HealthPlan Services claim form to be reimbursed.

For a claim form, sign on to MyKP at **mykp.kp.org**, 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 or Customer Services, as applicable, either at your local Kaiser Permanente Medical Center or by phone.

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

- Treatment of the medical condition is not available through 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

The *Authorized Evidence of Exclusion* is **not** a letter 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 or Customer Services, as applicable to obtain a denial of service letter. In general, the Supplemental Medical Plan provides coverage for the following services:

Services	You Pay	Maximum/Limits	Restrictions
Acupuncture	20%	N/A	Must be performed by a licensed acupuncturist. Services must be medically appropriate.
Alcohol and Chemical Dependency Inpatient room and board, physician visits and alternative treatment programs Outpatient Individual and group therapy	20%	N/A	Denial of service letter is required.

Services	You Pay	Maximum/Limits	Restrictions
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.
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.	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

Services	You Pay	Maximum/Limits	Restrictions
Includes room and board, ill patient physician visits and home care			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 HealthPlan Services plan 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 visits
- Private duty nursing care
- Private room in a hospital or other healthcare facility, unless due to a contagious disease
- Radiation therapy and radioactive materials used for therapeutic purposes
- Reconstructive surgery, unless otherwise required under the Women's Health and Cancer Rights Act
- Respiratory therapy
- Room and board charges, except as specifically noted in the “Covered Services” section
- Routine physical examinations
- Second and third medical opinions
- Surgery, surgeon, and assistant surgeon charges
- Ultraviolet light treatment
- Visiting nurse home visits
- Well or sick baby care

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

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

Filing a Claim

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

Preferred Provider Organization Plus Plan

This plan is available to Out-of-Area employees only.

The Preferred Provider Organization Plus (PPO Plus) plan allows you the choice of visiting any physician or medical facility to receive coverage. However, the plan pays higher benefits when you use physicians and facilities in the Cigna PPO network. For a list of providers, go online at **www.myCigna.com** or contact Cigna Healthcare at **855-429-1426**. You share the cost of PPO Plus expenses through deductibles and coinsurance.

Under the PPO Plus plan, you are responsible for filing your own claims and requesting any necessary forms if you utilize an out-of-network provider or facility. The PPO Plus plan is administered by Cigna Healthcare. You may visit their website at **www.myCigna.com**.

Prescription benefits under the PPO Plus plan are provided through the Cigna Healthcare pharmacy network. For a list of participating pharmacies or additional information about the prescription benefit, go online at **www.myCigna.com** or contact Cigna Healthcare at **855-429-1426**.

Annual Deductible

Before you begin to receive PPO Plus benefits, you must meet an annual deductible. Your annual deductible is:

- Individual coverage: $300
- Family coverage: $300 per person up to a maximum of $900 per family

Copayments may not be used to meet the deductible.

After you have paid the annual deductible, you share the cost of covered services by paying coinsurance, as shown in the Covered Services chart in this section. Cigna Healthcare will authorize payment of a percentage of the Maximum Reimbursable Charges (MRC) for out-of-network services charges, which are determined by

a review of 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 MRC for a particular service, you will be responsible for your percentage of MRC (according to the out-of-network costs in the chart below) and the full amount of any costs above the MRC.

Annual Out-of-Pocket Maximums

You have a maximum out-of-pocket cost for covered services in any calendar year. Your annual out-of-pocket maximums are:

Coverage	In-Network	Out-of-Network
Individual	$2,500	$5,000
Family	$4,000	$10,000

After you meet your out-of-pocket maximum, the PPO Plus plan will begin to cover MRC at 100% for the remainder of the calendar year. The following charges are not used to meet the out-of-pocket maximum:

- Charges for services that are not covered
- Charges for nursing services and custodial care
- Out-of-network charges in excess of MRC
- Charges incurred for failing to obtain timely pre-certification

In-Network Coverage

The PPO Plus plan provides you with access to the Cigna PPO network. In order to be covered under the in-network benefit, you must use the Cigna PPO network to receive your care.

Out-of-Network Coverage

If you see a physician outside the Cigna PPO network or need services not available within the network, you will pay a higher percentage of the total costs. You must pay the deductible before the plan pays benefits, except for prescription drugs (when followed by inpatient admission).

Pre-Certification

Whether or not you choose to use a network provider when you need hospitalization, including inpatient treatment, and certain outpatient procedures and diagnostic testing, you must receive pre-certification before you receive services. If you do not, the benefits payable under this plan will be reduced. In addition, failure to undergo pre-certification for out-of-network services will result in a $500 penalty applied to hospital inpatient or outpatient/diagnostic testing charges. The responsibility to initiate pre-certification will be determined as follows:

- If you go to a physician who is a participating provider, it is the responsibility of the participating physician to initiate pre-certification.
- If you go to a non-participating physician, it is your responsibility or that of your designated representative to initiate pre-certification.

For more information or to initiate a pre-certification, contact Cigna Healthcare at **855-429-1426**.

PPO Plus Plan at a Glance

In general, the PPO Plus plan provides coverage for the following medically necessary services:

Covered Services	In-Network Copay	In-Network Plan Pays	Out-of-Network Plan Pays	Maximum	Restrictions/ Comments
Office Visits (primary care)	$20 per visit	100%	90%		No charge for in-network preventive care
Office Visits (specialists)	$20 per visit	90%	90%		
Preventive Care and Immunizations	$0	100%	90%	N/A	If immunization is billed with an office visit on the same day, a $20 copayment applies.
Prescribed Drugs — Filled at a Participating Retail Pharmacy	$10 for generic $20 for formulary brand $30 for non-formulary brand	100%	70%	30-day maximum supply	Pharmacy plan does not cover injection drugs (other than insulin); see Infertility and Immunization sections for information on drug coverage for those services. Contraceptive devices and contraceptive drugs covered at 100%.
Prescribed Drugs — Mail Order filled through a Participating Pharmacy	$20 for generic $40 for formulary brand $60 for non-formulary brand	100%	N/A	90-day maximum supply	Pharmacy plan does not cover injection drugs (other than insulin); see Infertility and Immunization sections for information on drug coverage for those services. Contraceptive devices and contraceptive drugs covered at 100%.

Covered Services	In-Network Copay	In-Network Plan Pays	Out-of-Network Plan Pays	Maximum	Restrictions/ Comments
Prescribed Drugs — Long-Term Maintenance filled at a Participating Mail Order Pharmacy	$30 for generic $60 for formulary brand $90 for non-formulary brand	100%	70%	90-day maximum supply	Pharmacy plan does not cover injection drugs (other than insulin). See Infertility and Immunization sections for information on drug coverage for those services. Contraceptive devices and contraceptive drugs covered at 100%.
Abortion — elective and therapeutic	$0	90%	90%	N/A	
Acupuncture	$0	90%	90%	Annual limit 25 visits	Services must be performed by a licensed acupuncturist and be medically appropriate
Allergy Testing and Treatment	$0	90%	90%	N/A	
Ambulance	$0	90%	90%	N/A	Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.
Anesthesia	$0	90%	90%	N/A	
Bariatric Surgery	$0	90%	90%	N/A	
Biofeedback, Occupational, Physical, Physio, Rehabilitation, and Speech Therapy	$0	90%	90%	N/A	Must be prescribed by a physician

Covered Services	In-Network Copay	In-Network Plan Pays	Out-of-Network Plan Pays	Maximum	Restrictions/ Comments
Breast Feeding Supplies	$0	100%	N/A	N/A	Limited to the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.
Chemotherapy	$0	90%	90%	N/A	
Immunizations	$0	100%	90%		If billed with same day office visit, a $20 copay applies
Chiropractic Services	$0	70%	70%	$1,000 annual limit	Licensed chiropractor only
Dental Care for Accidental Injuries	$0	90%	90%	N/A	Covers reconstructive surgery required as a result of an accident injury treatment and must be received within 12 months of the accidental injury.
Dermatology	$0	90%	90%	N/A	
Dialysis	$0	90%	90%	N/A	
Durable Medical Equipment (DME)	$0	90%	90%	N/A	Pre-certification required for certain out-of-network DME. Failure to undergo pre-certification will result in a $500 deductible penalty for certain types of out-of-network DME (i.e., CPAP machines and wheelchairs).
Elective Sterilization	$0	100%	90%		
Emergency Room Services	$100	100%	100% after $100 copay	N/A	$100 copayment waived if admitted. Includes Professional, X-ray and/or Lab services

Covered Services	In-Network Copay	In-Network Plan Pays	Out-of-Network Plan Pays	Maximum	Restrictions/ Comments
					performed at the Emergency Room and billed by the facility as part of the ER visit.
Gender Transition	$0	90%	90%		See Gender Transition Exclusions and Limitations
Hearing Tests	$0	90%	90%	N/A	
Home Health Services	$0	90%	90%	Annual limit 100 days; 16 hours maximum per day	Includes outpatient private duty nursing when approved as medically necessary. Pre-certification required.
Hospice	$0	100%	100%		Requested by attending physician/ hospital. Failure to undergo pre-certification will result in a $500 deductible penalty for out-of-network facility.
Hospital — Inpatient and/or Outpatient	$0	90%	90%	N/A	Pre-certification required for inpatient hospital services. Failure to undergo pre-certification will result in a $500 deductible penalty for out-of-network facility.
Infertility Services	$0	90%	90%	$30,000 lifetime maximum	Includes coverage for infertility drugs. Surrogacy services not covered.
Lab Tests, X-rays, and Other Diagnostic Tests	$0	90%	90%	N/A	No charge for preventive tests or screenings subject

Covered Services	In-Network Copay	In-Network Plan Pays	Out-of-Network Plan Pays	Maximum	Restrictions/ Comments
					to certain guidelines such as age and frequency.
Mammography, PAP, and PSA Exam	$0	100%	100%	One per calendar year	May be subject to certain guidelines such as age.
Maternity	$0	90%	90%	N/A	
Mental Health Services — Inpatient	$0	90%	90%	N/A	Pre-certification required. Failure to undergo pre-certification will result in a $500 deductible penalty for out-of-network facility.
Mental Health Services — Outpatient	$20	100%	90%	N/A	Pre-certification required. Failure to undergo pre-certification will result in a $500 deductible penalty for out-of-network non-routine services (i.e., partial hospitalization).
Organ Transplants Through Cigna LifeSOURCE Facility	$0	100%	N/A		Transplant services must be authorized through Cigna LifeSOURCE facility for services to be covered 100%. Transplants determined to be experimental not covered. Stem cell and live organ transplants are covered. Donor services are covered for both stem cell and live organ transplants.

Covered Services	In-Network Copay	In-Network Plan Pays	Out-of-Network Plan Pays	Maximum	Restrictions/ Comments
Organ Transplants Through Non-LifeSOURCE Facility	$0	90%	90%		Transplants determined to be experimental not covered. Stem cell and live organ transplants are covered. Donor services are covered for both stem cell and live organ transplants.
Prosthetic and Orthotic Devices	$0	90%	90%		A diagnosis of physical impairment indicating the device is medically necessary is required.
Radiation Therapy	$0	90%	90%		Includes coverage for therapeutic radioactive materials.
Reconstructive Surgery	$0	90%	90%		Must be within one year if required as a result of an accident.
Skilled Nursing Facility, Rehabilitation Hospital	$0	90%	90%	Annual limit 100 days	Pre-certification required. Failure to undergo pre-certification will result in a $500 deductible penalty for out-of-network facility.
Shock Therapy	$0	90%	90%		Subject to deductible if services are for other than an office visit.
Substance Use Disorders — Inpatient	$0	90%	90%	N/A	Pre-certification required. Failure to undergo pre-certification will result in a $500

Covered Services	In-Network Copay	In-Network Plan Pays	Out-of-Network Plan Pays	Maximum	Restrictions/ Comments
					deductible penalty for out-of-network facility.
Substance Use Disorders — Outpatient Individual/Group Therapy Visits	$20	100%	90%	N/A	Pre-certification required. Failure to undergo pre-certification will result in a $500 deductible penalty for out-of-network non-routine services (i.e., partial hospitalization).
Surgery Performed in a Physician's Office — Primary Care	$20	100%	90%	N/A	
Surgery Performed in a Physician's Office — Specialty Care	$20	90%	90%	N/A	
Temporomandibular Joint Disorder (TMJ) Treatment	$0	90%	90%	N/A	Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.
Travel Services	$0	100%	N/A	Medical Lifetime Maximum: $10,000	See Travel Services
Ultraviolet Light Treatments	$0	90%	90%	N/A	Subject to deductible if services are for other than an office visit.
Urgent Care	$20	90%	90%	N/A	Includes Professional, X-ray and/or Lab services performed

Covered Services	In-Network Copay	In-Network Plan Pays	Out-of-Network Plan Pays	Maximum	Restrictions/ Comments
					at the Urgent Care Facility and billed by the facility as part of the urgent care visit.
Vision Care Eye Examinations	$20	100%	60%	Limit one exam per 12-month period	Charges in excess of usual and customary are the responsibility of the member.
Contact lenses for adults or children or eyeglass frames plus lenses for adults	N/A	$175	$175	Allowance every 24 months	Charges in excess of reasonable and customary are the responsibility of the member.
Frames plus lenses for children up to age 19	$0	100%	N/A	One pair of basic eyeglass frames plus lenses every 12 months	Charges in excess of reasonable and customary are the responsibility of the patient/employee
Urgent or Emergency Medical Care Outside the U.S.	N/A	N/A	90%	N/A	Medically necessary hospital / emergency only.

Please note: Coinsurance applies after deductible is met. Restrictions apply to both in-network and out-of-network services, unless otherwise noted.

Preventive Services

In accordance with the Patient Protection and Affordable Care Act and applicable regulations, the PPO Plus plan pays in-network covered services at 100% for the following preventive services:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (Task Force) with respect to the individual involved.
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

- With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force), including IUDs and diaphragms which are covered at 100%, in network.

Your physician may recommend additional services based on your family or medical history, which may not be covered at 100%.

Preventive services that must be covered at 100% change from time to time. Please contact Cigna Healthcare for a list of routine preventive services that may be covered by the PPO Plus plan.

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.

Copayment and/or cost share will apply for telemedicine services. You may need to submit a claim to get reimbursed if accessing an out-of-network provider. Certain Cigna PPO plan providers may not offer telemedicine appointments. Please check with your provider.

Exclusions and Limitations

The PPO Plus plan excludes and limits certain services. If you have questions about whether or not a particular service is covered, contact Cigna Healthcare at **855-429-1426**, or online **www.myCigna.com**. The following services are not covered under the PPO Plus plan:

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Covered Expense (as shown on The Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an In-Network benefits level or some other benefits level not otherwise applicable to the services received.
- Charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.

- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational, and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies or devices are experimental, investigational and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- The following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental Injury to teeth are covered provided a continuous course of dental treatment is started within twelve months of an accident.
- Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.

- Reversal of male or female voluntary sterilization procedures.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to garter belts, corsets, dentures and wigs.
- Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- All non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.

- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are medications to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under Covered Expenses.
- Massage therapy.

Gender Transition

If medically appropriate, the plan covers the cost of authorized gender transition surgery up to the covered charges for gender transition surgical services, less any cost sharing that you paid for those services.

- Genital surgery (male to female - clitoroplasty, labiaplasty, penile skin inversion, vagina construction, bilateral orchiectomy, penile amputation, urethromeatoplasy, plastic repair of intoitus, vaginoplasty) (female to male - hysterectomy, salpingo oopherectomy, colpectomy, phalloplasty, urethroplasty, scrotoplasty, plastic glans formation, Insertion of penile and testicular prosthesis)
- Breast augmentation and mastectomy

Exclusions

- Non-Genital Surgery - Male to Female (tracheal shaving, rhinoplasty, lipoplasty of the waist, facial bone reduction, face lifts, blepharoplasty, voice modification surgery) or Female to Male (liposuction and cosmetic chest reconstruction)
- Non-Genital Surgery - Female to Male (liposuction to reduce fat in hips thighs and buttocks; cosmetic chest reconstruction
- Cosmetic Surgery - Male to Female or Female to Male.
- Electrolysis or laser hair removal, except when used to prepare the perineum for SRS (Sexual Reassignment Surgery) and pharmaceuticals such as Vaniqa
- Voice therapy lessons
- Sperm procurement and storage in anticipation of future infertility, Gamete preservation and storage in anticipation of future infertility, Cryopreservation of fertilized embryos in anticipation of future infertility
- Surgery or other Services that are intended primarily to change or maintain your appearance, voice, or other characteristics, except for the covered transgender surgery services listed in this section

- Referrals outside the United States

Travel Services

Authorized eligible travel and lodging expenses when an In-network facility/provider is not available with a 60 miles radius from your primary home residence. Coverage for designated services only: services with state legislative limitations on access (e.g., abortion, gender affirmation services), In-patient and Outpatient Mental and Substance Use Disorder Services. Coverage when traveling to an in-network provider/facility only.

Lodging Limits: Hotel or similar accommodations if an overnight stay is required prior to or following a covered procedure limited to the charge for a single (double occupancy) room, including taxes, not to exceed $50/night, per person up to 2 people, for 1 or 2 nights as required, unless a longer stay was recommended by a physician. Does not include meals, international travel, hotel movies, entertainment, or any other services not specifically listed.

Filing a Claim

For information about PPO Plus plan claims and appeals procedures, please refer to the **Disputes, Claims, and Appeals** section.

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 isn’t 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.

Dental Plan Coverage

Benefits by Design offers you a choice of two dental plans — the Basic and Comprehensive plans.

You may also elect to waive dental coverage.

Who Is Eligible

You are eligible for dental 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.

When Coverage Begins

Dental coverage for you and your eligible dependents begins on the first day of the month following three months of employment.

How Dental Coverage Works

Hawaii Dental Service

With the Hawaii Dental Service plan you may visit any dentist you like, but visiting a dentist within Hawaii Dental Service's network of providers will save you money.

If you choose to have services performed by a non-participating dentist, you are responsible for the difference between the amount that the non-participating dentist actually charges and the amount paid by Hawaii Dental Service in accordance with your plan.

You can often make your annual dental maximum go further by choosing a dentist in Hawaii Dental Service's network, since he or she may charge less for the same services.

There are several ways to find a plan dentist:

Hawaii Dental Service

- Ask your current dentist if he or she participates in the Hawaii Dental Service network
- Call **844-379-4325** for a directory of participating dentists in your area
- View the Hawaii Dental Service directory online at **www.deltadentalhi.com**

Covered Services

The following chart provides details on the types of services and coverage levels provided by the Hawaii Dental Service plan.

Usual, Customary, and Reasonable Charges

In general, you pay the listed percentage of Usual, Customary, and Reasonable Charges (UCR) for these services. A Usual fee is the amount which an individual dentist regularly charges and receives for a given service or the fee actually charged, whichever is less. A Customary fee is within the range of usual fees charged and received for a particular service by dentists of similar training in the same geographic area. A Reasonable fee schedule is reasonable if it is Usual and Customary. Additionally, a specific fee to a specific patient is reasonable if it is justifiable considering special circumstances, or extraordinary difficulty, of the case in question.

Benefits and Covered Services	Comprehensive Your Cost	Basic Your Cost	Limitations
Diagnostic and Preventive Services			
Includes oral exams, teeth cleanings, X-rays, and sealants	No charge	No charge	Two oral exams and teeth cleanings per year; one fluoride treatment per year through age 17; one full mouth X-ray every five years; children

Benefits and Covered Services	Comprehensive Your Cost	Basic Your Cost	Limitations
			under age 15: two bitewing X-rays per year; children age 15 and older and adults: one bitewing X-ray per year
Basic Services			
Routine restoratives, including fillings	No charge	20%	
Endodontics			
Includes root canals	No charge	20%	
Periodontics			
Includes gum treatment	No charge	20%	
Oral Surgery	No charge	20%	
Major Services			
Includes crowns, inlays, onlays, and cast restorations	No charge	50%	Covered once every five years on the same tooth
Prosthodontics			
Bridges and dentures	40%	50%	In most cases covered once every five years
Dental implant surgery	40%	50%	
Orthodontics			
For children up to age 26 only	50%	50%	$1,500 lifetime maximum per child
Annual Deductible			
Individual	None	$50	
Family	None	$150	
Annual Maximum	$1,500	$1,500	Per person, per calendar year

Predetermination of Benefits

When you have a dental problem, a variety of corrective treatments may be available. The Hawaii Dental Service plan limits payment to certain corrective procedures. The Hawaii Dental Service plan has a prior authorization procedure called “predetermination of benefits.” This process permits review of the proposed treatment and allows your carrier to resolve any questions before, rather than after, the work is done, and is

required for any service over $400. As a result, both you and your dentist know in advance which treatments are covered and the estimated costs of those covered treatments. A predetermination of benefits does not guarantee payment. Call the HDS Customer Service toll-free at **844-379-4325** for a predetermination of benefits.

Services Not Covered

The following are exclusions and are not payable by the HDS Plan:

- Services that are not included as a benefit on the Contract's schedule of covered benefits;
- Services that are not covered procedure codes in the HDS Procedure Code Guidelines;
- Services to correct or alleviate congenital malformations including, but not limited to, cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorosis, and anodontia;
- Services to correct occlusion and services other than those for the replacement of structure loss from caries that are necessary to alter, restore, or maintain occlusion including, but not limited to, increasing vertical dimension, equilibration, periodontal splinting, orthodontic splinting, other splinting, restoration of tooth structure lost from attrition, abrasion, abfraction or temporomandibular joint ("TMJ"), restoration for tooth malalignment, gnathological recording, and treatment of disturbances of the temporomandibular joint;
- Charges for hospitalization including an emergency room visit;
- Services to correct or cure injuries or conditions covered under workers' compensation or other employer liability laws;
- Cosmetic services including, but not limited to, teeth whitening, cosmetic surgery, enamel hypoplasia, fluorosis, and anodontia;
- Ambulance services and any other means of transport;
- Services payable by a governmental entity, the Member's medical plan, or by another party; and
- All taxes imposed on services received by a Member.

For a complete list of exclusions or for more information about your plan, please contact HDS (see the **Contact Information** section).

When Coverage Ends

Your dental coverage ends on the last day of the month in which your employment with Kaiser Permanente ends or you no longer meet the eligibility requirements. Coverage for your dependents will end when your coverage ends or at the end of the month in which they become ineligible for coverage. However, you and/or your dependents may continue dental coverage through COBRA or purchase an individual plan, if available. If you do not elect dental coverage, you will not be eligible for COBRA dental coverage when you leave or change to an ineligible status.

For more information on enrolling in individual coverage, contact Hawaii Dental Service (see the **Contact Information** section). For more information on COBRA, see "Continuation of Benefits under COBRA."

Filing a Claim

For information about how to file a claim for dental benefits, or to appeal a denied claim, please refer to the **Disputes, Claims, and Appeals** section.

Survivor Benefits

In addition to the survivor benefits currently described in your SPD, the following Kaiser Permanente-administered benefits, which may be taxable in accordance with the law, will also be extended to your currently covered eligible surviving dependents for a set period of time should you die while still employed:

Medical Plan Benefits

Basic Medical Plan benefits will be provided to your covered surviving dependents — spouse, domestic partner, or registered civil union partner, and eligible dependent children up to the plan's limiting age — at the time of your death at Kaiser Permanente's expense for a period of time equal to one-half your length of service, using your service date (adjusted date of hire). Coverage for your spouse, domestic partner, or registered civil union partner may end sooner if he or she dies, remarries, or enters into a new domestic partnership, or civil union partnership. Coverage for your dependent children will continue until they no longer meet the eligibility requirements. Once any of your dependents become eligible for Medicare, he or she must enroll in all applicable parts of Medicare and assign Medicare benefits to Kaiser Permanente Senior Advantage to maintain Basic Medical Plan coverage.

Supplemental Medical Benefits

Your eligible surviving dependents and spouse, domestic partner, or registered civil union partner will maintain coverage in the Supplemental Medical Plan until the last day of the month in which you terminate employment with Kaiser Permanente.

Dental Benefits

Dental coverage for your covered eligible surviving dependents — spouse, domestic partner, or registered civil union partner, and eligible dependent children — at the time of your death will continue for three months after your official employment termination date or up to the plan's limiting age, whichever is earlier.

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:
   - the parents are married or living together, whether or not they have ever been married, and are not legally separated; or
   - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
6. If two or more plans cover a dependent child of parents who are divorced, separated, or living apart due to termination of a domestic partnership, and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
   - the parent with custody of the child; then
   - the spouse of the parent with custody of the child; then
   - the parent not having custody of the child; then
   - the spouse of the parent not having custody of the child;
7. Plans for active employees pay before plans covering laid-off or retired employees;
8. If the above do not apply, the plan that has covered the individual claimant the longest will pay first; only expenses normally paid by the plan will be paid under COB; and
9. Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

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. If you have funds available, you can use your Health Care Flexible Spending Account to pay for eligible expenses not paid by the primary plan or this plan.

Determining the Allowable Expense When This Plan Is Secondary

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

Allowable Expenses

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

When a Covered Person Qualifies for Medicare

Determining Which Plan Is Primary

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

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

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

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

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

Right to Receive and Release Needed Information

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

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

Overpayment and Underpayment of Benefits

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

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

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

Refund of Overpayments

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

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

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

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

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

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

Health Care Continuation

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

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

In addition, you may be able to continue your Health Care Flexible Spending Account (Health Care FSA) under COBRA on an after-tax basis, which may include reimbursement for health care expenses for you and your eligible dependents.

