Group Agreement Amendment

Kaiser Foundation Health Plan, Inc., Northern and Southern California Regions ("Health Plan") is amending *Evidence of Coverage* ("*EOC*") documents in your Group's *Group Agreement(s)* ("*Agreements*") in accord with the "Amendment of Agreement" section of your Agreements. The attached *EOC Amendment* includes the following changes (please read the *EOC Amendment* to determine how your Group's contract is impacted):

- Changes to Coverage and Cost Share for Fertility Services (California Senate Bill 729), effective on or after January 1, 2026, upon renewal
- Changes to Cost Share for Certain Other Services (Mental Health Parity and Addiction Equity Act) ("MHPAEA"), effective January 1, 2026
- Additional Changes to KP Plus Plans (MHPAEA), effective January 1, 2026

In accord with Medicare rules, Members with Kaiser Permanente Senior Advantage when Medicare is secondary coverage have the same coverage as active employees.

All amendments are deemed accepted by your Group unless your Group gives Health Plan written notice of nonacceptance within 15 days after the date of this amendment notice, in which case this Agreement will terminate pursuant to "Termination Due to Nonacceptance of Amendments" in the "Termination of Agreement" section of your *Agreement(s)*.

In accord with "Member Information" in the "Miscellaneous Provisions" section of your *Agreement(s)*, Group must inform Subscribers of this coverage change in its next regular communication to them, but in no event later than 30 days after Group receives the information.

Note: Some capitalized terms in this *EOC Amendment* have special meaning. Please see the "Definitions" section of an *EOC* in your *Agreement(s)* for terms you should know. In this document "non-Medicare *EOCs*" means all *EOCs* other than Kaiser Permanente Senior Advantage *EOCs*.

EOC Amendment

The changes in this *EOC* Amendment are incorporated into 2026 non-Medicare *Evidence of Coverage ("EOC")* documents:

- Changes to Coverage and Cost Share for Fertility Services (California Senate Bill 729), effective on or after January 1, 2026, upon renewal
- Changes to Cost Share for Certain Other Services (Mental Health Parity and Addiction Equity Act) ("MHPAEA"), effective January 1, 2026
- Additional Changes to KP Plus Plans (MHPAEA), effective January 1, 2026

EOCs will be updated to reflect any changes to coverage or Cost Share upon renewal on or after January 1, 2027.

Changes to Coverage and Cost Share for Fertility Services (California Senate Bill 729)

These changes apply to all large groups, except for qualified religious employers that have opted out of SB 729.

SB 729 requires cost share for Fertility Services to match the cost share for non-Fertility Services:

- The Cost Share for primary care office visits and specialty care office visits for Fertility Services match the Cost Share for primary care office visits and specialty care office visits in the "Office visits" table in the "Cost Share Summary."
- A new row was added in the "Fertility Services" table in the "Cost Share Summary" for storage of reproductive materials (pending regulatory approval). The Cost Share for reproductive materials is the same as "All other laboratory tests..."

The "Definitions" section was revised to include the following definitions:

- **Assisted Reproduction Agreement (pending regulatory approval):** A written agreement in accord with California Family Code Section 7962 between a person (Intended Parent) who intends to be the legal parent of a child born through assisted reproduction and a third party. The agreement defines the terms of the relationship between the parties. For the purposes of this *EOC,* "Assisted Reproduction Agreement" includes, but is not limited to: donor arrangements, surrogacy arrangements, and Gestational Carrier arrangements.
- **Fertility Services (pending regulatory approval):** Services to help a covered Member become a parent.
- **Gestational Carrier (pending regulatory approval):** A third party who is not an Intended Parent and who agrees to carry a pregnancy on behalf of the Intended Parent(s) pursuant to an Assisted Reproduction Agreement.
- **Intended Parent (pending regulatory approval):** A Member with an Infertility diagnosis who intends to become a legal parent of a child resulting from Services covered under the Fertility Services section.

