SETTLEMENT AGREEMENT AND RELEASE

THIS SETTLEMENT AGREEMENT AND RELEASE (the "Settlement Agreement") is entered into by and between the Secretary of the United States Department of Labor (the "Secretary") and Kaiser Foundation Health Plan, Inc. ("Kaiser") (collectively, "Parties"), by the Parties' duly authorized representatives. This Settlement Agreement is effective on the date the last party signs this Settlement Agreement ("Effective Date").

I. DEFINITIONS

In addition to the parenthetical definitions above, the following definitions apply to the bold terms of this Settlement Agreement.

1. "**Behavioral Health**" or "**MH/SUD**" means mental health/substance use disorder benefits and/or services for the treatment of mental health and substance use disorders. These terms may be used interchangeably.

2. "**BHI**" means behavioral health index, a composite score of overall behavioral health calculated from multiple questions pertaining to overall well-being, depression, anxiety, and functioning.

3. "**Clinician**" means a healthcare professional, both physicians and non-physicians, with direct patient-care responsibilities, but does not include nurses who do not have the authority to prescribe.

4. "**DOL**" means the United States Department of Labor.

5. "**DMHC**" means the California Department of Managed Health Care.

6. "**DMHC Settlement**" means the settlement agreement that Kaiser and the California Department of Managed Health Care executed on October 11, 2023.

7. "**EBSA**" means the Employee Benefits Security Administration of the United States Department of Labor.

8. "**Enrollee**" **or** "**Enrollees**" means a participant or beneficiary of an ERISA-covered Employee Welfare Benefit Plan, who during the time period covered by this Settlement Agreement, was a Kaiser member.

9. "**enrollee**" or "**enrollees**" means a Kaiser member, irrespective of whether that individual was a participant or beneficiary of an ERISA-covered Employee Welfare Benefit Plan.

10. "**EOC**" or "**EOCs**" means evidence of coverage.

11. "**EOB**" or "**EOBs**" means explanation of benefits.

12. "**ERISA**" means Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §§ 1001, *et seq*., which includes the Mental Health Parity and Addiction Equity Act of 2008, as amended, 29 U.S.C. § 1185a.

13. "**In-Network**" means the hospitals, physicians, medical groups, pharmacies, or other health care providers that Kaiser has designated as a plan provider in an enrollee's evidence of coverage or summary plan description.

14. "**Medical Groups**" means The Permanente Medical Group, Inc., and the Southern California Permanente Medical Group, which act as the primary in-network providers for Kaiser in California.

15. "**MHPAEA**" means the Mental Health Parity and Addiction Equity Act of 2008, as amended, 29 USC § 1185a

16. "**Monitoring Period**" means the two-year period during which Kaiser conducts two annual reports and eight quarterly reports as required by Section IV of this Settlement Agreement. For purposes of the quarterly reports, the first quarter shall begin on the first day of the month of the next quarter following the Effective Date of this Settlement Agreement (e.g., April 1, 2026 if the Effective Date is in February 2026).

17. "**M/S**" means medical and/or surgical benefits for health care services that do not include services for mental health conditions and substance use disorders.

18. "**Network**" or "**Networks**" means the facilities and providers that Kaiser contracts with to provide health care services to its enrollees.

19. **"NQTLs"** means nonquantitative treatment limitations, as that term is used in Mental Health Parity and Addiction Equity Act of 2008, as amended, 29 USC § 1185a.

20. **"Out-of-Network"** means facilities, providers, and suppliers who have not been designated as a plan provider by Kaiser to provide health care services to its enrollees.

21. **"Provider"** or **"Providers"** means any facility or professional service provider. Facility is understood to include hospitals, outpatient surgical facilities, skilled nursing facilities, qualified treatment facility, or pharmacy. Professional service provider is understood to include medical groups and qualified clinicians administering medical/surgical or mental health/substance use disorder services.

22. **"Reimburse"** means payment to an **Enrollee** or to a **Provider** for services rendered to an **Enrollee,** for eligible **Out-of-Network** services.

23. "**Secretary's Designee**" means the individuals designated in writing as such by **EBSA**. As of the Effective Date, those individuals are:

    Philip Hall, Senior Advisor Health Investigations
    Los Angeles Regional Office
    35 N. Lake Avenue
    Suite 300
    Pasadena, CA 91101
    Hall.Philip@dol.gov

    Jamidi Daiess, Senior Advisor Health Investigations
    San Francisco Regional Office
    90 7th Street
    Suite 11-300
    San Francisco, CA 94103
    Daiess.Jamidi@dol.gov

24. **"SPD"** means summary plan description.

II. RECITALS

The Parties intend to resolve the following **EBSA** investigations involving Kaiser in California: Matter Nos. 72-038093(50), 70-018268(50), and 70-018071(50).

Kaiser acknowledges the following:

(1) Kaiser is a health care service plan organized under California's Knox-Keene Health Care Service Plan Act. Kaiser is also an entity subject to **ERISA** that provides benefits, including for ERISA-governed employee welfare benefit plans, as a **Network** of healthcare providers, administrative services, and claims processing services to **ERISA**-covered plans. In California, Kaiser provides its **Network** services to its **enrollees** primarily through the Permanente Medical Group in Northern California and the Southern California Permanente Medical Group in Southern California. Kaiser acknowledges that the employee welfare benefit plans provided by its group policyholders, for which it either funds benefits or provides administrative services, must comply with **ERISA** and **MHPAEA**, including in the monitoring of **Network** adequacy and claims processing.

(2) Kaiser has an obligation to provide benefits described in plan documents and that such benefits must be provided consistent with the terms of plan documents. Kaiser acknowledges that a failure to provide benefits consistent with the terms of the plan documents can be evidence of a violation of its obligations, including fiduciary obligations, under **ERISA**.

(3) Kaiser acknowledges that **EBSA** has alleged non-compliance with **MHPAEA**'s parity requirements under investigation in **EBSA** Matter Nos. 72-038093(50), 70-018268(50), and 70-018071, for which Kaiser produced documents pursuant to subpoena from 10/18/2022-10/23/2023.

(4) Kaiser acknowledges that under **ERISA**, including without limitation section 404(a) (1)(D), it has an oversight duty over the **Medical Groups** to ensure fulfillment of its fiduciary obligations.

(5) Kaiser acknowledges that it must perform sufficient oversight to ensure that the **Medical Groups** are providing **Behavioral Health** benefits in accordance with plan documents in a timely and clinically appropriate manner in parity with the provision of **M/S** benefits, and that during the investigative period, Kaiser at times failed to fulfill these oversight obligations.

(6) Kaiser further acknowledges that, during the time period covered by **EBSA's** investigations, the **Medical Groups'** roles related to the provision of **Behavioral Health** services were not clearly defined. During the time period

covered by **EBSA**'s investigations, Kaiser acknowledges that, in part because of this lack of role clarity, Kaiser has exercised inconsistent oversight over the **Medical Groups** and has not always intervened when necessary. This led, during the time period covered by the investigations, to insufficient assessment under **MHPAEA**.

(7) Kaiser acknowledges that, in addition to **EBSA's** investigations, it was the subject of an investigation and an enforcement action initiated by the **DMHC** with respect to the provision of **Behavioral Health** services. In October 2023, Kaiser and the DMHC entered into the **DMHC Settlement** which included the design and implementation of a corrective action work plan which Kaiser asserts will address some of the areas of concern that **EBSA** has identified.

(8) Kaiser acknowledges that, during the time period covered by **EBSA**'s investigations, it lacked sufficient access to **Medical Group** data needed for sufficient oversight of its quality oversight functions. Specifically, in reference to **Behavioral Health** services, during the time period covered by the investigations, Kaiser did not have continuous access to data and lacked full transparency to assess performance and evaluation of the assessments and treatment plans provided by the **Medical Groups** and external contracted **Providers**. Kaiser asserts that these issues have been addressed. Kaiser acknowledges that its responsibility is more than passive monitoring; Kaiser has an affirmative, continuous obligation to oversee the quality of its **Network** to demonstrate compliance with **ERISA** and **MHPAEA**.

(9) Kaiser acknowledges that, to a significant extent, it relies on the **Medical Groups** to make **Out-of-Network** referrals and acknowledges that, at times during the time period covered by **EBSA'**s investigations, it did not exercise sufficient performance monitoring or continuous oversight of its **Medical Groups**.

(10) Kaiser acknowledges that, at times during the time period covered by **EBSA**'s investigations, it lacked sufficient access to **Medical Group** and external **Provider** data and that this impacted its ability to adequately monitor its **Network** and review the operations of the **Medical Groups** and external service **Providers** and to complete an in-operation analysis.

(11) Kaiser acknowledges that generally accepted standards of medical care and the exercise of clinical judgment must be used when determining the appropriate level of care, including initial assessments and continuing outpatient therapy. Kaiser acknowledges that its **EOC** and other documents under which it administers claims under **ERISA**-governed plans must be read in conformity with applicable state and federal law, and that provisions that violate state or federal law may not be followed. Kaiser acknowledges that it has a continuous oversight obligation to monitor for the use of appropriate clinical criteria. Kaiser acknowledges that during at least some portions of the time period covered by **EBSA**'s investigations it lacked sufficient

systems and processes for adequate monitoring of **Behavioral Health** policies and practices implemented by the **Medical Groups** and external contracted **Providers** such that **Providers** may have been permitted to rely on **BHI** scores from patient responses to questionnaires at intake and/or prior to each outpatient therapy visit to determine level of care and treatment progress.

(12) Kaiser acknowledges that it has obligations related to its provision of **Behavioral Health** and **M/S** services under **ERISA** and applicable state laws and regulations.

(13) Beginning before the **DMHC Settlement**, Kaiser contends that it began a program of transformational change to address these deficiencies. Kaiser shall have the opportunity to show the **DOL** that transformational change consistent with this Settlement Agreement has taken place both before and during the **Monitoring Period** that this Settlement Agreement requires.