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
- Dental plan
- Health Care FSA
- Employee Assistance Program

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

When You Are Eligible

If You Have a Change in Employment Status

You and your eligible dependents covered under the Kaiser Permanente-sponsored plans, are eligible to continue medical and dental coverage, as well as continue participating in the Health Care FSA, 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 you 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 change medical and dental options. You may also drop coverage for a family member or add the following dependents during any open enrollment:

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

Special Enrollment Rights

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

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

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

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

For more information on policies regarding Military Leaves, refer to the national HR Policies library, available on MyKP, or contact the NHRSC.

If You Die

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

If You or Your Dependents Are Disabled

If you 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 or your eligible dependents are no longer disabled.

COBRA Election Procedures

You and your eligible dependents who lose medical and/or dental coverage due to employment termination or reduction in hours or due to certain unpaid leaves of absence will be 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 limits, 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.

Health Care Flexible Spending Account COBRA Continuation

COBRA coverage under the Health Care FSA is offered to qualified beneficiaries who were enrolled in the Health Care FSA on the day before the qualifying event and have voluntary contributions remaining in their accounts. You may elect to continue to participate on an after-tax basis when you receive the COBRA election notice. However, you will be responsible for sending your current contribution each month directly to HealthEquity/WageWorks, our third-party administrator. This payment — made payable to WageWorks — should be mailed as a separate check each month. Please mail your check to the following address:

HealthEquity/WageWorks
P.O. Box 660212
Dallas, TX 75266-0212

If you fail to send your contributions by the due date, you will no longer be considered a participant in the plan. Expenses can be claimed up to the maximum amount elected for the calendar year, provided the eligible expenses are incurred while you are an active participant in the plan. Claims must be submitted prior to March 31 of the following year. The **use-or-lose** rule will apply, so any funds unclaimed after this date will be forfeited.

When Coverage Ends

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

- You and your eligible dependents become covered under any other group medical or dental plan
- You and 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 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 and/or dental plan. In addition, your eligible dependents may be eligible to extend coverage under COBRA for an additional 18 months or purchase an individual medical and/or dental plan. For full details about your COBRA coverage rights, contact HealthEquity/WageWorks.

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

COBRA Continuation for Retiree Health Benefits

Your covered eligible dependents may continue retiree health benefits under COBRA for the following plans, as applicable:

- Retiree medical plans
- Retiree Medical Health Reimbursement Account (Retiree Medical HRA) benefits

When You Are Eligible

Your covered eligible dependents may elect to continue coverage for up to 36 months, if the retiree health benefits end for one of the following qualifying events:

- You divorce, annul your marriage, or legally separate from your spouse, or terminate your domestic partnership, or
- Your children no longer qualify for dependent coverage under the terms of the plan, or
- Your death, unless there are survivor benefits (and coverage would not end) under the terms of the plan, or
- Commencement of bankruptcy proceedings by Kaiser Permanente.

Your HRA balance is prorated for divorce, annulment, and legal separation. If the HRA has a zero balance at the time of the qualifying event, COBRA coverage for the account will not be available. In addition, COBRA coverage for you and your covered dependents will end before the 36-month maximum period if the account has a zero balance.

Benefits for your covered eligible dependents while enrolled in COBRA coverage will be the same retiree health benefits you had immediately prior to the qualifying event.

If any changes are made to the retiree health benefits for non-COBRA participants, including changes to copayments or benefits, those changes will apply to you and your dependents.

COBRA Election Procedure

To elect to continue retiree health benefits through COBRA, you and your eligible dependents must contact the KPRC to provide notice of a qualifying event. Notice of a qualifying event must be provided to the KPRC within 60 days for divorce, legal separation, or loss of dependent status under the plan. They will, in turn, notify HealthEquity/WageWorks.

Your covered eligible dependents will be provided with a COBRA election form, which they must fill out and return within 60 days of the notification date shown on the form, or loss of coverage date, if later. If they do not return the form within 60 days of the notification date or the loss of coverage date, if later, HealthEquity/WageWorks will assume that coverage has been declined.

When Coverage Ends

COBRA coverage for the retiree health benefits will stop before the end of the 36-month maximum period if any of the following situations occur:

- Your eligible dependents become covered under any other group health plan
- You fail to pay the required premium on time
- Kaiser Permanente terminates all of its retiree health benefits

- For the HRA, when the account has a zero balance

Overview of Flexible Spending Accounts

Kaiser Permanente offers you two flexible spending accounts:

- Health Care Flexible Spending Account (Health Care FSA)
- Dependent Care Flexible Spending Account (Dependent Care FSA)

The flexible spending accounts allow you to set aside a portion of your pay through payroll deductions on a pre-tax basis to reimburse eligible health care and dependent care expenses that your benefits do not cover. The money you would have paid in taxes can instead be used to pay for qualified health care and dependent care expenses.

Since there is a tax advantage to participating in the spending accounts, the Internal Revenue Service (IRS) has strict rules and requirements for using the accounts. This section describes the general rules and requirements that are common to the spending accounts.

Who Is Eligible

You are eligible to participate in the flexible spending accounts if you are regularly scheduled to work 20 or more hours per week in an eligible status. You cannot be reimbursed for Dependent Care FSA expenses incurred while you are on a leave of absence.

There are additional eligibility requirements for the Dependent Care FSA (see “Additional Eligibility Requirements” for the Dependent Care FSA for more information).

When You Can Enroll

You may enroll in the Health Care and/or Dependent Care Flexible Spending Accounts at the following times:

- During your initial enrollment in Benefits by Design
- During the annual open enrollment period for the following plan year
- Within 31 days of a qualifying family or employment status change

Note: For the Dependent Care Flexible Spending Account only, you may make a mid-year enrollment change if you experience a significant change in your dependent care expenses, provided the change is imposed by a dependent care provider who is not your relative.

Payroll deductions for flexible spending accounts will appear on your pay notice after participation begins.

See the **Flexible Benefits** section for information about how to enroll.

Continuing Your Flexible Spending Account

You must re-enroll in your Health Care and/or Dependent Care Flexible Spending Accounts each year during open enrollment to continue participation. Otherwise, your contributions will revert to $0.

How the Spending Accounts Work

Based on your expected eligible health care and dependent care expenses, you decide how much you want to contribute to the Health Care and/or Dependent Care Flexible Spending Accounts, up to the plan contribution limits.

The amount you choose to put in an account is contributed over the plan year in equal installments. Deductions are made from the first two paychecks of each month. Since contributions are made before taxes are withheld, you do not pay Social Security tax, federal income tax, and in most areas, state income taxes on the money you put into a spending account.

When you have an eligible expense, you submit a claim for reimbursement to HealthEquity, the third-party administrator.

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

Rules You Should Know

The following restrictions apply to spending accounts:

- You must enroll each year during open enrollment if you wish to contribute to a flexible spending account for the following year. Your election does not automatically carry over from year to year. If you do not submit an election, your contribution will revert to $0 and you will not be enrolled for the following plan year
- Flexible spending accounts have different use-or-lose rules.

  Health Care FSA: You cannot receive a refund of your remaining Health Care FSA balance. However, you may carry over to the following plan year up to 20% of the annual maximum allowed contribution. Any remaining balance in excess of the allowed carry over amount for which you have not filed eligible claims by March 31 of the following plan year will be forfeited.

  Dependent Care FSA: You cannot receive a refund or carry over your balance from one year to the next. Any remaining balance for which you have not filed eligible claims by March 31 of the following plan year will be forfeited. This means that you need to calculate your expenses carefully to avoid overestimating.

- Expenses incurred prior to the effective date of your participation are not eligible under the flexible spending account plan rules and will not be reimbursed.
- The contributions that you make during a plan year must be used for expenses incurred while you are participating in the plan during that calendar year, except for the 20% annual maximum allowed contribution you can carry over from one year to the next with the Health Care FSA. However, you have until March 31 of the following year to file your claims.
- If you are on an unpaid leave of absence, including Family Medical Leave, your Health Care FSA contributions will stop unless you contact the NHRSC within 31 days of your status change to arrange after-tax contributions to your Health Care FSA. Please note that any qualifying expenses you incur during an unpaid leave of absence will not be reimbursed unless you are making after-tax contributions to your account.

- If you return to work from a leave of absence:

  - **During the same plan year,** you continue to be responsible for your original annual election amount. Therefore, your Health Care and/or Dependent Care Flexible Spending Accounts will restart when you return to active employment and your contributions will be increased so that at the end of the year you will have contributed the full amount of your annual election. However, you must notify the NHRSC within 31 days of returning from a leave of absence in order to change your contribution amount.
  - **During the following plan year,** your contributions will not automatically restart. This includes any Health Care and/or Dependent Care Flexible Spending Accounts elections you may have made during Open Enrollment. You must notify the NHRSC within 31 days of returning from leave if you want to enroll for the current plan year and elect your contribution amount.
- If you participate in both the Health Care FSA and the Dependent Care FSA, the two spending accounts are completely separate. You cannot transfer funds from one account to the other or use the funds in one account to pay for expenses covered under the other account.
- You will not be able to change your contribution amount or enroll in the plan outside of open enrollment unless you have a qualifying family or employment status change. For the Dependent Care FSA only, if you experience a significant change in the cost of your dependent care expenses (provided the change is not imposed by a dependent care provider who is a relative), you may be eligible to make a mid-year enrollment change. For more information see “Family and Employment Status Changes.”
- IRS rules require flexible spending accounts to be nondiscriminatory with regard to participation rates and average salary reduction amounts. 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.
- If you terminate your employment with Kaiser Permanente or become ineligible to participate in the flexible spending accounts, you may only continue to file claims for expenses incurred prior to your termination or change in status. Claims must be filed by March 31 of the year following your termination or change in status.
- You may elect to continue participation in the Health Care FSA through COBRA and submit claims for eligible expenses incurred after your termination or change in status date. However, your contributions will be made on an after-tax basis, so you will not realize any tax savings.

Tax Considerations

When you contribute to a flexible spending account, you lower your current Social Security, federal income tax, and in most cases, state income taxes. Another way to lower your income tax is to take a tax deduction for your eligible medical expenses or tax credit for dependent day care expenses when you file your income tax return. If you use the flexible spending accounts, you cannot also take a deduction or claim a federal or state tax credit for the same health care and/or dependent care expenses on your tax return. You may want to consult your tax advisor for more information about the best choices for your situation.

When You Leave

If you have a balance in your Health Care and/or Dependent Care Flexible Spending Accounts when your employment ends, you may continue to submit claims until March 31 of the following year for eligible expenses incurred prior to your termination date. Any funds that cannot be reimbursed for qualified expenses will be forfeited to the plan.

Health Care Flexible Spending Account

You can enroll in a Health Care Flexible Spending Account (Health Care FSA) to set aside pre-tax dollars for anticipated health care expenses not covered by your medical and dental plans, such as deductibles and copayments for you and your eligible dependents.

Your Contributions

The maximum Health Care FSA annual contribution in 2026 is $3,300. For the most up-to-date annual maximum contribution, sign on to MyKP. Your contributions are deducted from your pay in 24 equal amounts, which are reflected on the first two pay statements of each month throughout the year. The minimum pay period contribution is $10. If you become eligible for the Health Care FSA mid-year, the annual maximum is still available to you. In other words, you may elect a higher per-pay-period contribution in order to contribute the maximum amount over the remaining pay periods for that calendar year.

Carryover Contributions

If at the end of the plan year you have an unused Health Care FSA balance, you may carry over to the following plan year up to 20% of the annual maximum allowed contribution. Any remaining balance in excess of the allowed carry over amount for which you have not filed eligible claims by March 31 of the following plan year will be forfeited.

The carryover amount is separate from the Health Care FSA annual plan maximum allowed. This means your carryover balance is added to your Health Care FSA contributions for the new plan year.

If you do not make new Health Care FSA contributions for the following plan year during the annual open enrollment period, you may use your carryover balance.

Changing Your Contributions

You may change the amount you contribute to a Health Care FSA during the annual open enrollment period, for participation during the following year.

You cannot change your spending account contributions during the year unless you have a qualifying change in family or employment status. For a list of qualifying events, see “Family or Employment Status Changes” in the **Flexible Benefits** section.

You have 31 days from the date of the qualifying event to contact the NHRSC to start, stop, increase, or decrease contributions to a Health Care FSA. The contribution change must be consistent with the applicable event. For example, if your dependent child loses eligibility for benefits because he or she reaches the age limit, you may not increase your contributions to your Health Care FSA.

Eligible Dependents

You can use the Health Care FSA to pay for eligible health care expenses for yourself, your spouse, and your children — even if they are not eligible for, or enrolled in, one of the Kaiser Permanente-sponsored health care plans. You may also use the Health Care FSA for other members of your family and household if they qualify

as your tax dependent for health coverage purposes. Family and household members whose expenses are eligible for reimbursement from the Health Care FSA include the following:

- Your spouse (unless you are divorced, legally separated, or your marriage was annulled)
- Your or your spouse's child, legally adopted child, or a child placed with you for legal adoption under the age of 26, regardless of tax-dependent status
- Any relative, including a child age 26 or older, grandchild, brother, sister, parent, aunt, uncle, niece, or nephew, if you provide over one-half of his or her support in the calendar year
- Any non-relative who is a member of your household, including a qualified domestic partner who resides with you for the entire calendar year and receives more than one-half of his or her support from you and qualifies as a dependent on your federal income tax return

To be eligible, a dependent cannot be the qualifying child of another person. For example, if your domestic partner's child lives with you, that child cannot be your eligible dependent for the Health Care FSA if he or she is the tax dependent of your domestic partner or the child's other parent, even if you provide more than half the support for that child.

If an eligible child is not your tax dependent, a reimbursement claim for that child might need to be reported as taxable income for state tax purposes only.

Remember, the definition of eligible family members for the Health Care FSA may differ from the one used for dependent medical and dental coverage and from the one used in determining your personal income taxes. Contact your tax advisor if you have questions about an individual's qualification as your tax dependent.

Eligible Expenses

You may use your Health Care FSA to pay for expenses not covered or reimbursed through any health care plan. Below are some of the most common eligible Health Care FSA expenses:

- Acupuncture
- Alcoholism or drug dependency treatment
- Ambulance services
- Automobile modifications for disabled (*Letter of Medical Necessity* required)
- Birth control that has been prescribed
- Body scans for preventive purposes
- Chiropractic care
- Contact lenses, contact lens solution, and eyeglasses
- Deductibles and copayments
- Dental treatment (excludes teeth whitening)
- Expenses over your health care plan limits
- Eye surgery, radial keratotomy, LASIK, and vision correction
- Guide dog, service animal, or other such animal (*Letter of Medical Necessity* required)
- Hearing aids and hearing-impaired equipment
- Home health care
- Immunizations

- Infertility treatments
- Insulin, glucose monitoring kits, and diabetic supplies
- Lab and X-ray fees that are part of medical care
- Learning disability tuition (*Letter of Medical Necessity* required)
- Massage therapy (*Letter of Medical Necessity* required)
- Medical records charges
- Medical supplies and equipment, including wheelchairs
- Menstrual care products
- Mental health counseling and/or psychiatric care
- Nursing services
- Orthodontia
- Orthopedic shoes and orthotic inserts
- Osteopathy services
- Over-the-counter (OTC) drugs or medications, including but not limited to the following: cold and flu medicine; cough suppressants, allergy and sinus medicine; eye drops; pain relievers; toothache remedies; and topical products (e.g., Bengay, Neosporin)
- Oxygen and oxygen equipment
- Personal protective equipment
- Physical therapy
- Podiatric services
- Prescription medicine and drugs that are legal in the United States
- Prosthesis (artificial limb)
- Smoking cessation programs (Nicotine patches, lozenges, and gum may require a *Letter of Medical Necessity* or prescription.)
- Speech therapy
- Surgery (includes cosmetic surgery with a *Letter of Medical Necessity*)
- Sterilization procedures
- Transportation expenses for person receiving medical care
- Weight-loss programs (with a *Letter of Medical Necessity* referring to the underlying condition of obesity and stating that the program will treat the condition). Expenses for dietetic food are not eligible.
- Other medical expenses that qualify under the IRS rules governing a Health Care FSA and are not reimbursable under any other health plan.

Please note: To access the *Letter of Medical Necessity* form, sign on to MyKP and go to the Health Care FSA topic. To ensure your claims will be reimbursed without delay, please review the claims submission requirements posted on MyKP at **mykp.kp.org**.

Prequalification

Your Health Care FSA annual election is irrevocable under IRS rules, except in the event of a qualifying family or employment status change. Please check with your provider before you enroll in the Health Care

FSA to make sure that you qualify for reimbursement from the Health Care FSA for any procedure or medical service you may be planning. Once you have enrolled, you cannot stop or change your Health Care FSA contributions during the year if your physician or provider determines you are not a qualified candidate for a procedure you plan to pay for using Health Care FSA funds.

Expenses Not Covered

The following are examples of expenses not eligible for reimbursement from your Health Care FSA:

- Babysitting, to enable you to make doctor visits
- Contact lens insurance
- Dietary, nutritional, and herbal supplements used to maintain general health
- Exercise equipment and programs to promote general health
- Funeral, cremation, or burial services
- Long-term care
- Premiums for medical or dental care, life insurance, or disability plans
- Prepayments for services not yet incurred

For a full list of covered services and exclusions, contact HealthEquity.

Using Your Healthcare Debit Card

You will receive a HealthEquity Visa Health Account Card that you can use to pay for eligible Health Care FSA expenses such as medical copayments and prescriptions. The card works like a debit card that will be preloaded with your Health Care FSA balance. The Healthcare Debit Card is regulated by IRS rules, and, in some cases, you may be asked to provide HealthEquity with documentation to verify that the item or service purchased was an eligible expense. You can mail copies of your documentation to HealthEquity or submit them online at **healthequity.com** using the "Submit Receipt" link. You may also submit your documentation with the HealthEquity EZ Receipts mobile application (available at **healthequity.com**). If you are not able to verify your card transactions, then you are required to repay your account. Failure to submit sufficient proof or repayment may result in suspension or loss of your card privileges and possibly tax penalties. For additional information on the card verification process, please contact HealthEquity.

For the fastest reimbursement, submit your claim online at **healthequity.com** or via the mobile application (available at **healthequity.com**). If you wish to submit a claim by mail, contact HealthEquity.

For more information about how to file a Health Care FSA reimbursement claim, and how to file an appeal if your claim is denied, see the **Disputes, Claims, and Appeals** section.

Health Care Flexible Spending Account COBRA Continuation

You are eligible to continue your coverage on an after-tax basis. For more information, refer to the "Continuation of Benefits Under COBRA" section.

Dependent Care Flexible Spending Account

You can enroll in a Dependent Care Flexible Spending Account (Dependent Care FSA) to set aside pre-tax dollars for eligible dependent care expenses throughout the plan year. This benefit provides tax savings if you need dependent care services — for your children, a disabled spouse, or a disabled dependent living with you and incapable of self-care — in order to work.

Additional Eligibility Requirements for the Dependent Care FSA

In addition to the general eligibility rules for spending accounts, there are several eligibility requirements specific to a Dependent Care FSA. Federal tax laws require that you meet one or more of the following conditions:

- You are a single working parent
- You and your spouse both work
- You are a divorced working parent and have custody of the child(ren)
- Your spouse is a full-time student for at least five months of the plan year
- Your spouse is unemployed and actively seeking work
- Your spouse is mentally or physically impaired and incapable of self-care

Eligible Dependents

Expenses reimbursed through a Dependent Care FSA must be for eligible dependents (as defined by IRS rules). For the purposes of this plan, eligible dependents include the following:

- Your IRS tax-dependent child under age 13 who resides with you for more than half of the calendar year
- Your child under age 13 for whom you are the custodial parent for more than half of the calendar year but due to a divorce you have filed an agreement to give the non-custodial parent the tax exemption
- Your spouse who is mentally or physically incapable of self-care and who resides with you for more than half of the calendar year
- Other qualified dependents who are mentally or physically disabled and unable to care for themselves, and who reside with you for more than half of the calendar year

Expenses for care provided outside your home can be reimbursed only if the care is for your dependent under age 13 or any other qualifying person who regularly spends at least eight hours a day in your home.

The qualifying child of another taxpayer cannot be claimed as your eligible dependent. For example, you are not able to be reimbursed for expenses for the child of a domestic partner if the domestic partner claims the child as a dependent on his or her tax return or the child's other parent claims the child as a dependent. Domestic partners and their children are considered eligible dependents for this plan only if they qualify as a dependent for federal income tax purposes.

Your child cannot be an eligible dependent if you are divorced and do not have custody of the child, unless the custodial parent provides you with a signed, written declaration that he or she will not claim the child as a dependent on his or her tax return.

Remember, the definition of dependents for the Dependent Care FSA may differ from the one used for your medical and dental coverage and from the one used in determining your personal income taxes. You may want

to contact your tax advisor if you have questions about an individual's qualification as your dependent for purposes of eligibility to participate in the Dependent Care FSA.

Eligible Providers

Expenses reimbursed through a Dependent Care FSA must be for care provided by an eligible provider. Eligible providers include the following:

- Family members who cannot be claimed as dependents on your income tax return
- Your children who are age 19 or older
- Dependent care centers or licensed day care providers that comply with applicable state and local laws

Eligible Expenses

The IRS determines which qualifying expenses are eligible for reimbursement. Only dependent caretaking expenses that are employment related and necessary for you to be gainfully employed qualify for reimbursement. Some of the most common eligible Dependent Care FSA expenses for services in or out of your home include the following:

- Care at a licensed day or evening care center or after school care
- In home baby-sitting services, such as an au pair or nanny
- The cost of day camps (fees for supplies do not qualify)
- Practical nursing care for an adult
- Care inside or outside your home for your dependent under age 13 or any other qualifying dependent who regularly spends at least eight hours a day in your home

Expenses Not Covered

The following are some of the expenses that are not eligible for reimbursement from your Dependent Care FSA:

- Overnight camps
- Cost of a babysitter for personal purposes that are not employment related
- Care provided by your child under age 19 or by someone you claim as a dependent on your tax return
- Kindergarten or educational tuition expenses
- Summer school

IRS regulations require that if you are absent from work for more than two consecutive calendar weeks for any reason, your participation in the Dependent Care FSA will be suspended until you return to work (any expenses incurred during the period you were not actively participating in the Dependent Care FSA, are not eligible for reimbursement).

For a full list of covered services and exclusions, contact HealthEquity.

Your Contributions

For the entire plan year, the minimum per-pay-period contribution is $10. The maximum you can contribute to a Dependent Care FSA account depends on your family situation. Your contributions may not exceed the lesser of the following:

- $5,000 each year if you are single, head of household, or married. If your spouse also has a Dependent Care FSA account with Kaiser Permanente or with another employer, the limit applies to your combined contributions
- $2,500 a year if you are married and file separate tax returns
- The amount of your salary or the amount of your spouse’s salary if he or she earns less than $5,000 a year

Note: If your spouse is a full-time student or is disabled, the maximum allowable contribution may vary, depending on how many qualifying dependents you have and your spouse's earned income. For more information, speak to your tax preparer.

If you become eligible for Dependent Care FSA mid-year, the annual maximum is still available to you. In other words, you may elect a higher per-pay-period contribution in order to contribute the maximum amount for that calendar year.

Your Dependent Care FSA annual election is irrevocable under IRS rules, except in the event of a qualifying family or employment status change. Your Dependent Care FSA contribution amount should be based upon a careful estimate of expected dependent care expenses for your qualified dependents for the calendar year or the portion of the year in which you are a participant. Your annual election is deducted from your pay in 24 equal amounts, which are reflected on the first two pay statements of each month throughout the year.

Per IRS regulations, the Dependent Care FSA is intended to help you pay for eligible dependent care expenses to allow you to work. Therefore, if you take any type of leave of absence for more than two consecutive calendar weeks, your Dependent Care FSA contributions will stop; you cannot be reimbursed for expenses incurred while you are on leave. As soon as you return from your leave, you will resume participating in the plan.

Additional federal limits may apply. For more information, contact HealthEquity.

Changing Your Contributions

You may change your contributions each year during open enrollment for the following plan year. You may not change your election during the plan year unless you have a qualifying family or employment status change, or you experience a significant change in the cost of your dependent care expenses (provided the change is not imposed by a dependent care provider who is a relative). For a list of qualifying events, see "Family or Employment Status Changes" in the **Enrolling in Benefits** section.

You have 31 days from the date of the qualifying event to contact the NHRSC to start, stop, increase, or decrease contributions to a Dependent Care FSA. The contribution change must be consistent with the change in family or employment status.

Filing a Claim

Dependent Care FSA claim forms are available from HealthEquity at **healthequity.com.** Submit the completed claim form, including your provider's signature, to HealthEquity.

For the fastest reimbursement, submit your claim online at **healthequity.com** or via the mobile application (available at **healthequity.com**).

You may also fax it to **877-353-9236**, or mail it to the following address:

HealthEquity
Claims Administrator
P.O. Box 14053
Lexington, KY 40512

You will be reimbursed only up to the amount you have already contributed to your account; outstanding amounts will be automatically paid as you contribute more to your account. You may submit claims until March 31 of the following year for expenses incurred through December 31 of the previous year (the end of the plan year).

HealthEquity processes claim forms for reimbursement once a week, but you will need to allow for mailing time in both directions. Reimbursement is available by check or direct deposit.

If your Dependent Care FSA claim is denied, you do not have rights to an appeal under ERISA, but you may request a review of the denial by contacting HealthEquity. If you have questions about your spending account or claims or if you need a claim form, contact HealthEquity.