Under "Fertility Services" in the "Benefits" section, we have updated the coverage description as follows:

Fertility Services (pending regulatory approval)

We cover the Services described in this section under the following circumstances:

- The covered Member must be an Intended Parent who has an Infertility diagnosis

- Any third-party donors or Gestational Carriers must not be the Intended Parent

We cover the following Fertility Services subject to the limits described in this section:

- Diagnosis and treatment of Infertility
- Fertility Services including artificial insemination and in vitro fertilization (IVF)
  - Oocyte (egg) and sperm retrieval or procurement of donor materials as described below
  - Other associated imaging Services, laboratory Services, and office visits
  - Transfer of fresh and cryopreserved embryo(s)
- Cryopreservation and storage
- Any other Fertility Services to treat Infertility consistent with established medical practices and the most current professional guidelines published by American Society for Reproductive Medicine (ASRM)

The following covered Fertility Services are subject to treatment limits:

- Oocyte retrieval or procurement of donor materials is limited to three attempts per lifetime
  - Procurement of donor oocytes is limited to one cohort per active course of fertility treatment
- Sperm retrieval or procurement of donor materials limited to three attempts per lifetime
  - Procurement of donor sperm is limited to one vial of sperm per active course of fertility treatment
- Cryopreserved donor materials (oocytes, sperm, or embryos) must be obtained from a cryobank with a valid California tissue bank license
- Embryo transfers are limited to the transfer of one embryo at a time per active course of fertility treatment
- Storage is limited to 5 years per lifetime (or until your enrollment terminates, if earlier than 5 years) from the time genetic material is first cryopreserved

If you reach the treatment limits for oocyte or sperm retrievals, we will not cover any Services related to additional oocyte or sperm retrievals, including Prescription Drugs.

Donors and Gestational Carriers

Coverage for third party Fertility Services involving live donors or Gestational Carriers requires an Assisted Reproduction Agreement to be executed prior to the Intended Parent's third-party donor or Gestational Carrier receiving Fertility Services. Covered Fertility Services received by donors and Gestational Carriers are accumulated towards the Intended Parent's coverage and any applicable cost share is accumulated to the Intended Parent's deductible and/or out-of-pocket maximum. Retrieval services received by donors apply to the Intended Parent retrieval maximum and are subject to the limitations in the Intended Parent's *EOC*.

If the donor or Gestational Carrier is enrolled as a Member under this *EOC*, then any services received by the Gestational Carrier or donor that are not Fertility Services described in this section are covered in accordance with the terms and conditions of this *EOC*. However, Fertility Services and cost sharing are accumulated towards the coverage and retrieval maximums of the Intended Parent.

If the donor or Gestational Carrier is not enrolled as a Member under this *EOC*, then any services received by the Gestational Carrier or donor that are not related to Fertility Services are not covered under this *EOC*. Coverage is limited only to Fertility Services described in this section that are applied towards the Intended Parent's coverage. Any coverage for the Gestational Carrier based on their Assisted Reproductive Agreement with the Intended Parent terminates upon the confirmation of pregnancy.

You have a right to receive treatment for infertility and fertility services when you meet the requirements in Health and Safety Code section 1374.55.

If you have questions about how to obtain infertility treatment services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on your health plan identification card; 2) call the California Department of Managed Health Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at www.DMHC.ca.gov to request assistance in obtaining infertility treatment services.

Before starting or continuing a course of Fertility Services, you may be required to pay initial and subsequent deposits toward your Cost Share for some or all of the entire course of Services, along with any past-due fertility-related Cost Share. Any unused portion of your deposit will be returned to you. When a deposit is not required, you must pay the Cost Share for the procedure, along with any past-due fertility-related Cost Share, before you can schedule a fertility procedure.