NOW THEREFORE, the Parties agree as follows:

III. KAISER COMMITMENTS

The Secretary acknowledges that Kaiser has agreed to take corrective action to help ensure **enrollees** receive timely access to medically necessary **Behavioral Health** services and to change Kaiser's **Behavioral Health** delivery system to improve Kaiser's **Enrollees**' experiences and treatment outcomes in connection with the **DMHC Settlement**.[1] The Secretary contends that the **DOL** has primary enforcement jurisdiction over **MHPAEA**. Even though the **DOL** is not subject to the jurisdiction of the State of California and is not bound by the **DMHC Settlement**, the **DOL** agrees that Kaiser may utilize its commitments under the **DMHC Settlement** to satisfy Kaiser's obligations under Section III of this Settlement Agreement where such actions meet the Secretary's requirements, so long as the terms of this Settlement Agreement are met in full. Kaiser's commitments in this Settlement Agreement include the following:

1. Kaiser shall implement (or has already implemented) processes to ensure that all level-of-care and duration-of-care decisions regarding **MH/SUD** services are made by the treating **MH/SUD** clinician according to generally-accepted standards of medical care and consistent with the applicable **EOC**, **SPD** and applicable law. If Kaiser uses a number of outpatient sessions, appointments, or episodes to trigger a care review, that number and the review process shall be disclosed in the **EOC/SPD** if Kaiser does not satisfy the commitments in Sections III.2 and III.3.

[1] DMHC Settlement ¶ 100 (Oct. 11, 2023), https://wpso.dmhc.ca.gov/enfactions/dlocs/4367/1697136977902.pdf.

2. Kaiser shall not require or permit its **Network Providers** to use **BHI** scores as the sole determinant of the appropriate level or duration of care and shall not permit **BHI** scores to be used in a manner that is inconsistent with generally accepted standards of care.

3. Kaiser shall exercise reasonable oversight to ensure that, in connection with **Behavioral Health** outpatient programs, the **Providers** in Kaiser's **Network** do not impose care review/case review/case consultations after a pre-set number of sessions/appointments/treatment episodes that could reasonably result in the graduation from care/cessation of individual psychotherapy, unless such review and/or consultations, and the number of appointments triggering such review, are clearly identified in **EOCs** and **SPDs**, and are performed in parity as required by **MHPAEA**. If the review is being conducted solely to determine whether the patient needs to be elevated to a higher level of care, the requirements of the preceding sentence shall not apply, except that the review/consultation must still comply with the requirements of **MHPAEA**.

4. Kaiser shall implement (or already has implemented) processes to ensure that, under the terms of the coverage as written and in operation, all processes, strategies, evidentiary standards, or other factors used in the application of the **NQTLs** relating to **MH/SUD** benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in the application of the **NQTLs** to **M/S** benefits in the same benefits classification.

5. Kaiser shall exercise continuous and effective oversight to identify and address issues preventing or hindering enrollees from accessing **In-Network Behavioral Health** care, including those identified during its quarterly evaluations, described below in Section IV. Kaiser commits to the following activities as part of its oversight responsibilities:

   a. Kaiser shall create metrics and performance standards that are established and routinely monitored by Kaiser and documented to identify all issues preventing or hindering **Enrollees** from accessing **In-Network Behavioral Health** care;

   b. Kaiser shall take affirmative steps reasonably designed to address all identified issues preventing or hindering **In-Network Behavioral Health** care access;

c. Kaiser shall allocate the resources necessary to comply fully with each of the commitments set forth in this Settlement Agreement;

d. Kaiser shall reasonably define and document all steps taken to address identified issues preventing or hindering **In-Network Behavioral Health** care access; and

e. Kaiser shall use the same metrics and performance standards specified in subparagraph (a) to assess the effectiveness of steps to address issues preventing or hindering **In-Network Behavioral Health** access.

6. Kaiser shall make reasonable efforts to ensure that it maintains an adequate **Network** of MH/SUD Providers in parity with its network of M/S providers, including the recruitment of and/or contracting with new **Behavioral Health Providers** as necessary.

7. Kaiser shall implement (or already has implemented) processes to ensure that telehealth **Behavioral Health** services are provided consistent with generally-accepted standards of medical care.

8. Kaiser shall review and update its provider directories in accordance with the relevant requirements under state and federal law, but in any event no less frequently than every 90 days. Such processes shall include, but are not limited to, ensuring that the provider directories identify contracted **Providers** consistent with applicable law and regulatory requirements and that information in the directories is updated and revised, as necessary, upon receipt of information and confirmation by Kaiser that any information in the provider directories is inaccurate or incomplete.

9. Kaiser shall develop a process to ensure that intake appointments are not assigned to an **MH/SUD Clinician** when accepting new patients would prevent the **Clinician** from providing follow up appointments to their existing patients within legal timeframes.

10. Kaiser shall develop processes to review non-treating physician approval of inpatient care requests by its **Clinicians** for parity and shall bring the **MH/SUD** process in parity with the **M/S** process per the requirements of **MHPAEA**.

IV. QUARTERLY EVALUATIONS

1. Kaiser will provide annual reports to the Secretary for two (2) years following the Effective Date of this **Settlement Agreement**, based on measurements

and data elements set forth in Attachment A, comparing the adequacy of its **M/S Network** to its **MH/SUD Network**, on the following data points, in addition to any other data elements Kaiser uses to assess the adequacy of its **Network**:

a. Wait times for **Behavioral Health** appointments for new and existing patients and wait times for **M/S** appointments for new and existing patients;

b. Time and distance measurements for **MH/SUD** services and **M/S** services;

c. provider to **enrollee** ratios for **MH/SUD** and **M/S Providers**;

d. Bed availability for **MH/SUD** and **M/S** inpatient services using the underlying data reported from available sources including Inpatient Psychiatry and Integrated Urgent Services;

e. **enrollee** complaints; and

f. provider feedback.

Kaiser is solely responsible for ensuring that it has fulfilled its obligations under **MHPAEA**, including gathering information needed to assess compliance in operation for any **NQTLs** related to **Network** composition and **Network** adequacy, and identifying and resolving issues with **Network** access. However, within a reasonable time, but no longer than 90 days after the Effective Date of this Settlement Agreement, Kaiser shall provide to **EBSA** a detailed description of data elements, information and standards used for identifying specific **Network** adequacy issues/deficiencies using the data listed above. The Secretary shall have the opportunity to provide feedback and object. Such communications between **EBSA** and Kaiser shall not alter Kaiser's ultimate responsibilities.

2. For two (2) years following the Effective Date of this Settlement Agreement, Kaiser shall prepare quarterly reports identifying issues/deficiencies, if any, that need to be addressed to bring Kaiser's provision of **MH/SUD** services into parity, along with a description of planned actions Kaiser will take to do so. All reports after the initial report shall analyze the effectiveness of the actions taken to achieve parity.

3. For two (2) years following the Effective Date of this Settlement Agreement, Kaiser shall prepare the quarterly reports as described within this document and shall provide copies of the report to the **Secretary's Designee** within 30 days after the end of each quarter. The Secretary shall have the opportunity to object, provide feedback and/or request underlying documentation and data. Any reporting conducted under the **DMHC Settlement** may be used to satisfy Kaiser's reporting obligations under this Settlement Agreement, so long as the terms of this Settlement Agreement are met in full.

4. Kaiser shall timely designate a representative who will be available to respond to inquiries by **EBSA** about the reports, though inquiries regarding the quarterly reports shall be directed to Kaiser's counsel.

V. PAYMENT

To resolve the Secretary's allegations for violations of **ERISA** section 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D), Kaiser shall pay, from July 30, 2025 through the end of the **Monitoring Period**, a minimum of $28,323,219 to **Reimburse Enrollees** for eligible **Out-of-Network** services.

VI. 502(*l*) PENALTY

The Secretary, pursuant to **ERISA** section 502(*l*), 29 U.S.C. § 1132(*l*), is required to assess a penalty of 20% of the applicable recovery amount recovered for a breach of fiduciary duty. The Secretary hereby issues an assessment under ERISA section 502(*l*), of $5,664,643.80 to Kaiser, and agrees to accept a compromise of $2,832,321.90 (10% of the applicable recovery amount) as full satisfaction of that assessment. Kaiser waives the notice of assessment and service requirements of 29 C.F.R. § 2570.83. Kaiser waives any rights it may have to challenge, contest, appeal, or pursue any process or action to challenge or set aside the penalty as well as any right it may claim to seek any further reductions in the penalty.

Within five business days of the Effective Date of this Settlement Agreement Kaiser shall pay $2,832,321.90 to the **DOL** online by ACH transfer, credit card, debit card, or digital wallet by going to https://www.pay.gov/public/form/start/1063197296 or by going to www.pay.gov and searching Debt Collection EBSA-ERISA Civil Penalty. Kaiser shall use **EBSA** Case Number 72-038093 when prompted.

VII. REIMBURSEMENT OF ENROLLEES WHO OBTAINED OUT-OF-NETWORK CARE

1. In accordance with the provisions of this Section, Kaiser shall: (i) develop a process, to be approved by the Secretary, for identifying Enrollees who

attempted, but were unable, to obtain timely and/or clinically appropriate **Behavioral Health** care services **In-Network** and, who, as a result of such inability, self-referred to an **Out-of-Network Provider**; and (ii) **Reimburse** such **Enrollees** for qualifying out-of-pocket payments to such **Out-of-Network Providers** to the extent such payments exceed what the enrollees would have incurred had they received the care In-Network. The presumptions described in Attachment D shall apply to this Section.

2. Kaiser may utilize the same process and procedures it develops to comply with the **DMHC Settlement** to fulfill its reimbursement obligations under this Settlement Agreement, where such processes and procedures meet the Secretary's requirements, so long as the terms of this Settlement Agreement are met in full.

3. To comply with its reimbursement obligations as set forth above, Kaiser shall utilize the two-step process set forth below. Kaiser shall ensure that each phase of the process includes a robust system to ensure timely responses to **Enrollees'** inquiries relating to the reimbursement process. This robust system shall include a dedicated phone line staffed during regular business hours, a dedicated email inbox, and additional means to communicate to be determined by Kaiser and the Secretary. Kaiser shall implement processes to ensure communications with **Enrollees** be made in a culturally and linguistically appropriate manner calculated to be understood by the average **Enrollee**.

4. For **Enrollees** who received notice commencing on July 30, 2025, Kaiser shall provide the **Secretary's Designee** with the methodology and deidentified data (with claims identification numbers where applicable) used to identify the **enrollees** identified in Section VII. 5.a.i.-v within 30 days of the **Effective Date**. The Secretary shall have the opportunity to provide feedback, object, and/or request underlying documentation and data. Upon resolution of objections, Kaiser shall provide the **Secretary's Designee** with a final list showing the number of **Enrollees** by category, with indications where the same enrollees are included in more than one category. For **Enrollees** who will receive notice in the second batch, Kaiser shall use the same agreed-upon methodology and will provide the deidentified data to the **Secretary's Designee** no later than 30 days before the second batch of notices will be sent.

