Benefits for You

Kaiser Permanente Nurse Anesthetists Association

Southern California

January 2024

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 or through the negotiation process, if applicable. 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 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 and retiree benefits
- 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 HRconnect at **kp.org/hrconnect**.

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

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

TABLE OF CONTENTS

Department, Organization, or Service	Contact Information
National Human Resources Service Center (NHRSC)	Phone: **877-4KP-HRSC (877-457-4772)** Fax: **877-HRSC-FAX (877-477-2329)** Kaiser Permanente National Human Resources Service Center P.O. Box 2074 Oakland, CA 94604-2074 **kp.org/HRconnect**
Health Care	
Member Services Questions about KFHP medical plans	Northern/Southern California region Hours: 7 days a week, 24 hours a day (closed holidays) **800-464-4000** **800-777-1370 (TTY)**
Employee Assistance Program (EAP)	Northern California **kp.org/eap** Southern California **kp.org/eap** Georgia **888-678-0937 espyr.com*** Colorado **888-678-0937 espyr.com*** Hawaii **808-432-4922 kp.org/eap** Maui Health System **833-621-2993 kp.org/eap** Mid-Atlantic States **888-678-0937 espyr.com*** Northwest **503-813-4703 kp.org/eap** Washington **888-678-0937 espyr.com*** ***espyr.com** password = Kaiser**;** for Maui, 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**
Health Care (Dental)	
Delta Dental	Delta Dental of California **800-765-6003** **www.deltadentalins.com**
DeltaCare USA	**800-422-4234** **www.deltadentalins.com**
United Concordia	**800-937-6432** **www.ucci.com**

Department, Organization, or Service	Contact Information
Income Protection (Voluntary Programs)	
MetLife Questions and claims about the following plans, if applicable for your group: • Life Insurance • Short-Term Disability • Long-Term Disability • Accidental Death & Dismemberment	**800-638-6420 or 888-420-1661** **www.metlife.com/mybenefits**
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: • Accidental Insurance • Critical Illness	**800-433-3036** **cscmail@aflac.com** **Aflacgroupinsurance.com**
MetLife Questions and claims about Voluntary Term Life insurance	**888-420-1661 or 800-638-6420** **www.metlife.com/mybenefits**
MetLife Legal Plans Questions and claims about Legal Services	**800-821-6400** **www.legalplans.com**
Trustmark Insurance Company Questions and claims about Life Insurance with Long-Term Care Coverage	Beneficiary updates: **800-918-8877** Claims: **877-201-9373** **customercare@trustmarkbenefits.com**
Retirement Programs	
Kaiser Permanente Retirement Center (KPRC) Questions about pension plans and retirement benefits	Hours: M-F, 6 a.m. - 6 p.m. Pacific Time Phone**: 866-627-2826** Fax: **888-547-2304** **www.myplansconnect.com/kp**
Vanguard Questions about defined contribution retirement savings plans	Hours: M-F, 5:30 a.m. - 6 p.m. Pacific Time **800-523-1188** **www.vanguard.com**
Other Benefits	
HealthEquity 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** **www.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**

ENROLLING IN BENEFITS

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

Highlights of This Section

Eligibility for Benefits

Who Is Eligible

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

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

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

Eligible Dependents

Your eligible dependents include the following:

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

Eligible Grandchildren

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

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

Domestic Partners and Civil Union Partners

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

Enrolling a Dependent

You must enroll your dependents within 31 days of your date of hire, change to a benefited status, or when they first become eligible (such as date of birth, date of marriage, etc.). If you do not notify the 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 supporting documents 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.

If you have an eligible dependent that lives in a different Kaiser Permanente region, your dependent may enroll in medical coverage for that region. Contact the NHRSC for more information and an application.

You must notify the NHRSC within 31 days of the date an enrolled dependent becomes ineligible based on the previously stated criteria.

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

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
Domestic Partner	Copy of **one** of the following: • Notarized *of Domestic Partner Affidavit*, or • Certified local or state government domestic partner registration and *Domestic Partner Affidavit* (notarization not required)
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 **one** of the following: • Court-issued custody/guardianship papers • *Health Care Facility Minor Release Report*

Eligible Family Members	Required Documentation
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.
Grandchild who lives with you and meets the eligibility requirements	Copy of a certified birth certificate (proof of dependency may be required at any time)

Additional Information about Required Documentation for Benefits

- If you enroll a domestic partner, along with your certified domestic partner registration, you must also complete and submit the tax portion of the *Domestic Partner Affidavit* (form 3190 – available on HRconnect). Notarization is not required when submitting the tax portion of the affidavit.
- In order to enroll your domestic partner's dependents, you must also submit the required documentation for your domestic partner.
- If you are enrolling a newborn, and you do not yet have a birth certificate, a verification of birth letter from a Kaiser Foundation Health Plan (KFHP) hospital, KFHP-contracted hospital, or any other hospital is accepted.
- Foster children are not eligible for coverage without the *Notice of Intent to Adopt* certification.
- Contact Member Services 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 You Can Enroll

You may enroll in your benefits at the following times:

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

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

Open Enrollment

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

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

Some benefits are not subject to the annual open enrollment restriction, or are available for enrollment at any time (e.g., your 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 a substantial increase in your, your spouse's or domestic partner's work hours, or commencement of your spouse's or domestic partner's or child's employment

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

Family or Employment Status Changes

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

Type of Change	Effective Date
Add new dependents or change enrollment in medical plans	First of the month following date of event
Add a newborn or adopted child to medical plans	Date of event
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

Type of Change	Effective Date
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 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, please review the list available in the Benefits section of HRconnect.

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

Special Enrollment Rights

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

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

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

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 enroll in benefits during your initial enrollment period, 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 fail to enroll within 31 days of initial eligibility, you will be automatically enrolled in:

- KFHP medical coverage, for yourself only
- DeltaCare USA dental plan, for yourself only
- Company-paid Basic Life insurance coverage

Default coverage does not include any coverage for your dependents. You must wait until the next open enrollment period in order to enroll your dependents or change your dental 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. Your **pre-tax** benefits are as follows:

- 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:

- Optional Life insurance
- Benefits by Design Voluntary Programs

When Coverage Ends

Your benefit coverage ends at the end of the month in which you leave Kaiser Permanente, reclassify to an ineligible status, or go on certain unpaid leaves of absence. Please see each benefit section for specific information on when each coverage ends. For more information on leaves of absence, sign on to HRconnect at **kp.org/HRconnect** or refer to your *Collective Bargaining Agreement*.

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

HRconnect offers a quick, easy, and accurate way to view your current benefit choices and descriptions, as well as to elect or make changes to benefits when you have a qualifying employment event (such as moving from part-to full-time or a non-benefited to benefited status) or a family life event (such as marriage, birth or

adoption of a child), or if you transfer within Kaiser Permanente. You can access HRconnect at any time, from work or home, at **kp.org/HRconnect**.

Enrolling in Benefits Online

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

- **Enroll in or change** your benefits or coverage levels
- Add or remove dependents from your coverage
- Enroll in the Alternate Compensation Program, if applicable

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

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

Once you have submitted your enrollment, click the **Print** button to save your enrollment summary as a confirmation statement. To complete your dependent's enrollment, you must also provide required documentation (e.g., copy of certified birth certificate, copy of certified marriage certificate, *Kaiser Domestic Partner Affidavit,* etc.) to the NHRSC (see the "Required Documentation for Benefits" section). You may upload these documents directly to your case on **My Cases** on HRconnect (preferred), fax, or mail to:

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

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

Enrolling in the Alternate Compensation Program

You may choose to enroll in the Alternate Compensation Program (ACP) in lieu of certain benefits if you are already covered by another medical plan. You can enroll in ACP on HRconnect. You must provide proof that you have medical coverage from another source for your participation to begin. For more information see "Alternate Compensation Program."

Domestic 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 *Domestic Partner Affidavit* (form 3190 — available on HRconnect), you and your domestic partner must certify that you meet all of the following qualifications:

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

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

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

Covered Benefits

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

- Medical coverage
- Dental coverage
- 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)
- Parent Medical Coverage

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 HRconnect for more information on domestic partner benefits.

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

When Domestic Partner Coverage Begins

Your domestic partner's medical 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* (form #3170 – available on HRconnect) or a copy of a certified *Termination Certificate* filed with a state or local government within 31 days of the change. This qualifies as a family status change, which may allow you to change some of your benefits (see "Changes During the Plan Year").

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

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

If change is due to circumstances where you and/or your domestic partner no longer meet the eligibility criteria, your domestic partner may be eligible to continue medical 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.

Alternate Compensation Program

The Alternate Compensation Program (ACP) allows you to receive a wage differential above your base pay rate in lieu of participating in certain employer-paid benefits. If you are already covered by another medical plan and if you would prefer to receive extra income in exchange for your participation in certain benefits, the ACP may be of interest to you.

Who Is Eligible

You are eligible to participate in the ACP if you are regularly scheduled to work 20 or more hours per week in a benefits eligible status. You must provide annual proof that you have medical coverage from another source each year during open enrollment in order to continue your participation for the following payroll year.

Acceptable Proof of Medical Coverage

You may submit one of the following documents as proof of other medical coverage:

- A copy of your current medical card
- Certification of coverage from your HMO/Health Care provider
- Certification of coverage from another employer (must be on company letterhead)
- Medical Coverage Attestation for ACP Participation/Waiving Medical Coverage form (available online at **kp.org/HRconnect**)

If proof of other medical coverage is not received when you first elect to participate, or during the annual open enrollment period, you will not be enrolled in the ACP.

When You Can Enroll

You may enroll in the ACP when you begin working at Kaiser Permanente, when you become newly eligible for health and welfare benefits, when you are rehired or transfer into an ACP-eligible position, or during the open enrollment period.

Requirements for Participation

If you are newly eligible to participate in the ACP, you will be required to complete and submit the *Medical Coverage Attestation for ACP Participation/Waiving Medical Coverage* form **within 31 days** of making your election.

If you want to enroll in the ACP during the open enrollment period, submit the *Medical Coverage Attestation for ACP Participation/Waiving Medical Coverage* form by the last day of open enrollment.

Continuing Your Participation

Once you are enrolled in the ACP, your participation will continue from payroll year to payroll year provided that you submit annual proof of other medical coverage during the open enrollment period. A payroll year is determined by the biweekly payroll cycles and can begin prior to January 1 and end prior to December 31. Any designated holidays that fall on or after the beginning of the payroll year will be treated as a regular day off without pay.

When Coverage Begins

If you enroll when first eligible outside of open enrollment, your participation will start at the beginning of the first payroll period after the NHRSC receives your *Medical Coverage Attestation for ACP*

Participation/Waiving Medical Coverage form. If you enroll during open enrollment and provide the *Medical Coverage Attestation for ACP Participation/Waiving Medical Coverage* form, your participation will begin the first pay period of the following payroll year.

How ACP Works

The ACP provides a 20% pay differential over your base wage rate in lieu of your participation in certain employer-paid benefits.

If you participate in the ACP, you will receive a payout of all accrued Earned Time Off (ETO) hours upon entering the program. You will not accrue additional ETO hours while in the ACP. However, you may request two weeks of unpaid leave per calendar year. For more information on ETO, sign on to HRconnect.

As an ACP participant, you are not eligible for paid holidays. However, if you work on a designated holiday, you will be paid your straight time ACP rate, for all hours worked. For more information on holidays, sign on to HRconnect.

Your accrued ESL bank will be frozen upon entering the ACP, and no additional ESL hours will accrue while in the ACP. If you call in sick, you will not be paid for the time you are away from work. Once you return to the regular benefits program or are transferred to a non-ACP employee group, your frozen ESL hours will be available for use.

Your participation in the ACP does not affect your eligibility for retiree medical benefits. However, if you are enrolled in ACP on the date you terminate employment, you will not be eligible for retiree life insurance coverage.

As an ACP participant, you will continue to accrue Service and Credited Service toward your pension plan. However, your pension will be calculated based on your base wage rate (not the 20% ACP wage rate).

The following lists show which employer-provided benefits you are eligible for and which benefits you give up when you enroll in the ACP:

Eligible For:

- Kaiser Permanente Retirement Plan
- Commuter Spending Account
- Dependent Care Flexible Spending Account
- Employee Assistance Program
- Health Care Flexible Spending Account
- Jury Duty pay (paid at the ACP wage rate)
- Defined contribution retirement savings plan(s)
- Optional Life insurance
- Optional Accidental Death and Dismemberment insurance
- Parent Medical Coverage
- Shift differentials paid on all applicable hours
- Survivor Assistance
- Tuition Reimbursement Program
- Unpaid Leave of Absence
- Benefits by Design Voluntary Programs

Not Eligible For:

- Medical coverage
- Dental coverage
- Basic Life Insurance (employer paid)
- Supplemental Medical Coverage
- Designated holiday pay (for holidays not worked)
- Disability benefits
- Paid Leaves of Absence (such as Bereavement Leave, Educational Leave)
- Earned Time Off
- Extended Sick Leave

Additional information about ACP benefits:

- Sign on to HRconnect for more information on time off benefits and any leaves of absence
- You must be scheduled to work 32 or more hours per week to purchase Optional Life insurance.
- The Survivor Assistance benefit is paid at your base wage rate, not the 20% ACP rate.
- You are not eligible for benefits associated with any leaves.
- If you waive coverage due to ACP participation, you are not eligible to continue medical and dental coverage through COBRA.
- If you purchase Optional Life insurance through ACP, you will also receive Accidental Death and Dismemberment coverage.
- You may request up to two weeks of unpaid time off per year. Additional unpaid leave may be granted.

When Participation Ends

You can withdraw from the ACP during the open enrollment period or if you have a qualified family status change (e.g., birth, marriage, etc.) or qualified employment status change (e.g., change in scheduled hours, etc.). In addition, if you lose your other medical coverage for any reason, you must notify the NHRSC within 31 days of the event, withdraw from the ACP, and enroll in the regular benefits program.

If you terminate employment while participating in the ACP, you will have the option of continuing your Health Care Flexible Spending Account contributions on an after-tax basis through the Consolidated Omnibus Budget Reconciliation Act (COBRA). However, you will not be eligible to continue health and/or dental benefits through COBRA since you waived coverage when you enrolled in the ACP.

If at any time you become ineligible to participate in the ACP, you will be automatically withdrawn from the program.

For more information on the ACP, contact the NHRSC.

HEALTH CARE

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

Highlights of This Section

Overview of Medical Care

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

- You may elect health care coverage through the Kaiser Foundation Health Plan (KFHP).
- You may elect to purchase additional coverage through the Supplemental Medical Plan if you are enrolled in KFHP coverage and are regularly scheduled to work 32 or more hours per week.
- 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 **Enrolling in Benefits** section. For information on Qualified Medical Child Support Orders (QMCSO), please see the **Legal and Administrative Information** section.

Your Costs

Your medical plan premiums are employer-paid. 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 your date of hire.