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 usually three to five sessions. 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
- Work relationship issues
- Job performance problems
- Marital, family, or relationship difficulties
- Loneliness, depression, or anxiety
- Loss and grief
- Alcohol or drug misuse
- Addiction issues
- Care giving for family members

- Financial or legal referrals
- Domestic violence or other abuse
- Health and wellness issues

For more information, family member eligibility, or to contact a local EAP professional, see the **Contact Information** section.

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.

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

Employee Life Insurance

Your *Benefits by Design* Employee Life insurance benefits are paid to your beneficiary in the event of your death. You have a wide range of coverage options for financial protection that best suits your needs.

Who Is Eligible

You are eligible for Employee Life insurance if you are regularly scheduled to work 20 or more hours per week in a benefits-eligible status.
You must be eligible for Basic Life insurance in order to purchase Optional Life insurance.

When Coverage Begins

If elected, your Employee Life insurance coverage begins on the first of the month following your date of hire (or on your date of hire if it falls on the first of the month) in an eligible status, provided you have completed your enrollment before the deadline.

You must be actively at work for coverage to begin. If not, coverage will begin when you return to work in an eligible status. This actively-at-work provision also holds true for any changes you make to your Employee Life insurance coverage in subsequent years (for example, if you increase your coverage but you are on a leave of absence, the increase takes effect once you return to work).

How Optional Life Insurance Works

When you enroll in *Benefits by Design*, you may elect Optional Life insurance coverage in increments of $10,000 up to $50,000; or in increments of $50,000 from $100,000 up to $1,000,000. You may also choose to waive coverage. Your life insurance premium is deducted from your pay on a pre-tax basis. You may use your *Benefits by Design* credits to pay for your insurance.

Default Life Insurance

If you do not enroll in *Benefits by Design* when you are first eligible, you will receive default coverage, which includes Employee Life Insurance coverage in the amount of one times your annual salary, up to $50,000 (outside of Benefits by Design). You will not be able to change this election until the next open enrollment period or unless you have a qualifying employment or family status change (for more information, see “Changes During the Plan Year”).

Please note: If you enroll in other benefits but waive Optional Life insurance coverage, you will not receive default life insurance coverage.

Maximum Coverage

The maximum amount of employer-sponsored life insurance you may carry is $1,000,000 — including any employer-sponsored life insurance offered to you as a Kaiser Permanente employee.

Imputed Income

Internal Revenue Service (IRS) regulations require that Kaiser Permanente report the premium value for the amount of employer-provided coverage above $50,000 as taxable income on your W-2 form.

Under Section 79(a) of the Internal Revenue Code (IRC), the cost of employer-provided group term life insurance is included in an employee's gross income. The IRS calls this imputed income. There is an exclusion from imputed income for the cost of providing $50,000 in coverage. This means that employees can receive up to $50,000 in employer-provided life insurance coverage without having to pay income tax on the premiums for that coverage. For employer-provided coverage above $50,000, the employee is taxed on the balance of the cost of coverage.

The cost of coverage is determined by a table in the IRC. Like most life insurance, the cost increases by specific age brackets. The cost in the IRC table may differ from the actual premium cost of the insurance as paid by the employer or employee. If an employee contributes toward the cost of the insurance on an after-tax basis, the employee's contribution is credited toward the cost of coverage in excess of $50,000.

The premium value of employer-provided coverage over $50,000 will be reported as taxable income for federal, state, and FICA purposes. If this provision applies to you, your imputed income will be taxed, and the amount deducted will appear on the first two pay statements of each month throughout the year. Benefits from the Dependent Life and Accidental Death and Dismemberment (AD&D) plans, if elected are not included in determining the amount of coverage that is greater than $50,000.

If you have questions about actions that the IRS regulations require of Kaiser Permanente, contact the NHRSC. However, you should contact your tax advisor for specific advice about your tax return.

Medical Evidence of Insurability

Newly hired or newly eligible employees enrolling in *Benefits by Design* may elect up to $250,000 of Employee Life insurance coverage without going through MetLife's Medical Evidence of Insurability (MEOI) process if you elect coverage within 31 days of hire date or benefits eligibility date. MetLife will pay for the fee of the required paramedical exam, with no cost to the employee/applicant.

For coverage exceeding this amount, the MEOI process applies and includes the submission of a *Statement of Health* (SOH) form. You may be required to provide additional medical information or submit to a medical exam. If an exam is necessary, a MetLife-approved vendor will contact you directly to schedule an appointment.

A SOH form is required if:

- You are a newly eligible employee and you elected coverage above $250,000.
- You are a newly eligible employee who submitted your benefit election more than 31 days after becoming eligible.
- Your coverage was waived when first eligible and you later elect more than $50,000 in future years.

During open enrollment, you may increase coverage by one level without a SOH form. Increases beyond one level will require a SOH form.

If you are required to go through the MEOI process, you will receive an email message from MetLife asking you to complete a SOH form online. You will be asked to provide contact information, details about your health, including any past or current illness and any prescription medications as well as your doctor's contact information. Please follow the instructions to complete the SOH form online **within 60 days** of receipt of email to ensure timely processing of your insurance coverage by MetLife. You may request a paper SOH form from the NHRSC if you are not able to complete the form online.

The coverage amount subject to SOH will take effect when approval is received from MetLife and payroll deductions for the new amount have begun, provided you are actively at work.

Choosing Your Beneficiary

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

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

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

To name a beneficiary, access MetLife online through MyKP at **mykp.kp.org**. If you do not have access to a computer, you can designate your beneficiary by calling MetLife at **888-420-1661**, **prompt 5.**

If You Become Disabled

If you become totally and permanently disabled and unable to perform any occupation, your Employee Life insurance coverage may continue for up to one year after the date of your initial disability. However, if you provide proof acceptable to MetLife of your total disability — after having been totally disabled for at least nine months, but not more than 12 months — your life insurance will continue as shown below, provided you remain totally disabled:

Age You Become Disabled	Duration of Coverage from Date of Disability
Age 60 or less	To age 65
Age 61 but less than 65	48 months
Age 65 but less than 69	24 months
Age 69 and over	12 months

Coverage will continue without payment of premium from the date MetLife approves coverage based on your total disability. Your life insurance benefits under disability will end on the earliest of the following:

- The date you are no longer totally disabled

- The date you fail to provide proof of total disability as required by MetLife
- The date you refuse to be examined by a MetLife physician as required
- The date you reach one of the age or duration of coverage limits above
- The date of your death

Accelerated Benefit Option

If you are diagnosed with a terminal illness with a life expectancy of 12 months or less, you may apply for up to 50% of Employee Life insurance, Basic Life up to $25,000 and Optional Life up to $250,000, paid to you in a lump sum under the Accelerated Benefit Option (ABO). If you become terminally ill and opt for an accelerated benefit, your benefit amount will be actuarially reduced by MetLife. Accelerated benefits are paid only once and will reduce your life insurance benefit and the amount available to your beneficiaries.

In order to apply for this benefit, you must meet all of the following requirements:

- You must provide proof of the terminal illness through a physician certification (the insurance company retains the right to have you examined by health care providers of its choice at its own expense).
- Your life insurance coverage must be in effect when applying for ABO.
- You must have a minimum of $10,000 in life insurance coverage.

The ABO benefit is not payable if you have assigned your life insurance benefits to a third party. For further details and the necessary forms, contact the Executive Benefits HelplineNHRSC.

Assignment of Ownership

If you wish to assign ownership of your Employee Life insurance policy to another individual, contact the NHRSC for instructions and information.

When Coverage Ends

Your Employee Life insurance coverage ends on the date your employment ends or on the date you no longer qualify because of changes to your employment status. You have the option to convert this coverage to an individual policy within 31 days of the date on which your coverage ends.

Dependent Life Insurance

Dependent Life insurance pays a benefit in the event of the death of an eligible dependent. You can choose coverage for your spouse or domestic partner and your eligible children.

Who Is Eligible

You are eligible to elect Dependent Life insurance if you are regularly scheduled to work 20 or more hours per week in a benefits-eligible status, you are enrolled in Optional Life insurance, and you have eligible dependents. For the definition of eligible dependents, see the **Flexible Benefits** section.

When Coverage Begins

If you enroll when first eligible, your Dependent Life insurance coverage begins on the first of the month following your date of hire in a benefits-eligible status.

You must be actively at work on your benefit-effective date for Dependent Life insurance to take effect. In addition, your dependents may not be confined at home under a physician's care or receiving disability payments from any source or in a hospital or other medical institution. If you are not actively at work, coverage will begin when you return to work in a benefits-eligible status and/or your dependents are no longer under any of the above restrictions. This actively at work provision also holds true for any changes you make to your Dependent Life insurance coverage in subsequent years (for example, if you increase your coverage but you are on a leave of absence, the increase takes effect once you return to work).

How Dependent Life Insurance Works

You can cover your spouse or domestic partner, your eligible children, or both. You can choose among the following levels of coverage:

Spouse or Domestic Partner Coverage	Child Coverage
$10,000	$2,000
$20,000	$4,000
$30,000	$6,000
$40,000	$8,000
$50,000	$10,000
$75,000	
$100,000	

If you elect coverage for your spouse or domestic partner, you must purchase Optional Life insurance through *Benefits by Design* of at least twice the corresponding spouse/domestic partner amount. For example, if you elect the $40,000 level of Spouse/Domestic Partner coverage, you must elect at least $80,000 of Optional Life insurance (however, the $80,000 option is not available, so you must elect the next highest level, which is $100,000). To elect coverage for your child, you must purchase some level of Optional Life insurance through *Benefits by Design.*

The IRS requires that your Dependent Life insurance contribution be deducted from your pay on an after-tax basis; therefore, your *Benefits by Design* credits cannot be used for this benefit.

Medical Evidence of Insurability

You may enroll your spouse or domestic partner in Dependent Life Insurance either when you first become eligible for *Benefits by Design* or within 31 days of marriage or establishing a domestic partnership. Coverage up to $50,000 can be elected without completing MetLife's Medical Evidence of Insurability (MEOI) process.

A *Statement of Health* (SOH) form is required:

- When you elect Spouse or Domestic Partner coverage above $50,000.

- Late Enrollment: applies if benefit elections are submitted more than 31 days after a spouse or domestic partner becomes eligible.

During open enrollment, employees may increase coverage for their spouse or domestic partner by one coverage level without needing to submit a SOH form. Any increase beyond one level will require submission of an SOH form.

You may elect Dependent Life Insurance coverage for your child(ren) without completing the MEOI process, regardless of the coverage amount selected—provided it falls within the plan's allowable limits.

The MEOI process outlined for Employee Life Insurance also applies to Dependent Life Insurance.

Beneficiary

You are automatically the beneficiary for your eligible dependents.

Exclusions

No benefits are paid if your enrolled dependent's death is due to suicide within the first two years of coverage.

When Coverage Ends

Your Dependent Life insurance coverage ends on the date your employment ends, on the date you no longer qualify because of changes to your employment status, or when your dependents no longer meet the eligibility requirements. Your dependents have the option to convert their insurance to an individual policy within 31 days of termination of coverage.

Accidental Death and Dismemberment Insurance

Benefits by Design offers Accidental Death and Dismemberment (AD&D) insurance which provides additional income protection in case of injury or death resulting from an accident.

Who Is Eligible

You are eligible for AD&D insurance if you are regularly scheduled to work 20 or more hours per week in a benefits-eligible status.

You may purchase coverage for your eligible dependents. For a definition of eligible dependents, see the **Flexible Benefits** section.

When Coverage Begins

If elected, your AD&D coverage begins on the first of the month following your date of hire in a benefits-eligible status.

You must be actively at work on your benefit-effective date for AD&D coverage to take effect. In addition, your dependents may not be confined at home or in a hospital or other medical institution for Dependent AD&D coverage to take effect.

If you are not actively at work, coverage will begin when you return to work in an eligible status and/or your dependents are no longer confined. If you make a change to your AD&D coverage in the future, you must also be actively at work for the change to take effect.

Covering Your Dependents

In order to insure your eligible dependents under AD&D, you must elect AD&D coverage for yourself. Coverage for your spouse or domestic partner is 50% of your coverage, and coverage for each child is 10% of your coverage. If you and your spouse or domestic partner are both employed with Kaiser Permanente and eligible for AD&D coverage, our MetLife contract stipulates that only one of you may claim benefits for a dependent child under Dependent AD&D, even if both of you elect that coverage.

Your contribution for Employee AD&D coverage is made on a pre-tax basis, and you can use your *Benefits by Design* credits to purchase this coverage. Contributions for your Dependent AD&D coverage are made on an after-tax basis.

Coverage Options

You have the following AD&D coverage options under *Benefits by Design*:

Employee Coverage	Dependent Coverage (Spouse or Domestic Partner + Children)
$10,000	$5,000 + $1,000
$20,000	$10,000 + $2,000
$30,000	$15,000 + $3,000
$40,000	$20,000 + $4,000
$50,000	$25,000 + $5,000
$100,000	$50,000 + $10,000
$150,000	$75,000 + $15,000
$200,000	$100,000 + $20,000
$250,000	$125,000 + $25,000
$300,000	$150,000 + $30,000
$350,000	$175,000 + $35,000
No coverage	No Coverage

What Is Covered

If you suffer injuries as a result of an accident, a portion or all of your elected benefit is paid to you according to the following schedule:

When This Occurs	Plan Pays This Percentage of Benefit
Loss of life	100%

When This Occurs	Plan Pays This Percentage of Benefit
Loss of any combination of a hand, foot, or sight of one eye	100%
Loss of speech and hearing	100%
Brain damage	100%
Quadriplegia (paralysis of both arms and both legs)	100%
Loss of either one arm or one leg	75%
Paralysis of one arm and one leg on either side of the body	50%
Paraplegia (paralysis of both legs)	50%
Loss of one hand or one foot or sight of one eye	50%
Loss of speech or hearing	50%
Paralysis of one arm or leg	25%
Loss of thumb and index finger of same hand	25%
Coma	1% per month, beginning on the 7th day of the coma, to a maximum of 60 months

Exclusions

No benefits will be paid for any loss caused or contributed to by the following:

- Physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity
- Infection, other than infection occurring in an external accidental wound
- Suicide or attempted suicide
- Intentionally self-inflicted injury
- Service in the armed forces of any country or international authority, except the United States National Guard
- Any incident related to the following:
  - Travel in an aircraft as a pilot, crew member, flight student, or while acting in any capacity other than as a passenger
  - Travel in an aircraft or device used for testing or experimental purposes; by or for any military authority; or for travel or designed for travel beyond the Earth's atmosphere
- Committing or attempting to commit a felony
- The voluntary intake or use by any means of the following:
  - Any drug, medication, or sedative (unless it is taken or used as prescribed by a physician), or an over-the-counter drug, medication, or sedative taken as directed
  - Alcohol in combination with any drug, medication, or sedative
  - Poison, gas, or fumes
- War (whether declared or undeclared) or act of war, insurrection, rebellion, or riot

Exclusion for Intoxication

No benefits will be paid for any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.

Intoxicated means that the injured person's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

Reduction of Payment

If you are covered by AD&D insurance and are age 70 or older on the date of an accident, your payment will be reduced according to the following schedule:

Age on Date of Accident	Percent of Payment Payable
70 but less than 75	65%
75 but less than 80	45%
80 but less than 85	30%
85 and older	20%

Choosing Your Beneficiary

In the event of a dismemberment that does not result in death, you are the beneficiary. In case of your death, the beneficiary is the same person currently on file as the designated beneficiary for your Employee Life insurance. You are automatically the beneficiary of your Dependent AD&D insurance coverage.

When Coverage Ends

AD&D coverage for you or your dependent ends on the date your employment ends or on the date you no longer qualify because of changes to your employment status. In addition, Dependent AD&D coverage ends if your dependents no longer meet the eligibility requirements. You cannot convert this coverage to an individual plan.

Business Travel Accident Insurance

Business Travel Accident (BTA) insurance provides additional Accidental Death and Dismemberment (AD&D) insurance while you are traveling on company business. BTA benefits are paid in addition to any other benefits you may be eligible to receive.

BTA insurance is provided to you outside of *Benefits by Design*.

Who Is Eligible

You are eligible for BTA insurance if you are regularly scheduled to work at least 20 hours per week in an eligible status.

When Coverage Begins

You are automatically covered by BTA insurance beginning on your date of hire. Kaiser Permanente pays the premiums for this benefit.

How Business Travel Accident Insurance Works

BTA insurance provides 24-hour protection and covers you for certain losses sustained while traveling anywhere in the world on company business. BTA insurance provides a death benefit equal to four times your annual salary, up to a maximum of $250,000. The minimum death benefit payable is $100,000. The following chart shows the percentage of payable benefits for covered losses under the BTA insurance plan:

When This Occurs	Percentage of Payable Benefits
Loss of life	100%
Loss of a hand	50%
Loss of a foot	50%
Loss of speech and hearing	100%
Brain damage	100%
Quadriplegia (paralysis of both arms and both legs)	100%
Loss of either one arm or one leg on either side of the body	75%
Paraplegia (paralysis of both legs)	50%
Loss of sight of one eye	50%
Loss of speech or hearing	50%
Paralysis of one arm or leg	25%
Loss of thumb and index finger of same hand	25%
Coma	1% per month, beginning on the 7th day of the coma and for the duration of the coma, to a maximum of 60 months

Please note: There is an aggregate maximum of $5 million sustained by all insured persons under the group policy as a result of one covered accident. This means that the individual maximum benefit payable may be reduced if more than one covered employee suffers a loss as the result of the same accident.

In the event of dismemberment, the benefit is paid to you. In the case of your death, the benefit is paid to the beneficiary you designated for your employer-sponsored Life insurance.

Covered travel begins at the actual start of a business trip, whether it is from your home, work, or other location requested by, authorized or consented to by your employer. It ends upon your return to your home or work location, whichever comes first. Covered travel does not include vacation, leaves of absence, or travel between your residence and your regular work location. Losses suffered while on personal travel during a business trip are covered if the personal travel is no longer than seven days, is more than 100 miles from your

primary residence or regular work location, and the personal travel does not take place during vacation or leave of absence.

Coverage includes travel by airplane, automobile, bus, motorcycle, ship, or train.

Exclusions

BTA insurance does not cover losses resulting directly or indirectly, wholly or partly, when caused or contributed to by the following:

- Physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity
- Suicide or attempted suicide
- Intentionally self-inflicted injury
- Committing or attempting to commit a felony
- Use of any drug, medication, or sedative, unless it is used as prescribed by a physician or taken as directed
- Use of alcohol in combination with any drug, medication, or sedative
- Use of poison, gas, or fumes
- Infection, other than infection occurring in an external accidental wound or from accidental food poisoning
- Participation in hazardous activities such as scuba diving, bungee jumping, skydiving, hang gliding, ballooning, drag racing, driving a car fitted for competitive racing, aerial hunting, aerial skiing, or travel in an aircraft for the purpose of parachuting or otherwise exiting an aircraft while the aircraft is in flight except for the purpose of self-preservation
- Service in the armed forces of any country or international authority, except the United States National Guard
- Any nuclear reaction or release of nuclear energy; this includes the radioactive, toxic, explosive, or other hazardous or contaminating properties of radioactive matter
- The emission, discharge, dispersal, release, or escape of any solid, liquid, or gaseous chemical or biological agent
- War, whether declared or undeclared; or act of war, insurrection, rebellion, riot, or terrorist act
- Any incident related to travel in an aircraft or device in the following manner:
    - As a pilot, crew member, flight student, or while acting in any capacity other than as a passenger
    - Parachuting or otherwise exiting from such aircraft while the aircraft is in flight, except for the purpose of self-preservation
    - In an aircraft that does not have a valid Certificate of Airworthiness; is not flown by a pilot with a valid license to operate that aircraft; or which is owned, leased, controlled, or charted by the policyholder
    - In a device used for testing or experimental purposes; by or for any military authority for military purposes; for travel or designed for travel beyond the earth’s atmosphere; or for crop dusting, spraying, seeding, fire-fighting, sky diving, hand-gliding, sky writing, or aerial photography
    - In a device used for pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, or stunt or acrobatic flying
    - In a device used for any use which requires a special permit from the Federal Aviation Administration

Exclusion for Intoxication

No benefits will be paid for any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.

Intoxicated means that the injured person's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

When Coverage Ends

BTA insurance coverage ends on the date your employment ends or on the date you no longer qualify because of changes to your employment status. You cannot convert this coverage to an individual plan.

Temporary Disability Insurance

You may be eligible for Hawaii Temporary Disability Insurance (TDI) in the event you are temporarily unable to work due to a non-work related illness or injury.

For information regarding TDI, eligibility requirements, and benefits coverage, please call the Hawaii HR Services at **808-432-4927**.

Supplemental Disability Insurance

Supplemental Disability insurance provides income protection for you after you have been continuously disabled for at least 26 weeks. The benefits are administered through MetLife. You may elect Supplemental Disability insurance when you first become eligible for benefits.

Who Is Eligible

You are eligible for Supplemental Disability insurance if you are in a position with an employment status of 40 hours per week and have less than two years of service.

When Coverage Begins

If you elect to purchase Supplemental Disability Insurance, your coverage begins on your date of hire. You must be actively at work on your benefit effective date for your Supplemental Disability insurance to take effect.

Cost of Coverage

You pay the premiums for your Supplemental Disability Insurance. Premiums are deducted through automatic payroll deduction.

How Supplemental Disability Works

The minimum weekly Supplemental Disability benefit is 10% of the weekly benefit, before reductions for other income benefits, or $25, whichever is greater. The minimum weekly benefit may be affected by any overpayments MetLife is entitled to recover or rehabilitation incentive you may be eligible to receive.

When Benefits Begin

Supplemental Disability benefits begin after you have exhausted your available Extended Sick Leave or after 26 weeks of continuous disability, whichever is later.

Duration of Benefits

Supplemental Disability benefits are paid for a maximum of 104 weeks with continued physician certification. Your Supplemental Disability benefits will end on the earliest of the following:

- The date MetLife determines that you are no longer disabled
- The date following a period of 104 weeks of continuous disability
- If the Plan Administrator requires a medical examination and you fail to cooperate within 30 days following a written request
- The date you fail to provide proof of continuing disability to MetLife, or fail to have a medical exam
- The date of your death

Disability Defined

You are considered disabled if as a result of sickness or injury you meet MetLife's definition or Totally Disabled or Partially Disabled below.

- **Total Disability** means that you are unable to perform with reasonable continuity the substantial and material acts necessary to pursue your usual occupation and you are not working in your usual occupation.
- **Partial Disability** means while actually working in your usual occupation, you are unable to earn 80% or more of your predisability earnings.

Your disability can be the result of either sickness or injury. To be considered the result of an injury, a disability must have occurred within 90 days of the injury.

Usual occupation refers to any employment you were regularly performing for the employer when the disability began, but isn't necessarily limited to the specific job you were doing. If your occupation requires a license, the fact that you lose your license for any reason doesn't by itself define your condition as disability, for the purposes of an STD claim.

Substantial and material acts means the important tasks, functions and operations generally required in your usual occupation that cannot be reasonably omitted or modified. In determining what substantial and material acts are necessary for your usual occupation, MetLife will look not just at the duties required by your job, but also at whether those duties are customarily required of other employees who do that same job. If some of those duties fall outside of what is generally customary for your job, those duties--and specifically your inability to perform them as a result of a condition--won't be considered as part of the definition of disability.

Please note: MetLife uses their own definition of disability, which is different from that used by the Social Security Administration and Workers' Compensation.

What Is Not Covered

Benefits are not payable for injuries incurred by the following causes:

- Active participation in a riot

- Injuries resulting from participation in a felony
- Intentionally self-inflicted injuries or attempted suicide
- War-related disabilities

How to Apply for Benefits

Contact the National Human Resources Service Center (NHRSC) as soon as you believe you may be eligible for Supplemental Disability benefits. You, your doctor, and the NHRSC need to complete paperwork. Your Supplemental Disability claim must be submitted within three months from the day you are disabled in order for MetLife to approve your claim. For more information on filing claims, see the **Disputes, Claims and Appeals** section.

Benefits During Supplemental Disability

Most benefits do not continue during Supplemental Disability. However, your eligibility for a Medical Leave, Workers' Compensation, or Family Leave will determine whether benefits such as medical and dental coverage continue. For questions about your benefits continuation, contact the NHRSC.

Rehabilitation Benefits and Work Incentive

If MetLife determines that you are eligible for -- and you participate in -- an approved rehabilitation employment program, which may involve returning to work part-time or participating in vocational training or job modifications/accommodations, you may be eligible for the following:

- Receive 10 percent increase to your weekly benefit. This increase is applied prior to integration with other income sources such as TDI, Social Security, and/or Workers' Compensation.
- The weekly benefit will not be reduced by the amount you earn from working. However, the benefit may be reduced if your total income from work, other income and your weekly benefit exceeds 100 percent of your pre-disability earnings.

Family Care Incentive

If you work or participate in the Rehabilitation Program while disabled, MetLife will reimburse you for up to $60 per week for expenses you incur for family members to provide:

- Child care for dependents living with you, are dependent on you for support, and are under age 13
- Care for a family member living with you, is dependent on you for support and is incapable for independent living regardless of age due to mental or physical handicap.
- This weekly payment will continue up to the maximum benefit duration period or 24 months, whichever is earlier. Proof of the expense must be provided and cannot be charged by a family member.

When You Return to Work

You must provide your supervisor with a note signed by your doctor before you return to work. The note should include any limitations or restrictions on your ability to do your job and the estimated duration of those restrictions.

When Coverage Ends

Supplemental Disability coverage ends on the day you terminate employment with Kaiser Permanente or on the date you no longer meet eligibility requirements. If you become disabled prior to that termination date, you are eligible to make a claim and may still be able to receive benefits.

