Mental Health Trainees
Physical Therapy Specialty Projects
Northern California
March 2019
This document, called a Summary Plan Description or SPD, describes the benefits in effect as of the date on the front cover. The information in this SPD is a summary of important provisions and most common situations associated with your benefits when this SPD went to press. In case of any omission or conflict between what is written in this SPD and in the official plan documents, insurance contracts, or service agreements, the official plan documents, contracts, or agreements always govern.

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

If you are rehired by Kaiser Permanente or if you transfer between Kaiser Permanente employers, you must review the relevant plan document and the national Inter-Regional Transfer policy to determine whether your previous employment will be used to determine your eligibility for any specific benefit included in this SPD.
We are pleased to present you with this Summary Plan Description (SPD), which provides a general summary of the health and welfare and retirement benefits provided by Kaiser Permanente to eligible employees under various Kaiser Permanente plans. The SPD provides an explanation of the major features of the benefit programs in the following categories, which are governed by the Employee Retirement Income Security Act of 1974 (ERISA):

- medical coverage
- dental coverage
- life and disability insurance plans
- flexible spending accounts
- retirement plans
- Employee Assistance Program

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

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

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

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

<table>
<thead>
<tr>
<th>Department, Organization, or Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Human Resources Service Center (NHRSC)</td>
<td>Phone: <strong>877-4KP-HRSC</strong> (877-457-4772)</td>
</tr>
<tr>
<td></td>
<td>Fax: <strong>877-HRSC-FAX</strong> (877-477-2329)</td>
</tr>
<tr>
<td></td>
<td>Kaiser Permanente</td>
</tr>
<tr>
<td></td>
<td>National Human Resources Service Center</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 2074</td>
</tr>
<tr>
<td></td>
<td>Oakland, CA 94604-2074</td>
</tr>
<tr>
<td></td>
<td><a href="http://kp.org/myhr">kp.org/myhr</a></td>
</tr>
</tbody>
</table>

## 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**: 866-772-4273
  - [kp.org/eap](http://kp.org/eap)
- **Southern California**: 866-313-0013
  - [kp.org/eap](http://kp.org/eap)
- **Georgia**: 888-678-0937
  - [espyr.com](http://espyr.com)
- **Colorado**: 888-678-0937
  - [espyr.com](http://espyr.com)
- **Hawaii**: 808-432-4922
  - [kp.org/eap](http://kp.org/eap)
- **Mid-Atlantic States**: 888-678-0937
  - [espyr.com](http://espyr.com)
- **Northwest**: 503-813-4703
  - [kp.org/eap](http://kp.org/eap)
- **Washington**: 888-678-0937
  - [espyr.com](http://espyr.com)

## Health Care (Dental)

### Delta Dental

- Delta Dental of California
  - 800-765-6003
  - [www.deltadentalins.com](http://www.deltadentalins.com)

## Income Protection

### MetLife

Questions and claims about the following plans, if applicable for your group:

- Life Insurance
- Voluntary Term Life Insurance

- 800-638-6420 or 888-420-1661
  - [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits)
## CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Department, Organization, or Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefits by Design Voluntary Programs</strong>&lt;br&gt;Questions and claims about the following programs, as applicable:&lt;br&gt;• Legal Services&lt;br&gt;• Long-Term Care Insurance</td>
<td>Hours: M-F, 5 a.m. – 6 p.m. Pacific Time&lt;br&gt;866-486-1949</td>
</tr>
<tr>
<td><strong>Retirement Programs</strong>&lt;br&gt;Kaiser Permanente Retirement Center (KPRC)&lt;br&gt;Questions about pension plans and retirement benefits</td>
<td>Hours: M-F, 6 a.m. – 6 p.m. Pacific Time&lt;br&gt;Phone: 866-627-2826&lt;br&gt;Fax: 844-853-8493&lt;br&gt;www.ibenefitcenter.com/kp</td>
</tr>
<tr>
<td>Vanguard&lt;br&gt;Questions about defined contribution retirement savings plans</td>
<td>Hours: M-F, 5:30 a.m. – 6 p.m. Pacific Time&lt;br&gt;800-523-1188&lt;br&gt;www.vanguard.com</td>
</tr>
<tr>
<td><strong>Other Benefits</strong>&lt;br&gt;WageWorks&lt;br&gt;Questions and claims about the following plans, as applicable:&lt;br&gt;• Dependent Care Flexible Spending Account</td>
<td>Hours: M-F, 5 a.m. – 5 p.m. Pacific Time&lt;br&gt;www.wageworks.com&lt;br&gt;877-864-9546</td>
</tr>
</tbody>
</table>
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

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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. (For age and status requirements, see the chart in “Eligible Children.”)

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

Disabled Dependents

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

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

Eligible Children

Eligible children include:

• Your children

• Your spouse’s or domestic partner’s children

• Legally adopted children

• Children placed with you for adoption. You will be required to provide proof of your legal right to control the adoptive child’s health care. Until the adoption is final, children placed with you pending adoption are eligible for medical and dental coverage only
ENROLLING IN BENEFITS

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

Children must also meet the following age and status requirements:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Children Must …</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Dental</td>
<td>Be under the age of 26</td>
</tr>
<tr>
<td></td>
<td>(Coverage will continue through the end of the month in which your child turns 26, unless they are disabled; see “Disabled Dependents”)</td>
</tr>
</tbody>
</table>

**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 National Human Resources Service Center that you wish to enroll your new dependents within 31 days of when they become eligible, you must wait until the next annual open enrollment period to do so, unless you have a qualifying family or employment status change (see "Changes During the Plan Year").

When you enroll new dependents, you will be required to provide Kaiser Permanente with the names of all of the dependents you want covered under your plans, as well as proof of their relationship to you and their eligibility. Copies of supporting documents listed in the chart in “Supporting Documentation” must be received by 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, NHRSC may grant you an extension, up to 90 days from the original enrollment date. If you receive an extension from NHRSC and do not provide the required documentation within 90 days of the original enrollment date, your dependents will not be covered.

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

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

**Supporting Documentation**

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

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

Additional Information about Supporting Documentation

• If you enroll a domestic partner, you must also complete and submit the tax portion of the Kaiser Permanente Affidavit of Domestic Partnership. Notarization is not required when submitting this portion of the Kaiser Permanente Affidavit along with your certified domestic partner registration.

• In order to enroll your domestic partner’s dependents, you must also submit supporting documentation for your domestic partner.

• If enrolling a newborn, a verification of birth letter from a Kaiser Foundation Health Plan (KFHP) hospital or KFHP-contracted hospital is accepted in lieu of a birth certificate.

• Foster children are not eligible for coverage without the Notice of Intent to Adopt certification.

• Contact Member Services or Customer Service, as applicable for your region, to request an enrollment application, if one is required.

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

When Your Benefits and Coverage Begin

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

When You Can Enroll

You may enroll in your benefits at the following times:

• Within 31 days of your date of hire or transfer into a benefits-eligible position at Kaiser Permanente

• When you move from a health and welfare non-benefited status to a health and welfare benefited status

• During the annual open enrollment period

• If you lose other medical coverage for certain reasons, you may enroll in medical coverage (see “Special Enrollment Rights” for more information)

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

Open Enrollment

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

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

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

Changes During the Plan Year

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

**Qualifying Family Status Events**

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

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

**Qualifying Employment Status Events**

Changes in employment status include the following:

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

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

**Family or Employment Status Changes**

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

<table>
<thead>
<tr>
<th>Type of Change</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add new dependents or change enrollment in medical plans</td>
<td>First of the month following date of event</td>
</tr>
<tr>
<td>Add new dependents or change enrollment in dental plans</td>
<td>First of the month following date of event</td>
</tr>
<tr>
<td>Remove dependents from existing medical and/or dental plans</td>
<td>End of the month of date of event</td>
</tr>
<tr>
<td>Start, stop, increase or decrease your contributions to a Flexible Spending Account (as allowed by IRS regulations)</td>
<td>First of the month following date the change was processed by NHRSC.</td>
</tr>
</tbody>
</table>

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

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

Any benefit change you make must be consistent with the qualifying event. For 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 My HR.

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

Special Enrollment Rights

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

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

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

Tax Considerations

Internal Revenue Service (IRS) regulations 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.

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

Your pre-tax benefits are as follows:

• Contributions to a Dependent Care Flexible Spending Account

Your after-tax benefits are as follows:

• Optional Life insurance

When Coverage Ends

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

For more information on leaves of absence, sign on to My HR.

Your dependents’ coverage ends when yours does or when they no longer meet the eligibility requirements.
You may elect to continue some benefits under COBRA. For more information about COBRA, see the Health Care section.

**How to Enroll**

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

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

**Quick Steps for Enrolling in Benefits Online**

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

- Sign on at kp.org/myhr.
- Activate your account, if you have not already done so.
- Click **Benefits Enrollment** under **New Hire Actions** (for new hires) or **Employee Actions** (for existing employees) on the home page to begin the enrollment process.
- Review your benefits options.

- Enroll yourself and your dependents.
  - Click **Edit** next to each benefit. When you elect your medical coverage option, scroll down to the bottom of the page to add and enroll your dependents.
  - **Please note:** After you add dependents, you must click on the **Enroll** box next to their names to enroll them in your benefits.
  - Verify your elections and eligible dependent information.
- Click the **Continue** button at the bottom of the page to go to the **Authorizations** page.
- At the bottom of the **Authorizations** page, click the **Submit Final Choices** button to complete your enrollment. If you do not click **Submit Final Choices**, your elections will not be registered.
- When you see “Elections Submitted!” on the **Confirmation** page, you have successfully completed the enrollment process.
- Confirm your elections: You can come back to My HR 48 hours after you submit your elections to review a summary of your elections and ensure they have been captured correctly.

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

**Kaiser Permanente**  
National Human Resources Service Center  
P.O. Box 2074  
Oakland, CA 94604-2074  
Fax: 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.

