NEW ISSUE — BOOK-ENTRY ONLY **See "Ratings" herein**

$2,075,000,000
KAISER PERMANENTE
Taxable Bonds
Series 2017

$575,000,000 3.150% Series 2017 Bond (Green Bond) due May 1, 2027 Price: 99.635% Yield: 3.193 % CUSIP† 48305QAC7
$1,500,000,000 4.150% Series 2017 Bond due May 1, 2047 Price: 99.051% Yield: 4.206% CUSIP† 48305QAD5

Dated: Settlement Date **Interest Payable:** As described in "SUMMARY OF THE OFFERING"

This Offering Memorandum has been prepared to provide information in connection with the execution and delivery of the bonds listed above (the "Bonds"), issued by Kaiser Foundation Hospitals ("Hospitals"). The Bonds will bear interest at the rates set forth above and will be issued as fully registered bonds without coupons in the denomination of $1,000 or any integral multiple thereof. When issued, the Bonds will be registered in the name of Cede & Co., as nominee of The Depository Trust Company, New York, New York ("DTC"). DTC will act as securities depository for the Bonds, and individual purchases of Bonds will be made in book-entry only form, as described herein. Principal or redemption price, including Make-Whole Redemption Price (as defined herein), if any, of and interest on the Bonds will be payable by Wilmington Trust, National Association, as trustee (the "Trustee"), to DTC. Subsequent disbursements of such principal or redemption price, including Make-Whole Redemption Price, if any, and interest will be made to the individual purchasers of beneficial interests in the Bonds pursuant to DTC policies, as described herein. So long as Cede & Co. is the registered owner of the Bonds, references herein to the holders or registered owners of the Bonds shall mean Cede & Co. and shall not mean the beneficial owners of the Bonds. See APPENDIX C – "DTC BOOK-ENTRY SYSTEM AND GLOBAL CLEARANCE PROCEDURES" hereto.

Interest on the Bonds is payable on November 1, 2017 and semiannually thereafter on May 1 and November 1 of each year. In the event that the book-entry system shall no longer be used with respect to the Bonds, interest on the Bonds will be payable by check mailed to the registered owners of the Bonds on each interest payment date at their addresses as they appear on the bond registration books of the Trustee as of the fifteenth day of the month immediately preceding an interest payment date for the Bonds or as of a special record date established for the payment of defaulted interest.

The Bonds are general obligations of Hospitals, issued pursuant to the Indenture, as described herein, and will be payable from payments made by Hospitals under the Indenture and from certain funds held under the Indenture. The obligation of Hospitals under the Indenture will be guaranteed by Kaiser Foundation Health Plan, Inc. ("Health Plan, Inc."), Kaiser Hospital Asset Management, Inc. ("HAMI"), and Kaiser Health Plan Asset Management, Inc. ("HPAMI" and, together with Health Plan, Inc. and HAMI, the "Guarantors") pursuant to the Guarantee Agreement, as described herein (Hospitals, Health Plan, Inc., HAMI and HPAMI, collectively, are referred to herein as the "Credit Group").

The Bonds are subject to optional redemption prior to their respective stated maturities, as described herein.

Interest on and gain, if any, on the sale of the Bonds are not excludable from gross income for federal, state or local income tax purposes. See "CERTAIN UNITED STATES FEDERAL INCOME TAX CONSIDERATIONS" herein.

This cover page contains certain information for general reference only. It is not intended to be a summary of the security or terms of the Bonds. Investors are instructed to read the entire Offering Memorandum to obtain information essential to the making of an informed investment decision. Capitalized terms used on this cover page and not otherwise defined have the meanings given to such terms in the Indenture.

The Bonds are offered when, as and if received by the Underwriters, subject to prior sale and to the approval of certain legal matters for Hospitals and the Guarantors by their General Counsel and by Drinker Biddle & Reath LLP, special tax counsel, and for the Underwriters by their counsel, Squire Patton Boggs (US) LLP. It is expected that the Bonds in book-entry form will be available for delivery through the facilities of DTC in New York, New York, on or about May 3, 2017.

Goldman, Sachs & Co. **Citigroup** **J.P. Morgan**
Barclays **Morgan Stanley** **Wells Fargo Securities**

Date: April 25, 2017

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† A registered trademark of the American Bankers Association. CUSIP is provided by Standard & Poor's CUSIP Service Bureau, a Standard & Poor's Financial Services LLC business. CUSIP numbers have been assigned by an independent company not affiliated with the Credit Group or the Underwriters and are provided for convenience of reference only. None of the Credit Group or the Underwriters assumes any responsibility for the accuracy of such numbers, and no representation is made as to their correctness on the Bonds or as indicated above.

San Diego Medical Center

461 Beds
(Phase I: 321 beds)

565,000
Square Feet

LEED
Platinum

OPENING:
April 2017

This Offering Memorandum does not constitute an offer to sell the Bonds or the solicitation of an offer to buy, nor shall there be any sale of the Bonds by any person in any state or other jurisdiction to any person to whom it is unlawful to make such offer, solicitation or sale in such state or jurisdiction. No dealer, broker, salesman or any other person has been authorized to give any information or to make any representation other than those contained herein in connection with the offering of the Bonds, and, if given or made, such information or representation must not be relied upon. The Underwriters have provided the following sentence for inclusion in this Offering Memorandum. The Underwriters have reviewed the information in this Offering Memorandum in accordance with and as part of their responsibilities to investors under the federal securities laws as applied to the facts and circumstances of this transaction, but the Underwriters do not guarantee the accuracy or completeness of such information.

The information set forth in APPENDIX C – "DTC BOOK-ENTRY SYSTEM AND GLOBAL CLEARANCE PROCEDURES" hereto has been furnished by DTC, Clearstream Banking and Euroclear. Such information is believed to be reliable but is not guaranteed as to accuracy or completeness and is not to be construed as a representation by the Underwriters or the Credit Group. All other information set forth herein has been obtained from the Credit Group and other sources that are believed to be reliable, but such information is not guaranteed as to accuracy or completeness and is not to be construed as a representation by the Underwriters. The information and expressions of opinion herein are subject to change without notice, and neither the delivery of this Offering Memorandum nor any sale of the Bonds made hereunder shall create under any circumstances any indication that there has been no change in the affairs of the Credit Group or DTC, Clearstream Banking or Euroclear since the date hereof. This Offering Memorandum is submitted in connection with the issuance of the Bonds and may not be used, in whole or in part, for any other purpose.

The Bonds have not been registered with the Securities and Exchange Commission under the Securities Act of 1933, as amended (the "Securities Act"), and are being issued in reliance on an exemption under Section 3(a)(4) of the Securities Act. Neither the Indenture nor the Guarantee Agreement have been qualified under the Trust Indenture Act of 1939, as amended, in reliance upon exemptions contained in such act. The Bonds are not exempt in every jurisdiction in the United States; some jurisdictions' securities laws (the "blue sky laws") may require a filing and a fee to secure the Bonds' exemption from registration.

IN CONNECTION WITH THE OFFERING OF THE BONDS, THE UNDERWRITERS MAY OVERALLOT OR EFFECT TRANSACTIONS THAT STABILIZE OR MAINTAIN THE MARKET PRICE OF THE BONDS AT LEVELS ABOVE THAT WHICH OTHERWISE MIGHT PREVAIL IN THE OPEN MARKET. SUCH STABILIZING, IF COMMENCED, MAY BE DISCONTINUED AT ANY TIME.

In making an investment decision, investors must rely on their own examination of the terms of the offering, including the merits and risks involved. The Bonds have not been approved or disapproved by any federal or state securities commission or regulatory authority. Furthermore, the foregoing authorities have not confirmed the accuracy or determined the adequacy of this Offering Memorandum. Any representation to the contrary is a criminal offense.

CAUTIONARY STATEMENTS REGARDING FORWARD-LOOKING STATEMENTS IN THIS OFFERING MEMORANDUM

Certain statements included or incorporated by reference in this Offering Memorandum constitute "forward-looking statements." Such statements generally are identifiable by the terminology used such as "plan," "expect," "estimate," "budget" or other similar words. Such forward-looking statements include but are not limited to certain statements contained in the information under the captions "PLAN OF FINANCE," "BONDHOLDERS' RISKS" and "INFORMATION ABOUT KAISER—Management's Discussion and Analysis of the Combined Financial Position and Results of Operations of Kaiser" in this Offering Memorandum. The achievement of certain results or other expectations contained in such forward-looking statements involve known and unknown risks, uncertainties and other factors that may cause actual results, performance or achievements described to be materially different from any future results, performance or achievements expressed or implied by such forward-looking statements. None of Hospitals, Health Plan, Inc., HAMI or HPAMI plans to issue any updates or revisions to those forward-looking statements if or when its expectations or events, conditions or circumstances on which such statements are based occur or fail to occur.

INFORMATION CONCERNING OFFERING RESTRICTIONS IN CERTAIN JURISDICTIONS OUTSIDE THE UNITED STATES

REFERENCES HEREIN TO THE "ISSUER" MEAN HOSPITALS AND REFERENCES TO "BONDS" OR "SECURITIES" MEAN THE BONDS OFFERED HEREBY.

MINIMUM UNIT SALES

THE BONDS WILL TRADE AND SETTLE ON A UNIT BASIS (ONE UNIT EQUALING ONE BOND OF $1,000 PRINCIPAL AMOUNT). FOR ANY SALES MADE OUTSIDE THE UNITED STATES, THE MINIMUM PURCHASE AND TRADING AMOUNT IS 150 UNITS (BEING 150 BONDS IN AN AGGREGATE PRINCIPAL AMOUNT OF $150,000).

NOTICE TO INVESTORS IN THE EUROPEAN ECONOMIC AREA (THE"EEA")

THIS OFFERING MEMORANDUM IS NOT A PROSPECTUS FOR THE PURPOSES OF EUROPEAN COMMISSION DIRECTIVE 2003/71/EC (AS AMENDED) (THE "PROSPECTUS DIRECTIVE") AS IMPLEMENTED IN EACH MEMBER STATE OF THE EEA. IT HAS BEEN PREPARED ON THE BASIS THAT ALL OFFERS OF THE BONDS WILL BE MADE PURSUANT TO AN EXEMPTION UNDER ARTICLE 3 OF THE PROSPECTUS DIRECTIVE, AS IMPLEMENTED IN-MEMBER STATES OF THE EEA, FROM THE REQUIREMENT TO PRODUCE A PROSPECTUS FOR SUCH OFFERS. THIS OFFERING MEMORANDUM IS ONLY ADDRESSED TO AND DIRECTED AT PERSONS IN MEMBER STATES OF ITIE EEA WHO ARE "QUALIFIED INVESTORS" WITHIN THE MEANING OF ARTICLE 2(1)(E) OF THE PROSPECTUS DIRECTIVE AND ANY RELEVANT IMPLEMENTING MEASURE IN EACH MEMBER STATE OF THE EEA ("QUALIFIED INVESTORS"). THIS OFFERING MEMORANDUM MUST NOT BE READ, ACTED ON OR RELIED ON IN ANY SUCH MEMBER STATE OF THE EEA BY PERSONS WHO ARE NOT QUALIFIED INVESTORS. ANY INVESTMENT OR INVESTMENT ACTIVITY TO WHICH THIS OFFERING MEMORANDUM RELATES IS AVAILABLE ONLY TO QUALIFIED INVESTORS IN ANY MEMBER STATE OF THE EEA AND WILL NOT BE ENGAGED IN WITH ANY OTHER PERSONS. EACH PERSON WHO INITIALLY ACQUIRES ANY BONDS OR TO WHOM ANY OFFER OF BONDS MAY BE MADE WILL BE DEEMED TO HAVE REPRESENTED, ACKNOWLEDGED AND AGREED THAT IT IS A "QUALIFIED INVESTOR" WITHIN THE MEANING OF ARTICLE 2(1)(E) OF THE PROSPECTUS DIRECTIVE.

NOTICE TO PROSPECTIVE INVESTORS IN THE UNITED KINGDOM

THIS OFFERING MEMORANDUM HAS NOT BEEN APPROVED FOR THE PURPOSES OF SECTION 21 OF THE FINANCIAL SERVICES AND MARKETS ACT 2000 (THE "FSMA") AND DOES NOT CONSTITUTE AN OFFER TO THE PUBLIC IN ACCORDANCE WITH THE PROVISIONS OF SECTION 85 OF THE FSMA. THIS OFFERING MEMORANDUM IS FOR DISTRIBUTION ONLY TO, AND IS DIRECTED SOLELY AT, PERSONS WHO (I) ARE OUTSIDE THE UNITED KINGDOM, (II) ARE INVESTMENT PROFESSIONALS, AS SUCH TERM IS DEFINED IN ARTICLE 19(5) OF THE FINANCIAL SERVICES AND MARKETS ACT 2000 (FINANCIAL PROMOTION) ORDER 2005, AS AMENDED (THE "FINANCIAL PROMOTION ORDER"), (III) ARE PERSONS FALLING WITHIN ARTICLE 49(2)(A) TO (D) OF THE FINANCIAL PROMOTION ORDER, OR (IV) ARE PERSONS TO WHOM AN INVITATION OR INDUCEMENT TO ENGAGE IN INVESTMENT ACTIVITY (WITHIN THE MEANING OF SECTION 21 OF THE FSMA) IN CONNECTION WITH THE ISSUE OR SALE OF ANY SECURITIES MAY OTHERWISE BE LAWFULLY COMMUNICATED OR CAUSED TO BE COMMUNICATED (ALL SUCH PERSONS TOGETHER BEING REFERRED TO AS "RELEVANT PERSONS"). THIS OFFERING MEMORANDUM IS DIRECTED ONLY AT RELEVANT PERSONS AND MUST NOT BE ACTED ON OR RELIED ON BY PERSONS WHO ARE NOT RELEVANT PERSONS, INCLUDING IN CIRCUMSTANCES IN WHICH SECTION 21(1) OF THE FSMA APPLIES TO HOSPITALS. ANY INVESTMENT OR INVESTMENT ACTIVITY TO WHICH THIS OFFERING MEMORANDUM RELATES IS AVAILABLE ONLY TO RELEVANT PERSONS AND WILL BE ENGAGED IN ONLY WITH RELEVANT PERSONS. ANY PERSON WHO IS NOT A RELEVANT PERSON SHOULD NOT READ, ACT OR RELY ON THIS OFFERING MEMORANDUM OR ANY OF ITS CONTENTS.

NOTICE TO INVESTORS IN CANADA

NO PROSPECTUS HAS BEEN FILED WITH ANY SECURITIES COMMISSION OR SIMILAR REGULATORY AUTHORITY IN CANADA IN CONNECTION WITH THE OFFERING OF THE BONDS. NO SECURITIES COMMISSION OR SIMILAR REGULATORY AUTHORITY IN CANADA HAS REVIEWED OR IN ANY WAY PASSED UPON THIS OFFERING MEMORANDUM OR THE MERITS OF THE BONDS AND ANY REPRESENTATION TO THE CONTRARY IS AN OFFENCE. THIS OFFERING MEMORANDUM IS NOT, AND UNDER NO CIRCUMSTANCES IS TO BE CONSTRUED AS, AN ADVERTISEMENT OR A PUBLIC OFFERING OF THE BONDS IN CANADA.

THE BONDS MAY BE SOLD IN CANADA ONLY TO PURCHASERS PURCHASING, OR DEEMED TO BE PURCHASING, AS PRINCIPAL THAT ARE ACCREDITED INVESTORS, AS DEFINED IN NATIONAL INSTRUMENT

45-106 PROSPECTUS EXEMPTIONS OR SUBSECTION 73.3(1) OF THE SECURITIES ACT (ONTARIO), AND ARE PERMITTED CLIENTS, AS DEFINED IN NATIONAL INSTRUMENT 31-103 REGISTRATION REQUIREMENTS, EXEMPTIONS AND ONGOING REGISTRANT OBLIGATIONS. ANY RESALE OF THE BONDS MUST BE MADE IN ACCORDANCE WITH AN EXEMPTION FROM, OR IN A TRANSACTION NOT SUBJECT TO, THE PROSPECTUS REQUIREMENTS OF APPLICABLE SECURITIES LAWS.

SECURITIES LEGISLATION IN CERTAIN PROVINCES OR TERRITORIES OF CANADA MAY PROVIDE A PURCHASER WITH REMEDIES FOR RESCISSION OR DAMAGES IF THIS OFFERING MEMORANDUM (INCLUDING ANY AMENDMENT THERETO) CONTAINS A MISREPRESENTATION, PROVIDED THAT THE REMEDIES FOR RESCISSION OR DAMAGES ARE EXERCISED BY THE PURCHASER WITHIN THE TIME LIMIT PRESCRIBED BY THE SECURITIES LEGISLATION OF THE PURCHASER'S PROVINCE OR TERRITORY. THE PURCHASER SHOULD REFER. TO ANY APPLICABLE PROVISIONS OF THE SECURITIES LEGISLATION OF THE PURCHASER'S PROVINCE OR TERRITORY FOR PARTICULARS OF THESE RIGHTS OR CONSULT WITH A LEGAL ADVISOR.

PURSUANT TO SECTION 3A.3 OF NATIONAL INSTRUMENT 33-105 UNDERWRITING CONFLICTS (NI 33-105), THE UNDERWRITERS ARE NOT REQUIRED TO COMPLY WITH THE DISCLOSURE REQUIREMENTS OF NI 33-105 REGARDING UNDERWRITER CONFLICTS OF INTEREST IN CONNECTION WITH THIS OFFERING.

NOTICE TO INVESTORS IN SWITZERLAND

THIS OFFERING MEMORANDUM IS NOT INTENDED TO CONSTITUTE AN OFFER OR SOLICITATION TO PURCHASE OR INVEST IN THE BONDS DESCRIBED HEREIN. THE BONDS MAY NOT BE PUBLICLY OFFERED, SOLD OR ADVERTISED, DIRECTLY OR INDIRECTLY, IN, INTO OR FROM SWITZERLAND AND WILL NOT BE LISTED ON THE SIX SWISS EXCHANGE LTD. OR ON ANY OTHER EXCHANGE OR REGULATED TRADING FACILITY IN SWITZERLAND. NEITHER THIS OFFERING MEMORANDUM NOR ANY OTHER OFFERING OR MARKETING MATERIAL RELATING TO THE BONDS CONSTITUTES A PROSPECTUS AS SUCH TERM IS UNDERSTOOD PURSUANT TO ARTICLE 652A OR ARTICLE 1156 OF THE *SWISS CODE OF OBLIGATIONS* OR A LISTING PROSPECTUS WITHIN THE MEANING OF THE LISTING RULES OF THE SIX SWISS EXCHANGE LTD. OR ANY OTHER REGULATED TRADING FACILITY IN SWITZERLAND. ACCORDINGLY, THIS OFFERING MEMORANDUM IS COMMUNICATED IN OR FROM SWITZERLAND TO A LIMITED NUMBER OF SELECTED INVESTORS ONLY, AND NEITHER THIS OFFERING MEMORANDUM NOR ANY OTHER OFFERING OR MARKETING MATERIAL RELATING TO THE BONDS MAY BE PUBLICLY DISTRIBUTED OR OTHERWISE MADE PUBLICLY AVAILABLE IN OR FROM SWITZERLAND.

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SUMMARY OF THE OFFERING

Issuer	Kaiser Foundation Hospitals ("Hospitals")
Guarantors	Kaiser Foundation Health Plan, Inc., Kaiser Hospital Asset Management, Inc. and Kaiser Health Plan Asset Management, Inc.
Securities Offered	$575,000,000 3.150% Series 2017 Bond (Green Bond) due May 1, 2027 Price: 99.635% Yield: 3.193% $1,500,000,000 4.150% Series 2017 Bond due May 1, 2047 Price: 99.051% Yield: 4.206%
Interest Accrual Dates	Interest will accrue from the Settlement Date.
Interest Payment Dates	Interest on the Bonds is payable semi-annually on May 1 and November 1 of each year, commencing November 1, 2017.
Redemption	The Bonds maturing on May 1, 2027 are subject to optional redemption in whole or in part by Hospitals prior to maturity, on any Business Day, (i) before February 1, 2027, at the Make-Whole Redemption Price applicable to such Bonds, together with accrued interest thereon to the date fixed for redemption and (ii) on or after February 1, 2027, at a redemption price equal to 100% of the principal amount of such Bonds to be redeemed, together with accrued interest thereon to the date fixed for redemption, as further described herein. The Bonds maturing on May 1, 2047 are subject to optional redemption in whole or in part by Hospitals prior to maturity, on any Business Day, (i) before November 1, 2046, at the Make-Whole Redemption Price applicable to such Bonds, together with accrued interest thereon to the date fixed for redemption and (ii) on or after November 1, 2046, at a redemption price equal to 100% of the principal amount of such Bonds to be redeemed, together with accrued interest thereon to the date fixed for redemption, as further described herein.
Settlement Date	May 3, 2017
Authorized Denominations	$1,000 and any integral multiple thereof.
Form and Depository	The Bonds will be delivered solely in book-entry form through the facilities of DTC.
Use Of Proceeds	Hospitals will use proceeds of the Bonds for general corporate purposes consistent with the Credit Group's charitable purposes. See "PLAN OF FINANCE" herein.
Ratings	Fitch: A+, stable outlook S&P: AA-, stable outlook For an explanation of the ratings, see "RATINGS" herein.

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OFFERING MEMORANDUM

$2,075,000,000
KAISER PERMANENTE
Taxable Bonds
Series 2017

INTRODUCTORY STATEMENT

The following introductory statement is subject in all respects to the more complete information set forth in this Offering Memorandum. All descriptions and summaries of documents referred to herein do not purport to be comprehensive or definitive and are qualified in their entirety by reference to each such document. Terms used in this Offering Memorandum and not otherwise defined have the same meanings as in the Indenture (as defined below). See APPENDIX B – "SUMMARY OF PRINCIPAL DOCUMENTS—DEFINITIONS."

Purpose of the Offering Memorandum

This Offering Memorandum, including the cover page and the appendices hereto, is provided to furnish information in connection with the sale and delivery of $2,075,000,000 aggregate principal amount of Kaiser Permanente Taxable Bonds, Series 2017 (the "Bonds"), to be issued by Kaiser Foundation Hospitals, a California nonprofit public benefit corporation ("Hospitals").

The Bonds

The Bonds will be issued pursuant to and secured by an indenture, dated as of May 1, 2017 (the "Indenture"), between Hospitals and Wilmington Trust, National Association, as trustee (the "Trustee"). Kaiser Foundation Health Plan, Inc. ("Health Plan, Inc."), Kaiser Hospital Asset Management, Inc. ("HAMI") and Kaiser Health Plan Asset Management, Inc. ("HPAMI" and, together with Health Plan, Inc. and HAMI, the "Guarantors"), all California nonprofit public benefit corporations, will guarantee Hospitals' obligations under the Indenture, pursuant to a guarantee agreement, dated as of May 1, 2017 (the "Guarantee Agreement"), between the Trustee and the Guarantors. Subsequent to the issuance of the Bonds, Hospitals may issue Additional Bonds, which may be consolidated with the Bonds under a supplemental indenture, upon the terms and conditions set forth in the Indenture. See APPENDIX B – "SUMMARY OF PRINCIPAL DOCUMENTS—Indenture—Additional Bonds."

Kaiser Permanente

Kaiser Permanente is the trade name for the integrated health care delivery system that delivers health care services through an integrated system of health plans, hospitals and physician groups that are related through parent/subsidiary or contractual relationships or common boards of directors and senior management operating as the Kaiser Permanente Medical Care Program. Kaiser Permanente grew out of the prepaid health system established to serve workers and their families during the construction of the Grand Coulee Dam in the late 1930s. Later, Kaiser Permanente expanded to provide health care to workers and their families at the World War II Henry J. Kaiser shipyards in Richmond, California, the Portland-Vancouver area of Oregon and Washington, and the Kaiser Steel Mill in Fontana, California. Since then Kaiser Permanente has expanded nationally, and now operates in eight states and the District of Columbia, with a concentration of its member base and health care facilities in California.

Kaiser Permanente consists of the following: (1) Hospitals and its subsidiaries, including HAMI (described further below), (2) Health Plan, Inc. and its subsidiaries, including HPAMI (described further below) and five regional health plan organizations (the "Affiliated Health Plans" and, together with Health Plan, Inc., the "Health Plan Organizations"), and (3) eight independent medical groups (the "Permanente Medical Groups") and several other entities that engage in activity under the system known as the Kaiser Permanente Medical Care Program. Hospitals and its subsidiaries and Health Plan, Inc. and its subsidiaries are collectively referred to herein as "Kaiser" and references to "Kaiser" should not be considered to include the Permanente Medical Groups.

HAMI exists primarily to own certain capital assets and lease such assets for use by Hospitals in furtherance of Hospitals' health care delivery mission. HPAMI exists primarily to own certain capital assets and

lease such assets for use by Health Plan, Inc. in furtherance of Health Plan, Inc.'s health care delivery mission. Health Plan, Inc. serves members in California and Hawaii. The Affiliated Health Plans serve members in the other geographic regions – Colorado, Georgia, Mid-Atlantic States, Northwest and Washington – in which Kaiser Permanente operates. Health Plan, Inc. is a licensed "health care service plan" under the State of California Knox-Keene Health Care Service Plan Act of 1975, not an insurance company, and statements in this Offering Memorandum should not be construed otherwise. Each of Hospitals, HAMI, the Health Plan Organizations and HPAMI is a nonprofit corporation exempt from federal income taxation as an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code").

The Permanente Medical Groups are independent for-profit professional entities that provide physician services to members of the Health Plan Organizations through exclusive contractual arrangements. The Permanente Medical Groups, although part of the Kaiser Permanente Medical Care Program, are organizations independent of Kaiser and are not subsidiaries or affiliates. In addition, none of Hospitals, HAMI, HPAMI or the Health Plan Organizations has any shareholder or partnership interest in any of the Permanente Medical Groups. For more information on the corporate organization of Kaiser, see "INFORMATION ABOUT KAISER" herein.

Most Kaiser members enroll under agreements between their employers and one of the Health Plan Organizations. Services are provided principally at facilities owned by Hospitals or the Health Plan Organizations. In the California, Hawaii and Northwest regions, although Hospitals owns and operates hospitals, a significant amount of member care is also provided by non-owned community hospitals. In the Washington region, Kaiser Foundation Health Plan of Washington (formerly Group Health Cooperative) ("KFHP-WA") has contracts with local community hospitals for most hospital services but also owns and operates a hospital. In the Colorado, Georgia, and Mid-Atlantic States regions, Hospitals does not own or operate hospitals. Rather, it assumes the responsibility to arrange for hospital services required by Health Plan Organization members, usually at local community hospitals. In most regions, physician services are provided by physicians affiliated with the Permanente Medical Group that contracts exclusively with the regional Health Plan Organization or by community physicians that are under contract with that Permanente Medical Group. In the Washington region, there is a similar arrangement for physician services with the regional Permanente Medical Group; however, KFHP-WA also has contracts with community physicians. As of February 28, 2017, Kaiser collectively had more than 11.7 million members. See "INFORMATION ABOUT KAISER" herein

The Credit Group

Hospitals will be obligated to pay the principal or Make-Whole Redemption Price of and interest on the Bonds under the Indenture. Hospitals' obligations under the Indenture will be guaranteed by the Guarantors pursuant to the Guarantee Agreement. Hospitals and the Guarantors collectively are referred to herein as the "Credit Group." Hospitals and the Guarantors together comprise the Credit Group for purposes of the principal borrowing activity of Kaiser. Hospitals and the Guarantors are the only Kaiser entities with an obligation to make payments with respect to the Bonds. None of the Affiliated Health Plans, the other subsidiaries of Health Plan, Inc. or Hospitals, or the Permanente Medical Groups has any obligation to make payments with respect to the Bonds, nor is any of such organizations party to any agreement relating to the Bonds. The Credit Group is a subset of Kaiser, and the combined financial information included under the caption "INFORMATION ABOUT KAISER" and the combined audited financial statements included as Appendix A include the assets and operations of the members of the Credit Group and all other Kaiser entities. For the fiscal year ended December 31, 2016, the Credit Group generated 84.2% of the revenue and 99.5% of the net income of Kaiser and represented 97.4% of the net worth of Kaiser.

The Permanente Medical Groups, although part of the Kaiser Permanente Medical Care Program, are organizations independent of Hospitals and the Health Plan Organizations and are not subsidiaries or affiliates. Financial information for the Permanente Medical Groups is not reported in the combined financial statements of Kaiser.

The obligations of the Credit Group to make payments with respect to the Bonds are general unsecured obligations. No property or revenues of the Credit Group are pledged as security for the Bonds. No reserve fund will be established with respect to the Bonds. For a more detailed description of the obligations of Hospitals under

the Indenture and of the Guarantors under the Guarantee Agreement, see APPENDIX B – "SUMMARY OF PRINCIPAL DOCUMENTS."

Plan of Finance

The issuance of the Bonds is a component of Hospitals' financing plan. In addition to the issuance of the Bonds, (i) the California Health Facilities Financing Authority (the "Authority") is expected to issue two separate subseries of bonds bearing interest at fixed rates (the "Tax-Exempt Fixed Rate Bonds"), the interest on which will be excluded from gross income for federal income tax purposes under Section 103 of the Code, and (ii) the Authority is expected to issue three separate series of bonds bearing interest at variable rates (the "Tax-Exempt Variable Rate Bonds"), the interest on which will be excluded from gross income for federal income tax purposes under Section 103 of the Code. The Bonds, the Tax-Exempt Fixed Rate Bonds, and the Tax-Exempt Variable Rate Bonds, collectively, are referred to herein as the "Series 2017 Bonds." The obligation of Hospitals with respect to each series of the Series 2017 Bonds will be guaranteed by the Guarantors.

The proceeds of the Series 2017 Bonds are expected to be used, together with other funds, to (i) finance, including reimburse for, the costs of the construction, expansion, remodeling, renovation, furnishing, equipping and acquisition of certain health facilities (collectively, the "Projects"), (ii) refinance certain taxable commercial paper issued, and expected to be issued before the date of delivery of the Series 2017 Bonds, by Hospitals, the proceeds of which refinanced, or are expected to refinance before the date of delivery of the Series 2017 Bonds, certain bonds previously issued for the benefit of Hospitals, and (iii) with respect to the Bonds, fund general corporate purposes consistent with the Credit Group's charitable purposes. The proceeds of the Bond maturing on May 1, 2027 and certain of the Tax-Exempt Fixed Rate Bonds (collectively, the "Green Bonds"), however, will be used only to finance or reimburse, in whole or in part, capital expenditures and costs associated with the construction of one or more Eligible Green Projects (defined herein). For further information regarding the use of proceeds of the Series 2017 Bonds, including the Green Bonds, and the labeling of the Bond maturing on May 1, 2027 and certain of the Tax-Exempt Fixed Rate Bonds as "Green Bonds," see "PLAN OF FINANCE." In addition, a photograph of one of the Eligible Green Projects is set forth on the inside front cover of this Offering Memorandum. It is anticipated that the Series 2017 Bonds will be issued simultaneously, but the issuance of any series of the Series 2017 Bonds is not conditioned on the issuance of any other series.

THE BONDS

The following is a summary of certain provisions of the Bonds. Reference is made to the Bonds for the complete text thereof and to the Indenture for all of the provisions relating to the Bonds. The discussion herein is qualified by such reference.

General

The Bonds will be issued only as fully registered bonds and, when issued, will be registered in the name of Cede & Co. or such other name as may be requested by an authorized representative of The Depository Trust Company, New York, New York ("DTC"), as nominee of DTC. DTC will act as securities depository for the Bonds. Ownership interests in the Bonds may be purchased in book-entry form only in denominations of $1,000 or any integral multiple thereof. Principal or redemption price, including Make-Whole Redemption Price, if any, of and interest on the Bonds will be payable by the Trustee to DTC, which is obligated, in turn, to remit principal or redemption price, including Make-Whole Redemption Price, if any, and interest to DTC Participants, upon DTC's receipt of funds and corresponding detail information from the Trustee, for subsequent disbursement to Beneficial Owners of such Bonds. Beneficial interests in the Bonds may be held through DTC, Clearstream Banking, S.A ("Clearstream Banking") or Euroclear Bank S.A./N.V. ("Euroclear") as operator of the Euroclear System, directly as a participant or indirectly through organizations that are participants in such system. See APPENDIX C – "DTC BOOK-ENTRY SYSTEM AND GLOBAL CLEARANCE PROCEDURES."

The Credit Group cannot and does not give any assurances that DTC will distribute to DTC Participants or that DTC Participants or DTC Indirect Participants or others will distribute to the Beneficial Owners payments of principal or redemption price, including Make-Whole Redemption Price, if any, of and interest on the Bonds or any redemption notices or other notices or that they will do so on a timely basis or will serve and act in the manner

described in this Offering Memorandum. The Credit Group is not responsible or liable for the failure of DTC, any DTC Participant or any DTC Indirect Participant to make any payments or give any notice to a Beneficial Owner with respect to the Bonds or any error or delay relating thereto.

The Bonds will bear interest at the fixed rates set forth on the cover page hereof.

Interest on the Bonds is payable on November 1, 2017 and semiannually thereafter on May 1 and November 1 of each year. In the event that the book-entry system shall no longer be used with respect to the Bonds, interest on the Bonds will be payable by check mailed to the Beneficial Owners of the Bonds at their addresses as they appear on the bond registration books maintained by the Trustee as of the fifteenth day of the month (whether or not a Business Day) preceding each interest payment date for the Bonds (each a "Record Date"), provided, however, that interest shall be paid by wire transfer of immediately available funds to any owners of the Bonds of at least $1,000,000 in aggregate principal amount of the Bonds, according to wire instructions given to the Trustee in writing and on file prior to the applicable Record Date, or as of a special record date established for the payment of defaulted interest. The principal of the Bonds will be payable at the Corporate Trust Office of the Trustee.

Redemption

Optional Redemption. The Bonds maturing on May 1, 2027 are subject to redemption prior to their stated maturity at the written direction of Hospitals, in whole or in part on any Business Day (i) before February 1, 2027, at the Make-Whole Redemption Price applicable to such Bonds, together with accrued interest to the date fixed for redemption and (ii) on or after February 1, 2027, at a redemption price equal to 100% of the principal amount of such Bonds to be redeemed, together with accrued interest to the date fixed for redemption.

The Bonds maturing on May 1, 2047 are subject to redemption prior to their stated maturity at the written direction of Hospitals, in whole or in part on any Business Day, (i) before November 1, 2046, at the Make-Whole Redemption Price applicable to such Fixed Rate Bonds, together with accrued interest to the date fixed for redemption and (ii) on or after November 1, 2046, at a redemption price equal to 100% of the principal amount of such Fixed Rate Bonds to be redeemed, together with accrued interest to the date fixed for redemption.

As used herein, the Make-Whole Redemption Price shall mean the greater of (i) 100% of the principal amount of any Bonds being redeemed, or (ii) the sum of the present values of the remaining scheduled payments of principal and interest on any Bonds being redeemed (exclusive of interest accrued to the date of redemption) discounted to the redemption date on a semi-annual basis (assuming a 360-day year consisting of twelve 30-day months) at the Treasury Rate plus (i) for Bonds maturing on May 1, 2027, 15 basis points, or (ii) for Bonds maturing on May 1, 2047, 20 basis points. For purposes of this paragraph, the following definitions apply:

"Comparable Treasury Issue" means the United States Treasury security or securities selected by a Designated Investment Banker as having an actual or interpolated maturity comparable to the remaining term of the Bonds to be redeemed that would be utilized, at the time of selection and in accordance with customary financial practice, in pricing new issues of corporate debt securities of a comparable maturity to the remaining term of such Bonds.

"Comparable Treasury Price" means, with respect to any redemption date, the average of the Reference Treasury Dealer Quotations for such redemption date or, if the Designated Investment Banker obtains only one Reference Treasury Dealer Quotation, such Reference Treasury Dealer Quotation.

"Designated Investment Banker" means one of the Reference Treasury Dealers appointed by Hospitals.

"Reference Treasury Dealer" means each of Goldman, Sachs & Co, Citigroup Global Markets Inc., J.P. Morgan Securities LLC, Barclays Capital Inc., Morgan Stanley & Co. LLC, and Wells Fargo Securities, LLC or their respective affiliates which are primary U.S. government securities dealers, and their respective successors; provided that if Goldman, Sachs & Co, Citigroup Global Markets Inc., J.P. Morgan Securities LLC, Barclays Capital Inc., Morgan Stanley & Co. LLC, or Wells Fargo Securities, LLC or their respective affiliates shall cease to be a primary U.S. government securities dealer (a "Primary Treasury Dealer"), Hospitals shall substitute therefor another Primary Treasury Dealer.

"Reference Treasury Dealer Quotations" means, with respect to each Reference Treasury Dealer and any redemption date for the Bonds, the average, as determined by the Designated Investment Banker, of the bid and asked prices for the Comparable Treasury Issue (expressed in each case as a percentage of its principal amount) quoted in writing to the Designated Investment Banker by such Reference Treasury Dealer at 3:30 p.m., New York City time, on the third Business Day preceding such redemption date.

"Treasury Rate" means, with respect to any redemption date for the Bonds, the rate per annum equal to the semiannual equivalent yield to maturity or interpolated (on a day count basis) of the Comparable Treasury Issue, computed as of the second Business Day immediately preceding such redemption date, assuming a price for the Comparable Treasury Issue (expressed as a percentage of its principal amount) equal to the Comparable Treasury Price for such redemption date.

Selection of Bonds for Redemption. If less than all of the Bonds of a maturity are to be redeemed, the Trustee shall select the Bonds of a maturity to be redeemed from the Bonds Outstanding of such maturity not previously called for redemption on a pro-rata basis.

If the Bonds are registered in book-entry only form and so long as DTC or a successor Securities Depository is the sole registered owner of Bonds, if less than all of the Bonds of a maturity are called for prior redemption, the particular Bonds or portions thereof to be redeemed shall be selected on a pro rata pass-through distribution of principal basis in accordance with DTC procedures, provided that, so long as the Bonds are held in book-entry form, the selection for redemption of such Bonds shall be made in accordance with the operational arrangements of DTC then in effect. If the DTC operational arrangements do not allow for the redemption of the Bonds on a pro rata pass-through distribution of principal basis as discussed above, the Bonds will be selected for redemption, in accordance with DTC procedures, by lot.

It is Hospitals' intent that redemption allocations made by DTC be made on a pro rata pass-through distribution of principal basis as described above. However, Hospitals can provide no assurance that DTC, DTC's Direct and Indirect Participants or any other intermediary will allocate the redemption of Bonds on such basis.

Notice of Redemption; Effect of Redemption. Notice of redemption will be mailed by first class mail by the Trustee, not less than 20 days and not more than 60 days prior to the redemption date, to the Holders of any Bonds designated for redemption at their addresses appearing on the bond registration books of the Trustee. Each notice of redemption shall state the date of such notice, the date of issuance of the Bonds, the redemption date, the method of calculating the Make-Whole Redemption Price, or that the redemption price will be the aggregate principal amount of the Bonds to be redeemed, as applicable, the place or places of redemption (including the name and appropriate address or addresses of the Trustee), the maturity, the CUSIP number, if any, and, in the case of Bonds to be redeemed in part only, the respective portions of the principal amount thereof to be redeemed. The failure by the Trustee to mail notice of redemption to any one or more of the Holders of any Bonds designated for redemption shall not affect the sufficiency of the proceedings for the redemption of the Bonds with respect to the Holder or Holders to whom such notice was mailed. Notice of redemption having been given in accordance with the Indenture and moneys for payment of the Make-Whole Redemption Price or aggregate principal amount of, the Bonds to be redeemed, as applicable, together with interest accrued to the redemption date on, the Bonds (or portions thereof) so called for redemption being held by the Trustee, the Bonds so called for redemption shall become due and payable at the Make-Whole Redemption Price (and accrued interest) specified in such notice, and interest accrued on such Bonds to the date fixed for redemption, interest on such Bonds shall cease to accrue from and after the redemption date, and the Holders of said Bonds shall have no rights in respect thereof except to receive payment of said Make-Whole Redemption Price or aggregate principal amount of such Bonds, as applicable, and accrued interest to the date fixed for redemption from funds held by the Trustee for such payment.

Conditional Notice; Rescission of Notice of Redemption. Hospitals may instruct the Trustee to provide conditional notice of redemption, which may be conditioned on the receipt of money or any other event. If such conditions are not met, the Trustee shall give notice, as soon thereafter as practicable, in the same manner, to the same persons, as notice of redemption was given. Additionally, any notice of optional redemption may be rescinded by written notice given to the Trustee by Hospitals no later than two Business Days prior to the date specified for redemption. The Trustee shall give notice of such rescission as soon thereafter as practicable in the same manner, and to the same persons, as notice of such redemption was given.

Additional Bonds

The Indenture provides that, subsequent to the issuance of the Bonds, Hospitals may issue Additional Bonds pursuant to a supplemental indenture. Such Additional Bonds would have the same fixed interest rate, maturity date and redemption provisions as the maturity of the Bonds with which such Additional Bonds are consolidated with, and would constitute a part of the issue of the Bonds. As a condition to any such issuance of Additional Bonds, Hospitals would need to certify that, among other things, such issuance would not cause any adverse tax impact to the then existing Holders of outstanding Bonds. See APPENDIX B – "SUMMARY OF PRINCIPAL DOCUMENTS—Indenture—Additional Bonds."