Medical Evidence of Insurability

If you elect Supplemental Disability coverage when you are first eligible, you do not need to go through MetLife's Medical Evidence of Insurability (MEOI) process if you elect coverage within 31 days of hire date or benefits eligibility date.

However, if you waive coverage when you are initially eligible, you will be required to go through the MEOI process, which includes the submission of a *Statement of Health* (SOH) form. You may be required to provide additional medical information or submit to a medical exam. If an exam is necessary, a MetLife-approved vendor will contact you directly to schedule an appointment.

If you are required to go through the MEOI process, you will receive an email message from MetLife asking you to complete a SOH form online. You will be asked to provide contact information, details about your health, including any past or current illness and any prescription medications as well as your doctor's contact information. Please follow the instructions to complete the SOH form online **within 60 days** of receipt of email to ensure timely processing of your insurance coverage by MetLife. You may request a paper SOH form from the Executive Benefits DepartmentNHRSC if you are not able to complete the form online.

Long-Term Disability Insurance

Long-Term Disability (LTD) insurance provides income protection if you become disabled for longer than 180 days and cannot work. LTD is offered to you under *Benefits by Design.*

If you elect it, LTD insurance allows you to receive a benefit equal to a percentage of your pay each month while you are disabled. LTD benefits are administered through MetLife.

Who Is Eligible

You are eligible to elect LTD insurance if you are regularly scheduled to work 20 or more hours per week in an eligible status.

When Coverage Begins

If you enroll when you are first eligible, your coverage begins on the first of the month following 3 months of employment in an eligible status (your benefit-effective date). If you enroll during open enrollment and your Medical Evidence of Insurability (MEOI) is approved, your coverage begins on January 1 of the following year, or the date your MEOI is approved by MetLife, whichever is later.

You must be actively at work on your benefit-effective date for your LTD coverage to take effect. If you are not, coverage will begin when you return to work in an eligible status.

This actively at work provision also holds true for any changes you make to your LTD coverage in subsequent years (for example, if you increase your coverage, the increase takes effect once you are actively at work).

If you die while receiving LTD benefits, a survivor benefit is available if you have an eligible survivor (spouse or domestic partner, or unmarried child under age 25). It is equal to three times your monthly LTD benefit and is paid as a lump sum. If you do not have an eligible survivor, the benefit will be paid to your estate.

How Long-Term Disability Works

If you become disabled (per MetLife criteria and approval) you may be eligible to receive a benefit after 180 days of continuous disability. This is called your elimination period and begins on the day you become disabled. You must be under the continuous care of a health care provider during your elimination period, and no LTD benefits are payable during this time.

You have two levels of LTD coverage to choose from:

- 50% of your base monthly salary
- 60% of your base monthly salary

You may choose to waive coverage.

The actual amount of your LTD benefit will be determined by your predisability earnings, which are your base earnings at the time you initially become disabled.

If you qualify for disability benefits from other sources, such as sick leave or Extended Sick Leave (ESL), Temporary Disability Insurance (TDI), Workers' Compensation, or Social Security Disability or retirement, your LTD benefit will be integrated with those benefits (see "Coordination with Other Income").

If you die while receiving LTD benefits, a survivor benefit is available if you have an eligible survivor (spouse or domestic partner, or unmarried child under age 25). It is equal to three times your monthly LTD benefit and is paid as a lump sum. If you do not have an eligible survivor, the benefit will be paid to your estate.

Medical Evidence of Insurability

During your initial *Benefits by Design* enrollment, you may choose either the 50% or 60% Long-Term Disability (LTD) coverage without going through MetLife's Medical Evidence of Insurability (MEOI) process if you elect coverage within 31 days of hire date or benefits eligibility date. MetLife will pay for the fee of the required paramedical exam.

A *Statement of Health* (SOH) form is required if:

- Late enrollment: applies to a newly eligible employee who submits their benefit election more than 31 days after becoming eligible
- If you initially elect the 50% coverage level and later decide to increase to the 60% level during a future open enrollment.

You may be required to provide additional medical information or submit to a medical exam. If an exam is necessary, a MetLife-approved vendor will contact you directly to schedule an appointment. MetLife will pay for the fee of the required paramedical exam.

If you are required to go through the MEOI process, you will receive an email message from MetLife asking you to complete a SOH form online. You will be asked to provide contact information, details about your health, including any past or current illness and any prescription medications as well as your doctor's contact information. Please follow the instructions to complete the SOH form online within 60 days of receipt of email to ensure timely processing of your insurance coverage by MetLife. You may request a paper SOH form from the NHRSC if you are not able to complete the form online.

The coverage amount subject to SOH will take effect when approval is received from MetLife and payroll deductions for the new amount have begun, provided you are actively at work.

Disability Defined

You are considered disabled if, as a result of sickness or injury, you meet MetLife's definition of total disability or partial disability below:

- **Total disability** means that during your elimination period and the next 24 months, you are unable to perform with reasonable continuity the substantial and material acts necessary to pursue your usual occupation in the usual and customary way. After this time, total disability means that you are not able to engage with reasonable continuity in any occupation in which you could reasonably be expected to perform satisfactorily in light of your age, education, training, experience, station in life, physical capacity, and mental capacity; and that exists within a reasonable distance or travel time from your residence; or a distance or travel time equivalent to the distance or travel time you traveled to work before becoming disabled; or the regional labor market, if you reside (or resided prior to becoming disabled) in a metropolitan area.
- **Partial disability** means while actually working in your usual occupation, you are unable to earn 80% or more of your pre-disability earnings.

Your disability can be the result of either sickness or injury. To be considered the result of an injury, a disability must have occurred within 90 days of the injury.

Usual occupation refers to any employment you were regularly performing for the employer when the disability began, but is not necessarily limited to the specific job you were doing. If your occupation requires a license, the fact that you lose your license for any reason does not by itself define your condition as disability, for the purposes of an LTD claim.

Substantial and material acts means the important tasks, functions and operations generally required in your usual occupation that cannot be reasonably omitted or modified. In determining what substantial and material acts are necessary for your usual occupation, MetLife will look not just at the duties required by your job, but also at whether those duties are customarily required of other employees who do that same job. If some of those duties fall outside of what is generally customary for your job, those duties — and specifically your inability to perform them as a result of a condition — will not be considered as part of the definition of disability.

Please note: MetLife uses its own definition of disability, which is different from that used by Social Security Administration and Workers' Compensation.

Your loss of earnings must be a direct result of your sickness, pregnancy, or accidental injury. Economic factors such as, but not limited to, recession, job obsolescence, pay cuts, and job-sharing will not be considered in determining whether you meet the loss of earnings test.

Restrictions and Limitations

There is a pre-existing illness clause under LTD that excludes certain disabilities from eligibility for benefits.

You are not covered for a disability caused or substantially contributed to by a pre-existing condition or medical or surgical treatment of a pre-existing condition.

A pre-existing condition means you received medical treatment, care, or services for a diagnosed condition, or took prescribed medicine for a diagnosed condition, in the three months immediately before your LTD coverage began, and the disability caused or substantially contributed to by the condition begins in the first 12 consecutive months after the effective date of your LTD coverage.

If you are disabled due to a mental illness (other than schizophrenia, bipolar disorder, dementia, or organic brain disease), your LTD benefits will be limited to a lifetime maximum of the lesser of:

- 24 months; or
- the maximum benefit period.

If you are disabled due to alcohol or substance abuse or dependency, MetLife will require you to participate in an approved rehabilitation or recovery program in order to receive LTD benefits. Benefits will end either after your successful completion of an approved rehabilitation program or when you cease or refuse to participate in an approved rehabilitation program — whichever is earlier. Benefits will be limited to one period of disability in your lifetime for up to a maximum of 24 months.

How to Apply for Long-Term Disability Benefits

Contact MetLife as soon as you believe you have a claim. You may either complete a claim form with MetLife online at **www.metlife.com/mybenefits** or call MetLife's toll-free number, **888-420-1661**. If you need to confirm coverage and eligibility, you can review your profile on MyKP or call the NHRSC.

You and your health care provider will need to submit information concerning your disability claim. Your LTD claim must be filed with MetLife within twelve months from the day you are disabled in order for MetLife to consider your claim. For more information on filing claims, and how to appeal a denied claim, see the **Disputes, Claims, and Appeals** section.

When Benefits Begin

Once approved by MetLife, our insurer, your benefit payments begin after you have been continuously disabled for 180 days.

Please note: If coordination with other disability income brings your LTD benefit to $0, you will not receive a payment unless or until the coordination calculation results in a benefit greater than $0.

Duration of Benefits

If you are disabled before age 60, your LTD benefits continue until you recover, reach age 65, or die, whichever comes first. If you are disabled at or after age 60, your LTD benefits continue according to the following schedule — if you do not recover from your disability sooner.

Please note: If your disability qualifies as a psychiatric or substance abuse disability, your LTD benefits will continue for the lesser of 24 months, or the maximum duration shown below:

Age You Become Disabled	Maximum Duration of LTD Benefits
Less than 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Coordination With Other Income

The maximum benefit you can receive from LTD in combination with all other disability income sources (including Social Security, Workers' Compensation and State Disability Insurance) is a percentage of your regular base monthly salary at the time you become disabled (your predisability earnings). Your LTD benefit will be integrated with benefits from other disability plans as follows:

- If you elect the 50% coverage level and the total of your disability benefits from all sources exceeds 60% of your base monthly salary, then your LTD benefit will be reduced to bring your total combined benefits to a maximum of 60% of your predisability earnings.
- If you elect the 60% coverage level and the total of your disability benefits from all sources exceeds 70% of your base monthly salary, then your LTD benefit will be reduced to bring your total combined benefits to a maximum of 70% of your predisability earnings.

When integrated with other disability benefits, your LTD benefit will never exceed the coverage level (50% or 60%) that you choose.

Rehabilitation Benefits and Work Incentive

If MetLife determines that you are eligible for an approved rehabilitation program, you may receive up to an additional 10% of your predisability earnings when integrated with other income sources, such as earnings from part-time work, Social Security, and/or Workers' Compensation benefits.

While participating in an approved rehabilitation program, you may qualify for family care expenses of up to $250 per month.

If you are able to work part time while disabled, there is no offset for employment earnings during the first 24 months after you have satisfied your elimination period. However, your monthly LTD benefit will be reduced if your total income from all sources exceeds 100% of your predisability earnings. After the first 24 months

following your return to work, MetLife will reduce your monthly LTD benefit by 50% of the amount you earn from working while disabled.

When You Return to Work

You must provide your supervisor with a note signed by your health care provider before you return to work. The note should include any limitations or restrictions on your ability to do your job and the estimated duration of those restrictions.

Tax Considerations

You may choose to pay your LTD premiums on a pre-tax or after-tax basis. If you pay your premiums on a pretax basis, your LTD benefits will be subject to federal and state income taxes when they are paid to you. If you pay your premiums on an after-tax basis, your benefits will not be subject to income taxes.

If you change payment methods from year to year, MetLife will consider this if you become eligible to receive LTD benefits. When calculating your benefit, the payment method you used immediately before the first day of disability will be used to determine the taxability of the LTD benefit.

What Is Not Covered

Benefits are not payable for injuries incurred by the following causes:

- Any disability caused by intentionally self-inflicted injuries or attempted suicide
- Injuries as a result of participation in, commission, or attempt to commit a felony
- War or any act of war, declared or undeclared, insurrection, rebellion, or terrorist act
- Active participation in a riot

Benefits During Long-Term Disability

If you are qualified, you may be eligible for medical and Employee Life insurance coverage while you are on LTD. You may be eligible to continue your dental benefits under COBRA.

Your medical coverage will continue for a period equal to one-half of your continuous years of service with Kaiser Permanente, up to a maximum of five years. During this period, Kaiser Permanente continues to pay the premiums, and you must continue to pay any applicable cost-sharing. If you discontinue any required cost-sharing, your medical coverage will terminate.

If you are covered by Kaiser Permanente-sponsored Life insurance and become disabled, you may apply for a *Waiver of Premium*. If your application is approved, your Life insurance coverage will continue without requiring payment of premiums. For more information, see “Employee Life Insurance.”

Please note: MetLife uses its own definition of disability, which is different from that used by the Social Security Administration and Workers’ Compensation.

Retirement Benefits

You may be eligible to receive a distribution from your Kaiser Permanente-sponsored retirement savings plans before termination of employment if you qualify under the terms of these plans. Please see the **Retirement Programs** section for more information.

While you are on LTD, you will continue to accrue both pension and credited service under your Kaiser Permanente-sponsored defined benefit pension plan, if you are a participant in the plan, based on your work schedule as of your date of disability. Because of this additional accrual, you cannot claim pension plan retirement benefits while you are on LTD, unless you end your LTD status by signing a waiver of future LTD benefits.

In certain circumstances, a decision to waive future LTD benefits may be beneficial to you and your family. For example, if you are terminally ill, you may wish to waive LTD benefits and take a lump sum distribution from the pension plan, or another form of payment that provides for payments to a beneficiary after your death. The value of your pension benefits today may be greater than the combined value of your future LTD benefits and any pre-retirement death benefits that may be payable from the pension plan after your death. Your decision to waive LTD benefits should not be taken lightly because it is irrevocable. Every case is different, so we strongly suggest that you consult with your financial advisor before making a decision to waive future LTD benefits.

When Coverage Ends

Your LTD coverage ends on the date your employment ends or on the date you no longer qualify because of changes to your employment status, unless you are receiving disability benefits at that time. If you become disabled prior to that termination date, you are eligible to make a claim and may still be able to receive benefits. You cannot convert this coverage to an individual plan.

Continuation of Benefits During Permanent Disability

In the event that you become permanently disabled as defined by Social Security during active service, Kaiser Permanente will provide you and your currently covered eligible dependents with the following Kaiser Permanente-administered benefits, which may be taxable in accordance with the law, for a set period of time, depending on your length of service.

Less Than Two Years of Service

All benefits will cease when your accrued sick leave is exhausted, unless you choose to continue your benefits and pay the required premiums while on unpaid leave.

After Two Years of Service Without Eligibility for Early Retirement

Basic Medical Plan Benefits

If you become permanently disabled, Basic Medical Plan benefits will be provided to you and your eligible dependents — spouse, domestic partner, or registered civil union partner, and eligible dependent children up to

the plan's limiting age — at Kaiser Permanente's expense for a period of time equal to one-half your length of service, using your service date (adjusted date of hire).

Any required premium payments must be current in order to qualify for this coverage while on permanent disability.

Once you and/or any enrolled dependents become eligible for Medicare, you and/or they must enroll in all applicable parts of Medicare and assign Medicare benefits to Kaiser Permanente Senior Advantage to maintain Basic Medical Plan coverage.

Supplemental Medical Benefits

Supplemental Medical Plan coverage will continue for you and your currently covered eligible dependents through the last day of the month in which your official termination date occurs.

Any required premium payments must be current in order to qualify for this coverage while on permanent disability.

Dental Benefits

Dental coverage for you and your eligible dependents will continue through the last day of the month in which your official termination date occurs or up to the plan's limiting age, whichever is earlier.

Please note: Medical and dental coverage for your spouse, domestic partner, or registered civil union partner may end sooner if he or she dies, remarries, or enters into a new domestic partnership, or civil union partnership. Coverage for your dependent children will continue until they no longer meet the eligibility requirements.

After Two Years of Service With Eligibility for Early Retirement

Basic Medical Plan Benefits

You will receive Basic Medical Plan benefits for life, provided that you remain permanently disabled. This coverage will also be provided to your eligible spouse, domestic partner, or registered civil union partner, and eligible dependent children up to the plan's limiting age, who are covered on your plan at termination.

Any required premium payments must be current in order to qualify for this coverage while on permanent disability.

Once you and/or any enrolled dependents become eligible for Medicare, you and/or they must enroll in all applicable parts of Medicare and assign Medicare to Kaiser Permanente Senior Advantage to maintain Basic Medical Plan coverage.

Supplemental Medical Benefits

Supplemental Medical Plan coverage will continue for you and your currently covered eligible dependents through the last day of the month in which your official retirement date occurs.

Any required premium payments must be current in order to qualify for this coverage while on permanent disability.

Dental Benefits

Dental coverage for you and your currently covered eligible dependents will continue for a period of three months following your Early Retirement or up to the plan's limiting age, whichever is earlier. Any required premium payments must be current in order to qualify for this coverage while on permanent disability.

Please note: Medical and Dental coverage for your spouse, domestic partner, or registered civil union partner may end sooner if he or she dies, remarries, or enters into a new domestic partnership, or civil union partnership. Coverage for your dependent children will continue until they no longer meet the eligibility requirements.

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 MyKP 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

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 MyKP 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 and Legal Services Plus Parents Plans

The legal services plans provide you access to a nationwide network of attorneys. The plans, underwritten by MetLife Legal Plans, are available to you and your family for a monthly premium paid through payroll deductions. You have the option to sign up for the Legal Services plan for you and your immediate family or the Legal Services Plus Parents plan 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 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 these coverages will be taken on an after-tax basis from your first two paychecks of each month. The cost for the Legal Services Plan Plus Parents is more than the regular Legal Services plan. The cost of these plans 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 the 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 listed below. Only services highlighted in **bold** are available to parents, parents-in-law, stepparents, and grandparents through the Legal Services Plus Parents plan, 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 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 MyKP at **mykp.kp.org**.

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 or more of the following who survive you:

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

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

To name a beneficiary, access MetLife online through MyKP at **mykp.kp.org**. 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.

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 Salaried Retirement Plan Supplement to the Kaiser Permanente Retirement Plan

Kaiser Foundation Health Plan, Inc., and Hospitals (KFHP/H) provides eligible employees with the Kaiser Permanente Salaried Retirement Plan (Plan A). Plan A is a qualified defined benefit plan that is a supplement to the Kaiser Permanente Retirement Plan (KPRP). You earn retirement income under this plan based on a pension formula described in more detail below.

Who Is Eligible

You are eligible to participate in the plan if you are a Salaried employee or Resident Physician of the Kaiser Foundation Hospitals/Health Plan in the Hawaii Region.

When Your Participation Begins

If you meet the eligibility requirements above, you will automatically become a participant in the plan on the first anniversary of your hire date if you are compensated for at least 1,000 Hours of Service (see "Hours of Service") in the previous 12-month period. If you are compensated for fewer than 1,000 Hours of Service in your first 12 months of employment, you will become a participant on January 1 of the first calendar year in which you are compensated for at least 1,000 Hours of Service.

Participation Upon Your Rehire

If you terminate employment and are subsequently rehired at Kaiser Permanente as an eligible employee, and you were a participant in the plan before you left Kaiser Permanente you will become a participant in the plan on your date of rehire.

If you were not a participant in the plan when you left Kaiser Permanente, you will become a participant on the first anniversary of your rehire date if you are compensated for at least 1,000 Hours of Service (see "Hours of Service") during the previous 12-month period. If you are compensated for fewer than 1,000 Hours of Service in your first 12 months of employment, you will become a participant on January 1 of the first calendar year in which you are compensated for at least 1,000 Hours of Service. If you are not employed as an eligible employee on your rehire date, you will again become a participant only after you are employed as an eligible employee at Kaiser Permanente.

Hour of Service

An Hour of Service is any hour, including sick leave, vacation, holidays, and certain paid leaves of absence, for which you are compensated as an employee of Kaiser Permanente.

Vesting in Your Benefit

Vesting refers to your entitlement to a benefit. You are 100% vested in your benefit under the plan if you are a participant and meet either of the following conditions: (1) you have at least five Years of Service (see “Year of Service”), or (2) you are age 65 or older and are still actively employed by Kaiser Permanente. If you are vested, you are entitled to a benefit that will be payable when you turn age 65, or earlier if you meet the age and Years of Service requirements for early retirement before you terminate employment with Kaiser

Permanente. If you terminate employment with Kaiser Permanente without meeting either condition (1) or (2) above, you are not vested and not eligible for a benefit from the plan.

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

Year of Service

A Year of Service is any calendar year, whole or part, in which you are compensated for 1,000 or more Hours of Service. Generally, your compensated hours and certain periods of unpaid leaves count toward this requirement, as described in more detail in "Years of Service and Credited Service for Leaves."

Special rules apply to service before 1976.

Your Years of Service are used for purposes of determining participation, vesting and eligibility to receive pension benefits. You are eligible to receive pension benefits after satisfying different age and Years of Service requirements.

Credited Service

You earn a year of Credited Service for each calendar year during which you are compensated for 2,000 or more hours. Generally, you are credited with hours of employment for each compensated hour and for certain periods of unpaid leaves. Proportional Credited Service is granted in years in which you have fewer than 2,000 hours of employment.

Years of Service and Credited Service for Leaves

In certain circumstances, the plan recognizes hours for periods of unpaid leave toward Years of Service and/or Credited Service. For more information, call the Fidelity Service Center.

How Your Benefit Is Calculated

The amount of your benefit will be based on a formula that includes:

- Your Final Average Monthly Compensation
- Your Years of Credited Service
- The plan multiplication factor of 1.5%

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

The Benefit Formula

The formula that is used to calculate your lifetime Single Life Annuity monthly pension benefit, assuming your benefit is payable when you are age 65, is the greater of:

1.5% of your Final Average Monthly Compensation

X

Your years of Credited Service

or

$17.50 X Your years of Credited Service

–

Any applicable Pension Offset (see "Pension Offset Rules")

All other forms of payment are based on this calculation. To help you understand how the formula works, here is an explanation of its terms.

Final Average Monthly Compensation

Your Final Average Monthly Compensation (FAMC) is determined by looking at your monthly compensation rate for your last 120 months, or 10 years, of employment. Your monthly compensation rate is the rate of hourly base pay for the first compensated hour of each month multiplied by 173.33 (number of work hours in a month). Your highest monthly compensation rates over a consecutive 60-month, or five-year, period — typically the most recent 60-month period — are averaged to determine your FAMC. If you have fewer than 60 months of consecutive employment, your FAMC is the average of the monthly compensation rates for all months of employment.

The maximum annual eligible pay set by the Internal Revenue Code (IRC) that may be considered for benefit purposes for 2026 is $360,000. This amount may be indexed periodically for cost-of-living increases. In addition, the IRC limits the annual benefit that may be paid to you from the plan.

For the current maximums, contact the Fidelity Service Center.

How the Pension Calculation Works

Here is an example of how the Plan A formula works:

Carolyn retires at age 65 with 20 years of Credited Service. Her Final Average Monthly Compensation (FAMC) is $5,000. Her monthly Single Life Annuity pension benefit is:

1.5% X $5,000 = $75.00

X

20 years = $1,500

OR

$17.50 x 20 = $350

Carolyn's monthly pension will be approximately $1,500, payable to her for her lifetime as a Single Life Annuity beginning at age 65.

Other forms of payment are available and are based on the Single Life Annuity amount. See the "Available Forms of Payment" section.

Pension Offset Rules

If you are vested in a benefit from another qualified defined benefit plan maintained by a Kaiser Permanente entity, or from a Joint Labor Management Trust, and there are hours that are considered as Credited Service under both plans, your age 65 benefit under Plan A will be offset. Under the pension calculation formula, your Plan A benefit will be offset by the age 65 benefit attributable to the period of overlapping Credited Service. You will have to request your benefit from your earlier defined benefit plan separately.

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

a) Any vested accrued benefit you are eligible for under a Kaiser Permanente Washington defined benefit plan as of the date of your transfer or rehire, and

b) The actuarial equivalent of your balance as of January 31, 2017, in any defined contribution plans sponsored by GHC and its affiliates.

Maximum Benefits

Federal tax law limits the annual benefit that the plan can pay to you. The Plan Administrator will notify you if this limit affects the amount of your benefits.

When You Can Begin Your Benefit

If you are vested, you may qualify to begin receiving your benefit at:

- Normal Retirement
- Early Retirement
- Postponed Retirement
- In-Service Retirement

If you are vested and terminate your employment with all Kaiser Permanente entities before you qualify to begin receiving your benefit, you will later qualify to begin receiving a Deferred Vested pension. Only one of these types of benefits is payable from the plan, even if you satisfy the requirements for more than one type of benefit.

Normal Retirement

You will qualify for a Normal Retirement benefit if you terminate employment when you turn age 65. Your Normal Retirement benefit is the monthly benefit calculated under the benefit formula. If you qualify, you may elect to begin receiving your benefit on the first day of the month following your termination of employment.

Early Retirement

You will qualify for an Early Retirement benefit if you are at least age 55 with 15 or more Years of Service, or if your age and Years of Service equal 75 or more when you terminate employment.

If you meet these requirements, you may elect to begin receiving an Early Retirement benefit on the first day of any month after your termination of employment. Your Early Retirement benefit is calculated in the same manner as your Normal Retirement Benefit if you wait until age 65 to begin receiving your benefit.

However, if you elect to begin your Early Retirement benefit before you reach age 65, the amount of your monthly benefit will be reduced based on your age on your Benefit Commencement Date (the date your benefit payment begins). The following chart shows the percentage of your benefit payable at earlier ages:

Your Age When Payments Begin	Percentage of Normal Retirement Payable to You
65	100%
64	97%
63	94%
62	91%
61	88%
60	85%
59	80%
58	75%
57	70%
56	65%
55	60%

Your benefit will be adjusted to reflect your actual age. For example, if you retire at age 62½, your percentage will be approximately 92.5% (halfway between the percentages for age 62 and age 63) of the normal pension.