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

When Coverage Ends

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

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

Patient Protection Disclosure

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

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

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

Kaiser Foundation Health Plan

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

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

The information in this section is a summary only. It does not fully describe your benefit coverage. For details on your benefit coverage, including a complete list of benefits, services, exclusions, and limitations, refer to your *Evidence of Coverage*, the binding document between KFHP and its members. If you have any questions or problems using your KFHP coverage, or to obtain a copy of the *Evidence of Coverage* brochure, please contact Member Services**.**

Your KFHP Medical Plan at a Glance

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

Benefits	You Pay
Annual Out-of-Pocket Maximum	
Individual	$1,500
Two or more people	$3,000
Outpatient Care	
Office visits for illness/injury, including specialty care and OB/GYN	$10 per visit
Outpatient surgery	$10 per visit
Affordable Care Act Preventive Care Services, as defined by the region	No charge

Benefits	You Pay
Lab tests and X-rays	No charge
Immunizations (preventive)	No charge
Allergy testing	$10 per visit
Allergy injections	No charge
Inpatient Care	
Including room and board, surgical services, nursing care, anesthesia, X-rays, and lab tests	$100 per admission
Maternity Care	
Prenatal care	No charge
Labor, delivery, and recovery	$100 per admission
Routine postpartum visit	No charge
Well-child care	No charge (up to age 2)
Family Planning	
Outpatient	No charge
Inpatient	$100 per admission
Fertility Services	
Outpatient	$10 per visit
Inpatient	$100 per admission
Emergency Department	
Emergency room visits	$50 per visit (waived if admitted)
Urgent care visits	$10 per visit
Ambulance	
Medically necessary or Kaiser Permanente approved	No charge
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)	$5 generic / $10 brand
Mail order (up to 100-day supply)	$10 generic / $20 brand
ACA-mandated medications	No charge
COVID-19 Over-the Counter (OTC) Rapid Antigen Home Tests (up to 8 per month)	No charge

Benefits	You Pay
Mental Health Care	
Outpatient Individual	$10 per visit **Note:** You can be reimbursed for copayments for the first 20 visits in a calendar year by contacting HealthPlan Services.
Outpatient Group	$5 per visit
Inpatient	$100 per admission
Substance Use Disorder	
Outpatient Individual	$10 per visit
Outpatient Group	$5 per visit
Inpatient	$100 per admission (detox only)
Residential Treatment	$100 per admission
Skilled Nursing Facility	
Up to 100 days per calendar year	No charge
Physical, Speech, and Occupational Therapy	
Outpatient (must be prescribed by a Kaiser Permanente provider)	$10 per visit
Inpatient	$100 per admission
Durable Medical Equipment (DME), Prosthetic, and Orthotic Devices	
Must be prescribed by a Kaiser Permanente physician in accordance with Health Plan and DME Formulary guidelines	No charge
Vision Care	
Routine eye exams	No charge if covered as part of a preventive exam; otherwise $10 per visit
Eyeglasses and contact lenses, adults and children. **Note:** Charges in excess of the allowance do not apply to copayment limits.	$175 allowance toward one pair of eyeglass lenses and frames or contact lenses every 24 months
Home Health Care	
Must be prescribed by a Kaiser Permanente physician and authorized by the Home Health committee. Custodial care not covered.	No charge
Hearing Care	
Hearing exams	No charge if covered as part of a preventive exam; otherwise $10 per visit
Hearing aids	Not covered
Hospice Care	
In accordance with regional requirements	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, 7 days a week. Emergency care is defined as services that are provided by affiliated or non-affiliated providers after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, such that you reasonably believed that the absence of immediate medical attention would result in any of the following:

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

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

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

Emergency Care at Facilities Not Affiliated with Kaiser Permanente

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

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

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

Your Rights and Protections Against Surprise Medical Bills

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

Definition of “Balance Billing” (also referred to as “Surprise Billing”)

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or must pay the entire bill if you see a provider or visit a health care facility that is not in your health plan’s network. “Out-of-network” describes providers and facilities that have not signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

Surprise Billing

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

Balance Billing Protection

Emergency services

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

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

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may **not** ask you to give up your protections not to be balance billed.

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

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

Additional Protection When Balance Billing Is Not Allowed

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

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

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 the HRconnect at **kp.org/HRconnect**, or contact HealthPlan Services (see the **Contact Information** section).

Who Is Eligible

You and your eligible dependents are eligible to elect the Supplemental Medical Plan as long as you are enrolled in the Kaiser Foundation Health Plan (KFHP) and are regularly scheduled to work 32 or more hours per week.

How Supplemental Medical Works

If you wish to enroll in the Supplemental Medical Plan, you will be required to pay the premiums through automatic payroll deductions on the first two pay statements of each month for your coverage (and your eligible dependents, as applicable) for the first five years. After five years, the premiums are employer-paid.

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

Exceptions to this requirement are made for the following:

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

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

Authorized Evidence of Exclusion

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

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

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 from KFHP stating that your KFHP claim is denied because you chose to use a non-KFHP provider.

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

Covered Services

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

Services	You Pay	Maximum/Limits	Restrictions
Acupuncture	$10 per visit	N/A	Must be performed by a licensed acupuncturist. Services must be medically appropriate.
Alcohol and Chemical Dependency Inpatient room and board, physician visits and alternative treatment programs Outpatient Individual and group therapy	20%	N/A	Denial of service letter is required.
Biofeedback, Physical, Occupational, Physio, Speech, and Rehabilitation Therapy	20%	N/A	Denial of service letter is required. 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	$10 per visit	$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.

Services	You Pay	Maximum/Limits	Restrictions
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	A Includes wheelchairs, braces, hospital beds, and durable medical supplies. Denial of service letter is required.
Hospice Care Private duty nursing, up to 24 hours a day, by a registered nurse or a licensed practical nurse. Includes room and board, ill patient physician visits and home care	No charge	100 home care visits	Attending physician must certify the need for nursing care, not to exceed an 8 - hour shift by the same nurse in one day. Maximum of $50 per visit for a licensed social worker — not to exceed one visit per week. Denial of service letter is required.
Infertility Services	20%	$30,000 lifetime maximum	Denial of service letter is required. Surrogacy services not covered.
Jaw Joint Disorder Treatment	20%	$2,000 lifetime maximum	Denial of service letter is required.
Mental Health Services Inpatient and outpatient	20%	N/A	Denial of service letter is required
Podiatry	20%	N/A	Denial of service letter is required.
Skilled Nursing Facility Non-custodial room and board and ill-patient physician visits	20%	N/A	Denial of service letter is required.

Telemedicine Services

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

Dental Plan Options

Dental coverage is an important part of your comprehensive benefits program. You have an option of two prepaid dental plans during your first three years of employment. Once you have completed three years of employment, you will also have the option of electing the Delta Dental Preferred Provider Organization (PPO) plan.

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.

For details on dependent eligibility and tax considerations, see the **Enrolling in Benefits** section.

Your Costs

Your dental plan premiums are employer-paid. At the time you receive services, you will be responsible for any applicable charge or copayment.

When Coverage Begins

Your dental coverage is effective on the first day of the month following three months of employment. However, you must enroll within 31 days of your date of hire, when you become newly eligible for health and welfare benefits, or during the open enrollment period. Coverage for your eligible dependents begins when yours does, provided the NHRSC receives your enrollment information and required documentation (see the "Required Documentation for Benefits" chart).

How Dental Coverage Works

For the first three years of employment, you may participate in either the DeltaCare USA or the United Concordia dental plans.

These plans are closed network programs; in order to receive benefits, you must see a dentist from their respective directory of dentists. Once enrolled in the United Concordia, or DeltaCare USA plan, you will receive membership cards for yourself and your enrolled dependents. The membership cards will indicate your assigned dental office. If you wish to change your dental office after you receive your membership card, call your plan's customer service department to be assigned to another dental provider.

After three years of employment, you will have the opportunity to elect to participate in the Delta Dental PPO plan. You will have a 31-day enrollment period.

Delta Dental has a national network of more than 300,000 dentists who have agreed to charge fees approved by Delta. When you enroll in the Delta Dental PPO plan and use a Delta Dental PPO dentist, you will not have to submit a claim form, and you pay only your portion of the bill. While you are not required to use a dentist in the Delta Dental PPO network, if you choose not to, you will be responsible for filing your own claim forms for reimbursement. You will also have to pay the difference between the dentist's fees and the standard Delta Dental PPO negotiated rate in addition to the plan's coinsurance payment.

There are several ways you can find a Delta Dental PPO dentist:

- Ask your current dentist if he or she participates in the Delta Dental PPO network
- Call **888-335-8227** for a directory of participating dentists in your area
- View the Delta Dental PPO provider directory online at **www.deltadentalins.com**

Covered Services

Dental coverage is comprehensive and includes diagnostic, preventive, basic, major, and orthodontic services. The following chart provides an overview of the coverage offered and any associated costs or limits.

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.

Benefit	DeltaCare USA	United Concordia	Delta Dental PPO (3-year waiting period)	Limitations
	Your Cost	Your Cost	Your Cost	
Diagnostic and Preventive Services				
Includes oral exams and cleanings bitewing X-rays, fluoride treatments and sealants	No charge; Oral exams, cleaning, and bitewing X-rays once every 6 Months Fluoride treatment to age 19 once every 6 months; Sealants for permanent molars only through age 15	No charge; Once every 6 months; Dental cleaning. Additional Cleaning: $30 copayment child, $40 copayment adult (maximum of 1 additional every 6 months) Fluoride treatment once every 6 months to age 19. Sealants- 1 tooth per 3-year period through age 10 on permanent first molars and through age 15 on permanent second molars.	No charge; Twice every calendar year	See specific plan Column See basic services for sealants for Delta Dental PPO
Full mouth X-rays	No charge; Once every 2 years	No charge; Once every 3 years	No charge; Once every 3 years	See specific plan column
Genetic testing for susceptibility to oral disease	Not covered	No charge	Not covered	See specific plan column
Basic Benefits				
Routine restoratives, including fillings	No charge for most services **Note:** Copayments may apply for some services	No charge for most services **Note:** Copayments may apply for some services	10% Sealants only to permanent first molars through age 8 and second molars through age 15.	See specific plan column; Basic services include sealants for Delta Dental PPO.

Benefit	DeltaCare USA	United Concordia	Delta Dental PPO (3-year waiting period)	Limitations
	Your Cost	Your Cost	Your Cost	
Endodontics				
Includes root canals	No charge for most services **Note:** Copayments may apply for some services	No charge for most services **Note:** Copayments may apply for some services	10%	See specific plan column
Periodontics				
Includes gum treatment	No charge for most services **Note:** Copayments may apply for some services	No charge for most services **Note:** Copayments may apply for some services	10%	See specific plan column
Oral Surgery	No charge for most services	No charge for most services	10%	See specific plan column
Major Services				
Includes crowns, inlays, outlays, and cast restorations	No charge for most services **Note:** Copayments may apply for some services	No charge for most services **Note:** Copayments may apply for some services	10% In most cases, covered once every 5 years on same tooth	See specific plan column
Prosthodontics				
Bridges and dentures	No charge for most services **Note:** Copayments may apply for some services	No charge for most services **Note:** Copayments may apply for some services	30%	See specific plan column
Orthodontics	$350 start-up fees, plus $1,000 per child up to age 19 $350 start-up fees, plus $1,800 for adults and/or dependent adult child age 19 to age 26	$1,500 per child up to age 26 $2,000 per adults	50% up to a lifetime maximum of $1,500 per child to age 26 only	Some limitations may apply. Talk with your dentist.

Benefit	DeltaCare USA	United Concordia	Delta Dental PPO (3-year waiting period)	Limitations
	Your Cost	Your Cost	Your Cost	
Out-of-Network Dental Emergency	Maximum reimbursement of $100 per emergency, per enrollee, less the applicable copayment	Maximum reimbursement of $100 (Benefit is payable only if services were rendered more than 50 miles from your United Concordia provider's office)	As performed by any licensed dentist (the amount paid will be based on procedures performed)	
Annual Deductible				
Individual	None	None	None	
Family	None	None	None	
Annual Maximum	None	None	$1,500	Per person, per calendar year. The value of services covered at 100% count toward your annual maximum

Please note: The value of services covered at 100% count toward your annual maximum.

For more information regarding the cost of dental services, refer to the *Evidence of Coverage* brochure available from your dental plan.

Predetermination of Benefits (Delta Dental PPO Plan)

When you have a dental problem, a variety of corrective treatments may be available. Like most dental plans, your plan limits payment to certain corrective procedures. Your plan has a prior authorization procedure called predetermination of benefits for treatments and services estimated to exceed $300. This process permits review of the proposed treatment and allows your carrier to resolve any questions before, rather than after, the work is done. 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 **888-335-8227** for a predetermination of benefits.

Services Not Covered (Delta Dental PPO Plan)

Your dental plan does not cover the following services:

- Services for injuries covered by Workers' Compensation, or services that are paid by any federal, state, or local government agency, except MediCal
- Services for cosmetic purposes or for conditions that are a result of hereditary or developmental defects
- Treatment that restores tooth structure that is worn, that rebuilds or maintains chewing surfaces that are damaged because the teeth are out of alignment or occlusion, or that stabilizes teeth

- Any procedure, bridge, denture, or other prosthodontia service started before you were covered for dental benefits
- Experimental procedures
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by a dentist for treatment in any such facility
- Prescribed drugs or applied therapeutic drugs, premedication, or analgesia
- Anesthesia, except for general anesthesia given by a dentist for covered oral surgery
- Grafting tissues from outside the mouth to tissue inside the mouth, implants, or the removal of implants
- Implants (materials implanted into or on soft bone tissues inside the mouth)
- Services for any disturbance of the jaw joints, temporomandibular joints (TMJ), or associated muscles, nerves, or tissue
- Replacement of any existing restoration for any purpose other than restoring active tooth decay
- Charges for replacement or repair of an orthodontic appliance paid, in part or in full, by the plan
- Occlusal guards and complete occlusal adjustment
- Any procedure not specifically listed as a covered service is subject to be available on a fee-for-service basis
- Charges for lost or stolen prosthodontic appliances

In addition, there may be limitations on some of the covered services. For additional information, see your *Evidence of Coverage* brochure or contact your dental provider.

Please note: For additional information on services not covered, contact your dental carrier (see the **Contact Information** section).

Services Not Covered (DeltaCare USA)

Your dental plan does not cover the following services:

- Dental conditions for which Workers' Compensation is paid, or services that are paid by any federal, state, or local government agency, except MediCal
- Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.
- Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ)
- Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with the DeltaCare USA program or started after termination of eligibility for coverage
- All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility
- Dispensing of drugs not normally supplied in a dental facility
- Any procedure that the assigned Contract Dentist determines has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or is inconsistent with generally accepted standards for dentistry
- Consultations for non-covered benefits
- Dental services received from any dental facility other than the assigned Contract Dentist including the services of a dental specialist, unless expressly authorized in writing by Delta Dental or as cited under Emergency Services. To obtain written authorization, the Enrollee should call Delta Dental's Customer Service department at **800-422-4234**

- Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment
- Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
- Porcelain crowns, porcelain fused to metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age
- An initial treatment plan which involves the removal and reestablishment of the occlusal contacts of 10 or more teeth with crowns, onlays, fixed partial dentures (bridges), or any combination of these is considered to be full mouth reconstruction under the DeltaCare USA program. Crowns, onlays and fixed partial dentures associated with such a treatment plan are not covered Benefits. This exclusion does not eliminate the benefit for other covered services
- Extraction of teeth, when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars and orthodontic extractions
- Congenital malformations, except for the treatment of newborn children with congenital defects or birth abnormalities
- Treatment or extraction of primary teeth when exfoliation (normal shedding and loss) is imminent.
- Any procedure that is not specifically listed under *Schedule A, Description of Benefits and Copayments* in the DeltaCare USA *Evidence of Coverage* (EOC)
- Loss or theft of full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges)

Please note: For additional information on services not covered, contact your dental carrier (see the **Contact Information** section).