**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 “Supporting Documentation” chart. If you file a *Kaiser Permanente Affidavit of Domestic Partnership*, you and your domestic partner must certify that you meet all of the following qualifications:

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

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

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

**Covered Benefits**

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

- Medical coverage
- Dental coverage
- Employee Assistance Program (EAP)
- Continuation of medical, dental, and EAP coverage through COBRA
ENROLLING IN BENEFITS

• Flexible Spending Accounts, only if your domestic partner and/or your domestic partner’s child is your tax dependent

• Survivor pension benefits from your pension plan (in accordance with federal regulations)

Your domestic partner and/or his or her dependents may also be named as beneficiaries for life insurance, Survivor Assistance, 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 My HR for more information on domestic partner benefits.

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

When Domestic Partner Coverage Begins

Your domestic partner’s medical 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 should notify the HRSC 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.

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

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

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

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

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

Tax Effect of Domestic Partner Coverage

The Internal Revenue Service (IRS) requires Kaiser Permanente to withhold federal and Social Security taxes on the Fair Market Value (FMV) of employer-paid medical 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.

**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.
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**

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OVERVIEW OF MEDICAL CARE

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

• You may elect health care coverage through the Kaiser Foundation Health Plan (KFHP).
• You may also choose to waive medical coverage provided you show proof of coverage in another medical plan.

Who Is Eligible

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

Eligible Dependents

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

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

For information on Qualified Medical Child Support Orders (QMCSO), please see the Legal and Administrative Information section.

When Coverage Begins

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

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

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

When Coverage Ends

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

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

Grandfathered Health Plans

Kaiser Permanente believes that your employer-provided medical plans are “grandfathered health plans” under the Patient Protection and Affordable Care Act (“the Affordable Care Act”). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your health plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, such as the elimination of lifetime limits on benefits.
Questions regarding which protections apply and which protections do not apply to grandfathered health plans, and what might cause a plan to lose grandfathered health plan status can be directed to the plan administrator:

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

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

**Please Note:** The PPO Plus plan offered to employees who live and work outside a Kaiser Permanente Service Area is not considered a grandfathered health plan.

### 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 call Member Services. You can also obtain your *Evidence of Coverage* brochure on [kp.org](http://kp.org) (go to the [My health manager](http://kp.org) tab, click [My coverage and costs](http://kp.org), then click [My documents](http://kp.org) in the left hand navigation).

### Your Costs

When you receive services through Kaiser Foundation Health Plan, you do not need to pay a deductible or submit a claim form. Just pay any applicable charge or copayment at the time you obtain services.

### Your 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.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$1,500</td>
</tr>
<tr>
<td>Two or more people</td>
<td>$3,000</td>
</tr>
<tr>
<td><strong>Outpatient Care</strong></td>
<td></td>
</tr>
<tr>
<td>Office visits for illness/injury, including specialty care and OB/GYN</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Benefits</td>
<td>You Pay</td>
</tr>
<tr>
<td>----------------------------------------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Lab tests and X-rays</td>
<td>No charge</td>
</tr>
<tr>
<td>Immunizations (preventative)</td>
<td>No charge</td>
</tr>
<tr>
<td>Allergy testing</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Allergy injections</td>
<td>$3 per visit</td>
</tr>
<tr>
<td><strong>Inpatient care</strong></td>
<td></td>
</tr>
<tr>
<td>Including room and board, surgical services, nursing care,</td>
<td>No charge</td>
</tr>
<tr>
<td>anesthesia, X-rays, and lab tests</td>
<td></td>
</tr>
<tr>
<td><strong>Maternity Care</strong></td>
<td></td>
</tr>
<tr>
<td>Prenatal care</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Labor, delivery, and recovery</td>
<td>No charge</td>
</tr>
<tr>
<td>Routine postpartum visit</td>
<td>No charge</td>
</tr>
<tr>
<td>Well-baby care</td>
<td>$5 per visit (up to age 2)</td>
</tr>
<tr>
<td><strong>Family Planning</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Inpatient</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Infertility Services</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>$5 per visit (including lab,</td>
</tr>
<tr>
<td></td>
<td>X-ray, and prescriptions)</td>
</tr>
<tr>
<td>Inpatient</td>
<td>$5 per visit (including lab,</td>
</tr>
<tr>
<td></td>
<td>X-ray, and prescriptions)</td>
</tr>
<tr>
<td><strong>Emergency Department</strong></td>
<td></td>
</tr>
<tr>
<td>Emergency room visits</td>
<td>$5 per visit (waived if admitted)</td>
</tr>
<tr>
<td>Urgent care visits</td>
<td>$5 per visit</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td></td>
</tr>
<tr>
<td>Medically necessary or Kaiser Permanente-approved</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td></td>
</tr>
<tr>
<td>Note: Prescriptions must fall within KFHP Formulary guidelines,</td>
<td></td>
</tr>
<tr>
<td>unless specifically prescribed by a Kaiser Permanente physician.</td>
<td></td>
</tr>
<tr>
<td>KP Pharmacy (up to 100-day supply)</td>
<td>$5 generic/brand</td>
</tr>
<tr>
<td>Mail order (up to 100-day supply)</td>
<td>$5 generic/brand</td>
</tr>
<tr>
<td><strong>Mental Health Care</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient Individual</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Outpatient Group</td>
<td>$2 per visit</td>
</tr>
<tr>
<td>Benefits</td>
<td>You Pay</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td><strong>No charge</strong></td>
</tr>
<tr>
<td><strong>Alcohol and Drug Dependency Care</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient Individual</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Outpatient Group</td>
<td>$2 per visit</td>
</tr>
<tr>
<td>Inpatient</td>
<td><strong>No charge</strong></td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td></td>
</tr>
<tr>
<td>Up to 100 days per calendar year</td>
<td><strong>No charge</strong></td>
</tr>
<tr>
<td><strong>Physical, Speech, and Occupational Therapy</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient (must be prescribed by a Kaiser Permanente provider)</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Inpatient</td>
<td><strong>No charge</strong></td>
</tr>
<tr>
<td><strong>Durable Medical Equipment (DME), Prosthetic, and Orthotic Devices</strong></td>
<td></td>
</tr>
<tr>
<td>Must be prescribed by a Kaiser Permanente physician in accordance with Health Plan and DME Formulary guidelines</td>
<td><strong>No charge</strong></td>
</tr>
<tr>
<td><strong>Vision Care</strong></td>
<td></td>
</tr>
<tr>
<td>Routine eye exams</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Eyeglasses and contact lenses. Note: Charges in excess of the allowance do not apply to copayment limits.</td>
<td>$175 credit toward one pair of eyeglass lenses and frames or contact lenses (every 24 months)</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td></td>
</tr>
<tr>
<td>Must be prescribed by a Kaiser Permanente physician and authorized by the Home Health committee. Custodial care not covered.</td>
<td><strong>No charge (up to 100 visits per year)</strong></td>
</tr>
<tr>
<td><strong>Hearing Care</strong></td>
<td></td>
</tr>
<tr>
<td>Hearing exams</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Hearing aids</td>
<td><strong>Not covered</strong></td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td></td>
</tr>
<tr>
<td>Available within service area only</td>
<td><strong>No charge</strong></td>
</tr>
</tbody>
</table>

**Other Covered Services**

In addition to the benefits listed above, your medical plans also provide coverage for other medical benefits, including dialysis, health education, and organ transplants.
Additional Information About Certain Medical Services and Coverage

When You Are Expecting a Baby

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

Mastectomy Benefit

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

When You Need Emergency Care

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

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

Emergency Care at Facilities Not Affiliated With Kaiser Permanente

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

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

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

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

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

**What Is Not Covered**

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

- Care you could have received at a Kaiser Permanente facility before leaving the service area
- Follow up visits, even if medically necessary
- Routine or continuing care

**Exclusions and Limitations**

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

**Medical Plan Claims and Appeals**

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

**Arbitration Agreement**

If you are a Kaiser Foundation Health Plan member, any dispute between you, your heirs, relatives, personal representatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc., its contracted health care providers, their agents, employees, or other associated parties on the other hand, arising out of or relating to Kaiser Foundation Health Plan membership, including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or the delivery of, services or items, irrespective of the legal theories upon which the claim is asserted, 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 and their right to a court or jury trial and accept the use of binding arbitration.

The following types of claims are not subject to binding arbitration: Small Claims Court cases, claims subject to a Medicare appeals procedure as applicable to Kaiser Permanente Senior Advantage members, and claims that cannot be subject to binding arbitration under governing law.

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 or by visiting kp.org (go to the My health manager tab, click My coverage and costs, then click My documents in the left hand navigation).

**Please note:** This Arbitration requirement does not apply to medical plan claims or appeals insofar as they are governed by the rules and procedures listed in the *Disputes, Claims, and Appeals* section of this SPD.

**Dental Plan Coverage**

Kaiser Permanente offers you employer-paid dental coverage through Delta Dental.

You may also elect to waive dental coverage.
Who Is Eligible
You are eligible for dental coverage if you are regularly scheduled to work 20 or more hours per week in an eligible status. You may also enroll your eligible dependents.

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

How Delta Dental Coverage Works
Delta Dental has a national network of more than 300,000 dentists who have agreed to charge fees approved by Delta Dental. When you enroll in a Delta Dental plan and use a Delta Dental 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 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 your dentist’s fees and the standard Delta Dental negotiated rate in addition to your plan’s coinsurance amount.

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

- Ask your current dentist if he or she participates in the Delta Premier or PPO network
- Call 800-765-6003 for a directory of participating dentists in your area
- View the Delta Dental provider directory online at www.deltadentalins.com

Covered Services
The following chart provides details on the types of services and coverage levels provided by the Delta Dental plan.

Usual, Customary, and Reasonable Charges
In general, the plan pays the listed percentage of Usual, Customary, and Reasonable Charges (UCR) for these services. UCR charges are determined by taking an average of what dentists in your geographic region charge for each service.