SECURITY FOR THE BONDS

Guarantee Agreement

The Bonds of each Series will be payable solely from payments made by Hospitals under the Indenture, from payments made by the Guarantors under the Guarantee Agreement and from certain funds held under the Indenture. As the sole Kaiser party to the Indenture, Hospitals is the primary obligor for payments with respect to the Bonds. Pursuant to the Guarantee Agreement, each of the Guarantors guarantees the obligations of Hospitals under the Indenture. The payment obligations of Hospitals and the Guarantors are general unsecured obligations of each entity.

Covenants

Pursuant to the Indenture and the Guarantee Agreement, Hospitals and the Guarantors agree to comply with various covenants. In particular, Hospitals and the Guarantors agree that they will not create, assume or suffer to exist any security interest on any property or revenues of any Affiliated Corporation, other than Permitted Encumbrances, unless the obligations of Hospitals under the Indenture shall be secured prior to or equally and ratably with any indebtedness or other obligation secured with such security interest. Permitted Encumbrances include liens incurred in connection with certain outstanding indebtedness of the Affiliated Corporations and, within certain limitations, liens securing future indebtedness of the Affiliated Corporations. Hospitals and the Guarantors also agree not to sell, lease or otherwise dispose of any of their assets (including cash) or permit any Affiliated Corporation to sell, lease or otherwise dispose of any of its assets (including cash) in any Fiscal Year with a net book value in excess of 10% of Consolidated Net Tangible Assets unless any assets in excess of such limitation are sold, leased or disposed of at a price equal to their fair market value and Hospitals or the applicable Guarantor applies (or causes an Affiliated Corporation to apply) the net proceeds of such sale, lease or disposition, within 120 days of such sale, lease or disposition, to either the redemption of long-term indebtedness of Hospitals or the Guarantors or of any other Affiliated Corporation or the acquisition of additional assets. Other than these covenants, which are further described in, and the other covenants described in APPENDIX B – "SUMMARY OF PRINCIPAL DOCUMENTS," there are no covenants that restrict the activities, including the incurrence of additional indebtedness, of Hospitals or the Guarantors.

Considerations Regarding Enforceability of the Guarantee Agreement

The legal right and practical ability of the Trustee to enforce its rights and remedies against Hospitals under the Indenture and against the Guarantors under the Guarantee Agreement may be limited by laws relating to bankruptcy, insolvency, reorganization, fraudulent conveyance or moratorium and by other similar laws affecting creditors' rights. In particular, the obligation of a Guarantor under the Guarantee Agreement may be avoided or determined to be unenforceable under the United States Bankruptcy Code (the "Bankruptcy Code") or applicable state fraudulent transfer or conveyance statutes if the obligation was incurred without "fair consideration" or "reasonably equivalent value" to the Guarantor and if the incurrence of the obligation occurred when the Guarantor was insolvent or rendered the Guarantor insolvent or left the Guarantor with the inability to pay its debts as they came due or with unreasonably small capital. The standards for determining the fairness of consideration, whether there was reasonably equivalent value and insolvency are matters of judicial discretion and may vary under the Bankruptcy Code and other state statutes that may be applicable. In addition, the Trustee's ability to enforce such terms will depend upon the exercise of various remedies specified by such documents, which in many instances may

require judicial actions that often are subject to discretion and delay, may not otherwise be readily available, or may be limited by certain legal principles.

There exists common law authority and authority under certain statutes for the ability of the courts to terminate the existence of a nonprofit corporation or undertake supervision of its affairs on various grounds, including a finding that such corporation has insufficient assets to carry out its stated charitable purposes. Such court action may arise on the court's own motion or pursuant to a petition of the state attorney general or such other persons who have interests different from those of the general public, pursuant to the common law and statutory power to enforce charitable trusts and to see to the application of their funds to their intended charitable uses.

The various legal opinions delivered concurrently with the issuance of the Bonds will be qualified as to the enforceability of the various legal instruments by limitations imposed by state and federal laws, rulings, policy and decisions affecting available remedies, and by bankruptcy, reorganization or other laws of general application affecting the enforcement of creditors' rights or the enforceability of certain remedies or document provisions.

Availability of Remedies. The remedies available to the Trustee and the Holders of the Bonds upon an Event of Default under the Indenture or the Guarantee Agreement are in many respects dependent upon judicial actions which are often subject to discretion and delay. Under existing constitutional and statutory law and judicial decisions, including, specifically, the Bankruptcy Code, the remedies provided in the Indenture or the Guarantee Agreement may not be readily available or may be limited.

Bankruptcy. If a Credit Group member files for protection from creditors under the Bankruptcy Code, the rights and remedies of the Holders of the Bonds would be subject to various provisions of the Bankruptcy Code. If a Credit Group member were to commence a proceeding in bankruptcy, payments made by that member during the 90-day period immediately preceding such commencement (or, under certain circumstances, during the preceding one-year period) may be voided as preferential transfers to the extent such payments allow the recipients thereof to receive more than they would have received in the event of the liquidation of such Credit Group member. Security interests and other liens granted by such member to the Trustee and perfected during such preference period may also be voided as preferential transfers to the extent such security interest or other lien secures obligations that arose prior to the date of such grant or perfection.

A bankruptcy filing by a Credit Group member would operate as an automatic stay of the commencement or continuation of any judicial or other proceeding against such Credit Group member and its property and as an automatic stay of any act or proceeding to enforce a lien upon or to otherwise exercise control over its property as well as various other actions to enforce, maintain or enhance the rights of the Trustee. If the bankruptcy court so ordered, the property of such Credit Group member could be used for the financial reorganization of such Credit Group member. The rights of the Trustee to enforce its interest could be delayed during the pendency of the reorganization proceeding.

There are, however, a few exceptions to the automatic stay, including that the automatic stay does not stay the enforcement of governmental "police and regulatory power." This means, for example, that state and federal regulators may take actions to protect the health and safety of patients, so long as those actions are not motivated simply by the fact that the debtor is in bankruptcy and not paying its pre-bankruptcy obligations. In addition, the commencement of a bankruptcy case generally will not relieve a healthcare provider of its duty to comply with applicable state laws and regulatory schemes, particularly as it impacts public health and safety. A debtor in possession must "manage and operate" property of the estate "according to the requirements of the valid laws of the state" as if there were no bankruptcy. For example, the Bankruptcy Code requires that any sale of assets by a non-profit debtor, such as Hospitals, be "in accordance with any applicable provisions of nonbankruptcy law that govern" sales by non-profits.

A Credit Group member could also file a plan of reorganization in any such proceeding, which could include provisions modifying or altering the rights of creditors generally, or any class of them, secured or unsecured. The plan, when confirmed by a bankruptcy court, binds all creditors who had notice or knowledge of the plan and, with certain exceptions, discharges all claims against the debtor to the extent provided for in the plan. No plan may be confirmed unless certain conditions are met, among which are conditions that the plan is feasible, that it shall have been accepted by each class of claims impaired thereunder and that creditors in impaired classes of claims who

do not vote in favor of the plan will receive at least as much under the plan as they would receive in a liquidation of the debtor. Each class of claims has accepted the plan if at least two-thirds in dollar amount and more than one-half in number of an impaired class of creditors who cast votes on the plan vote in favor of the plan. Even if the plan is not so accepted by an impaired class of creditors, the plan may be confirmed if at least one impaired class of creditors has voted to accept the plan and the bankruptcy court finds that the plan is fair and equitable with respect to each class of non-accepting creditors impaired thereunder and does not discriminate unfairly. Any such plan could adversely affect the Owners and Beneficial Owners of the Bonds.

The obligations of Hospitals and the Guarantors under the Indenture and the Guarantee Agreement are not secured by a lien on or security interest in any assets or revenues of Hospitals and the Guarantors. In the event of bankruptcy of a Credit Group member, Bondholders would be unsecured creditors and would be in an inferior position to any secured creditors. In addition, in the event of bankruptcy of a Credit Group member, there is no assurance that any covenant contained in the Indenture or the Guarantee Agreement and certain other documents would survive.

Amendments to the Indenture and the Guarantee Agreement

Certain amendments to the Indenture and the Guarantee Agreement may be made with the consent of the Holders of not less than a majority of the outstanding principal amount of the Bonds. Such amendments may adversely affect the security of Holders of such Bonds. The rights of the Beneficial Owners of such Bonds to consent to these amendments and the process of soliciting consents are determined pursuant to the book-entry procedures of DTC or any successor Securities Depository.

PLAN OF FINANCE

General

Concurrently with the issuance of the Bonds, the Authority is expected to issue the Tax-Exempt Variable Rate Bonds and the Tax-Exempt Fixed Rate Bonds. The Tax-Exempt Variable Rate Bonds and the Tax-Exempt Fixed Rate Bonds are offered pursuant to separate official statements. Hospitals' obligations with respect to the Tax-Exempt Variable Rate Bonds and the Tax-Exempt Fixed Rate Bonds will be guaranteed by the Guarantors. The aggregate principal amount of Tax-Exempt Variable Rate Bonds and Tax-Exempt Fixed Rate Bonds expected to be issued by the Authority is $379,460,000 and $1,747,015,000, respectively.

The Projects

General. A portion of the proceeds of the Series 2017 Bonds is expected to be used to finance, including reimburse for, the costs of the Projects.

Green Projects. Kaiser is committed to sustainability and has long-term environmental stewardship goals to guide the organization's sustainability efforts through 2025. The stewardship goals are part of Kaiser's community benefit efforts and are intended to advance Kaiser's mission of improving the health of its members. To minimize its environmental impact, Kaiser is working to become "carbon net positive" by purchasing clean energy and carbon offsets, supporting sustainable agriculture by purchasing food from local producers that use sustainable practices, reducing waste production by recycling, reusing or composting non-hazardous waste, and conserving water. In addition, Kaiser strives to purchase products and materials that meet Kaiser's environmental standards, and meet international standards for environmental management, and is pursuing new collaborations to reduce environmental risks to food sheds, watersheds and air basins supplying the communities in which Kaiser's members live.

Kaiser estimates that the proceeds from the sale of the Green Bonds (the "Green Bond Proceeds") will be $1,072,905,379. An amount equal to the Green Bond Proceeds will be used to finance or reimburse, in whole or in part, capital expenditures and costs associated with the construction of one or more Eligible Green Projects. Eligible

Green Projects are defined as: Kaiser medical facilities that have received or are expected to receive LEED[(1)] gold or platinum certification. Eligible Green Projects include: (i) developed and completed medical facilities, (ii) existing medical facilities with scheduled opening dates following the issue date of the Green Bonds and (iii) future projects with scheduled opening dates up to the maturity date of the Green Bonds. The purpose of labeling the Bond maturing on May 1, 2027 and a subseries of the Tax-Exempt Fixed Rate Bonds as "Green Bonds" is to allow investors to invest directly in projects that Kaiser has identified as promoting environmentally sustainable construction.

Kaiser has or will identify Eligible Green Projects based on the above-mentioned eligibility criteria. Disbursements related to Eligible Green Projects will be agreed upon by Kaiser Finance, National Facilities Services and the Environmental Stewardship officer. A photograph of one of the Eligible Green Projects is set forth on the inside front cover of this Offering Memorandum.

Kaiser has worked with Sustainalytics U.S. ("Sustainalytics"), a provider of environmental, social and governance research and analysis. Sustainalytics evaluated Kaiser's green bond transaction set forth in this Offering Memorandum and the alignment thereof with relevant industry standards, and provided views on the robustness and credibility of the Green Bonds within the meaning of the Green Bond Principles 2016.

Pending allocation of the Green Bond Proceeds to Eligible Green Projects, Kaiser will track and maintain an amount equal to the balance of unallocated Green Bond Proceeds in cash, cash equivalents, short term marketable securities, and/or U.S. Treasuries.

Annually, until the Green Bond Proceeds are fully allocated, Hospitals will provide disclosure regarding the amount of Green Bond Proceeds allocated to Eligible Green Projects, a brief description of each such Eligible Green Project and the LEED rating achieved for each such Eligible Green Project. Disclosure will be made through the Electronic Municipal Market Access system of the Municipal Securities Rulemaking Board, accessible at www.emma.msrb.org, and the annual disclosure will be made when the Credit Group provides its Annual Report (defined herein). See "CONTINUING DISCLOSURE" herein. Once all Green Bond Proceeds are allocated and disclosure regarding such allocation is made, no further updates on the amount of Green Bond Proceeds allocated to Eligible Green Projects, any Eligible Green Project, or the LEED rating achieved for any Eligible Green Project will be provided.

The term "Green Bonds" is neither defined in nor related to the Indenture or the Guarantee Agreement. The use of such term in this Offering Memorandum is solely for identification purposes and is not intended to provide or imply that any owner of the Bond maturing on May 1, 2027 is entitled to any security other than as provided in the Indenture.

The Refinancing

From time to time, Hospitals has issued taxable commercial paper and used the proceeds to redeem or purchase bonds previously issued for the benefit of Hospitals. A portion of the proceeds of the Series 2017 Bonds is expected to be used to refinance certain of Hospitals' taxable commercial paper. In addition, Hospitals expects to further issue taxable commercial paper before the date of delivery of the Series 2017 Bonds to purchase certain bonds previously issued for the benefit of Hospitals, and expects to refinance such taxable commercial paper with a portion of the proceeds of the Series 2017 Bonds.

[(1)] Leadership in Energy and Environmental Design ("LEED") is a voluntary, third-party building certification process developed by the U.S. Green Building Council ("USGBC"), a non-profit organization. The USGBC developed the LEED certification process to (i) evaluate the environmental performance from a whole-building perspective over a building's life cycle, (ii) provide a definitive standard for what constitutes a "green building," (iii) enhance environmental awareness among architects and building contractors, and (iv) encourage the design and construction of energy-efficient, water-conserving buildings that use sustainable or green resources and materials.

The Bonds

Proceeds of the Bonds may be used for general corporate purposes consistent with the Credit Group's charitable purposes.

ESTIMATED SOURCES AND USES OF FUNDS

The proceeds to be received from the sale of the Series 2017 Bonds, together with funds of the Credit Group, are estimated to be applied as set forth below (with all amounts rounded to the nearest whole dollar):

	Bonds	Tax-Exempt Fixed Rate Bonds	Tax-Exempt Variable Rate Bonds
Sources of Funds:			
Par Amount of Bonds	$ 2,075,000,000	$ 1,747,015,000	$ 379,460,000
Net Original Issue Premium/(Discount)	(16,333,750)	152,682,321	62,170,726
Credit Group Equity Contribution	11,322,668	10,360,121	1,627,809
Total Sources of Funds	$ 2,069,988,918	$ 1,910,057,442	$ 443,258,535
Uses of Funds:			
Deposit to Proceeds Fund:			
Project Costs	$ 572,901,250	$ 812,493,280	$ –
Payment of Indebtedness	–	1,087,730,000	441,620,000
General Corporate Purposes	1,485,765,000	–	–
Costs of Issuance[(1)]	11,322,668	9,834,162	1,638,535
Total Uses of Funds	$ 2,069,988,918	$ 1,910,057,442	$ 443,258,535

[(1)] Includes legal, printing, rating agency, accounting, Trustee fees, underwriters' compensation and other costs of issuance.

INFORMATION ABOUT KAISER

Health Care Services

Kaiser Permanente is the trade name for the integrated health care delivery system operating as the Kaiser Permanente Medical Care Program that delivers health care services through an integrated system of health plans, hospitals and physician groups that are related through parent/subsidiary or contractual relationships or common boards of directors and senior management. Hospitals is the controlling member of HAMI. Health Plan, Inc. is the ultimate controlling member of HPAMI and each of the Affiliated Health Plans.

The Health Plan Organizations enter into contracts with individuals and groups to arrange covered medical services on a predominantly prepaid basis. Each member's rights and his or her relationship to a Health Plan Organization are purely contractual; members have no proprietary interest in Hospitals' or a Health Plan Organization's assets. Some of the benefits under membership contracts typically are hospital care, professional care in hospitals and physicians' offices, imaging and laboratory services, physical therapy, emergency ambulance service, health education and certain prescription drugs. The Health Plan Organizations provide certain support services to Hospitals and the respective Permanente Medical Groups. In addition to performing functions such as enrollment and certain other operational functions, all of the Health Plan Organizations operate pharmacies at non-hospital locations.

For hospital services, the Health Plan Organizations (with the exception of KFHP-WA) contract with Hospitals to provide or arrange hospital and related services. Under the hospital service agreements, Health Plan, Inc. or the respective Affiliated Health Plan pays Hospitals at rates and in amounts intended to meet Hospitals' expenses. Hospitals operates community hospitals, and staff privileges may be granted to practitioners who qualify for medical staff membership and/or clinical privileges. In the Colorado, Georgia and Mid-Atlantic States regions, Hospitals does not own or operate hospitals. Rather, it assumes the responsibility to arrange for hospital services required by Health Plan Organization members, usually at local community hospitals. Hospitals directly provides

hospital services to members of Health Plan, Inc. in California and Hawaii, and to members of the Affiliated Health Plan located in the Northwest region. Hospitals also contracts with local community hospitals and specialty hospitals in those regions to provide a portion of members' hospital care. In California, Hospitals also contracts with the local Permanente Medical Groups to manage or provide for certain hospital-based services. In the Washington region, KFHP-WA contracts directly with community facilities to provide hospital and other facility services, and also provides some services directly through clinical care facilities, including one hospital, that it owns and operates.

For physician services, each Health Plan Organization contracts exclusively with the local Permanente Medical Group to provide or arrange professional and related medical care covered by membership contracts. Each of the exclusive medical service agreements between the Health Plan Organization and the Permanente Medical Group (with the exception of the Washington region) is for a term of one year, renewable upon mutual agreement or remaining in effect until terminated. The Washington region medical service agreement has a three year term, renewable for successive three year terms. The compensation paid to all Permanente Medical Groups is negotiated on an annual basis at arm's length and in consideration of the provision of professional medical and related administrative services. In some cases, additional compensation is budgeted but is paid only if and to the extent that certain financial, member satisfaction, quality or other goals are met. The Permanente Medical Groups are principally organized as professional corporations (one is a partnership) and are responsible for their own physician recruitment, selection and staffing. In California, the responsibilities of the two Permanente Medical Groups include employment of allied health professionals, including nurses and physician assistants, and administrative personnel. In the other Kaiser Permanente regions, a subset of these personnel may be employed by the regional Permanente Medical Group or by the regional Health Plan Organization. The Permanente Medical Groups derive substantially all of their professional income from serving Kaiser members.

All financial and membership information provided herein has been derived from Kaiser records.

Membership, Product Mix and Competition

Membership. As of February 28, 2017, Kaiser, through organization participation and individual memberships, provided medical, hospital and other health care services and coverage to more than 11.7 million members. Approximately 75% of the Kaiser members are enrolled in Health Plan, Inc., which serves members in California and Hawaii. Although Kaiser is well established and maintains a strong market position in these states, its geographic concentration exposes it to regulatory constraints, local demographic trends and economic conditions, which may include more stringent provider contracting restrictions and pricing constraints, higher unemployment levels and weaker general business conditions as compared to other regions of the United States or the nation as whole. See "BONDHOLDERS' RISKS—Significant Risk Areas Summarized—State Regulation of MCOs and Insurance Companies" and "—General Economic Conditions, Bad Debt, Indigent Care and Investment Performance" herein.

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The following table shows the membership of each Health Plan Organization and Kaiser Permanente Insurance Company, a California corporation ("KPIC"), and the general geographic areas served as of December 31, 2016 and 2015:

	As of December 31, 2016[1]		As of December 31, 2015	
	Number of Members	Percentage of Total Members	Number of Members	Percentage of Total Members
Health Plan, Inc.				
Northern California	3,992,501	38%	3,859,954	38%
Southern California	4,264,119	40%	4,102,673	40%
Hawaii The Islands of Kauai, Oahu and Maui; Portions of the Island of Hawaii	249,687	2%	245,559	2%
Health Plan, Inc.	8,506,307	80%	8,208,186	80%
Affiliated Health Plans				
Mid-Atlantic States Metropolitan Washington, D.C. and Baltimore Areas	665,402	6%	615,677	6%
Northwest Portland and Salem, Oregon; Vancouver and Longview-Kelso, Washington Areas	552,651	5%	528,727	5%
Colorado Denver, Boulder and Colorado Springs Areas	663,240	6%	622,351	6%
Georgia Atlanta Area	284,213	3%	267,207	3%
Affiliated Health Plans	2,165,506	20%	2,033,962	20%
Kaiser Permanente Insurance Company	3,771	0%	4,151	0%
Total	10,675,584	100%	10,246,299	100%

[1] Excludes the impact of the acquisition of Group Health Cooperative. Following the acquisition, Group Health Cooperative was renamed Kaiser Foundation Health Plan of Washington, which is an Affiliated Health Plan. As of February 28, 2017, membership of the Affiliated Health Plans had grown, primarily as a result of the acquisition of Group Health Cooperative, and total membership of the Health Plan Organizations and KPIC was 11,708,462. For information regarding the acquisition, see "INFORMATION ABOUT KAISER – Group Health Cooperative Acquisition" and Note 3 to the audited combined financial statements included as Appendix A.

The table below presents the following information as of December 31, 2016, 2015 and 2014: (i) the membership of Health Plan, Inc. and the Affiliated Health Plans, including KPIC, if applicable; (ii) the percentage change from period to period of total membership in all Health Plan Organizations together; (iii) Medicare membership for all Health Plan Organizations together; and (iv) Medicare's percentage of total membership in all Health Plan Organizations together.

As of Dec. 31,	Health Plan, Inc. Membership	Affiliated Health Plans Membership[1]	Total Membership	Percentage Change	Medicare Membership[2]	Medicare's Percentage of Total Membership[2]
2016	8,506,307	2,169,277	10,675,584	4.2%	1,412,564	13.2%
2015	8,208,186	2,038,113	10,246,299	6.7%	1,344,642	13.1%
2014	7,675,162	1,925,048	9,600,210	5.7%	1,267,853	13.2%

[1] Includes KPIC. Excludes the impact of the acquisition of Group Health Cooperative. As of February 28, 2017, membership of the Affiliated Health Plans and KPIC had grown to 2,950,318, primarily as a result of the acquisition of Group Health Cooperative. For information regarding the acquisition, see "INFORMATION ABOUT KAISER – Group Health Cooperative Acquisition" and Note 3 to the audited combined financial statements included as Appendix A.

[2] Reflects the combined Medicare membership for Health Plan, Inc. and the Affiliated Health Plans.

HMO Products and Other Products. One of the earliest health maintenance organizations ("HMOs") in the United States, Kaiser continues to focus on its HMO products as its core offerings. Key features of the HMO products include prepayment for medical services and required utilization of in-network providers by members. These HMO products are made available to large-, mid- and small-sized employer groups, as well as to individuals. Kaiser also offers HMO products to Medicare and Medicaid beneficiaries through its participation in the Medicare

Cost, Medicare Advantage and Medicare Advantage-Prescription Drug programs and to Medicaid beneficiaries through its participation in certain states' Medicaid managed care programs. For fiscal years ended December 31, 2016 and 2015, Medicare revenues represented 27% of Kaiser's total operating revenues (the majority of Kaiser's Medicare revenue is received from the Medicare Advantage program). For each fiscal year ended December 31, 2016 and 2015, Medicaid payments represented 4% of Kaiser's total operating revenues.

As of December 31, 2016, all of the Health Plan Organizations had received at least a 4.5 (out of 5) Medicare Star rating from the Centers for Medicare and Medicaid Services ("CMS") for their Medicare Advantage plans, with 5 receiving 5 stars. Most of the Health Plan Organizations were rated first in their respective geographies in both Commercial and Medicare health plan ratings in the 2016-2017 annual report by the National Committee for Quality Assurance ("NCQA") (in the Northern California region, Health Plan, Inc. was rated first for Commercial and second for Medicare health plan ratings and, in the Southern California region, Health Plan, Inc. was rated second for Commercial and first for Medicare health plan ratings). In addition, Hospitals and the Health Plan Organizations have received numerous awards and honors from, among other organizations, CMS, NCQA, the State of California's Office of the Patient Advocate, U.S. News and The Leapfrog Group.

Kaiser also administers employers' and other entities' self-funded plans, as well as offers insured exclusive provider organization ("EPO"), point of service ("POS") and preferred provider organization ("PPO") products. These products are offered primarily through KPIC, which serves as an administrative services only ("ASO") administrator for employers' and other entities' self-funded plans (including certain Kaiser benefit plans) and as an insurer for KPIC's EPO, POS and PPO products, and through Kaiser Foundation Health Plan of Washington Options, Inc. in the Washington region, which also serves as an issuer of Medicare Supplemental products. As of December 31, 2016, approximately 2% of Kaiser's overall insured and administered ("covered") lives was derived from these ASO arrangements, EPO, POS and PPO coverages.

Employer Groups. Kaiser receives a significant portion of health plan premium revenue from employers who sponsor health plans. Some employer-sponsored health plans provide Kaiser a large number of "covered lives" through a single contractual relationship. There is no assurance that existing contracts with employers will be maintained or that similar contracts will be obtained in the future. Even if these contracts were maintained and the enrollment base increased, net income to Kaiser could still decline because of decreased contract premium rates or increased cost of providing services to members.

A subset of large and mid-sized employers enroll their employees in self-funded plans. Administration of self-funded plans presents additional regulatory and operational risks for Kaiser. Regulatory rulings that are specific to Kaiser may limit the size of this line of business and also may limit Kaiser's flexibility regarding the benefits structure of the self-funded plans that it serves.

Competition. Competitors of Kaiser include managed health care companies, insurance companies, for-profit and not-for-profit hospitals and health systems and health care professionals that have formed networks to directly contract with employers or with CMS. The principal competitive factors that affect Kaiser's business relate to the quality and pricing of its products and services; product innovation; consumer satisfaction; the accessibility and convenience of care delivery; efficiency of administrative operations; financial strength; and marketplace reputation. Kaiser's membership is also concentrated in certain geographic areas, and increased competition in those geographic areas could have a disproportionately adverse effect on Kaiser's operating results. See also "BONDHOLDERS' RISKS—Business Relationships and Other Business Matters—Competition and Retention of Members" herein.

Relationship of Hospitals and Health Plan, Inc. to their Subsidiaries

Hospitals' and Health Plan, Inc.'s relationships to their subsidiaries are primarily ones of control, not ownership. Only Hospitals and the Guarantors are obligated to make payments under the Indenture and the Guarantee Agreement, respectively. None of the revenues or assets of their subsidiaries are available to creditors of Hospitals and the Guarantors, including the Holders of the Bonds. Moreover, as discussed below, Hospitals and Health Plan, Inc. have had and, in the future, could have obligations to provide financial support to their own or each other's subsidiaries, which may not be members of the Credit Group.

Managed care organizations ("MCOs"), such as the Health Plan Organizations, are required by state law to meet minimum capital and deposit and/or reserve requirements in each state. Failure to maintain the minimum requirements could subject a Health Plan Organization to corrective action, including state supervision or liquidation. In order to bolster the reserves of Affiliated Health Plans, as well as to provide capital to support their own or each other's subsidiaries, Hospitals and Health Plan, Inc. have made, and in the future are expected to make, distributions, loans and contributions to these subsidiaries. Under certain circumstances, state laws restrict MCOs from paying dividends or making distributions to their parent corporations or corporate members or repaying intercompany loans or advances. Regulations in the states in which the Affiliated Health Plans operate may also be changed in the future to further increase net worth and/or reserve requirements for MCOs. Such increases could result in Hospitals and Health Plan, Inc. electing to loan or contribute additional funds to the Affiliated Health Plans. The Indenture and Guarantee Agreement do not limit the amounts of loans, distributions, or contributions that Hospitals or the Guarantors may make to their subsidiaries or affiliates.

Hospitals and some Health Plan Organizations have provided and may continue to provide material amounts of cash or other resources to the subsidiaries of Hospitals and Health Plan, Inc. These transfers are primarily subordinated loans, but may include, in limited cases, equity transfers. In particular, Hospitals has made subordinated loans to Affiliated Health Plans in the Georgia and Mid-Atlantic States regions, and expects to make additional subordinated loans to the Georgia and Northwest regions. Affiliated Health Plans in the Georgia and Mid-Atlantic States regions experienced net losses in 2014 and 2015, and the Georgia region experienced losses in 2016. In the Northwest region, subordinated debt may be required to support increased capital requirements related to growth and declines in retirement-related discount rates. The provision of subordinated loans, totaling approximately $1 billion, as of March 31, 2017, to Affiliated Health Plans in the Georgia and Mid-Atlantic States regions is intended, among other things, to address operating losses and to permit the internalization of medical services which previously have been provided by non-Kaiser Permanente providers. The internalization of medical services in these regions is expected to lead to higher quality and service and lower cost trends, thus leading to improved membership growth. In some cases, Hospitals and Health Plan, Inc. provide a financial guarantee for the debt of a related entity, which may be substantial on an annual or aggregate basis. Hospitals and Health Plan, Inc. have entered into a guarantee agreement under which they guarantee all of the liabilities, debt and obligations of each other, the Affiliated Health Plans and one Health Plan, Inc. non-plan subsidiary. The Indenture and the Guarantee Agreement do not limit the amount of investments, loans, guarantees or other financial commitments that Hospitals or the Guarantors may make to their subsidiaries or affiliates.

While many benefits may be derived from alliances of related entities in an integrated delivery system, many risks also are involved, and invested capital is subject to loss. As a result of these investments or other commitments, risks that may adversely affect the results of operations or financial condition of any of the Health Plan Organizations may have a corresponding adverse effect on the other Kaiser entities.

Relationship with Permanente Medical Groups

Kaiser depends on physicians affiliated with one of eight Permanente Medical Groups that contract with a Health Plan Organization through exclusive contracts and on community physicians who contract with one of the Permanente Medical Groups, or, in the Washington region, with KFHP-WA, to provide health care services to members. Historically, Kaiser has maintained close, cooperative relationships with the Permanente Medical Groups. Although Kaiser's management believes that such relationships will continue on mutually beneficial terms, there can be no assurance that they will continue or, if they do, that they will continue on their present terms. Any deterioration in the relationships between Kaiser and any Permanente Medical Group could materially and adversely affect Kaiser's business, financial condition and results of operations.

The Credit Group

The Credit Group consists of Hospitals, its wholly controlled subsidiary HAMI, Health Plan, Inc., and its wholly controlled subsidiary HPAMI. Only the members of the Credit Group are obligated to make payments with respect to the Bonds. Hospitals and Health Plan, Inc. have several subsidiaries that provide support services to Kaiser. Other than HAMI and HPAMI, none of the other subsidiaries of Hospitals or Health Plan, Inc. is obligated to make payments with respect to the Bonds, and none of the Permanente Medical Groups is obligated to make payments with respect to the Bonds. Except as noted, the financial information furnished herein and in the annual

financial statements incorporated herein as Appendix A is presented on a combined basis for all Kaiser entities. *Such combined financial information and financial statements incorporate information for entities of Kaiser that are not part of the Credit Group and that have no obligation to make payments with respect to the Bonds.*

The financial information included herein is qualified by reference to and should be read in conjunction with the combined financial statements and related notes and Credit Group financial information included in Appendix A hereto and under "INFORMATION ABOUT KAISER—Management's Discussion and Analysis of the Combined Financial Position and Results of Operations of Kaiser" herein.

The following table sets forth the Credit Group's contribution to several financial indicators of the financial position and operations of the combined group of Kaiser entities, expressed as a percentage of Kaiser as a whole, as of and for the years ended December 31, 2016, 2015 and 2014. Such information is unaudited.

	As of and for the Years Ended December 31,		
Indicator	**2016**	**2015**	**2014**
Revenue	84.2%	84.5%	84.4%
Net Income	99.5%	99.1%	100.0%
Net Worth	97.4%	97.4%	97.2%
Property, Plant and Equipment	91.7%	92.0%	92.1%
Cash and Investments	84.1%	83.3%	89.8%

The following table sets forth operating income and net worth (dollars in millions), as of and for the years ended December 31, 2016, 2015 and 2014, that is attributable to subsidiaries that are not members of the Credit Group.

	As of and for the Years Ended December 31,		
Indicator	**2016**	**2015**	**2014**
Operating income/(loss) of the non-Credit Group subsidiaries	$ 38	$ (96)	$ (82)
Net worth of the non-Credit Group subsidiaries	$ 708	$ 657	$ 588

The total net worth of the subsidiaries that are not members of the Credit Group, as a percentage of total combined net worth, was 3% in each of the fiscal years ended December 31, 2014, 2015 and 2016.

Strategy

Kaiser was founded over 70 years ago, and its mission is to provide high-quality, affordable health care services and to improve the health of its members and the communities it serves. To deliver on its mission, Kaiser brings high-quality health care and affordable coverage together into a single, vertically-integrated model. Kaiser's integrated model is based on prepayment of the provider system rather than the volume-driven, fee-for-service reimbursement that dominates the United States health care industry. In 2016, over 97% of Kaiser's operating revenue was generated through the Health Plan Organizations; the integrated system is designed with the intent that Hospitals' facilities function more like cost centers rather than revenue centers and physicians are prepaid to provide comprehensive, coordinated care and not for the quantity of services they provide. This is designed to align incentives to keep members healthy through preventive care and a focus on population health, and promotes collective accountability and collaboration, while maintaining the flexibility to make long-term investments at the enterprise level.

Kaiser has a three-part framework to guide its strategic efforts: (1) drive organizational performance, (2) achieve sustainable growth, and (3) lead health and health care change within the broader industry and society.

Organizational Performance. Kaiser has a number of initiatives that drive performance improvement.

Preventive Care. Preventive care plays a major role in keeping Kaiser's members healthy and managing costs, and is designed into Kaiser's care delivery model. For example, Kaiser has designed programs for the management of blood pressure, cholesterol, diabetes, and other chronic illnesses.

Information Technology. Kaiser has worked to integrate technology, infrastructure, data and advanced analytics to facilitate the flow of information across all stages of care. KP HealthConnect® is Kaiser's comprehensive electronic health system that includes electronic medical records and provider-patient messaging functions. It enables Kaiser to share clinical protocols and member health data across providers and care settings, with the aim of improving quality of care and reducing costs by identifying and eliminating gaps in care, encouraging preventive care, increasing the speed from diagnosis to treatment, reducing errors and duplications in tests and prescriptions, and decreasing unnecessary variations in care.

Kaiser has also established a secure, online member portal to help members engage in getting care or information they need, while staying informed about their personal health conditions. The portal allows members to email their physicians, schedule routine appointments, view lab test results online, refill prescriptions, learn about staying healthy, and receive notifications about health screenings or other needed preventive care. In 2015, 52% of Kaiser members' primary care interactions were virtual – by phone, email or video. The online portal also provides information to care providers to help them better partner with members and provide comprehensive care.

Consumer Focus. Kaiser's integrated model also provides a comprehensive platform aimed at improving members' consumer experience. Over the past decade, Kaiser has made significant improvements in service and member satisfaction and continues to work on improving members' experiences. This includes implementing a consistent set of experience standards for physicians and staff when serving members, and the online member portal noted above, which is part of a comprehensive digital strategy.

Cost Improvements. Kaiser strives to maintain a disciplined approach to cost structure improvements that promote affordability and quality of care. From 2014 to 2016, Kaiser's per member per month expense trends averaged 1.4%, which was 3.0% lower than the previous three-year average. Kaiser improves its cost structure by focusing on:

- Effectiveness – Programs to continuously improve care quality and clinical outcomes and provide the right care at the right time. Examples include providing preventive care, managing utilization appropriately, addressing complex care needs, eliminating unwarranted variations in care protocols, and improving the overall reliability of services.

- Efficiency – Providing services using an optimal resource level. Certain initiatives focus on hospital unit costs, while others concentrate on ambulatory care unit costs and productivity. Kaiser also is achieving greater administrative efficiency by enhancing its shared services capabilities. Strong membership growth also facilitates efficiency improvements, as Kaiser takes advantage of scale and distributes fixed costs across a larger member and revenue base.

- Input costs – Optimizing costs of the required resources. Kaiser actively manages the cost of physical resources (e.g., prescriptions, supplies, benefits) required to support various units of service. Kaiser achieves economies of scale through supply chain and shared services capabilities, and tries to leverage supplier relationships, marketplace expertise, clinically-based contracting processes, volume, and pharmacy distribution centers to help contain the costs of specialty drugs.

Innovation. At the Sidney R. Garfield Health Care Innovation Center in San Leandro, California, Kaiser teams apply their field experience to explore new care solutions through hands-on simulations, prototyping, and technology testing. Successful initiatives evolve into pilot programs at Kaiser medical centers, clinics, and offices. Along with improving care for its members, Kaiser also seeks to improve the health of all communities by sharing its care breakthroughs and advancements with other health care organizations.

Growth in Current, Contiguous and New Markets. Kaiser views sustainable growth as membership growth that supports Kaiser's mission of quality and affordability, complements Kaiser's commitment to integrated care, and provides sufficient operating margins to enable ongoing investment in Kaiser's mission and strategy. Kaiser has recently entered into long-term relationships consistent with this strategy. In June 2016, Hospitals and Dignity Health commenced a 20-year arrangement to jointly own and operate St. Joseph's Medical Center of Stockton and associated operations in Stockton, California, including St. Joseph's Behavioral Health Center. Under the arrangement, Hospitals has a 20% membership interest in a newly formed tax-exempt limited liability company

that owns and operates the facilities. Additionally, in January 2016, a subsidiary of Hospitals entered into a contract with certain entities of the State of Hawaii to manage, operate and provide health care services at the hospitals of the Maui Region of Hawaii Health Systems Corporation ("HHSC") under the terms of a 30-year transfer agreement. Certain existing facilities will be leased from HHSC. The transfer is expected to be completed on July 1, 2017.

Current Markets. Kaiser's growth strategy in current markets includes pricing for affordability, offering competitive product designs, providing high-quality and consumer-focused care and service, and actively participating in all sources of coverage (e.g., individual markets, group-sponsored, and government programs). Kaiser also strives for stable and predictable rate increases. Kaiser develops its pricing by focusing on high quality care with cost structure improvements to maintain affordability and margins that support the organization's investment needs.

Contiguous Markets. For growth in contiguous markets, Kaiser leverages existing infrastructure to extend the boundaries of current service areas. Recent activities include the expansion of services in Summit and Eagle Counties, Colorado; Eugene, Oregon; the island of Kauai; Santa Cruz, California; and in the Baltimore, Maryland area.

New Markets. Kaiser also is pursuing expansion into new areas. In February 2017, a subsidiary of Health Plan, Inc. acquired Group Health Cooperative in Seattle, Washington and its subsidiaries and, as a result, Kaiser's membership increased by 680,139 members as of February 28, 2017. See "—Group Health Cooperative Acquisition" herein.

Leader in Health and Health Care. Kaiser believes it has a role in positively impacting health and health care across the United States. Kaiser advocates for effective health policy and seeks to be a leader in transforming health care through its Total Health strategy, community benefit program, medical research, and education programs.

Total Health. Kaiser sees Total Health as a holistic approach toward addressing the underlying determinants of health beyond medical care, which includes family history and genetics, personal behaviors (including mental health and wellbeing) and environmental and social factors. Kaiser engages in the communities where its members live and looks beyond health care to improve health.

Community Benefit. Kaiser's Community Benefit program exists to support the charitable purpose of its mission. Kaiser's Community Benefit program makes investments with the goal of: (1) improving health care access for low-income, underserved populations including those eligible for Medicaid; (2) improving the quality of care in the safety net; (3) creating safe, healthy communities and environments; and (4) supporting research, educating practitioners, empowering consumers, and informing policymakers about evidence-based care and health. For the fiscal year ended December 31, 2016, Community Benefit expenditures were $2.5 billion.

Medical Research and Education. Kaiser's commitment to innovation includes supporting medical research to discover new and better ways to prevent and treat illness. Kaiser has eight regional research centers and one national center. It conducts and shares its research from studies and clinical trials on a wide range of health issues, including cancer, heart disease, diabetes, childhood obesity, and autism. Some highlights of Kaiser's research include research on immunizations, cancer and genomics. Kaiser participates in the Vaccine Safety Datalink, which is the nation's safety surveillance system for vaccines. The project is funded by the Immunization Safety Office of the Centers for Disease Control, and six of the nine participating health care organizations are Kaiser entities. Kaiser's cancer researchers strive to shape national screening guidelines for colon and bladder cancer and additionally are working in areas such as nutritional and social factors that influence survival after a breast cancer diagnosis. In addition, Kaiser is developing a 500,000 member biobank and an approach that is intended to translate genomic test results into practice.

Additionally, Kaiser is heavily involved in medical education. Kaiser operates a large graduate medical education program that trains approximately 3,000 residents every year. Nine Kaiser hospitals were named to The Leapfrog Group's "Top Teaching Hospitals" list.