5. **Phase 1**. Kaiser shall notify the **Enrollees** (identified below) that if, from January 1, 2021 to September 30, 2024, they attempted, but were unable, to obtain geographically appropriate, timely, and/or clinically appropriate

Behavioral Health care services **In-Network** and then, as a result of such inability, self-referred to an **Out-of-Network Provider**, they may be eligible for reimbursement for out-of-pocket payments they made to the **Out-of-Network Providers** to the extent such payments exceed what they would have incurred had they received the care **In-Network**, and that they are invited to submit a claim for consideration.

a. If it has not already done so, Kaiser shall provide the notice, in the form attached hereto as Attachment B, within 30 days of execution of this Settlement Agreement. Kaiser may send notice in two batches, the first of which shall be sent no later than 30 days after the **Effective Date** of this Settlement Agreement, if Kaiser has not already sent that first batch of notices. If Kaiser chooses to send notice in two batches, then the first batch shall include notices for **Enrollees** with potential claims from January 1, 2021, through December 31, 2023. The second batch shall include notices for **Enrollees** with potential claims after December 31, 2023, and shall be disseminated no later than six months after the first batch. The notice(s) shall be sent to the following categories of **Enrollees**:

   i. **Group A**: **Enrollees** who filed an appeal or grievance related to inability to obtain an **In-Network Behavioral Health** treatment from January 1, 2021, to the date Kaiser sends enrollees notice of the process to go **Out-of-Network** outlined in Section VIII.2.a-c;

   ii. **Group B**: **Enrollees** who submitted claims for reimbursement for **Out-of-Network Behavioral Health** services from January 1, 2021, to the date Kaiser sends enrollees notice of the process to go **Out-of-Network** outlined in Section VIII.2.a-c. but whose claims were denied based on the application of the denial codes identified in Attachment C in connection with the failure to obtain such care **In-Network**;

   iii. **Group C**: **Enrollees** who had an intake appointment with **an In-Network Provider** for **Behavioral Health** treatment but did not within the 3 months following the intake appointment have an **In-Network** follow-up appointment with an **In-Network Provider**;

   iv. **Group D**: **Enrollees** who had an intake appointment with **an In-Network Provider for Behavioral Health** treatment and had exactly four additional follow-up appointments with an **In-Network Provider**; and

v. **Group E**: **Enrollees** who conducted an E-visit on kp.org and were prompted to use self-help or educational resources and not presented with contact information to schedule an appointment, and, within the following 3 months, did not have an appointment with an **In-Network Provider**.

b. The notice shall meet the following requirements:

i. It shall be written and presented in a culturally and linguistically appropriate manner reasonably calculated to be understood by the average **enrollee**;

ii. It shall be presented in widely available formats that are suitable to be read online;

iii. The notice shall be electronically searchable by numbers, letters, or words in a format that is printable by an **enrollee**;

iv. The notice shall indicate that interpretation services are available, if needed;

v. The notice shall contain instructions for electronic and mail submission. The electronic submission option shall be electronically fillable and provide the ability to upload attachments; and

vi. Where applicable, the notice shall be consistent with electronic notices regulations 29 CFR § 2520.104b-1 and 29 CFR § 2520.104b-31.

6. **Phase 2**. In this phase, based on the information collected in Phase 1, Kaiser shall identify claims eligible for reimbursement and shall **Reimburse** pursuant to the criteria identified in Attachment D.

7. Kaiser shall not seek direct or indirect reimbursement from an **ERISA**-covered plan, plan sponsor, or **Enrollee** for any payments made pursuant to this Section. (Such payments, however, shall be subject to the **Enrollee**'s or a plan sponsor's financial responsibilities under the applicable plan, such as (a) maximum annual and lifetime benefits, if not prohibited by applicable law; (b) copayments and coinsurance; (c) deductibles; and (d) out-of-pocket maximums.)

VIII. OUT OF NETWORK ACCESS FOR ENROLLEES

1. Kaiser shall provide, and publicize to **Enrollees** the process for arranging for **Behavioral Health** inpatient and outpatient care for **Enrollees** with **Out-of-Network Providers** when **In-Network Providers** are not available, consistent with the requirements of **ERISA** and **MHPAEA**.

2. Publication of the Disclosures/ Notices

    a. The process for participants to obtain Out-of-Network access shall be publicized as required by law.

    b. Information about reimbursement for Groups A-E, including the FAQs and the dedicated phone number for assistance, referenced in Attachment B, shall be publicized as an "alert" in the "Important Notices" section of KP.org beginning with the date Kaiser begins issuing the notices required in Section VII.5, above, through the due date for claims set forth on the last notice Kaiser sends (Attachment B).

    c. Where applicable, the notice shall be consistent with electronic notices regulations 29 CFR § 2520.104b-1 and 29 CFR § 2520.104b-31.

3. Kaiser shall implement (or have implemented) processes to ensure that the treatment provided is consistent with generally accepted standards of medical care.

IX. PROOF OF CORRECTIVE ACTION

1. Proof of Changes to Policies, Practices & Notices

    a. Within 90 days of the **Effective Date** of this Settlement Agreement, Kaiser shall revise its policies, guidelines, and documented practices consistent with the material terms of this Settlement Agreement and where consistent with this Settlement Agreement, the **DMHC Settlement Agreement**.

        i. Within 90 days of execution of this Settlement Agreement and prior to implementation, Kaiser shall provide to the **Secretary's Designee** copies of its revised policies, guidelines, practices, and notices to participants required by this Settlement Agreement. The Secretary shall have 60 days to object to any language in the above referenced revised documents. If Kaiser believes that the Secretary's objections conflict with any directive of the **DMHC**, Kaiser shall provide the Secretary with the documents and communications evidencing such

conflicts, which the Secretary shall consider. The Secretary and Kaiser agree to work together in good faith to address any such conflicts. Within 7 days of resolution of objections, Kaiser shall provide the Secretary with final copies of the revised documents. This language shall have no effect on the Secretary's statutory right to investigate.

ii. After the conclusion of the two year reporting period identified above, within 30 days of a request by the Secretary, Kaiser shall provide the Secretary with a comparative analysis for the **NQTLs** addressed in this Settlement Agreement reflecting the comparative adequacy and accuracy of its **M/S** and **MH/SUD Networks**.

2. Proof of Adjudication and Corresponding Payments

a. Within 45 days after the end of each quarter, Kaiser shall provide written proof of adjudication and corresponding payments made during the quarter to the Secretary in care of the **Secretary's Designees**. Proof shall consist of the following multi-part process:

b. Kaiser shall provide:

i. A claims data spreadsheet with the fields listed in the attached sample template (see Attachment E-1); and

ii. An attestation by a corporate officer under penalty of perjury or criminal warning regarding the veracity of the information in process for the final reporting and confirmation of the spreadsheet (see Attachment template);

c. The Secretary shall have the option to obtain upon request copies of **EOBs** issued to **Enrollees** who submitted claims pursuant to Section VII and a selection of claims files for the claims that have been reimbursed under Section VII. The size of the selection and methodology of making the selection shall be at the discretion of the Secretary, but the Secretary shall take into consideration the burden on Kaiser when exercising its discretion. The Secretary shall also have the option to send a request for the following corresponding information:

i. Written proof of receipt of payment, such as canceled checks, wire confirmations, check registers, or other proof of payment documents that clearly show the payments were received by the intended recipients; and

ii. If the claims payments were part of bulk payments, the provider remittance advices or other documents that tie the claims to the bulk payments.

X. ERISA COMPLIANCE & RELEASE

1. Nothing in this Settlement Agreement is intended to modify or waive Kaiser's obligations to perform and document its comparative analyses of **NQTLs** as required by **ERISA** section 712(a)(8), and to otherwise comply with **MHPAEA**. If the Secretary, the Department of Health and Human Services, or the Department of the Treasury adopt any new rule, regulation, policy or order, or any applicable ERISA statute or regulation is amended or adopted, which obviates any of this Settlement Agreement's obligations or requirements, then such law, rule, regulation, policy or order shall take precedence over the requirements of this Settlement Agreement.

2. Nothing in this Settlement Agreement is intended to relieve Kaiser from compliance with the requirements of **ERISA**, as amended, 29 U.S.C. § 1001, *et seq*., or to limit **EBSA**'s right to investigate Kaiser's compliance with such requirements.

3. Release:

   a. By the Secretary. Except as necessary to enforce the rights and obligations in this Settlement Agreement, upon the execution of this Settlement Agreement **EBSA** and its agents, attorneys, representatives, assigns, predecessors and successors-in-interest, acting in their official capacities, will hereby release, waive, and forever discharge any and all claims, demands, actions, causes of action, liabilities in connection with investigations 72-038093(50), 70-018268(50), and 70-018071(50), January 1, 2020 through the **Effective Date** of this Settlement Agreement (as described in the Recitals section of this Settlement Agreement) (the "Released Claims"). **EBSA** shall not issue an initial determination letter or final determination letter under the 712(a)(8) statutory process or issue a findings letter for investigations 72-038093(50), 70-018268(50), and 70-018071(50). Subject to the foregoing release, nothing in this Settlement Agreement shall preclude any action to enforce the terms of this Settlement Agreement or preclude **EBSA** from continuing investigations other than the ones explicitly referenced in this paragraph, initiating new investigations, or initiating enforcement actions.

b. By Kaiser. Except as necessary to enforce the rights and obligations in this Settlement Agreement, upon the execution of this Settlement Agreement Kaiser will release, waive, and forever discharge any and all claims, demands, causes of action, liabilities, penalties, and fines, including those claims arising under the Equal Access to Justice Act or any other statute, rule, or regulation, that Kaiser may have against **EBSA** and its agents, attorneys, representatives, assigns, predecessors and successors-in-interest ("EBSA Releasees") in connection with investigations 72-038093(50), 70-018268(50), and 70-018071(50), January 1, 2020 through the **Effective Date** of this Settlement Agreement. Kaiser agrees not to institute, maintain, or prosecute any action or legal proceeding against the EBSA Releasees relating to the named investigations, or the settlement that is the subject of this Settlement Agreement. Nothing herein shall preclude any action to enforce the terms of this Settlement Agreement.

c. Nothing in this Settlement Agreement is binding on any governmental agency other than **EBSA**, and any successor agencies in the event **EBSA** is restructured in the future. With respect to the **DOL** , nothing in this Settlement Agreement shall preclude the Secretary from: (a) filing any amicus briefs in any case; (b) asserting any claim or filing any documents in any bankruptcy case; (c) assessing and collecting any mandatory civil penalty against Kaiser pursuant to **ERISA** section 502(l), 29 U.S.C. § 1132(l) as set forth in Section VI above, or in any case not listed in subsection a. of this release; (d) assessing and collecting any penalty under **ERISA** section 502(c)(2), 29 U.S.C. § 1132(c)(2), through administrative and judicial proceedings for any case not listed in Section a. of this release; (e) seeking immediate or *ex parte* injunctive relief in connection with Kaiser, if deemed necessary by the Secretary, in her sole discretion; or (f) instituting any criminal proceeding.