<table>
<thead>
<tr>
<th>Services</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and Preventive Services (includes oral exams, X-rays, and two teeth cleanings per year)</td>
<td>100%</td>
</tr>
<tr>
<td>Basic Services (includes fillings, simple extractions, root canals, and other surgical procedures and restorations)</td>
<td>80%</td>
</tr>
<tr>
<td>Major Services</td>
<td></td>
</tr>
<tr>
<td>Oral surgery (includes surgical tooth extractions)</td>
<td>80%</td>
</tr>
<tr>
<td>Periodontics (treatment of diseases of the gums)</td>
<td>80%</td>
</tr>
<tr>
<td>Endodontics (root canals and related therapy)</td>
<td>80%</td>
</tr>
<tr>
<td>Crowns, Jackets, and Restorations</td>
<td>50%</td>
</tr>
</tbody>
</table>
### Predetermination of Benefits

When you have a dental problem, a variety of corrective treatments may be available. Like most dental plans, your plan may limit payment for certain corrective procedures. Your plan has a prior authorization procedure called predetermination of benefits for services and treatments estimated to cost more than $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 your dental plan carrier for a predetermination of benefits.

### Services Not Covered for Delta Dental

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 Medicaid
- 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 prosthodontic 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 bone or soft tissue inside the mouth)
- Services for any disturbances of the jaw joints, temporomandibular joints (TMJ), or associated muscles, nerves, or tissues
- 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
- Charges for lost or stolen prosthodontic appliances

### Services and Plan Pays

<table>
<thead>
<tr>
<th>Services</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthodontic Services</td>
<td>50%</td>
</tr>
<tr>
<td>(includes bridges and dentures)</td>
<td></td>
</tr>
<tr>
<td>Orthodontic Services</td>
<td>50%</td>
</tr>
<tr>
<td>(for children under age 26)</td>
<td>($1,500 lifetime maximum benefit)</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>$50 per person / $150 per family</td>
</tr>
<tr>
<td>Annual Maximum</td>
<td>$1,500 per person</td>
</tr>
</tbody>
</table>
In addition, there may be limitations on some of the covered services. For a complete list of exclusions and limitations or for more information about your plan, please refer to your Evidence of Coverage brochure, which is available by contacting Delta Dental at 800-765-6003. You may also view, download, and print details of your benefits and coverage from the Delta Dental website, at www.deltadentalins.com.

**When Coverage Ends**

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

For more information on enrolling in individual coverage, contact your dental carrier. For more information on COBRA, see "Continuation of Benefits Under COBRA."

**Filing a Claim**

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

**Coordination of Benefits**

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

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

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

**Determining Which Plan Is Primary**

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

1. This plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
2. When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
3. A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
4. If you are receiving COBRA continuation coverage under another employer plan, this plan will pay benefits first;
5. Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has covered the parent for a longer period of time. This birthday rule applies only if:
   - the parents are married or living together whether or not they have ever been married and not legally separated; or
   - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;

6. If two or more plans cover a dependent child of parents who are divorced, separated, or living apart due to termination of a domestic partnership, and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
   - the parent with custody of the child; then
   - the spouse of the parent with custody of the child; then
   - the parent not having custody of the child; then
   - the spouse of the parent not having custody of the child;

7. Plans for active employees pay before plans covering laid-off or retired employees;

8. If the above do not apply, the plan that has covered the individual claimant the longest will pay first; only expenses normally paid by the plan will be paid under COB; and

9. Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

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

**Determining Primary and Secondary Plan**

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

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

**When This Plan Is Secondary**

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

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

The maximum combined payment you can receive from all plans will never exceed 100 percent of the total allowable expense.

**Determining the Allowable Expense When This Plan Is Secondary**

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

**Allowable Expenses**

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

**When a Covered Person Qualifies for Medicare**

**Determining Which Plan Is Primary**

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

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

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

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

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

**Right to Receive and Release Needed Information**

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

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

**Overpayment and Underpayment of Benefits**

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

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

**Refund of Overpayments**

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

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

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

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

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

For more information and the complete coordination of benefits provision for your 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.

**Continuation of Benefits under COBRA**

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

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

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

You can continue coverage under COBRA for your medical and dental plan and/or the Employee Assistance Program, your:

• Medical plans
• Dental plan
• 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 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.

When You Are Eligible

If You Have a Change in Employment Status

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

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

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

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

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

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

Special Enrollment Rights

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

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

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

If one of these qualifying events occurs after the start of the initial 18-month COBRA coverage period, your spouse or domestic partner and eligible children can apply for an additional 18 months of coverage under COBRA. It is your or your dependents’ responsibility to notify 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, your spouse or your domestic partner and your eligible children in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

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

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

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

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

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

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

If You Die

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

If You or Your Dependents Are Disabled

If you, your spouse or domestic partner, and eligible children are determined to be disabled as defined by the Social Security Act prior to the qualifying event or during the first 60 days of COBRA coverage, COBRA may be extended from 18 months up to a total of 29 months. You must notify 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 WageWorks within 60 days of the date Social Security determines that you, your spouse or domestic partner and your eligible children are no longer disabled.

**COBRA Election Procedures**

You, your spouse or domestic partner, and your eligible children who lose medical and/or dental coverage due to employment termination or reduction in hours or due to certain unpaid leaves of absence will be notified of COBRA election privileges by WageWorks. If coverage is lost due to your death, 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 must notify the NHRSC within 31 days of the qualifying event. The NHRSC will notify WageWorks of your eligible dependent’s loss of coverage to exercise his or her COBRA election privileges.

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

**Consider Your COBRA Decision Carefully**

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

You have 60 days to make a decision regarding continuation of group 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 or your spouse or domestic partner and your eligible children, have the same enrollment privileges that apply to similarly situated active employees. You may enroll eligible dependents during the year if there is a qualified change in family status or at open enrollment, and you can change coverage at open enrollment, subject to the same rules that apply to active employees. You may drop COBRA coverage at any time. Once you discontinue COBRA coverage, you may not elect it at a later date or re-enroll.

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

**Marketplace Individual Coverage**

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

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

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

**Employee Assistance Program COBRA Continuation**

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

**When Coverage Ends**

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

- You, your spouse or domestic partner, and/or your eligible children become covered under any other group medical or dental plan
- You, your spouse or domestic partner, and/or your eligible children become entitled to Medicare benefits after the qualifying event
- You fail to pay the required premium on time
- Kaiser Permanente terminates all of its group health plans
- You, your spouse or domestic partner, and/or your eligible children are on a COBRA disability extension and Social Security determines that you, your spouse or domestic partner, and/or your eligible children 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 spouse or domestic partner, and your eligible children may be eligible to extend coverage under COBRA for an additional 18 months, or purchase an individual medical and/or dental plan. For full details about your COBRA coverage rights, contact the National Human Resources Service Center.

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

**Overview of Flexible Spending Accounts**

Kaiser Permanente offers you the Dependent Care Flexible Spending Account (Dependent Care FSA). The Dependent Care FSA allows you to set aside a portion of your pay through payroll deductions on a pre-tax basis to reimburse eligible 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 dependent care expenses.

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

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

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

When You Can Enroll

You may enroll in the Dependent Care Flexible Spending Account 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

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 Dependent Care Flexible Spending Account each year during open enrollment to continue participation. Otherwise, your contributions will revert to $0.

How the Dependent Care Flexible Spending Account Works

Based on your expected dependent care expenses, you decide how much you want to contribute to the Dependent Care Flexible Spending Account, 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 pay periods 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 WageWorks, the third-party administrator. 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 a use-or-lose rule.
  
  You cannot receive a refund or carry over your balance from one year to the next. 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. However, you have until March 31 of the following year to file your claims.

• 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 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.

• 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 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.

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 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 FSADependent 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.

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 WageWorks.

**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

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 WageWorks.

**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. 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 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 My HR or from WageWorks at [www.wageworks.com](http://www.wageworks.com). Submit the completed claim form, including your provider’s signature, to WageWorks.

You may file your claim with the WageWorks EZ Receipts® mobile application (available at [www.wageworks.com](http://www.wageworks.com)). For the fastest reimbursement, submit your claim online at [www.wageworks.com](http://www.wageworks.com).

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

**WageWorks**
**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).

WageWorks 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 WageWorks. If you have questions about your spending account or claims or if you need a claim form, contact WageWorks.

**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.
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 gives your beneficiaries added financial assistance in the event of your death.

**Highlights of This Section**

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Employee Life Insurance

Your Employee Life insurance benefits include Basic Life insurance paid to your beneficiary in the event of your death. Basic Life insurance is employer-paid.

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.

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 $5,000 in employer-paid Basic Life insurance coverage.

Your Costs

The premiums for your Basic Life insurance are employer-paid.

Choosing Your Beneficiary

You must choose a beneficiary or beneficiaries when you enroll in life insurance coverage, naming the person(s) to receive benefits in the event of your death. You may name primary and secondary beneficiaries. Your benefits will be paid to your primary beneficiary. If no beneficiary is living or can be found or none was named, MetLife will place proceeds of the life insurance payment into a liability account where they will remain until either a beneficiary comes forward or the State escheats the funds.

To choose your beneficiaries, sign on to My HR at kp.or/myhr, click on Forms Finder on the home page, then look for the Beneficiary Designation (Met LIFE) link. The link will take you to the MetLife website where you can choose your beneficiaries. You may add or update your beneficiaries online at any time. For more information, contact the NHRSC.

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.

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

<table>
<thead>
<tr>
<th>Age When Disability Occurs</th>
<th>Duration of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 60 or less</td>
<td>To age 65</td>
</tr>
<tr>
<td>61 but less than 65</td>
<td>48 month</td>
</tr>
<tr>
<td>65 but less than 69</td>
<td>24 months</td>
</tr>
<tr>
<td>69 and older</td>
<td>12 months</td>
</tr>
</tbody>
</table>

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 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.

### 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 20 or more hours per week in a benefits-eligible status.

### When Coverage Begins

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

### How the Survivor Assistance Benefit Works

The 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 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.

For additional information or to obtain necessary forms, contact NHRSC.
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 the Benefits by Design Voluntary Programs

The Benefits by Design Voluntary Programs provide eligible employees with the opportunity to participate, at group rates, in programs such as legal services, long-term care, 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 you receive through Kaiser Permanente.