Kaiser will expand its medical education footprint with the Kaiser Permanente School of Medicine, Inc. (the "School of Medicine"), which is scheduled to open in the fall of 2019 in Pasadena, California. A subsidiary of Hospitals, the School of Medicine is a California nonprofit public benefit corporation. The School of Medicine intends to apply for exempt status under Section 501(c)(3) of the Code and is in the early stages of the accreditation process.

Group Health Cooperative Acquisition

On February 1, 2017, a subsidiary of Health Plan, Inc. acquired and became the sole corporate member of Group Health Cooperative, a Washington nonprofit corporation. After the acquisition, Group Health Cooperative was renamed Kaiser Foundation Health Plan of Washington ("KFHP-WA") and (together with its subsidiaries) became Kaiser's Washington region. In connection with the acquisition, Hospitals transferred cash to Health Plan, Inc.'s subsidiary for the acquisition. Additionally, the acquisition agreement commits $1 billion over the 10-year period following closing for capital improvements, key investments in infrastructure and other improvements at KFHP-WA (subject to capital and budget approval processes), and Kaiser expects $800 million in community benefit contributions in the region over the same period. Management believes that this acquisition has benefits with respect to growth and operations, furthers Kaiser's position as a market leader on the West Coast, and enhances the care provided in Washington.

KFHP-WA offers comprehensive, coordinated health care to an enrolled membership primarily for a fixed fee through its owned and leased facilities, employed providers, and contracted providers. KFHP-WA has operations substantially similar to the other Health Plan Organizations, including a contract with a regional Permanente Medical Group for physician services. See "INTRODUCTORY STATEMENT—Kaiser Permanente" and "INFORMATION ABOUT KAISER—Health Care Services" herein.

The following table summarizes certain financial information for Group Health Cooperative and its subsidiaries for the fiscal years ended December 31, 2016 and 2015.

(In Millions)	2016	2015
Premiums	$ 3,366	$ 3,223
Clinical services – net	362	325
Other	122	110
Total operating revenues	$ 3,850	$ 3,658
Total operating expenses	$ 3,841	$ 3,583
Operating income	$ 9	$ 75
Total nonoperating income	50	39
Excess of revenues over expenses	59	114
Change in net assets	80	79
Cash and investments	1,259	1,341
Net assets	1,113	1,034

Potential Changes to Kaiser

Like many health care providers, Hospitals and the Health Plan Organizations plan for and evaluate on a continuing basis potential acquisitions and divestitures of, and affiliations with, health care facilities and other organizations as part of their overall strategic planning and development process. In conducting its ongoing planning and property management functions, Kaiser reviews the use, compatibility, business and financial viability of its facilities and business operations and from time to time may pursue changes in the use, disposition or divesture of its facilities, other assets or business operations or cessation of business operations. Kaiser continues to evaluate its operations in order to improve operating and financial performance, while maintaining the focus on delivering integrated health care through the coordination of services by Hospitals, the Health Plan Organizations and the Permanente Medical Groups. As part of this process, Kaiser continuously evaluates and may sell or dispose of, or cease operations of, all or part of Kaiser. Further, as a result of any acquisition, disposition or cessation of business operations, the assets and operations of Kaiser may change from time to time.

Combined Financial Information of Kaiser

Combined Balance Sheets. Management has derived the following combined balance sheet of Kaiser for each of the three years ended December 31, 2016, 2015 and 2014 from Kaiser's audited combined financial statements of Health Plan, Inc. and subsidiaries and Hospitals and subsidiaries. The audited combined statements and Credit Group financial information for the years ended December 31, 2016 and 2015 are included in APPENDIX A – "COMBINED FINANCIAL STATEMENTS OF KAISER FOUNDATION HEALTH PLAN, INC. AND SUBSIDIARIES AND KAISER FOUNDATION HOSPITALS AND SUBSIDIARIES AND CREDIT GROUP FINANCIAL INFORMATION" hereto. *The combined financial statements incorporate information for entities of Kaiser that are not part of the Credit Group and that have no obligation to make payments with respect to the Bonds.*

COMBINED BALANCE SHEETS
(In millions)

	Years Ended December 31,		
Assets	**2016**	**2015**	**2014**
Current assets:			
Cash and cash equivalents	$ 434	$ 210	$ 288
Current investments	8,677	6,554	6,390
Securities lending collateral	631	1,068	1,528
Broker receivables	767	816	495
Due from associated medical groups	12	5	–
Accounts receivable - net	2,030	1,966	1,841
Inventories and other current assets	1,357	1,422	1,208
Total current assets	13,908	12,041	11,750
Noncurrent investments	25,756	26,189	26,081
Land, building, equipment, and software - net	24,342	23,782	23,484
Other long-term assets	607	585	600
Total assets	$ 64,613	$ 62,597	$ 61,915
Liabilities and Net Worth			
Current liabilities:			
Accounts payable and accrued expenses	$ 3,852	$ 2,977	$ 3,139
Medical claims payable	1,862	1,750	1,393
Due to associated medical groups	862	784	983
Payroll and related charges	1,828	1,694	1,832
Securities lending payable	631	1,068	1,528
Broker payables	849	1,160	819
Long-term debt subject to short-term remarketing arrangements - net	785	732	1,445
Other current debt	1,904	775	672
Other current liabilities	2,102	2,027	1,759
Total current liabilities	14,675	12,967	13,570
Long-term debt	4,754	6,060	5,505
Physicians' retirement plan liability	6,566	5,730	5,923
Pension and other retirement liabilities	9,148	10,525	13,700
Other long-term liabilities	2,380	2,418	2,390
Total liabilities	37,523	37,700	41,088
Net worth	27,090	24,897	20,827
Total liabilities and net worth	$ 64,613	$ 62,597	$ 61,915

Combined Information for Operations and Changes in Net Worth. Management has derived the following combined information for operations and changes in net worth of Kaiser for each of the three years ended December 31, 2016, 2015 and 2014 from Kaiser's audited combined financial statements of Health Plan, Inc. and subsidiaries and Hospitals and subsidiaries. The audited combined statements and Credit Group financial information for the years ended December 31, 2016 and 2015 are included in APPENDIX A – "COMBINED FINANCIAL STATEMENTS OF KAISER FOUNDATION HEALTH PLAN, INC. AND SUBSIDIARIES AND KAISER FOUNDATION HOSPITALS AND SUBSIDIARIES AND CREDIT GROUP FINANCIAL INFORMATION" hereto. *The combined financial statements incorporate information for entities of Kaiser that are not part of the Credit Group and that have no obligation to make payments with respect to the Bonds.*

COMBINED INFORMATION FOR OPERATIONS AND CHANGES IN NET WORTH
(In millions)

	Years Ended December 31,			Change 2016 vs. 2015		Change 2015 vs. 2014	
	2016	2015	2014	$	%	$	%
Revenues:							
Members' dues	$ 43,315	$ 40,956	$ 38,587	$ 2,359	5.8%	$ 2,369	6.1%
Medicare	15,414	14,436	13,347	978	6.8%	1,089	8.2%
Co-pays, deductibles, fees and other	5,822	5,357	4,506	465	8.7%	851	18.9%
Total operating revenues	64,551	60,749	56,440	3,802	6.3%	4,309	7.6%
Expenses:							
Medical services	30,486	27,732	26,410	2,754	9.9%	1,322	5.0%
Hospital services	16,664	16,364	14,619	300	1.8%	1,745	11.9%
Outpatient pharmacy and optical services	7,370	7,059	6,069	311	4.4%	990	16.3%
Other benefit costs	4,099	3,900	3,468	199	5.1%	432	12.5%
Total medical and hospital services	58,619	55,055	50,566	3,564	6.5%	4,489	8.9%
Health plan administration	4,008	3,928	3,697	80	2.0%	231	6.2%
Total operating expenses	62,627	58,983	54,263	3,644	6.2%	4,720	8.7%
Operating income	1,924	1,766	2,177	158	8.9%	(411)	(18.9%)
Other income and expense:							
Investment income - net	1,379	300	1,101	1,079	359.7%	(801)	(72.8%)
Interest expense	(183)	(198)	(205)	15	(7.6%)	7	(3.4%)
Total other income and expense	1,196	102	896	1,094	1,072.5%	(794)	(88.6%)
Net income	3,120	1,868	3,073	1,252	67.0%	(1,205)	(39.2%)
Pension and other retirement liability charges	(1,215)	2,997	(5,196)	(4,212)	(140.5%)	8,193	(157.7%)
Change in unrealized gains on investments	299	(793)	(110)	1,092	(137.7%)	(683)	620.9%
Change in restricted donations	(1)	(2)	15	1	(50.0%)	(17)	(113.3%)
Change in noncontrolling interest	(10)	–	(4)	(10)	–	4	(100.0%)
Change in net worth	2,193	4,070	(2,222)	(1,877)	(46.1%)	6,292	(283.2%)
Net worth at beginning of year	24,897	20,827	23,049	4,070	19.5%	(2,222)	(9.6%)
Net worth at end of year	$ 27,090	$ 24,897	$ 20,827	$ 2,193	8.8%	$ 4,070	19.5%

Management's Discussion and Analysis of the Combined Financial Position and Results of Operations of Kaiser

Except as noted, the following discussion relates to the combined financial position and results of operation of Kaiser and is not limited to the Credit Group.

Cautionary Statements. Certain statements included or incorporated by reference in this Offering Memorandum constitute "forward-looking statements." Such statements generally are identifiable by the terminology used such as "plan," "expect," "estimate," "budget" or other similar words. Such forward-looking statements include but are not limited to certain statements contained in the information under the captions "PLAN OF FINANCE," "BONDHOLDERS' RISKS" and "INFORMATION ABOUT KAISER" in this Offering Memorandum. The achievement of certain results or other expectations contained in such forward-looking statements involve known and unknown risks, uncertainties and other factors that may cause actual results, performance or achievements described herein to be materially different from any future results, performance or

achievements expressed or implied by such forward-looking statements. None of Hospitals, Health Plan, Inc., HAMI or HPAMI plans to issue any updates or revisions to those forward-looking statements if or when its expectations or events, conditions or circumstances on which such statements are based occur or fail to occur.

Accounting policies affect the presentation of financial information. For a description of significant accounting policies, see Note 2 to the audited combined financial statements included as Appendix A hereto.

Operations and Changes in Net Worth. Operating revenue improvements were primarily driven by membership growth of 5.7% in 2014, 6.7% in 2015 and 4.2% in 2016 and revenue increases per member per month of 1.8% in 2014, 0.7% in 2015 and 1.3% in 2016. Operating expenses increased per member per month at rates of 1.3% in 2014, 1.7% in 2015 and 1.2% in 2016. The operating margin of 3.9% in 2014 benefited from lower than anticipated cost trends, while the operating margins of 2.9% in 2015 and 3.0% in 2016 were consistent with management targets, represent a focus on affordability for Kaiser's members, and produced sufficient cash flow to sustain Kaiser's mission and business objectives.

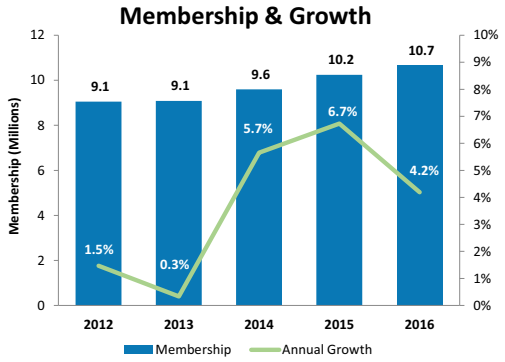
Investment income experienced significant fluctuation, declining in 2015 and increasing in 2016. These results are consistent with overall market performance when combined with the change in unrealized gains on investments. Management estimates that investment returns on the current and long-term marketable securities portfolio, excluding mark-to-market on derivatives and miscellaneous non-operating income and charges, was approximately 4.8% in 2014, 0.1% in 2015 and 6.6% in 2016.

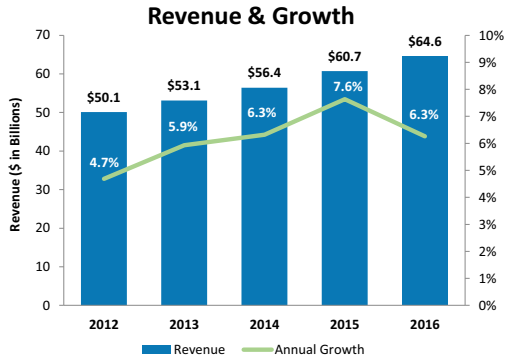
Pension and other retirement liability charges have impacted the change in net worth in each of the fiscal years ended December 31, 2014, 2015 and 2016. In each year, the primary cause of the charges was fluctuation in the discount rates applied to retirement liabilities. In 2015, the improvement in net worth for pension and other retirement liability charges of almost $3 billion was net of $843 million in charges related to actual investment returns in the pension portfolio, as compared to expected returns. For further detail, see footnotes 13, 14 and 15 of the audited combined financial statements included as Appendix A hereto.

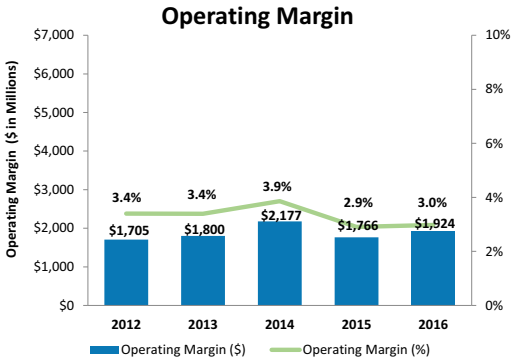
During the three-year period from 2014 to 2016, net worth grew by approximately $4 billion, as net income totaled approximately $8 billion, and the reduction to net worth from other charges and changes totaled $4 billion.

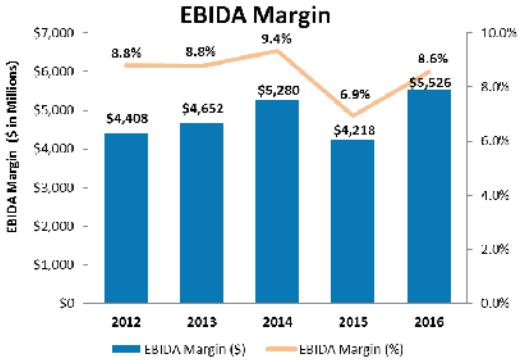
Key Balance Sheet Items. From December 31, 2014 to December 31, 2016, total assets grew by $2.7 billion. Cash and cash equivalents, combined with current investments, grew by $2.4 billion and noncurrent investments declined by $0.3 billion; funds for the February 1, 2017 closing of the Group Health Cooperative acquisition were designated as current. Securities lending collateral declined by almost $900 million due to financial market conditions. Land, building, equipment, and software-net grew by $858 million, reflecting continued investments in both technology and facilities to support member care, including building additional capacity for new members, net of depreciation and amortization.

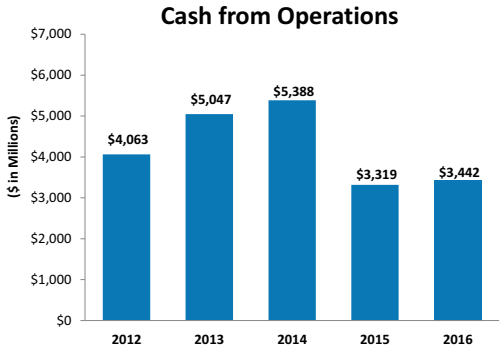
From December 31, 2014 to December 31, 2016, debt, including portions classified as current, declined by $179 million. In the same period, redemption of long-term bonds funded by taxable commercial paper increased the debt classified as current by a total of $572 million. Pension and other retirement liabilities decreased by almost $4.6 billion, predominately due to approximately $0.8 billion related to the discount rate and $3.8 billion related to increased funding of the plans. Funding of the Pension Plan was $1,589 million in 2015 and $1,731 million in 2016. Funding of postretirement benefits other than pension was $1.0 billion in 2015 and $1.6 billion in 2016. For further detail, see footnotes 12, 13, 14 and 15 of the audited combined financial statements included as Appendix A hereto.

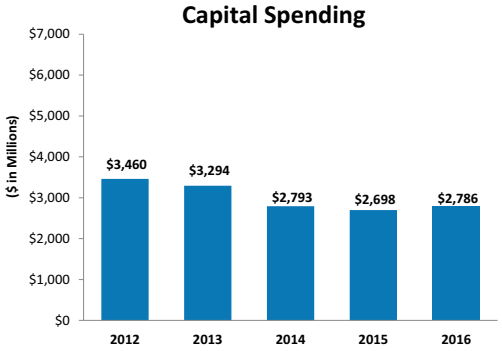

Membership & Growth
Membership (Millions)
9.1
9.1
9.6
10.2
10.7
1.5%
0.3%
5.7%
6.7%
4.2%
2012
2013
2014
2015
2016
Membership
Annual Growth

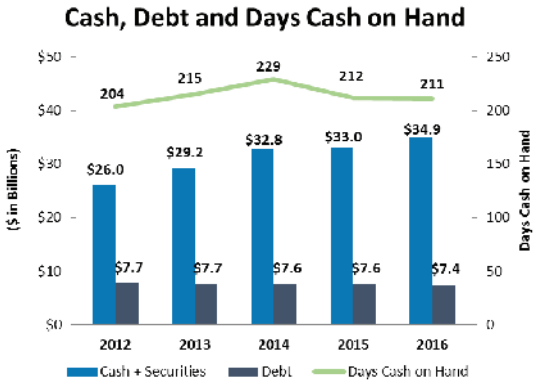

Revenue & Growth
Revenue ($ in Billions)
$50.1
$53.1
$56.4
$60.7
$64.6
4.7%
5.9%
6.3%
7.6%
6.3%
2012
2013
2014
2015
2016
Revenue
Annual Growth

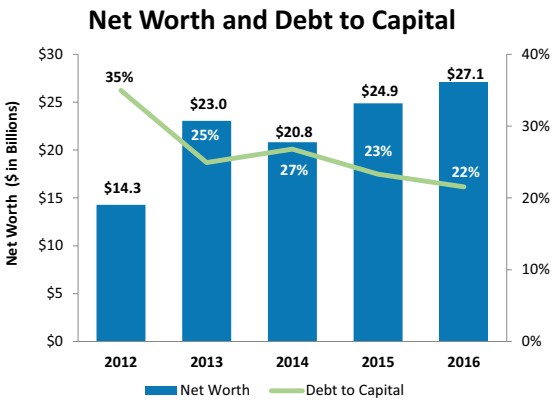

Operating Margin
Operating Margin ($ in Millions)
3.4%
3.4%
3.9%
2.9%
3.0%
$1,705
$1,800
$2,177
$1,766
$1,924
2012
2013
2014
2015
2016
Operating Margin ($)
Operating Margin (%)


EBIDA Margin
EBIDA Margin ($ in Millions)
8.8%
8.8%
9.4%
6.9%
8.6%
$4,408
$4,652
$5,280
$4,218
$5,526
2012
2013
2014
2015
2016
EBIDA Margin ($)
EBIDA Margin (%)


Cash from Operations
($ in Millions)
$4,063
$5,047
$5,388
$3,319
$3,442
2012
2013
2014
2015
2016


Capital Spending
($ in Millions)
$3,460
$3,294
$2,793
$2,698
$2,786
2012
2013
2014
2015
2016


Cash, Debt and Days Cash on Hand
($ in Billions)
Days Cash on Hand
204
215
229
212
211
$26.0
$29.2
$32.8
$33.0
$34.9
$7.7
$7.7
$7.6
$7.6
$7.4
2012
2013
2014
2015
2016
Cash + Securities
Debt
Days Cash on Hand


Net Worth and Debt to Capital
Net Worth ($ in Billions)
35%
$14.3
$23.0
25%
$20.8
27%
$24.9
23%
$27.1
22%
2012
2013
2014
2015
2016
Net Worth
Debt to Capital

Pension and Other Retirement Obligations. Health Plan, Inc. sponsors a defined benefit pension plan (the "Pension Plan") covering substantially all of its employees and the employees of Hospitals. Pension Plan assets are held primarily in a group trust whose investment portfolio consists of a diversified mixture of fixed income and equity securities and alternative investments. Under the Pension Plan's funding policy, the overall funding goal is to assure that sufficient funds are available to provide the required benefits to participants and beneficiaries, as benefits are due and payable. The long-term objective is to attain a funding level where assets equal 100% of the Pension Plan's economic liabilities. Each year, Health Plan, Inc. contributes amounts sufficient to meet minimum legal funding requirements, plus any additional amounts that Health Plan, Inc. determines are appropriate considering a variety of factors, including the Pension Plan's funded status and the cash flow of Health Plan, Inc.

Certain employees become eligible for post-retirement health care and life insurance benefits ("Post-Retirement Benefits Program") if they become eligible for retirement while working for the Health Plan Organizations or Hospitals.

Health Plan, Inc. provides defined retirement benefits for physicians associated with certain Permanente Medical Groups (the "Physicians' Retirement Plan"). Benefits are determined based on the length of service and level of compensation of each participant. The plan is unfunded and is not subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), but Health Plan, Inc. has designated a portion of its unrestricted assets for the Physicians' Retirement Plan. These investments are not held in trust or otherwise legally segregated and are not restricted, even though it has been intended that these assets be used to pay the obligations of the Physicians' Retirement Plan. As of December 31, 2016, the liability, including the current portion, was $6.8 billion, and the noncurrent investment assets that support this and other obligations totaled $25.8 billion.

The pension and post-retirement benefit obligations of Hospitals, the Health Plan Organizations and the Physicians' Retirement Plan are growing significantly and are not fully funded. As of December 31, 2016, the unfunded amounts of the Pension Plan and the Post-Retirement Benefits Program totaled $9.1 billion. These obligations have the potential to impose substantial liabilities on the Credit Group. Differences in actual experience or changes in these assumptions may result in expenses and recorded obligations in the future that are higher than expected or estimated. Investment performance, along with changes in interest rates and other factors not within the control of Health Plan, Inc. or Hospitals, may have a significant effect on accrued liabilities for pension and other retirement benefit obligations, as well as the amount and timing of contributions to fund these obligations. Such future funding requirements may negatively affect cash flow, reduce liquidity or decrease the net worth of the Credit Group and could have a material adverse effect on the financial condition or operations of the Credit Group.

In addition to the uncertainties described above, the rate of growth of these obligations presents significant financial risk for Kaiser. Management believes that reducing the rate of growth of pension and other post-retirement obligations will be important to the financial condition and operations of Kaiser. Management has pursued measures to reduce the rate of growth of such obligations, including, but not limited to, negotiating with unions to modify benefits. However, there is no assurance that sufficient reductions in the rate of growth of such obligations will be achieved.

For more information, see "INFORMATION ABOUT KAISER—Employees," "BONDHOLDERS' RISKS—Significant Risk Areas Summarized—Labor Costs, Disruption and Availability" and "—Business Relationships and Other Business Matters—Labor Relations and Collective Bargaining" herein.

See notes to combined financial statements in APPENDIX A – "COMBINED FINANCIAL STATEMENTS OF KAISER FOUNDATION HEALTH PLAN, INC. AND SUBSIDIARIES AND KAISER FOUNDATION HOSPITALS AND SUBSIDIARIES AND CREDIT GROUP FINANCIAL INFORMATION" hereto for additional information concerning Kaiser's pension and other post-retirement obligations. See also "BONDHOLDERS' RISKS—Business Relationships and Other Business Matters—Pension and Benefit Funds."

Liquidity and Capital Resources. Kaiser's primary sources of cash are revenue from members' dues, revenue from the Medicare program and supplemental revenue from co-payments and non-covered services. The primary uses of cash include health care costs, administrative costs, capital expenditures, investments and interest and principal payments on long-term debt. Kaiser's investment policies are designed to provide liquidity and maximize yield consistent with the reasonable preservation of capital. Management of Hospitals and Health Plan,

Inc. approve and monitor policies regarding the credit quality of both short- and long-term investments of Kaiser. Liquidity and capital resources maintained by Kaiser are sufficient to meet applicable regulatory financial stability and net worth requirements.

Investments of Kaiser at December 31, 2016, 2015 and 2014 (in millions) included:

	As of December 31,		
	2016	2015	2014
Investments – Current			
Equity – U.S.	$ 24	$ 31	$ 35
U.S. treasury and government agencies	4,054	2,264	2,164
Other debt instruments	4,599	4,259	4,191
Total	$ 8,677	$ 6,554	$ 6,390
Investments – Noncurrent			
Equity – U.S.	$ 3,908	$ 3,548	$ 3,952
Equity – International	4,596	4,920	5,215
Alternative Investments	6,841	6,277	4,936
U.S. treasury and government agencies	2,134	2,103	2,829
Other debt instruments	8,277	9,341	9,149
Total	$ 25,756	$ 26,189	$ 26,081

Capitalization. The following table sets forth the historical capitalization of Kaiser as of December 31, 2016, 2015 and 2014, and as adjusted, assuming that the Series 2017 Bonds were issued on December 31, 2016 and proceeds from the sale of the Series 2017 Bonds were applied as described in "PLAN OF FINANCE" herein.

	Year ended December 31,			
(In millions)	**2016 As Adjusted**	**2016 Actual**	**2015 Actual**	**2014 Actual**
Fixed Rate	$ 6,563	$ 2,336	$ 3,470	$ 3,508
Variable Rate[(1)]	2,946	3,221	3,443	3,460
Taxable Commercial Paper	779	1,886	654	654
Total Debt[(2)]	$ 10,288	$ 7,443	$ 7,567	$ 7,622
Net Worth	$ 27,090	$ 27,090	$ 24,897	$ 20,827
Total Debt to Capitalization	**27.5%**	**21.6%**	**23.3%**	**26.8%**

(1) Includes put bonds classified as current debt.
(2) Includes net premium/discount/amortization of issuance costs.

As of December 31, 2016, the total outstanding indebtedness of Kaiser that is subject to variable interest rate exposure, defined as all indebtedness that is subject to tender for purchase and reset prior to maturity, was $3.2 billion. This amount includes $175 million in bonds whose interest rates are currently fixed for periods of one to five years. For additional information regarding Kaiser's debt, see footnote 12 of the audited combined financial statements included as Appendix A hereto. See also "BONDHOLDERS' RISKS—Significant Risk Areas Summarized – Market Risk in Connection with Variable Rate Demand Bonds" and "—Market Risk in Connection with Commercial Paper."

Derivative Instruments. Hospitals and Health Plan, Inc. have entered into interest rate swap agreements to manage interest rate risk related to its fixed rate and variable rate debt and, in the future, may enter into other interest rate swap transactions (the "Swap Agreements"). Pursuant to certain Swap Agreements, Hospitals and Health Plan, Inc. pay fixed rates and receives variable rates based upon a percentage of, and a spread to various indices of, LIBOR.

The Swap Agreements are subject to periodic "mark-to-market" valuations and at any time may have a negative value to Hospitals or Health Plan, Inc. Certain existing Swap Agreements require Hospitals and Health Plan, Inc., in the event of a ratings downgrade (generally below BBB), to secure their obligations by posting

collateral. If triggered, the requirement to post collateral could draw down Kaiser's cash reserves or available credit. As of the date hereof, Hospitals and Health Plan, Inc. have not been required to post collateral under any of their Swap Agreements. Counterparties to the Swap Agreements may terminate the Swap Agreements upon the occurrence of certain "termination events" or "events of default." Hospitals and Health Plan, Inc. may terminate the Swap Agreements at any time upon the satisfaction of certain conditions. If the counterparty to a Swap Agreement, Hospitals, or Health Plan, Inc. terminates a Swap Agreement with a negative market value, Hospitals and Health Plan, Inc. may be required to make a termination payment to the counterparty, and such payment could be material in amount. Alternatively, a swap counterparty may be required to make a termination payment to Hospitals or Health Plan, Inc. Such payment could be delayed or not received if the swap counterparty has financial difficulties or declares bankruptcy, and in such instance, Hospitals and Health Plan, Inc. would be unsecured creditors. In the event of nonperformance by the counterparties to the Swap Agreements, Hospitals and Health Plan, Inc. could suffer adverse financial consequences. The current ratings of the counterparties to these Swap Agreements are at least "A-" or its equivalent from either Standard & Poor's (as defined below) or Moody's Investors Service or both.

At December 31, 2016, 2015 and 2014, Hospitals and Health Plan, Inc. had 11 Swap Agreements to manage interest rate fluctuations, with a total notional amount of $1.2 billion at each year end. The fair market value of these Swap Agreements was $(251) million, $(274) million and $(267) million, at December 31, 2016, 2015 and 2014, respectively.

Derivative financial instruments are also used by Kaiser's investment portfolio managers to protect investments against volatility. These instruments include futures, forwards, options and swaps. At December 31, 2016, 2015 and 2014, Kaiser's portfolio managers held $46 million, $(3) million and $38 million of such instruments. For the years ended December 31, 2016, 2015 and 2014, net changes in market values of such instruments totaled $59 million, $(9) million and $25 million, respectively, and gains resulting from derivative settlements totaled $(67) million, $152 million and $214 million, respectively.

Debt Service Coverage Ratios. The following table sets forth (dollar amounts in millions) debt service coverage ratios of Kaiser and the Credit Group as of and for the years ended December 31, 2016, 2015 and 2014. Such information is unaudited.

	As of and for the Years Ended December 31,					
	2016		2015		2014	
	Kaiser	Credit Group	Kaiser	Credit Group	Kaiser	Credit Group
Net Income Before Interest Expense, Depreciation and Amortization	$5,526	$5,349	$4,218	$4,047	$5,280	$5,126
Total Debt Service[(1)]	$ 296	$ 296	$ 237	$ 237	$ 252	$ 239
Debt Service Coverage (times)	18.7x	18.1x	17.8x	17.1x	21.0x	21.4x

(1) Total debt service includes only external interest expense related to debt and repayment of principal. Includes applicable credit, remarketing and other fees associated with such debt, as well as amortization of original issue premium and discount and issuance costs associated with such debt.

Compliance and Other Pending Matters

***Health Care Regulatory Compliance*.** Kaiser's Compliance, Ethics, and Integrity Program ("Compliance Program") identifies compliance issues through, among other things, independent compliance risk assessments and audits. The Chief Compliance Officer of Health Plan, Inc. and Hospitals reports directly to, and seeks guidance from, the Chief Executive Officer and the Audit and Compliance Committee of the boards of directors of Health Plan, Inc. and Hospitals. Regional Compliance Officers have dual reporting to the Chief Compliance Officer and Regional President or designee. Whether identified internally or as a result of a governmental inquiry, the Chief Compliance Officer or Regional Compliance Officers and their staffs investigate matters and work with governmental agencies, payors and others (as appropriate) to resolve the issues.

As part of ongoing compliance oversight, Health Plan, Inc. and Hospitals periodically identify potential overpayments from the Medicare, Medicaid, the Federal Employees' Health Benefits, or other federal programs. In this regard, Hospitals has preliminarily identified certain instances in which it has erroneously billed the Medicare or

Medicaid programs for services, and Health Plan, Inc. has identified certain instances in which erroneous data may have been submitted in connection with Medicare or other programs. Management believes that the billing and data errors at issue were a result of administrative errors or inadvertence and that, upon disclosure to the Office of the Inspector General (the "OIG") or the Medicare or other programs, repayment is the appropriate remedy.

The outcomes of these audits, investigations and inquiries are inherently uncertain, and it is possible that one or more of these matters could have a material adverse effect on the financial condition or operations of the Credit Group or Kaiser as a whole. See "—Government Audits and Investigations" herein.

CMS Surveys. CMS provides for ongoing hospital oversight through two survey avenues: (1) The Joint Commission, acting under the authority of CMS, re-certifies hospitals for continued participation in the Medicare and Medi-Cal/Medicaid programs, and (2) CMS contracts with the State of California Department of Public Health to, among other activities, investigate complaints regarding CMS certified hospitals. In January 2017, the California Department of Public Health ("CDPH") conducted an on-site survey at Hospitals' Los Angeles Medical Center ("KFH Los Angeles") related to four cases of legionella at KFH Los Angeles. During the survey, the CDPH - Los Angeles County District issued an Immediate Jeopardy statement of deficiencies to KFH Los Angeles. CDPH lifted the Immediate Jeopardy at the conclusion of its survey. On March 28, 2017, as a result of the survey, KFH Los Angeles received letters from CMS Region IX and the CDPH notifying the facility that it did not meet conditions of participation for the Medicare or Medi-Cal programs, and that procedural steps were underway to terminate the facility's provider status effective June 19, 2017, unless the facility demonstrated full compliance. The facility has submitted plans of correction intended to demonstrate such compliance and continued eligibility for Medicare and Medi-Cal participation. Management believes that KFH Los Angeles will be deemed in continued compliance with conditions of participation in the Medicare and Medi-Cal program and permitted to maintain its status as a Medicare and Medi-Cal provider. The outcome of the KFH Los Angeles survey and any further surveys of other Hospitals' facilities could result in citations, fines, criminal penalties, termination of the Medicare provider status of a Hospitals' facility and other sanctions upon Hospitals or the Health Plan Organizations, or could be the basis for private litigation. Other local, state, and federal investigations also could occur, any of which could result in further citations, fines, and other sanctions. Management currently does not believe such governmental actions will have a material adverse effect on the financial conditions or operations of Kaiser as a whole.

Government Audits and Investigations. Pursuant to a December 2013 civil subpoena, Health Plan, Inc. and Hospitals have been providing documents and information to the U.S. Department of Justice and Department of Health and Human Services - Office of Inspector General ("OIG") relating to Medicare Part C risk adjustment practices, policies, and programs. In February 2013, Group Health Cooperative (now KFHP-WA) received a subpoena from the United States Attorney's Office, Western District of New York, requesting information related to certain of KFHP-WA's Medicare Advantage risk adjustment submissions made for payment years 2008 through 2012. KFHP-WA has been in discussions with the United States Attorney's Office concerning the information requested by the subpoena. These matters could result in False Claims Act litigation. The government has recently intervened in a False Claims Act lawsuit against a different health plan relating to their risk adjustment practices.

In 2008, CMS announced that it would regularly conduct Risk Adjustment Data Validation audits ("RADV Audits") of Medicare Advantage plans, primarily targeted based on risk score growth, for compliance by the plans and their providers with proper coding practices, as further described in the Section herein entitled "BONDHOLDERS' RISKS—Regulation of the Healthcare Industry—Medicare and Medicaid." Health Plan, Inc.'s California Medicare Advantage plans (including both the Northern and Southern California regions) were selected by CMS for a RADV Audit of the 2006 risk adjustment data used to determine 2007 premium rates. In February 2013, CMS notified Health Plan, Inc. that there is no payment recovery associated with this audit. KFHP-WA's Medicare Advantage plans were selected by CMS for a contract-level RADV Audit of the 2012 risk adjustment data used to determine 2013 premium rates. KFHP-WA submitted its response to CMS on February 6, 2017 and is awaiting CMS's review of the same.

In addition, CMS also regularly conducts audits of aspects other than risk adjustment for Medicare Part C, as well as conducting audits on Medicare Part D and hospital and HMO cost reports. CMS is currently conducting such audits with the Health Plan Organizations and Hospitals.

In December 2016, the OIG began an audit of drug pricing across all Kaiser regions (except the Washington region) for calendar year 2015. The audit is currently in progress. The OIG is examining drug costs submitted in calendar year 2015 prescription drug event data and calendar year 2015 data used in the Health Plan Organization's Medicare Part D bids submitted in 2017.

The California Department of Health Care Services ("DHCS") conducted an audit of 2014 California Medi-Cal hospital cost reports. Because of changes in Medi-Cal's methodology for reimbursing hospitals, the audit resulted in DHCS contending that an element of Hospitals' methodology for reporting costs inflated certain Medi-Cal payments. DHCS is aware of the issue, is working directly with Hospitals toward a resolution and has asked Hospitals to submit a plan. As a result, Medi-Cal will reprocess certain Medi-Cal fee for service hospital claims from July 1, 2013 to the present. Hospitals is working on implementing an ongoing Medi-Cal monitoring program.

In March 2013, in connection with a regularly scheduled survey, the California Department of Managed Health Care ("DMHC") issued a report identifying mental health service deficiencies. Although Health Plan, Inc. disagrees that it was in violation of applicable regulations, in September 2014, Health Plan, Inc. agreed to a $4 million penalty. A subsequent report identified two deficiencies as not corrected in the areas of quality management/access and health education services. Those alleged deficiencies have been forwarded to the DMHC's Office of Enforcement, where the Health Plan, Inc. and DMHC continue to discuss the matters.

The outcomes of these audits, investigations and inquiries are inherently uncertain, and it is possible that one or more of these matters could have a material adverse effect on the financial condition or operations of the Credit Group or Kaiser as a whole.

Hospital Seismic Safety Act Compliance. In 1994, the California legislature enacted Senate Bill 1953, which requires that California hospitals evaluate and upgrade acute care facilities to meet the requirements of the Hospital Seismic Safety Act of 1983 by 2008 or 2030, depending upon the hospital's structural performance category classification. The statute was amended through the passage of Senate Bill 1661, Senate Bill 499, and Senate Bill 90 to allow hospitals in Seismic Performance Category 1 ("SPC-1") to apply for extensions of the original 2008 deadline to 2015 or 2020, provided that various statutory requirements were met by certain enumerated dates.

At this time, management believes the possibility of a material impact on the operations of Health Plan, Inc. and Hospitals from failure to comply with California hospital seismic safety law is remote. Phases 1 and 2 of Kaiser's hospital seismic replacement program for SPC-1 buildings have been completed on schedule and in accordance with the law, with all hospitals under such program now operational. Initial planning for Phase 3 of Kaiser's hospital seismic replacement program to meet the 2030 requirements for SPC-2 hospitals is now underway.

Schedules for upgrading and/or mitigating Kaiser's six remaining SPC-2 facilities are regularly reviewed and revised to be consistent with Hospitals' strategy and changes in legislation. A material impact on the operations of Health Plan, Inc. and Hospitals could occur if an acute care facility were required to close due to failure to upgrade or conduct a planned closure in accordance with the deadlines set forth by the current legislation due to any of the following factors: the construction market; the complexities of state and local planning, zoning and regulatory requirements; construction risks; and other factors.

Outsourcing of Information Operations and Utilization of Cloud Services

Kaiser relies on a number of outside vendors to process information on its behalf. Kaiser also has agreements with outside vendors to which Kaiser has outsourced a significant portion of its data center operations and management of certain call center software applications. In addition, Kaiser has increasingly engaged vendors to provide various cloud services, including Infrastructure as a Service, Platform as a Service and Software as a Service arrangements. Pursuant to certain of these arrangements, vendors have access to personal information of Kaiser members and patients. Even though Kaiser takes many precautions against the unauthorized use and disclosure of individually identifiable information by its vendors, including through the terms of its contracts and security requirements and through security audits and vulnerability assessments, it does not control the actions and practices of outside entities. In addition, despite the security measures Kaiser has in place to ensure compliance with applicable laws and rules, its facilities and systems and those of its third-party service providers may be

vulnerable to security breaches, acts of vandalism or theft, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Noncompliance with any privacy laws or any security breach involving the misappropriation, loss or other unauthorized disclosure of sensitive or confidential health or other personal information, whether by Kaiser or by one of its vendors, could have a material adverse effect on Kaiser's business, reputation and results of operations, and could result in any or all of the following: material fines and penalties; compensatory, special, punitive, and statutory damages; consent orders regarding privacy and security practices; and adverse actions against Kaiser's licenses to do business. See also "BONDHOLDERS' RISKS—Regulation of the Healthcare Industry—Security Breaches and Unauthorized Releases of Personal Information" herein.

Maintenance of Information Systems

Kaiser depends significantly on effective information systems, and Kaiser has many different information systems supporting both its clinical and business operations. Kaiser's information systems require an ongoing commitment of significant resources to maintain and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving industry and regulatory standards, compliance with legal requirements and changing customer preferences. In addition, Kaiser may from time to time obtain significant portions of its systems-related or other services or facilities from independent third parties, which may make Kaiser's operations vulnerable to such third parties' failure to perform adequately.

The failure to implement effective and efficient information systems, or the failure to maintain effective and efficient information systems, or the failure to efficiently and effectively consolidate information systems to eliminate redundant or obsolete applications, could have a material adverse effect on the financial condition or operations of Kaiser as a whole. If the information Kaiser relies upon to run its business were found to be inaccurate or unreliable or if Kaiser fails to implement or maintain its information systems and data integrity effectively, Kaiser could have a decrease in membership, problems in determining medical cost estimates and establishing appropriate pricing and reserves, disputes with customers and providers, regulatory problems, sanctions or penalties imposed, or increases in operating expenses or could suffer other adverse consequences. Also, as Kaiser converts or migrates members to more efficient and effective systems, the risk of disruption in customer service is increased during the migration or conversion process and such disruption could have a material adverse effect on the financial condition or operations of Kaiser as a whole. See also "BONDHOLDERS' RISKS—Business Relationships and Other Business Matters—Information Systems" herein.

Governance

Hospitals and Health Plan, Inc., both California nonprofit public benefit corporations, are non-stock corporations with common boards of directors and senior management. Control over the affairs of each corporation is vested in its board of directors, the members of which are elected by the board by class for three-year terms (except for up to three inside directors who are elected each year, one who serves as an *ex officio* member, one who may be the Chairman-Elect and one who is a member of senior management designated by the Chairman of the Board). The Affiliated Health Plans, all nonprofit corporations, are also non-stock corporations, and Health Plan, Inc. is the sole corporate member of each of the Affiliated Health Plans (except the sole corporate member of KFHP-WA is a wholly-controlled subsidiary of Health Plan, Inc.). All or a majority of the directors of each of the Affiliated Health Plans are elected by the board of directors of Health Plan, Inc.