XI. OTHER PROVISIONS

1. Headings. The headings contained in this Settlement Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Settlement Agreement.

2. Entire Agreement. This Settlement Agreement constitutes the entire agreement between the Parties and supersedes any prior agreement or understanding, whether oral or in writing, regarding the subject of this Settlement Agreement. This Settlement Agreement may not be amended or modified except by a writing signed by all Parties.

3. Waiver. No relaxation, forbearance, delay, or indulgence by a Party in enforcing its rights hereunder or the granting of time by such Party shall prejudice or affect its rights hereunder. A provision of this Settlement Agreement may be waived only by an instrument in writing executed by the waiving Party and specifically waiving such provision. The waiver of any provision of this Settlement Agreement by any Party shall not be deemed to be construed as a continuing waiver or a waiver of any other provision of this Settlement Agreement.

4. Authority. The undersigned representatives each expressly acknowledge and represent that they are authorized and empowered to execute this Settlement Agreement on behalf of the Parties represented.

5. Counterparts. This Settlement Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. An executed copy of this Settlement Agreement delivered by email shall be deemed to be as effective as an original signed copy.

FOR THE SECRETARY OF THE
UNITED STATES DEPARTMENT OF LABOR,
EMPLOYEE BENEFITS SECURITY ADMINISTRATION

_____ Dated: January 30, 2026
Marc A. Pilotin
Regional Solicitor of Labor

FOR KAISER FOUNDATION HEALTH PLAN, INC.

DocuSigned by:
kathy lancaster
_____ Dated: 2/6/2026 | 11:58 AM PST
6078ED2851D2485...
[Printed Name] Kathy Lancaster
[Position] CFO

Attachment A Compliance Reporting Addendum
Attachment B Short & Long Notice
Attachment C Denial Codes
Attachment D Adjudication Process & Criteria
Attachment E Template Attestation
Attachment E(1) Template Corrected Claims Spreadsheet

Attachment A
Compliance Reporting Addendum

Data to be Produced

I. Wait Times for New & Existing Patients – Outpatient

Outpatient Initial Wait Times

- **M/S:**
  - Primary Care Appointments
    - Kaiser will report quarterly, or on the frequency provided to the DMHC, by county and/or medical center, for medical group providers, the percentage of appointments within 10 business days, with a threshold of 80%.
  - Specialty Care Appointments
    - Kaiser will report quarterly, or on the frequency provided to the DMHC, by county and/or medical center, for medical group providers, the percentage of appointments within 15 business days, with a threshold of 80%.
    - Specialty Care includes: (a) allergy, (b) cardiology, (c) dermatology, (d) endocrinology, (e) gastroenterology, (f) gynecology, (g) head and neck surgery, (h) neurology, (i) ophthalmology, (j) orthopedics, (k) physical medicine, (*l*) surgery, and (m) urology.
- **M/H / SUD:**
  - Prescriber Appointments (e.g., MD, DO)
    - Kaiser will report quarterly, or on the frequency provided to the DMHC, by county and/or medical center, for medical group providers, the percentage of appointments within 10 business days, with a threshold of 80%.
  - Non-Prescriber Appointments
    - Kaiser will report quarterly, or on the frequency provided to the DMHC, by county and/or medical center, for medical group providers, the percentage of appointments within 10 business days, with a threshold of 80%.

Outpatient Follow-Up Wait Times

Kaiser will provide the PAAS Survey report on wait times for outpatient follow-up appointments for both M/S and MH/SUD based on the then-current reporting obligations to the DMHC presently as follows:

- **M/S**
  - Primary Care Appointments
    - Kaiser will report and will measure provider responses against appointment time standards.

- Specialty Care Appointments
  - Kaiser will report and will measure provider responses against appointment time standards.

- **M/H / SUD:**
  - Non-Prescriber Appointments
    - Kaiser will report and will measure provider responses against appointment time standards.
  - Prescriber Appointments
    - Kaiser will report and will measure provider responses against appointment time standards.

II. Time & Distance Measurements and Provider-to-Member Ratios – Outpatient & Inpatient

GeoAccess / Member-to-Provider Ratio

Kaiser will report based on the geographic distance and provider ratio requirements adopted by the DMHC. For purposes of this reporting, Kaiser will provide data regarding distance by county. Kaiser will also provide its NCQA reporting regarding GeoAccess.

- **M/S:**
  - Primary Care Appointments
    - Kaiser will report annually, for primary care providers, whether members live within a specified distance or minutes of Primary Care location, as well as the member to provider ratio.
    - Kaiser's standards will align with existing NCQA standards as well as with DMHC regulations and guidelines.
  - Specialty Care Appointments
    - Kaiser will report annually, for specialty care providers, whether members live within a specified distance or minutes of specialty care location, as well as the member to provider ratio.
    - Kaiser's standards will align with existing NCQA standards as well as with DMHC regulations and guidelines.
  - Hospitals
    - Kaiser will report annually, for hospitals, whether members live within a specified distance or minutes of hospital location.
    - Kaiser's standards will align with existing NCQA standards as well as with DMHC regulations and guidelines.
- **MH / SUD:**
  - Mental Health Providers

- Kaiser will report annually, for mental health providers, whether members live within a specified distance or minutes of provider location, as well as the member to provider ratio.
- Kaiser's standards will align with existing NCQA standards as well as with DMHC regulations and guidelines.

o Hospitals

- Kaiser will report annually, for hospitals, whether members live within a specified distance or minutes of hospital location.
- Kaiser's standards will align with existing NCQA standards as well as with DMHC regulations and guidelines.

III. Provider Feedback

Kaiser will report and summarize provider feedback concerning participant access to services on an annual basis. Kaiser will report results of annual provider survey rating the following access areas: (a) urgent care, (b) non-urgent primary care, (c) non-urgent specialty services, (d) non-urgent ancillary diagnostic and treatment services, (e) access to the referral and/or prior authorization process, with the responses being (1) very dissatisfied, (2) dissatisfied, (3) neither dissatisfied or satisfied, (4) satisfied, and (5) very satisfied.

IV. Participant and Beneficiary Complaints

Kaiser will report quarterly (or on the cadence reported to the DMHC) and provide data and analysis for member complaints concerning access to services, including cases resolved through the Kaiser's Complaint, Grievance, and Appeal procedures, as well as complaints identified in survey responses annually or on its regular cadence, whichever is more frequent. Kaiser will also provide the CAHPS Survey response on its regular cadence.

Kaiser monitors access concerns carefully and thoroughly as part of its comprehensive efforts, as described below:

Northern California

The NCAL Member Concern Committee ("NCAL MCC") submits a quarterly "Northern California Complaints and Grievances Report" to the NCAL Quality Oversight Committee. The report identifies the total number of cases, and identifies any trends from the prior year. With respect to access issues, the report differentiates between "Appointments" cases and "Referral" cases.

In addition, the NCAL MCC annually reviews and analyzes appeal overturn information, which includes analysis of the rate of appeal overturns involving access issues. The MCC also annually analyzes grievance data to identify possible network adequacy issues pursuant to NCQA standards and reports on the results of the annual CAHPS Survey, which includes measures on member satisfaction with respect to access.

Southern California

The SCAL Member Concerns Committee ("SCAL MCC") oversees issues regarding member complaints concerning access in a variety of ways, including the following:

- Prepare the "SCAL Complaint, Grievance, Appeal & OMR Report," which is a quarterly report that provides data and analysis regarding the volume and rates of complaints, grievances, appeals, and outside medical reviews on a quarterly basis.

- Report annually insights and updates on complaints, grievances, and appeals for particular medical center services areas, identifying both successes and opportunities across the spectrum of issues.

- Monitors and reports quarterly on the timeliness of processing complaints, grievances, and appeals—including complaints concerning access.

- Prepares an annual hospital complaints and grievances report, which is reviewed by the SCQC.

- Report annually on the Behavioral Health Member Experience Survey, which is administered to meet NCQA standard ME7.

- Analyzes and reports annually on the CAHPS survey, which is administered to meet NCQA standard ME7.

In addition to the work of the SCAL MCC, the Plan also receives annual reports from clinical consultants analyzing regional and statewide complaint activity. The Regional Access Committee further reviews the Plan's annual assessment of network adequacy pursuant to NCQA standards, and reports its findings. The Plan also conducts surveys periodically relating to member experience and satisfaction. The CAHPS Survey, in particular includes survey questions addressing participant access. The methodology for the CAHPS Survey is described in the survey reports.

Attachment B
Short Form Notice

[Date of Notice Here]

This message is not an advertisement or solicitation from a lawyer.

Notice ID:
Confirmation Code:

NOTICE

You may qualify for reimbursement if you went out-of-network and paid for certain services.

Kaiser Permanente has implemented a process to review claims and determine eligibility for reimbursement.

WHO MAY BE ELIGIBLE?

- You are or were a Kaiser Permanente member;
- While you were a Kaiser Permanente member you paid for certain out-of-network care because you attempted but could not access such care in-network; and
- You received out-of-network care after January 1, 2021.
- Note that not all out-of-network services are eligible for reimbursement. Reimbursement is limited to only certain types of services.

WHAT DO I NEED TO DO IF I WANT TO SEEK REIMBURSEMENT?

- Visit **www.OutofNetworkHealthClaims.com** and submit your claim within 180 days from the date of this notice and provide necessary information.

HOW CAN I GET HELP OR FIND MORE INFORMATION?

You can visit **www.OutofNetworkHealthClaims.com** to learn more and access the FAQs or call 1-877-684-4129 for assistance.