Services Not Covered (United Concordia)

Your dental plan does not cover the following services:

- Services determined by United Concordia to be the responsibility of Worker's Compensation, the employer's liability or health care plan, payable under any federal or state government program, or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile insurance policy, or for services for which benefits are payable under any other insurance
- Services which United Concordia determines are principally cosmetic, including, but not limited to, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures
- Treatment that restores tooth structure lost due to attrition, erosion or abrasion
- Services started or incurred prior to the eligibility date or after the termination date of coverage under United Concordia
- Services that United Concordia determines do not meet accepted standards of dental treatment, which are experimental or investigative in nature, or are considered enhancements to standard dental treatment
- Hospitalization and associated costs for rendering services in a hospital
- Prescription or non-prescription drugs, home care items, vitamins or dietary supplements
- Diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include such conditions as temporomandibular joint (TMJ) syndrome and craniomandibular disorders or other conditions of the joint linking the jawbone and the complex of muscles, nerves and other tissues related to that joint

- Services and/or appliances that alter the vertical dimension or alter, restore or maintain the occlusion, including, but not limited to, full mouth rehabilitation, splinting, appliances or any other method
- Services not specifically listed in the United Concordia Schedule of Benefits as a covered service
- Consultations by a specialty care dentist for services not specifically listed on the Schedule of Benefits as a Covered Service
- Replacement of lost, missing, stolen or damaged prosthetic device or orthodontic appliance or for duplicate dentures, prosthetic devices or any duplicative device
- Services provided outside of the office in which a member is enrolled and which are not pre-authorized by United Concordia (including specialty care services)
- Services the treating dentist or United Concordia determine to be clinically unnecessary, or do not have a reasonable, favorable prognosis
- Services necessary due to lack of cooperation with your dentist, or failure to comply with a professionally prescribed treatment plan
- The following, which are not included as orthodontic benefits: retreatment of orthodontic cases, changes in orthodontic treatment necessitated by patient non-cooperation, repair of orthodontic appliances, replacement of lost or stolen appliances, special appliances (including, but not limited to, headgear, orthopedic appliances, bite planes, functional appliances or palatal expanders), myofunctional therapy, cases involving orthognathic surgery, extractions for orthodontic purposes, and treatment in excess of twenty-four (24) months
- Elective extraction of teeth including but not limited to the removal of third molars
- Services required because of, or in connection with acts of war, declared on undeclared
- For implants, surgical insertion and/or removal of, and any appliances and/or prosthetics attached to implants

Please note: For additional information on services not covered, contact your dental carrier (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 or you go on certain unpaid leaves of absence.

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 or your dependents may continue dental coverage through COBRA or convert your group coverage to an individual plan within 30 days of loss of coverage. If you do not elect dental coverage, you will not be eligible for COBRA dental coverage when you leave. If you are on an unpaid leave of absence, you may also be able to continue certain benefits coverage through the leave of absence billing process (for information, contact the NHRSC).

For more information on enrolling in individual coverage, contact your dental carrier (see the **Contact Information** section). For more information on COBRA, see **Continuation of Coverage 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.

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 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* brochure, or call Member Services. If you have any questions about coordination of your dental benefits, please call your dental carrier.

Health Care Continuation

When you leave Kaiser Permanente, go on certain unpaid leaves of absence, or otherwise no longer meet the eligibility requirements, your employer-provided medical 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 National Human Resources Service Center.

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

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

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

When You Are Eligible

If You Have a Change in Employment Status

You 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 yourself and your eligible dependents if your coverage ends. Your coverage under the Kaiser Permanente-sponsored plans will continue through the end of the month in which any of the above events occur. Your COBRA coverage will become effective on the first day of the following month, provided you make a timely COBRA election and payment.

Please note: Individuals who do not elect COBRA within the 60-day election period cannot later enroll based on the same loss of coverage event.

During the period you continue coverage, an open enrollment period may be available, during which time you may add medical 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 yourself and your eligible dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

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

If qualified to continue medical 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 HRconnect, or contact the NHRSC.

If You Die

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

If You or Your Dependents Are Disabled

If you and/or your eligible dependents are determined to be disabled as defined by the Social Security Act prior to the qualifying event or during the first 60 days of COBRA coverage, COBRA may be extended from 18 months up to a total of 29 months at a higher premium. You must notify HealthEquity/WageWorks within 60 days of the receipt of your Social Security award letter, and no later than the expiration of your initial 18-month coverage period. You must also notify HealthEquity/WageWorks within 60 days of the date Social Security determines that you and/or your eligible dependents are no longer disabled.

COBRA Election Procedures

You and your eligible dependents who lose medical 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 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 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 HealthEquity/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/or your eligible dependents become covered under any other group medical or dental plan
- You and/or your eligible dependents become entitled to Medicare benefits after the qualifying event
- You fail to pay the required premium on time
- Kaiser Permanente terminates all of its group health plans
- You and/or your eligible dependents are on a COBRA disability extension and Social Security determines that you and/or your eligible dependents are no longer disabled

When your COBRA coverage ends, you may be eligible to purchase an individual medical 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:

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

When Your Dependents 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.

If the Sick Leave HRA or Retiree Medical HRA has a zero balance at the time of the qualifying event, COBRA coverage for the account will not be available. In addition, your COBRA coverage will end before the 36-month maximum period if the account has a zero balance.

Benefits for your eligible dependents while enrolled in COBRA coverage will be the same retiree health benefits you had immediately prior to the qualifying event, except the Sick Leave HRA balance and the Retiree Medical HRA balance is prorated for divorce, annulment and legal separation. COBRA coverage for your covered dependents will end before the 36-month maximum period if the account has a zero balance.

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 Sick Leave HRA or Retiree Medical HRA, when the account has a zero balance

COBRA Continuation for the Sick Leave Health Reimbursement Account

Your covered spouse and eligible children may continue Sick Leave Health Reimbursement Account (HRA) benefits under COBRA.

When You Are Eligible

Your covered spouse or domestic partner and eligible children may elect to continue Sick Leave HRA benefits under COBRA for up to 36 months 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 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.

The Sick Leave HRA balance for your covered spouse or domestic partner is prorated for divorce, annulment and legal separation while enrolled in COBRA coverage.

COBRA Election Procedure

To elect to continue Sick Leave HRA benefits through COBRA, you, your covered spouse or domestic partner, and eligible children must contact the KPRC to provide notice of a qualifying event. Notice of a qualifying event must be provided to the KPRC within 31 days of the qualifying event date. They will, in return, notify HealthEquity/WageWorks.

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

When Coverage Ends

COBRA coverage for the Sick Leave HRA will stop if any of the following situations occur:

- The completion of 36 months of coverage.
- The account has a zero balance.
- Kaiser Permanente terminates all of its retiree health benefits

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 Health Care Flexible Spending Account (Health Care FSA) if you are regularly scheduled to work 20 or more hours per week in an eligible status. You may participate in the Dependent Care Flexible Spending Account (Dependent Care FSA) regardless of your work schedule. 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:

- Within 31 days of your date of hire
- 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 **Enrolling in 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 annually 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 details on how to file a Health Care FSA claim refer to the **Disputes, Claims and Appeals** section or see “Using Your Healthcare Debit Card.” For information on how to file a Dependent Care FSA claim refer to "Filing a Claim" under the "Dependent Care Flexible Spending Account" 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 Dependent Care FSA/Health Care FSA 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 Dependent Care FSA/Health Care FSA 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 also 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 FSA or Dependent Care FSA 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. You may be able to continue your Health Care FSA participation through the end of the plan year if you continue to make contributions to the plan on an after-tax basis under COBRA (see “Continuation of Coverage Under COBRA”).

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 2024 is $3,050. For the most up-to-date annual maximum contribution, sign on to HRconnect. 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 **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 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 HRconnect 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 HRconnect at **kp.org/hrconnect**.

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 mobile application (available at **healthequity.com**). For additional information on the card verification process, please contact HealthEquity.

If you pay for eligible expenses out-of-pocket, you may obtain a Health Care FSA reimbursement claim form on HRconnect or 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

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

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

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

Parent Medical Coverage

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

Who Is Eligible

Eligible Employees

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

Eligible Parents

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

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

Medicare Eligibility and Coverage

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

When Your Eligible Parents May Enroll

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

- Within 31 days of your date of hire
- During the annual open enrollment period (you will be notified in advance of the dates)
- Outside of the open enrollment period within 31 days of the following qualifying events:
    - When an eligible parent first moves into a Kaiser Permanente Medicare service area in your region
    - When an eligible parent first becomes eligible for and enrolls in Parts A and B of Medicare

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

How to Enroll

To enroll a parent:

- Sign on to HRconnect and access the Benefits Enrollment page. The PMC enrollment information is at the end of the enrollment page.
- Complete the online request to have PMC enrollment forms emailed to you
- Once you receive the email, complete pages 1 and 2 of the *Parent Medical Coverage Enrollment Application* (4130) for each parent; **both you and your parent must complete and sign this form**.
- Submit a notarized *Domestic Partner Affidavit* (form 3190—available on HRconnect) or submit a copy of a certified domestic partnership registration filed with a local or state government if your or your spouse's parent's domestic partner is applying for coverage.
- Each eligible parent you wish to enroll must complete the *Kaiser Permanente Senior Advantage Election Form*.
- Please include your 8-digit employee number on the top of each form.
- Mail or fax all completed forms to the NHRSC within 31 days of the date you and/or your parent(s) become eligible, or before the end of the annual open enrollment period.

Each eligible parent must enroll separately.

Coverage Premiums

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

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

Medical Coverage Under This Plan

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

When Coverage Is Effective

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

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

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

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

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

When Parents Lose Coverage

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

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

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

When You Retire

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

Likewise, parents will not be eligible to enroll in the Parent Medical Coverage plan after you retire. For more information about this plan, visit HRconnect or contact the NHRSC.

INCOME PROTECTION

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

Highlights of This Section

Employee Life Insurance

Your Employee Life insurance benefits include Basic Life and Optional Life insurance options, and are paid to your beneficiary in the event of your death.

Who Is Eligible

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

Your Cost

Basic Life insurance is employer-paid.

You have the option to purchase Optional Life insurance at your own expense for the first two years, after which it becomes employer paid.

When Coverage Begins

Your Employee Life insurance coverage is effective on your date of hire or transfer to an eligible status (your benefit-effective date). You must be actively at work on your benefit-effective date for coverage to begin.

Basic Life Insurance

You are provided with $50,000 in employer-paid Basic Life insurance coverage. You may not waive this coverage, including any Accidental Death and Dismemberment coverage.

Basic Life insurance also includes $5,000 in Accidental Death and Dismemberment (AD&D) coverage.

Optional Life Insurance

Instead of Basic Life, you can elect the Optional Life insurance, which provides coverage equal to two times your annual salary, up to $750,000. For the first two years, you pay the premiums for the cost of coverage in excess of $50,000. After two years of premium payments, your Optional Life insurance coverage becomes employer paid.

If you elect Optional Life insurance coverage, you also receive Accidental Death and Dismemberment insurance coverage of two times your annual salary, up to $200,000. You must enroll within 31 days of your date of hire, when you become newly eligible for health and welfare benefits, or during the open enrollment period.

Your Costs

The premiums for your Basic Life insurance are employer-paid. If you elect to purchase Optional Life insurance, you pay the premiums through payroll deductions. Premiums are subject to change annually. You may obtain current premium rates by calling the National Human Resources Service Center. Premium rates will also appear on the Enrollment Tool when you enroll online.

Evidence of Insurability

If you choose to purchase Optional Life insurance when first eligible, you do not need to provide Evidence of Insurability (EOI), which is proof of your good health. However, if you initially decline Optional Life insurance coverage, you may be required to provide EOI if you wish to purchase it in the future.

A physical examination or other tests may be required by MetLife, our insurer, which may not be covered by your medical plan. If you are required to provide EOI, you will receive an email message from MetLife asking you to complete a Statement of Health. 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 EOI online to ensure timely processing of your insurance coverage by MetLife. You may also request a paper EOI form from the NHRSC if you are not able to complete the form online.

The coverage amount subject to EOI will not take effect until approval is received from MetLife and payroll deductions for the new amount have begun, provided you are actively at work.

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 deduction will appear on the first two pay statements of each month throughout the year.

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

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 ability to the extent of such payment. If a beneficiary or payee is a minor or incompetent to receive payment, MetLife will pay that person’s guardian.

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

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.

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 your life insurance, Basic Life up to $25,000 and Optional Life up to $325,000, 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 more than $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 NHRSC.

Continuation of Coverage without Premium When You Become Disabled

If you become totally and permanently disabled and unable to perform any occupation, your 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 six months, but not more than 12 months — your life insurance will continue as shown below, provided you remain totally disabled:

Age When Disability Occurs	Duration of Benefits
Age 60 or less	To age 65
61 but less than 65	48 months
65 but less than 69	24 months
69 and older	12 months

Coverage will continue without payment of premium from the date MetLife approves 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 reach one of the age limits above
- The date of your death
- The date you do not give MetLife proof of total disability, as required
- The date you refuse to be examined by a MetLife physician, as required.

For more information, contact the NHRSC.

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.

Accidental Death and Dismemberment Insurance

Accidental Death and Dismemberment (AD&D) insurance provides additional income protection for you in case of injury or death resulting from an accident.

Who Is Eligible

You are eligible for Accidental Death and Dismemberment (AD&D) insurance if you are regularly scheduled to work 20 or more hours per week in an eligible status. If you purchase Optional Life insurance, it also includes AD&D coverage in the amount of two times your annual salary, up to $200,000.

When Coverage Begins

Your AD&D coverage begins when your life insurance coverage begins, on your date of hire or transfer to an eligible status (your benefit-effective date).

You must be actively at work on your benefit-effective date for AD&D coverage to begin.

If you are not actively at work, coverage will begin when you return to work in an eligible status. If your AD&D coverage changes in the future, you must also be actively at work for the change to take effect.

Coverage Amount

Basic Life insurance also includes $5,000 in Accidental Death and Dismemberment (AD&D) coverage.

If you purchase Optional Life insurance, it also includes AD&D coverage in the amount of two times your annual salary, up to $200,000.

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%
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%

When This Occurs	Plan Pays This Percentage of Benefit
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

Certain types of losses are not covered. Dismemberment benefits are paid at a percentage of the death benefit.

Unless listed as an exclusion, the plan covers approved losses directly related to the injuries from an accident at any time, in any location, within 12 months of the accident.

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 Life insurance.

When Coverage Ends

Your AD&D 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.

Short-Term Disability Insurance

Short-Term Disability (STD) insurance provides income protection for a period of time if you are disabled due to a serious illness or injury. Your STD coverage provides benefits after your Extended Sick Leave benefits are exhausted. The benefits are administered through MetLife. You do not have to pay anything for STD benefits; your premiums are employer-paid.

Who Is Eligible

You are eligible for STD insurance if you are regularly scheduled to work 20 or more hours per week and you have less than two years of service.

When Coverage Begins

Your STD coverage begins on your date of hire, transfer, or move to an eligible status (your benefit effective date).

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

How Short-Term Disability Works

STD benefits provide you with a benefit equal to 50% of your base compensation on the last day of your elimination period, prorated by the number of hours you are regularly scheduled to work. If you qualify for disability benefits from other sources, such as State Disability Insurance, Social Security, and/or Workers' Compensation, your STD benefits will be reduced by these other sources and you may receive up to 60% of your base salary.

If MetLife determines that you are eligible for — and you participate in — an approved rehabilitation program, you may receive up to an additional 10% of your predisability earnings when integrated with other income sources.

When Benefits Begin

STD benefits begin on the later of the following:

- When you exhaust all Extended Sick Leave
- On the first day of hospitalization
- On the eighth day of continuous illness or injury

The elimination period is the period of time during which no STD benefits are payable, beginning on the day you become disabled, as defined above.

Once your STD benefits begin, if you return to work, and then become disabled again from the same condition within 90 days, you will not have to satisfy a new elimination period.

Duration of Benefits

STD benefits are paid for a maximum of 52 weeks with continued certification from your health care provider. Your STD benefits will end on the earliest of the following:

- The date MetLife determines that you are no longer disabled
- The date you decline to have a medical exam requested by MetLife
- The date you fail to provide required proof of continuing disability
- The date of your death
- After 52 weeks of benefit payments

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 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.
- **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 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 — 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.

What Is Not Covered

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

- Active participation in a riot
- Commission or attempt to commit a felony
- Intentionally self-inflicted injuries or attempted suicide
- War-related disabilities

How to Apply for Short-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 HRconnect or call the NHRSC.

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

Benefits During Short-Term Disability

Most benefits do not continue while you are receiving STD benefits. However, your eligibility for 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% increase to your monthly benefit. This increase is applied prior to integration with other income sources such as State Disability Insurance, Social Security and/or Workers' Compensation.
- The monthly 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 monthly benefit exceeds 100% 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 payment will commence with the fourth weekly payment and 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 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.