Legal Services

The legal services plan provides you access to a nationwide network of attorneys. The plan, underwritten by Hyatt 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 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

The legal services cost as of January 2019 is $20.50 per month. This amount is deducted in increments of $10.25 on an after-tax basis from your first two paychecks of each month. This amount is subject to change annually.

How Legal Services Work

To use your legal services, visit Hyatt 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 use Hyatt’s website at www.legalplans.com, click "enter here" under Employees/Members. 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)
INCOME PROTECTION

• 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 Hyatt 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, Hyatt 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 Hyatt 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 Hyatt Legal Plans' website at www.legalplans.com or call 800-821-6400.

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. If eligible, you may enroll in either or both coverages at any time. 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. Your coverage becomes effective on the first of the month following the end of the election period, provided MetLife approves your application.

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

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 at 866-486-1949 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 at 866-486-1949 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, 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. Spouse/civil union/domestic partner coverage cannot exceed the coverage amount you elect for yourself.

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, naming the person(s) to receive benefits in the event of your death. You may name primary and secondary beneficiaries. Your benefits will be paid to your primary beneficiary. If no beneficiary is living or can be found or none was named, MetLife will place proceeds of the life insurance payment into a liability account where they will remain until either a beneficiary comes forward or the State escheats the funds.

To choose your beneficiaries, sign on to My HR at kp.or/myhr, click on Forms Finder on the home page, then look for the Beneficiary Designation (Met LIFE) link. The link will take you to the MetLife website where you can choose your beneficiaries. You may add or update your beneficiaries online at any time. For more information, contact the NHRSC.

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 Benefits by Design Voluntary Programs at 866-486-1949.
Long-Term Care Insurance

Long-Term Care (LTC) insurance is designed to assist you and your eligible dependents with day-to-day living at home, at an assisted-living care facility, or at a nursing home. The LTC insurance program is called Home Care Plus™, distributed by ACSIA Partners and underwritten by Transamerica Life Insurance Company (Transamerica). Coverage is available at your own expense.

Who Is Eligible

You are eligible to apply for LTC insurance coverage for yourself and your eligible dependents if you are regularly scheduled to work 20 or more hours per week and have at least six months of continuous employment. Your application must be reviewed and approved by Transamerica in order to start participation in the coverage.

Eligible Dependents

The following dependents may qualify to apply for LTC Insurance coverage with full medical underwriting. Applicants must be age 18-79 to apply. Each dependent needs to submit a separate application.

- Your legal spouse or domestic partner (if you are legally separated, your separated spouse is not considered an eligible dependent)
- Your adult children
- Your parents and parents-in-law
- Your grandparents and grandparents-in-law
- Siblings (including step)
- Aunts, uncles, and cousins

When Coverage Begins

Your coverage begins after you complete the Application for Long-Term Care Insurance (ABC) form, submit to Transamerica, and are approved for coverage. Your coverage will begin the first of the month following the approval of your application.

Your Cost

You pay 100 percent 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. You may contact a long-term care insurance specialist at 866-486-1949 to obtain a personalized quote.

How Long-Term Care Insurance Works

LTC insurance provides coverage for out-of-pocket expenses for qualified long-term care services. As a newly hired or newly eligible employee, you may apply for LTC insurance coverage during the annual new hire enrollment period with simplified underwriting. To be eligible for simplified underwriting during the annual enrollment period, you must be age 18-65, and work at least 20 hours per week for at least six months. If you do not enroll when you first become eligible or you are over age 65, you and any dependents who may want to purchase this coverage must undergo a full underwriting process to qualify for LTC.

You may elect a pool amount and monthly benefit. You also can elect an optional offer that increases the pool amount by three percent 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

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

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.
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**

**RETIREMENT PROGRAMS**

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- Kaiser Permanente Tax-Sheltered Annuity Plan II .................................................. 65
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For Employees of The Permanente Medical Group, Inc.

The defined benefit and defined contribution plans described in this section do not apply to you.

The Permanente Medical Group, Inc. provides retirement benefits for eligible salaried employees under three separate programs: The Retirement Plan for Physicians and Salaried Employees of The Permanente Medical Group, Inc. (Plan 1) is an employer sponsored Defined Benefit Plan. The Permanente Contribution Plan of The Permanente Medical Group, Inc. (Plan 2) is an employer sponsored Money Purchase Pension Plan. The Permanente Medical Group, Inc., Salary Deferral Plan (Plan 3) is a voluntary employee Salary Deferral Plan.

Complete Summary Plan Descriptions for each of these plans will be provided to you separately at the time of eligibility.

Kaiser Permanente Employees Pension Plan Supplement to the Kaiser Permanente Retirement Plan

Kaiser Foundation Hospitals (KFH) or The Permanente Medical Group, Inc. (TPMG) provides eligible employees with a qualified defined benefit plan, an important piece of your future retirement income. KFHP/H offers the Kaiser Permanente Employees Pension Plan (KPEPP). TPMG offers the Kaiser Permanente Employees Pension Plan for The Permanente Medical Group (KPEPP-TPMG). For simplicity, this section will refer to the Plan as KPEPP, under which you earn retirement income based on a pension formula described in more detail below.

Who Is Eligible

You are eligible to participate in the plan if you are a Salaried or Non-Union Non-Exempt Employee of the Kaiser Foundation Hospitals/Health Plan in the Northern 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 anniversary of your hire date if you are compensated for at least 1,000 Hours of Service (see "Hours of Service") in the previous 12-month period. If you are compensated for fewer than 1,000 Hours of Service in your first 12 months of employment, you will become a participant on January 1 of the first calendar year in which you are compensated for at least 1,000 Hours of Service.

Participation Upon Your Rehire

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

Hour of Service

An Hour of Service is any hour, including sick leave, vacation, holidays, and 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 percent 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.

Year of Service

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

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

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

Years of Service and Credited Service for Leaves

In certain circumstances, the plan recognizes hours for periods of unpaid leave toward Years of Service and/or Credited Service. For more information, call the 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 1.2 percent

The Benefit Formula

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

$$\frac{1.2 \text{ percent of your Final Average Monthly Compensation} \times \text{Your years of Credited Service} - \text{Any applicable Pension Offset (see “Pension Offset Rules”)}}{1}$$
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 full-time compensation rate for your last 120 months, or 10 years, of employment. Your monthly compensation rate is the rate of base pay for the first compensated hour of each month multiplied by 173.33. 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 2019 is $280,000. 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, visit the Kaiser Permanente Retirement Center (KPRC) website at www.ibenefitcenter.com/kp, or from the home page on My HR at kp.org/myhr, click on the **Benefits & Wellness** tab, then click the **Pension Plans** link under **Retirement Benefits**, then click **My Pension Plan** in the **More** column. You may also call the KPRC.

**How the Pension Calculation Works**

Here is an example of how the KPEPP formula works:

Carolyn retires at age 65 with 20 years of Credited Service. Her Final Average Monthly Compensation (FAMC) is $4000. Her monthly pension — assuming she chooses the Single Life Annuity payment method — is:

\[
1.2 \text{ percent} \times 4000 = 48 \\
48 \times 20 \text{ years} = 960
\]

Carolyn’s monthly pension will be $960, payable to her for her lifetime as a Single Life Annuity beginning at age 65.

**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 KPEPP will be offset. Under the pension calculation formula, your KPEPP 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.

**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 10 or more Years of Service completed.

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, your benefits will be actuarially reduced to reflect early commencement. That is, your benefit is calculated under the basic formula and reduced to reflect your age on your Benefit Commencement Date.

For more information on this actuarial reduction, visit the KPRC website (from the My HR home page, click on the Benefits and Wellness tab, then click on Pension Plans under Retirement Benefits). You can also call the KPRC at 866-627-2826.

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 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, 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 70½, 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 70½.

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 70½, 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. If you were represented by a union in a former position at Kaiser Permanente, special rules may apply. 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 Kaiser Permanente Retirement Center (KPRC) website at www.ibenefitcenter.com/kp, or from the home page on My HR at kp.org/myhr, click on the Benefits & Wellness tab, then click the Pension Plans link under Retirement Benefits, then click on My Pension Plan in the More column. 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 percent 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 percent, 66\(\frac{2}{3}\) percent, and 75 percent Joint and Survivor Annuities:** Under this option, you receive a reduced monthly benefit until your death. If you die before your beneficiary, 50 percent, 66\(\frac{2}{3}\) percent, or 75 percent (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 percent, 66\(\frac{2}{3}\) percent, or 75 percent survivor benefit for the rest of your lifetime after your beneficiary’s death. This option requires the designation of one person as your beneficiary, and after your payments begin, you cannot change your beneficiary.

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

Once you begin receiving payments, you may not change your beneficiary. The monthly pension benefit you or your beneficiary receives under this option will be less than the monthly pension benefit under a Single Life Annuity because payments may continue after death. The actual difference depends on the percentage you elect (50 percent, 66\(\frac{2}{3}\) percent, or 75 percent) as well as the age difference between you and your beneficiary.

- **100 percent 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 percent 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 percent 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 70½. The amount of your spouse’s or designated domestic partner’s benefit will be the same as if you had selected the 50 percent 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.

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

If You Die After You Terminate Employment But Before Benefits Commence

If you die after you terminate employment, but before you make a written election to begin your benefits, and after you are vested, your spouse or designated domestic partner will be eligible for a lifetime monthly survivor benefit from the plan. This benefit is payable when you would have turned 65; however, your spouse may elect to begin payments when you would have been eligible for Early Retirement, but cannot defer payment later than April 1 following the year you would have reached age 70½. The amount of your spouse’s or designated domestic partner’s benefit will be the same as if you had selected the 50 percent 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 your death.

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

If You Die After Benefits Commence

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

Minimum Distribution Requirement

You are required by law to take a minimum distribution of your benefit by April 1 of the calendar year following the year in which you reach age 70½ 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.
**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.