Hospitals and Health Plan, Inc. are the sole corporate members of HAMI and HPAMI, respectively, and appoint their boards of directors. Members of the boards of directors of Hospitals and Health Plan, Inc. and their principal business affiliations are as follows:

Bernard J. Tyson
Chairman of the Board, Chief Executive Officer, President and *ex officio* director
Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals

Ramón Baez
Retired Senior Vice President, Customer Evangelist and Advocate
Hewlett Packard Enterprise

Regina Benjamin, M.D.
Founder of Bayou Clinic, Inc.
Former United States Surgeon General

Jeffrey E. Epstein
Operating Partner
Bessemer Venture Partners

Leslie S. Heisz
Former Managing Director Lazard Ltd.

David F. Hoffmeister
Former Senior Vice President and Chief Financial Officer
Life Technologies, Inc.

Judith A. Johansen
Former Chief Executive Officer
PacifiCorp

Kim J. Kaiser
Retired Pilot
Alaska Airlines

Edward Pei
Executive Vice President
Hawaii Bankers Association

Meg Porfido, J.D.
Retired Chief Human Resources Officer and Senior Vice President
Level 3 Communications

Richard P. Shannon, M.D.
Executive Vice President for Health Affairs
University of Virginia

Cynthia A. Telles, PhD
Director of Spanish Speaking Psychosocial Clinic
Associate Clinical Professor of Neuropsychiatric
Institute and Hospital and UCLA School of Medicine

A. Eugene Washington, M.D.
President and Chief Executive Officer
Duke University Health System

Certain members of senior management and administration of Kaiser are as follows:

BERNARD J. TYSON, Chairman of the Board, Chief Executive Officer, President and *ex officio* director, joined Kaiser in 1985. Mr. Tyson received both his bachelor's degree in Health Care Management and his MBA degree in Health Science Administration from Golden Gate University.

GREGORY A. ADAMS, Executive Vice President and Group President, joined Kaiser in 1999. Prior to joining Kaiser, he held several executive roles in the health care industry, providing strategic and operational leadership for hospitals, health systems and medical groups throughout the country. He received his bachelor's degree from Oglethorpe University and a master's degree in nursing administration from Wichita State University.

MARY ANN BARNES, Regional President, Hawaii Region, joined Kaiser in 1974. She received her bachelor's degree from Arizona State University and her MSN in administration from San Diego State University.

ANTHONY BARRUETA, Senior Vice President, Government Relations, joined Kaiser in 1994. Prior to joining Kaiser, Mr. Barrueta worked as a regulatory lawyer in private practice. He received his bachelor's degree from Boston College and a law degree from the University of Texas at Austin.

VANESSA M. BENAVIDES, Senior Vice President and Chief Compliance and Privacy Officer, joined Kaiser in 2015. Prior to joining Kaiser, Ms. Benavides was chief compliance officer for Tenet Healthcare. Ms. Benavides received her bachelor's degree from Vanderbilt University and a law degree from the University of Iowa College of Law.

BECHARA CHOUCAIR, M.D., M.S., Senior Vice President, Community Health and Benefit, joined Kaiser in 2016. Prior to joining Kaiser, he was senior vice president, safety net transformation and community health for Trinity Health. Dr. Choucair received his M.D. degree from American University of Beirut and a master's degree in health management from the University of Texas at Dallas.

CHARLES E. COLUMBUS, Senior Vice President and Chief Human Resources Officer, joined Kaiser in August 2009. Prior to joining Kaiser, he spent his career at Ford Motor Company, holding a number of senior labor and human resources positions. Mr. Columbus holds a Bachelor of Science degree in business administration from the University of Michigan.

PATRICK T. COURNEYA, M.D., Executive Vice President and Chief Medical Officer, joined Kaiser in 2014. Prior to joining Kaiser, he was medical director and associate medical director for HealthPartners Health Plan. Dr. Courneya received a bachelor's degree from the University of St. Thomas, St. Paul, Minnesota, and his M.D. degree from the University of Minnesota.

RICHARD D. DANIELS, Executive Vice President and Chief Information Officer, joined Kaiser in 2008. Prior to joining Kaiser, he was senior vice president and divisional CIO for Capital One. He received his bachelor's degree from Southwest Texas State University (now Texas State University).

KIM HORN, Regional President, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., joined Kaiser in 2012. Prior to joining Kaiser, she was president and chief executive officer of Priority Health. She received her degree from the University of Michigan.

KATHY LANCASTER, Executive Vice President and Chief Financial Officer, joined Kaiser in 1998. Prior to joining Kaiser, Ms. Lancaster worked for Prudential Healthcare. She received her bachelor's degree from Loyola Marymount University.

JANET A. LIANG, Regional President, Northern California Region, joined Kaiser in 2007. Prior to joining Kaiser, she held executive roles at Group Health Cooperative. She received her bachelor's degree from Boston University and a master's degree in health administration from the University of Washington.

ROLAND LYON, Regional President, Kaiser Foundation Health Plan of Colorado, joined Kaiser in 2002. Prior to joining Kaiser, he served in executive leadership roles at Catholic Healthcare West. He received his bachelor's degree from Brigham Young University and a master's degree in business administration from the University of California, Berkeley's Haas School of Business.

ANDREW R. MCCULLOCH, Regional President, Kaiser Foundation Health Plan of the Northwest, joined Kaiser in 2006. Prior to joining Kaiser, he served in executive roles at the University of North Carolina Health Care System, UW Medicine, PeaceHealth and Mercy Health. He received his bachelor's degree from Wesleyan University and a master's degree in healthcare administration from the University of Minnesota's School of Public Health.

THOMAS R. MEIER, Senior Vice President and Treasurer, joined Kaiser in September 1999. Prior to joining Kaiser, Mr. Meier worked at GATX Capital as Vice President Portfolio Management-Air Group. Before GATX Capital, Mr. Meier was Director, Investor Relations and Assistant Treasurer of APL, Limited. Mr. Meier graduated from California State University, Hayward, with a bachelor's degree in business administration and accounting.

JULIE MILLER-PHIPPS, Regional President, Southern California Region, joined Kaiser in 1977. Prior to her current position, she was Regional President, Kaiser Foundation Health Plan of Georgia, Inc. She received her

bachelor's degree from California State University, Fullerton and a master's degree in health care administration from the University of LaVerne.

SUSAN MULLANEY, Regional President, Kaiser Foundation Health Plan of Washington, joined Kaiser in 2008. Prior to joining Kaiser, she served in several leadership positions at Fairview Health Services. She received her bachelor's degree from Eastern Connecticut State University and a master's degree in health care policy and management from the University of Massachusetts, Amherst.

JIM SIMPSON, Regional President, Kaiser Foundation Health Plan of Georgia, Inc., joined Kaiser in 1997. Prior to joining Kaiser, he served in the audit practice and consulting groups of Deloitte & Touche, LLC and the Federal Deposit Insurance Corporation. He received his bachelor's degree from Southern Methodist University and his master's degree in accounting from the University of North Texas.

ARTHUR M. SOUTHAM, M.D., Executive Vice President, Health Plan Operations, joined Kaiser in May 2001. Prior to joining Kaiser, Dr. Southam was President and Chief Executive Officer of Health Systems Design Corporation. He received a bachelor's degree in neurosciences from Amherst College, his M.D. degree and a master's degree in Public Health from the University of California, Los Angeles, and his MBA degree from Pepperdine University.

MARK S. ZEMELMAN, Senior Vice President, General Counsel and Secretary, joined Kaiser in 1991. Prior to joining Kaiser, Mr. Zemelman worked at two national law firms. He received his bachelor's degree from the University of California, Santa Cruz and a law degree from the University of California, Hastings College of the Law.

Employees

As of December 31, 2016, Hospitals and the Health Plan Organizations had more than 118,000 employees, and the Permanente Medical Groups had more than 95,000 employees, including more than 21,000 physicians. Approximately 71% of Hospitals' and the Health Plan Organizations' combined total labor force was covered by collective bargaining agreements as of December 31, 2016. As of that same date, approximately 10% of Hospitals' and the Health Plan Organizations' total labor force was covered by collective bargaining agreements that are scheduled to expire within one year. HAMI and HPAMI currently have no employees.

Since 1997, the Kaiser Permanente entities have been party to a National Labor Management Partnership Agreement (the "Partnership Agreement") with the Coalition of Kaiser Permanente Unions ("Coalition"), which established the Labor Management Partnership. As of December 31, 2016, the Coalition consisted of 11 international unions and 28 local unions representing more than 64,000 Hospitals and Health Plan Organization employees across the regions and approximately 115,000 employees when including persons employed by the Permanente Medical Groups.

Kaiser Permanente and the Coalition renegotiated the current collective bargaining agreement (the "National Agreement") in June 2015, and it will expire September 30, 2018. The negotiations addressed key issues such as employee and retiree benefits and resulted in the modification of post-retirement medical benefits for certain union represented employees. Under the terms of the National Agreement, post-retirement medical plan design changes limit future employer costs. See "INFORMATION ABOUT KAISER—Management's Discussion and Analysis of the Combined Financial Position and Results of Operations of Kaiser—Pension and Other Retirement Obligations" herein for a description of the pension and post-retirement benefit obligations of Hospitals and the Health Plan Organizations and the potential to impose substantial liabilities on the Credit Group. Each union that voluntarily adopts the National Agreement also has its own local agreement with a Kaiser Permanente entity.

Through the National Agreement, physicians, management, unions and employees work together to meet shared goals of service excellence and market-leading performance by specifically promoting joint decision-making, union and employee involvement and performance improvement. The National Agreement addresses issues such as organizational performance, attendance, flexibility, patient and employee safety and growth of the Health Plan Organizations. Management believes that salary levels and benefits for union-represented Kaiser employees

generally are equal to or better than the prevailing market. Kaiser and the Coalition unions have mutually benefited from having all Coalition union contracts bargained simultaneously.

Approximately 28,000 additional Kaiser Permanente employees are members of non-Coalition unions. This includes more than 18,000 members of the California Nurses Association ("CNA"), most of whom are employed in Kaiser Permanente's Northern California region. Of this total, nearly 6,000 CNA members are employed by The Permanente Medical Group in the Northern California region. The current Northern California agreement with CNA's registered nurse and nurse practitioner unit will expire August 31, 2017. Management expects the parties will begin bargaining to renew the agreement in summer 2017. It is possible the collective bargaining agreement will expire before agreement is reached and disputes may arise, resulting in strikes and disruption in the Northern California region. In February 2017, Hospitals agreed on a collective bargaining agreement with CNA for its newest unit of inpatient and home care registered nurses at the KFH Los Angeles in Southern California, which will remain in effect through September 2021.

In connection with the Group Health Cooperative acquisition, Kaiser Permanente added approximately 1,000 physicians and more than 6,500 employees, of whom approximately 4,000 are represented by three unions whose collective bargaining agreements will remain in effect through 2018, 2019, and 2020, respectively. Additionally, in connection with the HHSC transaction in Hawaii, a subsidiary of Hospitals expects to employ approximately 1,600 workers, more than 1,400 of whom will likely be represented by two local unions. New collective bargaining agreements will be negotiated following the planned July 2017 transfer. It is possible the Hawaii region will experience work stoppages and other related actions during the anticipated negotiations. See "INFORMATION ABOUT KAISER—Strategy—Growth in Current, Contiguous and New Markets" and "—Group Health Cooperative Acquisition" herein.

With respect to the collective bargaining agreements that will expire within the year, failure to reach agreement on successor contracts could result in work stoppages, potential sympathy strikes by some union or individuals, and other adverse labor actions. Labor strikes have occurred in the past at Hospitals' and the Health Plan Organizations' health care facilities and may occur again in the future. A sustained labor action may materially impact the operations, financial position and cash flows of Kaiser. See "BONDHOLDERS' RISKS—Significant Risk Areas Summarized—Labor Costs, Disruptions and Availability" herein for a description of the general risks posed by labor disruptions.

Facilities and Capital Expenditures

Hospitals owns 39 licensed general acute care hospitals under 35 hospital licenses (including four licensed hospitals with multiple campuses). As of February 28, 2017, these facilities comprised in the aggregate over 7,850 licensed acute care patient beds. Hospitals and the Health Plan Organizations also own and/or operate more than 660 medical office buildings and other outpatient facilities.

In Northern California, hospital facilities are located in Antioch, Fremont, Fresno, Manteca/Modesto, Oakland/Richmond, Redwood City, Sacramento, Roseville, San Leandro, San Francisco, San Rafael, Santa Clara, Santa Rosa, San Jose, South Sacramento, South San Francisco, Vacaville, Vallejo and Walnut Creek. In Southern California, hospitals are located in Baldwin Park, Bellflower, Fontana/Ontario, Harbor City, Los Angeles, Moreno Valley, Orange County-Anaheim/Irvine, Panorama City, Riverside, San Diego (Zion Avenue and Clairemont Mesa Boulevard), West Los Angeles and Woodland Hills. Hospitals' hospital facilities are also located in Portland and Hillsboro, Oregon, and Honolulu, Hawaii. KFHP-WA also owns and operates a licensed hospital in Seattle, Washington. The hospital provides surgical services, as well as emergency department urgent care services, and it is in the process of reopening an inpatient and extended observation unit for medical/surgical patients.

Hospitals and the Health Plan Organizations continually evaluate the use of their hospitals and other facilities and operations. It is possible that some facilities may be sold or closed and that new ones will be added from time to time.

Kaiser has a 10-year capital plan (2016-2025) totaling approximately $42 billion, which management expects will be funded through a combination of cash provided from operations and borrowings. Some of this spending is directed toward land purchases, site preparation and construction of new hospital facilities and medical

office buildings, while some is allocated for renovations, expansions and/or seismic retrofitting of existing medical and administrative facilities. These capital expenditures contemplate an increase to 42 hospitals by 2025. It is projected that approximately 34% will be spent on maintenance and equipment, 30% will be spent on growth, 27% will be spent on technology and 9% will be spent on seismic. Kaiser also evaluates hospital acquisitions, from time to time. In 2010, Kaiser completed one seismic replacement (in Vallejo, California) and one major hospital expansion (in Santa Rosa, California). In 2011, Kaiser completed one new expansion hospital (in Ontario, California) and one major hospital expansion (in Sacramento, California). In 2012, Kaiser completed one seismic replacement (in Anaheim, California). In 2013, Kaiser completed one seismic replacement (in Fontana, California), and a new expansion hospital (in Hillsboro, Oregon). In 2014, Kaiser completed three seismic replacements (in San Leandro, Oakland, and Redwood City, California) and a major hospital expansion (in Los Angeles, California). In 2015, Kaiser opened one seismic replacement (in Harbor City, California) and a major hospital expansion (in Moreno Valley, California). In 2017, Kaiser completed one new expansion hospital (in San Diego, California on Clairemont Mesa Boulevard). A portion of Kaiser's capital expenditures is also typically applied to develop and upgrade information technology infrastructure, including Kaiser's digital and mobile strategies, KP HealthConnect®, telemedicine, as well as wireless and mobile applications.

Accreditations

As of December 31, 2016, Health Plan, Inc. in the Northern California region and Southern California region, the Health Plan Organization in the Northwest region, and the Health Plan Organization in the Mid-Atlantic States region had an Excellent Accreditation status from NCQA for their Commercial HMO and Medicare HMO products. Health Plan, Inc. in the Hawaii region had an Excellent Accreditation status for its Commercial HMO, Medicare HMO and Medicaid HMO products. The Health Plan Organization in the Colorado region had a Commendable Accreditation status for its Commercial HMO product and an Excellent Accreditation status for its Medicare HMO product. The Health Plan Organization in the Georgia region had a Commendable Accreditation status for its Commercial HMO product and an Excellent Accreditation status for its Medicare HMO product.

As of December 31, 2016, all of Hospitals' hospitals in the Hawaii, Northern California, Southern California and Northwest regions were accredited by The Joint Commission. Given the number of Hospitals' facilities, each hospital is at a different point in the accreditation cycle, and status may change based on accreditation survey findings. See "—Compliance and Other Pending Matters—CMS Surveys" herein.

Litigation

Gross Premiums Tax Litigation. In September 2015, a lawsuit was filed seeking to have the State of California impose the gross premiums tax on Health Plan, Inc. The lawsuit was filed after the California Court of Appeal issued a ruling that mere status as a "health care service plan" did not exempt either Blue Shield of California or Anthem Blue Cross from the gross premiums tax. Although strong defenses exist regarding this claim, an unfavorable outcome could have a material adverse effect on the financial condition or operations of Kaiser as a whole.

Pay Practice Litigation. A number of class action lawsuits relating to worker classification are currently pending against Kaiser. The lawsuits allege, among other things, that the plaintiffs are entitled to payment for overtime, off the clock work, rest periods and similar benefits. Each suit relates to workers who provide a particular type of service or care. Management currently does not believe such matters will have a material adverse effect on the financial condition or operations of Kaiser as a whole.

Non-Contracted Provider Litigation. In January 2008, Prime Healthcare Services, Inc. ("Prime"), a for-profit company that acquires and manages hospitals in several states, filed lawsuits against Health Plan, Inc., Hospitals and the Southern California Permanente Medical Group in California state court, alleging that Health Plan, Inc., Hospitals and the Southern California Permanente Medical Group underpaid Prime hospitals for care provided to Health Plan, Inc. members. During the years at issue, Prime hospitals generally did not have written contracts with Kaiser, and Health Plan, Inc., Hospitals, and the Southern California Permanente Medical Group contend that Prime did not contact Health Plan, Inc. and/or Hospitals to obtain authorization for post-stabilization care before rendering that care so they are not legally required to pay Prime for that post-stabilization care.

Health Plan, Inc., Hospitals and the Southern California Permanente Medical Group filed counterclaims against Prime alleging violation of unfair competition laws and other claims, and in January 2015, the parties agreed to arbitrate their dispute. The arbitration panel has proceeded in phases and will likely issue an award in the damages phase in May 2017. Prime sought Superior Court review of rulings from earlier phases of the arbitration, but the court has deferred ruling on petitions regarding the commercial claims arbitration until its completion. Health Plan, Inc., Hospitals and the Southern California Permanente Medical Group also unsuccessfully sought Superior Court review of the issue of whether Prime had to exhaust federal administrative process and could file suit only in federal court, which the parties had also agreed to arbitrate. That issue is on appeal to the California Court of Appeal.

Health Plan, Inc. is involved in several other legal proceedings in which providers are contesting the computation by Health Plan, Inc. of the reasonable and customary value of services provided to its members, often contending that they are entitled to be paid their full-billed charges.

Management currently does not believe any of the matters described above will have a material adverse effect on the financial condition or operations of Kaiser as a whole.

Managed Care Litigation. Several purported class action lawsuits challenge Kaiser's provision of behavioral health services and other benefits. Management currently does not believe such matters will have a material adverse effect on the financial condition or operations of Kaiser as a whole.

Other Litigation. As with most hospitals and MCOs, the entities within Kaiser are subject to certain legal actions that, in whole or in part, are not or may not be covered by insurance because of the type of action or amount or types of damages requested (*e.g.*, punitive damages), because of a reservation of rights by an insurance carrier, or because the action has not proceeded to a stage that permits full evaluation. Management does not anticipate that any such suits will ultimately result in damage awards or judgments in excess of self-insurance reserves or insured limits, other than matters that have been disclosed in this Offering Memorandum, or if such awards or judgments were to be entered, that they would have a material adverse impact on the financial condition or operations of Kaiser as a whole. There can be no assurance, however, that future litigation will not have such a material adverse effect.

The outcome of litigation is inherently uncertain, however, and it is possible that one or more of the litigation matters currently pending or threatened could have a material adverse effect on the financial condition or operations of Kaiser as a whole.

There is no controversy or litigation of any nature now pending against Hospitals or any Guarantor or, to the knowledge of their respective officers, threatened, seeking to restrain or enjoin the issuance or sale of the Bonds, or in any way contesting or affecting the validity of the Bonds, any proceedings of Hospitals or any Guarantor taken concerning the issuance, sale or delivery thereof, or the pledge or application of any moneys or security provided for the payment of the Bonds or use of the Bond proceeds.

BONDHOLDERS' RISKS

General

The purchase and ownership of the Bonds involve certain investment risks that are discussed throughout this Offering Memorandum. Each prospective purchaser of the Bonds (or a beneficial ownership interest therein) should make an independent evaluation of all of the information presented in this Offering Memorandum in order to make an informed investment decision. The following discussion of risk factors is not intended to be comprehensive or definitive but, rather, to summarize certain matters that could affect payment of the Bonds. It should be read in conjunction with all other parts of this Offering Memorandum. The operations, financial condition and cash flows of Kaiser may be affected by factors other than those described below or by factors that, while not material individually, could in the aggregate have a material adverse effect. No assurance can be given as to the nature of factors that may in the future affect, or the potential effects of those factors on, the operations, the financial condition or the cash flows of Kaiser. Investors must recognize that payment provisions for, and regulations and restrictions on, insurer, hospital and health system operations change frequently and that additional material

payment limitations and regulations or restrictions may be created, implemented or expanded while the Bonds are Outstanding.

The Bonds constitute general obligations of Hospitals, payable from payments made by Hospitals under the Indenture, payments by the Guarantors pursuant to the Guarantee Agreement and certain other funds held by the Trustee pursuant to the Indenture. No representation or assurance can be made that revenues will be realized in amounts and at times sufficient and available to Hospitals to make the payments under the Indenture or to the Guarantors to make payments under the Guarantee Agreement and, thus, to pay principal or Make-Whole Redemption Price of and interest on the Bonds.

Significant Risk Areas Summarized

Certain of the primary risks associated with the operations of Kaiser are briefly summarized in general terms below and are explained in greater detail in subsequent sections. The occurrence of one or more of these risks could materially impact the operations, financial position and cash flows of Kaiser entities and, in turn, the ability of Hospitals to make the payments under the Indenture or the Guarantors to make payments under the Guarantee Agreement.

Several of the federal statutes and regulations described herein may be substantially modified or repealed in whole or in part. During the November 2016 elections, several successful candidates for election to the U.S. Congress and President Trump campaigned on promises to effect modification or repeal of statutes and regulations, some of which are described herein. Although legislation proposed in the House of Representatives to amend certain key provisions of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to herein as the "ACA"), was not successful, future legislative or regulatory action to modify the ACA is likely. In addition, it is expected that legislation to effect tax reform and financial services reform, including rollback of the Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Dodd-Frank Act"), is likely to be introduced during the current congressional term. It is not certain whether or when legislation relating to such key areas will be introduced or passed. Reform legislation (if introduced and passed) could have a material impact on Kaiser's operations, financial position and cash flows. In addition, regulatory changes through adoption or repeal and executive actions taken by the Administration could materially impact Kaiser's operations, financial position and cash flows, even in the absence of statutory changes. Accordingly, the risk areas summarized under this caption "BONDHOLDERS' RISKS" may undergo significant change in the near term.

Kaiser Permanente's Integrated Delivery System and the Managed Care Industry. Kaiser Permanente is a trade name for the integrated health care delivery system operating as the Kaiser Permanente Medical Care Program, which integrates the institutional, payor and professional components of medical care in a unified delivery model through the relationships among Hospitals, the Health Plan Organizations and the Permanente Medical Groups. The entities that comprise Kaiser operate in a complex federal and state regulatory environment and are subject to a wide variety of federal and state laws, regulations, rules and governmental administrative policies and determinations, and those laws, regulations, rules and administrative policies and determinations are regularly subject to change. In addition, as an integrated delivery system, the failure to estimate, price for and manage health care costs in an effective manner could materially impact Kaiser's operations, financial position and cash flows. Further, maintaining an integrated delivery system is capital intensive and may create certain business liabilities for the entities that comprise Kaiser. Regulation, technology and physician/patient expectations require constant and often significant capital investment.

The Health Plan Organizations and the Permanente Medical Groups in each region in which Kaiser operates have mutually exclusive contractual relationships with each other (except KFHP-WA also contracts with local community hospitals and community physicians) and historically have functioned in close cooperation. Although management of Kaiser believes that the cooperative relationships will continue, there can be no assurance that they will continue in their present form or at all. A significant adverse change in the relationships between any of the Health Plan Organizations and any Permanente Medical Group, or the failure to maintain such relationships, could materially impact the operations, financial position and cash flows of Kaiser.

In a prepaid integrated delivery system, dues paid by individual members and groups constitute a significant source of revenue, but systems also rely to varying degrees on payment from the federal Medicare program. For MCOs, Medicare is a source of premium payments for the Medicare Part C and Medicare Part D programs as defined under "—Additional Revenue Sources" below. For hospitals, Medicare is one of the sources of payment for inpatient or hospital-based outpatient care rendered to Medicare beneficiaries. Future changes in program funding or in the underlying law and regulations, as well as in payment policy and timing, could materially impact MCOs' and hospitals' payment streams from Medicare. Congress and/or CMS have taken action and may take additional action in the future to decrease or restrain Medicare outlays for hospitals that provide services to Medicare beneficiaries and for MCOs that enter into Medicare managed care contracts with CMS to serve Medicare beneficiaries. If decreases or restraint in Medicare outlays continue, it is possible that this could materially impact the operations, financial position or cash flows of the entities that comprise Kaiser.

Health Care Reform. The ACA introduced an extensive set of new laws to the health care industry, which continue to be implemented. These laws address aspects of health insurance, health care, provider operations and health care delivery. Consequences of the ACA include reductions in payments to Medicare providers and Medicare Advantage plans, a requirement that most United States citizens and legal residents maintain health benefits coverage, a requirement that large employers offer coverage to their full-time workers, greater funding for federal and state fraud detection programs, new requirements and restrictions on the eligibility and coverage determinations of health insurers, including MCOs, an expansion of Medicaid, premium assistance and cost sharing reductions for low-income individuals, and increased regulation and federal oversight of health insurers and health benefit plans. The legislation also contains provisions intended to influence provider behavior and the nature, costs and outcomes of health care spending, all of which are likely to have less predictable effects. Changes wrought by or in response to federal health care reform may continue to cause or require health insurers and health care providers to modify their business strategies and practices, increase their risk of legal or contractual liability, and increase their costs or diminish their revenues, among other potential ramifications.

As noted above, President Trump and certain Congressional leaders promised a repeal of all or a portion of the ACA in 2017 in statements concerning their respective legislative agendas. The legislative repeal effort, to date, has not been successful. Changes to the ACA through regulatory action are likely. It is not clear whether the Administration and Congress will continue to attempt to effect changes to the ACA through additional legislative efforts or by limiting funding for certain aspects of the ACA. The effect of these actions, or others that may be taken, on Kaiser and the Credit Group are uncertain but could be material.

State Regulation of MCOs and Insurance Companies. Insurance companies and MCOs must be licensed by the jurisdictions in which they conduct business. Such jurisdictions, including but not limited to states, generally require periodic financial reports and establish minimum capital or restricted cash reserve requirements. MCOs and insurance companies are also regulated under state insurance holding company laws and regulations, which generally require registration with applicable state departments of insurance or other regulators and the filing of reports that describe capital structure, ownership, financial condition, certain intercompany transactions and general business operations. Some state insurance holding company laws and regulations require prior regulatory approval of acquisitions and material intercompany transfers of assets, as well as transactions between the regulated companies and their parent holding companies or affiliates. Compliance with these laws may restrict the ability of Kaiser to make revenues realized by one Health Plan Organization available to Kaiser as a whole, while minimum capital requirements may conversely necessitate funds transfers from some Kaiser entities to others. Such transfers could result in the movement of assets out of the Credit Group.

States, through legislation, regulatory action and the courts, impose various benefit mandates on MCOs, HMOs and other state-regulated health plans. ERISA regulated health plans, including commercial self-funded plans, generally are exempted from these state mandates. Thus, state mandates may adversely impact the competitiveness of state-regulated health plans. As part of the implementation of the ACA, the U.S. Department of Health and Human Services ("DHHS") directed states to identify a "benchmark plan" that includes a core set of Essential Health Benefits ("EHBs") required by the ACA, which will result in state regulated health plans offering more comprehensive and more standardized benefits. The impact of requirements that health plans offer more comprehensive coverage and comply with state mandates may continue to materially impact the Health Plan Organizations, MCOs, and other state-regulated health plans. Federal legislation to repeal, replace, or amend the ACA may reduce or otherwise materially alter the EHBs or other benefits covered by and premiums earned by state-

regulated health plans, impact reimbursements paid to health care providers for their services, and thereby have a material financial impact on Kaiser and the Credit Group.

Costs and Restrictions from Governmental Regulation. Nearly every aspect of health care insurance, hospital operations and health care delivery is subject to governmental regulation, including in some cases by multiple governmental agencies. The level and complexity of regulation and compliance audits appear to be increasing, imposing greater operational limitations, enforcement and liability risks, and sometimes significant and unanticipated costs.

Government "Fraud" Enforcement and Audits. "Fraud" in government funded health care programs is a significant concern of federal and state regulatory agencies overseeing health care programs and is one of the federal government's prime law enforcement priorities. The federal government and, to a lesser degree, state governments impose a wide variety of extraordinarily complex and technical requirements intended to prevent over-utilization based on economic inducements, misallocation of expenses, overcharging and other forms of "fraud" in the Medicare and Medicaid programs, as well as other state and federally-funded health care programs. This body of regulations impacts a broad spectrum of MCO activity, including billing and recordkeeping, membership referrals, product pricing, discounting and rebates, and marketing practices, and hospital activity, including billing and recordkeeping, physician contracting and recruiting, cost allocation, clinical trials, discounts, and other functions and transactions.

Violations and alleged violations may be deliberate but also frequently occur in circumstances where management is unaware of the conduct in question, as a result of mistake, or where the individual participants do not know or do not believe that their conduct is in violation of law. Violations may occur and be prosecuted in circumstances that do not have the traditional elements of fraud, and enforcement actions may extend to conduct that occurred in the past. Violations may carry material sanctions. Governmental agencies periodically conduct widespread investigations covering categories of services or certain accounting, pricing or billing practices.

Violations and Sanctions. Governmental agencies and/or private "whistleblowers" often pursue aggressive investigative and enforcement actions. The federal government has a wide array of civil, criminal, monetary and other penalties, including the suspension of essential hospital and other health care provider payments from the Medicare or Medicaid programs, or exclusion from those programs. Aggressive investigation tactics, negative publicity and threatened penalties can be, and often are, used to compel health care providers to enter into monetary settlements in exchange for releases of liability for past conduct, as well as agreements imposing prospective restrictions and/or mandated compliance requirements on health care providers. Such negotiated settlement terms may materially impact the reputation and operations, financial condition and financial performance of hospital and other health care providers. Multi-million dollar fines and settlements for alleged intentional misconduct, fraud or false claims are not uncommon in the health care industry. These risks are generally uninsured. Government enforcement and private whistleblower suits may increase in the hospital and health care sector, and many large hospital and other health care provider systems may be adversely affected.

General Economic Conditions, Bad Debt, Indigent Care and Investment Performance. The health insurance industry is affected by the economic environment in which it operates. High unemployment or workforce reduction will negatively impact the demand for health insurance products. Unfavorable economic conditions also have caused and could continue to cause some employers—particularly small employers—to stop offering all coverage and other employers to stop offering more comprehensive health insurance plans to employees. In addition, unfavorable economic conditions could adversely affect the ability to increase premiums or result in cancellation by certain customers of insurance products. These conditions could lead to a decrease in membership levels and membership dues and could materially impact operations, financial position and cash flows.

Hospitals and other medical services providers also are affected by economic downturns. To the extent that state, county or city governments are unable to provide a safety net of medical services, pressure is applied to local hospitals to increase free care. Economic downturns and lower funding of state Medicaid and other state health care programs may increase the number of patients treated by hospitals who are uninsured or otherwise unable to pay for some or all of their care. These conditions may give rise to increased bad debts and higher indigent care utilization.

In addition, economic downturns may result in declines in investment portfolio values, which may reduce or eliminate non-operating revenues. Reduced returns and losses in pension and benefit funds may result in increased funding requirements. Potential failure of lenders, insurers or vendors may negatively affect operations, financial position and cash flows of health care providers.

Competition. The managed health care industry is very competitive. The failure to compete, including maintaining or increasing membership, will materially impact the operations, financial position and cash flows of Kaiser. Competitors may have greater capabilities, resources or market share, a more established reputation, superior supplier or health care professional arrangements, better existing business relationships, lower profit margin or financial return expectations, or other factors that give such competitors a competitive advantage. In addition, competitive position may be materially impacted by significant merger and acquisition activity that occurs in the markets in which Kaiser operates, both among health care insurers, as well as hospitals, physician groups and other health care professionals.

In addition, hospitals and other health care providers face increased pressure to be transparent and provide information about cost and quality of services, which may lead to a loss of business as consumers and others make choices about where to receive health care services based upon publicly available information.

Technical and Clinical Developments. New clinical techniques and technology, as well as new pharmaceutical and genetic developments and products, may alter the course of medical diagnosis and treatment in unanticipated ways that may significantly change medical and hospital care. These new technologies could result in higher hospital costs, reductions or increases in patient populations and/or new sources of competition for hospitals, as well as increased costs for care delivery that may not be offset by higher premiums.

Labor Costs, Disruption and Availability. Inpatient health care facilities are labor intensive. Labor costs, including salary, benefits and other liabilities associated with the workforce, have significant impact on hospital operating costs and, in turn, MCOs' medical costs. Hospital and health care employees are increasingly organized in collective bargaining units and may be involved in work actions of various kinds, including work stoppages and strikes. Workforce disruption may negatively impact hospitals' revenues and reputation.

Overall costs of the hospital workforce and turnover are high, and pressure to recruit, train and retain qualified employees is expected to accelerate. From time to time, shortages of physicians and nursing and other technical personnel occur, which may impact hospitals and health care systems. Various studies have predicted that physician and nurse shortages will become more acute over time, as practitioners retire and patient volume exceeds the growth in new professionals. Shortages of other professional and technical staff such as pharmacists, therapists, laboratory technicians, billing coders and others also may occur. Economic conditions that create pressure to control and reduce wage and benefit costs would further strain the supply of those professionals. Personnel shortages may materially increase Hospitals' costs of operation.

Pension and Benefit Funds. As large employers, hospitals and MCOs are incurring significant expenses to fund pension and benefit plans for employees and former employees and to fund required workers' compensation benefits. Plans are often underfunded, or may become underfunded, and funding obligations in some cases may be erratic or unanticipated and may require significant commitments of available cash needed for other purposes.

Medical Liability Litigation and Insurance. Medical liability litigation is subject to public policy determinations and legal and procedural rules that may be altered from time to time, with the result that the frequency and cost of such litigation, and resultant liabilities, may increase in the future. MCOs and hospitals may be affected by negative financial and liability impacts on physicians. Many states including California have adopted laws to limit potential medical tort liability and corresponding insurance rates by addressing issues such as statutes of limitation, caps on non-economic damages, and limits on attorney fees. Laws that address medical tort liability are regularly subject to proposed legislation or ballot initiatives which seek to repeal, in whole or in part, such reforms. If these repeal efforts are successful, in whole or in part, medical liability recoveries and medical liability insurance rates could rise significantly, which would have a negative financial impact on Kaiser and the Credit Group. Costs of insurance, including self-insurance, may increase dramatically.

Nonprofit Health Care Environment and Tax Reform. The significant tax benefits received by nonprofit, tax-exempt organizations may cause their business practices to be scrutinized by public officials and the press, and subject them to legal challenges with respect to their ongoing qualification for tax-exempt status and those benefits. Within the health care industry, practices that have been examined, criticized or challenged have included pricing practices, billing and collection practices, charitable care and executive compensation. Challenges to exemptions from real property taxes and other taxes have succeeded from time to time. Multiple governmental authorities, including state attorneys general, the Internal Revenue Service (the "IRS"), Congress and state legislatures have held hearings and carried out audits regarding the conduct of tax-exempt organizations, including tax-exempt hospitals. These efforts will likely continue in the future. Citizen organizations, such as labor unions and patient advocates, have also focused public attention on the activities of tax-exempt health care organizations and raised questions about their practices. Proposals to increase the regulatory requirements for nonprofit health care organizations' retention of tax-exempt status, such as by establishing a minimum level of charity care, have also been introduced repeatedly in Congress. Significant changes in the requirements applicable to nonprofit, tax-exempt health care organizations and challenges to or loss of the federal or state tax-exempt status of non-profit health care organizations generally or to the entities that comprise Kaiser in particular could materially impact the operations, financial position or cash flows of Kaiser.

Tax reform may be introduced with such reform likely focused on lowering corporate and individual tax rates, while eliminating certain tax preferences and other tax expenditures, including the authority to issue tax-exempt bonds for certain purposes. Any future tax reform could materially impact the operations, financial position and cash flows of Kaiser. Additionally, such tax reform may materially impact the market price or marketability of the Bonds in the secondary market.

Market Risk in Connection with Variable Rate Demand Bonds. The Credit Group has outstanding variable rate demand bonds and there are no dedicated external liquidity facilities for these bonds. If these variable rate bonds cannot be remarketed following their tender, or converted to another interest rate mode, the Credit Group will be required to pay the purchase price of bonds tendered and not remarketed with its own funds. The interest rates on those bonds has fluctuated significantly over time, and any sustained upward movement could increase the Credit Group's cost of capital.

Market Risk in Connection with Commercial Paper. Hospitals has outstanding commercial paper. The market for commercial paper has been and may continue to be adversely affected by disruption in the credit markets. To date, Hospitals has been able to successfully roll its commercial paper, but there is no assurance that it will be able to do so in the future. Any failure to successfully roll maturing commercial paper could trigger an obligation of Hospitals to pay maturing commercial paper, which could materially impact the operations, financial position and cash flows of Kaiser.

Interest Rate Swaps and Hedge Risk. The Credit Group is party to interest rate swap agreements. Certain interest rate swap agreements executed by health care providers to manage interest rate risk in connection with bond financing failed to serve their purpose during and after the Great Recession as financial counterparties suffered downgrades and failed in some instances. Market interest rate fluctuations also affected the value of these hedging arrangements, with generally lower market rates adversely affecting the value of floating-to-fixed rate interest rate swap agreements and requiring substantial payments to financial counterparties in order to terminate those agreements. Absent termination, interest rate swap agreements must be generally "marked-to-market" periodically for financial accounting purposes, with changes in valuation reflected in a borrower's financial statements.

Integration and the Managed Care Industry

Membership Dues. In a prepaid integrated delivery system, dues paid by individual members and groups constitute the majority of revenue. The system uses dues to pay the costs of health care services delivered to members. The amount of dues assessed against each member, the timing of the organization's receipt of dues and composition of members all pose risks to the financial condition of an MCO. In addition, the dollar amount of dues may not cover the actual cost of providing the contracted-for services. The failure to estimate, price for and manage health care costs in an effective manner could materially impact operations, financial position and cash flows. Health care and operating costs are influenced by Kaiser's ability to manage such costs through underwriting criteria, product design, negotiation of favorable provider contracts and medical management programs. Costs also

can be affected by a wide array of external, often uncontrollable, events, including the member population characteristics, changes in health care practices, general inflation and medical cost inflation, new technologies, increased use of services, increased cost of individual services, natural catastrophes or other large-scale medical emergencies, epidemics, new mandated benefits or other regulatory changes. Relatively small differences between estimated and actual health care costs or utilization rates can result in significant changes in Kaiser's financial results.

In addition, federal funding provides premium assistance to low-income individuals, which contributes to dues paid to Health Plan Organizations by members. Changes to federal law that may eliminate or reduce premium assistance may result in loss of membership and reduced revenues for the Health Plan Organizations.

Kaiser typically establishes the amount of dues seven months prior to commencement of the 12-month membership. Because of the time lag, there may be a variation between actual health care costs and the estimates reflected in the amount of member dues. In addition, the ability to increase members' dues may be delayed by regulations or other factors.

In addition, financial results that Kaiser reports for any particular period include estimates of costs that have been incurred for which claims are still outstanding. These estimates involve an extensive degree of judgment. Inaccuracy of estimates may materially impact the operations, financial position and cash flows of Kaiser.