When Coverage Ends

STD coverage ends on the day you terminate employment with Kaiser Permanente, when you complete two years of service, 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. If you are on an approved Medical Leave, your eligibility for STD coverage may continue, and you can file a claim for disability benefits for the illness or injury for which you were originally disabled. If you are on an approved non-Medical Leave, your eligibility for STD coverage ends on the last day of the month in which your leave began. You are not eligible to convert your STD to an individual plan when you leave.

Long-Term Disability Insurance

Long-Term Disability (LTD) insurance provides income protection if you become disabled for an extended period and cannot work. LTD allows you to receive a benefit equal to a percentage of your pay each month while you are disabled.

The benefits are administered through MetLife. You do not have to pay anything for LTD benefits; your premiums are employer-paid.

Who Is Eligible

You are eligible for LTD insurance if you are regularly scheduled to work 20 or more hours per week in an eligible status and you have two or more years of service.

When Coverage Begins

Your LTD coverage begins the first of the month after you complete two years of continuous employment.

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.

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.

The actual amount of your LTD benefit will be 50% of your pre-disability earnings, which are your base earnings as of your last day of active work before your disability began.

If you qualify for disability benefits from other sources, such as sick leave or Extended Sick Leave (ESL), State Disability Insurance (SDI), Workers' Compensation, or Social Security Disability or retirement, your LTD benefit will be integrated with those benefits and you can receive up to a total of 60% of your base earnings from all sources. If the total of your other disability benefits exceeds 60% of your base earnings, no LTD benefit may be payable.

When integrated with other disability benefits, your LTD benefit from MetLife will never exceed 50%.

If you return to work for 90 days or less during your elimination period, those days will count toward your elimination period. However, if you return to work for more than 90 days before satisfying your elimination period, you will have to begin a new elimination period.

Once your LTD benefits begin, if you return to work, and then become disabled again from the same condition within 3 months, you will not have to satisfy a new elimination period.

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 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 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

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 per occurrence maximum of 36 months or the maximum benefit period, whichever is less.

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 36 months or the maximum benefit period, whichever is less.

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 HRconnect 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

LTD benefits are paid according to the following table, with continued physician certification, based on your age when you become disabled — 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 36 months, or the maximum duration shown below:

Age You Become Disabled	Maximum Duration of LTD Benefits
Under 61	To age 65
61	48 months
62	48 months
63	48 months
64	48 months
65	48 months
66	48 months
67	24 months
68	24 months
69 and over	12 months

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, State Disability Insurance (SDI), 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.

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

Most benefits do not continue as a result of being eligible for LTD benefits. 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.

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.

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.

Survivor Assistance

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

Who Is Eligible

You are eligible for the Survivor Assistance benefit if you are regularly scheduled to work.

When Coverage Begins

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

How Survivor Assistance Works

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

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

To designate a beneficiary, complete the *Beneficiary Designation Survivor Assistance form #3130* (available on HRconnect).

When Coverage Ends

Survivor Assistance coverage ends on the day you terminate employment with Kaiser Permanente or on the date you no longer qualify because of changes to your employment status. You cannot convert this coverage to an individual plan.

Benefits by Design Voluntary Programs

Overview of Benefits by Design Voluntary Programs

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

Accident Insurance

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

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

Who Is Eligible

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

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

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

When Coverage Begins

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

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

Your Cost

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

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

How Accident Insurance Works

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

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

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

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

Covered Services, Injuries, and Conditions

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

- Accident follow-up treatment
- Ambulance
- Appliances (within 6 months after accident)

- Blood/plasma/platelets
- Burns (2nd and 3rd degree)
- Chiropractic or alternative therapy
- Concussion
- Dislocations
- Emergency dental work
- Emergency room observation
- Eye injuries
- Facilities fee for outpatient surgery
- Family member lodging
- Fractures
- Hospitalization
- Initial treatment (at hospital emergency room, urgent care facility, or doctor's office or facility)
- Inpatient surgery and anesthesia
- Lacerations
- Major diagnostic testing
- Outpatient surgery and anesthesia
- Pain management
- Paralysis
- Post-traumatic stress disorder
- Prescriptions
- Prosthesis
- Rehabilitation unit
- Residence/vehicle modification
- Surgery and anesthesia
- Therapy
- Traumatic brain injury
- Wellness benefit tests (once per calendar year)

Organized Athletic Activity Benefit

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

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

Exclusions

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

- Cosmetic surgery
- Felony
- Illegal occupation
- Racing
- Suicide
- Sickness
- Self-inflicted injuries
- Sports
- War

Choosing Your Beneficiary

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

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

When Coverage Ends

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

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

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

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

Critical Illness Insurance

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

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

Who Is Eligible

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

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

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

When Coverage Begins

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

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

Your Cost

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

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

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

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

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

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

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

How Critical Illness Insurance Works

You choose from the following coverage options:

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

Critical Illness Coverage Option 1	Benefit Amounts
Employee Only	$20,000
Employee and Spouse or Civil Union/Domestic Partner	$20,000 / $20,000
Employee and Children	$20,000 / $10,000
Family (Employee, Spouse or Civil Union/Domestic Partner, and Children)	$20,000 / $20,000 / $10,000

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

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

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

Covered Critical Illnesses

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

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

Additional Covered Conditions and Specified Diseases

Childhood Conditions

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

Tier I Specified Diseases

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

Tier II Specified Disease

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

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

Exclusions and Limitations

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

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

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

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

Choosing Your Beneficiary

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

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

When Coverage Ends

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

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

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

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

Legal Services

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

Who Is Eligible

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

When Coverage Begins

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

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

Your Cost

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

The cost is subject to change annually. Information on the current cost is available on HRconnect at **kp.org/HRconnect**.

How Legal Services Work

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

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

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

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

Covered Services

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

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

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

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

Exclusions

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

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

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

Life Insurance with Long-Term Care Coverage

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

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

Who Is Eligible

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

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

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

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

When Coverage Begins

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

Your Cost

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

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

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

How Life Insurance with Long-Term Care Coverage Works

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

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

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

Life Insurance

The life insurance component of this program pays a death benefit if you or a covered dependent should die while enrolled in the plan. It also allows for an accelerated benefit in the case of terminal illness: up to 75% of the death benefit can be paid while you are still living, if life expectancy is 24 months or less. Payment of this accelerated benefit reduces the death benefit payable to beneficiaries.

Long-Term Care

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

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

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

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

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

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

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

Exclusions and Limitations

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

Exclusions Under Life Insurance

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

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

Exclusions Under LTC Coverage

The plan does not pay LTC benefits for loss:

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

Pre-existing Condition Limitation

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

Choosing Your Beneficiary

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

When Coverage Ends

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

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

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

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

Voluntary Term Life Insurance

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

Who Is Eligible

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

When Coverage Begins

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

To enroll in Voluntary Term Life, access MetLife online through HRconnect at **kp.org/HRconnect**.

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 HRconnect. Sign on to **kp.org/HRconnect**.

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

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.

Long-Term Care Insurance

Effective July 1, 2021, Transamerica is no longer accepting new applications for long-term care insurance. If you enrolled prior to July 1, 2021, your long-term care insurance coverage will continue as long as you continue to pay the premiums. For questions about your coverage, please call Benefits by Design Voluntary Programs at ***866-486-1949****.*

Your Cost

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

How Long-Term Care Insurance Works

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

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

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

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

When Coverage Ends

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

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

RETIREMENT PROGRAMS

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

Highlights of This Section

Kaiser Permanente Nurse Anesthetists Pension Plan Supplement to the Kaiser Permanente Retirement Plan

Southern California Permanente Medical Group (SCPMG) provides eligible employees with the Kaiser Permanente Nurse Anesthetists Pension Plan (KPNAPP). KPNAPP 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 an employee of Southern California Permanente Medical Group (SCPMG) represented by KPNAA in the Southern California Region.

When Your Participation Begins

If you meet the eligibility requirements above, you will automatically become a participant in the plan on the first day you are employed by Kaiser Permanente regardless of your employment status or work schedule.

Participation Upon Your Rehire

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

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 below.

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 completing different age and Years of Service requirements.

Credited Service

Effective January 1, 2003, you earn a year of Credited Service for each calendar year during which you are compensated for 1,800 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 1,800 hours of employment.

For each calendar year prior to January 1, 2003, in which you were a participant in the plan, Credited Service will be based on a 2,000-hour year. Proportional Credited Service is counted for any complete or partial year during which you are credited with 1,000 or more but fewer than 2,000 Hours of Service.

Credited Service for Unused Sick Leave

If you have satisfied the requirements for retirement eligibility under KPNAPP, all of your unused Sick Leave hours accrued prior to January 1, 2010, will be counted as Credited Service for pension plan benefit calculation purposes.

If you have not satisfied the requirements for retirement eligibility but have a minimum of 250 hours of unused Sick Leave upon termination, your unused Sick Leave hours accrued prior to January 1, 2010, will be counted as additional Credited Service, provided you are vested on the day before your termination.

If you terminate employment with Kaiser Permanente after you are vested in the plan but before you have satisfied the requirements for retirement eligibility, your unused Sick Leave hours — regardless of when you earned them — will be recognized as Credited Service subject to applicable minimum sick leave hours at the time of termination. There is no cash-out option.

All eligible unused sick leave hours accrued starting January 1, 2010, and going forward will be converted at 80% of value and deposited into your Sick Leave Health Reimbursement Account (Sick Leave HRA).

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 KPRC.

Service and Credited Service for Union Leaves

You may receive credit towards a Year of Service and Credited Service while on a Union Leave of Absence. A maximum of one Year of Service and Credited Service will be counted in a calendar year for a Long-Term Union Leave. If you are elected to a union office, you may be eligible for Elected Union Official Leave and a maximum of two consecutive Years of Service and Credited Service are counted. Recognition of periods for Long-Term Union Leaves and Elected Union Official Leaves will count toward Service and Credited Service effective for leaves that begin on or after October 1, 2000.

Service for Certain Workers' Compensation Leaves of Absence

If you were earning Credited Service under the plan immediately before a Workers' Compensation Leave of Absence (WCLOA), you may count up to a maximum of 1,000 hours of WCLOA taken on or after October 1, 2000, toward the satisfaction of service requirements for Early or Disability Retirement. WCLOA hours do not count for vesting or Credited Service under the plan.

For more information about the policy, call the KPRC.

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 1.45%

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:

1.45% of your Final Average Monthly Compensation

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 2024 is $345,000. 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 KPRC.

How the Pension Calculation Works

Here is an example of how the KPNAPP formula works:

Carolyn retires at age 65 with 20 years of Credited Service. Her Final Average Monthly Compensation (FAMC) is $10,000. Her monthly Single Life Annuity pension benefit is:

1.45% X $10,000

=

$145.00

X

20 years = $2,900

–

Any applicable Pension Offset (see “Pension Offset Rules”)

Carolyn’s monthly pension will be approximately $2,900, 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 Credited Service under both plans, your age 65 benefit under KPNAPP will be offset. Under the pension calculation formula, your KPNAPP 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:

- 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
- 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, Disability Retirement, or Postponed 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 Years of Service, or if your age and Years of Service equal 75 or more.

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 various ages:

Your Age When Payments Begin	Percentage of Normal Retirement Payable to You
65	100%
64	95%
63	90%
62	85%
61	80%
60	75%
59	70%
58	65%
57	60%
56	55%
55	50%

Your benefit will be adjusted to reflect your actual age. For example, if you retire at age 62½, your percentage will be approximately 87.5% (halfway between the percentages for age 62 and age 63) of the Normal Retirement benefit.

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

Disability Retirement

You will qualify for a Disability Retirement benefit if you are eligible for disability benefits under Title II of the Social Security Act and meet the following requirements:

- You have at least 10 Years of Service with Kaiser Permanente
- Your date of disability, as determined by the Social Security Administration, is on or before your termination date with Kaiser Permanente.

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

If you elect to begin your Disability Retirement benefit before you reach age 65, the amount of your accrued monthly benefit will be paid without reduction.

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, Early Retirement or Disability 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.

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 KPRC.

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 KPRC website at **www.myplansconnect.com/kp**, or from the HRconnect home page at **kp.org/hrconnect**. You may also call the KPRC.

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%, 66%, 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.

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.

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 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.

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 KPRC 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.

If you do not have a spouse or a designated domestic partner, please refer to the Qualified Dependent Death Benefit below to determine if any benefit may be payable following your death while you are employed.

If You Die After You Terminate Employment But Before Benefits Commence

If you die after you terminate employment, but before the KPRC has received your written election forms 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.

If You Die After Benefits Commence

If you die after the KPRC 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.

Qualified Dependent Death Benefit

If you die while employed by your employer and after you are vested, but you are not married and do not have a designated domestic partner, monthly survivor benefits will be paid to your Qualified Dependent, as defined below. The amount of the benefits will be based on your benefit as of the date of death and will be determined as if you had retired on the day before your death. Your pension will be distributed as if you had elected the 10-year Certain and Life Annuity with your Qualified Dependent as beneficiary. Payments to a Qualified Dependent may begin the first day of the month following your date of death.

Generally, the Qualified Dependent Death Benefit will be paid only if you die while employed and are not married and do not have a designated domestic partner at the time of your death. However, if you die while employed, and are survived by a spouse or domestic partner and by a Qualified Dependent, and your surviving spouse or domestic partner dies before the 10th anniversary of your death, a benefit is payable to your Qualified Dependent. This monthly benefit begins the month after the death of your spouse or domestic partner and continues until the 10th anniversary of your death.

Definition of Qualified Dependents

Definition I: For the purposes of this benefit, a Qualified Dependent is defined as your biological or legally adopted child who is 18 years of age or younger on the date of your death. If there is more than one child, the benefit will be divided equally among all the children.

Definition II: If there are no minor children meeting Definition I above, a Qualified Dependent is defined as a person in the following categories (if there is more than one person in the category, the benefit will be divided equally among the persons in that category):

- Your biological or legally adopted child who is older than 18 years old
- Your foster child
- A descendant of your son or daughter (including a legally adopted child), such as a grandchild or great-grandchild
- Your stepson or stepdaughter
- Your brother, sister, stepbrother, or stepsister
- Your father or mother
- An ancestor of either your father or mother
- Your stepfather or stepmother
- Your niece or nephew
- Your aunt or uncle
- Your son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law

A Qualified Dependent listed in Definition II above must, on the date of your death, be claimed as a dependent on your income tax return and live in your home as his or her principal abode. Qualified Dependents enrolled and actively attending school are considered to have your home as their principal abode. Proof of relationship for Definitions I and II and tax dependent status for Definition II will be required.

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 do not make a timely election, you will be paid in the normal form of payment.

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 KPRC. 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 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 KPRC website at **www.myplansconnect.com/kp** or the HRconnect home page at **kp.org/HRconnect**. You may also call the KPRC (see the **Contact Information** section).

Kaiser Permanente 401(k) Retirement Plan

The Kaiser Permanente 401(k) Retirement Plan (KP401K) 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.

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 have the option to make after-tax contributions through the plan's Roth feature. You will receive a Personal Identification Number (PIN) from Vanguard for the automated VOICE network. Access your account through the Vanguard website at **www.vanguard.com**, the VOICE network, or a Participant Services Associate at **800-523-1188**. Your **Kaiser Permanente 401(k) Retirement Plan** plan number is **090310.** 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 $19,500 in 2024.

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

Your total contributions will be monitored on an ongoing basis and reviewed at the end of the year. If you exceed your total contribution limit, you will be notified and refunded any excess contributions. For the most up-to-date IRS limits, visit **irs.gov** and search for "contribution limits."

Roth After-Tax Employee Contributions

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

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

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

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

Roth In-Plan Conversions

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

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

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

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

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

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

If You Are Age 50 or Older

If you are age 50 or older, or if you will reach age 50 by December 31 of this year, you are eligible to make an additional catch-up contribution to your plan for this year and in subsequent years. The maximum allowable catch-up contribution in 2024 is $7,500. Your regular contribution limit and catch-up contribution limit may change from year to year.