Covered Fertility Services do not include the following services:

- Services that are not related to the Medically Necessary treatment of Infertility as defined in this *EOC*

  Non-medical fees, including but not limited to legal fees, agency fees, shipping fees, travel fees, finder fees, broker fees, transport fees, other administrative costs, and compensation to a donor, Gestational Carrier and/or other third party involved in an Assisted Reproduction Agreement

  Health care costs for any third party involved in an Assisted Reproduction Agreement that are not Medically Necessary Fertility Services

  Any physical health or mental health screenings administered as part of the third-party selection process for a donor or Gestational Carrier prior to the execution of an Assisted Reproduction Agreement
- Services related to the procurement, cryopreservation, and storage of semen, oocytes, and embryos, except when part of covered Fertility Services

For the following Services, refer to these sections

- Diagnostic Services provided by Plan Providers who are not physicians, such as EKGs and EEGs (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Fertility preservation Services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Outpatient administered drugs (refer to "Administered Drugs and Products")
- Prescription Drugs (refer to "Outpatient Pharmacy Services")

Changes to Cost Share for Certain Other Services (Mental Health Parity and Addiction Equity Act) (MHPAEA)

Cost Share for certain Services is changing as described below to comply with requirements in MHPAEA. If you have paid more than the Cost Share described below, a credit will be issued.

Please read the description of each change below to determine whether the *EOC* for your coverage is impacted.

Mental health and substance use disorder treatment visits and Urgent Care

Urgent Care related to a mental health or substance use disorder is covered at the same Cost Share as non-urgent care for the same condition.

Mental health and substance use disorder programs

Cost Share for the following mental health and substance use disorder programs from Plan Providers is changing in some plans:

- Partial hospitalization
- Other intensive psychiatric treatment programs for mental health conditions
- Behavioral Health Treatment for Autism Spectrum Disorder
- Intensive outpatient and day-treatment programs for substance use disorders
- Methadone maintenance treatment

Cost Share for these programs is changing as follows:

- If the Cost Share for any of these programs is a Coinsurance with per-day maximum, Cost Share for all of these programs is reduced to "No charge."
- If the Cost Share for any of these programs is a Copayment greater than $0, but at least one of these programs has a Cost Share of "No charge," Cost Share for all of these programs is reduced to "No charge."

Ambulance transportation

Cost Share for ambulance transportation is changing in some plans:

- If the Cost Share for emergency department visits is "No charge" and ambulance transportation is a Copayment, the Cost Share for ambulance transportation is reduced to "No charge."
- If the Cost Share for emergency department visits and ambulance transportation are both a Copayment, and the Copayment for ambulance is greater than the Copayment for emergency department visits, the Copayment for ambulance transportation is reduced to the emergency department visit Copayment.
- If the Cost Share for emergency department visits is "No charge" and ambulance transportation is a Coinsurance, the Cost Share for ambulance transportation is reduced to "No charge."
- If the Cost Share for emergency department visits is a Copayment other than $0 and ambulance transportation is a Coinsurance, the Cost Share for ambulance transportation is the same Copayment as emergency department visits.
- If the Cost Share for emergency department visits is a Coinsurance and ambulance transportation is a Copayment, the Cost Share for ambulance transportation is the same Coinsurance as emergency department visits up to a maximum of the existing Copayment amount per trip.
- If emergency department visits are not subject to the Plan Deductible but ambulance transportation is subject to the Plan Deductible, ambulance transportation is no longer subject to the Plan Deductible.

Non-emergency psychiatric van transport

Non-emergency psychiatric transport van Services are covered at "No charge," not subject to the Plan Deductible in all plans, except subject to the Plan Deductible in HSA-Qualified HDHP Plans.

Additional Changes to KP Plus Plans (MHPAEA)

In *EOCs* for KP Plus plans, Cost Share for certain Services from Non-Plan Providers is changing as described below to comply with requirements in MHPAEA. The process for submitting a claim for these Services is the same as any other Services that are part of the KP Plus benefit as described in the "Post-Service Claims and Appeals" section of the *EOC*.

Mental health and substance use disorder programs

Coverage for the following Services has been added to your KP Plus out-of-network benefit (these services count toward the annual limit of a combined total of 10 covered outpatient Services from Non-Plan Providers):

- Partial hospitalization
- Other intensive psychiatric treatment programs for mental health conditions
- Behavioral Health Treatment for Autism Spectrum Disorder
- Intensive outpatient and day-treatment programs for substance use disorders
- Methadone maintenance treatment
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program

The Copayment for these Services is $20 more than when received from a Plan Provider.