Scan to see Notice
Escanee para ver el Aviso
扫描查看通知
Quét để xem Thông báo

ATTENTION. Language assistance is available at no cost to you. You can ask for interpreter services, including sign language interpreters. You can ask for materials translated into your language or alternative formats, such as braille, audio, or large print. You can also request auxiliary aids and devices. Call 1-877-684-4129 and press the number 1.

انتبه. تتوفر خدمات المساعدة اللغوية دون أي تكلفة عليك. ويمكنك طلب خدمات الترجمة الفورية، بما في ذلك الترجمة الفورية بلغة الإشارة. كما يمكنك طلب ترجمة المواد إلى لغتك أو طلبها بتنسيقات بديلة، مثل طريقة برايل أو التسجيلات الصوتية أو المطبوعات بأحرف كبيرة. ويمكنك طلب أدوات وأجهزة مساعدة إضافية. اتصل على الرقم 1-877-684-4129، واضغط على الرقم 3، واذكر اللغة التي ترغب أن تتحدث بها إلى الموظف.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Ձեզ հասանելի է անվճար լեզվական օգնություն: Դուք կարող եք խնդրել բանավոր թարգմանչի ծառայություններ, այդ թվում՝ ժեստերի լեզվի թարգմանիչներ: Կարող եք խնդրել ձեր լեզվով թարգմանված նյութեր կամ այլընտրանքային ձևաչափերով, ինչպիսիք են՝ Բրայլի գրերը, աուդիոն կամ խոշոր տառերով տպագրվածները: Կարող եք նաև պատվիրել օժանդակ սարքեր և պարագաներ: Զանգահարեք 1-877-684-4129 հեռախոսահամարով, սեղմեք 3 թիվը և ներկայացուցչին ասեք ձեր նախընտրած լեզուն:

注意。 您可以免费获得语言帮助。 **您可以要求**获得口译服务，包括手语翻译。 **您可以要求将**资料翻译成您的语言或以其他格式提供，如盲文、音频或大字体印刷。 **您**还可以要求获得辅助工具和设备。 请拨打 1-877-684-4129，**按 3 号**键，并向接线员说明您偏好的语言。

.توجه. خدمات پشتیبانی زبانی به‌صورت رایگان در اختیار شما قرار دارد. می‌توانید درخواست خدمات ترجمه، از جمله مترجم زبان اشاره، بدهید می‌توانید درخواست کنید که مطالب به زبان شما ترجمه شوند یا در قالب‌های جایگزین مانند بریل، صوتی یا چاپ درشت ارائه شوند. همچنین می‌توانید درخواست ابزار و وسایل کمکی بدهید. با شماره 1-877-684-4129 تماس بگیرید، عدد 3 را فشار دهید و زبان مورد نظر خود را به اپراتور اعلام کنید.

ध्यान दें। आपके लिए भाषा सहायता बिना किसी लागत के उपलब्ध है। आप दुभाषिया सेवाओं का अनुरोध कर सकते हैं, जिसमें सांकेतिक भाषा दुभाषिए भी शामिल हैं। आप अपनी भाषा में अनूदित सामग्री या वैकल्पिक प्रारूपों, जैसे ब्रेल, ऑडियो, या बड़े अक्षरों में छपी सामग्री के लिए पूछ सकते हैं। आप सहायक उपकरण और सहायक सामग्री का भी अनुरोध कर सकते हैं। 1-877-684-4129 पर कॉल करें, नंबर 3 दबाएं, और एजेंट को अपनी पसंदीदा भाषा बताएं।

CEEB TOOM. Muaj kev pab cuam txhais lus pub dawb rau koj. Koj thov tau kom txais kev pab txhais lus, suav nrog cov kws txawj piav tes. Koj thov tau kom txais ntaub ntawv uas muab txhais ua koj yam lus los yog lwm hom, xws li cov ntawv rau neeg dig muag nyeem, cov suab kaw, los sis cov tsiaj ntawv loj. Koj kuj thov tau kom txais cov tshuab pab mloog lus. Hu mus rau 1-877-684-4129, nias naj npawb 3, thiab qhia koj yam lus rau tus uas teb xov tooj.

LONGC HNYOUV JANGX LONGX OC. Mbenc duqv maaih porv waac bun muangx mv zuqc ndortv nyaanh cingv. Se gorngv meih qiemx zuqc longc porv waac nyei mienh nor mborqv finx lorz oc, corc maaih porv waac nyei mienh longc buoz wuv faan waac bun mangc. Meih corc haih tov longc naaiv deix nyungc horngh sou porv cuotv benx meih nyei waac bun longc a'fai fiev benx da'nyeic nyungc sou-guv, beiv gorngv fiev nzangc pokc bun hluo, bungx waac-qiex bun muangx, a'fai aamx bieqc domh zeiv. Meih corc haih tov taux tengx jaa-dorngx aengx caux gong-bou jauv-louc. Mborqv finx,lorz 1-877-684-4129, zatv bieqc nam mber 3, aengx caux mbuox ninh mbuo gorn zangc hiuv meih oix gorngv benx haaix nyungc waac.

ご案内 通訳・翻訳サービスが無料で受けられます。 手話通訳を含め、通訳サービスを利用することができます。 普段お使いの言語への資料の翻訳や、点字、音声、大きな活字など、別の形式での提供を要望可能です。 また、視聴覚を補助する器具や機器も要望できます。 1-877-684-4129**に電話し、電話機の「3」を押した後、お望みの言語を代理人に伝えてください。**

ចំណាំ៖ មានផ្តល់ជូនជំនួយភាសាដោយមិនគិតថ្លៃសម្រាប់អ្នក។ អ្នកអាចស្នើសុំសេវាបកប្រែផ្ទាល់មាត់ រួមទាំងអ្នកបកប្រែភាសាសញ្ញាបានផងដែរ។ អ្នកអាចស្នើសុំគេបកប្រែឯកសារជាភាសារបស់អ្នក ឬទម្រង់ផ្សេងទៀតបាន ដូចជាអក្សរស្ទាប សំឡេង ឬអក្សរពុម្ពធំៗ។ អ្នកក៏អាចស្នើសុំជំនួយអមនិងឧបករណ៍បានផងដែរ។ ហៅទូរសព្ទទៅលេខ 1-877-684-4129 ចុចលេខ 3 ហើយបញ្ជាក់ភាសាដែលអ្នកចង់បានទៅកាន់ភ្នាក់ងារ។

참고. 언어 지원은 무료로 제공됩니다. 수화 통역사를 포함하여, 통역 서비스를 신청할 수 있습니다. 귀하의 언어로 번역된 자료나 점자, 음성녹음, 큰활자본 등 대체 형식을 요청할 수 있습니다. 보조기구 및 기기를 요청할 수도 있습니다. 1-877-684-4129로 전화해서 3번을 누르고 나서, 상담원에게 귀하가 원하시는 언어를 알려주세요.

ໝາຍເຫດ. ມີການຊ່ວຍເຫຼືອດ້ານພາສາທີ່ທ່ານບໍ່ຈຳເປັນຕ້ອງເສຍຄ່າ. ທ່ານສາມາດຮ້ອງຂໍການບໍລິການລ່າມແປພາສາ, ລວມທັ້ງລ່າມແປພາສາມື. ທ່ານສາມາດຮ້ອງຂໍໃຫ້ແປເອກະສານຕ່າງໆ ເປັນພາສາ ຫຼື ຮູບແບບເອກະສານອື່ນໄດ້ ເຊັ່ນ: ເປັນອັກສອນນູນ, ສຽງ ຫຼື ຕົວພິມໃຫຍ່. ນອກຈາກນັ້ນ, ທ່ານສາມາດຮ້ອງຂໍເຄື່ອງຊ່ວຍເຫຼືອ ແລະ ບໍລິການເສີມໄດ້. ໂທຫາ 1-877-684-4129, ກົດໝາຍເລກ 3 ແລະ ແຈ້ງພາສາທີ່ທ່ານຕ້ອງການໃຫ້ພະນັກງານຮັບຊາບ.

NÁÁNÁŁT'ÁÁH. Díí binahji' nihá níłch'ígíí baa hane' dóó áshłééhígíí éí doo biniiyéé' da. T'áá shoodí, nihá níłch'ígíí yaa hane'ígíí bee yáhoot'éél, bikáá' dah naashá (Sign Language) yáhoot'éélígíí t'áá ajiłtsoh. Díí t'áá ajiłtsoh níłch'ígíí bee hane'ígíí nihá bizaad yáhoot'éél dóó t'áá ajiłtsoh t'áá íiyisí ch'iyáánígi índa audio bee, braille bee, dóó nánízhoozhígíí bee áłahgo bídahwiit'aah. T'áá shoodí, nihá bíká anilyeedígíí át'éego bikáá' dah naasháhgo ádoolníił. 1-877-684-4129 béésh bee hane'é, t'áá łá'í yáhooł'aah 3, dóó t'áá nihá bizaad yáhoot'éél nihá naaltsoos yáhoot'éélígíí t'áá iiná.

ਧਿਆਨ ਦਿਓ ਭਾਸ਼ਾ ਸਬੰਧੀ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਸਾਈਨ ਭਾਸ਼ਾ ਲਈ ਦੁਭਾਸ਼ੀਏ ਸਮੇਤ ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਲਈ ਕਹਿ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕੀਤੀ ਸਮੱਗਰੀ ਦੀ ਜਾਂ ਵਿਕਲਪਕ ਫਾਰਮੇਟ ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ, ਆਡੀਓ ਜਾਂ ਵੱਡੇ ਪ੍ਰਿੰਟ ਦੀ ਮੰਗ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਹਾਇਕ ਏਡ ਅਤੇ ਡਿਵਾਇਸਾਂ ਦੀ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। 1-877-684-4129 'ਤੇ ਫੋਨ ਕਰੋ, 3 ਨੰਬਰ ਦਬਾਓ ਅਤੇ ਏਜੰਟ ਨੂੰ ਆਪਣੀ ਤਰਜੀਹੀ ਭਾਸ਼ਾ ਬਾਰੇ ਦੱਸੋ।

ВНИМАНИЕ! Языковая помощь предоставляется вам бесплатно. Вы можете обратиться с запросом о предоставлении услуг переводчика, включая услуги сурдопереводчика. Вы можете обратиться с запросом о переводе материалов на ваш язык или в альтернативных форматах, таких как шрифт Брайля, аудиозапись или крупный шрифт. Вы также можете запросить вспомогательные средства и устройства. Позвоните по номеру 1-877-684-4129, нажмите «3» и сообщите сотруднику ваш предпочтительный язык.