You are eligible to make catch-up contributions only after you have reached your applicable annual limit for regular contributions. The following chart outlines the annual contribution limits (pre-tax and Roth combined, as applicable) in 2024:

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

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

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

Military 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) 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**.**

Employer Contributions

Matching Contribution Program

You are eligible to receive a matching contribution if you have at least one year of employment with Kaiser Permanente and contribute to the plan.

Kaiser Permanente will match 100% of your employee contributions to the plan, up to a maximum of 1.25% of your eligible earnings, which exclude bonus and incentive pay and Alternate Compensation Program (ACP) compensation in lieu of benefits coverage, if applicable.

Each pay period, you will receive a matching contribution based on your employee contributions and your eligible earnings. This amount will be credited to your account according to your existing investment options and fund allocations. You may make changes to your investment selections and fund allocations at any time.

In order to receive the full 1.25% employer matching contribution, you must make employee contributions equal to at least 2% of your eligible pay. This is because you can make employee contributions to the plan in full percentages only. Therefore, a 1% employee contribution will be matched at 1%; an employee contribution of 2% or more will be matched at 1.25%. If you are not contributing to the plan, you will not receive any employer matching contribution under this plan.

Optimization Feature

If your contributions to the plan stop during the year — for example, because you reach the pre-tax maximum contribution limit before the end of the year — as long as you are employed on December 31 of that year, your matching contributions will be optimized. Here's how it works:

If you contributed at least 2% of your annual eligible pay before your contributions to the plan stopped, Kaiser Permanente will make an additional matching contribution after the end of the year, to ensure that you receive a full 1.25% of your annual earnings in matching contributions.

For example, Carolyn decides to contribute at a rate of 10%, but has to stop contributing mid-year for personal reasons. She makes $50,000 a year, paid over 26 pay periods.

For each pay period, she earns $1,923 and contributes 10% of that, or $192 dollars, into her retirement savings plan. She stops after 13 pay periods and contributes $2,500 in total for the year. Kaiser Permanente's matching contributions up to that point total about $312 (1.25% of $1,923, X 13 pay periods = $312).

If Carolyn had contributed throughout the entire year, Kaiser Permanente's match would have been $625 or 1.25% of $50,000.

Therefore, because Carolyn contributed 5% of her annual pay to the plan when you consider the whole year ($2,500/$50,000), Kaiser Permanente will contribute, through the optimization feature, another $313 (the difference between $312 and $625) to the retirement savings plan after the end of the year, to ensure she gets the full 1.25% employer match for the year.

Performance-Based Contribution Program

You may be eligible to receive a performance-based contribution under the plan if you have at least one year of employment with Kaiser Permanente. In addition, you must be in an eligible position represented by a Labor Management Partnership union that participates in the Performance-Based Contribution Program on the last day of the final pay period of the year. If your annual payroll eligible earnings are less than $500 per year, you are not eligible for the employer contribution under this program.

At the end of each year, if your region exceeds certain performance targets by at least 0.25%, Kaiser Permanente will make a contribution to your plan equal to 1% of your eligible earnings, which excludes bonus and incentive pay, and Alternate Compensation Program (ACP) compensation in lieu of benefits coverage, if applicable. This amount will be credited to your plan account. If you are not contributing to the plan, an account will be opened for you, provided you and your region meet all other requirements.

Employer contributions will be invested according to your current investment allocation. If you are not currently enrolled in the plan at that time, the employer contribution will be invested in the Qualified Default Investment Alternative (QDIA) fund, the plan's default fund. You may change investment options at any time.

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 2024 is $345,000. 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 $60,000 in 2024
- 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 for the "highly compensated" participants.

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

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.

Employer Contributions

Your employer contributions for the Performance-Based Contribution Program and the Matching Contribution Program will be vested at the rate of 20% each year of employment with Kaiser Permanente. This means that once you have completed five years of employment, the employer contributions plus any earnings will be 100% available to you upon termination. You are 100% vested after five years of employment, or when you reach age 65 and are still actively employed at Kaiser Permanente, whichever is earlier. If you already have five or more years of employment with Kaiser Permanente when you receive your first employer contribution, the contributions will be 100% vested as soon as they are added to your account.

Forfeitures

On the date you terminate employment with Kaiser Permanente, any amount in your employer contribution account that is not vested will be forfeited on the earlier of: (1) the date you receive payment of your vested employer contribution account, or (2) five consecutive years from your termination date, provided you are not re-employed by Kaiser Permanente within that period.

If you receive a distribution from your employer contribution account and are rehired by Kaiser Permanente before reaching five consecutive years from your termination date, you may repay the full amount of the distribution. The repayment must be in a single sum within five years of your reemployment date. If you repay your distribution within the five-year period, the forfeited amounts will be restored to your employer

contribution account. If you do not repay the amount within five years, any amounts forfeited from your account will not be restored.

If you are rehired after five consecutive years from your termination date, you will not receive any of the non-vested portion of the account. Any undistributed vested funds will be maintained as a separate and fully vested account. You may not repay any amount previously distributed to you, and your account will not be credited with the amount originally forfeited.

Choosing Your Beneficiary

When you become a participant, you should name a beneficiary to receive payment of your account if you die. Under the plan your spouse is legally entitled to 50 percent of your account upon your death, unless certain requirements are satisfied. If you are married, age 35 or older, and you want someone other than your spouse to receive more than 50 percent of your account, your beneficiary designation must be accompanied by a written, notarized statement of your spouse's consent to be valid. If you are married and name a non-spouse beneficiary before the year in which you reach age 35, your beneficiary will automatically revert back to your spouse on January 1 of that year. To re-designate a non-spouse beneficiary, you must complete a new beneficiary form, again with your spouse's written consent.

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

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

There is a $50 loan application fee applied to each loan.

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

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

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

If You Go on an Unpaid Leave of Absence

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

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

If you are on an unpaid leave of absence for more than 12 months, and you do not arrange to make up missed payments, the balance owing on your loan is deemed to be distributed to you. The distribution (other than any portion made up of Roth contributions and earnings that qualify for tax-free treatment, if applicable) is considered taxable income in the year you receive it, and you may also be subject to tax penalties, depending on your age and employment status. Special rules apply if you are on a military leave of absence.

If You Transfer to Another Employee Group or Terminate Employment

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

When You Can Receive a Distribution

Normally, you are entitled to receive your plan account balance when your employment with Kaiser Permanente ends. You can defer receiving payment until April 1 of the year following your termination or the year you reach 73, whichever is later, if you have more than $1,000 in your account on 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 and forms. You will receive payment as soon as administratively possible, once Vanguard receives your forms.

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

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

In-Service Withdrawal

Age 59½ Withdrawal

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

Hardship Withdrawal

Based on federal requirements, while you are employed at Kaiser Permanente, in most cases, you can withdraw your 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

If the value of your account is more than $1,000, you can elect a distribution of all or a portion of your account and you can elect the specific type of contributions within your account to be distributed. For example, you can elect 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 $1,000 when you retire or terminate your employment with Kaiser Permanente for your account to remain open.

You may elect to have your full or partial distribution paid in one of the following payment options:

- **Lump Sum:** The total value of your account is paid to you in a single payment. This is the normal form of payment of your benefits if you are not married.
- **Single Life Annuity:** The total value of your account is used to purchase a non-transferable single life annuity that provides monthly income to you for your lifetime only. If you are married and select a Single Life Annuity, you are legally required to obtain your spouse's consent. This consent must be in writing and notarized no more than 180 days before the benefits begin.
- **50%, 66⅔%, 75%, and 100% Joint and Survivor Annuity:** You may elect to have an adjusted benefit paid to you for the joint lives of you and another person (your Joint Annuitant). You may choose to receive an adjusted monthly income while you are both alive, and then 100%, 75%, $66^{2}/_{3}$%, 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 percentage of your Joint Annuitant when benefits begin. If your Joint Annuitant is not your spouse, an additional adjustment may be needed to meet the minimum distribution and you are legally required to obtain your spouse's consent. This consent must be in writing and notarized no more than 180 days before the benefits begin.
- **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 $1,000 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 $1,000 threshold.

If You Die

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

- If you have a valid beneficiary designation on file, payment will be made to your beneficiary (or beneficiaries).

- If you die and have Roth after-tax contributions in your plan, the five-year period carries over to your beneficiary. Once the five-year period is satisfied, distributions of your account, including any earnings, to your beneficiary are tax-free.
- If your beneficiary is a minor, the following are eligible representatives who may act on behalf of that minor:
  - the court-appointed guardian or conservator
  - the person whom you name as the minor's representative in your last will and testament as admitted to probate
  - a person deemed by the Plan sponsor to be authorized to act for the minor
- If you do not have a valid designated beneficiary on file at the time of your death or if your designated beneficiary dies and you have not named another beneficiary before your death, payment of your account will be made in the following order:
  - - To your surviving legal spouse
  - - If none, then to your estate
- If the remaining balance is more than $1,000, 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
- You are age 59½ or older

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.

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 Benefits 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.

Sick Leave Health Reimbursement Account

When you terminate employment or retire from Kaiser Permanente, you may be eligible for the Sick Leave Health Reimbursement Account (HRA). The Sick Leave HRA allows you and your eligible dependents to pay for out-of-pocket qualified medical, dental, vision, and hearing care expenses on a tax-free basis.

Who Is Eligible

You are eligible for the Sick Leave HRA if you terminate employment with Kaiser Permanente on or after January 1, 2010, and you meet all of the following requirements:

- You are at least age 55 when you terminate employment with Kaiser Permanente.
- You have 15 or more years of service as defined by the Kaiser Permanente-sponsored pension plan — even if you do not participate in the plan — when you terminate employment with Kaiser Permanente. If you qualify for disability retirement under your defined benefit pension plan, the Sick Leave HRA age and service requirements are waived.
- You are eligible for Kaiser Permanente medical coverage on your last day of employment (you do not need to be enrolled in the plan). If you are on an approved unpaid leave of absence at the time of your termination of employment, you must be eligible for Kaiser Permanente medical coverage on the last day prior to the start of your unpaid leave of absence.

Eligible Dependents

For purposes of the Sick Leave HRA your eligible dependent is any individual who is your dependent as defined in the Internal Revenue Code (IRC), and is eligible to be covered under a Kaiser Permanente medical plan at the time your employment ends. You may add eligible dependents or drop ineligible dependents after your employment ends through the Kaiser Permanente Retirement Center (KPRC), the third-party administrator of the Sick Leave HRA plan. Please note that the definition of dependent for the Sick Leave HRA may differ from what is used for your medical and dental coverage, or when determining your personal income taxes.

The definition of eligible dependents is described below:

- Your legal spouse, unless you are divorced, legally separated, or your marriage was annulled. Your spouse must be someone to whom you are legally married under federal law.
- Your domestic partner and his or her children under age 26 are considered eligible dependents for this plan only if they qualify as dependents on your federal income tax return. You may not use your Sick Leave HRA to pay expenses for the child of your domestic partner if your domestic partner or the child’s other parent claims the child as a dependent on his or her tax return.
- Your children under age 26, including natural, stepchildren, legally adopted children, children placed with you for legal adoption, a child for whom you have been appointed legal guardian, and children who are

covered by a Qualified Medical Child Support Order (QMCSO). Coverage may be extended for children who are incapable of self-support due to a mental or physical disability that begins before they reach age 26.

You may want to contact your tax advisor if you have questions about an individual's qualification as your dependent.

Amount Available Through Your Sick Leave HRA

Kaiser Permanente Contributions

Upon termination, the accrued, unused Extended Sick Leave (ESL) in your current ESL account is converted at 80% of value and is available through your Sick Leave HRA. Your straight-time hourly wage rate is used to calculate your Sick Leave HRA amount. For additional information regarding ESL, sign on to HRconnect or refer to your current Collective Bargaining Agreement.

A minimum of $100 is required to establish an account for you. There is no maximum balance. If your sick leave conversion value to the Sick Leave HRA at termination of employment is less than $100, Kaiser Permanente will not establish an account for you. In addition, sick leave hours will be forfeited, and there will be no cash-out.

Only Kaiser Permanente can make contributions to your Sick Leave HRA. You may not make contributions to your Sick Leave HRA.

When You Become a Participant

When you become eligible for the Sick Leave HRA, a notional account — which is an account where funds are made available only when you present a reimbursement claim — will be established for you automatically. You will receive a welcome letter from the Kaiser Permanente Retirement Center (KPRC) with detailed information about the plan.

You do not need to take any action to enroll in the Sick Leave HRA. You will automatically become a participant in the Sick Leave HRA on the first of the month following the date of your employment termination.

How to File a Claim

For information about how to file a claim for reimbursement from the Sick Leave HRA, and how to appeal a denied claim, refer to the **Disputes, Claims, and Appeals** section.

Using Your HRA Debit Card

You will receive an HRA Debit Card that you can use to pay for eligible Sick Leave HRA expenses such as medical copays and prescriptions. The card works like a debit card. It is preloaded with your Sick Leave 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 Expenses

You may use your Sick Leave HRA to be reimbursed for the following eligible expenses. This is a sample list only. If a particular service is covered by your Kaiser Permanente medical plan, you may still submit your copayments to the Sick Leave HRA for reimbursement. If you use your Sick Leave HRA to pay for eligible expenses, you cannot take a tax deduction on your income tax return for the same expense.

Please note: You may be reimbursed for medical premiums when they are paid to Kaiser Permanente for a Kaiser Permanente-sponsored medical plan only, such as Kaiser Foundation Health Plan or Kaiser Permanente Senior Advantage. Premiums you pay for a non-Kaiser Permanente medical plan are not reimbursable through the Sick Leave HRA, unless you live in an area where a Kaiser Permanente medical plan is not available.

Eligible expenses include:

- Acupuncture
- Alcoholism treatment
- Ambulance service
- Automobile modifications for disabled
- Body scans
- Chiropractic care
- Contact lenses, contact lens solutions, and eyeglasses
- Dental insurance premiums and/or copayments
- Dental treatment, implants, dentures and adhesives (excludes bleaching or whitening)
- Eye surgery, radial keratotomy, LASIK, and vision correction
- Hearing exams, hearing aids and hearing-impaired equipment
- Home health care
- Hospital services and inpatient care (includes meals but excludes phone and TV)
- Insulin and glucose monitoring kits and supplies
- Lab and X-ray fees that are part of medical care
- Long-term care insurance premiums for medical care
- Medical and nursing services and treatment in nursing home
- Medical insurance copayments
- Medical insurance premiums paid for a Kaiser Permanente medical plan only
- Medical records charges
- Medical supplies and equipment, including walkers, wheelchairs, and upkeep costs
- Medicare premiums
- Menstrual care products
- Optometric and ophthalmologist fees
- Orthotics
- Over-the-counter 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
- Premiums paid under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
- Prescription eyeglasses, sunglasses, and reading glasses (excluding sunglass clips)
- Prescription medicine and drugs that are legal in the United States
- Surgery (medically necessary and legal)
- Transportation expenses for person receiving medical care
- Weight-loss programs (must be prescribed by a physician to treat a specific medical condition)

Expenses Not Covered

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

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

Please note: If you are reimbursed for eligible expenses under the Sick Leave HRA, you cannot be reimbursed for the same expenses under the Retiree Medical HRA.

Additional restrictions may apply because an HRA may only reimburse federally approved HRA eligible expenses. If you have additional questions about Sick Leave HRA, contact the Kaiser Permanente Retirement Center (KPRC) at **866-627-2826** or click the **Reimbursement Center** link at **www.myplansconnect.com/kp**.

When Your Account Closes

Your Sick Leave HRA will be closed and benefits terminated when any of the following conditions are met:

- When you exhaust the funds in your Sick Leave HRA and your account balance reaches zero ($0), as indicated on your quarterly statement from the Kaiser Permanente Retirement Center (KPRC).
- Upon your death, if you have no surviving eligible dependents.

- Upon the death of your surviving eligible dependents.
- During the termination or retirement process, it is determined that you are not eligible for Sick Leave HRA.

If You Return to Work

If you return to work at Kaiser Permanente in any capacity and for any entity (Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, or the Permanente Medical Groups), your Sick Leave HRA will be suspended and unavailable to you and your eligible dependents.