If you are eligible and elect to begin receiving your benefit before age 55, your benefit will be reduced an additional 5% per year for the period between your age on your Benefit Commencement Date and age 55. In no event will your benefit be less than the actuarially reduced benefit reflecting your age on your Benefit Commencement Date.

If you wait until you reach age 65 (the plan's Normal Retirement Age) to receive your benefit, it will not be reduced.

Deferred Vested Pension

You will qualify for a Deferred Vested benefit if you terminate employment from all Kaiser Permanente entities after you become vested, but before you qualify for Normal Retirement or Early Retirement. If you qualify, you may elect to begin your Deferred Vested benefit on the first day of the month following the month in which you reach age 65. Your Deferred Vested benefit is calculated in the same manner as your Normal Retirement benefit if you wait until age 65 to begin receiving your benefit.

You may elect to begin receiving a reduced benefit before age 65 if you meet the Years of Service requirement for Early Retirement when you terminate employment and later meet the age requirement. In this situation the amount of your monthly benefit will be reduced based on your Benefit Commencement Date.

See “Early Retirement” for the reductions that are applied to your benefit if payment begins before 65.

In-Service Retirement

You will qualify for In-Service Retirement if you are still employed by KFHP/H in an employee group eligible for this benefit after you reach age 65. If you qualify, you may elect to start receiving your In-Service Retirement benefit on the first day of any month following the month in which you reach age 65. Your In-Service Retirement benefit is the same as your Normal Retirement benefit (or benefit earned to the date your benefit starts if later than 65).

You may continue to earn additional benefits under the plan after you commence your In-Service Retirement benefit if you continue your employment. However, any additional benefit that you may earn will not be payable until you terminate your employment with KFHP/H. When you retire, your benefit will be recalculated under the benefit formula based on your FAMC and total years of Credited Service at that time, and reduced by the In-Service Retirement benefit you already received on an actuarially adjusted basis. While your final retirement benefit will not be reduced below the In-Service retirement benefit you initially received, it is also unlikely to increase. The form of payment you elected for In-Service Retirement will automatically apply to additional benefits, if any, earned after your In-Service Retirement distribution.

Postponed Retirement

If you continue your employment with Kaiser Permanente after you reach age 65, you can defer payment of your benefit until you terminate your employment. At that time, you may elect to receive a Postponed Retirement benefit beginning on the first day of any month after you terminate. Your Postponed Retirement benefit is a monthly benefit for your lifetime generally equal to the greater of: (1) the actuarially adjusted Normal Retirement benefit (age 65); or (2) your benefit calculated using your Final Average Monthly Compensation (FAMC) and Credited Service at retirement. The amount you receive under certain forms of payment may decrease as a result of your increased age when payment of the benefit begins.

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, if the plan allows, 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 not legally related to the Permanente Medical Groups.

Please note that federal tax law requires that you begin your Postponed Retirement benefit by April 1 after the year in which you reach age 73, or, if later, the year in which you terminate your employment from the Kaiser Permanente legal entity where you are working as of April 1 of the year after you attained age 73.

If you have questions regarding the effect of your continued employment beyond age 65, contact the Fidelity Service Center.

Deferred Payment

You may elect to defer payment of your benefit beyond the earliest date you are entitled to begin receiving it. If you defer your benefit beyond age 65, your benefit will be actuarially increased to reflect the delayed

payment. However, federal tax law requires that you begin your benefit by April 1 after the year in which you reach age 73, or, if later, the year in which you terminate your employment with the applicable Kaiser Permanente entity.

Employees Who Transfer Among Kaiser Permanente Entities

The terms of the pension plans offered by Kaiser Permanente are not uniform. If your employee group has participated in multiple supplements or plans, or if you transfer jobs with your employer, or if you transfer among Kaiser Permanente entities during your career, you might participate in different pension plans and the terms of those plans may differ significantly. Keep this in mind and if you transfer, review the *Summary Plan Description* for the terms of each pension plan.

How Benefits Are Paid

You must complete and return a retirement commencement package and any other required forms or documentation to receive your earned plan benefit. To begin the commencement process, visit the Fidelity Service Center website at **netbenefits.com**. You may also call the Fidelity Service Center (see the **Contact Information** section).

When you apply for your benefit, you can select the standard form of payment or one of the alternate forms of payment. It is important to consider the available forms of payment carefully before making your selection. Once you begin to receive benefits, you cannot change your form of payment. The form of payment you select may have a number of tax implications. You should carefully consider your personal financial situation when selecting a form of payment. The plan, its fiduciaries and its sponsoring employers cannot offer financial or tax advice on this subject. For assistance, please consult a tax advisor or financial planner.

Standard Forms of Payment

If you are single: The standard form of payment is the Single Life Annuity.

If you are married: Your spouse is entitled by federal law to receive benefits, so your standard form of payment is the 50% Joint and Survivor Annuity. Therefore, you are legally required to obtain your spouse's consent to elect other forms of payment. The consent must be in writing and notarized no more than 90 days before the benefits begin.

Please see below for descriptions of these and the other available forms of payment under the plan.

Available Forms of Payment

- **Lump Sum:** Under this option, you receive a one-time lump sum amount. After you receive the Lump Sum payment, there are no more payments due under the plan. The Lump Sum can be rolled over into a traditional IRA, Roth IRA or another employer's qualified plan, if that plan accepts rollovers.
- **Single Life Annuity:** Under this option, you receive a monthly pension benefit until your death. However, all pension payments stop when you die regardless of marital status. This is the standard form of payment if you are not married (as defined by federal law) on your Benefit Commencement Date.

- **50%, 66⅔%, and 75% Joint and Survivor Annuities:** Under this option, you receive a reduced monthly benefit until your death. If you die before your beneficiary, 50%, 66⅔%, or 75% (as elected by you) of the amount you receive will then be paid to your beneficiary as long as he or she lives. However, if your beneficiary dies before you, your monthly benefit will be reduced to the 50%, 66⅔%, or 75% survivor benefit for the rest of your lifetime after your beneficiary's death. This option requires the designation of one person as your beneficiary, and after your payments begin, you cannot change your beneficiary.

  The 50% Joint and Survivor Annuity is the standard form of payment if you are married (as defined by federal law). If you are married, you must select this form of payment with your spouse as your beneficiary unless your spouse consents to a different election. Your spouse’s consent must be on the appropriate form and notarized.

  Once you begin receiving payments, you may not change your beneficiary. The monthly pension benefit you or your beneficiary receives under this option will be less than the monthly pension benefit under a Single Life Annuity because payments may continue after death. The actual difference depends on the percentage you elect (50%, 66⅔%, or 75%) as well as the age difference between you and your beneficiary.
- **100% Joint and Survivor Annuity with 15-Year Guarantee Period and Pop-Up:** Under this option, you receive a reduced monthly benefit until your death. If you die before your Joint and Survivor Annuity beneficiary, 100% of the monthly payment you received will then be paid to that beneficiary as long as he or she lives. However, if your Joint and Survivor Annuity beneficiary dies first, the monthly amount payable to you will “pop up” to the Single Life Annuity monthly amount for the duration of your life. If you and your Joint and Survivor Annuity beneficiary both die before the 180 months (15 years) of guaranteed payments are made, payments equal to the 100% Joint and Survivor Annuity monthly benefit will be made to a designated beneficiary until the expiration of the guaranteed payment period.

  If your designated beneficiary does not survive to the end of the guaranteed payment period, the present value of the remaining payments will be paid to that beneficiary’s estate. This option requires the designation of both a Joint and Survivor Annuity beneficiary and a beneficiary for the guarantee period benefit. If you and your Joint and Survivor Annuity beneficiary die before 180 payments and there is no surviving designated beneficiary, the remaining payments will be made to your surviving spouse or domestic partner if any. If there is no surviving spouse or domestic partner, the present value of the remaining payments will be paid to your estate.
- **5-, 10-, 15- and 20-Year Certain and Life Annuity:** Under this option, you receive a monthly pension benefit for your lifetime with payments that will be made for a period of at least 5, 10, 15, or 20 years, whichever you select. If you die before the end of the specified period, your designated beneficiary will receive the monthly payments for the remainder of the specified period.

  If your designated beneficiary dies before the end of the specified period, the present value of the remaining monthly benefits will be paid in accordance with the plan.

  For example, if you elect the 10-year option and die after receiving payments for only six years, your beneficiary would receive monthly payments for the remaining four years. If you live longer than 10 years, payments will continue to you for as long as you live, but there are no payments to your beneficiary after your death.

  The monthly amount paid to you under this option will be less than you would receive under a Single Life Annuity because of the possibility that payments will continue after your death. The actual difference depends on your age at retirement and the length of the specified period. Unlike a Joint and Survivor Annuity, you can change your beneficiary for this form of payment after your payments begin.

- **Level Income Annuity Option at Age 62, 65 or your Social Security Normal Retirement Age:** Under this option, you receive an increased monthly payment during your lifetime until age 62, age 65 or your Social Security Normal Retirement Age (SSNRA), as you elect. Thereafter, it provides a reduced monthly payment for your life in order to provide an approximate level retirement benefit when the reduced monthly payment is combined with your estimated benefit from Social Security. This option is only available if your requested Benefit Commencement Date is before the leveling age. The leveling age is the age at which the payment decreases. The first decreased payment will be the first month following the leveling age. The plan offers the following leveling ages: 62, 65, or SSNRA.
- **5-, 10-, 15- and 20-Year Certain and Life Annuity with Level Income Option at Age 62, 65 or your Social Security Normal Retirement Age:** Under this option, you receive an increased monthly payment during your lifetime until age 62, age 65 or your Social Security Normal Retirement Age (SSNRA), as you elect. Thereafter, it provides a reduced monthly payment payable for your life in order to provide an approximate level retirement benefit when the reduced monthly payment is combined with your estimated benefit received from Social Security. If you die during the period you elect (5, 10, 15 or 20 years), your beneficiary will receive the remaining payments until all of the specified payments have been made. This option is only available if your Benefit Commencement Date is before the leveling age. The leveling age is the age at which the payment decreases. The first decreased payment will be the first month following the leveling age. The plan offers the following leveling ages: 62, 65, or SSNRA.
- **Fixed Monthly Installments:** Under this option, you receive a fixed number of monthly payments, and then all payments stop. You may elect to receive installments for 60, 120, 180, 240, or 360 months, or any months up to 360. If you die after your payments stop because you have received the fixed number of monthly payments, there will be no benefit paid to any beneficiary. If you die before you receive the fixed number of monthly payments, your surviving designated beneficiary will receive monthly installments for the remainder of the fixed period.

The amount payable under each method is determined using actuarial assumptions and the interest rate specified by the plan. You will be provided with estimates of the amounts payable under each of the different methods as part of your commencement package.

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 *Summary Plan Description* (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.

If You Die

If You Die While Still Employed

If you die while still employed at Kaiser Permanente and after you are vested, your spouse or designated domestic partner will be eligible for a lifetime monthly survivor benefit from the plan.

This benefit is payable when you would have turned 65; however, your spouse may elect to begin payments when you would have been eligible for Early Retirement, but cannot defer payment later than April 1

following the year you would have reached age 73. The amount of your spouse's or designated domestic partner's benefit will be the same as if you had selected the 66⅔% Joint and Survivor Annuity form of payment and died on the day of your spouse's Benefit Commencement Date. Domestic partners must begin receiving a distribution before the first anniversary of your death.

In order to designate your domestic partner for pre-retirement survivor benefits, you must complete a *Designation of Domestic Partner for Pre-Retirement Survivor Benefits* form. This form is different than the form that is required to add your domestic partner to your medical and/or dental benefits. If you would like to designate your domestic partner for this benefit, please contact the Fidelity Service Center for the appropriate form. If you do not designate your domestic partner, a pre-retirement survivor benefit is payable to your domestic partner if you qualified for this benefit and if proof of domestic partnership is provided, such as: 1) a copy of a certified domestic partner registration from a state or local government or 2) a copy of a civil union certificate.

No pension benefit is payable if, on the date of your death, you are not married or if you do not have a domestic partner.

If You Die After You Terminate Employment But Before Benefits Commence

If you die after you terminate employment, but before you make a written election to begin your benefits, and after you are vested, your spouse or designated domestic partner will be eligible for a lifetime monthly survivor benefit from the plan.

This benefit is payable when you would have turned 65; however, your spouse may elect to begin payments when you would have been eligible for Early Retirement, but cannot defer payment later than April 1 following the year you would have reached age 73. The amount of your spouse's or designated domestic partner's benefit will be the same as if you had selected the 50% Joint and Survivor Annuity form of payment and died on the day of your spouse's Benefit Commencement Date. Domestic partners must begin receiving a distribution before the first anniversary of your death.

No pension benefit is payable if, on the date of your death, you are not married or if you do not have a domestic partner.

If You Die After Benefits Commence

If you die after the Fidelity Service Center receives your written election to have your benefits begin, and you elected a form of payment that provides for payments after death, benefits will continue to your beneficiary pursuant to that form of payment. If you made a written election of a form of payment that does not provide for payments after death, no additional payments will be made after your death. Special rules apply in the event you are married and your spouse is not your beneficiary.

Minimum Distribution Requirement

You are required by law to take a minimum distribution of your benefit by April 1 of the calendar year following the year in which you reach age 73 or retire, whichever is later. All of the plan's forms of payment are designed to meet the minimum distribution requirements. Minimum distributions are not eligible to be rolled into an IRA or another tax-qualified retirement plan.

If You Are Rehired

If you are rehired by Kaiser Permanente and are scheduled to work 20 or more hours per week, or actually work at least 1,000 Hours of Service in a calendar year, any retirement benefits you are currently receiving from the plan will be suspended. If you are scheduled to work less than 20 hours per week and you work fewer than 1,000 Hours of Service in a year, your benefits will continue. Your Years of Service and Credited Service earned during the time you are re-employed are used to determine any additional benefits when you terminate employment again. Your future benefits will be reduced based on any benefits already distributed to you.

Unclaimed Benefit Process

You are required to keep your most current address on file with the Fidelity Service Center. If you cannot be located within 90 days (or 180 days for any Voluntary Employee Contributions) of the 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. There are some exceptions, such as a Qualified Domestic Relations Order (QDRO) and qualified federal tax liens. For details of this provision, see the **Legal and Administrative Information** section.

Tax Considerations

Kaiser Permanente intends that the plan be tax qualified. With tax-qualification, your accruals under the plan are not currently taxable to you and you are taxed when you actually receive pension payments from the plan. Such payments will generally be taxable as ordinary income in the year received. However, the tax rules which apply to this plan are complex and apply differently to each individual. Kaiser Permanente does not guarantee the tax treatment of the plan or any distributions from the plan.

The Plan Administrator will provide you with a written notice at the time you become eligible to receive a distribution of benefits, which describes in general the tax consequences of the available distribution options. The Plan Administrator cannot advise you on your taxes. You should seek qualified tax advice regarding your own specific situation before making a decision as to the desired method and timing of distribution. You also may wish to review IRS Publication 575 “Pension and Annuity Income,” available free of charge online or at your local IRS office.

Potential Loss of Benefits

The plan is intended to provide you with a retirement benefit. However, some individuals may not qualify for a benefit and others may lose a benefit even if they once qualified. You should be aware that the following are some, but not all, of the possible reasons you may not receive part or all of a benefit:

- If you do not meet the requirements for eligibility to participate, you will not be entitled to any benefit.
- If you terminate employment before becoming vested, you may lose any benefit you have earned
- If all or a portion of your benefits are awarded to an alternate payee pursuant to a QDRO, you will not receive your entire benefit

- If the plan is terminated with insufficient assets to provide your benefit, and if the PBGC does not guarantee all of your benefit, then your benefit may be reduced or may be lost altogether.
- If the plan should be disqualified by the IRS, contributions made to the plan and earnings on plan assets may result in current taxable income to you.
- If the plan should overpay any benefits to you, the Plan Administrator has the right to offset the overpayment against future benefit payments to you, to recover the overpayment directly from you, or to use any other methods to recover the overpayment.
- As described above, in some circumstances no death benefits will be paid on your behalf.
- If the plan is less than 80% funded, then you will be provided with a notice of the plan's funding level and certain restrictions on amendments, benefits and accruals may apply.

For More Information

For more information about your plan benefit or to obtain a pension estimate, visit the Fidelity Service Center website at **netbenefits.com**. You may also call the Fidelity Service Center (See the **Contact Information** section).

Kaiser Permanente Supplemental Savings and Retirement Plan

The Kaiser Permanente Supplemental Savings and Retirement Plan (Plan B), a qualified defined contribution retirement savings plan, is a money purchase pension plan.

Who Is Eligible

You are eligible to participate in the plan if you are a Salaried employee or Resident Physician in the Hawaii Region.

When You Are Eligible

You are eligible to participate in the plan on the first pay period following the second anniversary of your date of hire.

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

How to Enroll

If you are newly hired or transferred, Vanguard will automatically send you an eligibility notice when you become eligible for the plan. You may enroll at any time online at **http://kpenroll.vanguard-education.com**. You will receive a Personal Identification Number (PIN) from Vanguard for the automated VOICE network. Access your account through the Vanguard website at **www.vanguard.com**, the VOICE network, or a Participant Services Associate at **800-523-1188**. Your **Kaiser Permanente Supplemental Savings and**

Retirement Plan number is **092528**. 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"

Employer Contributions

When you become a participant, Kaiser Permanente automatically begins to make contributions to your account. These contributions will equal 5% of your eligible earnings.

You will not owe income tax on employer contributions and any investment earnings until you receive a distribution from the plan.

Making After-Tax and Rollover Contributions to Your Account

After-Tax Employee Contributions

You can make after-tax contributions once you become eligible. You can contribute from 1% to 10% of your eligible earnings to your account. Your contributions are deducted from your pay after the applicable income taxes are withheld. When you take a distribution from your account, you will not owe any income tax on your after-tax employee contributions. However, you will owe income tax on any investment earnings associated with your contributions.

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.

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), 401(k), or 457b plans that you have with previous employers into your plan account. You must complete a rollover contribution form and submit it to Vanguard. More information is available online at **www.vanguard.com** or by calling Vanguard'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 2026 is $360,000. This amount may be indexed periodically for cost-of-living increases. Employer contributions to your account will only be calculated on pay up to the maximum compensation limit. 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."

Annual Addition Limit

The maximum amount you and your employer can contribute cannot exceed the annual addition limit which is the least of the following:

- The maximum limit allowed by the Internal Revenue Code (IRC) — which is $72,000 in 2026
- 100% of your annual compensation

Annual addition limits are calculated and monitored throughout the year. Your employee and employer contributions automatically stop when you reach your contribution limit. If you reach the limit, Vanguard will automatically restart your contribution the first pay period of the following year. 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 contributions to your account. This means that you are entitled to the total value of your contributions, employer 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 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.

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 is available online at **www.vanguard.com** or by calling Vanguard's VOICE network at **800-523-1188**. You may also obtain information and make changes to your account on your mobile device. Go to **vanguard.com/bemobile** to download the Vanguard app so you can access your account on the go.

Upon becoming a participant, any contributions to your account will be invested in the Qualified Default Investment Alternative (QDIA) until you select an investment option. The QDIA is the JPMorgan SmartRetirement Fund with the target date closest to the year in which you will reach age 65. Each JPMorgan SmartRetirement Fund is a well-diversified, professionally managed, automatic investment option designed to care for all of the assets within your employer retirement plan. The fund will gradually shift its emphasis from more aggressive investments to more conservative ones based on the approximate year (the target date) when an investor in the fund would attain age 65. Contact Vanguard to learn about your QDIA fund.

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

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

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

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

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 the lesser of: (1) 50% of your vested account balance, (2) $50,000, or (3) 100% of the portion of your account balance that includes your pre-tax employee contributions, rollover and/or transfer amounts, if applicable 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 2%.

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 58 months from the loan issue date.
- If you borrow on a long-term basis, you must repay the loan within 12 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 are married, federal law requires that your spouse consent to all loans. As a result, your application for a loan must be accompanied by a written, notarized statement of your spouse's consent.

If You Go on an Unpaid Leave of Absence

If you go on an unpaid leave of absence, payroll deductions for your plan loan automatically stop. You have the option to make 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 owed 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 73, whichever is later, if you have more than $5,000 in your account as of your termination date.

When Vanguard receives notice of your termination date, you will receive account distribution information. Contact Vanguard to receive payment as soon as administratively possible.

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

There are two types of in-service withdrawals available under the plan: age 65 withdrawals and after-tax withdrawals.

Age 65 Withdrawal

Upon attaining age 65 or older, you may take an in-service withdrawal of all or part of your Plan B account balance (both employer contributions and after-tax employee contributions and any applicable earnings) while still working at Kaiser Permanente. You may receive this one-time in-service withdrawal in many of the available forms of payment permissible under the terms of the plan (for more information on the available forms of payment, see “How Benefits Are Paid” below). If you are married, federal law requires that your spouse consent to all withdrawals.

If you choose an in-service withdrawal from the plan, when you retire you may be eligible for additional payments from the plan.

After-Tax Withdrawal

While you are still employed by Kaiser Permanente, you may withdraw your after-tax employee contributions plus investment earnings on your contributions by requesting a withdrawal.

The Internal Revenue Service (IRS) requires that investment earnings on your after-tax employee contributions be distributed on a prorated basis. Any investment earnings withdrawn are taxable as ordinary income and subject to an automatic 20% federal income tax withholding. If you are under 59½, the taxable portion may be subject to a 10% federal tax penalty and any applicable state tax penalties, in addition to ordinary income tax.

You can find out the amount available to you for withdrawal online at **www.vanguard.com**, or you can access this information by calling VOICE. If you have an outstanding loan, you may be limited on the amount you can withdraw.

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

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 less than $5,000, your account will be closed, and the amount will be rolled over into an Individual Retirement Account (IRA) in your name.

If the value if 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.

- **Single Life Annuity:** The total value of your account is used to purchase a non-transferable single life annuity that provides monthly income to you for your lifetime only. This is the normal form of payment of your benefits if you are not married.
- **50%, 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. 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 and you are single, the normal form of payment is the Single Life Annuity. Your spouse is entitled by federal law to receive benefits in the form of a 50% Joint and Survivor Annuity, which is the normal form of payment if you are married. Therefore, you are legally required to obtain your spouse's consent to any other type of distribution before it can be paid to you. This consent must be in writing and notarized no more than 90 days before the benefits begin.

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 your beneficiary is a minor, contact Vanguard for rules on who may act as a representative on behalf of that 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 beneficiary may elect any form of payment and may defer receiving payment until April 1 of the year following the year in which you would have reached age 73. Your spouse 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. Non-spouse beneficiaries may elect tax-free rollovers to an "inherited" IRA set up to specifically receive survivor benefits from the plan.

Tax Considerations

Since your contributions to the plan are made after taxes are withheld, they are not taxable when distributed to you. However, any investment earnings or employer contributions you receive are taxable as ordinary income, including any loans that are outstanding.

The federal government also requires 20% of the taxable portion of most distributions to be automatically withheld unless you directly transfer your benefit to a tax-deferred IRA, another Kaiser Permanente-sponsored defined contribution plan — such as the TSA — if you are a participant in that plan, or another employer's qualified retirement plan.

If you are under age 55 when you terminate and you receive a distribution before you are 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 elect any distribution from the plan.

Rollovers to Another Plan or Tax-Deferred IRA

Taxable distributions from your plan may be rolled over into another employer's qualified plan or a tax-deferred IRA. If an eligible distribution is rolled over, income taxes will be deferred until you later withdraw the funds. Remember that you may leave your account in your current plan until you are required to take a minimum distribution (see "Minimum Distribution Requirement"). Before choosing to roll over your distributions into another employer's qualified plan or an IRA, you should 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 73 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.

Kaiser Permanente Tax-Sheltered Annuity Plan

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

Who Is Eligible

You are eligible to 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
- 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 will receive a Personal Identification Number (PIN) from Vanguard for the automated 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 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 24,500 in 2026.

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), including any employer contributions and/or rollover contributions, 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 2026 is $8,000. 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 2026:

Regular Contribution Limit	Catch-Up Contribution Limit	Combined Contribution Limit
$24,500	$8,000	$32,500

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 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.

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), 457(b), or 401(k) plans that you have with previous employers into your plan account. You must complete a rollover contribution form and submit it to Vanguard. More information is available online at **www.vanguard.com** or by calling Vanguard's VOICE network at **800-523-1188**.

Vesting

Vesting refers to your entitlement to a benefit.

Employee Contributions

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.

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 2026 is $360,000. This amount may be indexed periodically for cost-of-living increases. Employer contributions to your account will only be calculated on pay up to the maximum compensation limit. 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."

Annual Addition Limit

The maximum amount you and your employer can contribute cannot exceed the annual addition limit which is the least of the following:

- The maximum limit allowed by the Internal Revenue Code (IRC) — which is $72,000 in 2026
- 100% of your annual compensation

Annual addition limits are calculated and monitored throughout the year. Your employee and employer contributions automatically stop when you reach your contribution limit. If you reach the limit, Vanguard will automatically restart your contribution the first pay period of the following year. 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.

Choosing Your Beneficiary

When you become a participant, you should name a beneficiary to receive payment of your account if you die. You may choose anyone you want as your beneficiary. However, if you are married and you want to choose someone other than your spouse as your beneficiary, your beneficiary designation must be accompanied by a written, notarized statement of your spouse's consent to be valid. 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 is available online at **www.vanguard.com** or by calling Vanguard's VOICE network at **800-523-1188**. You may also obtain information and make changes to your account on your mobile device. Go to **vanguard.com/bemobile** to download the Vanguard app so you can access your account on the go.