ATENCIÓN. La asistencia de idiomas está disponible sin costo para usted. Puede solicitar servicios de interpretación, incluidos intérpretes de lenguaje de señas. Puede solicitar materiales traducidos a su idioma o en formatos alternativos, como braille, audio o letra grande. También puede solicitar ayudas y dispositivos auxiliares. Llame al 1-877-684-4129 y presione el número 2.

PAUNAWA. Mayroong tulong pangwika na available nang walang bayad para sa inyo. Maaari kayong humingi ng mga serbisyo ng interpreter, kabilang ang mga sign language interpreter. Maaari kayong humingi ng mga materyales na isinalin sa inyong wika o sa mga alternatibong format, tulad ng braille, audio, o malalaking letra. Maaari rin kayong humiling ng mga pantulong na kagamitan at device. Tumawag sa 1-877-684-4129, pindutin ang numerong 3, at sabihin sa agent ang wikang nais ninyo.

โปรดทราบ คุณสามารถขอรับความช่วยเหลือด้านภาษาได้โดยไม่มีค่าใช้จ่ายใดๆ คุณสามารถขอรับบริการล่าม รวมถึงล่ามภาษามือได้ คุณสามารถขอให้แปลเอกสารเป็นภาษาของคุณหรือในรูปแบบอื่น เช่น อักษรเบรลล์ เสียง หรือตัวอักษรขนาดใหญ่ได้ คุณยังสามารถขออุปกรณ์เสริมและความช่วยเหลือเพิ่มเติมได้ด้วย โทร 1-877-684-4129 แล้วกดหมายเลข 3 และแจ้งภาษาที่คุณต้องการให้เจ้าหน้าที่ทราบ

УВАГА. Мовна допомога надається безкоштовно. Ви можете звернутися за послугами перекладача, включаючи сурдоперекладача. Ви можете попросити матеріали, перекладені на вашу мову або в інші формати, такі як шрифт Брайля, аудіо або великий шрифт. Ви також можете попросити допоміжні засоби та пристрої. Зателефонуйте за номером 1-877-684-4129, натисніть цифру 3 і вкажіть оператору бажану мову.

CHÚ Ý. Quý vị được hỗ trợ ngôn ngữ miễn phí. Quý vị có thể yêu cầu dịch vụ phiên dịch, bao gồm cả phiên dịch ngôn ngữ ký hiệu. Quý vị có thể yêu cầu dịch tài liệu sang ngôn ngữ của quý vị hoặc ở các định dạng thay thế, chẳng hạn như chữ nổi Braille, âm thanh hoặc chữ in cỡ lớn. Quý vị cũng có thể yêu cầu các thiết bị và dụng cụ hỗ trợ. Gọi số 1-877-684-4129, nhấn phím số 3, và nói cho nhân viên biết ngôn ngữ mà quý vị muốn sử dụng.

Attachment B
Long Form Notice

This message is not an advertisement or solicitation from a lawyer.

NOTICE

You may qualify for reimbursement if you went out-of-network for mental health/substance use disorder care.

WHO MAY BE ELIGIBLE?

- You are or were a Kaiser Permanente member.
- While you were a Kaiser Permanente member you paid for out-of-network mental health/substance use disorder care because you attempted, but couldn't access in-network care.
- You received out-of-network care after January 1, 2021.

WHAT DO I NEED TO DO IF I WANT TO SEEK REIMBURSEMENT?

1. Submit your claim within 180 days from the date you received notice:
   - Log on to Kaiser Permanente's claims adjudication website at www.OutofNetworkHealthClaims.com.
   - Follow directions to log in and upload the required information.

2. Provide the necessary information:
   - Names and phone numbers of the out-of-network providers.
   - Bills or invoices from out-of-network providers showing the dates of services, services provided, and amounts billed.
   - Proof of payments made to the out-of-network providers.
   - Your preferred contact information.

We will contact you if Kaiser Permanente needs additional information to evaluate your claim.

WHAT WILL YOU GET? If eligible, you may receive reimbursement for all or part of the out-of-network mental health/substance use disorder services you paid for. To learn more about the claims process, refer to the FAQs.

WHAT IF I STILL HAVE A BILL FOR MENTAL HEALTH/SUBSTANCE USE DISORDER SERVICES TO PAY? If you have an unpaid bill that would qualify for reimbursement, check the FAQs to learn what to do.

WHAT HAPPENS IF I DON'T SUBMIT A CLAIM FOR REIMBURSEMENT?
There is no requirement to participate in this claims review process. If you do not participate, you retain whatever rights you had to participate in Kaiser Permanente's grievance and appeals process consistent with the terms of your Evidence of Coverage.

WHAT HAPPENS IF I SUBMIT A CLAIM? If you submit an eligible claim and accept reimbursement through this claims review process, you cannot afterward sue Kaiser Permanente or submit a grievance or appeal for additional reimbursement.

If you submit a claim that is determined to not be eligible for reimbursement, you will receive written notice and you retain whatever rights you had to participate in Kaiser Permanente's grievance and appeals process consistent with the terms of your Evidence of Coverage.

HOW CAN I GET HELP OR FIND MORE INFORMATION? You can visit www.OutofNetworkHealthClaims.com to learn more and access the FAQs or call 1-877-684-4129 for assistance.

ATTENTION. Language assistance is available at no cost to you. You can ask for interpreter services, including sign language interpreters. You can ask for materials translated into your language or alternative formats, such as braille, audio, or large print. You can also request auxiliary aids and devices. Call 1-877-684-4129 and press the number 1.

انتبه. تتوفر خدمات المساعدة اللغوية دون أي تكلفة عليك. ويمكنك طلب خدمات الترجمة الفورية، بما في ذلك الترجمة الفورية بلغة الإشارة. كما يمكنك طلب ترجمة المواد إلى لغتك أو طلبها بتنسيقات بديلة، مثل طريقة برايل أو التسجيلات الصوتية أو المطبوعات بأحرف كبيرة. ويمكنك طلب أدوات وأجهزة مساعدة إضافية. اتصل على الرقم 1-877-684-4129، واضغط على الرقم 3، واذكر اللغة التي ترغب أن تتحدث بها إلى الموظف.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Ձեզ հասանելի է անվճար լեզվական օգնություն: Դուք կարող եք խնդրել բանավոր թարգմանչի ծառայություններ, այդ թվում՝ ժեստերի լեզվի թարգմանիչներ: Կարող եք խնդրել ձեր լեզվով թարգմանված նյութեր կամ այլընտրանքային ձևաչափերով, ինչպիսիք են՝ Բրայլի գրերը, աուդիոն կամ խոշոր տառերով տպագրվածները: Կարող եք նաև պատվիրել օժանդակ սարքեր և պարագաներ: Զանգահարեք 1-877-684-4129 հեռախոսահամարով, սեղմեք 3 թիվը և ներկայացուցչին ասեք ձեր նախընտրած լեզուն:

注意。 您可以免费获得语言帮助。 **您可以要求**获得口译服务，包括手语翻译。 **您可以要求将**资料翻译成您的语言或以其他格式提供，如盲文、音频或大字体印刷。 **您**还可以要求获得辅助工具和设备。 请拨打 1-877-684-4129，**按 3 号**键，并向接线员说明您偏好的语言。

توجه. خدمات پشتیبانی زبانی به‌صورت رایگان در اختیار شما قرار دارد. می‌توانید درخواست خدمات ترجمه، از جمله مترجم زبان اشاره، بدهید. می‌توانید درخواست کنید که مطالب به زبان شما ترجمه شوند یا در قالب‌های جایگزین مانند بریل، صوتی یا چاپ درشت ارائه شوند. همچنین می‌توانید درخواست ابزار و وسایل کمکی بدهید. با شماره 1-877-684-4129 تماس بگیرید، عدد 3 را فشار دهید و زبان مورد نظر خود را به اپراتور اعلام کنید.

ध्यान दें। आपके लिए भाषा सहायता बिना किसी लागत के उपलब्ध है। आप दुभाषिया सेवाओं का अनुरोध कर सकते हैं, जिसमें सांकेतिक भाषा दुभाषिए भी शामिल हैं। आप अपनी भाषा में अनूदित सामग्री या वैकल्पिक प्रारूपों, जैसे ब्रेल, ऑडियो, या बड़े अक्षरों में छपी सामग्री के लिए पूछ सकते हैं। आप सहायक उपकरण और सहायक सामग्री का भी अनुरोध कर सकते हैं। 1-877-684-4129 पर कॉल करें, नंबर 3 दबाएं, और एजेंट को अपनी पसंदीदा भाषा बताएं।

CEEB TOOM. Muaj kev pab cuam txhais lus pub dawb rau koj. Koj thov tau kom txais kev pab txhais lus, suav nrog cov kws txawj piav tes. Koj thov tau kom txais ntaub ntawv uas muab txhais ua koj yam lus los yog lwm hom, xws li cov ntawv rau neeg dig muag nyeem, cov suab kaw, los sis cov tsiaj ntawv loj. Koj kuj thov tau kom txais cov tshuab pab mloog lus. Hu mus rau 1-877-684-4129, nias naj npawb 3, thiab qhia koj yam lus rau tus uas teb xov tooj.

LONGC HNYOUV JANGX LONGX OC. Mbenc duqv maaih porv waac bun muangx mv zuqc ndortv nyaanh cingv. Se gorngv meih qiemx zuqc longc porv waac nyei mienh nor mborqv finx lorz oc, corc maaih porv waac nyei mienh longc buoz wuv faan waac bun mangc. Meih corc haih tov longc naaiv deix nyungc horngh sou porv cuotv benx meih nyei waac bun longc a'fai fiev benx da'nyeic nyungc sou-guv, beiv gorngv fiev nzangc pokc bun hluo, bungx waac-qiex bun muangx, a'fai aamx bieqc domh zeiv. Meih corc haih tov taux tengx jaa-dorngx aengx caux gong-bou jauv-louc. Mborqv finx,lorz 1-877-684-4129, zatv bieqc nam mber 3, aengx caux mbuox ninh mbuo gorn zangc hiuv meih oix gorngv benx haaix nyungc waac.