Suspension begins on the first of the month following your rehire date. Your account will remain suspended until you terminate or retire again. Remember, eligible claims must be incurred while your account is active. Claims incurred while your Sick Leave HRA is suspended will not be reimbursed.

If You Die

Upon your death, your surviving eligible dependents may continue to be reimbursed for eligible expenses from your Sick Leave HRA if there is any amount still available.

Affordable Care Act Rules

Special rules under the Affordable Care Act (ACA) provide that coverage under a standalone HRA is considered minimum essential coverage. If you have minimum essential coverage you may not be eligible to receive a subsidy through the ACA Marketplace until the amount available through your HRA is gone.

Traditional Retiree Medical Benefits

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.

Benefits Determined by Grandfathered Status

If you are a Grandfathered employee (as defined below) and you meet the eligibility requirements for retiree medical benefits at the time you terminate employment, you will be offered the traditional retiree medical benefit described below.

If you are not a Grandfathered employee, but you meet the eligibility requirements for retiree medical benefits at the time you terminate employment, you will be offered the Modified Retiree Medical Benefit as described in the "Modified Retiree Medical Benefit" section which follows.

Please note: If you are a non-grandfathered employee who terminates or retires on or after January 1, 2017, and meet the eligibility requirements for retiree medical benefits, you will be offered the Modified Retiree Medical Benefit, which will take effect in 2028. For more information, see the "**Modified Retiree Medical Benefit** section."

Grandfathered Employees

If you had 10 or more years of service as of January 1, 1990, you are considered a Grandfathered employee, and your eligibility and benefits may differ. Please refer to the "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, or if your age and service equal 75 or more with at least 15 years of service, or if you are a Disability Retiree with at least 10 Years of Service. Please note: If you are a Disability Retiree, you must be eligible for disability benefits under Title II of the Social Security Act, and the date of disability, as determined by the Social Security Administration, must be on or before the termination date from Kaiser Permanente.

Please note: If you are an Alternate Compensation Program participant and meet the requirements mentioned above when you terminate employment, you are eligible for retiree medical coverage.

When Benefits Begin

Your retiree medical benefits begin at age 65, or when you become eligible for and enroll in Medicare, whichever is earlier.

If you terminate employment and are eligible for Disability Retirement, you and your eligible dependents will be enrolled in company-paid retiree KFHP coverage effective the later of the first day of the month following your retirement date, or when the KPRC receives your Social Security Disability Award under Title II.

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, 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 medical plan offered to active employees in effect when you receive services. When you become eligible for and enroll in Medicare, you will be offered coverage coordinated with Medicare.

Your Retiree Medical Coverage

You will receive Medicare-coordinated coverage equivalent to the medical plan offered to active employees in effect at the time you commence your retiree medical benefits.

Your benefit also includes Supplemental Medical Plan coverage. If your retiree medical benefits begin before age 65, then you will receive coverage equivalent to the medical plan offered to active employees in effect at the time you receive services, including any copayments, coinsurance and/or cost share (if any) applicable to active employees.

You may also enroll your eligible dependents.

Your Costs

Kaiser Permanente pays the cost of your retiree medical benefit premiums. You share the costs for medical coverage through copayments for certain 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 **Enrolling in Benefits** section for a description of domestic partner benefits.

How to Enroll

Enrolling at Age 65 or Older

You and your eligible spouse or domestic partner must enroll according to plan rules in order to receive Kaiser Permanente retiree medical benefits.

To begin your enrollment process, contact the KPRC at least 90 days prior to your retirement date or when you become eligible for retiree medical benefits. 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 and for you to receive any applicable benefit updates.

Your retiree medical coverage will be integrated with Medicare. To enroll in Medicare, please follow these steps up to three months before you and any eligible dependents become Medicare-eligible (typically at age 65):

1. Enroll in Medicare Parts A and B by contacting your local Social Security Administration Office at **800-772-1213** or visiting **www.ssa.gov/medicare/sign-up**.
    - In most cases, the enrollment process can be completed within a few weeks, but it is important to start the process at least three months prior to your 65th birthday to ensure that coverage begins when needed.
    - In addition to any applicable monthly premium that you pay for your retiree medical coverage, Medicare requires that you pay a monthly premium for Part B. If you do not enroll in Medicare when you are first eligible, you may be subject to a late enrollment penalty.
2. Receive your Medicare Health Insurance card, which includes your **Medicare Number** and **Medicare Parts A and B coverage start date**.

Once you have your **Medicare Parts A and B coverage start date**, you will have 60 days from your retiree medical coverage start date to complete your enrollment for your Kaiser Permanente retiree medical benefits coverage. If you do not complete your retiree medical benefits enrollment within this time frame, you will not be enrolled in your Kaiser Permanente medical coverage. Your next opportunity to enroll will be during a future open enrollment period or within 31 days of a qualified life status change.

To enroll in and make your benefit elections and assign your Medicare, if applicable, you have the following two options available:

Option 1: Enroll online

Access the KPRC website at **www.myplansconnect.com/kp** to enroll in your Retiree Health and Welfare benefits and complete your Electronic Group Medicare Assignment.

Option 2: Enroll with a dedicated KPRC representative

Contact a KPRC representative at **866-627-2826**, Monday through Friday from 6 a.m. to 6 p.m. Pacific time. Representatives are available to process your Retiree Health and Welfare benefits enrollment and your Electronic Group Medicare Assignment.

Enrolling Under Age 65

You and your eligible spouse or domestic partner must enroll according to plan rules in order to receive retiree medical benefits.

To begin your retiree medical benefits enrollment process, contact the KPRC at least 90 days prior to your eligibility. 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 and for you to receive any applicable benefit updates.

To enroll in coverage, log on to the KPRC website at **www.myplansconnect.com/kp** to get started. You can also contact a KPRC representative by phone at **866-627-2826**. Representatives are available to process your Retiree Health and Welfare benefits enrollment.

If you wish to enroll, you must submit your elections within **60 days** from your coverage begin date. If you do not enroll in coverage when you are eligible, you may do so during a future open enrollment period or within 31 days of a qualified life status change.

Once you become Medicare-eligible, you must enroll in Medicare Parts A and B and assign your Medicare coverage to Kaiser Permanente. For more information about how to enroll in Medicare, see "Enrolling at Age 65 or Older."

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 enroll in all applicable parts of Medicare (including Parts A and B), and enroll in Kaiser Permanente Senior Advantage. Kaiser Permanente will automatically assign your Part D for you when you enrolled in the Kaiser Permanente Senior Advantage Plan; a specific assignment is not required by you. You are responsible for paying the Medicare Part B and D premiums and surcharges.

If you do not enroll in Medicare and sign over your Medicare by enrolling in the Kaiser Permanente Senior Advantage group plan, your retiree medical coverage will be terminated. You will have an opportunity to reenroll in retiree medical during the next open enrollment period. If you move to an area where there is no Kaiser Permanente Senior Advantage plan available, please contact the KPRC.

When enrolling in the Kaiser Permanente Senior Advantage Plan, you and your spouse or domestic partner assign all applicable parts of Medicare (including Parts A, B, and D) to Kaiser Permanente. If you assign your Medicare coverage to another provider, Medicare will notify Kaiser Permanente and your retiree medical coverage will be terminated.

Important: If you live in a Kaiser Permanente Senior Advantage Service Area, you must enroll in a Kaiser Permanente Senior Advantage group plan in order to receive employer-provided coverage.

Please note: If you live in the Kaiser Permanente Southern California Service Area, you may continue your retiree medical coverage without signing over your Medicare benefits to Kaiser Permanente. You can continue your coverage by paying a non-assignment premium surcharge. The non-assignment premium surcharge is the difference between the premium rate if you do not assign Medicare and the Kaiser Permanente Senior Advantage premium rate. Please contact the KPRC for details.

Medicare Part D Surcharge Reimbursements

If you are required to pay the Medicare Part D Income-Related Monthly Adjustment Amount (IRMAA) surcharge, you may be reimbursed for some or all of the IRMAA for a maximum of two years. You must maintain Medicare Part D coverage in order to continue retiree coverage. The KPRC will send you a letter informing you of the Medicare Part D reimbursement process and you will need to return documentation to the KPRC within 90 days of the date stated on the letter.

To be eligible for reimbursement, you must have had eligible annual earnings above $97,000 from Kaiser Permanente (as indicated in Box 1 on your Form W-2) in one of the last two years before your retirement. The reimbursement amount is only for any Part D IRMAA you pay as a retiree. It does not include any Part D IRMAA payable on coverage for any of your dependents. In addition, if you had any other earnings outside of Kaiser Permanente, that amount will not be taken into consideration when determining the monthly IRMAA

reimbursement for which you are eligible. Consequently, the Medicare Part D IRMAA reimbursement you receive from Kaiser Permanente may be less than what you are required to pay. To find the most current annual earnings amount subject to Medicare Part D IRMAA, sign on to **medicare.gov**. For additional details about the Medicare Part D IRMAA reimbursement benefit, please contact the KPRC.

If You Move Outside Your Home Region

If you move outside of your home region as a retiree, the medical benefits available to you may differ depending on where you move. Your home region is defined as the Kaiser Permanente region from which you retired and became eligible for retiree medical benefits. It is important for you to contact the KPRC at least two months before your move to alert them of your new address, for information on the retiree medical coverage available to you in your new location, and to ensure that your new retiree medical benefits start on time.

If You Move to Another Kaiser Permanente Region

As a retiree from either the Northern California or Southern California region, your home region is defined as both Northern and Southern California Kaiser Permanente Service Areas. If you move from the Northern California Service Area to the Southern California Service Area, or vice versa, you will maintain the same retiree medical coverage and receive services as a part of the Intra-California Reciprocity Agreement. The service areas are determined by zip codes. Although the benefits you receive under Kaiser Permanente Senior Advantage will be similar, if you were enrolled in either Northern or Southern California and move to the other Service Area, you will need to submit an enrollment application for your coverage to continue. Please contact the KPRC for details.

If you move to another Kaiser Permanente region after retirement, you may enroll in the Out-of-Region (OOR) plan. For additional information and to enroll in coverage, please contact the KPRC.

Please 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 any Kaiser Permanente Medicare Service Area

If you move to a zip code outside of the Kaiser Permanente Medicare service area for longer than 90 days, you will not be eligible for the Kaiser Permanente Senior Advantage Plan.

Kaiser Permanente provides the Out-of-Area Plan (OOA) if you move to a location that is not part of any Kaiser Permanente Service Area. This may include geographical locations within the State of California that are not included in the Northern and Southern California Service Areas. Coverage is limited. For additional information, please contact the KPRC.

Retiree Medical Coverage for Survivors

After You Retire

In the event of your death during retirement, your spouse or domestic partner and eligible children may continue or begin benefits, based on the Years of Service requirements note below, based on when you would have been eligible. Survivor benefits will end if your spouse or domestic partner remarries or enters a new domestic partner relationship. Eligibility for your children will end at age 26. Please note that your disabled dependents age 26 or older will lose eligibility for benefits in the event of your death.

Before You Retire

If you die while actively employed, and after becoming eligible for retiree medical benefits, your spouse or domestic partner and eligible children may continue benefits (or begin benefits, based on when you would have been eligible). Survivor benefits will end if your spouse or domestic partner remarries or enters a new domestic partner relationship. Eligibility for your children will end at age 26. Please note that your disabled dependents age 26 or older will lose eligibility for benefits in the event of your death.

Dependents who lose eligibility either before or after you retire may continue coverage at their own expense under COBRA or purchase coverage through the Health Insurance Marketplace. Contact the KPRC or refer to the **Health Care** section for an explanation of COBRA.

When Retiree Medical Benefits End

Your retiree medical benefits will end upon your death or if you fail to assign your Medicare benefits to Kaiser Permanente as required. For more information, refer to “Medicare Assignment.”

If your benefits end due to death, benefits may continue for your eligible dependents. Refer to “Retiree Medical Coverage for Survivors.”

If you change your status after retirement (e.g., legal separation, divorce, adoption, or domestic partnership) you must report your change in status to the KPRC within 31 days in order to have your level of benefits adjusted.

Rehired Retirees

If you are receiving retiree medical benefits from Kaiser Permanente and are rehired into a position that offers health and welfare benefits, you will be offered active medical benefits applicable to the employee group by which you are re-employed, and your retiree medical benefits will stop. 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.

If you are rehired into a position that does not offer health and welfare benefits, your retiree medical benefits may continue during your re-employment period, provided you continue to be in a position that does not offer any health and welfare benefits.

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.

Important Note: The new plan design will take effect in 2028.

Until the new plan design takes effect, you will be offered the Traditional Retiree Medical benefit described in the above section.

Grandfathered Employees

This section does not apply to Grandfathered employees, regardless of retirement date. Please refer to the **Traditional Retiree Medical Benefits** section above for the definition of a Grandfathered employee and information about your retiree medical benefits.

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, or if your age and service equal 75 or more with at least 15 Years of Service or if you are a Disability Retiree with at least 10 Years of Service. Please note: If you are a Disability Retiree, you must be eligible for disability benefits under Title II of the Social Security Act, and the date of disability, as determined by the Social Security Administration, must be on or before the termination date from Kaiser Permanente. You must also be eligible for medical benefits on your last day of employment. Please see below for the definition of a Year of Service.

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.

However, if your pension plan at retirement provides for prorated service under 1,000 compensated Hours of Service per year, any calendar year in which you are compensated for fewer than 1,000 Hours will be prorated based on the provisions of your pension plan.

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 earlier. Your benefits will begin after you enroll according to plan rules.

If you terminate employment and are eligible for Disability Retirement, you and your eligible dependents will be enrolled in company-paid retiree KFHP coverage effective the later of the first day of the month following your retirement date, or when the KPRC receives your Social Security Disability Award under Title II. Beginning January 1, 2028, or once you become Medicare eligible (whichever is later), you will receive benefits as stated in this section.

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.

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 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 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 required for dependents of active employees.

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 medical plan that is in effect for active employees at the time they receive services.

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 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 will 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, the medical benefits available to your eligible dependents may differ depending on where you move. Your home region is defined as the Kaiser Permanente Region from which you retired and became eligible for retiree medical benefits. For additional information, please contact the KPRC.

If you move to another Kaiser Permanente Region after retirement, your eligible dependents may enroll in the Out-of-Region (OOR) plan. Kaiser Permanente provides the Out-of-Area Plan (OOA) if you move to a location that is not part of any Kaiser Permanente Service Area.

It is important for you to contact the KPRC at least 2 months before you move to alert them of your new address, for information on the retiree medical coverage available in your new location, and to ensure that your eligible dependents new retiree medical benefits art on time.

Please note: The benefits your eligible dependents receive if you move to another Region may be different than the benefits offered in your home Region.

How the Modified Retiree Medical Benefit Works

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

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

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

- Retiree Medical Premium Subsidy to help pay for the lowest cost Kaiser Permanente Senior Advantage premiums.

- Retiree Medical Health Reimbursement Account to help pay for eligible medical expenses associated with Kaiser Permanente Senior Advantage or other Medicare plans enrolled in through the Modified Retiree Medical benefit.

When you enroll in Kaiser Permanente Senior Advantage through the plan's enrollment process after enrolling in Medicare, you and your eligible dependents will also have Supplemental Medical Plan coverage as part of your 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 enroll in all applicable parts of Medicare (including Parts A, B), and enroll in Kaiser Permanente Senior Advantage. Kaiser Permanente will automatically assign your Part D for you when you enroll in the Kaiser Permanente Senior Advantage plan; a specific assignment is not required by you. You are responsible for paying the Medicare Part B and D premiums and surcharges.

If you do not enroll in Medicare and sign over your Medicare by enrolling in the Kaiser Permanente Senior Advantage 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 move to an area where there is no Kaiser Permanente Senior Advantage Plan available, please contact the KPRC.