Upon becoming a participant, any contributions to your account will be invested in the Qualified Default Investment Alternative (QDIA) until you select an investment option. The QDIA is the JPMorgan SmartRetirement Fund with the target date closest to the year in which you will reach age 65. Each JPMorgan SmartRetirement Fund is a well-diversified, professionally managed, automatic investment option designed to care for all of the assets within your employer retirement plan. The fund will gradually shift its emphasis from more aggressive investments to more conservative ones based on the approximate year (the target date) when an investor in the fund would attain age 65. Contact Vanguard to learn about your QDIA fund.

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

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

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

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

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 58 months from the loan issue date.
- If you borrow on a long-term basis, you must repay the loan within 12 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 owed 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 73, whichever is later, if you have more than $5,000 in your account as of your termination date.

Please note: If you have a Roth account, you can avoid IRS-required age 73 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 73. 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, please contact Vanguard and consult with your tax advisor.

When Vanguard receives notice of your termination date, you will receive account distribution information. Contact Vanguard to receive payment as soon as administratively possible.

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 employee pre-tax and/or Roth after-tax contributions, rollover contributions, and applicable investment earnings from your plan account.

Hardship Withdrawal

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

Financial hardship includes money needed for the following:

- College tuition for yourself, your spouse or domestic partner, or your dependents
- Medical expenses for yourself, your spouse or domestic partner, or your dependents
- Purchasing your primary residence or avoiding eviction from or foreclosure on your home
- Certain expenses relating to the repair of damage to your principal residence that qualify as a casualty deduction under the Internal Revenue Code
- 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 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. For example, you can to have your pre-tax contributions distributed, but not your Roth after-tax contributions. 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 less than $5,000, your account will be closed, and the amount will be rolled over into an Individual Retirement Account (IRA) in your name.

If the value if 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.
- **Partial Termination Withdrawal:** A portion of your account is paid to you in a single payment.
- **Single Life Annuity:** The total value of your account is used to purchase a non-transferable single life annuity that provides monthly income to you for your lifetime only. 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 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.
- **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.

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.

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.

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, contact Vanguard for rules on who may act as a representative on behalf of that 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 beneficiary may elect any form of payment and may defer receiving payment until April 1 of the year following the year in which you would have reached age 73. Your spouse 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. 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 reached 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 73 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.

The Modified Retiree Medical Benefit

Kaiser Permanente offers retiree medical benefits to employees who meet certain age and years of service requirements as active employees and who meet other eligibility requirements as described below.

Overview of Your Retiree Medical Benefits

If you meet the eligibility requirements for retiree medical benefits at the time you terminate employment, you will be offered the **Modified Retiree Medical Benefit**. You must enroll in the Kaiser Permanente Senior Advantage (KPSA) plan through your plan's enrollment process after enrolling in Medicare (see the **How to Enroll** section). Your retiree medical benefits will include:

- KPSA plan
- Retiree Medical Premium Subsidy – to help pay for your KPSA premiums
- Retiree Medical Health Reimbursement Account (HRA) – to help pay for eligible medical expenses associated with your KPSA plan

Grandfathered Employees

If you were hired before June 1, 1985 you are considered a Grandfathered employee, and your eligibility and benefits may differ. Please refer to the "Eligibility for Grandfathered Employees" paragraphs in the sections below, where applicable, for information on how your benefits may differ.

Who Is Eligible

You will be offered retiree medical benefits if you retire from Kaiser Permanente at age 55 (or later) with at least 15 Years of Service. You must also be eligible for medical benefits on your last day of employment. If

you retire while on a leave of absence, you must have been eligible for active medical coverage at the start of your leave of absence. Please see below for the definition of a Year of Service. **If your spouse or domestic partner also receives retiree medical benefits and you elect to enroll under their plan, you will not be eligible for the benefits in this section.**

Eligibility for Grandfathered Employees

If you were hired before June 1, 1985 you are eligible if you retire at age 55 or older with at least 15 Years of Service, or if your age and years of service equal 75 or more. You must also be eligible for medical benefits on your last day of employment.

Definition of a Year of Service for Retiree Medical Benefits

A Year of Service for retiree medical eligibility and to determine the initial Retiree Medical Health Reimbursement Account (HRA) balance is any calendar year in which you are compensated for at least 1,000 Hours of Service from a Kaiser Permanente payroll. In general, any calendar year in which you are compensated for fewer than 1,000 Hours of Service will not count toward retiree medical eligibility or toward the Retiree Medical HRA formula. An Hour of Service is any hour for which you are compensated from a Kaiser Permanente payroll, including hours worked, paid vacation and sick time, and other paid leaves.

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

When Benefits Begin

You will be offered retiree medical benefits when you turn age 65 or when you become eligible for and enroll in Medicare, whichever is later. Your benefits will begin after you enroll according to plan rules.

If You Retire After Age 65

If you meet the eligibility requirements (see above), and you retire after age 65, you will be offered retiree medical benefits effective the first day of the month following your retirement date.

Grandfathered Employees

If you are a Grandfathered employee and you retire prior to age 65, you will be offered retiree medical benefits effective the first day of the month following your retirement date. Until you reach Medicare eligibility, you will be offered coverage equivalent to the plan offered to active employees in effect when you receive services

If you move outside the service area, you will be offered the Comprehensive Medical Plan. When you become eligible for and enroll in Medicare, you will be offered the Modified Retiree Medical Benefit.

Contact the Kaiser Permanente Retirement Center (KPRC) for more information about these plans.

How to Enroll

To begin retiree medical benefits, contact the Kaiser Permanente Retirement Center (KPRC) at least 90 days prior to your eligibility date. The KPRC will also attempt to contact you at your last known address. It is important to keep your address current with the KPRC so that they can contact you when you are eligible to commence benefits.

You must enroll according to plan rules in order to receive retiree medical benefits. The KPRC will provide you with instructions on how to commence your benefits. You will also receive information on the Retiree Medical HRA, and (if eligible), the Retiree Medical Premium Subsidy. You must first:

- Sign up for Medicare Parts A and B by contacting the Social Security Administration at **www.medicare.gov.**
- Once you receive your Medicare claim number, please call the Kaiser Permanente Medicare Sales Service Center at **877-603-0086** to enroll in your retiree medical benefits. You must call this toll-free number to enroll; otherwise, your subsidy (if applicable) will not be applied.

Your Medicare-eligible spouse or domestic partner must follow the same steps to enroll in retiree medical benefits.

Please refer to "Medicare Assignment" for more information.

Dependent Coverage

Your dependents are subject to the same eligibility requirements as dependents of active employees.

If you were hired prior to January 1, 2014: Retiree medical benefits for your spouse or domestic partner and eligible children begin when your retiree medical benefits begin.

Eligible dependents **who do not qualify for Medicare** will be offered coverage under a plan similar to the plan that is in effect for active employees at the time they receive services. If you choose to extend retiree medical benefits to your domestic partner and his or her eligible dependents, the benefits provided may result in taxable income to you. Refer to the **Flexible Benefits** section of your SPD for information on the tax effects of domestic partner benefits.

Coverage for your spouse or domestic partner stops when he or she becomes eligible for Medicare. Your spouse or domestic partner must enroll in the Kaiser Permanente Senior Advantage individual plan, in accordance with plan rules (refer to the “How to Enroll” section). Once your spouse or domestic partner becomes eligible for Medicare, Kaiser Permanente may then provide a Retiree Medical Premium Subsidy to help pay for his or her Kaiser Permanente Senior Advantage premiums, if eligible (refer to the "Retiree Medical Premium Subsidy" section). Your eligible children’s coverage stops when they reach the age limits or otherwise become ineligible.

If you move outside of your home region, your eligible dependents who do not qualify for Medicare will be offered that region's KFHP Mid-level medical plan with Supplemental Medical Plan coverage.

If you move outside of the Kaiser Permanente Service Areas, your eligible dependents who do not qualify for Medicare will be offered coverage under the out-of-area plan in effect at the time services are received.

If you were hired on or after January 1, 2014: Your dependents will not be eligible for medical coverage or the Retiree Medical Premium Subsidy when you retire, but you may be reimbursed for the Medicare-eligible

medical expenses of your spouse or tax-dependent domestic partner from your Retiree Medical Health Reimbursement Account.

How the Modified Retiree Medical Benefit Works

The retiree medical benefits are integrated with the Kaiser Permanente Senior Advantage individual plan to help pay for your health care expenses in retirement.

Note: Annually, it is important you review the Kaiser Permanente Senior Advantage individual plan(s) available through the Kaiser Permanente's Retiree Medical Plan in your area as there may be cost and benefit changes from year to year. Visit **medicare.kaiserpermanente.org** for more information.

Here's how the benefits work:

You enroll in the Kaiser Permanente Senior Advantage individual plan through the plan's enrollment process after enrolling in Medicare. Kaiser Permanente provides you a:

- Kaiser Permanente Senior Advantage individual plan
- Retiree Medical Premium Subsidy to help pay for the lowest cost Kaiser Permanente Senior Advantage individual plan premiums. **Note: The Subsidy is only for employees hired before January 1, 2014**
- Retiree Medical Health Reimbursement Account to help pay for eligible medical expenses associated with Kaiser Permanente Senior Advantage or other Medicare individual plans enrolled in through the Modified Retiree Medical benefit.

Medicare Assignment and Reimbursements

Once you and your spouse or domestic partner become eligible for Medicare, your retiree coverage will be integrated with Medicare. You and your spouse or domestic partner, when eligible, must:

1. Enroll in all applicable parts of Medicare (including Parts A and B) and
2. Enroll in Kaiser Permanente Senior Advantage individual plan which assigns you and your spouse or domestic partner in all Medicare benefits (including Parts A, B and D) to Kaiser Permanente. Kaiser Permanente will automatically assign your Part D for you.

You are responsible for paying the Medicare Part B and D premiums and surcharges to Social Security Administration.

If you fail to enroll and assign Medicare by enrolling in the Kaiser Permanente Senior Advantage individual plan through the plan's enrollment process, your Retiree Medical Premium Subsidy will not be applied, and you will not be able to utilize the Retiree Medical Health Reimbursement Account until you enroll.

If you assign your Medicare coverage to another provider, Medicare will notify Kaiser Permanente, and your retiree medical coverage will be terminated. You will have an opportunity to reenroll in retiree medical during the next open enrollment period.

Important: If you live in a Kaiser Permanente Senior Advantage Service Area, you must enroll in a Kaiser Permanente Senior Advantage individual plan, according to the plan rules, in order to receive employer-provided coverage. If you move to an area where there is no Kaiser Permanente Senior Advantage plan available, please contact the KPRC.

Medicare Part B Premium Reimbursements

If you are a Grandfathered employee, you and your spouse or domestic partner will be reimbursed for standard Medicare Part B premiums.

In order to be eligible for Medicare Part B premium reimbursements, you and your eligible spouse or domestic partner must be enrolled in the Kaiser Permanente Senior Advantage or Medicare Advantage plan (as applicable) through the plan's enrollment process. To receive your Medicare Part B premiums retroactive to your initial Medicare enrollment date, you must assign your Medicare coverage to Kaiser Permanente Senior Advantage or Medicare Advantage plan (as applicable) within two months of enrolling in your Kaiser Permanente retiree Medicare medical coverage or when you transition from your Kaiser Permanente retiree non-Medicare medical coverage to the Kaiser Permanente retiree Medicare medical coverage. If you assign your Medicare coverage after two months, you will not be reimbursed retroactively to the initial Medicare enrollment date. You will also not be reimbursed for any Medicare Part B late enrollment penalties.

Retiree Medical Premium Subsidy

The Retiree Medical Premium Subsidy applies to eligible employees hired before January 1, 2014.

If you meet the eligibility requirements, Kaiser Permanente's Retiree Medical plan will provide both you and your eligible spouse or domestic partner with a Kaiser Permanente Senior Advantage (KPSA) individual plan option and a Retiree Medical Premium Subsidy. You and your eligible spouse or domestic partner must enroll in the KPSA individual plan option offered through the Kaiser Permanente Retiree Medical Plan's enrollment process.

The monthly applicable Retiree Medical Premium Subsidy is equal to the lesser of the maximum subsidy amount or the premium for the lowest cost KPSA plan in your service area. Each year, the maximum subsidy increases 3%.

In years that you elect a KPSA individual plan offered through the Kaiser Permanente Retiree Medical Plan's enrollment process with a premium that exceeds the monthly applicable Retiree Medical Premium Subsidy, you will be responsible for paying the difference in order to maintain your KPSA individual plan coverage. You can use the Retiree Medical Health Reimbursement Account (Retiree Medical HRA) to be reimbursed for the difference or pay out-of-pocket (see the "Retiree Medical Health Reimbursement Account" section for more information).

If you live within a KPSA individual plan service area in any Kaiser Permanente Region, the Retiree Medical Premium Subsidy may only be used for Kaiser Permanente Senior Advantage individual plan or Kaiser Permanente Medicare Advantage individual plan premiums. If a Kaiser Permanente Senior Advantage individual plan or Kaiser Permanente Medicare Advantage individual plan is not available where you live, you can use your Retiree Medical Premium Subsidy to pay for any medical premiums permitted by the Internal Revenue Code, including non-Kaiser Permanente Senior Advantage Medicare supplement plans or Medicare Advantage plans.

Please note: If the KPSA individual plan premium (or other allowable plan premium, if you live outside a Kaiser Permanente service area) is less than the monthly applicable Retiree Medical Premium Subsidy amount, you will not receive the difference.

If you were hired on or after January 1, 2014, you are not eligible for the Retiree Medical Premium Subsidy.

Tax Considerations

If you have a domestic partner or civil union partner who does not qualify as your dependent for tax purposes as defined by the Internal Revenue Code, the value of the Retiree Medical Premium Subsidy provided to your non-tax-dependent domestic partner or civil union partner will be taxable income to you. Contact your tax advisor for more information.

Retiree Medical Health Reimbursement Account

Once you retire from Kaiser Permanente and you become eligible for and enroll in Medicare, you can access a Retiree Medical Health Reimbursement Account (HRA). The Retiree Medical HRA is a notional account, which is an account where funds are made available only when you present a reimbursement claim.

Retiree Medical HRA Balance

The initial balance of the Retiree Medical HRA will be based on Years of Service, as defined in the "Definition of a Year of Service for Retiree Medical Benefits" section, with Kaiser Permanente at retirement or termination.

The initial Retiree Medical HRA balance will be based on $2,500 for every Year of Service. For example, if you retire from Kaiser Permanente with 30 Years of Service, the initial Retiree Medical HRA balance will be $75,000.

Please note: When you reach age 85, an HRA Supplement of $10,000 will be added to the Retiree Medical HRA balance. If you have depleted the HRA before age 85, it will be re-established with a $10,000 balance.

How the Retiree Medical HRA Works

When you have eligible medical expenses, you submit a claim for reimbursement. When you become eligible to access the Retiree Medical HRA, you will receive a letter that will explain how the HRA works in detail from Kaiser Permanente Retirement Center (KPRC).

For more information about the Retiree Medical HRA, or to access your account, you may visit the KPRC website at **www.myplansconnect.com/kp**. You can also call the KPRC (see the **Contact Information** section).

Using Your Retiree Medical HRA Debit Card

You will receive a Retiree Medical HRA Debit Card that you can use to pay for eligible Retiree Medical HRA expenses such as medical copayments and prescriptions. The card works like a debit card. It is preloaded with your Retiree Medical HRA balance. The HRA Debit Card is regulated by IRS rules, and, in some cases, you may be asked to provide the KPRC with documentation to verify that the item or service purchased was an eligible expense.

You can mail copies of your documentation to:

Kaiser Permanente Retirement Center
Reimbursement Center
P.O. Box 2844
Fargo, ND 58108

If you have an eligible non-tax-dependent domestic partner, you will not receive the HRA Debit Card due to certain tax rules, but you may still submit your eligible expenses for reimbursement by filing a claim. For information on how to file a claim, please refer to the **Disputes, Claims, and Appeals** section. For additional information on the HRA Debit Card, please contact the KPRC.

Eligible Medical Expenses

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

If you live in a Kaiser Permanente Senior Advantage or Medicare Advantage Service Area, as applicable, you may use the Retiree Medical HRA to be reimbursed for expenses that are approved under Internal Revenue Code Section 213(d) for Medicare eligible services connected with a Kaiser Permanente medical plan offered through the retiree medical benefit. This includes expenses incurred at a Kaiser Permanente facility, such as Kaiser Permanente Medicare Advantage copayments and deductibles (including copayments and deductibles related to prescription drugs for Medicare-eligible services), over-the-counter medications, menstrual care products, Kaiser Permanente Medicare Advantage premiums not covered by the subsidy, and copayments and deductibles for your Medicare-eligible spouse or tax-dependent domestic partner. Expenses for additional services or products, including, but not limited to dental, vision, and hearing aids, received through a Kaiser Permanente enhanced Medicare-related plan (such as the Kaiser Permanente Advantage Plus Individual Plan), provided that such expenses are incurred at a Kaiser Permanente facility, are also eligible. To confirm whether an expense is for a Medicare-eligible service, visit **https://www.medicare.gov/coverage** and search for the test, item, or service.

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

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

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

Expenses Not Covered

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

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

- Expenses in excess of the Retiree Medical HRA account balance
- Expenses incurred before you were eligible to access the Retiree Medical HRA or while you are employed at Kaiser Permanente
- Expenses for someone that does not qualify as your dependent under the Internal Revenue Code
- Reimbursement for your children's health care expenses
- Babysitting expenses due to doctor visits
- Baldness treatments or hair transplants
- Cosmetic surgery, procedures, services, and products (non-medically necessary)
- Dental veneers or bonding (non-medically necessary)
- Dietary, nutritional and herbal supplements used to maintain general health
- Diet foods
- Electrolysis
- Exercise equipment or programs to promote general health
- Family and marriage counseling
- Funeral services
- Marijuana or other Schedule 1 controlled substances (even for medical purposes)
- Medical insurance premiums paid for a non-Kaiser Permanente medical plan, except as noted above if you live outside of a Kaiser Permanente service area, or for another employer's plan
- Medicare Part B or Part D premiums
- Medicare Part B or Part D surcharges, such as late enrollment surcharges and the income-related monthly adjustment amount
- Recreational lessons, such as swimming or dancing
- Vacation expenses (even if recommended by a doctor)
- Varicose vein cosmetic procedure

Additional federal limits may apply.

How to File a Retiree Medical HRA Reimbursement Claim

For information about how to file a claim for reimbursement from the Retiree Medical HRA, and how to appeal a denied claim, please see the **Disputes, Claims, and Appeals** section.

When the Retiree Medical HRA Closes

The Retiree Medical HRA will be closed and benefits terminated when any of the following conditions are met:

- The Retiree Medical HRA balance reaches zero ($0)
- If the balance reaches zero before you reach age 85, the HRA will be re-established with the HRA Supplement of $10,000, and benefits will be reinstated, when you reach age 85
- Upon your death, if you have no surviving spouse or domestic partner who was an eligible dependent as defined in the Internal Revenue Code
- Upon the remarriage, recommitment, or death of your surviving spouse or eligible domestic partner

Please note: When you reach age 85, an HRA Supplement of $10,000 will be added to the Retiree Medical HRA balance. If you have depleted the HRA before age 85, it will be re-established with a $10,000 balance.

How the Retiree Medical HRA Works

When you have eligible medical expenses, you submit a claim for reimbursement. When you become eligible to access the Retiree Medical HRA, you will receive a letter that will explain how the HRA works in detail from Kaiser Permanente Retirement Center (KPRC).

For more information about the Retiree Medical HRA, or to access your account, you may visit the KPRC website at **www.myplansconnect.com/kp** or sign on to **kp.org/HRconnect**. You can also call the KPRC (see the **Contact Information** section).

Using Your Retiree Medical HRA Debit Card

You will receive a Retiree Medical HRA Debit Card that you can use to pay for eligible Retiree Medical HRA expenses such as medical copayments and prescriptions. The card works like a debit card. It is preloaded with your Retiree Medical HRA balance. The HRA Debit Card is regulated by IRS rules, and, in some cases, you may be asked to provide the KPRC with documentation to verify that the item or service purchased was an eligible expense.

You can mail copies of your documentation to:

Kaiser Permanente Retirement Center
Reimbursement Center
P.O. Box 2844
Fargo, ND 58108

If you have an eligible non-tax-dependent domestic partner, you will not receive the HRA Debit Card due to certain tax rules, but you may still submit your eligible expenses for reimbursement by filing a claim. For information on how to file a claim, please refer to the **Disputes, Claims, and Appeals** section. For additional information on the HRA Debit Card, please contact the KPRC.

Eligible Medical Expenses

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

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

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

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

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

Expenses Not Covered

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

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

- Expenses in excess of the Retiree Medical HRA account balance
- Expenses incurred before you were eligible to access the Retiree Medical HRA or while you are employed at Kaiser Permanente
- Expenses for someone that does not qualify as your dependent under the Internal Revenue Code
- Reimbursement for your children's health care expenses
- Babysitting expenses due to doctor visits
- Baldness treatments or hair transplants

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

Additional federal limits may apply.

How to File a Retiree Medical HRA Reimbursement Claim

For information about how to file a claim for reimbursement from the Retiree Medical HRA, and how to appeal a denied claim, please see the **Disputes, Claims, and Appeals** section.

When the Retiree Medical HRA Closes

The Retiree Medical HRA will be closed and benefits terminated when any of the following conditions are met:

- The Retiree Medical HRA balance reaches zero ($0). If the balance reaches zero before you reach age 85, the HRA will be re-established with the HRA Supplement of $10,000, and benefits will be reinstated, when you reach age 85
- Upon your death, if you have no surviving spouse or domestic partner who was an eligible dependent as defined in the Internal Revenue Code
- Upon the remarriage, recommitment, or death of your surviving spouse or eligible domestic partner

Retiree Medical Benefits for Survivors

Retiree Medical HRA for Surviving Spouse or Tax-Dependent Domestic Partner

If you die before the Retiree Medical HRA balance reaches zero, any balance in the Retiree Medical HRA will be available for your surviving spouse, or for a surviving domestic partner who was a dependent as defined by the Internal Revenue Code, (but not for children) for eligible medical expenses.

If you die before becoming eligible to use the Retiree Medical HRA, but after you satisfied the Modified Retiree Medical benefit age and years of service eligibility requirements, your surviving spouse or eligible domestic partner may access the Retiree Medical HRA when you would have reached age 65.

If you die before reaching age 85, your surviving spouse or eligible domestic partner will be able to access the additional HRA Supplement amount when you would have reached age 85.

Your spouse or tax-dependent domestic partner's eligibility to access the HRA as a survivor will end if he or she remarries or enters a new domestic partner relationship.

Retiree Medical Premium Subsidy for Surviving Spouse or Domestic Partner

If you die after you become eligible for, and begin to receive, the Retiree Medical Premium Subsidy, your surviving spouse's or domestic partner's Retiree Medical Premium Subsidy will continue until remarriage or recommitment.

If you die after you meet the age and years of service eligibility requirements for retiree medical benefits, but before benefits begin, your surviving spouse's or domestic partner's Retiree Medical Premium Subsidy will commence, subject to applicable rules, when you would have turned age 65, and will continue until remarriage, recommitment or death.

Please note: Your surviving domestic partner does not have to be your tax dependent in order to be eligible for the subsidy.

Survivor Benefits for Pre-Medicare Eligible Dependents

If you die after you meet the age and years of service eligibility requirements for retiree medical benefits, but before benefits begin, and your dependents are eligible for retiree medical benefits, medical coverage for your surviving eligible dependents will start when you would have been eligible.

Coverage for Surviving Pre-Medicare Eligible Spouse or Domestic Partner

If at the time medical benefits are to start, your surviving spouse or domestic partner is not yet Medicare eligible, he or she will receive coverage as described in "Dependent Coverage" earlier in this section. After reaching Medicare eligibility, he or she may become eligible for a Retiree Medical Premium Subsidy and the Retiree Medical HRA, per the eligibility rules for each of those benefits. Survivor benefits will end if your spouse or domestic partner remarries or enters a new domestic partner relationship.

Coverage for Eligible Surviving Children

Your surviving children — if they are eligible — will be offered medical coverage at the time you would have been eligible as described in "Dependent Coverage" earlier in this section. Their coverage will end the last day of the month in which they turn age 26, or otherwise become ineligible, whichever is earlier. Please note that your disabled dependents age 26 or older will lose eligibility for benefits in the event of your death.

Coverage for Eligible Surviving Children

Your surviving children — if they are eligible — will be offered medical coverage at the time you would have been eligible as described in **Dependent Coverage** earlier in this section. Their coverage will end the last day

of the month in which they turn age 26, or otherwise become ineligible, whichever is earlier. Please note that your disabled dependents age 26 or older will lose eligibility for benefits in the event of your death.

If You Move to a KPSA Service Area in Another Region

If you move to a Kaiser Permanente Senior Advantage Service Area in another Kaiser Permanente region:

- You will need to enroll in the Kaiser Permanente Senior Advantage individual plan available in your new location. Please call the Kaiser Permanente Medicare Sales Service Center at **877-603-0086** to enroll in your retiree medical benefits in your new service area. You must call this toll-free number to enroll; otherwise, your subsidy will not be applied. Kaiser Permanente Senior Advantage plan services and costs vary from region to region, and your coverage and costs will change accordingly.
- You will need to disenroll from the Kaiser Permanente Senior Advantage individual plan in your prior location (if enrolled). Please contact the Kaiser Permanente Medicare Sales Service Center for additional information.
- Your Retiree Medical Premium Subsidy amount (if eligible) will be based on the region from which you terminate or retire, increasing 3% per year. If the lowest cost Kaiser Permanente Senior Advantage Plan individual plan premium in your new region is higher than your Retiree Medical Premium Subsidy amount, you will need to pay the difference and can use the Retiree Medical HRA to help pay for this cost. If your new premium is less than your Retiree Medical Premium Subsidy amount, you will not receive the difference.
- You will continue to have access to the Retiree Medical HRA for Kaiser Permanente plan expenses in the new service area as long as you have enrolled according to the plan rules.