**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.

**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 percent 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.ibenefitcenter.com/kp, or from the My HR home page at kp.org/myhr, click on the Benefits & Wellness tab, lick on the Pension Plans link under Retirement Benefits, then click on My Pension Plan in the More column. You may also call the KPRC.

Kaiser Permanente Employees Pension Plan - Supplemental Retirement Income Plan
The Kaiser Permanente Employees Pension Plan - Supplemental Retirement Income Plan (KPEPP-SRIP), a qualified defined contribution retirement savings plan, is a money purchase pension plan.

Who Is Eligible
You are eligible to participate in the plan if you are a Salaried or Non-Union Non-Exempt Employee in the Northern California Region

When You Are Eligible
You are eligible to participate in the plan when you are eligible to participate in the Kaiser Permanente Employees Pension Plan. Generally, this is the first anniversary of your date of hire, if you worked at least 1,000 hour during that previous 12-month period.

How to Enroll
When you are eligible for the plan, Kaiser Permanente automatically sets up an account for you and Vanguard sends you an eligibility notice. For information on your plan’s features, please contact Vanguard. You will receive a Personal Identification Number (PIN) from Vanguard for the automated VOICE network. You can access your account through the Vanguard website at www.vanguard.com, the VOICE network, or a Participant Services Associate at 800-523-1188. Your plan number for KPEPP-SRIP is 093210. You can make your payroll deferral election and investment elections online. You will be prompted to name beneficiaries during the online enrollment process. 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 After-Tax and Rollover Contributions to Your Account

After-Tax Employee Contributions

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

Rollover Contributions

If you are eligible to participate and have assets in a former employer’s eligible plan, you may roll over those retirement assets into your Kaiser Permanente plan without being subject to the annual addition limit. Please note that assets rolled over into your plan may not be withdrawn during your employment, except in the form of a loan, if eligible.

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 2019 is $280,000. This amount may be indexed periodically for cost-of-living increases. In addition, your annual maximum contribution may be limited by the IRC.

Vesting

Vesting refers to your entitlement to a benefit. You are immediately 100 percent vested in contributions to your account. This means that you are entitled to the total value of your contributions, employer contributions, and any investment earnings in your account when you leave Kaiser Permanente.

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 younger than age 35, you may not designate anyone other than your spouse to receive more than 50 percent of the value of your account, regardless of whether or not your spouse agrees to the designation. You may change your designated beneficiary at any time, except as described for your spouse.

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 percent of your fully vested account in Vanguard Brokerage Option. Investment funds are reviewed by the Investment Committee on an ongoing basis, and the actual funds offered through the plan are subject to change. A complete list of funds and more information about the Vanguard Brokerage Option is available online at www.vanguard.com or by calling Vanguard’s VOICE network at 800-523-1188.

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

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

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

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

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

Changing Your Investments

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

Receiving Information About Your Investments

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

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

You may also access information by calling the Vanguard VOICE network, an automated toll-free telephone service that enables you to request account information and execute transactions via a touch-tone telephone. With the touch of a few buttons, you can obtain your account balance, confirm your investment allocations for
future contributions, or request a transaction. Updated information about account transactions is available at approximately 8 a.m. Eastern time on the day after the transaction is processed.

Borrowing From Your Account

If you have at least $2,000 in your plan account as of your loan application date, you can borrow up to 50 percent of your vested account balance or $50,000, whichever is less, 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 percent.

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

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

There is a $50 loan application fee applied to 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 are married, federal law requires that your spouse consent to all loans. As a result, your application for a loan must be accompanied by a written, notarized statement of your spouse’s consent.

If You Go on an Unpaid Leave of Absence

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

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

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

If You Transfer to Another Employee Group or Terminate Employment

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

Normally, you will receive your account balance when your employment with Kaiser Permanente ends. You can waive this requirement on the distribution form you complete and return to the plan recordkeeper. You can defer receiving payment until April 1 of the year following your termination or the year you reach 70½, whichever is later, if you have more than $5,000 in your account as of your termination date.

When Vanguard receives notice of your termination date, you will receive account distribution information and forms. Your distribution may be in the form of cash and/or as an “in-kind” distribution (if possible), which is a payment made in the form of securities, based on your existing account investments. You should receive payment within 30 days following the return of your forms to Vanguard.

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

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

In-Service Withdrawal

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

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

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

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

How Benefits Are Paid

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

• **Lump Sum:** The total value of your account is paid to you in a single payment.

• **Single Life Annuity:** The total value of your account is used to purchase a non-transferable single life annuity that provides monthly income to you for your lifetime only. This is the normal form of payment of your benefits if you are not married.

• **50 percent, 66⅔ percent, 75 percent, and 100 percent Joint and Survivor Annuity:** You may elect to have an adjusted benefit paid to you for the joint lives of you and another person (your Joint Annuitant). You may choose to receive an adjusted monthly income while you are both alive, and then 100 percent, 75 percent, 66⅔ percent, or 50 percent of that amount will be paid to the survivor after either of you dies. The amount of adjustment for a Joint and Survivor Annuity is based upon your age and the age of your Joint Annuitant when benefits begin. If your Joint Annuitant is not your spouse, an additional adjustment may be needed to meet the
minimum distribution requirement. The 50 percent Joint and Survivor Annuity is the normal form of payment if you are married.

- **Installments:** The value of your account is paid to you in monthly, quarterly, or annual installments over a period of two to 25 years. In no event shall the payment extend beyond your life expectancy, nor shall any payment, except the last, be less than $100. You continue to direct the investment of your account until the installment payments are completed. You may request a total or partial distribution of your remaining account at any time.

Your installment options include declining balance, fixed dollar, or fixed percentage payments. Declining balance payments allow you to take regular installments over a specific number of years, based on the remaining number of payments and your balance at the time of each payment. Fixed dollar payments allow you to specify the dollar amounts you would like to withdraw at intervals you choose (monthly, quarterly, annually). Fixed percentage payments allow you to specify the percentage of your balance you would like to withdraw at intervals you choose (monthly, quarterly, annually).

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

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

**Required Distribution of Small Accounts**

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

**If You Die**

Here is what happens if you die before you commence your vested benefits from the plan or if you have a vested benefit remaining in your account:
• If you have a valid beneficiary designation on file, payment will be made to your beneficiary (or beneficiaries).

• If you do not have a valid designated beneficiary on file at the time of your death or if your designated beneficiary dies and you have not named another beneficiary before your death, payment of your account will be made in the following order:
  - To your surviving legal spouse
  - If none, to your surviving children (natural or adopted) on an equal share basis
  - If none, to your surviving parents on an equal share basis
  - If none, then to your estate

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

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

**Tax Considerations**

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

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

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

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

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

**Rollovers to Another Plan or Tax-Deferred IRA**

Taxable distributions from your plan may be rolled over into another employer’s qualified plan or a tax-deferred IRA. If an eligible distribution is rolled over, income taxes will be deferred until you later withdraw the funds. Remember that you may leave your account in your current plan until you are required to take a minimum distribution (see “Minimum Distribution Requirement”). Before choosing to roll over your distributions into another employer’s qualified plan or an IRA, you should 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 70½ or retire, whichever is later. All of the plan’s forms of payment meet the minimum distribution requirement. Minimum distributions are not eligible to be rolled over into an IRA or another tax-qualified retirement plan. If you do not make a timely election, you will be paid in the normal form of payment.

Unclaimed Benefits Process

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

Assignment of Benefits

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

Kaiser Permanente Tax-Sheltered Annuity Plan II

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

Who Is Eligible

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

Automatic Enrollment in Pre-Tax Employee Contributions

New hires are automatically enrolled in the plan at a payroll deferral rate of 2 percent of eligible pay. Your contributions will automatically be deducted from each paycheck on a pre-tax basis, and you will be 100 percent vested in your contributions and any associated earnings. Your contributions will be invested in the Qualified Default Investment Alternative (QDIA), the plan’s default investment option. You may move money between funds at any time.
Automatic Increases
Each year after your first year of participation, your pre-tax employee contribution rate will be increased by 1 percent until you reach the plan’s designated automatic savings limit of 6 percent. This automatic annual contribution rate increase will generally occur as soon as possible after the first day of April each year, unless you choose to change the month of the annual increase. You can always contribute more than 6 percent as long as your contribution rate does not exceed the plan’s annual limit (which is 75 percent of eligible pay) or the IRS annual contribution limit, whichever is less. You may also change your contribution rate at any time.

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

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

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

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

If you want to make any of the changes described in this paragraph, 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 Tax-Sheltered Annuity Plan II plan number is 094998. You can make your payroll deferral election and investment elections online at any time. You will be prompted to name beneficiaries when you activate your online account access.

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

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

• Click **Beneficiaries** under “Do It Yourself”

### Making Contributions to Your Account

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

#### Pre-Tax Employee Contributions

Based on your election, contributions are deducted from your paycheck each pay period, and your gross pay will be reduced by the amount of your contributions. Your contributions are deducted from your pay before federal and state 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 percent and 75 percent 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 $19,000 in 2019.

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

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

#### 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](http://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 percent 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 a given year, you are eligible to make an additional pre-tax catch-up contribution to your plan for that year and in subsequent years. The maximum allowable catch-up contribution in 2019 is $6,000. Your annual contribution limit and catch-up contribution limit may change from year to year.

You are eligible to make catch-up contributions only after you have reached your applicable annual contribution limit. The following chart outlines the annual contribution limit in 2019:

<table>
<thead>
<tr>
<th>Pre-Tax Contribution Limit</th>
<th>Catch-Up Contribution Limit</th>
<th>Combined Contribution Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>$19,000</td>
<td>$6,000</td>
<td>$25,000</td>
</tr>
</tbody>
</table>

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

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

Maximum Compensation Limit

The maximum compensation limit is the annual eligible pay under the Internal Revenue Code (IRC) that may be considered for benefit purposes. The maximum compensation limit for 2019 is $280,000. This amount may be indexed periodically for cost-of-living increases. In addition, your annual maximum contribution may be limited by the IRC.

Vesting

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

**Choosing Your Beneficiary**

When you become a participant, you 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 younger than age 35, you may not designate anyone other than your spouse to receive more than 50 percent of the value of your account, regardless of whether or not your spouse agrees to the designation. You may change your designated beneficiary at any time, except as described for your spouse.