When enrolling in the Kaiser Permanente Senior Advantage Plan, you and your spouse or domestic partner assign all applicable parts of Medicare (including Parts A, B, and D) to Kaiser Permanente. If you assign your Medicare coverage to another provider, Medicare will notify Kaiser Permanente and your retiree medical coverage will be terminated.

Important: If you live in a Kaiser Permanente Senior Advantage Service Area, you must enroll in a Kaiser Permanente Senior Advantage plan, according to the plan rules, in order to receive employer-provided coverage.

Medicare Part D Surcharge Reimbursements

If you are required to pay the Medicare Part D Income-Related Monthly Adjustment Amount (IRMAA) surcharge, you may be reimbursed for some or all of the IRMAA for a maximum of two years. You must maintain Medicare Part D coverage in order to continue retiree coverage. The KPRC will send you a letter informing you of the Medicare Part D reimbursement process and you will need to return documentation to the KPRC within 90 days of the date stated on the letter.

To be eligible for reimbursement, you must have had eligible annual earnings above $97,000 from Kaiser Permanente (as indicated in Box 1 on your Form W-2) in one of the last two years before your retirement. The reimbursement amount is only for any Part D IRMAA you pay as a retiree. It does not include any Part D IRMAA payable on coverage for any of your dependents. In addition, if you had any other earnings outside of Kaiser Permanente, that amount will not be taken into consideration when determining the monthly IRMAA reimbursement for which you are eligible. Consequently, the Medicare Part D IRMAA reimbursement you receive from Kaiser Permanente may be less than what you are required to pay. For additional details about the Medicare Part D IRMAA reimbursement benefit, please contact the KPRC.

Retiree Medical Premium Subsidy

The Retiree Medical Subsidy applies to eligible employees hired before January 1, 2021.

Kaiser Permanente's Retiree Medical plan will provide both you and your eligible spouse or domestic partner with a Kaiser Permanente Senior Advantage (KPSA) option and a Retiree Medical Premium Subsidy. You and your eligible spouse or domestic partner must enroll in the KPSA 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. In 2024, the subsidy is up to $130.37 per month. Each year, the maximum subsidy increases 3%.

In years that you elect a KPSA 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 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 KPSA plan service area in any Kaiser Permanente Region, the Retiree Medical Premium Subsidy may only be used for Kaiser Permanente Senior Advantage or Kaiser Permanente Medicare Advantage plan premiums. If a Kaiser Permanente Senior Advantage or Kaiser Permanente Medicare Advantage 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 Medicare Advantage supplement plans.

Please note: If the KPSA 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, 2021, you are not eligible for the Retiree Medical 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. This is separate from the Sick Leave Health Reimbursement Account.

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 $2,000 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 $60,000.

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 at age 85 with at $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.

For more information about the Retiree Medical HRA, or to access your account, you may visit the Kaiser Permanente Retirement Center (KPRC) website. You can also call the KPRC.

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 copays 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 service area, you may use the Retiree Medical HRA to be reimbursed for expenses that are approved under Internal Revenue Code Section 213(d) for Medicare-eligible services connected with a Kaiser Permanente medical plan offered through the retiree medical benefit. This includes expenses such as Kaiser Permanente Senior Advantage 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 plan with your request for reimbursement.

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

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

Please note: If you are reimbursed for eligible expenses under the Retiree Medical HRA, you cannot be reimbursed for the same expenses under the Sick Leave HRA.

Expenses Not Covered

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

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

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

- Vacation expenses (even if recommended by a doctor)
- Varicose vein cosmetic procedure

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, 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 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 Plan Service Area in another Kaiser Permanente region:

- You will need to enroll in the Kaiser Permanente Senior Advantage 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 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 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 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 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.
- 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.
- 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, refer to the **Dependent Coverage** earlier in this section.

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 Plan (or a Medicare supplemental plan or Medicare Advantage Plan, if you live in an area with no Kaiser Permanente Senior Advantage 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.

Rehired Retirees

If you are receiving retiree medical benefits from Kaiser Permanente and are rehired into a position that offers health and welfare benefits, you will be offered active medical benefits applicable to the employee group by which you are re-employed, and your retiree medical benefits will stop. 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.

If you return in a position that does not offer health and welfare benefits, access to your retiree medical benefits will be temporarily suspended until you re-retire, in accordance with federal laws and regulations at the time of your rehire.

If You Transfer, or Terminate Employment and Return to Work

Breaks In Service

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

If you are rehired after a break in service, the following rule applies*:

- If you have a break in service of more than two years, or if you have a break in service of less than two years, but you had less than six months of employment before your break in service, the date you are rehired after the break in service (your adjusted hire date) will be used to determine what benefits you are

eligible for when you retire. Please note that your compensated hours (including Earned Time Off, Extended Sick Leave, Sick Leave, flexible personal days, vacation, holidays, and paid leaves of absence, as applicable, for which you are compensated as an employee of Kaiser Permanente) before your break in service will count toward the post-retirement benefit Years of Service eligibility requirement.

- If you have a break in service of less than two years, and you had six months or more of employment before your break in service, your original hire date (or most recent adjusted hire date, if applicable) will be used to determine what post-retirement benefits you may be eligible for upon retirement.
- If you have a break in service and are rehired into another Kaiser Permanente region, you will be subject to the applicable break in service policy for the employee group and region into which you are rehired.

Important Note: You will not lose Years of Service accrued prior to a break in service. However, your eligibility for post-retirement benefits and the benefits you are offered will be based on a number of factors, including your hire date (or adjusted hire date), your Years of Service, your age, and the date you retire.

If you return to active employment in an eligible status at Kaiser Permanente, your retiree medical benefits when you separate from service following that rehire will be the benefits applicable to the group you re-retire from on the date of your most recent separation from service.

* Service is counted as a Kaiser Permanente employee. If you began employment with Kaiser Permanente as a result of an acquisition, and have service from your Kaiser Permanente-acquired employer, additional pension and post-retirement service may be counted, per the terms of your Acquisition Agreement, based on the date you started with Kaiser Permanente. Please refer to the Acquisition Agreement for details about how this may apply to you.

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.

Retiree Life Insurance

Kaiser Permanente provides 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

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

- You are regularly scheduled to work 32 hours per week in an eligible status on your last day of employment
- You meet the eligibility requirements for Early, Normal, Postponed, or Disability retirement. See "When You Can Begin Your Benefit" under the Kaiser Permanente Nurse Anesthetists Pension Plan Supplement to the Kaiser Permanente Retirement Plan section.

How Retiree Life Insurance Works

If you had Basic Life Insurance as an active employee, you will receive $2,000 in retiree life insurance at retirement.

If you had Optional Life Insurance coverage as an active employee, the initial amount of your Retiree Life Insurance coverage is equal to the amount of Optional Life Insurance in effect at the time of retirement. That amount will remain for one month following your retirement date. Thereafter, your coverage will reduce by 1% per month for 75 months until it reaches the greater of 25% of the original coverage amount or $2,000.

Imputed Income

According to Internal Revenue Service (IRS) regulation, the premium cost of employer-paid 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 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 Retiree Life insurance coverage may be reinstated depending on your last position, employment status, and employee group.

Service for Leased Employees

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

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

- Pension plan participation eligibility
- Pension plan vesting
- Pension plan Early Retirement eligibility

- Pension plan eligibility for Disability Retirement (if applicable)
- Defined contribution plan vesting (if applicable)
- Eligibility for employer contributions under defined contribution plans such as Plan B, TPMG's Plan 2 or the Kaiser Permanente Supplemental Savings and Retirement Plan for Union Groups (KPSSRPUG) (if applicable)
- Eligibility for participation in employer matching contributions (if applicable) to a tax-deferred retirement savings plan, such as KP401K or the Tax-Sheltered Annuity (TSA) plan
- Eligibility for a Sick Leave Health Reimbursement Account (Sick Leave HRA) (if applicable) Any service granted under this program will **NOT count** toward:
- Retiree Medical, Retiree Life Insurance and any other retiree health and welfare plan eligibility
- Eligibility for the Retiree Medical Health Reimbursement Account associated with the modified retiree medical benefit
- Credited Service for benefit accrual purposes under any Kaiser Permanente defined benefit plan
- Other Kaiser Permanente programs (such as vacation)

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

DISPUTES, CLAIMS, AND APPEALS

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

Highlights of This Section

Health and Welfare Eligibility and Enrollment Disputes

If you have a question relating to you or your dependent's eligibility for health and welfare benefits, including enrollment disputes, you must contact the National Human Resources Service Center. If you disagree with the NHRSC's response, you may ask for a *Benefits Request for Administrative Review* Form 3460 (also available on HRconnect) and submit a written dispute. Your request for an administrative review must be received by the NHRSC within six months of the event that gives rise to your initial question. A final determination will be made by the NHRSC regarding your inquiry within 90 days after the request for an administrative review is received.

General Information About ERISA Claims and Appeals

This section provides some general information that applies to claims for benefits under various types of plans (if applicable, as you may not participate in all of these types of benefit plans). It also provides additional information about filing claims and appeals for the following categories of plans and types of coverage:

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

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

Use of an Authorized Representative

You may authorize a representative to help you pursue a claim or appeal on your behalf. Your representative need not be an attorney. Your representative may be asked to provide evidence that you have authorized him or her to represent you. The fact that you assign your right to receive benefits to a health care provider does not, by itself, mean that you have designated that health care provider as your representative. If your claim or appeal involves health benefits, then you (or the affected family member) may be asked to provide a written authorization that permits the health plan to provide personal health information to your representative.

However, a licensed health care professional familiar with your medical condition may act as your representative with respect to a claim (or appeal) for urgent care without providing any further evidence that he or she is your representative. Please let the claims administrator know if you would like responses to your claim or appeal to be sent directly to you instead of your authorized representative.

What Is a Claim for Benefits

Federal law requires that a plan follow specific procedures when you make a claim for benefits or appeal a denial of your claim for benefits. A "claim" for benefits is a formal request by you (or your beneficiary) for the payment of benefits you believe are due under the terms of an employee benefit plan covered by the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The procedures apply to the benefits described

in this **Disputes, Claims, and Appeals** section of the *Summary Plan Description* (SPD). 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 Permanente Claims Administration - SCAL
P.O. Box 7004
Downey, CA 90242-7004

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

Appeals

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

KFHP appeals should be sent to:

Kaiser Foundation Health Plan, Inc.
Special Services Unit
P.O. Box 23280
Oakland, CA 94623

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

Arbitration Agreement

As a Kaiser Foundation Health Plan member, (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between you, your heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings.

You agree to give up your right to a jury trial and accept the use of binding arbitration. The full arbitration provision is contained in the *Evidence of Coverage.* You can obtain a copy of the *Evidence of Coverage* brochure by calling Member Services.

If paying your half of the neutral arbitrator's fees and cost would cause you extreme hardship, you may petition for relief from paying one half of the neutral arbitrator's fees and expenses by requesting an application to proceed *in forma pauperis* from the following address:

Kaiser Foundation Health Plan
Legal Department
P.O. Box 12916
Oakland, CA 94604

Member Satisfaction Grievance Process

The California Department of Managed Health Care is responsible for regulating health care service plans. The Department has a toll-free telephone number, **800-400-0815,** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers **800-735-2929** (TTY) or **888-877-5378** (TTY) to contact the department. You can access and download complaint forms and instructions online at **www.dmhc.ca.gov.** If you have a grievance against a health plan, you should contact the plan and use the plan's grievance process. If you need the Department's help with a complaint involving an emergency grievance or with a grievance that has not been satisfactorily resolved by the plan, please call **800-400-0815.**

Supplemental Medical Plan Claims and Appeals

Claims

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

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

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

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

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

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

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

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

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

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

Continuing Claims

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

Appeals

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

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

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

Dental Plans Claims and Appeals

Delta Dental

If you receive services from a dentist in the Delta Dental network, you do not need to file any claims — your Delta Dental dentist will file the claims for you. If you have questions about the services you receive from a Delta Dental dentist, you may discuss the matter with your dentist, or if you continue to have concerns, you may contact Delta Dental through the contact listed below:

Delta Dental of California
P.O. Box 997330
Sacramento, CA 95899-7330
Phone: 800-765-6003
www.deltadentalins.com

If Your Claim Is Denied

If your claim for benefits is fully or partially denied, you are entitled to a review of that decision by Delta Dental. Your written request should be sent to the above address and must be submitted within 180 days after you receive notice of claim denial. The request should include the reason you believe the claim was improperly denied and any appropriate data, including a copy of the treatment form, Notice of Payment and any other relevant information.

Upon request and free of charge, Delta Dental will provide you with copies of any pertinent documents that are relevant to the claim, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in denying or modifying the claim. For more information, call Delta Dental.

DeltaCare USA and United Concordia

If you have questions about the services you receive from a dentist, you should first discuss the matter with your dentist, or if you continue to have concerns, you may contact the dental plan directly at one of the contacts listed below:

DeltaCare USA
12898 Towne Center Drive
Cerritos, CA 90703-8759
Phone: 800-422-4234
www.deltadentalins.com

United Concordia
P.O. Box 10194
Van Nuys, CA 91410-0194
Phone: 800-937-6432
www.ucci.com

If your claim for benefits is fully or partially denied, you are entitled to a review of that decision by the dental plan. Your written request should be sent to the above address. This request must be submitted within 180 days after you receive notice of claim denial. The request should include the reason you believe the claim was improperly denied and any appropriate data.

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 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 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 it 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 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 Claims

Filing a Claim

Dependent Care FSA claim forms are available from HRconnect or 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:

- Short Term Disability (STD) plans
- Long-Term Disability (LTD) plans

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 end. If MetLife does not contact you by the end of the elimination period for your long-term disability benefits and you believe you are eligible for the benefits, 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.

You may contact them at the address below:

California Department of Insurance
Claims Service Bureau
300 S. Spring St., 11th Floor
Los Angeles, CA 90013
Phone: 213-346-6570

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
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* booklet 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* booklet for your plan.

Sick Leave Health Reimbursement Account Claims and Appeals

Filing a Claim

When you have eligible expenses, you submit a claim for reimbursement. The claim must be submitted within 12 months of the date you incur the expense. In order for expenses to be eligible for reimbursement, you must incur them while you are actively participating in the Sick Leave HRA. When you become eligible to access the Sick Leave HRA, you will receive a letter that will explain how the HRA works in detail.

Your claim is considered abandoned if the plan administrator has not been able to make contact with you during a five-year period starting the date you incurred the expense, at your last known address. After five years, your uncashed reimbursement check will be considered forfeited, and the amount of the claim will be permanently deducted from your Sick Leave HRA account.

For more information about the Sick Leave HRA, you may visit the Kaiser Permanente Retirement Center (KPRC) website at **www.myplansconnect.com/kp.** You can also call the KPRC at **866-627-2826.**

You can submit your claims for reimbursement in the following ways:

Fax: Fax your claim form and documentation to **844-853-8493**

Mail: Mail your claim form and documentation to:

KPRC
P.O. Box 2844
Fargo, ND 58108

Appeals for Denied Sick Leave HRA Claims

If your claim for benefits under the Sick Leave 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:

KPRC
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 Sick Leave 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.

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.

For more information about the Retiree Medical HRA, you may visit the Kaiser Permanente Retirement Center (KPRC) website at **www.myplansconnect.com/kp.** You can also call the KPRC at **866-627-2826.**

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:

KPRC
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:

KPRC
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 D Reimbursement Claims and Appeals

Filing a Claim for Reimbursement of Medicare Part D IRMAA Surcharge

You can submit your claims for reimbursement Medicare Part D Income-Related Monthly Adjustment Amount (IRMAA) surcharge 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
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 Medicare Part D IRMAA Claims

If your claim for Medicare Part D IRMAA reimbursement 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
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 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 KPRC. You can reach the KPRC online by visiting their website at **www.myplansconnect.com/kp.** You can also call the KPRC at **866-627-2826** Monday through Friday 6 a.m. to 6 p.m. Pacific time. Additional information about your retirement benefits can be found on HRconnect at **kp.org/HRconnect.**

The KPRC 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 KPRC 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 after discussion with a representative from the KPRC, 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) December 31, 2017, (ii) your termination of employment, and (iii) 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 are a participant in a defined contribution plan and wish to receive a distribution of any account balance you have in the plan, contact Vanguard online at **www.vanguard com** or by calling the VOICE network at **800-523-1188.**

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

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

Statute of Limitations

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

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

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

Deadlines for Responding to Your Claims

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

Appeal

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

Defined Benefit Plan

Kaiser Permanente Retirement Center (KPRC)
Attn: Kaiser Permanente Administrative Committee Appeals Subcommittee
P.O. Box 9924
Providence, RI 02940-4024

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 Kaiser Permanente Retirement Center (KPRC).