If you were hired before January 1, 2014: Your eligible dependents who do not qualify for Medicare will be offered coverage as described in "Dependent Coverage" earlier in this section.

Note: The benefits you receive if you move to another region may be different than the benefits offered in your home region; however, you are still required to assign your Medicare benefits to Kaiser Permanente once you become eligible for Medicare.

If You Live Outside of a KPSA Service Area

If you live in a location where no Kaiser Permanente Senior Advantage Plan is available:

- You may purchase a non-Kaiser Permanente Senior Advantage Medicare supplement plan or Medicare Advantage Plan of your choice.
- You may use the Retiree Medical Premium Subsidy (if eligible) to pay for premiums associated with the plan or for any medical premiums allowed by the Internal Revenue Code, for you and your Medicare-eligible spouse or domestic partner.
- You can use the Retiree Medical HRA for Medicare supplement plan or Medicare Advantage Plan premiums in excess of any subsidy, and any deductibles, coinsurance, and copayments associated with the Medicare plan you or your spouse or tax-dependent domestic partner enroll in, in accordance with Internal Revenue Code guidelines.
- **If you were hired before January 1, 2014:** Your eligible dependents who do not qualify for Medicare will be offered coverage under the out-of-area medical plan in effect at the time services are received.

Please note: Kaiser Permanente Senior Advantage Plan service areas are generally defined by ZIP code. Visit **kp.org/medicare** for more information on where these plans are offered.

When Retiree Medical Benefits End

Retiree Medical coverage continues as long as you continue to pay any required premiums and maintain enrollment in the Kaiser Permanente Senior Advantage individual plan (or a Medicare supplemental plan or Medicare Advantage Plan, if you live in an area with no Kaiser Permanente Senior Advantage individual plan). If you do not pay the required premiums for your coverage or maintain your enrollment as described above, your coverage will be terminated in accordance with the Kaiser Permanente Senior Advantage or other plan terms. Similarly, if you do not pay any required premiums for your eligible spouse, domestic partner and/or eligible children's plans, their coverage will be terminated.

If You Terminate Employment and Return to Work

Breaks In Service

If you terminate employment with Kaiser Permanente and are rehired in a benefit-eligible position, the period between your original termination date and your rehire date is called a break in service. The period between your hire or rehire date and your termination date is called an employment period.

Employees hired before June 1, 1985: If you were originally hired before June 1, 1985, had a break in service of more than six months, and your prior employment period was less than two years in a status position, the date that you are rehired after the break in service will be used to determine when your retiree medical benefit begins, if eligible.

If, however, you are rehired within six months or have at least two years of prior service in a status position, then your original date of hire is moved forward by the break in service period, and this new date will be used to determine when your retiree medical benefit begins, if eligible.

For subsequent terminations and rehires, if your most recent break in service is more than six months and if your most recent prior employment period is less than two years in a status position, your last calculated date of hire is moved forward by the most recent employment period plus the most recent break in service period. If not your most recent break in service is less than six months or your most recent prior employment period is at least two years in a status position, your last calculated date is moved forward by the most recent break in service period. The new calculated date will be used to determine when your retiree medical benefit begins, if eligible.

Employees hired on or after June 1, 1985: A break in service will have no effect on your entitlement to retiree medical benefits provided to employees hired on or after June 1, 1985, as long as you satisfy all eligibility requirements for this retiree medical coverage, including the total Years of Service requirement.

Transferred Employees

If you transfer from one employee group to another, your retiree medical benefits will be the ones offered by the employee group from which you last retire.

Rehired Retirees

If you are receiving retiree medical benefits from Kaiser Permanente and are rehired your retiree medical benefits will stop, even if you return in a non-benefited position. Upon re-retirement, your retiree medical

benefits will be the benefits applicable to the group you re-retire from on the date of your most recent separation from service.

Retiree Life Insurance

Kaiser Permanente provides Grandfathered Retiree Life insurance coverage when you retire.

If eligible, you will be automatically enrolled in employer-paid retiree life insurance.

When you retire, you will need to name a beneficiary to receive payment of your life insurance benefits in the event of your death. If you had designated beneficiaries for your life insurance as an active employee, please note that these beneficiary designations **will not carry over** to Retiree Life insurance. You will need to re-designate your beneficiaries for this benefit. Please contact the KPRC for more information.

Who Is Eligible

The following guidelines apply if you are an employee hired before January 1, 2014.

You are eligible for Grandfathered Retiree Life insurance if you meet the following requirements when you terminate employment:

- You are age 55 or older with at least 15 Years of Service or your age plus Years of Service equals 75
- You are enrolled in employer-paid life insurance on your last day of employment

If you were hired on or after January 1, 2014: You are not eligible for Retiree Life insurance coverage.

Grandfathered Retiree Life Insurance

If eligible, you will receive Grandfathered Retiree Life coverage in an amount equal to 50% of your final annual salary on the date of your retirement, up to $375,000. This coverage will continue for one month without reduction. Thereafter, the amount of your coverage will decrease by 1% of the original coverage each month for 75 months, until it reaches a minimum of 25% of the original amount, or $2,000, whichever is higher.

Imputed Income

According to Internal Revenue Service (IRS) regulation, the premium cost of employer-paid Grandfathered Retiree Life coverage in excess of $50,000 is considered imputed income. Each year that you remain covered, an applicable amount of imputed income will be included as taxable income on your Form W-2.

You are able to make a one-time, irrevocable election to reduce your life insurance coverage to $50,000 and avoid imputed income. Consult your tax advisor if you have any questions about your own tax situation.

Cost of Coverage

The premium for your Grandfathered Retiree Life insurance coverage is employer-paid.

Conversion Privilege

You have the option to convert amounts of your life insurance lost due to retirement. You may convert your life insurance coverage to an individual policy within 31 days of your retirement.

You may not convert your coverage retroactively. Contact the KPRC for an explanation of your life insurance conversion rights.

When Coverage Ends

Your Retiree Life insurance coverage ends if you return to work with any Kaiser Permanente entity and become eligible for benefits based on your work schedule.

When you resume your retirement, your Grandfathered Retiree Life insurance coverage may be reinstated depending on your last position, employment status, and employee group. Otherwise, if you return to work in a non-benefits-eligible position, your Retiree Life coverage continues for your and your eligible dependents.

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 Fidelity.

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 MyKP) 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 and retiree medical 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* (SPD). 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 pursuant to the terms of a specific plan (e.g., a long-term disability benefit or an early retirement benefit under the defined benefit plan).

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

Your Right to Appeal a Denied Claim

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

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

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

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

Health Plan Claims and Appeals

There are special rules that apply to claims and appeals for benefits under a health plan such as a medical plan, a dental plan, or the Health Care 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.
Attn: Claims Administration
P.O. Box 378021
Denver, CO 80237

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.
Attn: Regional Appeals Office
711 Kapiolani Blvd.
Honolulu, HI 96814

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

Supplemental Medical 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**.

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

Preferred Provider Organization Plus (PPO Plus) Plan Claims and Appeals

How To File Your Claim

If your plan provides coverage when care is received only from In-Network providers, you may still have Out-of-Network claims (for example, when Emergency Services are received from an Out-of-Network provider) and should follow the claim submission instructions for those claims. Claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form. You may get the required claim forms from the website listed on your identification card or by using the toll-free number on your identification card.

CLAIM REMINDERS

Be sure to use your Member ID and Account/Group Number when you file Cigna's claims forms, or when you call your Cigna Claim Office. Your Member ID is the ID shown on your Benefit Identification Card. Your Account/Group Number is shown on your Benefit Identification Card.

Be sure to follow the instructions listed on the back of the claim form carefully when submitting a claim to Cigna.

Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within 180 days for Out-of-Network benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within 180 days for Out-of-Network benefits, the claim will not be considered valid and will be denied.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or conceals

for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

Appeals

Medical - When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you" or "your" also refers to a representative or provider designated by you to act on your behalf; unless otherwise noted. We want you to be completely satisfied with the services you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start With Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you may call the toll-free number on your ID card, explanation of benefits, or claim form and explain your concern to one of our Customer Service representatives. You may also express that concern in writing. We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Mail your claim or any inquiry to:

Cigna Appeals Unit
P.O. Box 188011
Chattanooga, TN 37422-8011
Phone: 855-429-1426

Internal Appeals Procedure

To initiate an appeal of an adverse benefit determination, you must submit a request for an appeal to Cigna within 180 days of receipt of a denial notice. If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call or write us at the toll-free number on your ID card, explanation of benefits, or claim form.

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional. We will respond in writing with a decision within 30 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination or a postservice Medical Necessity determination. We will respond within 60 calendar days after we receive an appeal for any other postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, this information will be provided automatically to you as soon as possible and

sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You may request that the appeal process be expedited if the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your health care provider would cause you severe pain which cannot be managed without the requested services.

If you request that your appeal be expedited, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level-one appeal would be detrimental to your medical condition. When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

External Review Procedure

If you are not fully satisfied with the decision of Cigna's internal appeal review and the appeal involves medical judgment or a rescission of coverage, you may request that your appeal be referred to an Independent Review Organization (IRO). The IRO is composed of persons who are not employed by Cigna, or any of its affiliates. A decision to request an external review to an IRO will not affect the claimant's rights to any other benefits under the plan. There is no charge for you to initiate an external review. Cigna and your benefit plan will abide by the decision of the IRO.

To request a review, you must notify the Appeals Coordinator within 4 months of your receipt of Cigna's appeal review denial. Cigna will then forward the file to a randomly selected IRO. The IRO will render an opinion within 45 days. When requested, and if a delay would be detrimental to your medical condition, as determined by Cigna's reviewer, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility, the external review shall be completed within 72 hours.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim including, if applicable, the date of service, provider and claim amount; diagnosis and treatment codes, and their meanings; the specific reason or reasons for the adverse determination including, if applicable, the denial code and its meaning and a description of any standard that was used in the denial; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitle to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined below; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a), if applicable; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of an adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as

Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record or other information which: was relied upon in making the benefit determination; was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the appeal processes. However, no action will be brought at all unless brought within 3 years after a claim is submitted for In-Network Services.

Arbitration Agreement - Hawaii Region

Except as provided in this Dispute Resolution section of Kaiser Permanente's *Guide to Your Health Plan* (Guide), or by applicable law, any and all claims, disputes, or causes of action arising out of or related to your Guide or *Evidence of Coverage* (EOC), its performance or alleged breach, or the relationship or conduct of the parties, including but not limited to any and all claims disputes, or causes of action based on contract, tort, statutory law, or actions in equity, shall be resolved by binding arbitration.

This includes but is not limited to any claim asserted:

By or against a Member, a patient, the heirs or the personal representative of the estate of the Member or patient, or any other person entitled to bring an action for damages, arising from or related to harm to the member or patient as permitted by applicable federal or Hawaii state law existing at the time the claim is filed ("Member Parties"). For purposes of this Agreement, all family members of the member or patient who have derivative claims arising from such harm, shall also be deemed "Member Parties" and bound to these arbitration terms. On account of death, bodily injury, physical ailment, mental disturbance, or economic loss arising out of the rendering or failure to render medical services or the provision or failure to provide benefits under this Agreement, except when binding arbitration is explicitly not permitted by applicable law, premises liability, or arising out of any other claim of any nature, irrespective of the legal theory upon which the claim is asserted; and

By or against one or more of the following entities or their employees, officers or directors ("Kaiser Permanente Parties"):

- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals
- Hawaii Permanente Medical Group, Inc.
- The Permanente Federation, LLC

- Any individual or organization that contracts with an organization named above to provide medical services to Health Plan Members, when such contract includes a provision requiring arbitration of the claim made

Notwithstanding any provisions to the contrary in this Agreement, the following claims shall not be subject to mandatory arbitration:

- Claims for monetary damages within the jurisdictional limit of the Small Claims Division of the District Courts of the State of Hawaii
- Actions for appointment of a legal guardian of a person or property subject to probate laws
- Purely injunctive orders reasonably necessary to protect Kaiser Permanente's ability to safely render medical services (such as temporary restraining orders, and emergency court orders)
- Claims that may not be subject to binding arbitration under applicable federal or state law
- For Medicare members, claims subject to Medicare appeals process

Initiating Arbitration

A demand for arbitration shall be initiated by sending a registered or certified letter to each named party against whom the claim is made, with a notice of the existence and nature of the claim, the amount claimed and a demand for arbitration. Any Kaiser Permanente Parties shall be served by registered or certified letter, postage prepaid, addressed to the Kaiser Permanente Parties in care of the Health Plan at Kaiser Foundation Health Plan, Inc., Member Services, 711 Kapiolani Boulevard, Honolulu, HI 96813. The arbitrators shall have jurisdiction only over persons and entities actually served.

Arbitration Proceedings

Within 30 days after the service of the demand for arbitration, the parties shall agree on a panel of arbitrators from which to select arbitrators or shall agree on particular arbitrators who shall serve for the case. If the parties cannot agree on any panel of arbitrators or particular arbitrators within the 30 days, then the panel of arbitrators shall be that of Dispute Prevention and Resolution, Inc. ("DPR"). Unless the parties agree to any other arbitration service and rules, DPR shall administer the arbitration and its arbitration rules shall govern the arbitration (including rules for selection of arbitrators from a panel of arbitrators, if the parties have not already agreed upon particular arbitrators to serve). Kaiser Permanente shall notify DPR (or such other arbitration service as may be chosen by the parties) of the arbitration within 15 days following the expiration of the 30-day period noted above.

Within 30 calendar days after notice to DPR, the parties shall select a panel of three arbitrators from a list submitted to them by the arbitration service. In all claims seeking a total monetary recovery less than $25,000.00, and in any other case where the parties mutually agree, a panel of one arbitrator selected by both parties from a list submitted to them by the arbitration service will be allowed. The arbitrator(s) will arrange to hold a hearing in Honolulu (or such other location as agreed by the parties) within a reasonable time thereafter.

Limited civil discovery shall be permitted only for production of documents that are relevant and material, taking of brief depositions of treating physicians, expert witnesses and parties (a corporate party shall designate the person to be deposed on behalf of the corporation) and a maximum of three other critical witnesses for each side (i.e., respondents or claimants), and independent medical evaluations.

The arbitrator(s) will resolve any discovery disputes submitted by any party, including entry of protective orders or other discovery orders as appropriate to protect the parties' rights under this paragraph.

Any payment for the fees and expenses of the arbitration service and the arbitrator(s) shall be borne one-third by the Member Parties and two-thirds by the Kaiser Permanente Parties. Each party shall bear their own attorney's fees, witness fees, and discovery costs.

The arbitrator(s) may decide a request for summary disposition of a claim or particular issue, upon request of one party to the proceeding with notice to all other parties and a reasonable opportunity for the other parties to respond. The standards applicable to such request shall be those applicable to analogous motions for summary judgment or dismissal under the Federal Rules of Civil Procedure.

In claims involving benefits and coverage due under this Agreement or disputes involving operation of the Plan, Health Plan's determinations and interpretations, and its decisions on these matters are subject to de novo review. The arbitration award shall be final and binding. The Member Parties and Kaiser Permanente Parties waive their rights to jury or court trial. With respect to any matter not expressly provided for herein, the arbitration will be governed by the Federal Arbitration Act, 9 U.S.C. Chapter 1.

General Provisions

All claims based upon the same incident, transaction or related circumstances regarding the same Member or same patient shall be arbitrated in one proceeding (for example, all Member Parties asserting claims arising from an injury to the same Health Plan Member, shall be arbitrated in one proceeding).

A claim for arbitration shall be waived and forever barred if on the date notice thereof is received, the claim, if it were then asserted in a civil action, would be barred by the applicable Hawaii statute of limitations. All notices or other papers required to be served or convenient in the conduct of arbitration proceedings following the initial service shall be mailed, postage prepaid, to such address as each party gives for this purpose. If the Federal Arbitration Act or other law applicable to these arbitration terms is deemed to prohibit any term in this Agreement in any particular case, then such term(s) shall be severable in that case and the remainder of this Agreement shall not be affected thereby. Class actions and consolidation of parties asserting claims regarding multiple members or patients are prohibited. The arbitration provisions in this Agreement shall supersede those in any prior Agreement.

Arbitration Confidentiality

Neither party nor the arbitrator(s) may disclose the substance of the arbitration proceedings or award, except as required by law or as necessary to file a motion regarding the award pursuant to the Federal Arbitration Act, in any federal or state court of appropriate jurisdiction within Hawaii, and in that event, the parties shall take all appropriate action to request that the records of the arbitration be submitted to the court under seal.

Special Claims

Medical Malpractice Claims Prior to initiating any arbitration proceedings alleging medical malpractice, Member Parties shall first submit the claim to a Medical Inquiry and Conciliation Panel pursuant to Chapter 671, Hawaii Revised Statutes, Sections 11-19. Following the rendering of an advisory decision by the Medical Inquiry and Conciliation Panel, if the claim has not been withdrawn or settled, Member Parties shall serve a demand for arbitration on Kaiser Permanente Parties as specified in the "Initiating arbitration" section.

Benefit Claims If the Member Party has a claim for benefits that is denied or ignored (in whole or in part), the Member Party may pursue legal action in federal or state court, as appropriate, after the Member Party has exhausted the claims and appeals process and, if applicable, external review process. The court will decide who should pay court costs and legal fees. If the Member Party is successful, the court may order the person or entity the Member Party has sued to pay these costs and fees. If the Member Party loses, the court may order the Member Party to pay these costs and fees, for example, if it finds the Member Party's claim is frivolous. If the Member Party has any questions about the Member Party's plan, the Member Party should contact Health Plan at **800-966-5955**.

Although benefit-related claims may not be required to be resolved by binding arbitration pursuant to this section, Member Parties may still make a voluntary election to use binding arbitration to resolve these claims, instead of court trial, by filing a demand for arbitration upon Kaiser Permanente Parties pursuant to the provisions of the "Initiating Arbitration" section. If a voluntary election to use binding arbitration is made by a Member Party, the arbitration shall be conducted pursuant to the "Dispute Resolution" section of your Guide or EOC.

External Appeal of Internal Review Decisions If you disagree with Kaiser Permanente's final internal benefit determination, you may request voluntary binding arbitration pursuant to the procedures in this Agreement. In addition to the arbitration procedures set forth in this Agreement which may be elected by the Member (but are not mandatory), Hawaii Revised Statutes Chapter 432E also creates certain external review rights for Members to submit a request for external review to the State Insurance Commissioner within 130 days from the date of Kaiser's final internal determination. These rights are subject to the limitations noted in the next paragraph, and are subject to the requirements and limitations in Hawaii Revised Statutes Chapter 432E (including exhausting all of Kaiser Permanente's internal complaint and appeals procedures before requesting external review, except as specified in Chapter 432E for situations when simultaneous external review is permitted to occur or Kaiser Permanente has failed to comply with federal requirements regarding its claims and appeals process). A complete description of Kaiser Permanente's claims and appeals process is described in the "Appeals" section of your Guide or EOC.

Chapter 432E external reviews are limited to situations where (a) the complaint is not for allegations of medical malpractice, professional negligence or other professional fault by health care providers, and (b) the complaint relates to an adverse action as defined in Hawaii Revised Statutes Chapter 432E. Health Plan may object to external reviews under Chapter 432E which do not meet the standards for external review under applicable federal and state law and Health Plan reserves its full rights and remedies in this regard. The recitation of state law provisions shall not be deemed to constitute any waiver of such objections.

Senior Advantage Member Claims

Complaints and appeals procedures for Senior Advantage Members are described in the Kaiser Permanente Senior Advantage Evidence of Coverage (KPSA EOC). The arbitration provisions of this KPSA EOC apply only to Senior Advantage Member claims asserted on account of medical malpractice or a violation of a legal duty arising out of this KPSA EOC, irrespective of the legal theory upon which the claim is asserted.

Dental Plans Claims and Appeals

Hawaii Dental Service

If you have questions about the services you receive from a Hawaii Dental Service (HDS) dentist, you may discuss the matter with your dentist, or if you continue to have concerns, you may contact HDS at **800-232-2533 ext. 248**.

HDS will provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for denial. If you have a question or complaint regarding eligibility, the denial of dental services or claims, the policies, procedures, and operations of Hawaii Dental Service, or the quality of dental services performed by an HDS dentist, contact HDS. You have 90 days after you receive notice of a denial of dental services or claims to appeal that denial. You will need to submit a copy of the subscriber's Evidence of Benefits (EOB) report, the dentist's bill, and any relevant documents along with your appeal request. Clearly explain your complaint and send it to the following address:

ATTN: Customer Service Manager
Hawaii Dental Service
900 Fort Street Mall, Suite 1900
Honolulu, Hawaii 96813

Flexible Spending Accounts Claims and Appeals

Health Care Flexible Spending Account

Filing a Claim

You will receive a HealthEquity Visa Health Account Card that you can use to pay for eligible Health Care FSA expenses such as medical copayments and prescriptions. The card works like a debit card that will be reloaded with your Health Care FSA annual goal amount. The Healthcare Debit Card is regulated by IRS rules, and, in some cases, you may be asked to provide HealthEquity with documentation to verify that the item or service purchased was an eligible expense. You can mail copies of your documentation to HealthEquity or submit them online at **healthequity.com** using the "Submit Receipt" link. You may also submit your documentation with the HealthEquity EZ Receipts mobile application (available at **healthequity.com**). For additional information on the card verification process, please contact HealthEquity.

You must file your claim for expenses incurred during the plan year by March 31 of the following year.

For the fastest reimbursement, submit your claim online at **healthequity.com** or via the HealthEquity EZ Receipts mobile application (available at **healthequity.com**). If you wish to submit a claim by mail, contact HealthEquity.

You may receive your reimbursement either by check or direct deposit. You may check on the status of your claim or payment online at **healthequity.com**.

According to IRS rules, an expense is considered incurred when service is actually received, not when you are billed or when you pay for the service.

Appeals for Health Care Flexible Spending Account Claims

If your claim for benefits under the Health Care Flexible Spending Account is denied, you have the right to appeal the decision. You must make the appeal request within 180 days after the date of the claim denial notice. Send the written request to the claims administrator for the plan as follows:

Health Care Flexible Spending Account:
HealthEquity Claims Appeal Board
P.O. Box 991
Mequon, WI 53092-0993

You can also send the appeal by fax to **877-220-3248**.

The request must explain why you believe a review is in order, and it must include supporting facts and any other pertinent information. The claims administrator may require you to submit such additional facts, documents, or other material as it may deem necessary or appropriate in making its review.

Dependent Care Flexible Spending Account

Filing a Claim

Dependent Care FSA claim forms are available from HealthEquity at **healthequity.com.** Submit the completed claim form, including your provider's signature, to HealthEquity.

For the fastest reimbursement, submit your claim online at **healthequity.com** or via the mobile application.

You may also fax it to **877-353-9236**, or mail it to the following address:

HealthEquity
Claims Administrator
P.O. Box 14053
Lexington, KY 40512

You will be reimbursed only up to the amount you have already contributed to your account; outstanding amounts will be automatically paid as you contribute more to your account. You may submit claims until March 31 of the following year for expenses incurred through December 31 of the previous year (the end of the plan year).

HealthEquity processes claim forms for reimbursement once a week, but you will need to allow for mailing time in both directions. Reimbursement is available by check or direct deposit.

If your Dependent Care FSA claim is denied, you do not have rights to an appeal under ERISA, but you may request a review of the denial by contacting HealthEquity. If you have questions about your spending account or claims or if you need a claim form, contact HealthEquity.

Disability Plans Claims and Appeals

There are special rules that apply to claims and appeals under the long-term disability plan. Your claim might be made in different circumstances. For example, you might be applying for long-term disability benefits. If

the claims administrator decides to discontinue payment of your long-term disability benefits before they were scheduled to end (e.g., because the claims administrator believes that you are no longer disabled), then that decision will be treated as a denial of your claim for long-term disability benefits and you may appeal that denial in accordance with the rules noted below. If you seek to extend payment of your disability benefits, then that request will be treated as a claim for benefits and the claims administrator will respond to your claim as noted below.

The disability claims and appeals rules also apply to claims and appeals for benefits under other types of plans where the claims administrator for that other type of plan must determine that you are disabled in order to approve your claim. For example, if different rules apply for the amount of or the payment commencement date of benefits under a retirement plan when you are disabled and the issue in your claim and appeal is whether or not you are disabled, then these rules apply with respect to that part of your retirement plan claim and appeal. Similarly, if an insurance plan includes a waiver of your payment of premiums while you are disabled, then these rules apply with respect to a claim or appeal relating to the premium waiver. However, if the claims administrator under the other plan does not need to determine whether you are disabled, but instead only needs to find out whether someone else has determined that you are disabled, then these special rules do not apply. For example, if the claims administrator of a retirement plan only needs to determine whether the Social Security administration or the claims administrator for the long-term disability plan has determined whether you are disabled, then these special rules do not apply if your claim or appeal is based on whether you are entitled to the benefit under the retirement plan.