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 percent of your fully vested account in Vanguard Brokerage Option. Investment funds are reviewed by the Investment Committee on an ongoing basis, and the actual funds offered through the plan are subject to change. A complete list of funds and more information about the Vanguard Brokerage Option is available online at [www.vanguard.com](http://www.vanguard.com) or by calling Vanguard’s VOICE network at 800-523-1188.

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

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

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

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

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

Changing Your Investments

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

Receiving Information About Your Investments

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

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

You may also access information by calling the Vanguard VOICE network, an automated toll-free telephone service that enables you to request account information and execute transactions via a touch-tone telephone. With the touch of a few buttons, you can obtain your account balance, confirm your investment allocations for future contributions, or request a transaction. Updated information about account transactions is available at approximately 8 a.m. Eastern time on the day after the transaction is processed.

Borrowing From Your Account

If you have at least $2,000 in your plan account as of your loan application date, you can borrow up to 50 percent of your vested account balance or $50,000, whichever is less, 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 percent.

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

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

There is a $50 loan application fee applied to 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 are married, federal law requires that your spouse consent to all loans. As a result, your application for a loan must be accompanied by a written, notarized statement of your spouse’s consent.

If You Go on an Unpaid Leave of Absence

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

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

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

If You Transfer to Another Employee Group or Terminate Employment

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

When You Can Receive a Distribution

Normally, you are entitled to receive your plan account balance when your employment with Kaiser Permanente ends. You can defer receiving payment until April 1 of the year following your termination or the year you reach 70½, whichever is later, if you have more than $5,000 in your account as of your termination date.

Please note: If you have a Roth account, you can avoid IRS-required age 70½ 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 70½. You may need to wait five years after the rollover to take a tax-free distribution of earnings from your Roth IRA. However, your beneficiaries will be required to take minimum distributions after your death. For more information on Roth IRAs, sign on to vanguard.com/ira.

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

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

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

In-Service Withdrawal

Age 59½ Withdrawal

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

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

Financial hardship includes money needed for the following:
- College tuition for yourself, your spouse or domestic partner, or your dependents
- Medical expenses for yourself, your spouse or domestic partner, or your dependents
- Purchasing your primary residence or avoiding eviction from or foreclosure on your home
- Certain expenses relating to the repair of damage to your principal residence that qualifies as a casualty deduction
- Payments for burial or funeral expenses for your deceased parent, spouse, domestic partner, or dependent

For a complete list of hardship circumstances, contact Vanguard at 800-523-1188.

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

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

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

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

How Benefits Are Paid

If you have $5,000 or less in your account when you retire or leave Kaiser Permanente, you will receive a Lump Sum payment.

If the value of your account is more than $5,000, 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.

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.
- **Single Life Annuity**: The total value of your account is used to purchase a non-transferable single life annuity that provides monthly income to you for your lifetime only. This is the normal form of payment of your benefits if you are not married.
- **50 percent, 66 2/3 percent, 75 percent, and 100 percent Joint and Survivor Annuity**: You may elect to have an adjusted benefit paid to you for the joint lives of you and another person (your Joint Annuitant). You may choose to receive an adjusted monthly income while you are both alive, and then 100 percent, 75 percent, 66 2/3 percent, or 50 percent of that amount will be paid to the survivor after either of you dies. The amount of adjustment for a Joint and Survivor Annuity is based upon your age and the age of your Joint Annuitant when benefits begin. If your Joint Annuitant is not your spouse, an additional adjustment may be needed to meet the
minimum distribution requirement. The 50 percent Joint and Survivor Annuity is the normal form of payment if you are married.

- **Installments:** The value of your account is paid to you in monthly, quarterly, or annual installments over a period of two to 25 years. In no event shall the payment extend beyond your life expectancy, nor shall any payment, except the last, be less than $100. You continue to direct the investment of your account until the installment payments are completed. You may request a total or partial distribution of your remaining account at any time.

Your installment options include declining balance, fixed dollar, or fixed percentage payments. Declining balance payments allow you to take regular installments over a specific number of years, based on the remaining number of payments and your balance at the time of each payment. Fixed dollar payments allow you to specify the dollar amounts you would like to withdraw at intervals you choose (monthly, quarterly, annually). Fixed percentage payments allow you to specify the percentage of your balance you would like to withdraw at intervals you choose (monthly, quarterly, annually).

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

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

**Required Distribution of Small Accounts**

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

**If You Die**

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

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

- If you 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 you do not have a valid designated beneficiary on file at the time of your death or if your designated beneficiary dies and you have not named another beneficiary before your death, payment of your account will be made in the following order:
  - To your surviving legal spouse
  - If none, to your surviving children (natural or adopted) on an equal share basis
- If none, to your surviving parents on an equal share basis
- If none, then to your estate

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

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

Tax Considerations

Your plan has been designed to provide you with significant tax advantages.

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

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

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

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

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 percent 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 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 70½ or retire, whichever is later. All of the plan’s forms of payment meet the minimum distribution requirement. Minimum distributions are not eligible to be rolled over into an IRA or another tax-qualified retirement plan. If you do not make a timely election, you will be paid in the normal form of payment.

Unclaimed Benefits Process

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

Assignment of Benefits

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

If You Terminate Employment and Return to Work

Breaks In Service

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

If you are rehired into an employee group covered under this SPD, the following rule applies:
• If you have a break in service of two or more years, or if you have a break in service of less than two years, but you had less than two years of employment in a benefits-eligible position before your break in service, your adjusted hire date — the date you are rehired after the break in service — will be used to determine what benefits you are eligible for when you retire.

• If you have a break in service of less than two years, and you had two years or more of employment in a benefits-eligible position before your break in service, your original hire date (or most recent adjusted hire date) will be used to determine what post-retirement benefits you may be eligible for upon retirement.

If you are rehired into an employee group not covered under this SPD, then you will be subject to the break in service rule applicable to the employee group into which you are rehired. If you are rehired into an employee group covered under this SPD and then you subsequently transfer into an employee group not covered under this SPD, you will retain your original or adjusted hire date (as applicable), based on the break in service rule applicable to the employee group into which you were rehired before your transfer. However, the benefits you are offered at retirement will be the ones applicable to the Kaiser Permanente employee group from which you retire.

Important Note: You will not lose Years of Service (as defined below) 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 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-retain from on the date of your most recent separation from service.

If you were already using your retiree medical benefits before your rehire, any Retiree Medical HRA amount will be reduced by reimbursements you received, but the amount may be increased if you have additional years of service.

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 retire.

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.

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Health and Welfare Eligibility and Enrollment Disputes

If you have a question relating to you or your dependent’s eligibility for health and welfare benefits, including enrollment disputes, you must contact the National Human Resources Service Center. If you disagree with the NHRSC’s response, you may ask for a Request for an Administrative Review Form and submit a written dispute. Your request for an administrative review must be received by the NHRSC within six months of the event that gives rise to your initial question. 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)
• Disability plans and other plans where benefits depend on whether you are disabled
• Retirement plans and retiree medical eligibility determinations
• Other plans subject to ERISA (e.g., life insurance plans)

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

Use of an Authorized Representative

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

What Is a Claim for Benefits

Federal law requires that a plan follow specific procedures when you make a claim for benefits or appeal a denial of your claim for benefits. A “claim” for benefits is a formal request by you (or your beneficiary) for the payment of benefits you believe are due under the terms of an employee benefit plan covered by the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The procedures apply to the benefits described in this Disputes, Claims, and Appeals section of the Summary Plan Description (SPD). These procedures do not apply to claims filed with respect to benefits not covered under ERISA, or to other company programs, unless otherwise stated.
Except in the case of claims or appeals under a health plan involving urgent care, you must submit in writing your claim for benefits or your appeal of a denial of a claim. You must submit your claim to the relevant person specified in the “Claims and Appeals” section for each particular plan in this SPD. For example, it would not be a formal claim for benefits if you submitted your request for a benefit to your supervisor. Similarly, see the “Claims and Appeals” section for each plan in this SPD (that follows this “General Information” section) to find out if a particular form is required to submit a claim with respect to a specific plan.

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

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

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

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

**Information Provided by the Plan If Your Claim Is Denied**

If the claims administrator denies your claim, then you will receive a written response from the claims administrator explaining the reasons for the denial. (The deadlines for the claims administrator to inform you of a claim denial are summarized later in this section.) If your health plan claim for benefits is denied, then your Explanation of Benefits may serve as the written claim response. However, when responding to a health plan claim for urgent care, sometimes the claims administrator will communicate its decision orally so that you receive a faster response. The oral response will be followed up by a written response within three days after the oral response.

A denial of a claim includes any of the following responses: a failure to provide advance approval for a service (applies only when the plan requires pre-approval for the service); a failure to provide, in whole or in part, a particular service; a failure to pay, in whole or in part, for services that were performed; a reduction or termination
of previously-approved benefits; or a failure to provide, in whole or in part, a requested benefit pursuant to the terms of a specific plan (e.g., a long-term disability benefit or an early retirement benefit under the defined benefit plan).