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

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

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

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

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

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

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

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

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

General Information About Other Types of Claims and Appeals

The following rules relate to claims and appeals that are not made under health plans, 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, Accidental Death and Dismemberment, and Voluntary Term Life insurance plans, as applicable.

Accident and Critical Illness Insurance Claims

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

You can file a claim with Aflac online as follows:

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

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

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

Fax: **866-849-2970**
Email: **groupclaimfiling@aflac.com**

Deadlines for Responding to your Claim

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

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

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

How to Appeal a Denial of Your Initial Claim

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

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

The appeal must be mailed to the following address:

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

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

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

Deadlines for Responding to Your Appeal

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

What to Do About a Denial After Final Review

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

Legal Services Claims and Appeals

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

Send completed claims to the address below:

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

Deadlines for Responding to Your Claims

MetLife Legal Plans will make a decision on your claim within a reasonable period but not later than 90 days after it receives your claim form. In some cases, MetLife Legal Plans will notify you, before the end of the normal 90-day maximum period for responding to your claim, that additional time is required to process your claim on account of special circumstances. In that event, MetLife Legal Plans may take up to an additional 90 days to respond to your claim. When MetLife Legal Plans requests the 90-day extension, it will indicate the special circumstances and the date by which it expects to make a decision on your claim.

How to Appeal a Denial of Your Initial Claim

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

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

Deadlines for Responding to Your Appeal

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

What to Do About a Denial After Final Review

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

Life Insurance, Accidental Death and Dismemberment, 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 California Department of Insurance. You may contact them at the address below:

California Department of Insurance
Claims Service Bureau
300 S. Spring St., 11th Floor
Los Angeles, CA 90013
Phone: 213-346-6570

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

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

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

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

Mail: **Trustmark Insurance**

P.O. Box 2906

Clinton, IA 52733

Fax: **508-853-0310**

Email: **LifeClaimsVB@trustmarkbenefits.com**

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

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

Deadlines for Responding to your Claim

Trustmark will make a determination on your claim within 45 calendar days of receipt of your proof of loss. If more time is required to make a claim determination, within the same 45 calendar days, Trustmark will provide the claimant with written notice of the need for additional time. The notice will specify any additional information required to make a determination.

How to Appeal a Denial of Your Initial Claim

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

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

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

Fax: **508-853-0310**

Email: **LifeClaimsVB@trustmarkbenefits.com**

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

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

Deadlines for Responding to Your Appeal

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

What to Do About a Denial After Final Review

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

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

Long-Term Care Claims and Appeals

Contact Transamerica LTC at **866-745-3545** to initiate a claim. You must submit a written request for any claim determination. Send completed claims to:

Transamerica Life Insurance Company
P.O. Box 159
Cedar Rapids, IA 52406-0159
Fax: 866-630-7502
Phone: 866-745-3545

Deadlines for Responding to Your Claims

Transamerica LTC will make a decision on your claim within a reasonable period, usually within 10 business days, but not later than 90 days after it receives your claim form. In some cases, Transamerica LTC will notify you, before the end of the normal 90-day maximum period for responding to your claim, that additional time is required to process your claim on account of special circumstances. In that event, Transamerica LTC may take

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

How to Appeal a Denial of Your Initial Claim

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

Transamerica Life Insurance Company
P.O. Box 159
Cedar Rapids, IA 52406-0159
Fax: 866-630-7502
Phone: 866-745-3545

Deadlines for Responding To Your Appeal

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

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

What to Do About a Denial After Final Review

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

LEGAL AND ADMINISTRATIVE INFORMATION

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

Highlights of This Section

Administration of the Plans

Entity	Plan Sponsor	Plan Administrator
Southern California Permanente Medical Group	Southern California Permanente Medical Group Walnut Center 393 E. Walnut St. Pasadena, CA 91188 EIN #95-1750445	**For Health and Welfare Plans** Kaiser Foundation Health Plan, Inc. 1 Kaiser Plaza 20th Floor Bayside Oakland, CA 94612 **For Defined Benefit Plans** Kaiser Permanente Administrative Committee (KPAC) 1 Kaiser Plaza 20th Floor Bayside Oakland, CA 94612 **For Defined Contribution Plans** Kaiser Foundation Health Plan, Inc. 1 Kaiser Plaza 20th Floor Bayside Oakland, CA 94612

Service of Legal Process

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

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

Employees of Southern California Permanente Medical Group:

Southern California Permanente Medical Group
393 E. Walnut Street
Pasadena, CA 91188

Administrative Powers and Responsibilities

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

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

- The discretionary authority to make and enforce rules for the administration of each employee benefit plan, including the designation of forms to be used in such administration
- The discretionary authority to construe and interpret each and every document setting forth the applicable terms of a plan, including official plan documents, SPDs, and insurance contracts
- The discretionary authority to decide questions regarding the eligibility of any person to participate in any employee benefit plan
- The discretionary authority to approve or deny claims for benefits under each employee benefit plan unless discretionary authority has been delegated in writing to a third party, such as an insurer, claims administrator or Administrative Committee
- The discretionary authority to appoint or employ agents, including but not limited to, counsel, accountants, consultants, and other persons to assist in the administration of each employee benefit plan

Welfare and Retirement Plans

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

Plan Name/Plan Options	Plan Sponsor EIN #	ID No.	Type of Plan	Claims Administrator	Type of Adminis-tration	Plan Trustee	Funding Medium	Contributing Source
HEALTH AND WELFARE PROGRAMS								
Kaiser Foundation Health Plan, Inc., Health and Welfare Plan	94-1340523	560	Health and Welfare Programs					
The Southern California Permanente Medical Group, Health and Welfare Plan	95-1750445	560	Health and Welfare Programs					
Kaiser Foundation Health Plan			Insured	Kaiser Permanente Claims Administration - SCAL P.O. Box 7004 Downey, CA 90242-7004	Insured	N/A	Insured agreement premiums 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
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
Group Dental Insurance			Insured	Delta Dental of California 100 First Street San Francisco, CA 94105	Insured	N/A	Insured agreement premiums paid from general assets	Employer and employee
Group Dental Insurance			Insured	United Concordia P.O. Box 10194 Van Nuys, CA 91410-0194	Insured	N/A	Insured agreement premiums paid from general assets	Employer
Group Dental Insurance			Insured	DeltaCare USA 12898 Towne Center Drive Cerritos, CA 90703-8759	Insured	N/A	Insured agreement premiums paid from general assets	Employer
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 Short-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
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

Plan Name/Plan Options	Plan Sponsor EIN #	ID No.	Type of Plan	Claims Administrator	Type of Adminis-tration	Plan Trustee	Funding Medium	Contributing Source
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
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 Columbus, GA 31993	Insured	N/A	N/A	Employee
Critical Illness Insurance			Insured	Continental American Insurance Company P.O. Box 84075 Columbus, GA 31993	Insured	N/A	N/A	Employee
Legal Services			Legal Services	MetLife Legal Plans, Director of Administration 1111 Superior Avenue E, Suite 800 Cleveland, OH 44114-2507	Third-Party	N/A	N/A	Employee
Life Insurance with Long-Term Care Coverage			Insured	Trustmark Insurance Company 400 Field Drive Lake Forest, IL 60045	Insured	N/A	N/A	Employee
Voluntary Term Life Insurance			Insured	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100	Insured	N/A	N/A	Employee
Long-Term Care Insurance			Insured	Transamerica Life Insurance Company P.O. Box 159 Cedar Rapids, IA 52406-0159	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
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
The Southern California Permanente Medical Group, Health Care Flexible Spending Account	95-1750445	550	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 1950 Franklin Street, 15th Floor Oakland, CA 94112	Self-Funded	N/A	Self-funded; paid from general assets	Employer
RETIREMENT PLANS								
Kaiser Permanente Nurse Anesthetists Pension Plan for the Southern California Medical Group	95-1750445	001	Pension-401(a) Defined Benefit Plan	Kaiser Permanente Retirement Center P.O. Box 9922 Providence, RI 02940-4022	Third-Party/ Record Keeper	State Street Bank Retiree Services P.O. Box 550858 Jacksonville FL 32255-0868	Trust	Employer contributions
Kaiser Permanente 401(k) Plan	94-1340523	025	401(k) 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 pre-tax and/or Roth contributions

Plan Name/Plan Options	Plan Sponsor EIN #	ID No.	Type of Plan	Claims Administrator	Type of Adminis-tration	Plan Trustee	Funding Medium	Contributing Source
RETIREE HEALTH AND WELFARE PROGRAMS								
Southern California Permanente Medical Group, Retiree Health and Welfare Plan	95-1750445	550	Health and Welfare Programs					
Group Medical Insurance: Kaiser Foundation Health Plan	94-1340523	580	Insured	Kaiser Foundation Health Plan, Inc. 1 Kaiser Plaza Oakland, CA 94612	Insured	State Street Bank and Trust Company 1200 Crown Colony Dr., 2nd Floor Quincy, MA 02169	Trust	Employer and Employee
Retiree Medical Health Reimbursement Account (SCPMG)		585	Reimburse ment Account	Kaiser Permanente Retirement Center P.O. Box 9923 Providence, RI 02940-4023	Third-Party	N/A	N/A	Employer
Retiree Medical Premium Subsidy (SCPMG)			Self-Funded	Kaiser Permanente Retirement Center P.O. Box 9923 Providence, RI 02940-4023	Third-Party	N/A	N/A	Employer
Sick Leave Health Reimbursement Account			Reimburse ment Account	Kaiser Permanente Retirement Center P.O. Box 9923 Providence, RI 02940-4023	Third-Party	N/A	N/A	Employer
Group Life Insurance			Insured	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100	Insured	State Street Bank and Trust Company 1200 Crown Colony Dr., 2nd Floor Quincy, MA 02169	Trust	Employer and Employee

Separation From Service

Your Kaiser Permanente retirement plans and the Internal Revenue Code (IRC) require that there be a bona fide separation from service before there can be a distribution of retirement benefits. This means that there can be no intent at the time of your separation (when you leave and retire from Kaiser Permanente) on either your

part or that of your supervisor or other Kaiser Permanente personnel to re-employ you after you have taken a distribution of benefits. This bona fide separation from service requirement means you may not leave with the intent to return as an employee or in such other capacities as consultant or contractor. This does not mean you may never return to Kaiser Permanente. You may return at some time in the future if you are applying for a bona fide open position. However, if you return, it must be because of changed circumstances after you terminate and retire, and not because of an agreement made prior to termination and retirement. If you are under age 65 when you terminate, a move to a different legal entity does not constitute a Separation From Service, and you cannot take a distribution.

Age 65 Exception

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

Retirement Plan Termination Insurance

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

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

The PBGC guarantee generally does not cover: (1) benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates; (2) some or all of benefit increases and new benefits based on plan provisions that have been in place for 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; and (6) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay; (7) defined contribution plans; and (8) retiree medical benefits.

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

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

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

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

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

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

Third Party Responsibility

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

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

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

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

Obligations of the Eligible Employee and/or Covered Dependent

The eligible employee and/or covered dependent shall:

- Not assign any rights or causes of action he or she may have against others (including under insurance policies) which may implicate the Plan's right to reimbursement, subrogation or restitution without the express written consent of the Plan;
- Cooperate with the Plan and take any action that may be necessary to protect the Plan's interests as described in this SPD.
- Immediately take or regain possession of any property subject to the Plan's equitable lien by contract in his or her own name, place it in a segregated account within his or her control at least in the amount of the equitable lien, and not alienate it or otherwise take any action so that such property is not in his or her possession prior to the satisfaction of such equitable lien by contract; and

- Promptly notify the Plan of the possibility that the circumstances regarding the payment of benefits by the Plan may be subject to the Plan's right of reimbursement, subrogation or restitution, or of the submission of any claim or demand letter, the filing of any legal action or request for any alternative dispute resolution process, or of the commencement of any trial or alternative dispute resolution process (at least 30 days prior notice), or of any agreement (relating to any claim, legal action or alternative dispute resolution), that relates to any property that may be subject to the Plan's rights of subrogation, reimbursement, restitution, to an equitable lien by contract, or as beneficiary of a constructive trust.

No Duty to Independently Sue or Intervene

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

Recovery of Overpayments

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

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

Qualified Domestic Relations Order

In the event of a separation or dissolution of marriage, a court may issue an order directing one or more of your retirement plans to pay some or all of your benefits for alimony, child support, or divided community property.

Within a reasonable period after the plan receives the order, it will determine whether the order is a Qualified Domestic Relations Order (QDRO) and will advise you in writing of its determination, or it will ask a court to decide the question.

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

QDRO Fees

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

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

For additional information about a QDRO for your defined benefit plan, contact the Kaiser Permanente Retirement Center (KPRC).

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

Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) creates or recognizes the rights of a child or other dependent of a participant who, by virtue of a Domestic Relations Order, is entitled to receive medical benefits through the participant's coverage. You will be contacted by TSPMG Human Resources 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 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:

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

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

For Self-funded plans:

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

For Fully-insured plans:

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

For Plans adminstered by HealthPlan Services:

All Regions	1-800-216-2166
TTY	711

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ไทย (Thai): ท่านมีสิทธิที่จะได้รับความช่วยเหลือในภาษาของท่านโดยไม่เสียค่าใช้จ่าย หากท่านมีคำถามเกี่ยวกับสิทธิประโยชน์ของท่าน หรือท่านจำเป็นต้องดำเนินการภายในวันที่ที่กำหนดไว้ โปรดติดต่อหมายเลขที่ให้ไว้สำหรับรัฐหรือเขตพื้นที่ของท่านเพื่อคุยกับล่าม

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

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

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

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

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

KAISER PERMANENTE®

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Language assistance services are available from our Member Services Contact Center 24 hours a day, seven days a week (except closed holidays). Interpreter services, including sign language, are available at no cost to you during all hours of operation. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. In addition, you may request health plan materials translated in your language, and may also request these materials in large text or in other formats to accommodate your needs. For more information, call 1-800-464-4000 (TTY users call 711).

A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. A grievance includes a complaint or an appeal. For example, if you believe that we have discriminated against you, you can file a grievance. Please refer to your Evidence of Coverage or Certificate of Insurance or speak with a Member Services representative for the dispute-resolution options that apply to you. This is especially important if you are a Medicare, Medi-Cal, MRMIP, Medi-Cal Access, FEHBP, or CalPERS member because you have different dispute-resolution options available.

You may submit a grievance in the following ways:

- By completing a Complaint or Benefit Claim/Request form at a Member Services office located at a Plan Facility (please refer to Your Guidebook for addresses)
- By mailing your written grievance to a Member Services office at a Plan Facility (please refer to Your Guidebook for addresses)
- By calling our Member Service Contact Center toll free at 1-800-464-4000 (TTY users call 711)
- By completing the grievance form on our website at kp.org

Please call our Member Service Contact Center if you need help submitting a grievance.

The Kaiser Permanente Civil Rights Coordinator will be notified of all grievances related to discrimination on the basis of race, color, national origin, sex, age, or disability. You may also contact the Kaiser Permanente Civil Rights Coordinator directly at:

Kaiser Permanente Civil Rights Coordinator
One Kaiser Plaza
12th Floor, Suite 1223
Oakland, CA 94612

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
1-800-368-1019
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 2024

KAISER PERMANENTE®

SPD-SC-KPNAA-1/2024