Additional Revenue Sources. Medicare is the federal health insurance system under which health care providers are paid for services provided to eligible elderly persons, disabled persons and certain persons diagnosed with end stage renal disease. Medicare consists of four parts: Part A, which covers inpatient hospitalization, skilled nursing facility care, hospice care and home health agency care ("Medicare Part A"); Part B, which covers physician and other outpatient services and certain drugs ("Medicare Part B"); Medicare Part C, the Medicare Advantage program, under which MCOs, such as the Health Plan Organizations, may contract with CMS to provide Medicare Part A and Medicare Part B care and additional benefits to Medicare beneficiaries in exchange for a prepaid, capitated payment set by CMS ("Medicare Part C"); and Medicare Part D, which covers Medicare prescription drugs and is furnished through private Medicare Advantage plans or on a free-standing basis by private prescription drug benefit plans that have contracted with CMS ("Medicare Part D"). Medicare Part D payments to prescription drug plans are partly capitated through a risk-sharing arrangement and partly claims-based through a reinsurance payment mechanism. The Health Plan Organizations each contract to provide services covered under Medicare Part C (which includes Medicare Part A and Medicare Part B services) and Medicare Part D. Hospitals provides inpatient services to members that are covered under the Medicare managed care contracts between the Health Plan Organizations and Medicare. In addition, Hospitals is enrolled in the Medicare programs to provide Medicare Part A services to Medicare beneficiaries who are not members. Medicare is administered by CMS, which delegates to the states the process for certifying hospitals to which CMS will make payment. In order to achieve and maintain Medicare certification, hospitals must meet CMS's "Conditions of Participation" on an ongoing basis, as determined by the state and/or The Joint Commission. The requirements for Medicare certification are subject to change, and, therefore, it may be necessary for hospitals to effect changes from time to time in their facilities, equipment, personnel, billing, policies and services.

Revenue from Medicare under Medicare Advantage and Medicare Part D is based in part on bids submitted in the year prior to the contract year. Currently, payments to Medicare Advantage plans are determined annually by comparing plan bids to benchmark rates developed by CMS. Payments to Medicare Part D plans are based on the national weighted average of bids submitted by all plans. The value of such bids and premiums charged depends on estimates of future health care costs over the fixed contract period, and, as described above the actual cost of providing the contracted-for services may exceed what was estimated and reflected in the bids or premiums. Relatively small differences between estimated and actual health care costs or utilization rates can result in significant changes in Kaiser's financial results.

In addition, policymakers have been attentive to the cost of the Medicare Advantage program relative to traditional fee-for-service Medicare and the U.S. Congress and President Trump have discussed cuts to federal funding of health care programs, which may include reduced federal spending on traditional Medicare and Medicare Advantage plans. Fluctuations in payments to Medicare Advantage plans by the federal government are common. In addition, given the focus of the U.S. Congress and the Trump Administration on reduced federal spending on

health insurance and health care programs, federal Medicare spending may continue to be scrutinized. Continued decreases or restraint in Medicare outlays may materially impact the operations, financial position and cash flows of Kaiser.

State Medicaid and other state health care programs also may be important to hospital and MCO financial results. These programs often pay hospitals and MCOs at levels that may be below the actual cost of the care provided. Since Medicaid is partially funded by states, the potentially weak financial condition of states may result in lower funding levels and/or payment delays, which could have a material adverse impact on hospitals and MCOs. In addition, the federal government reimburses state Medicaid programs on average for more than 60% of state Medicaid expenditures, and U.S. Congress and President Trump are considering legislative proposals to change or reduce federal Medicaid spending. In this regard, federal legislation being considered would eliminate the Medicaid expansion implemented under the ACA and change the way in which the federal government reimburses states for Medicaid programs. Changes to Medicaid eligibility and spending may significantly reduce Medicaid payments to hospitals, health care providers, and MCOs covering Medicaid beneficiaries.

Relations with Physicians. MCOs contract with physicians for services, and the commercial success of MCOs is substantially dependent on a continued ability to contract for these services at competitive prices. Failure to develop and maintain satisfactory relationships with physicians could materially impact the business, operations, financial position and cash flows of an MCO. In any particular market, physicians could refuse to contract, demand higher payments, or take other actions that could result in higher medical costs, less desirable service for members or difficulty meeting regulatory or accreditation requirements. In some markets, multi-specialty physician groups may have significant market positions or near monopolies. If these providers refuse to contract with an MCO, use their market position to negotiate contracts that are unfavorable to the MCO or place an MCO at a competitive disadvantage, an MCO's ability to market products or to be successful in those areas could be materially impacted.

Most of the Health Plan Organizations contract exclusively with local Permanente Medical Groups on an annual basis (the Washington region medical service agreement has a three-year term and KFHP-WA contracts with local community hospitals and community physicians). Permanente Medical Groups may contract with external community physicians to provide some health care services to members. Although management of Kaiser believes that the cooperative relationships among the Health Plan Organizations, the Permanente Medical Groups and external physicians in each region in which Kaiser operates will continue, the physicians who practice with or provide services for the Permanente Medical Groups could terminate their arrangement or become unable or unwilling to continue practicing medicine with or provide services for the Permanente Medical Groups. There is and likely will be heightened competition to employ physicians in the markets where Kaiser operates. Kaiser's inability to maintain or grow satisfactory relationships with the physicians who practice with or provide services for the Permanente Medical Groups, or to retain members following the departure of a physician, as well as the Permanente Medical Groups' ability to acquire or recruit physicians, could materially impact the operations, financial position and cash flows of Kaiser. In addition, retention and recruitment of physicians may require substantial financial investment.

Relations with Health Care Providers. MCOs contract with hospitals for services, and their results of operations and prospects are substantially dependent on a continued ability to contract for these services at competitive prices. Failure to develop and maintain satisfactory relationships with hospitals could materially impact the operations, financial position and cash flows of an MCO. In any particular market, hospitals could refuse to contract, demand higher payments, or take other actions that could result in higher medical costs, less desirable service for members or difficulty meeting regulatory or accreditation requirements. In some markets, some hospital organizations may have significant market positions or near monopolies. If these hospitals refuse to contract with an MCO, use their market position to negotiate contracts that are unfavorable to the MCO or place an MCO at a competitive disadvantage, an MCO's ability to market products or to be successful in those areas could be materially impacted.

All of the Health Plan Organizations, other than KFHP-WA, contract with Hospitals to provide or arrange hospital and related services. In the Colorado, Georgia and the Mid-Atlantic States regions, Hospitals does not own or operate hospitals. Rather it assumes the responsibility to arrange for hospital services required by Health Plan Organization members, usually at local community hospitals. In the Washington region, KFHP-WA holds the contracts with local community hospitals and community physicians.

Health Care Reform

Federal Health Care Reform. The health care industry is the subject of changing statutory and regulatory requirements and consequently will be subject to structural and operational changes and challenges for a substantial period of time. The full ramifications of health care reform and changes to the laws and regulations governing health insurance and health care may become apparent only over time and through subsequent regulatory and judicial interpretations. As stated above under "—Significant Risk Areas Summarized," Congress and President Trump's Administration may attempt to effect changes to the ACA through legislative and regulatory actions or by limiting funding for certain aspects of the ACA. The uncertainties regarding the implementation or modification of the ACA create unpredictability for the strategic and business planning efforts of health care providers and plans alike.

As a result of the adoption of the ACA in 2010 and subsequent promulgation of regulations, substantial changes have and continue to occur in the United States health care system. The ACA is far reaching and transformative in scope. It includes numerous provisions affecting the structure of the health insurance market, the delivery of health care services, the financing of health care costs, reimbursement of health care providers, and the legal obligations of health insurers, providers and employers. Several coverage-related provisions took effect soon after enactment of ACA in 2010; many more took effect in 2014 upon implementation of a much broader range of the ACA's market reforms, and other provisions are planned to take effect at specified times over the next several years. The ACA also resulted in the promulgation of substantial regulations with significant effects on the health care industry, and new regulations continue to be promulgated. Thus, the health care industry is, and will continue to be, subject to significant statutory and regulatory requirements and contractual terms and conditions, which will result in structural and operational changes and challenges for a substantial period of time. See "BONDHOLDERS' RISKS—Significant Risk Areas Summarized—Costs and Restrictions from Governmental Regulation" herein. In addition, uncertainties regarding further development and implementation of, and possible modification to, the ACA and related regulations create unpredictability for the strategic planning efforts of health care providers and MCOs, which in itself constitutes a risk.

The ACA was designed, in substantial part, to make health care more available to millions who were uninsured or underinsured by subsidizing the premium costs and out-of-pocket costs of health insurance for persons who fall below certain income levels. The ACA accomplished that objective through various provisions, summarized as follows: (i) the creation of active markets places (referred to as exchanges) in which individuals and small employers can purchase health care insurance for themselves and their families or their employees and dependents, (ii) providing means-tested subsidies for premium costs and cost-sharing to certain individuals and families based upon their income relative to the applicable federal poverty levels for their location, (iii) mandating that individual consumers obtain a minimum level of health care insurance and providing for penalties for consumers that do not comply with limited exceptions, (iv) establishing a minimum level of health care insurance to be provided by employers to full-time employees and providing for penalties on certain employers whose employees purchase coverage through the individual exchange and qualify for subsidies, (v) expansion of private commercial insurance coverage generally through such reforms as prohibitions on denials of coverage for pre-existing conditions and the establishment of a minimum threshold of comprehensive coverage necessary to fulfill the individual mandate, and (vi) expansion of existing public programs, including Medicaid, for individuals and families. The ACA also contained other provisions designed to address the availability, cost and quality of health insurance and health care services, and also taxes and other provisions to pay for some of the reforms and subsidies included in the ACA.

Many provisions of the ACA have a significant impact on health care providers and MCOs like the Health Plan Organizations. Many aspects of the ACA continue to be implemented and the expected future impact on MCOs and health care providers is uncertain. For example, since 2014 when many of the market reforms established by the ACA took effect, a number of insurance carriers decided to either not participate in or withdraw from the exchanges and the individual and small group markets, leaving fewer insurers to cover health risks of individuals and families, and this trend may continue. As insurers withdraw and health insurance markets consolidate, additional pressure is placed on insurers that remain in the market. Insurers remaining in the market must cover risks that would otherwise be spread among a greater number of health insurers. This trend of less competition has the potential to raise health insurance rates, destabilize insurance markets, and threaten the financial viability of insurers who remain in the market. This trend also has the potential to cause adverse selection and rapid

cost increases in the individual market as people in good health opt out of more expensive coverage and people with high-cost health conditions remain insured.

The ACA also adopted a number of reforms designed to stabilize the individual and small group insurance markets, known as the reinsurance, risk adjustment and risk corridor programs. While the risk adjustment program is permanent, the reinsurance and risk corridor programs lasted only until the end of 2016. Payments overdue from the federal government to insurers, including the Health Plan Organizations, through the risk corridor and reinsurance program remain subject to ongoing litigation and constitute an uncertain financial impact on Kaiser.

The ACA also includes cuts in Medicare reimbursement and increased taxes. CMS is proposing a modest increase in baseline Medicare Advantage payment rates for 2018 of 0.45% on average, down from 0.85% last year. When factoring in the risk coding tendencies, the average change in Medicare Advantage insurers' revenue is expected to climb 2.95% as compared to a 3.05% increase in 2017. Unforeseen cost-cutting provisions have impacted health care providers by, among other things, payment based on specified performance parameters and reduction of Medicare market basket updates.

Past proposals to impose additional federal rate regulation on the health care insurance industry might also be enacted in the future, resulting in constraints on the ability of MCOs to set premiums to cover anticipated expenditures. If decreases or restraint in Medicare are enacted, it is possible that this could materially impact the operations, financial position or cash flows of Kaiser.

Beginning in 2011, health insurance issuers and plans were required to rebate to enrollees the value of any retained revenue or expenditures on costs, other than those incurred in paying medical claims and conducting quality initiatives, in excess of 85% of premium revenue (80% in the individual or small group market). These minimum medical loss ratio ("MLR") requirements have required some health insurance issuers to refund portions of customer's premiums or cause them to revise plan benefits, change pricing, adjust their mix of business or exit segments of the market. The ACA included a requirement that most individuals obtain health insurance coverage beginning in 2014 and also a requirement that large employers offer coverage to their employees or pay a financial penalty. In addition, the laws included certain new taxes and fees, including an excise tax on high premium insurance policies (which becomes effective in 2020), and new fees on companies such as the Health Plan Organizations. An 85% MLR applies to Medicare Advantage plans since 2014. The full effect of the ACA on health insurance issuers and health insurance markets has not yet been realized. Health insurance markets and company finances continue to change in response to the ACA, and this creates continued uncertainty.

The ACA imposes fees on insurers, including the Health Plan Organizations, that may translate into rate changes. The fees include (i) the annual health insurer fee, beginning in 2014 and collection of which was suspended for 2017 but will be applied in 2018, unless Congress takes further action, which is collected as a percent of premium on all fully-insured plans where the size of this fee varies depending on the insurer's net written premiums, (ii) the Patient-Centered Outcomes Research Institute fee, which is assessed on all fully-insured and self-insured health plans annually beginning in 2012 through 2019, to fund a research institute with a broad goal of improving the overall quality and efficiency of the health care system, (iii) the Transitional Reinsurance Program Contribution, collected from all insurers, self-funded plans and third-party administrators beginning in 2014, to help stabilize the individual market during the first years of operation of the exchanges, and (iv) a 40% excise tax, beginning in 2020, on the "excess benefit" of any employer-sponsored group health plan with costs that exceed a pre-determined level. The imposition of fees on fully insured plans such as those offered by Kaiser and not on self-insured plans may continue to have an adverse impact on Kaiser because it increases the competitive attractiveness of self-insured plans. It is possible that this could materially impact the operations, financial position or cash flows of Kaiser.

Health care "fraud and abuse" laws will continue to create compliance challenges for health care providers as well. The ACA itself contains more than 32 sections related to health care fraud and abuse and program integrity. These include amendments to existing criminal, civil, and administrative anti-fraud statutes and increases in funding for enforcement and efforts to recoup prior federal health care payments to providers. The additional compliance requirements and increased emphasis on enforcement and monetary recoupment heighten the legal and financial exposure of health care providers.

In addition, much of the expansion in coverage under the ACA is through increased eligibility in the Medicaid program. The ACA provided for the expansion of Medicaid programs to a broader population with incomes up to 133% of federal poverty levels ("FPL") beginning in January 2014. In its June 2012 ruling, the United States Supreme Court determined that any expansion of Medicaid must be at the option of individual states and not a mandatory obligation. The State of California approved expansion of Medi-Cal coverage, effective January 1, 2014, to include adults with incomes up to 138% of the FPL who are under age 65, not pregnant and not otherwise currently eligible for Medi-Cal. The low level of reimbursement for Medicaid enrollees could have an unfavorable effect on issuers such as the Health Plan Organizations.

The ACA also imposed additional requirements on tax-exempt hospitals, including obligations to adopt and publicize a financial assistance policy; limit charges to patients who qualify for financial assistance to the lowest amount charged to insured patients; and control the billing and collection processes. Additionally, tax-exempt hospitals must conduct a community needs assessment and adopt an implementation strategy to meet those identified needs. Failure to satisfy these conditions may result in the imposition of fines and the loss of tax-exempt status. See "BONDHOLDERS' RISKS—Tax-Exempt Status and Other Tax Matters—Maintenance of the Tax-Exempt Status of Kaiser Entities" herein.

Challenges to the ACA. President Trump and certain Congressional leaders promised a repeal of all or a portion of the ACA in 2017 in statements concerning their respective legislative agendas. The legislative repeal effort, to date, has not been successful. Changes to the ACA through regulatory action are likely. It is not clear whether the Administration and Congress will continue to attempt to effect changes to the ACA through additional legislative efforts or by limiting funding for certain aspects of the ACA. On January 20, 2017, President Trump issued an executive order that may be used to prevent enforcement of the individual mandate and the requirement that large employers offer coverage to their full-time workers. This has the potential to cause adverse selection and rapid cost increases in the individual market as people in good health opt out of more expensive coverage and people with high-cost health conditions remain insured. If the individual mandate is not enforced while the current individual market rules remain in place, health insurance issuers, including the Health Plan Organizations, will be less able to respond to market conditions with underwriting, product and pricing flexibility and will have greater exposure to material adverse impacts on their finances and operations.

The ACA contemplates that the federal government will reimburse health insurance issuers for cost sharing reductions (i.e., lower deductibles, copays and co-insurance) for low-income individuals enrolled in certain qualified health plans purchased through exchanges. In a case pending in federal court, *House v. Price (*previously known as *House v. Burwell)*, a federal district court held that the federal government did not have constitutional authority to pay health plan issuers offering certain coverage through the exchanges for cost sharing reductions because U.S. Congress did not appropriate funds for the program. At the request of the parties, this federal case was stayed pending an appeal. If the district court decision stands (including by virtue of the Administration's failure to pursue appeal) or is upheld on appeal, then health insurance issuers may not be compensated for cost sharing reductions they provided to their members, and may be required to continue to provide, and this could materially impact the operations, financial position or cash flows of Kaiser. Elimination of cost sharing subsidies may also make health insurance less affordable for many members, reducing the number of people who get coverage or use that coverage, disrupting the individual health insurance market, and having a further adverse impact on Kaiser.

The ACA also contemplated that health insurance issuers that experienced unexpectedly high health care costs would receive payments under the temporary risk corridors program that ended in 2016. The risk corridors program set a target for exchange participating insurers to spend 80% of premium dollars on health care and quality improvement. Insurers with costs less than 3% of the target amount must pay into the risk corridors program; the funds collected were used to reimburse plans with costs that exceed 3% of the target amount. This program was intended to work in conjunction with the ACA's MLR provision, which requires most individual and small group insurers to spend at least 80% of premium dollars on enrollee's medical care and quality improvement expenses, or else issue a refund to enrollees. Payments overdue from the federal government to insurers, including the Health Plan Organizations, through the risk corridor program remain subject to ongoing litigation and constitute an uncertain financial impact on Kaiser.

The full ramifications of changes to the ACA and regulations adopted thereunder will only become apparent over time and through subsequent regulatory and judicial interpretations. Although efforts to legislatively

repeal certain provisions of the ACA have thus far been unsuccessful, it is anticipated that efforts to modify the ACA through regulations or by limiting funding will continue. In addition, legislative actions to repeal or modify all or portions of the ACA could be proposed in the future. Uncertainty remains regarding the continued implementation of the ACA, which creates significant uncertainty in the health insurance and health care markets, which could materially impact the operations, financial position or cash flows of Kaiser. In this regard:

- Changes to the Medicaid program and reduced federal spending on Medicaid may have adverse financial impacts on Kaiser both in terms of the revenues earned by the Health Plan Organizations to cover Medicaid recipients and revenues earned by Kaiser entities to care for Medicaid recipients.

- Efforts to reduce Medicare provider payments and Medicare Advantage payments may continue.

- Reductions in premium assistance and cost sharing reduction subsidies may result in more people becoming uninsured. In addition, reduced marketing of the health care exchanges also may result in more people being unable to afford care or coverage. As a result, Health Plan Organizations may experience reduced enrollment. People previously insured who become uninsured may reduce their utilization of health care services and be unable to pay for care that is provided.

- Health insurance premiums in the individual and small group market may change, resulting in unpredictable consequences for people who may or may not seek to enroll in coverage, which could impact the mix of Kaiser's members and result in higher utilization of health care services.

- Changes to regulations on the sale of health insurance across state lines may impact the number and mix of Kaiser's members.

The impact that efforts, whether legislative, regulatory or judicial, to effect changes to the ACA will have on health insurance markets, the total number of insured individuals, the mix of people covered by insurance, the level of coverage, utilization of health care services, reimbursements to health care providers, and the resulting impact on the finances and operations of health insurance issuers and health care providers are uncertain. These impacts depend on the actual legislative and regulatory actions taken and market forces. Modification of all or part of the ACA could materially impact the operations, financial position and cash flows of Kaiser.

Investors are encouraged to review legislative, regulatory and judicial developments relating to the ACA as they occur and to assess their potential effects on health care providers, MCOs and the health care industry.

California Health Care Reform. The State of California enacted several laws intended to implement the ACA within the required federal timeframes. The Governor took the extraordinary step of calling the State Legislature into Special Session in 2013 specifically to address issues relating to the State of California's implementation of the ACA within the federal timelines.

California started taking steps to implement the ACA shortly after it became federal law.

- The State of California established a health insurance exchange within a year of passage of the ACA. In October 2012, California named its exchange "Covered California." Covered California launched its insurance website and enrollment websites on time and began accepting enrollees in 2013. On January 31, 2017, Covered California closed its fourth open enrollment period, which resulted in the enrollment of approximately 412,000 new consumers and approximately 1.3 million individuals though the renewal process. Covered California appears to be largely operationally successful; however, it has faced several administrative issues including delays in enrollment eligibility determinations for Medi-Cal, errors in verifying tax information and reporting advanced premium tax credit amounts, and public confusion over plan coverage. Recently, Covered California has announced the creation of the Office of the Ombudsmen to resolve consumer complaints and answer questions about Covered California's policies and practices.

- The State of California approved expansion of Medi-Cal coverage, effective January 1, 2014, to include adults with incomes up to 138% of the FPL who are under age 65, not pregnant and not otherwise currently eligible for Medi-Cal.

- All 58 of California's counties are covered by Medi-Cal managed plans as of the end of 2014.

- The implementation of health care reform has extended coverage under Medi-Cal to an additional four million Californians in three years and added new services such as treatment for substance abuse and mental health. The expansion has already increased State General Fund costs by more than $1 billion annually, and was projected to increase to more than $2 billion by 2017-2018 as the federal government begins to reduce its share of costs beginning in 2017.

During the past decade, California state legislators have frequently introduced proposals to reform the health care delivery system and the insurance market. On February 17, 2017, the Californians for a Healthy California Act ("SB-562") was introduced in the California State Senate. SB-562 seeks to establish a single-payer health care coverage program and health care cost control system for the benefit of all residents of the state. Kaiser's membership and operations are concentrated in the California health care market. Depending on the structure of reform proposals, enactment of insurance market and delivery system reforms could materially impact the operations, financial position and cash flows of Kaiser. In addition, changes to the design and funding of Medi-Cal, additional oversight of the rate-setting process, and other potential legislative and regulatory changes impacting Covered California could materially impact the operations, financial position and cash flows of Kaiser. It is not possible to predict what actions will be taken relating to a delivery system or insurance market reform in future years by the California voters, the California State Legislature and the Governor of California.

Regulation of MCOs and Insurance Companies

Each Health Plan Organization must be licensed by and is subject to regulation in the jurisdiction(s) in which it conducts business. For example, states require periodic financial reports and enforce minimum capital or restricted cash reserve requirements. Health plans and insurance companies are also regulated under state insurance holding company regulations, and some of the activities of the Health Plan Organizations may be subject to other health care-related regulations and requirements, including those relating to PPOs, MCOs and licensure requirements. In addition, under state guaranty association laws, certain insurance companies can be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of impaired or insolvent insurance companies (including state insurance cooperatives) that write the same line or similar lines of business. Any such assessment could expose insurers to the risk of paying a portion of an impaired or insolvent insurance company's claims through state guaranty association assessments.

Certain of the Health Plan Organizations provide products or services to government agencies, and these relationships are subject to the terms of contracts held with the government agencies and to laws and regulations regarding government contracts. Among others, certain laws and regulations restrict or prohibit companies from performing work for government agencies that might be viewed as an actual or potential conflict of interest. These laws may limit a Health Plan Organization's ability to pursue and perform certain types of work, thereby materially impacting the operations, financial position and cash flows of Kaiser.

The Health Plan Organizations also must obtain and maintain regulatory approvals to market its benefits products, increase the amount of membership dues charged for certain benefits products and complete certain acquisitions and divestitures. Membership dues, which are equivalent to premium rates, are subject to regulatory review or approval by state and federal governments. Additionally, Kaiser is required to submit data on proposed membership dues increases to DHHS for monitoring purposes. Delays in obtaining necessary approvals or the failure to obtain or maintain required approvals could materially impact the operations, financial position and cash flows of Kaiser.

In *Harlick v. Blue Shield of California* ("Harlick"), the Ninth Circuit Court of Appeals interpreted California's Mental Health Parity Act ("MHPA") to require Blue Shield of California to provide residential treatment for a member with an eating disorder, even though residential treatment was excluded from the member's policy. Other litigants are pursuing a broad construction of the *Harlick* decision to require health plans to provide

all medically necessary treatment for conditions covered by the MHPA, even if the coverage is expressly excluded by the health plan or exceeds the benefits provided for physical ailments. It is not known whether this decision and other related decisions will be upheld, but the cost of implementing the *Harlick* decision, as well as a broad construction, could adversely affect the operations, financial position and cash flows of Kaiser.

Regulation of the Health Care Industry

The health care industry is regulated at the federal, state, local and international levels. The laws and rules governing Kaiser's business and interpretations of those laws and rules are subject to frequent change. To avoid material impacts to its business in this highly regulated environment, Kaiser must adapt to changes in federal and state regulations.

Fraud and False Claims. The federal government has enacted health care "fraud and abuse" laws to broadly regulate services to government program beneficiaries and requirements for submitting claims for services provided to beneficiaries. State governments have enacted similar laws. Under both state and federal laws, MCOs, hospitals and other health care providers may be subject to extraordinary penalties for a wide variety of conduct, including activities that could otherwise be considered to be relatively innocent in commercial settings other than health care, such as discounting. Punishable conduct includes submitting claims for services that are not provided, billing in a manner that does not comply with government requirements, providing inaccurate claims information, billing for services deemed to be medically unnecessary, billing with an illegal inducement to utilize or refrain from utilizing a service or product, misallocating health plan administrative costs or providing inaccurate pricing data in Medicare bid submissions. Reckless or intentional mistakes (such as billing errors), especially those punishable under the False Claims Act as described below, may be subject to extreme penalties.

Federal and state governments have a broad range of criminal, civil and administrative sanctions available to penalize health care fraud, including excluding a hospital or MCO from participating in the Medicare and/or Medicaid program, civil monetary penalties, suspending Medicare and/or Medicaid payments, and imprisonment. Fraud cases may be prosecuted by one or more government entities and/or private individuals, and more than one available sanction may be, and often are, imposed for violations.

Fraud investigations, settlements, prosecutions and related publicity can have a significant adverse effect on hospitals and MCOs. See "BONDHOLDERS' RISKS—Regulation of the Healthcare Industry—Enforcement Activity" below. Major elements of these often highly technical laws and regulations are generally summarized below.

False Claims Act. The federal False Claims Act ("FCA") prohibits the knowing or reckless submission of a false, fictitious or fraudulent claim for payment or approval for payment for which the federal government provides, or reimburses all, or at least some portion of the requested money or property. FCA violations that occurred prior to August 1, 2016 are punishable in an amount not to exceed $11,000 per claim, plus three times the amount of monetary damages. For FCA violation occurring on or after August 1, 2016, FCA civil penalties increase to as much as almost $22,000 per claim, plus three times the amount of damages that the federal government sustains because of the false claim. In extreme circumstances, violation of the FCA may result in criminal penalties. FCA investigations and cases have become common in the health care field and may cover a range of activity from intentionally inflated billings, to highly technical billing infractions, to allegations of inadequate care. The FCA also permits individuals to initiate civil actions on behalf of the government in lawsuits called "qui tam" actions. Qui tam plaintiffs, or "whistleblowers," can share in the damages recovered by the government or recover independently if the government does not participate. It is important to note that when FCA penalties increase, so do the financial rewards for whistleblowers, increasing their incentive to allege false or fraudulent claims. The FCA has become one of the government's primary tools for policing health care fraud. Violation or alleged violation of the FCA most often results in compliance agreements and settlements that require multi-million dollar payments and also may result in significant repayments, penalties, exclusion from federal programs, criminal liability, or reputation damage that could have a material adverse impact on a hospital or MCO.

Under the ACA, the FCA has been expanded to include overpayments that are discovered by a health care provider and are not promptly refunded to the applicable federal health care program, even if the claims relating to the overpayment were initially submitted without any knowledge that they were false. This expansion of the FCA

exposes hospitals and other health care providers to liability under the FCA for a considerably broader range of claims than in the past.

Anti-Kickback Law. The federal Anti-Kickback Law (the "Anti-Kickback Law") makes it a felony to knowingly and willfully offer, pay, solicit or receive remuneration, directly or indirectly, in return for referring, ordering, purchasing, leasing, recommending or arranging for the referral of, any product or service that is reimbursable by Medicare, Medicaid or other health care programs funded in whole or in part by the federal government.

The Anti-Kickback Law is broadly drafted and establishes penalties for individuals and organizations on both sides of the prohibited transaction. Each violation under the Anti-Kickback Law may result in a fine of up to $25,000 and/or imprisonment for up to five years. In addition, conviction results in mandatory exclusion from participation in federal health care programs. Individuals who violate the Anti-Kickback Law may still face exclusion from federal health care programs at the discretion of the Secretary of DHHS, even absent a conviction. The government also may assess civil penalties, which could result in treble damages plus $50,000 for each violation of the Anti-Kickback Law. Although the Anti-Kickback Law does not afford a private right of action, the FCA provides a vehicle whereby individuals may bring qui tam actions alleging violations of the Anti-Kickback Law. As noted, when a private citizen sues on behalf of the federal government and is successful, they receive a percentage of the ultimate recovery for their "whistleblower" efforts. Violation or alleged violation of the Anti-Kickback Law can result in settlements that require multi-million dollar payments and compliance agreements.

In addition to certain statutory exceptions to the Anti-Kickback Law prohibitions, the OIG has promulgated a number of regulatory "safe harbors" under the Anti-Kickback Law designed to protect certain payment and business practices from prosecution under the statute. Failure to meet a safe harbor may subject the participants to a risk of prosecution if one or more of the purposes for the transaction is to induce referrals in violation of the law. The safe harbors described in the regulations are narrow and do not cover some common economic relationships between and among hospitals, physicians and other health care providers.

The broad scope of the Anti-Kickback Law and similar state law prohibitions, along with the variable interpretations and enforcement of such laws can have a chilling effect on contractual arrangements of hospitals, pharmacies and MCOs that otherwise would be financially beneficial. In addition, penalties or exclusion from the Medicare or Medicaid programs could materially impact the operations, financial position or cash flows of a hospital, pharmacy or MCO.

Stark Referral Law. The federal "Stark" statute and related regulations (together, the "Stark Law") prohibit a physician's referral of Medicare patients for certain designated health services (including inpatient and outpatient hospital services, clinical laboratory services, and radiation and other imaging services) to entities with which the referring physician has a financial relationship, unless one of a wide range of exceptions applies. A financial relationship may exist in the form of an investment or ownership interest or a direct or indirect compensation arrangement. The Stark Law also prohibits the entity furnishing the designated services from billing Medicare, or any other payor or individual, for services performed pursuant to a prohibited referral. The Stark Law establishes a number of exception and grants the Secretary of DHHS the power to create additional exceptions. The government does not need to prove that a defendant knew the referral was prohibited to establish a violation of the Stark Law. If certain technical requirements are not met, many ordinary business practices and economically desirable arrangements between hospitals and physicians arguably constitute prohibited "financial relationships" within the meaning of the Stark Law. The broad scope of the Stark Law and similar state law prohibitions may discourage hospitals and MCOs from entering into business relationships that would otherwise be legally permissible and financially beneficial. Most providers of designated health services with physician relationships have exposure to liability under the Stark Law.

Medicare may deny payment for all services related to a prohibited referral and a hospital that has billed for such services may be obligated to refund the amounts collected from the Medicare program. For example, if an office lease between a hospital and a large group of heart surgeons is found to violate the Stark Law, the hospital could be obligated to repay CMS for the payments received from Medicare for all of the heart surgeries performed by all of the physicians in the group for the duration of the lease; a potentially significant amount. The government could also seek substantial civil monetary penalties, and in some cases, a hospital may be liable for fines up to three

times the amount of any monetary penalty, and/or be excluded from the Medicare and Medicaid programs. In addition, violations of the Stark Law are increasingly being prosecuted under the FCA, triggering the FCA penalties discussed above. Repayments to CMS, settlements, fines or exclusion for a Stark violation or alleged violation would materially impact a hospital.

There have been a series of regulations promulgated to clarify and implement the Stark statute, with some regulations having made the Stark statute more difficult to interpret clearly, thereby increasing the possibility that inadvertent violations may occur.

CMS has established a voluntary self-disclosure program under which hospitals and other entities may report Stark Law violations and seek a reduction in potential refund obligations. However, the program is relatively new and therefore it is difficult to determine at this point in time whether it will provide significant monetary relief to hospitals that discover inadvertent Stark Law violations.

Medicare and Medicaid.

Audits. MCOs and hospitals that participate in the Medicare and Medicaid programs are subject from time to time to audits and other investigations relating to various aspects of their operations and billing practices, as well as to retroactive audit adjustments to reimbursement claimed under these programs. Medicare and Medicaid regulations also provide for withholding reimbursement payments in certain circumstances. New billing rules and reporting requirements for which there is no clear guidance from CMS or state Medicaid agencies could result in claims submissions being considered inaccurate. The penalties for violations may include an obligation to refund money to the Medicare or Medicaid program, payment of criminal or civil fines and, for serious or repeated violations, exclusion from participation in federal health programs. Following direction from Congress, CMS has become increasingly focused on program integrity, meaning the detection and deterrence of fraud, waste and abuse, and has authorized a number of auditing programs to validate data, assess the justifiability of claims and recoup improper or erroneous payments. Among these are the recovery audit contractor ("RAC") program and others described below. CMS enlists RACs to assure accurate payments to providers under Medicare and Medicaid. RACs search for potentially improper payments from prior years that may not have been detected through CMS' existing program integrity efforts. RACs are private contractors, paid on a contingency fee basis, and use their own software and review processes to determine areas for review. Although required to identify both overpayments and underpayments, RACs have in practice collected significantly more in overpayments from providers in proportion to the underpayments paid to providers.

Authorized by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Medicare Integrity Program ("MIP") was established to deter fraud and abuse in the Medicare program. Funded separately from the general administrative contractor program, the MIP allows CMS to enter into contracts with outside entities and insure the "integrity" of the Medicare program. These entities, Medicare zone program integrity contractors ("ZPICs"), formerly known as program safeguard contractors, are contracted by CMS to review claims and medical charts, both on a prepayment and post-payment basis, conduct cost report audits and identify cases of suspected fraud. ZPICs have the authority to deny and recover payments as well as to refer cases to the Office of Inspector General. ZPICs have the ability to compile claims data from multiple sources in order to analyze the complete claims histories of beneficiaries for inconsistencies.

In addition, CMS conducts Risk Adjustment Data Validation audits ("RADV Audits") to detect errors in the coded medical record data that Medicare Advantage plans submit to CMS to receive risk-adjusted premium payments. CMS conducts RADV Audits at the contract level. Payment recovery is based on extrapolation of audit findings, allowing CMS to extend any overpayments identified in audit samples to a plan contract's entire Medicare Advantage population. CMS compares the contract's result to a Fee for Service Adjuster (the "FFS Adjuster"). If the contract's payment recovery estimate is higher than the FFS Adjuster, the plan must repay CMS the difference. Such contract-level repayments may be significant in amount and may result in CMS's conducting additional RADV Audits on other plans operated by an MCO.

Audits may result in reduced reimbursement or repayment obligations related to past alleged overpayments and also may delay Medicare payments to providers pending resolution of any appeals. Pending investigations of fraud, as well as compliance deficiencies identified during audits, also may result in termination of a Medicare

Advantage plan contract or suspension of an MCO from the Medicare Advantage program. The ACA also amended certain provisions of the FCA (as defined herein) to include retention of overpayments as a false claim and added provisions regarding the timing of obligations to identify, report and reimburse overpayments. Audit reviews, payment recovery or fraud detection may result in withholdings, reimbursement adjustments or repayments that collectively could materially impact the operations, financial position and cash flows of Kaiser.

Medicare Payment for Preventable Medical Errors. CMS regulations prohibit hospitals from assigning patient cases to diagnosis-related groups with higher payments where a secondary diagnosis warranting higher payment is one of several specified health conditions and was acquired in the hospital. These specified conditions include certain infections and serious preventable errors ("never events"), for which hospitals will not receive reimbursement unless the conditions were present at the time of admission. Never events may be publicized and may negatively impact a hospital's reputation, thereby reducing future utilization and potentially increasing the possibility of liability claims. The incidence of adverse events and their payment implications continue to be an area of focus for regulators.

Exclusions from Medicare or Medicaid Participation. The government may exclude from Medicare and/or Medicaid program participation a health care provider that is convicted of a criminal offense relating to delivery of any item or service reimbursed under Medicare or a state health care program, any criminal offense relating to patient neglect or abuse in connection with the delivery of health care, fraud against any federal, state or locally financed health care program or an offense relating to the illegal manufacture, distribution, prescription, or dispensing of a controlled substance. The government also may exclude individuals or entities under certain other circumstances, such as an unrelated conviction of fraud or other financial misconduct relating either to the delivery of health care in general or to participation in a federal, state or local government program. States also may exclude from participation in the Medicaid program any providers who have been excluded from participation in the Medicare program and vice versa. Exclusion from the Medicare and/or Medicaid program results in a bar on payments from all federal health care programs for services furnished by or at the direction of the excluded individual or entity. Exclusion of a hospital, even within a large integrated health care system, would likely materially impact the system's operations, financial position and cash flows.

Civil Monetary Penalties. The federal Civil Monetary Penalty Act authorizes imposition of substantial monetary penalties against entities for a wide range of abuses, including: (i) offering or providing remuneration to a federal health care program beneficiary that is likely to influence the receipt of items or services reimbursable by such programs; (ii) knowingly or willfully soliciting or receiving remuneration for a referral of a federal health care program beneficiary; (iii) using a payment intended for a federal health care beneficiary for another use; and (iv) submitting a claim for services provided by an individual or entity that is unlicensed or excluded from federal health care program participation. Civil monetary penalties have been assessed in recent years against MCOs for improper marketing practices by brokers and agents selling health care products on the MCOs' behalf and for MCOs' payments to such agents, as well as for other marketing misconduct related to participation in the Medicare Advantage and Medicare Part D prescription drug plans. As a result, CMS and state departments of insurance have increased their scrutiny of the marketing practices of Medicare Advantage and Medicare Part D insurance products.

Antitrust. Antitrust liability may arise in a wide variety of circumstances, including medical staff privilege disputes, payor contracting, physician relations, joint ventures, merger, affiliation and acquisition activities, certain pricing or salary setting activities, as well as other areas of activity. The application of the federal and state antitrust laws to health care is evolving (especially as the ACA is implemented) and, therefore, not always clear. Currently, the most common areas of potential liability are joint action among providers with respect to payor contracting and medical staff credentialing disputes.

Violation of the antitrust laws could result in criminal and/or civil enforcement proceedings by federal and state agencies, as well as actions by private litigants. In certain actions, private litigants may be entitled to treble damages, and in others, governmental entities may be able to assess substantial monetary fines. Entities that comprise Kaiser are involved in activities from time to time of the types described above. When or to what extent liability, if any, may arise cannot be predicted. Liability for violations and the direct and indirect cost of defending asserted violations may be substantial. Among the remedies available against persons found liable of violating antitrust prohibitions are treble damages, payment of plaintiff's attorney fees and, in the case of a consolidation, divestiture, any of which could be significant. The ability to consummate mergers, acquisitions or affiliations may

also be impaired by the antitrust laws, potentially limiting the ability of health care industry participants to fulfill their strategic plans.

HIPAA, HITECH Act, GLBA and Other Privacy and Security Regulation. HIPAA addresses the portability of health insurance and the confidentiality of individual's health information. HIPAA includes provisions affecting both the group and individual health insurance markets, including both fully insured and self-funded employee benefit plans, and includes provisions related to guaranteed availability and renewability of individual and small group health coverage, renewability, limits coverage exclusions based on preexisting conditions, and creates opportunities to enroll for coverage outside open enrollment periods on the occurrence of certain life events including the loss of coverage due to employment disruption, death of a subscriber, marriage, birth, adoption or placement for adoption of a child. Many of these "portability" provisions have been amended through health care reform. HIPAA also added criminal sanctions for health care fraud and applies to all health care benefit programs, whether public or private. HIPAA provides for punishment of a health care provider for knowingly and willfully embezzling, stealing, converting or intentionally misapplying any assets of a health care benefit program. A provider convicted of health care fraud could be subject to mandatory exclusion from Medicare.

The administrative simplification provisions of HIPAA apply to "covered entities" and in a more limited manner to "business associates" of those covered entities. Covered entities include health care providers, health care insurers and health maintenance organizations, and employer group health plans. Federal regulations promulgated pursuant to HIPAA include minimum standards for electronic transactions and code sets, and for the privacy and security of protected health information. Disclosure of certain broadly defined protected health information is prohibited unless expressly permitted under the provisions of HIPAA or its implementing regulations, or authorized by the affected individual. HIPAA's confidentiality provisions extend not only to an individual's medical records or health insurance enrollment records but also to a wide variety of health care clinical and financial settings where privacy restrictions often impose new communication, operational, accounting and billing restrictions. These add costs and create potentially unanticipated sources of legal liability. HIPAA imposes civil monetary penalties for violations and criminal penalties for knowingly obtaining or using individually identifiable health information. HIPAA privacy regulations do not preempt more stringent state laws and regulations, which may also apply to Kaiser.

Provisions in the 2009 Health Information Technology for Economic and Clinical Health Act (the "HITECH Act") increase the maximum civil monetary penalties for violations of HIPAA and grant enforcement authority of HIPAA to state attorneys general. The HITECH Act also (i) extends the reach of some of the HIPAA requirements beyond "covered entities," (ii) imposes a breach notification requirement on HIPAA covered entities, and business associates, (iii) limits certain uses and disclosures of individually identifiable health information and (iv) further restricts covered entities' marketing communications. Many states have also enacted laws requiring businesses to furnish notice to individuals affected by a breach of the security of unencrypted personally identifiable information held in an electronic system of records. In some jurisdictions state attorneys general must also receive notice. In the event of such an occurrence, Kaiser must assess its exposure under HIPAA and the HITECH Act as well as these state breach notification laws.