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

**Your Right to Appeal a Denied Claim**

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

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

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

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

**Health Plan Claims and Appeals**

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

**Types of Claims**

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

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

**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.

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.
DISPUTES, CLAIMS, AND APPEALS

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

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

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

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

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

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

Medical Plans Claims and Appeals

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

Emergency Claims
Depending on where you receive emergency care, you may be responsible for paying for emergency services at a facility not affiliated with Kaiser Permanente and submitting your claim to Kaiser Permanente Claims and Referrals. Once you submit a claim, KFHP will reimburse you — if the emergency treatment would normally have been covered by KFHP and if delaying treatment would have resulted in death, serious disability, or jeopardy to your health. KFHP will pay reasonable charges, excluding your emergency copayment, any other copayments that would have applied at Kaiser Permanente, or any amounts payable under insurance and government programs other than Medicaid. Claims must be submitted within 12 months of treatment.
Where to File Your KFHP (including Emergency) Claims

Submit your completed claim forms to:

Kaiser Foundation Health Plan, Inc.
Claims Administration Department
P.O. Box 12923
Oakland, CA 94604

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

Appeals

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

KFHP appeals should be sent to:

Kaiser Foundation Health Plan, Inc.
Claims Administration Department
P.O. Box 12923
Oakland, CA 94604

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

Arbitration Agreement

If you are a Kaiser Foundation Health Plan member, any dispute between you, your heirs, relatives, personal representatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc., its contracted health care providers, their agents, employees, or other associated parties on the other hand, arising out of or relating to Kaiser Foundation Health Plan membership, including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or the delivery of, services or items, irrespective of the legal theories upon which the claim is asserted, 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 and their right to a court or jury trial and accept the use of binding arbitration. The following types of claims are not subject to binding arbitration: Small Claims Court cases, claims subject to a Medicare appeals procedure as applicable to Kaiser Permanente Senior Advantage members, and claims that cannot be subject to binding arbitration under governing law. The full arbitration provision is contained in the Evidence of Coverage. You can obtain a copy of the Evidence of Coverage brochure by calling Member Services at 800-464-4000 or by visiting kp.org (go to the My health manager tab, click My coverage and costs, then click My documents in the left hand navigation).

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:
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](http://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**.

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](http://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.

Retirement Plan Benefits Claims and Appeals

**Defined Benefit Plan Claims**

*If you are an employee of The Permanente Medical Group, Inc., this section does not apply to you. Please refer to the Summary Plan Description for The Retirement Plan for Physicians and Salaried Employees of The Permanente Medical Group, Inc. (Plan 1) for information regarding your defined benefit claims process.*

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.ibenefitcenter.com/kp. From the My HR home page, click on the Benefits & Wellness tab, then click the Pension Plans link under Retirement Benefits. You can also call the KPRC at 866-627-2826 Monday through Friday 6 a.m. to 6 p.m. Pacific time.

They 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 need 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 an employee of The Permanente Medical Group, Inc., this section does not apply to you. Please refer to the Summary Plan Description for The Permanente Contribution Plan of The Permanente Medical Group, Inc. (Plan 2) and The Permanente Medical Group, Inc., Salary Deferral Plan (Plan 3) for information regarding your defined contribution plan claims process.

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

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

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

Statute of Limitations

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

Any claim regarding your form of payment or the failure to timely pay, in whole or in part, your account as of your benefit starting date must be filed within one year of your benefit starting date. In addition, any claim for benefits under the appropriate plan must be filed by the later of December 2016 or two years following the date you knew or should have known that a contribution should have been made to your account.
No legal action can be brought more than one year after the later of (i) the date of the initial denial of your claim, or (ii) if a timely request for appeal of the denial had been made, the date of the denial of your appeal.

**Deadlines for Responding to Your Claims**

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

**Appeal**

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

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

**Deadlines for Responding to Your Appeal**

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

**Decision on Review**

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

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

**Leased Employee Service Claims**

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

The KPRC will provide you with a questionnaire to complete, along with an opportunity to submit evidence of your eligibility for such additional service. Examples of such evidence include:
• W-2s for the years you worked for the leasing company for work performed at Kaiser Permanente.
• An accounting report, your time card or an invoice from the leasing company reflecting the dates and total hours of work performed at Kaiser Permanente.

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

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

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

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

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

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

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

General Information About Other Types of Claims and Appeals

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

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

Life Insurance, and Voluntary Term Life Claims

You or your beneficiary must contact the NHRSC 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 following address:
Legal Services Claims and Appeals

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

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

How to Appeal a Denial of Your Initial Claim

If your claim is denied, Hyatt Legal 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 Hyatt Legal. 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 Hyatt Legal to give your appeal proper consideration. Upon your written request, Hyatt Legal 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:

**Hyatt Legal**  
**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 Hyatt Legal denies your appeal, Hyatt Legal 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, Hyatt Legal 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, Hyatt Legal may take up to an additional 60 days to respond to your appeal. When Hyatt Legal requests the 60-day extension, it will indicate the special circumstances in writing. If Hyatt Legal needs additional information from you to resolve your appeal, then Hyatt Legal 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 Hyatt Legal 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.
Long-Term Care Claims and Appeals

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

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

Deadlines for Responding to Your Claims

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

How to Appeal a Denial of Your Initial Claim

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

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

Deadlines for Responding To Your Appeal

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

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

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

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

Highlights of This Section

LEGAL AND ADMINISTRATIVE INFORMATION

- Administration of the Plans
- Service of Legal Process
- Administrative Powers and Responsibilities
- Welfare and Retirement Plans
- Separation From Service
- Retirement Plan Termination Insurance
- Third Party Responsibility
- Qualified Domestic Relations Order
- Qualified Medical Child Support Order
- Statement of ERISA Rights
- THE RIGHT TO AMEND OR TERMINATE THE PLANS
Administration of the Plans

<table>
<thead>
<tr>
<th>Entity</th>
<th>Plan Sponsor</th>
<th>Plan Administrator</th>
</tr>
</thead>
</table>
| Kaiser Foundation Health Plan, Inc./Kaiser Foundation Hospitals | Kaiser Foundation Health Plan, Inc.  
One Kaiser Plaza  
Oakland, CA 94612  
510-271-5940  
EIN # 94-1340523 | **For Health and Welfare Plans**  
Kaiser Permanente Administrative Committee (KPAC)  
One Kaiser Plaza  
Oakland, CA 94612 |
| | | **For Defined Benefit Plans**  
Kaiser Permanente Administrative Committee (KPAC)  
One Kaiser Plaza  
Oakland, CA 94612 |
| | | **For Defined Contribution Plans**  
The Permanente Medical Group, Inc.  
1800 Harrison St., 7th Fl  
Oakland, CA 94612  
EIN # 94-2728480 |
| The Permanente Medical Group, Inc. | The Permanente Medical Group, Inc.  
1800 Harrison St., 7th Fl  
Oakland, CA 94612  
EIN # 94-2728480 | **For Health and Welfare Plans**  
Kaiser Foundation Health Plan, Inc.  
One Kaiser Plaza  
Oakland, CA 94612 |
| | | **For Defined Benefit Plans**  
The Permanente Medical Group, Inc.  
1800 Harrison St., 7th Fl  
Oakland, CA 94612 |
| | | **For Defined Contribution Plans**  
The Permanente Medical Group, Inc.  
1800 Harrison St., 7th Fl  
Oakland, CA 94612 |

Service of Legal Process

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

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

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

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

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

Welfare and Retirement Plans

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

<table>
<thead>
<tr>
<th>Plan Name/Plan Options</th>
<th>Plan Sponsor</th>
<th>EIN #</th>
<th>ID No</th>
<th>Type of Plan</th>
<th>Claims Administrator</th>
<th>Type of Administration</th>
<th>Plan Trustee</th>
<th>Funding Medium</th>
<th>Contributing Source</th>
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<tr>
<td>HEALTH AND WELFARE PROGRAMS</td>
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<td>The Permanente Medical Group, Inc., Health and Welfare Plan</td>
<td>94-2728480</td>
<td>550</td>
<td>Health and Welfare Programs</td>
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<tr>
<td>Plan Name/Plan Options</td>
<td>Plan Sponsor EIN #</td>
<td>ID No.</td>
<td>Type of Plan</td>
<td>Claims Administrator</td>
<td>Type of Administration</td>
<td>Plan Trustee</td>
<td>Funding Medium</td>
<td>Contributing Source</td>
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<tr>
<td>Kaiser Foundation Health Plan</td>
<td>Insured Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612</td>
<td>Insured</td>
<td>Kaiser Foundation Health Plan, Inc. One Kaiser Plaza Oakland, CA 94612</td>
<td>Insured agreement premiums paid from general assets</td>
<td>Employer and employee</td>
<td></td>
<td></td>
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<tr>
<td>Group Dental Insurance</td>
<td>Insured Delta Dental of California 100 First Street San Francisco, CA 94105</td>
<td>Insured</td>
<td>Delta Dental of California 100 First Street San Francisco, CA 94105</td>
<td>Insured agreement premiums paid from general assets</td>
<td>Employer</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Group Life Insurance</td>
<td>Insured MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100</td>
<td>Insured</td>
<td>MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100</td>
<td>Insured agreement premiums paid from general assets</td>
<td>Employer and employee</td>
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<td></td>
</tr>
<tr>
<td>Group Long-Term Disability Insurance</td>
<td>Insured MetLife Disability Unit P.O. Box 14590 Lexington, KY 40511-4590</td>
<td>Insured</td>
<td>MetLife Disability Unit P.O. Box 14590 Lexington, KY 40511-4590</td>
<td>Insured agreement premiums paid from general assets</td>
<td>Employer</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Dependent Care Flexible Spending Account</td>
<td>Flexible Spending Account WageWorks P.O. Box 14053 Lexington, KY 40512</td>
<td>Third-Party</td>
<td>WageWorks P.O. Box 14053 Lexington, KY 40512</td>
<td>N/A</td>
<td>Employee</td>
<td></td>
<td></td>
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<tr>
<td>Legal Services</td>
<td>Legal Services Hyatt Legal Plans Director of Administration 1111 Superior Avenue E, Suite 800 Cleveland, OH 44114-2507</td>
<td>Third-Party</td>
<td>Hyatt Legal Plans Director of Administration 1111 Superior Avenue E, Suite 800 Cleveland, OH 44114-2507</td>
<td>N/A</td>
<td>Employee</td>
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<td></td>
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<td>Voluntary Term Life Insurance</td>
<td>Insured MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100</td>
<td>Insured</td>
<td>MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100</td>
<td>N/A</td>
<td>Employee</td>
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<tr>
<td>Long-Term Care Insurance</td>
<td>Insured Transamerica Life Insurance Company P.O. Box 869093 Plano, TX 75086</td>
<td>Insured</td>
<td>Transamerica Life Insurance Company P.O. Box 869093 Plano, TX 75086</td>
<td>N/A</td>
<td>Employee</td>
<td></td>
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<tr>
<td>Employee Assistance Program</td>
<td>Self-Funded Kaiser Foundation Health Plan, Inc., One Kaiser Plaza Oakland, CA 94612</td>
<td>Self-Funded</td>
<td>Kaiser Foundation Health Plan, Inc., One Kaiser Plaza Oakland, CA 94612</td>
<td>Self-funded; paid from general assets</td>
<td>Employer</td>
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</table>
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.