ご案内 通訳・翻訳サービスが無料で受けられます。 手話通訳を含め、通訳サービスを利用することができます。 普段お使いの言語への資料の翻訳や、点字、音声、大きな活字など、別の形式での提供を要望可能です。 また、視聴覚を補助する器具や機器も要望できます。 1-877-684-4129に電話し、電話機の「3」を押した後、お望みの言語を代理人に伝えてください。

ចំណាំ៖ មានផ្តល់ជូនជំនួយភាសាដោយមិនគិតថ្លៃសម្រាប់អ្នក។ អ្នកអាចស្នើសុំសេវាបកប្រែផ្ទាល់មាត់ រួមទាំងអ្នកបកប្រែភាសាសញ្ញាបានផងដែរ។ អ្នកអាច ស្នើ សុំ គេបកប្រែឯកសារ ជា ភាសា របស់ អ្នក ឬ ទម្រង់ ផ្សេង ទៀតបាន ដូចជា អក្សរ ស្តាប សំឡេង ឬ អក្សរពុម្ព ធំៗ។ អ្នកក៏អាចស្នើសុំជំនួយអម និងឧបករណ៍បានផងដែរ។ ហៅទូរសព្ទទៅលេខ 1-877-684-4129 ចុចលេខ 3 ហើយបញ្ជាក់ភាសាដែលអ្នកចង់បានទៅកាន់ភ្នាក់ងារ។

참고. 언어 지원은 무료로 제공됩니다. 수화 통역사를 포함하여, 통역 서비스를 신청할 수 있습니다. 귀하의 언어로 번역된 자료나 점자, 음성녹음, 큰활자본 등 대체 형식을 요청할 수 있습니다. 보조기구 및 기기를 요청할 수도 있습니다. 1-877-684-4129로 전화해서 3번을 누르고 나서, 상담원에게 귀하가 원하시는 언어를 알려주세요.

ໝາຍເຫດ. ມີການຊ່ວຍເຫຼືອດ້ານພາສາທີ່ທ່ານບໍ່ຈຳເປັນຕ້ອງເສຍຄ່າ. ທ່ານສາມາດຮ້ອງຂໍການບໍລິການລ່າມແປພາສາ, ລວມທັງລ່າມແປພາສາມື. ທ່ານສາມາດຮ້ອງຂໍໃຫ້ແປເອກະສານຕ່າງໆ ເປັນພາສາ ຫຼື ຮູບແບບເອກະສານອື່ນໄດ້ ເຊັ່ນ: ເປັນອັກສອນນູນ, ສຽງ ຫຼື ຕົວພິມໃຫຍ່. ນອກຈາກນັ້ນ, ທ່ານສາມາດຮ້ອງຂໍເຄື່ອງຊ່ວຍເຫຼືອ ແລະ ບໍລິການເສີມໄດ້. ໂທຫາ 1-877-684-4129, ກົດໝາຍເລກ 3 ແລະ ແຈ້ງພາສາທີ່ທ່ານຕ້ອງການໃຫ້ພະນັກງານຮັບຊາບ.

NÁÁNÁŁT’ÁÁH. Díí binahji’ nihá níłch’ígíí baa hane’ dóó áshłééhígíí éí doo biniiyéé’ da. T’áá shoodí, nihá níłch’ígíí yaa hane’ígíí bee yáhoot’ééł, bikáá’ dah naashá (Sign Language) yáhoot’ééłígíí t’áá ajiłtsoh. Díí t’áá ajiłtsoh níłch’ígíí bee hane’ígíí nihá bizaad yáhoot’ééł dóó t’áá ajiłtsoh t’áá íiyisí ch’iyáánígi índa audio bee, braille bee, dóó nánízhoozhígíí bee áłahgo bídahwiit’aah. T’áá shoodí, nihá bíká anilyeedígíí át’éego bikáá’ dah naasháhgo ádoolníłł. 1-877-684-4129 béésh bee hane’é, t’áá łá’í yáhooł’aah 3, dóó t’áá nihá bizaad yáhoot’ééł nihá naaltsoos yáhoot’ééłígíí t’áá iiná.

ਧਿਆਨ ਦਿਓ ਭਾਸ਼ਾ ਸਬੰਧੀ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਸਾਈਨ ਭਾਸ਼ਾ ਲਈ ਦੁਭਾਸ਼ੀਏ ਸਮੇਤ ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਲਈ ਕਹਿ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕੀਤੀ ਸਮੱਗਰੀ ਦੀ ਜਾਂ ਵਿਕਲਪਕ ਫਾਰਮੈਟ ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ, ਆਡੀਓ ਜਾਂ ਵੱਡੇ ਪ੍ਰਿੰਟ ਦੀ ਮੰਗ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਹਾਇਕ ਏਡ ਅਤੇ ਡਿਵਾਇਸਾਂ ਦੀ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। 1-877-684-4129 'ਤੇ ਫੋਨ ਕਰੋ, 3 ਨੰਬਰ ਦਬਾਓ ਅਤੇ ਏਜੰਟ ਨੂੰ ਆਪਣੀ ਤਰਜੀਹੀ ਭਾਸ਼ਾ ਬਾਰੇ ਦੱਸੋ।

ВНИМАНИЕ! Языковая помощь предоставляется вам бесплатно. Вы можете обратиться с запросом о предоставлении услуг переводчика, включая услуги сурдопереводчика. Вы можете обратиться с запросом о переводе материалов на ваш язык или в альтернативных форматах, таких как шрифт Брайля, аудиозапись или крупный шрифт. Вы также можете запросить вспомогательные средства и устройства. Позвоните по номеру 1-877-684-4129, нажмите «3» и сообщите сотруднику ваш предпочтительный язык.

ATENCIÓN. La asistencia de idiomas está disponible sin costo para usted. Puede solicitar servicios de interpretación, incluidos intérpretes de lenguaje de señas. Puede solicitar materiales traducidos a su idioma o en formatos alternativos, como braille, audio o letra grande. También puede solicitar ayudas y dispositivos auxiliares. Llame al 1-877-684-4129 y presione el número 2.

PAUNAWA. Mayroong tulong pangwika na available nang walang bayad para sa inyo. Maaari kayong humingi ng mga serbisyo ng interpreter, kabilang ang mga sign language interpreter. Maaari kayong humingi ng mga materyales na isinalin sa inyong wika o sa mga alternatibong format, tulad ng braille, audio, o malalaking letra. Maaari rin kayong humiling ng mga pantulong na kagamitan at device. Tumawag sa 1-877-684-4129, pindutin ang numerong 3, at sabihin sa agent ang wikang nais ninyo.

โปรดทราบ คุณสามารถขอรับความช่วยเหลือด้านภาษาได้โดยไม่มีค่าใช้จ่ายใดๆ คุณสามารถขอรับบริการล่าม รวมถึงล่ามภาษามือได้ คุณสามารถขอให้แปลเอกสารเป็นภาษาของคุณหรือในรูปแบบอื่น เช่น อักษรเบรลล์ เสียง หรือตัวอักษรขนาดใหญ่ได้ คุณยังสามารถขออุปกรณ์เสริมและความช่วยเหลือเพิ่มเติมได้ด้วย โทร 1-877-684-4129 แล้วกดหมายเลข 3 และแจ้งภาษาที่คุณต้องการให้เจ้าหน้าที่ทราบ

УВАГА. Мовна допомога надається безкоштовно. Ви можете звернутися за послугами перекладача, включаючи сурдоперекладача. Ви можете попросити матеріали, перекладені на вашу мову або в інші формати, такі як шрифт Брайля, аудіо або великий шрифт. Ви також можете попросити допоміжні засоби та пристрої. Зателефонуйте за номером 1-877-684-4129, натисніть цифру 3 і вкажіть оператору бажану мову.

CHÚ Ý. Quý vị được hỗ trợ ngôn ngữ miễn phí. Quý vị có thể yêu cầu dịch vụ phiên dịch, bao gồm cả phiên dịch ngôn ngữ ký hiệu. Quý vị có thể yêu cầu dịch tài liệu sang ngôn ngữ của quý vị hoặc ở các định dạng thay thế, chẳng hạn như chữ nổi Braille, âm thanh hoặc chữ in cỡ lớn. Quý vị cũng có thể yêu cầu các thiết bị và dụng cụ hỗ trợ. Gọi số 1-877-684-4129, nhấn phím số 3, và nói cho nhân viên biết ngôn ngữ mà quý vị muốn sử dụng.

Attachment C

Denial Codes

Denial Codes: CLD84, BED07, BED12, AUD01, AUD02, AUD03, AUD04, AUD05, AUD06, CED13, CLD41, CLD66, CLD69, CRD04, CRD05, PRD05, PRD07, and any equivalent codes applicable to plans that use separate third-party administrative services for claims administration.

Attachment D

Adjudication Process and Criteria

I. Notice and Reminders

Kaiser shall use a third-party vendor to provide notices to **Enrollees**. If the **Enrollee** has designated a preferred method for receiving communications from Kaiser, the notice shall be sent using the **Enrollee's** preferred method. If a preferred method has not been designated, notice shall be sent electronically to the email address on file for the **Enrollee**. Where there is no email address on file and Kaiser's vendor is unable to identify an email address for the **Enrollee**, notice shall be sent to the physical address on file.

Kaiser shall send two reminders to recipients who have not yet responded to the initial notice. The first reminder shall be sent 30 days after the initial notice and the second reminder shall be sent 30 days after the first reminder.

Kaiser's vendor shall use industry standard methods to address notices that are returned as undeliverable. The general description of the industry standards and additional practices are described below in Section IV of this Attachment.

Enrollees must make claims by July 30, 2026.

II. Adjudication Guidelines

(A) Kaiser shall begin the review and adjudication process upon receiving claims to determine eligibility for reimbursement. In the case of Groups A and B, where claims for reimbursement are received, but the submitted claims lack all the requested information, Kaiser shall proceed to review and adjudicate the claims based on the information in the preexisting claim file if that claim file contains the necessary required information.

(B) Starting within 60 days after notices are sent, Kaiser shall provide the Secretary with monthly reports regarding its review. The monthly reports shall include de-identified information regarding the number of claims received, the amount claimed, the number of claims deemed eligible for reimbursement, the amount reimbursed, the number of claims denied, the reason(s) for denial and the number of claims subject to further investigation. Upon request, the Kaiser shall

provide clarifying information, and if necessary, underlying information pertaining to the monthly report.