The breach notification obligation, in particular, may expose covered entities , including hospitals, health plans and providers, to heightened liability. Under the HITECH Act, in the event of a data privacy breach, covered entities are required to notify affected individuals and the federal government. If more than 500 individuals are affected by the breach, (i) the covered entity must also notify the media and (ii) the federal government posts a description of the breach on its website. These reporting obligations increase the risk of government enforcement as well as class action lawsuits, especially if large numbers of individuals are affected by a breach. The HITECH Act also established programs under Medicare and Medicaid to encourage the "meaningful use" of certified electronic health record technology or to impose penalties for failure to meet meaningful use standards.

The use and disclosure of individually identifiable health data by insurers is also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act ("GLBA") or state statutes implementing GLBA, which generally require insurers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a third party, and which generally require safeguards for the protection of personal information.

Security Breaches and Unauthorized Releases of Personal Information. Federal and state authorities are increasingly focused on the importance of protecting the confidentiality of individuals' personal information, including protected health information ("PHI"). In addition to the data breach notification requirements of HIPAA, many states have enacted laws requiring businesses to notify individuals and possibly other entities of security breaches that result in the unauthorized release of individually identifiable personal information. In some states, notification requirements may be triggered even where such information has not been used or disclosed, but has been inappropriately accessed. State consumer protection laws also may provide the basis for legal action for privacy and security breaches, including providing for compensatory or punitive damages, statutory damages, administrative fines or civil penalties or other legal remedies, and may, unlike HIPAA, authorize a private right of action. In particular, the public nature of security breaches exposes health care organizations to increased risk of individual or class action lawsuits from patients, members or other affected individuals, in addition to government enforcement. Failure to comply with restrictions on patient privacy or to maintain robust information security safeguards, including taking steps to ensure that contractors who have access to PHI and other personal information maintain the confidentiality of such information, could consequently damage a health care organization's reputation and materially adversely affect business operations.

Experienced computer programmers and hackers may be able to penetrate computer network security and misappropriate or compromise confidential information or that of third parties, create system disruptions or cause shutdowns. In addition, sophisticated hardware and operating system software and applications may contain defects in design or manufacture, including "bugs" and other problems that could unexpectedly interfere with the operation of the system. The costs to eliminate or alleviate cyber or other security problems, bugs, viruses, worms, malicious software programs and security vulnerabilities could be significant, and efforts to address these problems may not be successful and could result in interruptions, delays, and cessation of service that may impede medical care or other critical functions, and possibly result in a loss of existing or potential members, reduction in revenue and increase in expenses.

Kaiser manages and stores PHI and other personal information of its patients, members and other individuals relating to its business, the disposal of which is subject to federal and state regulation. Breaches of security measures or the accidental loss, inadvertent disclosure, improper disposal or unapproved dissemination of PHI or other personal information of individuals, including the potential loss or disclosure of such information or data as a result of fraud, trickery or other forms of deception, could expose Kaiser, its members, its patients, or other affected individuals to a risk of loss or misuse of this information, result in litigation and potential liability, regulatory review, government enforcement, including criminal sanctions and/or penalties, damage brand and reputation or otherwise harm business. In addition, the cost and operational consequences of implementing further data protection measures could be significant.

Portions of Kaiser's IT infrastructure also may experience interruptions, delays or cessations of service or produce errors in connection with systems integration, maintenance or migration work that takes place from time to time. Kaiser may not be successful in implementing new systems and transitioning data, which could cause business disruptions and be more expensive, time consuming, disruptive and resource-intensive. Such disruptions could adversely impact Kaiser's ability to provide services and interrupt other processes. Increased costs, damaged reputation, reduction in revenue or lost customers resulting from these disruptions could materially impact the operations, financial position or cash flows of Kaiser.

Controlled Substances. The Drug Enforcement Agency increasingly is investigating pharmacies and hospitals for potential violations of the Controlled Substances Act (the "CSA"). The CSA is a federal statute that regulates the manufacture, importation, possession, use and distribution of certain substances that DHHS determines should be controlled by the Drug Enforcement Agency. Pursuant to the CSA, individuals and organizations that are authorized to handle controlled substances are required to maintain complete and accurate inventories and records of all transactions involving controlled substances and ensure security for stored controlled substances. The failure to maintain accurate purchase and dispensing records, insufficient compliance procedures and controls regarding the distribution of controlled substances, and diversion of controlled substances for personal use or illicit sale violate the CSA. Penalties for violation of the CSA could be significant.

Enforcement Activity. Enforcement activity against health care providers has increased, and enforcement authorities have adopted aggressive approaches. In the current regulatory climate, it is anticipated that many MCOs,

hospitals, pharmacies and physician groups will be subject to an audit, investigation or other enforcement action regarding the health care fraud laws mentioned above.

Enforcement authorities are often in a position to compel settlements by providers charged with or being investigated for false claims violations by withholding or threatening to withhold Medicare, Medicaid and/or similar payments and/or by instituting criminal action. In addition, the cost of defending such an action, the time and management attention consumed and the facts of a case may dictate settlement. Therefore, regardless of the merits of a particular case, an MCO, hospital, pharmacy or physician group could experience materially adverse settlement costs, including costs associated with implementation of any settlement agreement. Prolonged and publicized investigations could be damaging to the reputation and business regardless of outcome.

Certain acts or transactions may result in violation or alleged violation of a number of the federal health care fraud laws described above, as well as similar state anti-fraud or false claim laws, and, therefore, penalties or settlement amounts often are compounded. Generally these risks are not covered by insurance. Enforcement actions may involve multiple hospitals and/or pharmacies in a network or multiple health plans offered by an MCO, as the government often extends enforcement actions regarding health care fraud to other hospitals, pharmacies and/or health plans operated or provided by the same organization. Therefore, fraud-related violations or allegations of violations identified as being materially adverse for one hospital, pharmacy or health plan could have materially adverse consequences for a network or integrated delivery system as a whole.

In addition, administrative regulations may require less proof of a violation than do criminal laws, and, thus, health care providers may have a higher risk of penalties as a result of administrative enforcement actions.

Enforcement Affecting Clinical Research. In addition to increasing enforcement of laws governing payment and reimbursement, the federal government also has stepped up enforcement of laws and regulations governing clinical trials conducted at hospitals. DHHS elevated and strengthened its Office of Human Research Protection, one of the agencies responsible for monitoring federally funded research. In addition, the National Institutes of Health significantly increased the number of facility inspections that these agencies perform. The Food and Drug Administration ("FDA") also has authority over clinical trials conducted in hospitals when these trials are conducted on behalf of sponsors seeking FDA approval to market the drug or device being researched. Moreover, the Office of Inspector General (the "OIG"), in its recent "Work Plans" has included several enforcement initiatives related to reimbursement for experimental drugs and devices (including kickback concerns) and has issued compliance program guidance directed at recipients of extramural research awards from the National Institutes of Health and other agencies of the U.S. Public Health Service. These agencies' enforcement powers range from substantial fines and penalties to exclusion of researchers and suspension or termination of entire research programs. Errors in billing the Medicare program for care provided to patients enrolled in clinical trials that is not eligible for Medicare reimbursement can subject hospitals to sanctions as well as repayment obligations.

EMTALA. The Emergency Medical Treatment and Active Labor Act ("EMTALA") is a federal civil statute that requires hospitals to medically screen for emergency medical conditions in patients presenting to the hospital for treatment and to stabilize a patient's emergency medical condition before discharging or transferring the patient, regardless of health insurance coverage or ability to pay. A hospital that violates EMTALA is potentially subject to civil penalties of up to $50,000 per offense and exclusion from the Medicare and Medicaid programs. In addition, a hospital may be liable for any claim by an individual who has suffered harm as a result of a violation.

Licensing, Surveys, Investigations and Audits. Health facilities are subject to numerous legal, regulatory, professional and private licensing, certification and accreditation requirements. These include, but are not limited to, requirements of state licensing agencies and the accreditation standards of The Joint Commission. Renewal and continuation of certain of these licenses, certifications and accreditations are based on inspections or other reviews generally conducted in the normal course of business of health facilities. Loss of, or limitations imposed on, hospital licenses or accreditations could reduce hospital utilization or revenues, or a hospital's ability to operate all or a portion of its facilities, which could materially impact the hospital or an affiliated MCO.

Negative Rankings Based on Clinical Outcomes, Cost, Quality, Patient Satisfaction and Other Performance Measures. Health plans, Medicare, Medicaid, employers, trade groups and other purchasers of health services, private standard-setting organizations and accrediting agencies increasingly are using statistical and other

measures in efforts to characterize, publicize, compare, rank and change the quality, safety and cost of health care services provided by hospitals and other institutional health care providers. The ACA shifts payments from paying for volume to paying for value, based on various health outcome measures. Published rankings such as "score cards," "pay for performance" and other financial and non-financial incentive programs are being introduced to affect the reputation and revenue of hospitals and other institutional health care providers and, in some instances individual practitioners, to influence the behavior of consumers, providers and health care delivery systems, such as Kaiser. Currently prevalent are measures of quality based on clinical outcomes of patient care, reduction in costs, patient satisfaction and investment in health information technology. Measures of performance set by others that characterize a hospital or other institutional health care provider negatively may adversely affect its reputation and financial condition.

Environmental Laws and Regulations. Hospitals are subject to a wide variety of federal, state and local environmental and occupational health and safety laws and regulations. These include, but are not limited to: air and water quality control requirements; waste management requirements; specific regulatory requirements applicable to pharmaceuticals, medical waste, asbestos and radioactive substances; requirements for providing notice to employees and members of the public about hazardous materials handled by or located at the hospital; and requirements for training employees in the proper handling and management of regulated materials and wastes.

Health facilities may be subject to requirements related to investigating and remedying hazardous substances located on their property, including such substances that may have migrated off the property. Typical hospital operations include the handling, use, storage, transportation, disposal and/or discharge of hazardous, infectious, toxic, radioactive, flammable and other hazardous materials, wastes, pollutants and contaminants. As such, hospitals are particularly susceptible to the practical, financial and legal risks associated with environmental laws and regulations. Such risks may result in damage to individuals, property or the environment; may interrupt operations and/or increase their cost; may result in legal liability, damages, injunctions or fines; and may result in investigations, administrative proceedings, civil litigation, criminal prosecution, penalties or other governmental agency actions; and may not be covered by insurance, which could materially impact Hospitals.

ERISA. The provision of services to certain employee benefit plans, including certain health care, group insurance and large case pensions benefit plans, is subject to ERISA, a complex set of laws and regulations subject to interpretation and enforcement by the IRS and the Department of Labor (the "DOL"). ERISA regulates how goods and services are provided to or through certain types of employer-sponsored health benefit plans, particularly self-funded plans. DOL regulations under ERISA set standards for claim payment and member appeals, along with associated notice and disclosure requirements. Some administrative services and other activities may also be subject to regulation under ERISA. Congress has considered various forms of managed care reform legislation which could fundamentally alter the treatment of coverage decisions under ERISA. In addition, there have been proposals to limit ERISA's preemptive effect on state laws, which could increase the liability exposure for MCOs that offer employer-sponsored health benefit plans and permit greater state regulation of their operations.

Network Adequacy Laws and Regulations. Health insurance companies and MCOs, including the Health Plan Organizations, offer health benefit plans that provide or pay for services through provider networks that must comply with state and federal network adequacy laws and regulations. These laws and regulations generally require that insurance companies and MCOs contract with a sufficient number and variety of providers across a health plan's service area to assure that health care services are accessible to enrollees in network plans. Network adequacy has been a focus of federal and state legislatures and regulators over the last several years and is an evolving area of policy. In many cases, regulatory standards for network adequacy have been developed to measure access in a network model as opposed to an integrated care delivery model like that of the Health Plan Organizations. The ability of organizations to meet network adequacy requirements depends on contracting arrangements with providers that are renegotiated from time to time. Competition from other health insurance companies and MCOs and present or future market conditions may cause health care providers in certain areas, markets or specialties to not contract with the Health Plan Organizations on a case by case basis or more generally within an area or market. The failure of health care providers to contract with the Health Plan Organizations may adversely affect Kaiser's financial condition and operating results. A health plan that cannot maintain an adequate network in an area or market may be required to pay for health care services performed by non-contracted providers at higher reimbursements rates than expected, require the plan to withdraw from an area or market until network adequacy is restored, or bring the plan under regulatory scrutiny which may require the plan to scale-down or

discontinue operations. The unpredictability of market competition, market conditions, future relationships with providers, and the risk that network adequacy laws and regulations could change, could have a material adverse impact on the finances of the Health Plan Organizations and the Credit Group.

Nonprofit Health Care Environment

The nonprofit tax-exempt organizations of Kaiser, including Hospitals, HAMI, HPAMI and the Health Plan Organizations, are subject to federal, state and local laws, regulations, rulings and court decisions relating to their organization and operation, including their operation for charitable purposes. At the same time, Kaiser entities conduct large-scale complex business transactions and are often the major employers in their geographic areas. There can often be a tension between the rules designed to regulate a wide range of charitable organizations and the day-to-day operations of a complex health care organization.

The operations and practices of health care providers are routinely challenged or criticized for inconsistency or inadequate compliance with the regulatory requirements for, and societal expectations of, nonprofit tax-exempt organizations. These challenges, in some cases, are broader than concerns about compliance with federal and state statutes and regulations, and instead examine core business practices of health care organizations. A common theme of these challenges is that nonprofit health care organizations may not confer community benefits that equal the benefits received from tax-exempt status. Areas that have come under examination have included pricing practices, billing and collection practices, charitable care, methods of providing and reporting community benefit, executive and director compensation and benefits, exemption of property from real property taxation, private use of facilities financed with tax-exempt bonds and others. Challenges and inquiries have come from a variety of sources, including state attorneys general, the IRS, labor unions, Congress, state legislatures, and patients, and in a variety of forums, including hearings, audits and litigation. The challenges and examinations, and any resulting legislation, regulations, judgments or penalties, could materially impact the operations, financial position and cash flows of Kaiser.

IRS Examination of Compensation Practices and Hospital Community Benefit. For many years, the IRS has been concerned about executive compensation practices of tax-exempt health care organizations. In 2004, the IRS began a new program to measure compliance by tax-exempt organizations with requirements that they not pay excessive compensation and benefits to their officers and other insiders. In February 2009, the IRS issued its Hospital Compliance Project Final Report (the "IRS Final Report") that examined tax-exempt organizations' practices and procedures with regard to compensation and benefits paid to their officers and other defined "insiders." The IRS Final Report indicates that the IRS will continue to heavily scrutinize executive compensation arrangements, practices and procedures of tax-exempt hospitals and other tax-exempt organizations and, in certain circumstances, may conduct further investigations or impose fines on executives or managers of tax-exempt organizations.

The IRS also has undertaken a community benefit initiative directed at hospitals. The IRS Final Report determined that the reporting of community benefit by nonprofit hospitals varied widely, both as to types of programs and expenditures classified as community benefit and the measurement of community benefits. As a result, the IRS issued the revised Form 990 that includes Schedule H, effective for tax years beginning after March 23, 2010, which is designed to provide uniformity regarding types of programs and expenditures reported as community benefit by nonprofit hospitals. As the IRS collects and reviews information from hospitals about the level and types of community benefit provided, the IRS may issue a more stringent interpretation of community benefit. Findings from Schedule H reports also may revive proposals in Congressional committees which, from time to time, have been made to codify additional requirements for hospitals' tax-exempt status, including requirements to conduct a regular community needs analysis and to provide minimum levels of charity care. Additionally, the ACA contains requirements for nonprofit hospitals in order to maintain their tax-exempt status, which include a requirement to conduct a community health needs assessment, among other requirements.

Congressional Hearings. Senate and House committees have conducted several nationwide investigations of hospital billing and collection practices and prices charged to uninsured patients and have considered reforms to the nonprofit sector, including proposed reform in the area of tax-exempt health care organizations, as part of health care reform generally. In addition, the House Ways and Means Committee and Senate Finance Committee continue to evaluate comprehensive tax reform. The Ways and Means Committee has formed several tax reform working

groups including one focused on the Charitable/Exempt Organizations sector. Comprehensive tax reform could impact tax exemption for all organizations, not only health care organizations which are tax-exempt under Section 501(c)(3) of the Code.

Litigation Relating to Billing and Collection Practices. Lawsuits filed in both federal and state courts have alleged, among other things, that hospitals have failed to fulfill their obligations to provide charity care to uninsured patients and have overcharged uninsured patients. Most of the cases filed in federal court have been dismissed, but some cases are proceeding in various state courts around the country with inconsistent results. It has been reported that some hospitals have entered into substantial settlements.

Class Actions. Nonprofit hospitals and health systems have long been subject to a wide variety of litigation risks, including liability for care outcomes, employer liability, property and premises liability, and peer review litigation with physicians, among others. In recent years, consumer class action litigation has emerged as a potentially significant source of litigation liability for nonprofit hospitals and health systems. These class action suits have most recently focused on hospital billing and collections practices and breaches of privacy, and they may be used for a variety of currently unanticipated causes of action. Since the subject matter of class action suits may involve uninsured risks, and since such actions often involve large classes of alleged plaintiffs, they may have material adverse consequences on hospitals and health systems in the future.

Challenges to Real Property Tax Exemptions. Recently, the real property tax exemptions afforded to certain nonprofit health care providers by state and local taxing authorities are being scrutinized, and in some cases have been challenged in court, on the grounds that the health care providers were not engaged in sufficient charitable activities. Court challenges have been based on a variety of grounds, including allegations of aggressive billing and collection practices and excessive financial margins and operations that closely resemble for-profit businesses. Several of these disputes have been determined in favor of the taxing authorities or have resulted in settlements. In addition, some states have proposed overhauling their property tax exemption laws. While Kaiser management is not aware of any current challenge to the tax exemption afforded to any material Kaiser real property, there can be no assurance that these types of challenges will not occur in the future.

The foregoing are some examples of the challenges and examinations facing nonprofit health care organizations. They are indicative of a greater scrutiny of the billing, collection and other business practices of these organizations and may indicate an increasingly difficult operating environment for health care organizations, including Kaiser. The challenges and examinations, and any resulting legislation, regulations, judgments, or penalties, could have a material adverse effect on hospitals and other health care providers, including the entities that comprise Kaiser, and, in turn, the ability of the Credit Group to make payments with respect to the Bonds.

General Economic Conditions

The disruption of the credit and financial markets in 2008 resulted in volatility in the securities markets, limitations on access to credit, significant losses in investment portfolios, fluctuations in interest rates, increased business failures, and consumer and business bankruptcies. In response to this disruption of the credit and financial markets, federal legislation has been enacted. The American Recovery and Reinvestment Act of 2009 (the "Recovery Act") included several provisions intended to provide financial relief to the health care sector including a requirement that states promptly reimburse health care providers and a subsidy to the unemployed for health insurance premium costs. The Recovery Act and resulting regulations also established a framework for the implementation of a nationally-based health information technology program. In addition, in July 2010, the Dodd-Frank Act was enacted in an effort to stabilize the credit and financial markets. The President and the Congressional majority leaders and members of their caucuses have expressed their opposition to elements of the Dodd-Frank Act and their intent to modify it.

The health care sector, including both the health insurance industry and health care providers, was not immune to the disruption of the credit and financial markets. Unfavorable economic conditions caused employers to stop offering certain health care coverage as an employee benefit or to offer coverage on a voluntary, employee-funded basis as a means to reduce operating costs. In addition, unemployment rates were higher than historic norms, which impacted the demand for private health insurance products. The market turmoil also increased stresses on the

budgets of states such as California, which resulted in reductions in Medicaid payment rates and delays of payment of amounts due under Medicaid and other state or local payment programs.

Additional legislation and regulatory action, as well as repeal of certain legislation enacted in response to the disruption of the credit and financial markets, continues to be considered by Congress, various federal agencies and foreign governments. The effects of these legislative, regulatory and other governmental actions, including implementation or repeal of the Dodd-Frank Act, upon the entities that comprise Kaiser, their access to credit and their investment portfolio is uncertain.

Business Relationships and Other Business Matters

Competition and Retention of Members. Integrated health care delivery systems operate in a highly competitive industry. Increased competition from a wide variety of potential sources, including, but not limited to, other hospitals, inpatient and outpatient health care facilities, clinics, physicians, insurers, MCOs, preferred provider organizations, physician hospital organizations, physician services organizations and third-party administrators, may adversely and materially affect the revenues of a prepaid integrated delivery system. Existing and potential competitors, including for-profit health care systems and MCOs, may not be subject to various regulations and restrictions applicable to Kaiser, and may be more flexible in their ability to adapt to competitive opportunities and risks. Competition also may arise from new sources not currently anticipated or prevalent.

The ACA has authorized several alternative payment programs for Medicare that promote, reward or necessitate integration among hospitals, physicians and other providers. These programs include the Medicare Shared Savings Program, which, beginning in 2012, provides incentives to accountable care organizations to coordinate care for a defined patient population to achieve higher quality and cost efficiencies. The ACA also established a new entity, the Center for Medicare and Medicaid Innovation, which is empowered and directed to test new payment and service delivery models in the Medicare and Medicaid programs, such as "bundled payments" and payments that reward collaboration among physicians, hospitals, post-acute care providers and community clinics. Changes to the Medicare reimbursement model and similar shifts in the commercial health care market toward quality-based and condition or episode-based payments are likely to favor integrated delivery systems, such as Kaiser. These systems may be better able than stand-alone providers to realize efficiencies, coordinate services across the continuum of patient care, track performance and monitor and control patient outcomes. The development of new integrated delivery systems may, however, create new competitors for Kaiser. Provider-owned integrated delivery systems, in particular, may compete with Kaiser and other group model MCOs for patients, health care purchasers and affiliated physicians.

To remain competitive, an MCO must be capable of attracting and maintaining enrolled members. Customer contracts are subject to negotiation, and customers may seek to contain benefit costs or expand covered services or physicians by choosing among different competitors in the health benefits industry and their product offerings. In addition, large employer groups account for a substantial portion of most MCOs' membership base, and withdrawal by any single large employer group from an MCO's network could result in the loss of a material number of covered lives. Competitive factors include overall cost, plan design, customer service, quality and sufficiency of medical provider networks, quality of medical management programs and the ranking and reputation of the MCO. Membership also can be affected by reductions in workforce by existing customers due to economic conditions. Geographic concentration may exacerbate the impact of these competitive forces.

Following the acquisition of Group Health Cooperative, approximately 73% of the members of the Health Plan Organizations were located in California. This concentration creates a risk to Kaiser in the event Health Plan, Inc. experiences significant membership losses. Failure to grow and diversify membership geographically or by product type or to retain contracts or members at favorable prices could materially impact the operations, financial position or cash flows of Kaiser.

Pharmacy Costs. Pharmacy costs are affected by drug prices generally, and price increases can materially impact the operations, financial positions and cash flows of Kaiser. Many MCOs include a prescription drug benefit for their members and have contractual relationships with pharmaceutical manufacturers or wholesalers that provide purchase discounts and volume rebates on certain prescription drugs. Changes in existing purchase discount and

volume rebates arrangements with pharmaceutical manufacturers may reduce the discounts or volume rebates MCOs receive and materially impact operations, financial position and cash flows of Kaiser.

Affiliations, Merger, Acquisition and Divestiture. Kaiser management evaluates and pursues potential acquisition, merger and affiliation candidates as part of the overall strategic planning and development process. As part of its ongoing planning and property management functions, Kaiser management also reviews the use, compatibility and business viability of regional operations, including pursuing changes in the use, disposition or divestiture of assets or operations. Likewise, Kaiser management occasionally receives offers from, or conducts discussions with third parties about the potential acquisition of assets or operations, or about the potential sale of existing Kaiser assets or operations. As a result, Kaiser's current composition, assets and operations may change from time to time.

In addition, Kaiser management may pursue transactions with third parties, like health insurers or plans, preferred provider organizations, third-party administrators and health insurance-related businesses. Kaiser management will consider these arrangements if there is a perceived strategic or operational benefit. Any initiative may involve significant capital commitments and/or capital or operating risk and may materially impact the operations, financial position and cash flows of Kaiser.

The effectiveness of Kaiser's organizational structure, strategic plan development and implementation, culture and operating model impacts Kaiser's ability to achieve its strategic, financial and operational objectives.

Information Systems. The ability to accurately estimate costs of care, adequately price products and services, provide effective service to customers in an efficient and uninterrupted fashion, engage in epidemiologic and health status research in large populations, perform data analytics and accurately report financial results depends on the integrity of the data stored within information systems. Information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems, regulatory standards and changing customer patterns. Inaccurate or unreliable information for decision-making purposes could result in health care costs that are higher than estimated, loss of existing customers or research funding, problems in establishing appropriate pricing, disputes with customers, physicians and other health care professionals, regulatory problems, increases in operating expenses or other adverse consequences.

Electronic media also are increasingly being used in clinical operations, including computerization of order entry functions and implementation of clinical decision-support software. Reliance on information technology to assist clinical decision-making and patient management imposes new expectations on physicians and other workforce members to be adept at using and managing electronic systems. It also introduces risks related to patient safety, as well as the privacy, accessibility and preservation of health information. Health information systems also may be subject to different or higher standards (such as CMS meaningful U.S. standards) or greater regulation (such as the HIPAA Security Rule) than other information technology or the paper-based systems previously used by health care providers, which may increase the cost, complexity and risks of operations, or other adverse consequences.

Despite Kaiser's implementation of network security measures, its information technology systems may be vulnerable to breaches, hacker attacks, computer viruses, physical or electronic break-ins and other similar events or issues. The Federal Bureau of Investigation has expressed concern that health care systems are a prime target for such cyber-attacks due to a higher financial payout for medical records in the black market, and health care systems have recently been subject to such attacks. Such events or issues could lead to the inadvertent disclosure of protected health information or other confidential information, which could materially impact the operations, financial position and cash flows of Kaiser.

Labor Relations and Collective Bargaining. Many health care providers are large employers with a wide diversity of employees. Many employees of hospitals are unionized, and many hospitals have collective bargaining agreements with one or more labor organizations. Employees subject to collective bargaining agreements may include essential nursing and technical personnel, as well as food service, maintenance and other trade personnel. Renegotiation of such agreements upon expiration may result in significant cost increases to hospitals. Employee

strikes or other adverse labor actions may have an adverse impact on operations, revenue and the reputation of a hospital. Certain Kaiser employees are covered by collective bargaining agreements.

Wage and Hour Class Actions and Litigation. Federal law and many states impose standards related to worker classification, eligibility and payment for overtime, liability for providing rest periods and similar requirements. Large employers with complex workforces, such as hospitals and MCOs, are susceptible to actual and alleged violations of these standards. In recent years there has been a proliferation of lawsuits over these "wage and hour" issues, often in the form of large, sometimes multi-state, class actions. For large employers such as hospitals and MCOs, such class actions can involve multi-million dollar claims, judgments and/or settlements. A major class action decided or settled adversely to Kaiser could materially impact its operations, financial position and cash flows.

Health Care Worker Classification. Health care providers, like all businesses, are required to withhold income taxes from amounts paid to employees. If the employer fails to withhold the tax, the employer becomes liable for payment of the tax imposed on the employee. On the other hand, businesses are not required to withhold federal taxes from amounts paid to a worker classified as an independent contractor. The IRS has established criteria for determining whether a worker is an employee or an independent contractor for tax purposes. If the IRS were to reclassify a significant number of a health care provider's independent contractors as employees, back taxes and penalties could be material.

Employer Status. Hospitals are major employers with mixed technical and nontechnical workforces. Labor costs, including salary, benefits and other liabilities associated with a workforce, have significant impacts on operations, financial position and cash flows. Developments affecting hospitals as major employers include: (i) imposing higher minimum or living wages; (ii) enhancing occupational health and safety standards; (iii) expanding the definition of "disability" under the Americans with Disabilities Act; (iv) a proliferation of acceptable bargaining units in health care; and (v) penalizing employers of undocumented immigrants. Legislation or regulation on any of the above or related topics could materially impact the operations, financial position and cash flows of Kaiser.

Staffing. In recent years, the health care industry has suffered from a scarcity of nursing personnel, respiratory therapists, pharmacists, mental health providers and other trained health care technicians. In addition, aging medical staffs and difficulties in recruiting physicians are leading to physician shortages. A significant factor underlying this trend includes a decrease in the number of persons entering such professions. Further, as hospitals and other health care providers transition to a population health model of care delivery, there is a greater need for care coordinators, and the need is outpacing the supply of qualified personnel. Shortages in all of these specialties may intensify in the future. Competition for health care professionals, coupled with increased recruiting and retention costs, may increase hospital operating costs, possibly significantly. This trend could materially impact the operations, financial position and cash flow of hospitals and integrated delivery systems. This scarcity may further be intensified if utilization of health care services increases as a consequence of the ACA's expansion of the number of insured consumers. As payments to health care facilities and organizations that employ or contract with physicians, nurses and other health care professionals are reduced, pressure to control and possibly reduce wage and benefit costs may further strain the supply of those professionals.

Pension and Benefit Funds. As large employers, hospitals and MCOs are incurring significant expenses to fund pension and benefit plans for employees and former employees and to fund required workers' compensation benefits. Funding obligations in some cases may be erratic or unanticipated and can be material. Various factors, including investment declines that erode principal, changes in participant demographics, changes in plan benefits, changes in assumption about future trends, changes in interest rate levels and discount rates can result in pension and benefit plans being under-funded, necessitating significant commitments of available cash or operating revenue needed for other purposes. Such factors could have a material adverse impact on hospitals and MCOs. Health Plan, Inc. sponsors a defined benefit pension plan that covers substantially all employees and also provides defined retirement benefits for physicians associated with certain Permanente Medical Groups.

Professional Liability Claims, Property and General Liability Insurance. Professional liability and other actions alleging wrongful conduct and seeking punitive damages are sometimes filed against health care providers. Depending on the jurisdiction where litigation is filed, insurance may not provide coverage for judgments for punitive damages. Litigation sometimes arises from the corporate and business activities of hospitals or health

benefit plans. Types of legal actions may include employment and employment-related suits, employee benefit claims, breach of contract actions, tort claims, shareholder suits, intellectual property-related litigation, or claims related to health care benefits coverage and payment. As with professional liability, some of these risks may be covered by insurance, but some are not. For example, some antitrust claims or business disputes are not covered by insurance or other sources and may, in whole or in part, be a liability of Kaiser if determined or settled adversely.

Health care organizations are highly dependent on the condition and functionality of their physical facilities. Damage from earthquake or other natural causes, fire, drought, deliberate acts of destruction or various facilities system failures may have a material adverse impact on hospitals' and MCOs' operations, results of operations or financial condition. Kaiser generally maintains property and casualty insurance in some combination of purchased, self-insurance and re-insurance policies to cover property damage.

Construction Risks. Hospitals expects to undertake substantial construction projects over the next several years to replace and renew patient care facilities. Construction projects are subject to a variety of risks, including but not limited to strikes, shortages of materials and labor, adverse weather conditions, and delays in issuance of required building permits or other necessary approvals or permits, including environmental approvals, regulatory approvals and land use entitlements. Such events could delay occupancy. Cost overruns may occur due to change orders, delays in the construction schedule, scarcity of building materials and construction inflation, general contractor or subcontractor mismanagement, labor and other factors. Cost overruns could cause the costs to exceed available funds.

Proprietary Rights. The protection of proprietary rights is based on agreements with customers, confidentiality agreements with employees, trademarks, trade secrets, copyrights and patents. However, these legal protections and precautions may not prevent misappropriation of proprietary information. In addition, substantial litigation regarding intellectual property rights exists in the software industry, which may be increasingly subject to third-party infringement claims as the number of products and competitors in the industry grows. Such litigation and misappropriation of proprietary information could hinder Kaiser's ability to market and sell products and services, as well as adversely affect revenues and results of operations.

Investment Results. Kaiser has significant holdings in a broad range of investments. Market fluctuations may affect the value of those investments, and those fluctuations may be and historically have been at times material. Relatively low interest rates on investments, such as those experienced during recent years, have adversely impacted investment income, and a prolonged low interest rate environment could further adversely affect investment income.

Tax-Exempt Status and Other Tax Matters

Maintenance of the Tax-Exempt Status of Kaiser Entities. The tax-exempt status of the outstanding tax-exempt debt issued for the benefit of Hospitals depends upon maintenance by each of the Credit Group members of its status as an organization described in Section 501(c)(3) of the Code. The maintenance of such status is contingent on compliance with rules in the Code and related regulations and rulings regarding the organization and operation of tax-exempt entities, including their operation for charitable and other permissible purposes and their avoidance of transactions that may cause their earnings or assets to inure to the benefit of private individuals. As these general principles were developed primarily for public charities that do not conduct large-scale technical operations and business activities, they often do not adequately address the myriad operations and transactions entered into by a modern health care organization. Although traditional activities of health care providers, such as medical office building leases, have been the subject of interpretations by the IRS in the form of Private Letter Rulings, many activities or categories of activities have not been fully addressed in any official opinion, interpretation or policy of the IRS.

The ACA also contains requirements for tax-exempt hospitals set forth in Section 501(r) of the Code. Under the ACA, each tax-exempt hospital facility is required to (i) conduct a community health needs assessment at least every three years and adopt an implementation strategy to meet the identified community needs, (ii) adopt, implement and widely publicize a written financial assistance policy and a policy to provide emergency medical treatment without discrimination, (iii) limit charges to individuals who qualify for financial assistance under such tax-exempt hospital's financial assistance policy to no more than the amounts generally billed to individuals who

have insurance covering such care and refrain from using "gross charges" when billing such individuals, and (iv) refrain from taking extraordinary collection actions without first making reasonable efforts to determine whether the individual is eligible for assistance under such tax-exempt hospital's financial assistance policy.

On December 29, 2014, the Secretary of the Treasury issued final regulations under Section 501(r) of the Code that provide detailed and comprehensive guidance relating to requirements for community health needs assessments, financial assistance policies, emergency medical care policies, limitations on charges and billing and collection practices, and also provide guidance on consequences of failure to satisfy Section 501(r) requirements. These final regulations are complex and may be administratively burdensome to implement. Generally, the regulations apply to tax years beginning after December 29, 2015.

In addition, the Treasury Department is required to review information about each tax-exempt hospital's community benefit activities at least once every three years, as well as to submit an annual report to Congress with information regarding the levels of charity care, bad debt expenses, unreimbursed costs of government programs, and costs incurred by tax-exempt hospitals for community benefit activities. The periodic reviews and reports to Congress regarding the community benefits provided by 501(c)(3) hospitals may increase the likelihood that Congress will require such hospitals to provide a minimum level of charity care in order to retain tax-exempt status and may increase IRS scrutiny of particular 501(c)(3) hospital organizations.

It is not possible to predict how or whether Section 501(r) will be affected by possible repeal or revision of the ACA.

In recent years, the IRS has issued a number of formal and informal statements of policy and interpretation that have increased uncertainty over the IRS's position on a wide variety of activities commonly undertaken by health care organizations. Tax-exempt health care providers currently are subject to an increased degree of scrutiny and enforcement activity by the IRS, including the submission of increased amounts of information under the revised Form 990. The United States Congress also has increased its scrutiny of tax-exempt entities, including health care providers. Among other things, Congress has particularly focused on (i) the governance of tax-exempt entities, (ii) the nature and amount of charity care and community benefit provided by tax-exempt health care providers and (iii) the potential or actual use of charitable assets for private benefit.

In recent years, the IRS has increased the frequency and scope of its audit and other enforcement activity regarding tax-exempt health care organizations. If the IRS were to find that Hospitals, any Guarantor or any of the Health Plan Organizations has participated in activities in violation of certain regulations or rulings, the tax-exempt status of such entity could be in jeopardy. Loss of tax-exempt status by Hospitals or any Guarantor potentially could result in loss of tax exemption of the tax-exempt debt issued for the benefit of Hospitals, and defaults in covenants regarding the tax-exempt debt and other obligations likely would be triggered. Loss of tax-exempt status also could result in substantial tax liabilities on income of Kaiser. For these reasons, loss of tax-exempt status of Hospitals, any Guarantor or any Affiliated Health Plan could have a material adverse effect on the financial condition or operations of Kaiser.

In lieu of revocation of exempt status, the IRS may impose penalty excise taxes on certain "excess benefit transactions" involving 501(c)(3) and 501(c)(4) organizations and "disqualified persons." An excess benefit transaction is one in which a disqualified person or entity receives more than fair market value from the exempt organization or pays the exempt organization less than fair market value for property or services, or shares the net revenues of the tax-exempt entity. A disqualified person is a person (or an entity) who is in a position to exercise substantial influence over the affairs of the exempt organization during the five years preceding an excess benefit transaction. The statute imposes excise taxes on the disqualified person and any "organization manager" who knowingly approves participation in an excess benefit transaction.

In some cases, the IRS has imposed substantial monetary penalties on tax-exempt hospitals in lieu of revoking their tax-exempt status.

Congress enacted Section 501(m) in 1986, under which an organization that is tax-exempt under Section 501(c)(3) can maintain its tax-exempt status only if no substantial part of its activities consists of providing commercial-type insurance. The application and scope of Section 501(m) are not well defined. Management of

Kaiser believes that the activities of Kaiser do not consist in substantial part of providing commercial-type insurance, but there is no assurance that regulators or courts of law would agree.

The IRS periodically conducts audits of large tax-exempt health care organizations (the "Audit Program"). Such audits are conducted by teams of revenue agents, often take years to complete and require the expenditure of significant staff time by both the IRS and taxpayers. Revenue agents often occupy office space on the taxpayer's premises for the duration of the audit. The audits are led by senior Tax Exempt and Government Entities Division revenue agents who examine a wide range of possible issues, including the community benefit basis of exemption, private inurement and private benefit, partnerships and joint ventures, retirement plans and employee benefits, employment taxes, tax-exempt bond financing, political contributions and unrelated business taxable income.

There is no assurance that Hospitals, any Guarantor or any other Health Plan Organization will not be the subject of the Audit Program in the future. Kaiser believes that it has properly complied with the tax laws in all material respects. Nevertheless, because of the complexity of the tax laws and the presence of issues about which reasonable persons can differ, an audit pursuant to the Audit Program could result in additional taxes, interest and penalties. Such an audit ultimately could affect the tax-exempt status of Hospitals, any Guarantor or any Affiliated Health Plan as well as the exclusion from gross income for federal income tax purposes of the interest payable on the tax-exempt debt of such entity.

State and Local Tax Exemption. It is likely that the loss by Hospitals, any Guarantor or any Affiliated Health Plan of federal tax exemption would also trigger a challenge to its state tax exemption. Depending on the circumstances, such event could be material and adverse to that entity and Kaiser as a whole.

State, county and local taxing authorities undertake audits and reviews of the operations of tax-exempt health care providers with respect to their real property tax exemptions. In some cases, particularly where authorities are dissatisfied with the amount of services provided to indigents, the real property tax-exempt status of the health care providers has been questioned or revoked. The majority of the real property of Kaiser is currently treated as exempt from real property taxation. Although the real property tax exemptions of Kaiser with respect to its core hospital facilities are not, to the knowledge of management of Kaiser, under challenge or investigation, an audit could lead to a challenge that could adversely affect the real property tax exemption of Kaiser entities.

It is not possible to predict the scope or effect of future legislative or regulatory actions with respect to taxation of nonprofit corporations. There can be no assurance that future changes in the laws and regulations of state or local governments will not materially adversely affect the financial condition or operations of Kaiser by requiring payment of income, local property or other taxes.

Risks Related to Financial Products

Increased Interest Rates. Certain outstanding bonds issued for the benefit of Hospitals are variable rate obligations, the interest rates on which could rise. Such interest rates vary on a periodic basis and may be converted to a fixed interest rate. This protection against rising interest rates is limited, however, because the borrowing entities would be required to continue to pay interest at the variable rate until they are permitted to convert the obligations to a fixed rate pursuant to the terms of the applicable transaction documents.

Liquidity Risk. None of the outstanding variable rate bonds issued for the benefit of Hospitals and none of Hospitals' commercial paper is secured by external dedicated liquidity. The Credit Group has entered into remarketing agreements with respect to those bonds to provide for their remarketing and has entered into dealer agreements with respect to its commercial paper to provide for the roll of maturing commercial paper. In addition, Hospitals maintains a line of credit for general corporate purposes that could support Hospitals' obligation to pay the purchase price of bonds if they cannot be remarketed or the maturing principal of commercial paper that cannot be rolled. If any such bonds are tendered, or deemed tendered, and not able to be remarketed or commercial paper matures and cannot be rolled, Hospitals will be obligated to purchase those bonds or pay maturing principal of commercial paper, as applicable, from its own funds, although Hospitals may draw on its line of credit, to the extent amounts are available to be drawn at such time. Hospitals' ability to purchase any such variable rate bonds or pay maturing principal of commercial paper, as applicable, may be adversely affected by a variety of factors, including a reduction in investment income and a lack of availability of external liquidity from credit. In addition, the

performance of the remarketing agent or dealer could affect the remarketing of any such variable rate demand bonds or the roll of any such commercial paper.