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**
1200 K Street NW, Suite 930
Washington, D.C. 20005-4026
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 Qualified Domestic Relations Order (QDRO) applicable to your Kaiser Permanente defined contribution retirement savings plans is $350 for each plan, even if multiple plans are included in one QDRO.

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

For additional information about a QDRO for your defined benefit and defined contribution retirement plan(s), contact QDRO Consultants at 800-527-8481.

Qualified Medical Child Support Order

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

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

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

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

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

### Statement of ERISA Rights

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

- Examine, without charge, at the Plan Administrator’s office, copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

- Obtain copies of all the plan documents and other plan information upon written request to the plan administrator through the NHRSC. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the plan’s annual financial report. The Plan Administrator is required to furnish each participant with a copy of the Summary Annual Report/annual funding notice free of charge.

- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to be entitled to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The plan must provide the statement free of charge.

- Continue group health plan coverage for yourself, spouse or dependents through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- A reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

- Prudent actions by plan fiduciaries. In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire
you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

- If your claim for a (pension, welfare) benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

**Assistance with Your Questions**

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

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

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

**THE RIGHT TO AMEND OR TERMINATE THE PLANS**

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

**English:** You have the right to get help in your language as 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.

### For Self-funded plans:

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<td>Southern California Region</td>
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<td>Colorado Region</td>
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<td>Mid-Atlantic States Region</td>
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<tr>
<td>Northwest Region</td>
<td>866-800-3402</td>
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<td>District of Columbia</td>
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### TTY

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<th>Region</th>
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<td>All Regions</td>
<td>800-216-2166</td>
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<td>TTY</td>
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Cebuano (Bisaya): Anaa moy katungod nga mangayo og tabang sa inyo pinulongan ug kini walay bayad. Kung naka mo pangutana bahin sa inyo benepisyo o may mga butang nga nanginahanlangan sa inyo paglihok sa dili pa usa ka pilo nga petsa, palihug lang pagtawag sa mga numero sa telepono nga gihtag 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 pwoong omw kopwe neuneu aninis non kapasen fonoumw (Chuukese), ese karno. Ika mei wor omw kapas eis usun omw pekin insurance, are ika a men auclea 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 aewwe epwe anisuk non kapasen fonoumw.

Français (French): Un assistant gratuit dans votre langue est à votre disposition. Si vous avez des questions à propos de vos avantages ou si vous devez prendre des mesures 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 શેર પુષ્ચત થવું દર્શાવે તમારી લાભમાં મદદ મળવાની અધકાર છે. તમને તમારા લાભની લિખાવી શકી શકો છો, તમારા ક્રમના ધોરણની પુલાવની તમને ફાળવી દેશની જુ લેશ એવી ટૂટી પાલાંખી તમારા લેખનલો અમલ નથી પર કેન કરો.

Kreyòl Ayisyen (Haitian Creole): Ou gen dwa pou jwenn ed nan lang ou gratis. Si ou gen nempòt kesyon sou aplikasyon ou an oswa asians ou ak Kaiser Permanente, oswa si nan avi a sa a gen bagay ou sipoze fe avan yon sèten dat, rele nimewou nou mete pou Eta oswa reyjon ou a pou w ka pale ak yon entèpre.

‘ōelelo Hawai‘i (Hawaiian): He pono a ua loa‘a no kekahiki kokua me kau‘ōelelo ina makemake a he manuhi no ho‘i. Ina he mea nānā kāu e pili ana i kāu pono ke‘au i ka polokalama ola kino, a i ‘ole inā ka ha‘i nei ia‘oe e hana koke aku i keia ma mua o kekahiki la i waiho ia, e kelepono aku i ka helu i loa‘a nei no kāu moku‘āina a i ‘ole pana‘aina no ka wela’au ‘ana me kekahiki kanaka unuhi ‘ōelelo.

हिन्दी (Hindi): आपको खिलों की सील कुछ आपकी आपदा में नादद पाने का अधिकार है। यदि आप आपके लाभ के बारे में कोई सवाल पूछना वाले हैं तो आपको किसी निस्चित ताज़ा तक कोई कारागार करने की आवश्यकता है, तो आप आपके राज्य के लिए दिये गए नियम पर निर्भर करने के लिए दु:खित करने से बच करे।

Hmoob (Hmong): Koj muaj cai tau txais kev pab txhais ua koy hom lus pub dawb. Yog koj muaj lus nung txog koj cov txiaj ntsii, lossis koj yuav tsum tau ua raws li hnb hais tseg ntawd, hru rau tus nab npawb xovtooj ntamw lub xeeb lossis hauv ib cheeb tsam uas tau muab rau koj mus tham nrog iq tug kws txhais lus.

Igbo (Igbo): I nwere iike inweta enyemaka n’asusu gi na akwughi ugo o bula. O buru na i nwere ajụ i basara elele gi, ma o bu na achọ ka i mee ihe tupu otu ubochi, kpoo nomba enye naka steeli ma o bu mpaahara gi i i kwukorita okwu n’etiti onye okowa okwu.

Ilokano (Ilocano): Adda dda ti karbonganyo a dumawat iti tulong iti pagsasao nga awan ti bayingano. No adcaankayo kadagiti saludos maipanggip kadagiti benefisioyo wennyo, mangkalikagum kadakayo a rumbeng nga aramidero ti addang iti espesipiko a petsa, tawagam ti numero nga inpaay para ti estado wennyo 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、通訳とお話しください。

ភាសាខ្មែរ (Khmer): អ្នកអាចបានសិក្សាអំពីប្រតិបត្តិអំពីការបង្កើតការណ៍ដែលអាចធ្វើឲ្យអ្នករង្វាន់។ សូមជ្រើសរើសទំនភ្ជាប់ដែលបានបង្កើតការណ៍ដែលអាចធ្វើឲ្យអ្នករង្វាន់។ ប៉ុន្តែអ្នកអាចត្រូវបានទ្វីបដោយសំខាន់។

한국어 (Korean): 귀하에게는 한국어 통역 서비스를 무료로 받으실 수 있는 권리가 있습니다. 귀하의 특정 해택이나 이 통역 서비스의 요구에 따라 어느 날까지 조치를 취해야만 하는 경우, 제공된 귀하의 주 및 지역 경제조사로 연락해 통역사와 통화하십시오.

ລາວ (Laotian): ໃນពេលដែលអ្នកចង់ស្មើសម្រាប់ការបង្កើតការណ៍ដែលអាចធ្វើឲ្យអ្នករង្វាន់។ ប្រសិនបើអ្នកចង់បង្កើតការណ៍ដែលអាចធ្វើឲ្យអ្នករង្វាន់។ សូមជ្រើសរើសទំនភ្ជាប់ដែលបានបង្កើតការណ៍ដែលអាចធ្វើឲ្យអ្នករង្វាន់។

Kajin Majol (Marshallese): Ewør jimmwe eo am in bök jpan ilo kajin eo am ejeljok wonaan. Ne ewor am kajitok kon jbaan ko am, ak nie kwoj aikuuj in makutkut mkot jän juon raan eo emo an kalikkar, kaljok nömbo oo ej leolj jran state eo am ak jküm bwe kwon maroñi kônono ippän juon ri-ukot.

Naabehlo (Navajo): Doo bik’é asíniiháágo ata’i lanee bee núka i doolwol. Bee naa áháyáhii doob bee núka ána’i álko’í bin'i’i dílako, éi doodago náa yoołkáąłgi há-to’édégo yi’i dlilil ni’í di’ii négo, bik’elgo béésh bee hane’i naaltsoc bikea’i’i’i hóódlah nítaa yalaaltsocjí’é éi doodago sáadí naate’i’i álko’i’i halné’i’i bich’ii’i hádiidzii.

नेपाली (Nepali): तपाईंले कुनै खर्च विना आफ्नो भाषामा सहयोग पाउने अधिकार छ। यदि सुविधास्वरुप वारोला तपाईंले कुनै प्रकारहरूभए, अथवा कुनै निर्धारित सिद्ध तपाईंले कुनै कार्यान्वयन गर्ने आवश्यक भए, कुनै दिशाशंका, कुनै गर्ने तपाईंलो राज्य वा क्षेत्र का लागि उपलब्ध नम्बरमा फोन फोन होस्।

Afaa Oromo (Oromo): Baasisi malee afaa keetiin gargaarsa argachuuuhaa migma qabda. Waa’ee tajaajila keetii ilaachisee gaaffii yoo qabaatte, yookaan yoo guyyaa muraa irradkiri tarkanfii akka fuchattu gaafatame, lakkoofsa bibilaa naannoo yookaan goodina keetiif konname bibiluuudhaan turumamaa haashoissii.

فارسی (Persian): این حق داریده که بدون هزینه ای به زبان خود کمک دریافت کنید. اگر دریایی، مراحلی که به دست آورید، با آزمایشات روز به روز، استفاده از تأثیر فعالیت ادامه دیابند. برای سوخته کنید، یک مرحله، دو هفته نخست، یک چهارم یک هفته، و یک هفته بعد از هفته نخست.

lokaiah Pohnpeian (Pohnpeian): Komw anehki pvang en repahki sounkawewe he omw palien lokaiah ni sichte isaias. Ma mi ien owmi kalelapak ohng kosoandi me pid kamwau pe kan, de anahne komwi en mewikci ohng rahn me kilelidi, ah komw anahne koah nempo me sanaicr (insert number here) ohng owmni palien wehi pwe komwi en lokaiaheng owmni tungcoul soun kawewe.

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.
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 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 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
800-368-1019
800-537-7697 (TDD)