(C) Eligibility for reimbursement is subject to confirmation by Kaiser that at the time the **Enrollee** received **Out-of-Network** care the **Enrollee** was covered by a Kaiser plan. Eligibility for reimbursement also requires enrollees to submit sufficient documentations and proof, including bills and payments, to allow Kaiser to confirm that: (1) the **Enrollee** attempted, but was unable, to obtain timely and geographically accessible clinically appropriate behavioral health care services **In-Network**; (2) as a result of the inability to obtain timely and geographically accessible clinically appropriate care, the **Enrollee** subsequently went **Out-of-Network**; (3) has an unpaid bill from or paid money out of pocket to an **Out-of-Network Provider** who was licensed and qualified to provide the services the **Enrollee** received; and (4) the **Out-of-Network** services were medically necessary, clinically appropriate, reasonably proximate, under the circumstances, to the time of the attempt to obtain **In-Network** services, and the same type of services and intended to treat same or related type of condition for which the **Enrollee** had sought **In-Network** care. To the extent necessary and relevant for the adjudication of a claim, Kaiser shall review **Enrollee** medical and claim records already in Kaiser's systems.

Any claims processing rules or guidelines which Kaiser develops in Phase 1 shall be consistent with this Settlement Agreement and its Attachments and Kaiser shall not restrict **Enrollee** eligibility or reimbursement amounts in any matter other than identified herein. The Secretary shall have the opportunity to provide feedback, object, and/or request underlying documentation and data prior to implementation of these claims processing rules or guidelines.

None of the presumptions outlined below will constitute satisfaction of subsections (3) and (4) above. The reimbursement of claims will be in accordance with the following:

(i) For **Enrollees** in Groups A-D, if the **Enrollee** had an intake evaluation for inpatient and/or outpatient care with an **In-Network Provider** before obtaining care from an **Out-of-Network Provider**, the intake evaluation shall be presumed to meet the attempt requirement of subsections (1) and (2) above.

(ii) For outpatient appointments falling under Groups A-C, a non-detrimental designation shall not be considered in determining inability to obtain a timely appointment under subsections (1) and (2) above. This provision does not preclude the use of medical records to determine timeliness.

(iii) For **Enrollees** in Group C, the failure to offer a timely and geographically appropriate appointment during the intake will constitute a presumption that the inability requirements set forth in subsections (1) and (2) above.

(iv) For **Enrollees** in Group D, before issuing a denial based on the conclusion that treatment goals were met at the time of graduation from care and before the Enrollee obtained **Out-of-Network** services, Kaiser will review the notes and assessment by the **Out-of-Network Clinician** to help determine if treatment goals were in fact met at the time treatment ceased with the Kaiser **Clinician**.

(v) For those **Enrollees** in Group D, if at the time of graduation from care, the **Enrollee** had not met treatment goals, then the inability requirements set forth in subsections (1) and (2) above will be presumed to have been met. This presumption applies only if the graduation resulted in cessation of care.

(vi) For those **Enrollees** in Group E, who were subject to an E-visit that did not present the **Enrollee** with contact information to schedule an appointment as step 1 of the Care Plan and whose responses scored 5 or higher on the GAD7 or PHQ9 administered in the E-visit shall be presumed to meet the inability requirements set forth in subsections (1) and (2) above.

(viii) Kaiser shall reimburse eligible claims pursuant to the reimbursement process and guidelines established in agreement with the Secretary, following Kaiser's receipt and evaluation of claims submitted and consistent with this Settlement Agreement. The Secretary acknowledges and agrees that, under certain circumstances, the full amount the member paid to an **Out-of-Network Provider** may not be reimbursed by Kaiser. Both the maximum number of appointments and the maximum amount reimbursed per appointment can be subject to reasonable and appropriate limits that conform to the generally accepted standards of medical care appropriate to the treatment sought in accordance with the applicable evidence of coverage (LOCUS, CAL LOCUS, and ASAM). With

respect to reimbursement amount per appointment, the maximum Kaiser shall be required to pay will be the 75th percentile of the Fair Health Charge Benchmark for the specific services and geography at issue.

(ix) All reimbursement of eligible claims shall be subject to the **Enrollees**' financial responsibility under the applicable plan including the following: (a) maximum annual and lifetime benefits, if not prohibited by applicable law; (b) copayments and coinsurance; (c) individual and family deductibles; and (d) out-of-pocket maximums.

(x) The reimbursement determined pursuant to the terms of this Settlement Agreement and Attachment D shall be the maximum Kaiser will pay any **Enrollee** pursuant to this Agreement.

III. Payment of Eligible Claims and Denial Notice

Kaiser shall begin reimbursement of eligible claims no later than 180 days after initial notice is distributed. **Enrollees** receiving payment shall be required to agree to waive any claims related to the **Out-of-Network** services for which they received reimbursement. A copy of the waiver **Enrollees** are required to sign is set forth in Section V of this Attachment.

Where a claim is deemed not eligible for reimbursement, Kaiser shall provide the **Enrollee** with a written notice of denial describing the basis for the decision and information about the **Enrollee's** rights, including the right to appeal, under applicable law, including 29 CFR § 2560.503-1 and the applicable **EOC**.

Reimbursement of eligible claims shall be made directly to the **Enrollee** or, if deceased, the **Enrollee's** estate. An exception shall be made in those cases where the **Enrollee** has not yet paid the claim, but the claim itself has been verified. In such cases, only the billing **Provider** shall be reimbursed.

Payment shall be made by check. If a reimbursement check is not cashed within 60 days of issuance, Kaiser shall twice contact the **Enrollee** using the contact information provided by the **Enrollee** to verify receipt and/or obtain new contact information using industry standards, and if necessary, reissue the payment to ensure **Enrollee** receives payment.

For all checks not cashed or deposited by an **Enrollee**, Kaiser shall hold the payment for one year, and thereafter escheat the funds to the state unclaimed property fund of the state where the **Enrollee** resided at the time the claim was submitted.

IV. Industry Standard for Handling Undeliverable Notices

The vendor will send the notice via email to all valid email addresses included on the contact list. Prior to sending, the vendor follows best practices to both validate emails and increase deliverability. Specifically, prior to distributing the email notice, it subjects the email addresses to a cleansing and validation process. The email cleansing process will remove extra spaces, fix common typographical errors in domain names, and correct insufficient domain suffixes (e.g., gmal.com to gmail.com, gmail.co to gmail.com, yaho.com to yahoo.com, etc.). The email addresses will then be subjected to an email validation process whereby each email address will be compared to known bad email addresses. The vendor maintains a database of email addresses that were returned as permanently undeliverable, commonly referred to as a hard bounce, from prior campaigns. Where an address has been returned as a hard bounce within the last year, that email is designated as a known bad email address. Those **Enrollees** who are deemed to have bad email addresses shall receive notices via U.S. mail. For notices sent via U.S. mail, the vendor will use first class U.S. mail, postage pre-paid, using the following best practices to increase the deliverability rate: (i) updated utilizing the United States Postal Service's ("USPS") National Change of Address database, which provides updated address information for individuals or entities who have moved during the previous four years and filed a change of address with the USPS; (ii) notices returned by the USPS with a forwarding address will be re-mailed to the new address provided by the USPS; (iii) notices returned to the USPS without forwarding addresses will be subjected to an address verification search (commonly referred to as "skip tracing") utilizing a wide variety of data sources, including public records, real estate records, electronic directory assistance listings, etc., to locate updated addresses; (iv) notices will be re-mailed to those potential recipients for whom updated addresses were identified via the skip tracing process.

V. Waiver

I affirm that all the information I provided in this submission is true and accurate to the best of my knowledge, and that the documents I enclosed are authentic. I consent to Kaiser Foundation Health Plan, Inc. reviewing the documents that I have enclosed for the purpose of adjudicating my claim. I further consent to the Kaiser Permanente Notice Administrator accessing the documents for their submission to Kaiser Foundation Health Plan, Inc. I understand that I may need to provide written authorization to Kaiser Foundation Health Plan, Inc. for the release of medical records and I agree to provide written authorization for the release of those records to Kaiser Foundation Health Plan, Inc. I further understand that if my claim is approved and I accept the reimbursement Kaiser Foundation Health Plan, Inc. provides, I will not have any right to seek additional reimbursement for the services identified in my claim.

Signature Printed Name Date

Attachment E

Attestation Regarding Claims Payments Achieved in

EBSA Investigation xx-xxxxxx(xx) Case Name

I, [NAME, Chief Compliance Officer] of Kaiser Foundation Health Plan, Inc. ("Kaiser"), certify under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

1. Kaiser provides benefits to members of ERISA covered plans.

2. Pursuant to Kaiser's re-adjudication of XYZ claims pursuant to the Settlement Agreement between Kaiser and the U.S. Department of Labor, to settle the U.S. Department of Labor's investigation of XXXXX, Kaiser reprocessed XYZ claims.

3. The total of all re-adjudication payments issued to participants and beneficiaries of ERISA covered plans to date is [$ amount]. As of the date of this attestation, [$XXXXXXX] of those payments have cleared, as shown in Column X of the attached spreadsheet [Exhibit 4(a)]. The total number of ERISA-covered plans involved is X. The total number of participants involved is X.____

4. The dates of service for the XYZ were between [insert date range]. The dates of payment to enrollees occurred in [insert range of payment dates].

5. As of the date of this attestation, Kaiser confirms that it has reprocessed and issued payments for all claims specified in the attached spreadsheet.

6. Kaiser issued Explanations of Benefits ("EOB") to all affected members on or around the date(s) Kaiser processed the XYZ corrective claim payments. On xx/xx/2025, Kaiser transmitted the EOBs to EBSA through its secure file transfer portal.

_____

Name, Chief Compliance Officer

Kaiser Foundation Health Plan, Inc.

Attached: Spreadsheet of XYZ claims corrections

Attachment E(1)
Template Corrected Claims Spreadsheet

New or Original Claim ID	Date of Service [DOS]	Adjusted Claim ID (if applicable)	Adjusted Claims Date of Service (if applicable)	Member ID	For Payments made directly to Providers -- Provider Name	Plan/Sponsor Name	Total Benefit Paid	Network Status (INN/OON)	Payment Made To	Paid Date	Check Number/Wire Transfer Confirmation Reference #	Status of Payment [cleared, outstanding, voided]