For a description of the variable rate bonds issued for the benefit of Hospitals, Hospitals' commercial paper, and the line of credit, see Note 12 to the audited combined financial statements included as Appendix A.

Risks Related to Interest Rate Swap Agreements. Hospitals and Health Plan, Inc. have previously entered into Interest Rate Swap Agreements and may enter into additional interest rate swap agreements from time to time in the future (collectively, the "Swap Agreements") with qualified swap providers. The Swap Agreements are and will be subject to periodic "mark-to-market" valuations and at any time may have a negative value to Hospitals and Health Plan, Inc. The Swap Agreement counterparties may terminate any of the Swap Agreements upon the occurrence of certain "termination events" or "events of default," and Hospitals and Health Plan, Inc. may terminate the related Swap Agreements at any time. If a counterparty to any of the Swap Agreements, Hospitals or Health Plan, Inc. terminates any Swap Agreement when the Swap Agreement has a negative value to Hospitals or Health Plan, Inc., Hospitals or Health Plan, Inc. may be required to make a termination payment to the related counterparty, and such payment could be material.

Downgrades in Debt Ratings. Rating agencies periodically review the ratings assigned to the debt issued by or for the benefit of Kaiser. Ratings reflect each rating agency's independent opinion of the Credit Group's financial strength, operating performance, ability to meet debt obligations or obligations to policyholders and other factors, and such ratings are subject to change. Debt ratings impact both the cost and availability of future borrowings and, accordingly, the cost of capital. In addition, claims paying ability is influenced by nationally recognized statistical rating organizations and increasingly is an important factor in establishing the competitive position of MCOs, as well as successful marketing of benefits products. Downgrades from ratings agencies, should they occur, may adversely affect Kaiser's business, operations, financial position and cash flows.

Other Risk Factors

In the future, the following factors, among others, may adversely affect the operations of or revenues of health care providers and/or MCOs or the market value of the Bonds.

(a) Efforts by governmental agencies to limit the cost of hospital and health plan services, to reduce the number of beds and to reduce the utilization of hospital facilities by such means as preventive medicine, improved occupational health and safety and outpatient care or comparable regulations.

(b) Cost increases without corresponding increases in revenue resulting from, among other factors: increases in the salaries, wages and fringe benefits of hospital and clinic employees; increases in costs associated with advances in medical technology or with inflation; or future legislation that would prevent or limit the ability to increase revenues.

(c) The inability to obtain future governmental approvals to undertake projects necessary to remain competitive both as to membership dues, as well as quality and scope of care.

(d) Inability to meet or continue to comply with legal, regulatory, professional and private licensing and accreditation requirements, all or some of which may be subject to renewal based on inspection or other criteria.

(e) Increased demand for hospital services and resulting increased medical costs that might ensue from natural disasters, pandemics or other causes.

(f) Cost and availability of any insurance, such as professional liability, fire, automobile and general comprehensive liability coverages, which health care facilities of a similar size and type generally carry.

(g) The occurrence of a natural or man-made disaster, such as an earthquake, that could damage facilities, interrupt utility service to the facilities, interrupt computer services to facilities or otherwise impair operations and the generation of revenues from the facilities.

CERTAIN UNITED STATES FEDERAL INCOME TAX CONSIDERATIONS

The following summary of certain United States ("U.S.") federal income tax consequences of the purchase, ownership and disposition of the Bonds is based upon laws, regulations, rulings and decisions now in effect, all of which are subject to change (including changes in effective dates), which change may be retroactive, or possible differing interpretations. It deals only with Bonds held as capital assets and does not purport to deal with persons in special tax situations, such as financial institutions, insurance companies, regulated investment companies, dealers in securities or currencies, persons holding Bonds as a hedge against currency risks or as a position in a "straddle" for tax purposes, or persons whose functional currency is not the U.S. dollar. It also does not deal with Holders other than investors who purchase Bonds in the initial offering at the first price at which a substantial amount of such substantially identical Bonds are sold to the general public. Persons considering the purchase of the Bonds should consult their own tax advisors concerning the application of U.S. federal income tax laws to their particular situations as well as any consequences of the purchase, ownership and disposition of the Bonds arising under the laws of any other taxing jurisdiction.

As used herein, the term "U.S. Holder" means a beneficial owner of a Bond that is for U.S. federal income tax purposes (i) a citizen or resident of the United States, (ii) a corporation (including an entity treated as a corporation for U.S. federal income tax purposes) created or organized in or under the laws of the United States, any state thereof or the District of Columbia, (iii) an estate, the income of which is subject to U.S. federal income taxation regardless of its source or (iv) a trust if (a) a court within the United States is able to exercise primary supervision over the administration of the trust and one or more United States persons have the authority to control all substantial decisions of the trust, or (b) the trust was in existence on August 20, 1996 and properly elected to continue to be treated as a United States person. Moreover, as used herein, the term "U.S. Holder" includes any holder of a Bond whose income or gain in respect of its investment in a Bond is effectively connected with a U.S. trade or business.

If a partnership (including for this purpose any entity treated as a partnership for U.S. federal income tax purposes) is the beneficial owner of any Bond, the treatment of a partner in a partnership will generally depend on the status of such partner and the activities of such partnership. A partnership and any partner in a partnership holding Bonds should consult its own tax advisor.

Payments of Interest

Payments of interest on a Bond generally will be taxable to a U.S. Holder as ordinary interest income. A U.S. Holder using the accrual method of accounting for U.S. federal income tax purposes must include interest paid or accrued on the Bonds in ordinary income as the interest accrues, while a U.S. Holder using the cash receipts and disbursements method of accounting for U.S. federal income tax purposes must include interest in ordinary income when payments are received or constructively received by the Holder, except as described immediately below.

If a Bond is issued at an original issue discount ("OID") it will be a "Discount Bond." OID is the excess of the stated redemption price at maturity (the principal amount) over the "issue price" of a Discount Bond, provided that excess equals or exceeds a statutory de minimis amount (one-quarter of one percent of the Discount Bond's stated redemption price at maturity multiplied by the number of complete years to its maturity (or, if required by applicable Treasury Regulations, to an earlier call date)). The issue price of a Discount Bond is the initial offering price to the public (other than to bond houses, brokers or similar persons acting in the capacity of underwriters or wholesalers) at which a substantial amount of the Discount Bonds of the same maturity is sold pursuant to that offering. For federal income tax purposes, OID accrues to the Holder of a Discount Bond over the period to maturity based on the constant yield method, compounded semiannually (or over a shorter permitted compounding interval selected by the Holder). The portion of OID that accrues during the time a U.S. Holder owns a Discount Bond (i) is interest includable in the U.S. Holder's gross income for federal income tax purposes, and (ii) is added to the U.S. Holder's tax basis for purposes of determining gain or loss on the maturity, redemption, prior sale, or other

disposition of the Discount Bond. The effect of OID is to accelerate the recognition of taxable income for a U.S. Holder using the cash method of accounting during the term of the Discount Bond.

HOLDERS OF DISCOUNT BONDS SHOULD CONSULT THEIR TAX ADVISORS AS TO THE DETERMINATION FOR FEDERAL TAX PURPOSES OF THE AMOUNT OF OID PROPERLY ACCRUABLE OR AMORTIZABLE IN ANY PERIOD WITH RESPECT TO THE DISCOUNT AND AS TO OTHER FEDERAL TAX CONSEQUENCES AND THE TREATMENT OF OID FOR PURPOSES OF STATE OR LOCAL TAXES ON, OR BASED ON, INCOME.

Disposition of a Bond

Except as discussed above, upon the sale, exchange or retirement of a Bond, a U.S. Holder generally will recognize taxable gain or loss equal to the difference between the amount realized on the sale, exchange or retirement (other than amounts representing accrued and unpaid interest) and such U.S. Holder's adjusted tax basis in the Bond. A U.S. Holder's adjusted tax basis in a Bond generally will equal such U.S. Holder's initial investment in the Bond, increased by any OID includible in the owner's ordinary income for the Bond and decreased by the amount of payments, other than interest payments, received with respect to such Bond as described above under the section entitled "Payments of Interest." Such gain or loss generally will be long-term capital gain or loss if the Bond has been held by the U.S. Holder at the time of disposition for more than one year. If the U.S. Holder is an individual, long-term capital gain will be subject to reduced rates of taxation. The deductibility of capital losses is subject to certain limitations.

Effect of Defeasance

Defeasance of any of the Bonds may result in a reissuance thereof, in which event the Holder will recognize taxable gain or loss equal to the difference between the amount realized from the sale, exchange or retirement (less any accrued stated interest which will be taxable as such) and the Holder's adjusted tax basis in the Bonds.

Medicare Tax

An additional 3.8% tax is imposed on the net investment income (which includes interest, and gains from a disposition of a Bond) of certain individuals, trust and estates. Prospective investors in the Bonds should consult their tax advisors regarding the possible applicability of this tax to an investment in the Bonds.

Non-U.S. Holders

A non-U.S. Holder will not be subject to United States federal income taxes on payments of principal or interest (including OID) on a Bond, unless such non-U.S. Holder is a bank receiving interest described in section 881(c)(3)(A) of the Code. To qualify for the exemption from taxation, the Withholding Agent, as defined below, must have received a statement from the individual or corporation that:

- is signed by the beneficial owner of the Bond under penalties of perjury,
- certifies that such owner is not a U.S. Holder, and
- provides the beneficial owner's name and address.

A "Withholding Agent" is the last United States payor (or a non-U.S. payor who is a qualified intermediary, U.S. branch of a foreign person, or withholding foreign partnership) in the chain of payment prior to payment to a non-U.S. Holder (which itself is not a Withholding Agent). Generally, this statement is made on an IRS Form W-8BEN or W-8BEN-E, which is effective for the remainder of the year of signature plus three full calendar years unless a change in circumstances makes any information on the form incorrect. Notwithstanding the preceding sentence, a W-8BEN or W-8BEN-E with a U.S. taxpayer identification number will remain effective until a change in circumstances makes any information on the form incorrect, provided that the Withholding Agent reports at least annually to the beneficial owner on IRS Form 1042-S. The beneficial owner must inform the

Withholding Agent within 30 days of such change and furnish a new W-8BEN or W-8BEN-E. A non-U.S. Holder who is not an individual or corporation (or an entity treated as a corporation for federal income tax purposes) holding the Bonds on its own behalf may have substantially increased reporting requirements. In particular, in the case of Bonds held by a foreign partnership (or foreign trust), the partners (or beneficiaries) rather than the partnership (or trust) will be required to provide the certification discussed above, and the partnership (or trust) will be required to provide certain additional information.

A non-U.S. Holder whose income with respect to its investment in a Bond is effectively connected with the conduct of a U.S. trade or business would generally be taxed as if the holder was a U.S. person provided the holder provides to the Withholding Agent an IRS Form W-8ECI.

Certain securities clearing organizations, and other entities who are not beneficial owners, may be able to provide a signed statement to the Withholding Agent. However, in such case, the signed statement may require a copy of the beneficial owner's W-8BEN or W-8BEN-E (or the substitute form).

Generally, a non-U.S. Holder will not be subject to United States federal income taxes on any amount that constitutes capital gain upon retirement or disposition of a Bond, unless such non-U.S. Holder is an individual who is present in the United States for 183 days or more in the taxable year of the disposition and such gain is derived from sources within the United States. Certain other exceptions may be applicable, and a non-U.S. Holder should consult its tax advisor in this regard.

The Bonds will not be includible in the estate of a non-U.S. Holder unless at the time of such individual's death, payments in respect of the Bonds would have been effectively connected with the conduct by such individual of a trade or business in the United States.

The Foreign Account Tax Compliance Act ("FATCA") generally imposes a 30% withholding tax on interest payments and proceeds of sale of interest-bearing obligations for payments made after the relevant effective date to certain foreign financial institutions that fail to certify their FATCA status, and investment funds and non-financial foreign entities if certain disclosure requirements related to direct and indirect United States shareholders and/or United States accountholders thereof are not satisfied.

Under applicable Treasury Regulations and IRS guidance including Notice 2015-66, a withholding tax of 30% will generally be imposed, subject to certain exceptions, on payments of (a) interest, and (b) gross proceeds from the sale or other disposition of notes on or after January 1, 2019. In the case of payments made to a "foreign financial institution" (generally including an investment fund), as a beneficial owner or as an intermediary, the withholding tax generally will be imposed, subject to certain exceptions, unless such institution (i) enters into (or is otherwise subject to) and complies with an agreement with the U.S. government (a "FATCA Agreement") or (ii) is required by and complies with applicable foreign law enacted in connection with an intergovernmental agreement between the United States and a foreign jurisdiction (an "IGA"), in either case to, among other things, collect and provide to the U.S. or other relevant tax authorities certain information regarding U.S. account holders of such institution. In the case of payments made to a foreign entity that is not a financial institution (as a beneficial owner), the tax generally will be imposed, subject to certain exceptions, unless such entity provides the withholding agent with a certification that it does not have any "substantial" U.S. owner (generally, any specified U.S. person that directly or indirectly owns more than a specified percentage of such entity) or that identifies its "substantial" U.S. owners. If the notes are held through a foreign financial institution that enters into (or is otherwise subject to) a FATCA Agreement, such foreign financial institution (or, in certain cases, a person paying amounts to such foreign financial institution) generally will be required, subject to certain exceptions, to withhold such tax on payments of interest and gross proceeds described above made to (x) a person (including an individual) that fails to comply with certain information requests or (y) a foreign financial institution that has not entered into (and is not otherwise subject to) a FATCA Agreement and is not required to comply with FATCA pursuant to applicable foreign law enacted in connection with an IGA. Coordinating rules may limit duplicative withholding in cases where the withholding described above in "Non-U.S. Holders" or below in "Backup Withholding" also applies.

If any amount of, or in respect of, U.S. withholding tax were to be deducted or withheld from payments on the Bonds as a result of a failure by an investor (or by an institution through which an investor holds the notes) to comply with FATCA, neither the Issuer nor any paying agent nor any other person would, pursuant to the terms of

the Bonds, be required to pay additional amounts with respect to any notes as a result of the deduction or withholding of such tax. Each Non-U.S. Holder should consult its own tax advisor regarding the application of FATCA to the ownership and disposition of the Bonds.

Backup Withholding

Backup withholding of United States federal income tax may apply to payments made in respect of the Bonds to registered owners who are not "exempt recipients" and who fail to provide certain identifying information (such as the registered owner's taxpayer identification number) in the required manner. Generally, individuals are not exempt recipients, whereas corporations and certain other entities generally are exempt recipients. Payments made in respect of the Bonds to a U.S. Holder must be reported to the IRS, unless the U.S. Holder is an exempt recipient or establishes an exemption. Compliance with the identification procedures described in the preceding section would establish an exemption from backup withholding for those non-U.S. Holders who are not exempt recipients.

In addition, upon the sale of a Bond to (or through) a broker, the broker must report the sale and withhold on the entire purchase price, unless either (i) the broker determines that the seller is a corporation or other exempt recipient or (ii) the seller certifies that such seller is a non-U.S. Holder (and certain other conditions are met). Certification of the registered owner's non-U.S. status would be made normally on an IRS Form W-8BEN under penalties of perjury, although in certain cases it may be, possible to submit other documentary evidence.

Any amounts withheld under the backup withholding rules from a payment to a beneficial owner would be allowed as a refund or a credit against such beneficial owner's United States federal income tax provided the required information is furnished to the IRS.

THE TAX DISCUSSION SET FORTH ABOVE IS INCLUDED FOR GENERAL INFORMATION ONLY AND MAY NOT BE APPLICABLE DEPENDING UPON A HOLDER'S PARTICULAR SITUATION. HOLDERS SHOULD CONSULT THEIR TAX ADVISORS WITH RESPECT TO THE TAX CONSEQUENCES TO THEM OF THE OWNERSHIP AND DISPOSITION OF THE BONDS, INCLUDING THE TAX CONSEQUENCES UNDER FEDERAL, STATE, LOCAL, FOREIGN, AND OTHER TAX LAWS AND POSSIBLE EFFECTS OF CHANGES IN TAX LAWS.

ERISA CONSIDERATIONS

The Employee Retirement Income Security Act of 1974, as amended ("ERISA") and Section 4975 of the Code prohibit certain transactions between employee benefit plans subject to Title I of ERISA tax qualified retirement plans and individual retirement accounts under the Code (collectively, the "Plans") or investment vehicles whose assets are deemed to include assets of Plans and persons who, with respect to a Plan, are fiduciaries or other "parties in interest" within the meaning of ERISA or "disqualified persons" within the meaning of the Code. Each person investing in the Bonds will be deemed to represent that either (i) it is not acting on behalf of or investing any assets of a Plan or (ii) its purchase, holding and disposition of the Bonds will not constitute a prohibited transaction under ERISA or Section 4975 of the Code for which there is no applicable exemption. In addition, each fiduciary of a Plan ("Plan Fiduciary") must give appropriate consideration to the facts and circumstances that are relevant to an investment in the Bonds, including the role that such an investment in the Bonds would play in the Plan's overall investment portfolio. Each Plan Fiduciary, before deciding to invest in the Bonds, must be satisfied that such investment in the Bonds is a prudent investment for the Plan, that the investments of the Plan, including the investment in the Bonds, are diversified so as to minimize the risk of large losses and that an investment in the Bonds complies with the documents of the Plan and related trust, to the extent such documents are consistent with ERISA. All Plan Fiduciaries, in consultation with their advisors, should carefully consider the impact of ERISA and the Code on an investment in any Bond.

Further, any plan subject to any laws or regulations substantially similar to Title I of ERISA or Section 4975 of the Internal Revenue Code (such as laws governing "church plans" or "governmental plans" that are not subject to ERISA), and any person acting on behalf of or investing the assets of such a plan, that purchases, holds or disposes of the Bonds will be deemed to represent that its purchase, holding or disposition of the Bonds does not constitute and will not result in a violation of such similar laws or regulations. In addition, the persons responsible

for the investment of assets of such a plan, in consultation with their advisors, should carefully consider the impact of such other laws or regulations on an investment in any Bond.

CONTINUING DISCLOSURE

Hospitals and the Guarantors will execute a continuing disclosure certificate (the "Continuing Disclosure Certificate") in which they will covenant for the benefit of Holders and Beneficial Owners of the Bonds to provide certain financial information and operating data relating to Kaiser by not later than six months following the end of Kaiser's fiscal year (which currently is December 31) (each, an "Annual Report"), commencing with the report for the fiscal year ending December 31, 2017 (due on or before June 30, 2018), and not later than 60 days after the end of each fiscal quarter (except the fourth fiscal quarter), unaudited financial information for Kaiser for such fiscal quarter, including a balance sheet, a cash flow statement and a consolidated statement of operations (each, a "Quarterly Report"). The Annual Report and quarterly information will be filed by the Credit Group, or its dissemination agent, if any, with the Municipal Securities Rulemaking Board ("MSRB") on its Electronic Municipal Market Access System ("EMMA") website. Since the Bonds are taxable securities issued directly by Hospitals, Hospitals' continuing disclosure undertaking relating to the Bonds is not required pursuant to Rule 15c2-12 promulgated under the Securities and Exchange Act of 1934, as amended, and EMMA is not directly available for the filing of annual or quarterly reports relating to the Bonds. The Credit Group will, however, file such reports on EMMA so long as it has tax-exempt bonds outstanding, using the CUSIP numbers for such tax-exempt bonds. If no such tax-exempt bonds are outstanding, the Credit Group will make such reports available through any other nationally recognized disclosure site or through a website of any member of the Credit Group. See APPENDIX D – "FORM OF CONTINUING DISCLOSURE CERTIFICATE."

APPROVAL OF LEGALITY

Certain legal matters will be passed upon for Hospitals and the Guarantors by their General Counsel and by Drinker Biddle & Reath LLP, special tax counsel, and for the Underwriters by their counsel, Squire Patton Boggs (US) LLP, San Francisco, California. Counsel to the Underwriters undertake no responsibility for the accuracy, completeness or fairness of this Offering Memorandum.

COMBINED FINANCIAL STATEMENTS

The Combined Financial Statements of Kaiser Foundation Health Plan, Inc. and Subsidiaries and Kaiser Foundation Hospitals and Subsidiaries and Credit Group Financial Information, as of December 31, 2016 and 2015 and for the years then ended, included in APPENDIX A, have been audited by KPMG LLP, independent auditors, as stated in their report, dated February 14, 2017, included in APPENDIX A.

RATINGS

Fitch Ratings ("Fitch") has assigned the Bonds a long term rating of "A+" with a stable outlook. S&P Global Ratings, a Standard & Poor's Financial Services LLC business, which is a subsidiary of The McGraw-Hill Companies ("Standard & Poor's"), has assigned the Bonds a long term rating of "AA-" with a stable outlook. Kaiser has furnished to Fitch and Standard & Poor's certain information and materials concerning the Bonds and themselves. No application was made to any other rating agency for the purpose of obtaining additional ratings on the Bonds. Any explanation of the significance of such ratings may only be obtained from the rating agency furnishing the same. Generally, rating agencies base their ratings on such information and materials and on investigations, studies and assumptions made by the rating agencies themselves. There is no assurance that the ratings mentioned above will remain in effect for any given period of time or that they might not be lowered or withdrawn entirely by the rating agencies, if in their judgment circumstances so warrant. Any such downward change in or withdrawal of the ratings might have an adverse effect on the market price or marketability of the Bonds.

UNDERWRITING

Pursuant to the Bond Purchase Contract for the Bonds (the "Purchase Contract"), Goldman, Sachs & Co. ("Goldman Sachs"), as representative of the underwriters named on the cover of this Offering Memorandum

(collectively, the "Underwriters" and each, an "Underwriter"), has agreed to purchase the Bonds at a purchase price of $2,058,666,250 (representing the aggregate principal amount of the Bonds, less original issue discount of $16,333,750). In addition, Hospitals will pay the Underwriters an underwriting fee of $10,375,000 in connection with the marketing and sale of the Bonds. The Purchase Contract for the Bonds provides that the Underwriters will purchase all of the Bonds, if any are purchased, and contains the agreements of Hospitals and the Guarantors to indemnify the Underwriters against certain liabilities. The Purchase Contract also provides that the fees of counsel for the Underwriters will be paid by Hospitals. The Underwriters may offer and sell the Bonds to certain dealers and others at prices lower than the offering prices (or yields) stated on the front cover page hereof, and the offering prices (or yields) may be changed from time to time by the Underwriters.

The Underwriters and their respective affiliates are full service financial institutions engaged in various activities, which may include sales and trading, commercial and investment banking, advisory, investment management, investment research, principal investment, hedging, market making, brokerage and other financial and non-financial activities and services. Certain of the Underwriters and their respective affiliates have provided, and may in the future provide, a variety of these services to Kaiser entities and to persons and entities with relationships to Kaiser entities, for which they received or will receive customary fees and expenses.

In the ordinary course of their various business activities, the Underwriters and their respective affiliates, officers, directors and employees may purchase, sell or hold a broad array of investments and actively trade securities, derivatives, loans, commodities, currencies, credit default swaps and other financial instruments for their own account and for the accounts of their customers, and such investment and trading activities may involve or relate to assets, securities and/or instruments of Kaiser entities (directly, as collateral securing other obligations or otherwise) and/or persons and entities with relationships with Kaiser entities. The Underwriters and their respective affiliates may also communicate independent investment recommendations, market color or trading ideas and/or publish or express independent research views in respect of such assets, securities or instruments and may at any time hold, or recommend to clients that they should acquire, long and/or short positions in such assets, securities and instruments.

Citigroup Global Markets Inc., one of the Underwriters of the Bonds, has entered into a retail distribution agreement with UBS Financial Services Inc. ("UBSFS"). Under this distribution agreement, Citigroup Global Markets Inc. may distribute municipal securities to retail investors through the financial advisor network of UBSFS. As part of this arrangement, Citigroup Global Markets Inc. may compensate UBSFS for their selling efforts with respect to the Bonds.

J.P. Morgan Securities LLC, one of the Underwriters of the Bonds, is also a dealer of Hospitals' taxable commercial paper, a portion of which is expected to be refinanced with proceeds of the Bonds, and currently holds and may in the future hold Hospitals' taxable commercial paper notes or other obligations of Kaiser or its affiliates in its inventory.

Morgan Stanley & Co. LLC, one of the Underwriters of the Bonds, has entered into a retail distribution arrangement with its affiliate Morgan Stanley Smith Barney LLC. As part of this arrangement, Morgan Stanley & Co. LLC may distribute municipal securities to retail investors through the financial advisor network of Morgan Stanley Smith Barney LLC. As part of this arrangement, Morgan Stanley & Co. LLC may compensate Morgan Stanley Smith Barney LLC for its selling efforts with respect to the Bonds.

Wells Fargo Securities is the trade name for certain securities-related capital markets and investment banking services of Wells Fargo & Company and its subsidiaries, including Wells Fargo Securities, LLC, member NYSE, FINRA, NFA, and SIPC.

MISCELLANEOUS

The foregoing and subsequent summaries or descriptions of provisions of the Bonds, the Indenture, the Continuing Disclosure Certificate and the Guarantee Agreement and all references to other materials not purporting to be quoted in full are only brief outlines of some of the provisions thereof and do not purport to summarize or describe all of the provisions thereof, and reference is made to said documents for full and complete statements of their provisions. The appendices attached hereto are a part of this Offering Memorandum. Copies, in reasonable quantity, of the Indenture, the Continuing Disclosure Certificate and the Guarantee Agreement may be obtained upon request directed to the Corporate Trust Office of the Trustee.

This Offering Memorandum has been delivered by Hospitals and by the Guarantors. This Offering Memorandum is not to be construed as a contract or agreement among any of Hospitals, the Guarantors and the purchasers or Holders of the Bonds.

KAISER FOUNDATION HOSPITALS
KAISER FOUNDATION HEALTH PLAN, INC.
KAISER HOSPITAL ASSET MANAGEMENT, INC.
KAISER HEALTH PLAN ASSET MANAGEMENT, INC.

By: /s/ Thomas R. Meier
Authorized Representative

APPENDIX A

COMBINED FINANCIAL STATEMENTS OF KAISER FOUNDATION HEALTH PLAN, INC. AND SUBSIDIARIES AND KAISER FOUNDATION HOSPITALS AND SUBSIDIARIES AND CREDIT GROUP FINANCIAL INFORMATION

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KAISER FOUNDATION HEALTH PLAN, INC. AND SUBSIDIARIES AND KAISER FOUNDATION HOSPITALS AND SUBSIDIARIES

Combined Financial Statements and
Credit Group Financial Information

December 31, 2016 and 2015

(With Independent Auditors' Reports Thereon)

KAISER FOUNDATION HEALTH PLAN, INC. AND SUBSIDIARIES AND KAISER FOUNDATION HOSPITALS AND SUBSIDIARIES

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KPMG LLP
Suite 1400
55 Second Street
San Francisco, CA 94105

Independent Auditors' Report

The Boards of Directors
Kaiser Foundation Health Plan, Inc.
and Kaiser Foundation Hospitals:

We have audited the accompanying combined financial statements of Kaiser Foundation Health Plan, Inc. and Subsidiaries (Health Plans) and Kaiser Foundation Hospitals and Subsidiaries (Hospitals), which comprise the combined balance sheets as of December 31, 2016 and 2015, and the related combined statements of operations and changes in net worth, and cash flows for the years then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these combined financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the combined financial position of Health Plans and Hospitals as of December 31, 2016 and 2015, and the results of their operations and their cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG LLP

San Francisco, California
February 14, 2017

KAISER FOUNDATION HEALTH PLAN, INC. AND SUBSIDIARIES AND KAISER FOUNDATION HOSPITALS AND SUBSIDIARIES

Combined Balance Sheets

December 31, 2016 and 2015

(In millions)

Assets	2016	2015
Current assets:		
Cash and cash equivalents	$ 434	$ 210
Current investments	8,677	6,554
Securities lending collateral	631	1,068
Broker receivables	767	816
Due from associated medical groups	12	5
Accounts receivable - net	2,030	1,966
Inventories and other current assets	1,357	1,422
Total current assets	13,908	12,041
Noncurrent investments	25,756	26,189
Land, buildings, equipment, and software - net	24,342	23,782
Other long-term assets	607	585
Total assets	$ 64,613	$ 62,597
Liabilities and Net Worth		
Current liabilities:		
Accounts payable and accrued expenses	$ 3,852	$ 2,977
Medical claims payable	1,862	1,750
Due to associated medical groups	862	784
Payroll and related charges	1,828	1,694
Securities lending payable	631	1,068
Broker payables	849	1,160
Long-term debt subject to short-term remarketing arrangements - net	785	732
Other current debt	1,904	775
Other current liabilities	2,102	2,027
Total current liabilities	14,675	12,967
Long-term debt	4,754	6,060
Physicians' retirement plan liability	6,566	5,730
Pension and other retirement liabilities	9,148	10,525
Other long-term liabilities	2,380	2,418
Total liabilities	37,523	37,700
Net worth	27,090	24,897
Total liabilities and net worth	$ 64,613	$ 62,597

See accompanying notes to combined financial statements.

KAISER FOUNDATION HEALTH PLAN, INC. AND SUBSIDIARIES AND KAISER FOUNDATION HOSPITALS AND SUBSIDIARIES

Combined Statements of Operations and Changes in Net Worth

Years ended December 31, 2016 and 2015

(In millions)

	2016	2015
Revenues:		
Members' dues	$ 43,315	$ 40,956
Medicare	15,414	14,436
Copays, deductibles, fees, and other	5,822	5,357
Total operating revenues	64,551	60,749
Expenses:		
Medical services	30,486	27,732
Hospital services	16,664	16,364
Outpatient pharmacy and optical services	7,370	7,059
Other benefit costs	4,099	3,900
Total medical and hospital services	58,619	55,055
Health Plan administration	4,008	3,928
Total operating expenses	62,627	58,983
Operating income	1,924	1,766
Other income and expense:		
Investment income - net	1,379	300
Interest expense	(183)	(198)
Total other income and expense	1,196	102
Net income	3,120	1,868
Change in pension and other retirement liability charges	(1,215)	2,997
Change in net unrealized gains on investments	299	(793)
Change in restricted donations	(1)	(2)
Change in noncontrolling interest	(10)	—
Change in net worth	2,193	4,070
Net worth at beginning of year	24,897	20,827
Net worth at end of year	$ 27,090	$ 24,897

See accompanying notes to combined financial statements.

KAISER FOUNDATION HEALTH PLAN, INC. AND SUBSIDIARIES AND KAISER FOUNDATION HOSPITALS AND SUBSIDIARIES

Combined Statements of Cash Flows

Years ended December 31, 2016 and 2015

(In millions)

	2016	2015
Cash flows from operating activities:		
Net income	$ 3,120	$ 1,868
Adjustments to reconcile net income to net cash provided from operating activities:		
Depreciation and software amortization	2,299	2,158
Other amortization	(76)	(6)
Loss (gain) recognized on investments - net	(752)	175
Loss on land, buildings, equipment, and software - net	31	60
Changes in assets and liabilities:		
Accounts receivable - net	(64)	(125)
Due from associated medical groups	(7)	(5)
Other assets	83	(211)
Accounts payable and accrued expenses	814	11
Medical claims payable	112	357
Due to associated medical groups	(9)	(204)
Payroll and related charges	134	(138)
Pension and other retirement liabilities	(2,233)	(959)
Other liabilities	(10)	338
Net cash provided from operating activities	3,442	3,319
Cash flows from investing activities:		
Additions to land, buildings, equipment, and software	(2,786)	(2,698)
Proceeds from sales of land, buildings, and equipment	5	5
Proceeds from investments	37,699	38,930
Investment purchases	(38,278)	(40,169)
Decrease in securities lending collateral	437	460
Broker receivables / payables	(262)	20
Issuance of notes receivable	(170)	(161)
Prepayment and repayment of notes receivable	107	144
Other investing	24	28
Physicians' retirement plan liability	491	524
Net cash used in investing activities	(2,733)	(2,917)
Cash flows from financing activities:		
Issuance of debt	3,261	1,454
Prepayment and repayment of debt	(3,298)	(1,472)
Decrease in securities lending payable	(437)	(460)
Change in restricted donations	(1)	(2)
Change in noncontrolling interest	(10)	—
Net cash used in financing activities	(485)	(480)
Net change in cash and cash equivalents	224	(78)
Cash and cash equivalents at beginning of year	210	288
Cash and cash equivalents at end of year	$ 434	$ 210
Supplemental cash flows disclosure:		
Cash paid for interest - net of capitalized amounts	$ 214	$ 212
Noncash changes in accounts payable related to purchases of fixed assets	$ 61	$ —

See accompanying notes to combined financial statements.

(1) Description of Business

The accompanying combined financial statements include Kaiser Foundation Health Plan, Inc. and Subsidiaries (Health Plans) and Kaiser Foundation Hospitals and Subsidiaries (Hospitals). Health Plans and Hospitals are primarily not-for-profit corporations whose capital is available for charitable, educational, research, and related purposes. Health Plans are primarily health maintenance organizations and are generally exempt from federal and state income taxes. Membership at December 31, 2016 and 2015 was 10.7 million and 10.2 million, respectively. At December 31, 2016 and 2015, the percentage of enrolled membership in California was approximately 77% and 78%, respectively. The principal operating subsidiary of Kaiser Foundation Hospitals is Kaiser Hospital Asset Management, Inc. (KHAM). The principal operating subsidiaries of Kaiser Foundation Health Plan, Inc. (Health Plan, Inc.) are:

Kaiser Foundation Health Plan of Colorado
Kaiser Foundation Health Plan of Georgia, Inc.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Kaiser Foundation Health Plan of the Northwest
Kaiser Health Plan Asset Management, Inc. (KHPAM)

Independent Medical Groups (Medical Groups) cooperate with Health Plans and Hospitals in conducting the Kaiser Permanente Medical Care Program. Health Plans contracts with Hospitals and the Medical Groups to provide or arrange hospital and medical services for members. Hospitals also contracts with the Medical Groups for certain professional services. Contract payments to the Medical Groups represent a substantial portion of the expenses for medical services reported in these combined financial statements. Payments from Health Plans and Hospitals constitute substantially all of the revenues for the Medical Groups. Because the Medical Groups are independent and not controlled by Health Plans and Hospitals, their financial statements are not combined or consolidated with Health Plans and Hospitals.

At December 31, 2016 and 2015, the percentage of Health Plans' and Hospitals' total labor force covered under collective bargaining agreements was approximately 71% and 70%, respectively. At December 31, 2016, approximately 10% of the workforce was covered under collective bargaining agreements that were scheduled to expire within one year. At December 31, 2016, none of the workforce was working under an expired agreement, and approximately 1% of the workforce was in a new bargaining unit that was negotiating an agreement.

Health Plans and Hospitals strive to improve the health and welfare of the communities they serve through their Community Benefit investment programs. Community Benefit expenditures provide funding for programs that serve communities through research, community-based health partnerships, the provision of charity care to low-income patients, direct health coverage for low-income families, and collaboration with community clinics, health departments, and public hospitals.

Cost-based methods are used to account for losses incurred under the care and coverage lines of business qualifying for treatment as Community Benefit. Patients assigned to these lines of business must first prove eligibility based upon family income relative to the Federal Poverty Guidelines. Most costs determined to be

Community Benefit are allocated across the lines of business following pre-determined allocation rules applied within the organization's cost accounting systems. Certain Community Benefit costs are determined using the out-of-pocket costs directly billed to patients or a cost-to-charge ratio applied to uncompensated charges associated with care provided to these patients.

For the year ended December 31, 2016, Community Benefit expenditures (at cost, net of approximately $3.0 billion of related revenues) were $2.5 billion, representing 3.9% of operating revenue. In comparison, for the year ended December 31, 2015, Community Benefit expenditures (at cost, net of $2.6 billion of related revenues) were $2.1 billion, representing 3.5% of operating revenue.

(2) Summary of Significant Accounting Policies

(a) Basis of Presentation

The financial statements of Health Plans and Hospitals are presented on a combined basis due to the operational interdependence of these organizations and because their governing boards and management are substantially the same. These combined financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America (GAAP). All material intercompany balances and transactions have been eliminated. Management has evaluated subsequent events through February 14, 2017, which is the date that these combined financial statements were issued.

(b) Cash and Cash Equivalents

Cash and cash equivalents include interest-bearing deposits purchased with an original or remaining maturity of three months or less. Cash and investments that are restricted per contractual or regulatory requirements are classified as noncurrent investments and excluded from cash and cash equivalents.

(c) Investments

Investments include equity, U.S. Treasury, government agencies, money market funds, and other marketable debt securities and are reported at fair value. Investments are categorized as current assets if they are intended to be available to satisfy current liabilities. Alternative investments are reported under the equity method. Certain investments are illiquid and are valued based on the most current information available. Other-than-temporary impairment and recognized gains and losses, which are recorded on the specific identification basis, and interest, dividend income, and income from equity method alternative investments are included in investment income - net. Health Plans and Hospitals have designated a portion of their investments for the physicians' retirement plan liability related to defined retirement benefits provided for physicians associated with certain Medical Groups. These investments are unrestricted assets of Health Plans and Hospitals. A portion of investment income that represents the expected return on the investments designated for the physicians' retirement plan has been recorded as a reduction in the provision for physicians' retirement plan benefits and is excluded from investment income - net, as described in the *Physicians' Retirement Plan* note.

Investments are regularly reviewed for impairment and a charge is recognized when the fair value is below cost basis and is judged to be other-than-temporary. In its review of assets for impairment that is deemed other-than-temporary, management generally follows the following guidelines:

- Substantially all investments are managed by outside investment managers who do not need Health Plans' or Hospitals' management preapproval for sales; therefore, substantially all declines in value below cost are recognized as impairment that is other-than-temporary.
- For other securities, losses are recognized for known matters, such as bankruptcies, regardless of ownership period, and investments that have been continuously below book value for an extended period of time are evaluated for impairment that is other-than-temporary.

All other unrealized losses and all unrealized gains on investments are included as other changes in net worth.

Interest income is calculated under the effective interest method and included in investment income - net. Dividends are included in investment income - net on the ex-dividend date, which immediately follows the record date.

Health Plans' and Hospitals' investment transactions are recorded on a trade date basis.

(d) Securities Lending Collateral and Payable

Health Plans and Hospitals enter into securities lending agreements whereby certain securities from their portfolios are loaned to other institutions. Securities lent under such agreements remain in the portfolios of Health Plans and Hospitals. Health Plans and Hospitals receive a fee from the borrower under these agreements, which is recognized ratably over the period that the securities are lent. Collateral, primarily cash, is required at a rate of 102% of the fair value of securities lent and is carried as securities lending collateral. The obligation of Health Plans and Hospitals to return the cash collateral is carried as securities lending payable. The fair value of securities lending collateral is determined using level 1 or 2 inputs as appropriate, as defined in the *Fair Value Estimates* note. The fair value of the loaned securities is monitored on a daily basis, with additional collateral obtained or refunded as the fair value of the loaned securities fluctuates.

(e) Broker Receivables and Payables

Broker receivables and payables represent current amounts for unsettled securities sales or purchases.

(f) Inventory

Inventories, consisting primarily of pharmaceuticals and supplies, are carried at the lower of cost (generally first-in, first-out or average price) or market.

(g) Land, Buildings, Equipment, and Software

Land, buildings, equipment, and software are stated at cost less accumulated depreciation and amortization. Interest is capitalized on facilities construction and internally developed software work in progress and is added to the cost of the underlying asset. Software, which includes internal and external costs incurred in developing or obtaining computer software for internal use, is capitalized. Qualifying costs incurred during the application development stage are capitalized. Depreciation and amortization begin when the project is substantially complete and ready for its intended use. Software is amortized on a straight-line basis over the estimated useful lives, generally ranging from 3 to 7 years. Buildings and equipment are depreciated on a straight-line basis over the estimated useful lives of the various classes of assets, generally ranging from 3 to 34 years.

Management evaluates alternatives for delivering services that may affect the current and future utilization of existing and planned assets and could result in an adjustment to the carrying values or remaining lives of such land, buildings, equipment, and software in the future. Management evaluates and records impairment losses or adjusts remaining lives, where applicable, based on expected utilization, projected cash flows, and recoverable values.

Maintenance and repairs are expensed as incurred. Major improvements that increase the estimated useful life of an asset are capitalized. Upon the sale or retirement of assets, recorded cost and related accumulated depreciation are removed from the accounts, and any gain or loss on disposal is reflected in operations.

Management estimates the fair value of asset retirement obligations that are conditional on a future event if the amount can be reasonably estimated. Estimates are developed through the identification of applicable legal requirements, identification of specific conditions requiring incremental cost at time of asset disposal, estimation of costs to remediate conditions, and estimation of remaining useful lives or date of asset disposal.

(h) Medical Claims Payable

The cost of health care services is recognized in the period in which services are incurred. Medical claims payable consists of unpaid health care expenses to third party providers, which include an estimate of the cost of services provided to Health Plans' members by the third party providers that have been incurred but not reported. The estimate for incurred but not reported claims is based on actuarial projections of costs using historical paid claims and other relevant data. Estimates are monitored and reviewed and, as claim payments are received, adjudicated, and paid, estimates are revised and are reflected in current operations. Such estimates are subject to actual utilization of medical services, changes in membership and product mix, claim submission and processing patterns, medical inflation, and other relevant factors. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided. While the ultimate amount of paid claims is dependent on future developments, management is of the opinion that the reserves for claims are adequate to cover such claims.