Claims

MetLife is the insurer and third-party administrator for the following:

- Long-Term Disability (LTD) plan
- Supplemental Disability Insurance plan

You may either complete a claim form with MetLife online at **www.metlife.com/mybenefits** or call MetLife's toll-free number, **888-420-1661**, to initiate your claim. After you initiate your claim, your MetLife claims representative will reach out and walk you through the steps and identify the documentation required to complete your claim.

In the event of a long-term disability, you will receive a customized packet of information that will include several documents, including your *Reimbursement Agreement and Authorization for Release of Information*. All documents must be completed and returned to MetLife in a timely manner. You will also need to submit a copy of your Social Security award or denial letter, *Workers' Compensation Statement* notice, and/or birth certificate, and your health care provider may need to submit documentation concerning your medical care and your disability. MetLife has the right to require this information as part of the proof of claim for the following: (a) satisfactory evidence that you have made application for all other income benefits such as, but not limited to, Supplemental Disability Income, and have furnished all required proofs of such benefits, and (b) in the event that a claim for any such other income benefits has been disallowed, satisfactory evidence that such claim has been disallowed. Your manager/supervisor will also be asked to complete a *Supervisor's Statement* describing the type of work you do and the physical requirements of your job.

In most cases, if you are eligible for long-term disability benefits, MetLife will contact you before your short-term disability benefits ends. If MetLife does not contact you by the end of the elimination period for

your long-term disability benefit and you believe you are eligible for the benefit, contact your short-term disability claims representative for assistance. You may also write or call MetLife at:

MetLife Disability Unit
P.O. Box 14590
Lexington, KY 40511-4590
Phone: 888-420-1661

Deadlines for Responding to Your Claims for Disability Benefits

The claims administrator will make a decision on your claim within a reasonable period but not later than 45 days after it receives your claim form. In some cases, the claims administrator will notify you, before the end of the normal 45-day maximum period for responding to your claim, that additional time is required to process your claim for reasons beyond the control of the claims administrator. Any 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 30 days to respond to your claim. The claims administrator may again notify you, before the end of the initial 30-day extension, that additional time is required to process your claim for reasons beyond the control of the claims administrator. In that event, the claims administrator may take up to another 30 days to respond to your claim. When the claims administrator requests either the first or second 30-day extension, it will tell you the standards that must be satisfied to approve your benefit claim, the unresolved issues that require a delay in the decision on your claim, and the additional information needed to resolve those issues. You will be provided at least 45 days to provide the requested information. If the claims administrator needs additional information from you, then the claims administrator may decide not to count the time between the date you are requested to send the additional information and the date the information is received towards the required deadlines.

Appeals

If your claim is denied, MetLife will provide you with a written response and you will have the right to file an appeal in writing. Your written appeal must be received by the claims administrator at the following address within 180 days after your claim was denied:

MetLife Disability Unit
P.O. Box 14590
Lexington, KY 40511-4590
Phone: 888-420-1661

New or Additional Evidence

If any new or additional evidence is considered, relied upon, or generated by the claims administrator in connection with the determination of your appeal, such evidence must be provided to you, free of charge, and as soon as possible and sufficiently in advance of the date on which your appeal will be decided so that you may be given a reasonable opportunity to respond.

Deadlines for Responding to Your Appeal for Disability Benefits

If the claims administrator denies your appeal, then the claims administrator will provide a written response within a reasonable period but not later than 45 days after it receives your appeal. In some cases, the claims

administrator will notify you, before the end of the normal 45-day maximum deadline for responding to your appeal, that additional time is required to process your appeal for reasons beyond the control of the claims administrator. In that event, the claims administrator may take up to an additional 45 days to respond to your appeal. When the claims administrator requests a 45 day extension, it will inform you of the special circumstances requiring the extension and the date on which it expects to make a decision on your appeal. If the claims administrator needs additional information from you to resolve your appeal, then the claims administrator 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 45 days that the claim administrator 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.

Retiree Benefits Claims and Appeals

Unless otherwise noted, retiree medical claims must be filed within 12 months of the date of service or when the expense was incurred.

Retiree Health and Welfare Eligibility Claims

To dispute your eligibility for retiree health and welfare benefits, contact the KPRC to obtain an inquiry/claim form. You will need to complete the form and submit a written inquiry to the address listed below within six (6) months of the event that gives rise to the question:

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

The KPRC will review your written inquiry and provide you with a response no later than 90 days after they receive your inquiry.

Retiree Health and Welfare Benefits Eligibility Appeals

If you do not agree with the KPRC determination, you may appeal the response by submitting a written request for review to the Kaiser Permanente Administrative Committee-Appeals Subcommittee (Committee) within 90 days of the date on the response to your written inquiry. Your request for review will need to be in writing and

state all the facts in support of the appeal. You may submit written comments, documents, records or other information relating to your appeal.

The written request for review will need to be sent to the following address:

Kaiser Permanente Retirement Center (KPRC)
Attn: Kaiser Permanente Administrative Committee-Appeals Subcommittee
P.O. Box 9923
Providence, RI 02940-4023

Upon request and free of charge, you will be provided with reasonable access to, and copies of all documents, records and other information relevant to your eligibility appeal.

If you choose to appeal the decision, the Committee will act on your request for review at the regularly scheduled meeting of the Committee that immediately follows receipt of such request, unless the request is filed within the 30 days preceding the date of the meeting. In that case, the Committee shall act on the request no later than the date of the second regularly scheduled meeting of the Committee following the request for review. In all circumstances, if there are special circumstances that require additional time, the Committee will provide written notice of the extension prior to the applicable Committee meeting and the date by which the decision will be made. In all cases, the Committee shall act no later than the third regularly scheduled meeting following the Plan's receipt of such request.

After its review, the Committee will either reverse the earlier decision or it will deny the appeal. If the appeal is denied, written notice of the denial will be provided to you within five days of the Committee's decision.

The written denial upon review will contain specific reasons for the Plan's decision and specific references to the relevant Plan provisions upon which the decision is based.

If the final decision (after the required levels of appeal) is adverse to you, you (or your representative) may then file an action for benefits in state or in federal court under Section 502(a) of ERISA. Any legal action regarding denied retiree health and welfare eligibility inquiries or claims must be filed within one year of the event that gave rise to the inquiry or claim.

Please note: You are required to first comply with this appeals procedure before pursuing your claim in any judicial or administrative proceeding. If you do not pursue and exhaust your rights under this procedure in a timely manner, the Committee's decision will become final and binding.

Retiree Medical Claims and Appeals

Claims

If you wish to submit a claim for benefits under the Kaiser Permanente Senior Advantage Plan, contact Member Services or refer to the *Evidence of Coverage* for your plan.

Appeals

For appeals of denied medical benefit claims, you may write to the address shown in the denial notice. Please refer to the *Evidence of Coverage* for your plan.

Retiree Medical Health Reimbursement Account Claims and Appeals

Filing a Retiree Medical HRA Claim

When you have eligible expenses, you submit a claim for reimbursement. In order for expenses to be eligible for reimbursement, you must incur them while you are actively participating in the Retiree Medical Health Reimbursement Account (HRA). When you become eligible to access the Retiree Medical HRA, you will receive a letter that will explain how the Retiree Medical HRA works in detail from Kaiser Permanente Retirement Center (KPRC).

For more information about the Retiree Medical HRA, you may visit the KPRC website at **www.myplansconnect.com/kp**. You can also call the KPRC (see the **Contact Information** section).

You can submit your claims for reimbursement from the Retiree Medical HRA in the following ways:

Fax: Fax your claim form and documentation to **844-853-8493**

Mail: Mail your claim form and documentation to:

Kaiser Permanente Retirement Center
Reimbursement Center
P.O. Box 2844
Fargo, ND 58108

The KPRC will review your claim and provide you with a determination no later than 30 days after they receive your claim. The written claim decision, if a denial, will contain specific reasons for the plan's decision and specific references to the relevant plan provisions upon which the decision is based.

Appeals for Denied Retiree Medical HRA Claims

If your claim for benefits under the Retiree Medical HRA is denied, you have the right to appeal the decision. You must make the appeal request within 180 days after the date of the claim denial notice. Send the written request to the Kaiser Permanente Retirement Center (KPRC) at the following address:

Kaiser Permanente Retirement Center (KPRC)
Attn: Kaiser Permanente Administrative Committee-Appeals Subcommittee
P.O. Box 2844
Fargo, ND 58108

The request must explain why you believe a review is in order, and it must include supporting facts and any other pertinent information. The KPRC may require you to submit such additional facts, documents, or other material as it may deem necessary or appropriate in making its review.

Upon request and free of charge, you will be provided with reasonable access to, and copies of all documents, records and other information relevant to your claim.

If you choose to appeal the claim determination, the KPRC will issue a written decision upon review within 60 days after it receives your request for review. The review by the KPRC will not afford deference to the initial claim denial, but will assess the information you provide as if the KPRC was looking at the claim for the first

time. The written decision upon review will contain specific reasons for the plan's decision and specific references to the relevant plan provisions upon which the decision is based.

If the final decision (after the required levels of appeal) is adverse to you, you (or your representative) may then file an action for benefits in state or in federal court under Section 502(a) of ERISA. Any legal action regarding denied Retiree Medical HRA claims must be filed within one year of the event that gave rise to the claim.

Please note: You are required to first comply with this appeals procedure before pursuing your claim in any judicial or administrative proceeding. If you do not pursue and exhaust your rights under this procedure in a timely manner, this decision will become final and binding.

Medicare Part B Reimbursement Claims and Appeals

Filing a Claim for Reimbursement of Medicare Part B Premiums

You may request reimbursements of Medicare Part B premiums quarterly, but no later than June 30 of the following calendar year. You will need to submit a *Medicare Part B Reimbursement Request* form in order to be reimbursed for Medicare Part B premiums you have paid.

To be reimbursed for the Medicare Part B premiums you paid during a calendar quarter, your completed reimbursement request form must be postmarked or received by the Kaiser Permanente Retirement Center (KPRC) by the last day of the month of the quarter for which you are requesting reimbursement.

You can mail or fax it to the following:

Kaiser Permanente Retirement Center
Reimbursement Center
P.O. Box 2844
Fargo, ND 58108-2844
Fax: (844) 853-8493

You must submit a reimbursement request form after you pay your Medicare Part B premium to Medicare. If you submit your reimbursement request form before you pay your Medicare Part B premiums, the reimbursement request will be denied.

You have until June 30 of the following calendar year to submit the completed reimbursement request form, along with any required documents, for the prior calendar year's Medicare Part B premiums. You will need to enroll in retiree medical benefits before you can be eligible for Medicare Part B premium reimbursement (see the "How to Enroll" section in the **Retirement Programs** section).

If you are eligible to receive reimbursement for Medicare Part B premiums, please follow the steps below:

- Visit **www.myplansconnect.com/kp**
- Select the "Tools & Support" link and under the "Documents & Forms"
- Download and complete the *Medicare Part B Reimbursement Request* form
- Send the form, along with the required documents (see "Required Documentation") to the address or fax number noted on the form

Important: Your form must be postmarked or received via fax by the deadline for requesting reimbursement. If you fax your form, please keep a copy of your fax confirmation for your records.

Note: If you have a spouse or domestic partner who is also eligible for Medicare Part B premium reimbursement, he or she must complete a separate form for his or her reimbursement and submit the required documents.

To be reimbursed as soon as possible, you may submit your documents quarterly, no later than the end of the calendar month of the quarter, to be reimbursed for that quarter. For example, to be reimbursed for the first quarter of the year (January through March), your documents must be postmarked or faxed no later than March 30. All reimbursement requests for the calendar year must be submitted by June 30 of the following calendar year. If you submit a reimbursement request after June 30 of the following calendar year, your request will be denied.

Required Documents

For the first quarter of each year, along with your completed reimbursement form, you must also submit the following documents to ensure your reimbursement is processed timely:

- **If your Medicare Part B premiums are deducted from your Social Security check**, please include a copy of the current year's Social Security Award letter that shows the Medicare Part B premium amount being deducted.
- **If you pay your Medicare Part B premiums directly to Medicare**, please include a copy of the current year's billing statement from the Centers for Medicare and Medicaid Services (CMS).

For more information on the Medicare Part B premium reimbursement process, contact the Kaiser Permanente Retirement Center (KPRC). Representatives are available via Live Chat at **www.myplansconnect.com/kp** or by phone at **866-627-2826** Monday through Friday from 6 a.m. to 6 p.m. Pacific time. If you are calling internationally, dial the international call access code, plus the country calling code, then **857-362-5935**. For TDD/TTY support dial **800-695-1317**.

Appeals

If your claim is denied, you (or your representative) may appeal the claim denial by submitting a written appeal of the decision within 180 days after the date you receive a denial notice. Your request for review will need to be in writing and state all the facts in support of the appeal. You may submit written comments, documents, records or other information relating to your appeal. The written request for review will need to be sent to the Kaiser Permanente Administrative Committee-Appeals Subcommittee (Committee) at the following address:

Kaiser Permanente Retirement Center (KPRC)
Attn: Kaiser Permanente Administrative Committee-Appeals Subcommittee
P.O. Box 2691
Fargo, ND 58108

Upon request and free of charge, you will be provided with reasonable access to, and copies of all documents, records, and other information relevant to your claim. If you choose to appeal the claim determination, the Committee will issue a written decision upon review within 60 days after it receives your request for review. The review by the Committee will not afford deference to the initial claim denial, but will assess the information you provide as if the Committee was looking at the claim for the first time. The written decision

upon review will contain specific reasons for the plan's decision and specific references to the relevant plan provisions upon which the decision is based.

If the final decision (after the required levels of appeal) is adverse to you, you (or your representative) may then file an action for benefits in state or in federal court under Section 502(a) of ERISA. Any legal action regarding denied Medicare Part B premium reimbursement claims must be filed within one year of the event that gave rise to the claim.

Please note: You are required to first comply with this appeals procedure before pursuing your claim in any judicial or administrative proceeding. If you do not pursue and exhaust your rights under this procedure in a timely manner, this decision will become final and binding.

Retirement Plan Benefits Claims and Appeals

Defined Benefit Plan Claims

If you are a participant in a defined benefit plan, you may be entitled to retirement benefits when you leave Kaiser Permanente. To receive any type of retirement benefits under the plan, you must apply to the Fidelity Service Center. You can reach the Fidelity Service Center online by visiting their website at **netbenefits.com**. You can also call the Fidelity Service Center at **866-602-0411** Monday through Friday 5:30 a.m. to 6 p.m. Pacific time.

The Fidelity Service Center will process your request for a retirement benefit and mail you the appropriate distribution packet. The packet will include an estimate of the amount of retirement benefits to which you are entitled, along with the forms you will need to complete in order to receive your benefit. The distribution process is not complete until the Fidelity Service Center receives your accurately completed authorization forms.

Please note: Each distribution packet includes an expiration date. The distribution process must be completed on or before the expiration date or you may be required to restart the distribution process from the beginning. Restarting the distribution process may affect your distribution amount.

If you want to contest the amount to be distributed to you, your calculation of service, benefit eligibility, or a similar issue, after discussion with a representative from the Fidelity Service Center, he or she will provide you with a *Claim Initiation Form* for the 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 the failure to timely pay your previously determined benefit as of the benefit commencement date, your form of payment, and/or any adjustment to your benefits either before or after the normal retirement date must be filed within one year of your benefit commencement date.

In addition, any claim under the plan must be filed within two years following the latest of (i) your termination of employment and (ii) the date you were provided with written notice of your vested status and/or the components of your benefit payment.

Defined Contribution Plan Claims

If you wish to contest the amount to be distributed to you, your calculation of service, benefit eligibility, or a similar issue, 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.

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.

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 within 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.

Appeals

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

Defined Benefit Plan

For standard mail sent through the U.S. Postal Service:

Fidelity Service Center
Claims & Appeals
P.O. Box 770003
Cincinnati, OH 45277-0070

For overnight mail:

Fidelity Service Center
100 Crosby Parkway
Mailzone: KC1F-D
Covington, KY 41015

Defined Contribution Plan

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 Fidelity Service Center.

The Fidelity Service Center 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 Fidelity Service Center 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 Fidelity Service Center 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 Fidelity Service Center 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, retirement plans, eligibility for retiree medical or Medicare Part B premium reimbursements, and that are not subject to the special rules for disability benefits.

MetLife is the insurer and third-party administrator for the Life Insurance, Retiree Life Insurance, Accidental Death and Dismemberment, Business Travel Accident, and Voluntary Term Life insurance plans, as applicable.

Life Insurance, Retiree Life Insurance, Accidental Death and Dismemberment, Business Travel Accident, 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 have Accidental Death and Dismemberment insurance, a legal action on an AD&D claim may only be brought during the period that begins 60 days after the date proof of the event is filed and ends three years after the date such proof is required by MetLife. If you wish, you may take the matter up with the Department of Insurance in your state.

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.

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:

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:

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.

Legal Services and Legal Services Plus Parents Plans 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.

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 Oakland, CA 94612 510-271-5940 EIN # 94-1340523	**For Health and Welfare Plans** Kaiser Permanente Administrative Committee (KPAC) 1 Kaiser Plaza Oakland, CA 94612 510-271-5940 **For Defined Benefit Plans** Kaiser Permanente Administrative Committee (KPAC) 1 Kaiser Plaza Oakland, CA 94612 **For Defined Contribution Plans** Kaiser Foundation Health Plan, Inc. 1 Kaiser Plaza Oakland, CA 94612

Service of Legal Process

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

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

Administrative Powers and Responsibilities

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

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

- The discretionary authority to make and enforce rules for the administration of each employee benefit plan, including the designation of forms to be used in such administration
- The discretionary authority to construe and interpret each and every document setting forth the applicable terms of a plan, including official plan documents, SPDs, and insurance contracts
- The discretionary authority to decide questions regarding the eligibility of any person to participate in any employee benefit plan
- The discretionary authority to approve or deny claims for benefits under each employee benefit plan unless discretionary authority has been delegated in writing to a third party, such as an insurer, claims administrator or Administrative Committee
- The discretionary authority to appoint or employ agents, including but not limited to, counsel, accountants, consultants, and other persons to assist in the administration of each employee benefit plan

Welfare and Retirement Plans

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

Plan Name/Plan Options	Plan Sponsor EIN #	ID No.	Type of Plan	Claims Administrator	Type of Administration	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 Permanente National Claims Administration - Colorado P.O. Box 373150 Denver, CO 80237-3150	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

Plan Name/Plan Options	Plan Sponsor EIN #	ID No.	Type of Plan	Claims Administrator	Type of Adminis-tration	Plan Trustee	Funding Medium	Contributing Source
Preferred Provider Organization (PPO) Plus Plan			Self-Funded	Cigna Appeals Unit P.O. Box 188011 Chattanooga, TN 37422-8011	Self-Funded	N/A	Self-funded; paid from general assets	Employer and employee
Group Dental Insurance			Insured	Hawaii Dental Service 900 Fort Street Mall Suite 1900 Honolulu, HI 96813	Insured	N/A	Insured agreement premiums paid from general assets	Employer and employee
Group Life Insurance			Insured	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100	Insured	N/A	Insured agreement premiums paid from general assets	Employer and employee
Group Long-Term Disability Insurance			Insured	MetLife Disability Unit P.O. Box 14590 Lexington, KY 40511-4590	Insured	N/A	Insured agreement premiums paid from general assets	Employer and employee
Supplemental Disability Insurance			Insured	MetLife Disability Unit P.O. Box 14590 Lexington, KY 40511-4590	Insured	N/A	Insured agreement premiums paid from general assets	Employee
Group Accidental Death and Dismemberment Insurance			Insured	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100	Insured	N/A	Insured agreement premiums paid from general assets	Employer and employee
Business Travel Accident Insurance			Insured	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100	Insured	N/A	Insured agreement premiums paid from general assets	Employer
Dependent Care Flexible Spending Account			Flexible Spending Account	HealthEquity P.O. Box 14053 Lexington, KY 40512	Third-Party	N/A	N/A	Employee
Accident Insurance			Insured	Continental American Insurance Company P.O. Box 84075	Insured	N/A	N/A	Employee

Plan Name/Plan Options	Plan Sponsor EIN #	ID No.	Type of Plan	Claims Administrator	Type of Adminis-tration	Plan Trustee	Funding Medium	Contributing Source
				Columbus, GA 31993				
Critical Illness Insurance			Insured	Continental American Insurance Company P.O. Box 84075 Columbus, GA 31993	Insured	N/A	N/A	Employee
Legal Services and Legal Services Plus Parents Plans			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
Voluntary Term Life Insurance			Insured	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100	Insured	N/A	N/A	Employee
Kaiser Foundation Health Plan Inc., Health Care Flexible Spending Account	94-1340523	590	Flexible Spending Account	HealthEquity P.O. Box 14053 Lexington, KY 40512	Third-Party	N/A	N/A	Employee
Employee Assistance Program			Self-Funded	Kaiser Permanente Employee and Physician Assistance Program 1 Kaiser Plaza, 23rd Floor, Oakland, CA 94612	Self-Funded	N/A	Self-funded; paid from general assets	Employer

Plan Name/Plan Options	Plan Sponsor EIN #	ID No.	Type of Plan	Claims Administrator	Type of Adminis-tration	Plan Trustee	Funding Medium	Contributing Source
RETIREMENT PLANS								
Kaiser Permanente Salaried Retirement Plan	94-1340523	001	Pension-401(a) Defined Benefit Plan	Fidelity Service Center P.O. Box 770003 Cincinnati, OH 45277-0070	Third-Party/ Record Keeper	State Street Bank Retiree Services P.O. Box 550858 Jacksonville, FL 32255-0868	Trust	Employer contributions
Kaiser Permanente Supplemental Savings and Retirement Plan	94-1340523	003	Pension-401(a) 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	Trust	Employer and Employee after-tax contributions
Kaiser Permanente Tax-Sheltered Annuity Plan	94-1340523	039	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
RETIREE HEALTH AND WELFARE PROGRAMS								
Kaiser Foundation Health Plan, Inc., Retiree Health and Welfare Plan	94-1340523	580	Health and Welfare Programs		Insured	State Street Bank and Trust Company 1200 Crown Colony Dr., 2nd Floor Quincy, MA 02169	Trust	Employer
Retiree Medical Health Reimbursement Account (KFHP/H)	94-1340523	585	Reimburse ment Account	Kaiser Permanente Retirement Center P.O. Box 2844 Fargo, ND 58108	Third-Party	N/A	N/A	Employer
Retiree Medical Premium Subsidy (KFHP/H)				Kaiser Permanente Retirement Center P.O. Box 9923 Providence, RI 02940-4023	Third-Party	N/A	N/A	Employer

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 Kaiser Permanente 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 fewer 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. The Plan Administrator's recovery of overpayments shall comply with any limits under applicable law.

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 $450 for each plan, even if multiple plans are included in one Domestic Relations Order.

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

For additional information about a QDRO for your defined benefit plan, contact the Fidelity Service Center.

For additional information about a QDRO for your defined contribution retirement savings plan(s), contact Vanguard.

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 preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

- Prudent actions by plan fiduciaries. In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.
- If your claim for a (pension, welfare) benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

Assistance with Your Questions

Not all of the plans described in this SPD are subject to ERISA provisions. If you have any questions about your plans, you should contact the National Human Resources Service Center. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, contact the U.S. Department of Labor, Employee Benefits Security Administration at **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:

Ɓăsɔ̀ɔ̀ - wùdù (Bassa): Ɔ mɔ̀ nì kpé ɓɛ́ m̀ ké gbo-kpá-kpá dyé ɖé m̀ mìɔùn nìin ɓíɖí-wùdù mú pídyi. Ɔ jŭ ké m̀ dyi dyi-diè-ɖɛ̀ ɓě ɓéɖé ɓá kpáná ɓě m̀ kɔ̃̀ m̀ ké dyéɛ jè dyí, mɔɔ ɔ jŭ ké wa dyi níin m̀ mɛ nyu ɖɛ ɖíé ɓě ɓó wé jɛ̀ɛ́ ɖò kɔ̃ɛɛ ní, nìí, m̀ mɛ ɖá nɔ̀bà ɓɛ́ wa tòà ɓó nì ɓóɖóɔ̀ mɔɔ ɓó nì gbɛ̌ɛ̀ɔ̀ bìɛ, ɓɛ́ m̀ ké nyɔ-wuɖuún-zà-nyɔ̀ ɖò 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:

California Region	1-800-788-0710
Colorado Region	1-855-364-3184
Hawaii Region	1-800-238-5742
Mid-Atlantic States Region	1-855-364-3185
Northwest Region	1-866-616-0047
Georgia Region	1-855-364-3185
TTY	711

For Fully-insured plans:

California	1-800-788-0710
Colorado	1-855-364-31
District of Columbia	1-855-364-31
Georgia	1-855-364-31
Hawaii	1-800-238-57
Maryland	1-855-364-31
Oregon	1-855-364-31
Virginia	1-855-364-31
Washington	1-866-458-5479
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 yoołkáálgi 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.

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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	**1-855-364-3184** **711 (TTY)**	2500 South Havana Aurora, CO 80014
Georgia	**1-855-364-3185** **711 (TTY)**	Nine Piedmont Center 3495 Piedmont Road, NE Atlanta, GA 30305-1736
Hawaii	**1-800-238-5742** **711 (TTY)**	711 Kapiolani Blvd Honolulu, HI 96813
Mid-Atlantic States	**1-855-364-3185** **711 (TTY)**	2101 East Jefferson Street Rockville, MD 20852
Northwest	**1-866-616-0047** **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.**

A publication of
Benefits Compliance Communications
Total Rewards
January 2026

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SPD_HI-SAL/January 2026