Health Plans and Hospitals record anticipated reinsurance recoveries for high cost claims eligible for reimbursement under the Patient Protection and Affordable Care Act (PPACA) as described in *The PPACA Health Insurance Providers Fee, Reinsurance, Risk Adjustment, and Risk Corridors Programs* note. The amount recorded is an estimate as the ultimate adjudication of these claims is conducted by the government.

(i) Due to Associated Medical Groups

Due to associated medical groups consists primarily of unpaid medical expenses owed to the Medical Groups for medical services provided to members under medical services agreements with Health Plans. The cost of medical services is recognized by Health Plans in the period in which services are provided and is reflected as a component of medical and hospital services expenses.

(j) Self-Insured Risks

Costs associated with self-insured risks, primarily for professional, general, and workers' compensation liabilities, are charged to operations based upon actual and estimated claims. The portion estimated to be paid during the next year is included in current liabilities. The estimate for incurred but not reported self-insured claims is based on actuarial projections of costs using historical claims and other relevant data. Estimates are monitored and reviewed and, as settlements are made or estimates are revised, adjustments are reflected in current operations. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided. While the ultimate payments for self-insured claims are dependent on future developments, management is of the opinion that the reserve for self-insured risks is adequate. Insurance coverage, in excess of the per occurrence self-insured retention, has been secured with insurers or reinsurers for specified amounts for professional, general, and workers' compensation liabilities. Decisions relating to the limit and scope of the self-insured layer and the amounts of excess insurance purchased are reviewed each year, subject to management's analysis of actuarial loss projections and the price and availability of acceptable commercial insurance.

(k) Premium Deficiency Reserves

Premium deficiency reserves and the related expense are recognized when it is probable that expected future health care and maintenance costs under a group of existing contracts will exceed anticipated future premiums and reinsurance recoveries over the contract period. If applicable, premium deficiency reserves extending beyond one year are shown as a long-term liability. Expected investment income and interest expense are included in the calculation of premium deficiency reserves, as appropriate. The level at which contracts are grouped for evaluation purposes is generally by geographic region. The methods for making such estimates and for establishing the resulting reserves are reviewed and updated, and any resulting adjustments are reflected in current operations. At December 31, 2016 and 2015, premium deficiency reserves were $16 million and $45 million, respectively. Given the inherent variability of such estimates, the actual liability could differ significantly from the calculated amount.

(l) Derivative Financial Instruments

Derivative financial instruments are utilized primarily to manage the interest costs and the risk associated with changing interest rates. Health Plans and Hospitals enter into interest rate swaps with investment or commercial banks with significant experience with such instruments. In addition, certain investments include derivative products. The changes in the fair value of these derivative instruments are included in investment income - net and settlement costs are recorded as interest expense or investment income - net.

Derivative financial instruments are also utilized to manage the risk of holding equity investments, primarily to hedge downside volatility risk. Heath Plans and Hospitals enter into derivatives such as put-spread collars with similar investment or commercial banks noted above. The changes in fair value for these derivatives are included in investment income - net.

Derivative financial instruments are utilized by Health Plans' and Hospitals' investment portfolio managers. These instruments include futures, forwards, options, and swaps. The changes in fair value for these derivative financial instruments are included in investment income - net.

(m) Revenue Recognition

Members' dues revenue includes premiums from employer groups and individuals. Members' dues revenue is recognized over the period in which the members are entitled to health care services.

Health Plans estimates accrued retrospective premium adjustments for certain group health insurance contracts based on claims experience and the provisions of the contract. Health Plans records accrued retrospective premiums as an adjustment to members' dues. For the years ended December 31, 2016 and 2015, the amount of premiums written by Health Plans subject to the retrospective rating feature were $932 million and $786 million, respectively. During the years ended December 31, 2016 and 2015, revenue derived under these contracts was 2.1% and 1.9%, respectively, of total members' dues. During the years ended December 31, 2016 and 2015, retrospective dues reductions derived under these contracts were $21 million and $15 million, respectively.

Health Plans participate in certain contracts with commercial large groups that include provision for risk adjustment of dues premiums, based on comparative data provided by Health Plans as well as other health plan vendors participating in these same arrangements. Settlements are typically calculated and paid according to the contract provisions and final settlements are made after the contract terms expire. For the years ended December 31, 2016 and 2015, dues subject to these risk adjustment arrangements comprise 8.8% and 8.5%, respectively, of total members' dues. For the years ended December 31, 2016 and 2015, $42 million and $87 million, respectively, have been recorded as reductions to revenue for these risk adjustment arrangements.

The majority of Health Plans' and Hospitals' Medicare revenue is received from the Medicare Advantage Program (Part C). Revenues for Part C include capitated payments, which vary based on health status, demographic status, and other factors. Medicare revenues also include accruals for

estimates resulting from changes in health risk factor scores. Such accruals are recognized when the amounts become determinable and collection is reasonably assured. Part C revenue is finalized after all data is submitted to Medicare and the final settlement is made after the end of the year.

In addition, Medicare benefits include a voluntary prescription drug benefit (Part D). Revenues for Part D include capitated payments made from Medicare adjusted for health risk factor scores. Revenues also include amounts to reflect a portion of the health care costs for low-income Medicare beneficiaries and a risk-sharing arrangement to limit the exposure to unexpected expenses. Related accruals are recognized monthly based on cumulative experience and membership data. Part D revenue is finalized after all data is submitted to Medicare and the final settlement is made after the end of the year.

Medicare Part C and D revenue is subject to governmental audits and potential payment adjustments. The Centers for Medicare & Medicaid Services (CMS) performs coding audits to validate the supporting documentation maintained by Health Plans and its care providers.

Certain Medicare revenues are paid under cost reimbursement plans based on pre-established rates, and the final settlement is made after the end of the year. Estimates of final settlements of the cost reports are recorded by Health Plans in current operations.

Estimates of retrospective adjustments resulting from coding audits, cost reports, and other contractual adjustments are recorded in the time period in which members are entitled to health care services. Actual retrospective adjustments may differ from initial estimates.

Premiums collected in advance are deferred and recorded as dues collected in advance or Medicare payments received in advance. Revenue is adjusted to reflect estimates of collectability, including retrospective membership adjustment trends and economic conditions. Revenue and related receivables are exclusive of charity care. A portion of revenues derived under contracts with the United States Office of Personnel Management is subject to audit and potential retrospective adjustments.

Patient services revenue is included in copays, deductibles, fees, and other revenue in the statement of operations and is recognized as services are rendered. Bad debt expense related to patient services revenue is calculated based on historical bad debt experience and recorded as an offset to patient services revenue (net of contractual allowances, charity care, and discounts).

Health Plans provides coverage to certain Medicaid members through contracts with third parties. Third party Medicaid revenue is included in copays, deductibles, fees, and other revenue in the statement of operations. For both years ended December 31, 2016 and 2015, revenues related to these arrangements were $1.4 billion.

(n) Pension and Other Postretirement Benefits

Health Plans' and Hospitals' defined benefit pension and other postretirement benefit plans are actuarially evaluated and involve various assumptions. Critical assumptions include the discount rate

and the expected rate of return on plan assets, and the rate of increase for health care costs (for postretirement benefit plans other than pension), which are important elements of expense and/or liability measurement. Other assumptions involve demographic factors such as retirement age, mortality, turnover, and the rate of compensation increases. Health Plans and Hospitals evaluate assumptions annually, or when significant plan amendments occur, and modify them as appropriate. Pension and other postretirement costs are allocated over the service period of the employees in the plans.

Health Plans and Hospitals use a discount rate to determine the present value of the future benefit obligations. The discount rate is established based on rates available for high-quality fixed-income debt securities at the measurement date whose maturity dates match the expected cash flows of the retirement plans.

Differences between actual and expected plan experience and changes in actuarial assumptions, in excess of a 10% corridor around the larger of plan assets or plan liabilities, are recognized into benefits expense over the expected average future service of active participants. Prior service costs and credits arise from plan amendments and are amortized into postretirement benefits expense over the expected average future service to full eligibility of active participants.

Effective January 1, 2017, Health Plans and Hospitals changed the method used to determine the service and interest cost pertaining to pension and other postretirement benefits expense. Historically, a weighted average discount rate was used in the calculation of service and interest costs. The new method utilizes a "spot rate approach" and provides a more precise measurement of service and interest costs by applying the spot rate along an interest rate yield curve for each expected future cash flow of a retirement plan. This change is considered a change in accounting estimate that is inseparable from a change in accounting principle and accordingly will be accounted for prospectively. It is estimated the spot rate approach will result in a reduction in pension and other postretirement benefits expense of approximately $280 million during 2017.

(o) Donations and Grants Made or Received

Donations and grants made are recognized at fair value in the period in which a commitment is made, provided the payment of the donation or grant is probable and the amount is determinable. Donations or grants received, including research grants, are recognized at fair value in the period the donation or grant was committed unconditionally by the grantor or in the period the donation or grant requirements are met, if later.

(p) Use of Estimates

The preparation of these combined financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts. Allowance for uncollectible accounts receivable; estimated fair value of investments; Medicare revenue accruals; Medicare reserves; incurred but not reported medical claims payable; physicians' retirement plan liabilities; pension and other retirement liabilities; premium deficiency reserves; self-insured

professional liabilities; self-insured general and workers' compensation liabilities; land, buildings, equipment, and software impairment and useful lives; investment impairment; and certain amounts accrued related to the PPACA Reinsurance, Risk Adjustment, and Risk Corridors Programs represent significant estimates. Actual results could differ materially from those estimates. As occurs from time to time, negotiations with labor partners may result in changes to compensation and benefits. These changes are reflected in the financial statements as appropriate when agreements are finalized.

(q) Reclassifications

Certain reclassifications have been made in these combined financial statements to conform 2015 information to the 2016 presentation.

(r) The PPACA Health Insurance Providers Fee, Reinsurance, Risk Adjustment, and Risk Corridors Programs

The PPACA requires Health Plans to pay a Health Insurance Providers (HIP) fee that is assessed based on Health Plans' prior year net premiums as a percentage of total premiums for all U.S. health plans. The Internal Revenue Service (IRS) has provided Health Plans its final assessment of $498 million for 2016, and the amount was paid and expensed in 2016. The 2017 HIP fee was suspended for the 2017 calendar year.

The PPACA also includes three programs designed to mitigate health plan risk. Two are temporary and one is permanent.

The Reinsurance Program is temporary, and provides for partial reimbursement of certain high cost claims for non-grandfathered individual members, beginning in 2014 and continuing through 2016. As described in the *Summary of Significant Accounting Policies - Medical Claims Payable* note, certain amounts have been recorded in 2016 and 2015 as expected claims reimbursements under this program. For the years ended December 31, 2016 and 2015, Health Plans has recorded $146 million and $301 million, respectively, for estimated recoveries from the Reinsurance Program. For the years ended December 31, 2016 and 2015, Health Plans has recorded $218 million and $342 million, respectively, of Reinsurance fees.

The Risk Adjustment Program is permanent, and provides for retrospective adjustment of revenue for non-grandfathered individual and small group market plans, whether inside or outside PPACA exchanges. The Risk Adjustment Program is designed such that payments to plans with higher relative risk are funded by transfers from plans with lower relative risk. For the years ended December 31, 2016 and 2015, Health Plans has recorded $845 million and $11 million, respectively, in net revenue reductions related to the Risk Adjustment Program.

The Risk Corridors Program is temporary, beginning in 2014 and continuing through 2016. This program provides for gains and losses on the individual and small group market plans. For the years ended December 31, 2016 and 2015, Health Plans has recorded $7 million and $(66) million, respectively, in net revenue increases (reductions) related to the Risk Corridors Program.

At December 31, the net receivables (payables) for PPACA Reinsurance recoveries, Risk Adjustment settlements, and Risk Corridors settlements were as follows (in millions):

	2016	2015
Reinsurance recoveries	$ 150	$ 229
Risk Adjustment settlements	(654)	(39)
Risk Corridors settlements	1	(5)
Total	$ (503)	$ 185

(s) Recently Issued Accounting Standards

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2014-09 *Revenue from Contracts with Customers (Topic 606)*. The ASU will replace most existing revenue recognition guidance in U.S. GAAP when it becomes effective. The new standard is effective for Health Plans and Hospitals on January 1, 2018, as amended by ASU No. 2015-14 *Revenue from Contracts with Customers (Topic 606): Deferral of the Effective Date*. The standard permits the use of either the retrospective or cumulative effect transition method. Management has not yet selected a transition method. Additional disclosures will be added as required by the standard.

Management is currently evaluating the impact of adoption on the combined financial statements and related disclosures. Management has analyzed contracts with customers, accounting policies, and has held discussions with key internal stakeholders. There are significant variable revenues recognized by Health Plans and Hospitals that management is in the process of evaluating. Management's current practice for recognizing these variable revenues is using a best estimate approach.

In February 2015, the FASB issued ASU No. 2015-02 *Consolidation (Topic 810)*. The amendments in this update affect reporting entities that are required to evaluate whether they should consolidate certain legal entities. The new standard is effective for Health Plans and Hospitals on January 1, 2017. Early application is permitted. Management has evaluated this accounting standard and it is not expected to have a significant effect on the combined financial statements and related disclosures.

In April 2015, the FASB issued ASU No. 2015-03 *Interest - Imputation of Interest (Subtopic 835-30)*. The amendments in this update require that debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct deduction from the carrying amount of that debt liability, consistent with debt discounts. The new standard was adopted by Health Plans and Hospitals as of January 1, 2016. The standard requires retrospective treatment at adoption and there were $29 million of accrued debt issuance costs at December 31, 2015 presented within other long-term assets, which have been reclassified as a reduction to long-term debt. At December 31, 2016, accrued debt issuance costs were $23 million.

In April 2015, the FASB issued ASU No. 2015-05 *Intangibles - Goodwill and Other - Internal-Use Software (Subtopic 350-40)*. The amendments in this update provide guidance to customers about

whether a cloud computing arrangement includes a software license. The new standard was adopted by Health Plans and Hospitals in 2016. Management has selected the prospective transition method. The adoption of this standard did not have a significant effect on the combined financial statements and related disclosures.

In July 2015, the FASB issued ASU No. 2015-11 *Inventory - Simplifying the Measurement of Inventory (Topic 330)*. The amendments in this update change the measurement principle for inventory from the lower of cost or market to lower of cost and net realizable value. The new standard is effective for Health Plans and Hospitals on January 1, 2017. The standard requires the application of the prospective transition method. Management has evaluated this accounting standard and it is not expected to have a significant effect on the combined financial statements and related disclosures.

In January 2016, the FASB issued ASU No. 2016-01 *Financial Instruments - Overall (Subtopic 825-10)*. The standard requires entities to measure equity investments that are not accounted for under the equity method or do not result in consolidation to be recorded at fair value and recognize any changes in fair value to net income. Investments that qualify for a practicability exception would not require a change in accounting. The disclosure of fair value of investments held at amortized cost will no longer be required. The new standard is effective for Health Plans and Hospitals on January 1, 2019. Early application is permitted but not earlier than January 1, 2018. The standard requires the use of the cumulative effect transition method, except for equity securities without readily determinable fair values, for which the standard requires the application of the prospective transition method. The impact of adoption will result in the change in fair value of available for sale equity securities being reflected in net income and a reduction in the fair value disclosures for certain securities carried at amortized cost.

In February 2016, the FASB issued ASU No. 2016-02 *Leases (Topic 842)*. The standard introduces new requirements to increase transparency and comparability among organizations for leasing transactions for both lessees and lessors. ASU No. 2016-02 requires a lessee to record a right-of-use asset and a lease liability for all leases with terms longer than 12 months. These leases will be either finance or operating, with classification affecting the pattern of expense recognition. The new standard is effective for Health Plans and Hospitals on January 1, 2019. Early application is permitted. The standard requires the application of the modified retrospective transition method. Additional disclosures will be added as required by the standard.

Management is in the process of evaluating necessary changes to information technology systems, accounting policies, and processes to support the adoption of the standard. Management expects to record significant amounts for right-of-use assets and lease liabilities on its combined balance sheets from a lessee perspective. Health Plans and Hospitals do not have significant lessor activity.

In March 2016, the FASB issued ASU No. 2016-07 *Investments - Equity Method and Joint Ventures (Topic 323)*. The amendments in this update eliminate the requirement to retroactively adopt the equity method of accounting when an investment qualifies for the use of the equity method as a result of an increase in the level of ownership or degree of influence. The new standard is effective for Health Plans and Hospitals on January 1, 2017. The standard requires the use of the prospective transition method. Management has evaluated this accounting standard and it is not expected to have a significant effect on the combined financial statements and related disclosures.

In June 2016, the FASB issued ASU No. 2016-13 *Financial Instruments - Credit Losses (Topic 326)*. The amendments in this update replace the incurred loss impairment methodology in current GAAP with a methodology that reflects expected credit losses and requires consideration of a broader range of reasonable and supportable information to inform credit loss estimates. The new standard is effective for Health Plans and Hospitals on January 1, 2021. Early application is permitted but not earlier than January 1, 2019. The standard requires the use of the cumulative effect transition method, except for debt securities for which an other-than-temporary impairment had been recognized before the effective date, for which the standard requires the application of the prospective transition method. Management has evaluated this accounting standard and it is not expected to have a significant effect on the combined financial statements and related disclosures.

In August 2016, the FASB issued ASU No. 2016-14 *Not-for-Profit Entities (Topic 958)*. The amendments in this update make certain improvements that address many, but not all, of the identified issues about the current financial reporting for not-for-profits. The new standard is effective for Health Plans and Hospitals on January 1, 2018. Early application is permitted. The standard requires the use of the retrospective transition method. Management is evaluating the effect that ASU No. 2016-14 will have on its combined financial statements and related disclosures. Management has not determined the effect of the standard on its ongoing financial reporting.

In August 2016, the FASB issued ASU No. 2016-15 *Statement of Cash Flows (Topic 230), Classification of Certain Cash Receipts and Cash Payments.* The amendments in this update address eight specific cash flow issues with the objective of reducing the existing diversity in practice. The new standard is effective for Health Plans and Hospitals on January 1, 2019. Early application is permitted. The standard requires the use of the retrospective transition method. Management is evaluating the effect that ASU No. 2016-15 will have on its combined financial statements and related disclosures. Management has not determined the effect of the standard on its ongoing financial reporting.

(3) Acquisition of Group Health Cooperative and Maui Health System Agreement

Acquisition of Group Health Cooperative

On February 1, 2017, Kaiser Foundation Health Plan of Washington (KFHPW), a subsidiary of Health Plan Inc., acquired and became the sole corporate member of Group Health Cooperative (GHC), a Washington nonprofit corporation. After closing of the acquisition, GHC will remain the sole shareholder of Group Health Options, Inc. (GHO), a Washington for-profit corporation (GHC and its subsidiaries are collectively

referred to herein as, Group Health). Following the acquisition, KFHPW was renamed "KFHPW Holdings" (Holdings), GHC was renamed "Kaiser Foundation Health Plan of Washington," and GHO was renamed "Kaiser Foundation Health Plan of Washington Options, Inc.".

Group Health offers comprehensive, coordinated health care to an enrolled membership primarily for a fixed fee through its owned and leased facilities, employed providers, and contracted providers. In addition, Group Health provides certain health care services on a fee for service basis to both enrollees and nonenrollees. Through this acquisition, Health Plans expects to better meet the needs of individuals as well as large commercial and national accounts with employees who live and work in Washington.

Following execution of a definitive Acquisition Agreement on December 2, 2015, $2 billion was transferred from Hospitals to Holdings and restricted for purposes of completing this acquisition and related transactions. At December 31, 2016, this restricted asset is included in current investments in the combined financial statements. At closing, Holdings transferred approximately $1.8 billion in cash, of which $75 million was deposited into escrow for possible future indemnity claims. In addition to and separate from this transaction consideration, the Acquisition Agreement requires $1 billion to be spent over the 10 year period following closing (subject to standard capital and budget approval processes) for capital improvements and key investments in infrastructure and other improvements at Group Health, and also states that $800 million in community benefit contributions is expected to be made over the same period.

Group Health and Group Health Permanente, P.C. (GHP), an independent Washington professional services corporation, have an existing exclusive arrangement for the provision of physician and certain other medical services to Group Health enrollees. As part of the successful completion of the Group Health acquisition, Holdings and GHP entered into agreements to continue that arrangement following closing of the Group Health acquisition, including payments to GHP of up to $200 million, recognized primarily as operating expenses and intangible assets.

Due to the limited time since the closing of the Group Health acquisition, the valuation activities and related acquisition accounting are incomplete at this time. As a result, the purchase price allocation and other acquisition related disclosures have not been provided.

Maui Health System Agreement

In January 2016, Maui Health System, A Kaiser Foundation Hospitals LLC (MHSKFH), a subsidiary of Hospitals, entered into a contract with State of Hawaii entities to manage, operate, and provide health care services at hospitals of the Maui Region of Hawaii Health Systems Corporation under the terms of a 30 year transfer agreement. The agreement includes an option for MHSKFH to extend for a potential of two more 10 year terms. Certain existing facilities will be leased from the State of Hawaii entities with financial responsibility of any additional investments to the facilities to be shared between MHSKFH and the State of Hawaii entities during the first 10 years, and MHSKFH will be eligible to receive annual operating support from the State of Hawaii. The transfer is expected to be completed on July 1, 2017.

(4) Fair Value Estimates

The carrying amounts reported in the balance sheets for cash and cash equivalents, securities lending collateral, broker receivables, accounts receivable - net, accounts payable and accrued expenses, medical claims payable, due to associated medical groups, payroll and related charges, securities lending payable, and broker payables approximate fair value.

Investments, other than alternative investments, as discussed in the *Investments* note, are reported at fair value. The fair values of investments are based on quoted market prices, if available, or estimated using quoted market prices for similar investments. If listed prices or quotes are not available, fair value is based upon other observable inputs or models that primarily use market-based or independently sourced market parameters as inputs. In addition to market information, models also incorporate transaction details such as maturity. Fair value adjustments, including credit, liquidity, and other factors, are included, as appropriate, to arrive at a fair value measurement. Certain investments are illiquid and are valued based on the most current information available, which may be less current than the date of these combined financial statements.

The carrying value of alternative investments, which include absolute return, risk parity, and private equity, is reported under the equity method, which management believes to approximate fair value. The fair values of alternative investments have been estimated by management based on all available data, including information provided by fund managers or the general partners. The underlying securities within absolute return investments are typically valued using quoted prices for identical or similar instruments within active and inactive markets. The underlying holdings within private equity investments are valued based on recent transactions, operating results, and industry and other general market conditions.

Health Plans and Hospitals utilize a three-level valuation hierarchy for fair value measurements. An instrument's categorization within the hierarchy is based upon the lowest level of input that is significant to the fair value measurement. For instruments classified in level 1 of the hierarchy, valuation inputs are quoted prices for identical instruments in active markets at the measurement date. For instruments classified in level 2 of the hierarchy, valuation inputs are directly observable but do not qualify as level 1 inputs. Examples of level 2 inputs include: quoted prices for similar instruments in active markets; quoted prices for identical or similar instruments in inactive markets; other observable inputs such as interest rates and yield curves observable at commonly quoted intervals, volatilities, prepayment speeds, loss severities, credit risks, and default rates; and market-correlated inputs that are derived principally from or corroborated by observable market data. For instruments classified in level 3 of the hierarchy, valuation inputs are unobservable inputs for the instrument. Level 3 inputs incorporate assumptions about the factors that market participants would use in pricing the instrument.

The fair value of long-term debt is based on level 2 inputs for debt with similar risk, terms, and remaining maturities. At December 31, 2016 and 2015, the carrying amount of long-term debt totaled $5.6 billion and $6.9 billion, respectively. At December 31, 2016 and 2015, the estimated fair value of long-term debt was approximately $5.7 billion and $7.1 billion, respectively.

At December 31, 2016 and 2015, Health Plans and Hospitals held derivative financial instruments including interest rate swaps, as well as futures, swaps, and forwards held within investment portfolios. The estimated fair values of derivative instruments were determined using level 2 inputs, including available market information and valuation methodologies, primarily discounted cash flows. Additional description and the fair value of derivative instruments are contained in the *Derivative Instruments* note.

(5) Investments

Management's methods for estimating fair value of financial instruments are discussed in the *Fair Value Estimates* note.

At December 31, 2016, the estimated fair value of current investments by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Significant unobservable inputs level 3	Total
U.S. equity securities	$ 24	$ —	$ —	$ 24
Debt securities issued by the U.S. government	—	3,200	—	3,200
Debt securities issued by U.S. government agencies and corporations	—	58	—	58
Debt securities issued by U.S. states and political subdivisions of states	—	61	—	61
Foreign government debt securities	—	90	—	90
U.S. corporate debt securities	—	2,267	—	2,267
Foreign corporate debt securities	—	1,009	—	1,009
U.S. agency mortgage-backed securities	—	735	—	735
Non-U.S. agency mortgage-backed securities	—	216	—	216
Other asset-backed securities	—	723	—	723
Short-term investment funds	—	294	—	294
Total	$ 24	$ 8,653	$ —	$ 8,677

At December 31, 2016, the estimated fair value of noncurrent investments by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Significant unobservable inputs level 3	Total
U.S. equity securities	$ 3,744	$ 164	$ —	$ 3,908
Foreign equity securities	2,690	1,455	—	4,145
Global equity funds	—	451	—	451
Debt securities issued by the U.S. government	—	1,238	—	1,238
Debt securities issued by U.S. government agencies and corporations	—	100	—	100
Debt securities issued by U.S. states and political subdivisions of states	—	182	—	182
Foreign government debt securities	—	1,157	—	1,157
U.S. corporate debt securities	—	3,566	—	3,566
Foreign corporate debt securities	—	1,387	—	1,387
U.S. agency mortgage-backed securities	—	614	—	614
Non-U.S. agency mortgage-backed securities	—	235	8	243
Other asset-backed securities	—	241	—	241
Short-term investment funds	—	1,021	—	1,021
Other	143	518	1	662
Alternative investments:				
Absolute return	—	1,165	911	2,076
Private equity	—	—	4,089	4,089
Risk parity	—	—	676	676
Total	$ 6,577	$ 13,494	$ 5,685	$ 25,756

At December 31, 2015, the estimated fair value of current investments by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Significant unobservable inputs level 3	Total
U.S. equity securities	$ 31	$ —	$ —	$ 31
Debt securities issued by the U.S. government	—	1,500	—	1,500
Debt securities issued by U.S. government agencies and corporations	—	48	—	48
Debt securities issued by U.S. states and political subdivisions of states	—	56	—	56
Foreign government debt securities	—	40	—	40
U.S. corporate debt securities	—	2,003	—	2,003
Foreign corporate debt securities	—	966	—	966
U.S. agency mortgage-backed securities	—	660	—	660
Non-U.S. agency mortgage-backed securities	—	351	—	351
Other asset-backed securities	—	593	—	593
Short-term investment funds	—	297	—	297
Other	—	9	—	9
Total	$ 31	$ 6,523	$ —	$ 6,554

At December 31, 2015, the estimated fair value of noncurrent investments by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Significant unobservable inputs level 3	Total
U.S. equity securities	$ 3,538	$ 10	$ —	$ 3,548
Foreign equity securities	2,888	1,281	—	4,169
Global equity funds	—	751	—	751
Debt securities issued by the U.S. government	—	1,139	—	1,139
Debt securities issued by U.S. government agencies and corporations	—	117	—	117
Debt securities issued by U.S. states and political subdivisions of states	—	184	—	184
Foreign government debt securities	—	1,101	—	1,101
U.S. corporate debt securities	—	3,322	—	3,322
Foreign corporate debt securities	—	1,407	—	1,407
U.S. agency mortgage-backed securities	—	663	—	663
Non-U.S. agency mortgage-backed securities	—	179	11	190
Other asset-backed securities	—	196	—	196
Short-term investment funds	—	2,613	—	2,613
Other	82	429	1	512
Alternative investments:				
Absolute return	—	1,272	964	2,236
Private equity	—	—	3,234	3,234
Risk parity	—	—	807	807
Total	$ 6,508	$ 14,664	$ 5,017	$ 26,189

At December 31, 2016, debt and equity securities available-for-sale were as follows (in millions):

	Amortized cost	Gross unrealized gains	Gross unrealized losses	Fair value
U.S. equity securities	$ 3,267	$ 665	$ —	$ 3,932
Foreign equity securities	3,562	583	—	4,145
Global equity funds	359	92	—	451
Debt securities issued by the U.S. government	4,427	11	—	4,438
Debt securities issued by U.S. government agencies and corporations	152	6	—	158
Debt securities issued by U.S. states and political subdivisions of states	215	28	—	243
Foreign government debt securities	1,190	57	—	1,247
U.S. corporate debt securities	5,571	262	—	5,833
Foreign corporate debt securities	2,316	80	—	2,396
U.S. agency mortgage-backed securities	1,338	11	—	1,349
Non-U.S. agency mortgage-backed securities	451	8	—	459
Other asset-backed securities	949	15	—	964
Short-term investment funds	1,315	—	—	1,315
Other	650	12	—	662
Total	$ 25,762	$ 1,830	$ —	$ 27,592

At December 31, 2015, debt and equity securities available-for-sale were as follows (in millions):

	Amortized cost	Gross unrealized gains	Gross unrealized losses	Fair value
U.S. equity securities	$ 3,031	$ 548	$ —	$ 3,579
Foreign equity securities	3,657	512	—	4,169
Global equity funds	506	245	—	751
Debt securities issued by the U.S. government	2,630	9	—	2,639
Debt securities issued by U.S. government agencies and corporations	158	7	—	165
Debt securities issued by U.S. states and political subdivisions of states	214	26	—	240
Foreign government debt securities	1,109	32	—	1,141
U.S. corporate debt securities	5,225	100	—	5,325
Foreign corporate debt securities	2,347	26	—	2,373
U.S. agency mortgage-backed securities	1,311	12	—	1,323
Non-U.S. agency mortgage-backed securities	534	7	—	541
Other asset-backed securities	782	7	—	789
Short-term investment funds	2,910	—	—	2,910
Other	521	—	—	521
Total	$ 24,935	$ 1,531	$ —	$ 26,466

At December 31, available-for-sale debt securities by contractual maturity and mortgage-backed and other asset-backed debt securities were as follows (in millions):

	2016		2015	
	Amortized cost	Fair value	Amortized cost	Fair value
Due in one year or less	$ 2,356	$ 2,362	$ 3,585	$ 3,587
Due after one year through five years	7,604	7,702	5,852	5,881
Due after five years through ten years	2,563	2,671	2,536	2,567
Due after ten years	3,313	3,557	3,141	3,279
U.S. agency mortgage-backed securities	1,338	1,349	1,311	1,323
Non-U.S. agency mortgage-backed securities	451	459	534	541
Other asset-backed securities	949	964	782	789
Total	$ 18,574	$ 19,064	$ 17,741	$ 17,967

For the year ended December 31, 2016, the reconciliation of investments with fair value measurements using significant unobservable inputs (level 3) was as follows (in millions):

	Debt securities	Alternative investments	Total
Beginning balance	$ 12	$ 5,005	$ 5,017
Transfers out of level 3	—	(9)	(9)
Total net losses:			
Realized	1	249	250
Unrealized	—	—	—
Purchases	1	1,364	1,365
Sales	(1)	(933)	(934)
Settlements	(4)	—	(4)
Ending balance	$ 9	$ 5,676	$ 5,685
Total realized and unrealized year-to-date net gains related to assets held at December 31, 2016	$ —	$ 223	$ 223

For the year ended December 31, 2015, the reconciliation of investments with fair value measurements using significant unobservable inputs (level 3) was as follows (in millions):

	Equity securities	Debt securities	Alternative investments	Total
Beginning balance	$ 26	$ 14	$ 3,501	$ 3,541
Transfers out of level 3	(28)	—	—	(28)
Total net gains (losses):				
Realized	1	1	(42)	(40)
Unrealized	6	(1)	—	5
Purchases	—	—	1,834	1,834
Sales	(5)	—	(288)	(293)
Settlements	—	(2)	—	(2)
Ending balance	$ —	$ 12	$ 5,005	$ 5,017
Total realized and unrealized year-to-date net gains (losses) related to assets held at December 31, 2015	$ 5	$ —	$ (42)	$ (37)

Transfers between fair value input levels, if any, are recorded at the end of the reporting period. Transfers between fair value input levels occur when valuation inputs used to record or disclose assets or liabilities change from one level of the valuation hierarchy to another. During the years ended December 31, 2016

and 2015, there were no transfers between assets with inputs with quoted prices in active markets for identical assets (level 1) and assets with inputs with significant other observable inputs (level 2).

Investments include specific funds held in trust accounts related to collateral requirements for certain reinsurance agreements. At December 31, 2016 and 2015, the values of these funds were $44 million and $53 million, respectively.

Absolute return investments use advanced investment strategies, including derivatives, to generate positive long-term risk adjusted returns. Private equity investments consist of funds that make direct investments in private companies. Risk parity funds use risk as the primary factor to allocate investments among asset classes. Management meets with alternative investment fund managers periodically to assess portfolio performance and reporting and exercises oversight over fund managers. At December 31, 2016, Hospitals had original commitments related to alternative investments of $7.9 billion, of which $4.7 billion was invested, leaving $3.2 billion of remaining commitments. At December 31, 2015, Hospitals had original commitments related to alternative investments of $6.7 billion, of which $3.7 billion was invested, leaving $3.0 billion of remaining commitments.

For the years ended December 31, investment income - net was comprised of the following (in millions):

	2016	2015
Other-than-temporary impairment	$ (622)	$ (1,426)
Recognized gains	1,349	1,401
Recognized losses	(344)	(299)
Income from equity method alternative investments	532	152
Interest, dividends, and other income - net	876	771
Derivative income	15	136
Total investment income - net	1,806	735
Less investment income included in operating income	(427)	(435)
Investment income - net	$ 1,379	$ 300

For the years ended December 31, 2016 and 2015, Health Plans and Hospitals recorded impairment of certain investments in accordance with the policy described in the *Summary of Significant Accounting Policies - Investments* note. During the years ended December 31, 2016 and 2015, there was $2 million and $1 million, respectively, of impairment of alternative investments.

Absolute return, risk parity, and private equity investments include redemption restrictions. Absolute return and risk parity investments require 10 to 90 day written notice of intent to withdraw and are often subject to the approval and capital requirements of the fund manager. Absolute return and risk parity investments of $599 million are subject to lock-up periods of up to 3 years. Private equity agreements do not include provisions for redemption. Distributions will be received as the underlying investments of the funds are liquidated, which is expected over the next 11 years.

The majority of debt and equity securities can be redeemed within 10 days. Debt and equity investment funds of $1.2 billion are redeemable between 10 and 30 days. Equity investment funds of $282 million have a redemption period of between 30 days and 1 year. No debt or equity investments require a redemption period of greater than 1 year.

(6) Derivative Instruments

(a) Interest Rate Swaps

At both December 31, 2016 and 2015, Health Plans and Hospitals had 11 agreements to manage interest rate fluctuations (Interest Rate Swaps) with a total notional amount of $1.2 billion. At December 31, 2016 and 2015, the fair values of these agreements were $(251) million and $(274) million, respectively, and were recorded in other long-term liabilities. For the years ended December 31, 2016 and 2015, Health Plans and Hospitals recorded $33 million and $35 million, respectively, in interest expense relating to the Interest Rate Swaps. For the years ended December 31, 2016 and 2015, net changes in fair values totaled $23 million and $(7) million, respectively, and were recorded in investment income - net.

These derivatives contain reciprocal provisions whereby if Health Plans' and Hospitals' or the counterparties' credit rating was to decline to certain levels, provisions would be triggered requiring Health Plans and Hospitals or the counterparties to provide certain collateral. At December 31, 2016 and 2015, no collateral was required to be posted by either Health Plans and Hospitals or the counterparties.

(b) Derivatives Held in Investment Portfolios

At December 31, 2016 and 2015, Health Plans' and Hospitals' portfolio managers held $46 million and $(3) million, respectively, of futures, forwards, options, and swaps to attempt to protect investments against volatility. For the years ended December 31, 2016 and 2015, net changes in fair values totaled $59 million and $(9) million, respectively, and were recorded in investment income - net. For the years ended December 31, 2016 and 2015, gains (losses) resulting from derivative settlements totaled $(67) million and $152 million, respectively, and were recorded in investment income - net.

(c) Information on Derivative Gain (Loss) and Fair Value

Management's methods for estimating fair value of financial instruments are discussed in the *Fair Value Estimates* note.

Information on Derivative Gain (Loss) Mark-to-Market Valuation Recognized in Income

(In millions)

Derivatives not designated as hedging instruments	Statement of operations category	Gain (loss) recognized in income on derivatives for the years ended December 31, 2016	2015
Interest rate swaps - related to debt	Investment income - net	$ 23	$ (7)
Interest rate swaps - other	Investment income - net	31	1
Options, rights, and warrants	Investment income - net	(1)	19
Futures and forwards	Investment income - net	29	(29)
		$ 82	$ (16)

Information on Derivative Settlement Costs Recognized in Income

(In millions)

Derivatives not designated as hedging instruments	Statement of operations category	Gain (loss) recognized in income on derivatives for the years ended December 31, 2016	2015
Interest rate swaps - related to debt	Interest expense	$ (33)	$ (35)
Interest rate swaps - other	Investment income - net	(4)	(51)
Futures and forwards	Investment income - net	(83)	202
Options, rights, and warrants	Investment income - net	20	1
		$ (100)	$ 117

Information on Fair Value of Derivative Instruments - Assets

(In millions)

Derivatives not designated as hedging instruments	Balance sheet category	Fair value at December 31, 2016	2015
Interest rate swaps - other	Noncurrent investments	$ 47	$ 13
Futures and forwards	Noncurrent investments	64	33
Options, rights, and warrants	Noncurrent investments	7	1
		$ 118	$ 47

Information on Fair Value of Derivative Instruments - Liabilities

(In millions)

Derivatives not designated as hedging instruments	Balance sheet category	Fair value at December 31, 2016	2015
Interest rate swaps - related to debt	Other long-term liabilities	$ 251	$ 274
Interest rate swaps - other	Other long-term liabilities	25	22
Futures and forwards	Other long-term liabilities	38	25
Options, rights, and warrants	Other long-term liabilities	9	3
		$ 323	$ 324

(7) Accounts Receivable - net

At December 31, accounts receivable - net were as follows (in millions):

	2016	2015
Members' dues	$ 799	$ 709
Patient services	387	390
Medicare	315	317
Reinsurance recoveries	150	231
Risk Adjustment receivables	15	66
Other	564	399
	2,230	2,112
Allowances for bad debt	(200)	(146)
Total	$ 2,030	$ 1,966

(8) Inventories and Other Current Assets

At December 31, inventories and other current assets were as follows (in millions):

	2016	2015
Inventories - net	$ 832	$ 871
Prepaid expenses	455	481
Other	70	70
Total	$ 1,357	$ 1,422

(9) Land, Buildings, Equipment, and Software - net

At December 31, land, buildings, equipment, and software - net were as follows (in millions):

	2016	2015
Land	$ 1,884	$ 1,821
Buildings and improvements	32,627	30,761
Furniture, equipment, and software	11,654	10,791
Construction and software development in progress	1,379	1,920
	47,544	45,293
Accumulated depreciation and amortization	(23,202)	(21,511)
Total	$ 24,342	$ 23,782

Health Plans and Hospitals capitalize interest costs on borrowings incurred during the construction, upgrade, or development of qualifying assets. Capitalized interest is added to the cost of the underlying assets and is depreciated or amortized over the useful lives of the assets. During the years ended December 31, 2016 and 2015, Health Plans and Hospitals capitalized $26 million and $28 million, respectively, of interest in connection with various capital projects.

Asset retirement obligations relate primarily to the following: leased building restoration, building materials containing asbestos, leaded wall shielding, storage tanks (above ground and below ground), chillers or cooling tower chemicals, mercury in large fixed-components, and hard drives requiring data wiping prior to disposal. At December 31, 2016 and 2015, the liability for asset retirement obligations was $103 million and $85 million, respectively. At December 31, 2016 and 2015, the unamortized asset related to these retirement obligations was $19 million and $13 million, respectively.

(10) Medical Claims Payable

For the years ended December 31, activity in the liability for medical claims payable was as follows (in millions):

	2016	2015
Balances at January 1	$ 1,750	$ 1,393
Incurred related to:		
Current year	9,117	8,342
Prior years	(144)	(33)
Total incurred	8,973	8,309
Paid related to:		
Current year	7,415	6,795
Prior years	1,446	1,157
Total paid	8,861	7,952
Balances at December 31	$ 1,862	$ 1,750

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately adjudicated and paid. Liabilities are reviewed and revised as information regarding actual claims payments becomes known. Negative amounts reported for incurred related to prior years result from claims being adjudicated and paid for amounts less than originally estimated.

(11) Other Liabilities

At December 31, other current liabilities were as follows (in millions):

	2016	2015
Self-insured risks	$ 388	$ 393
Dues collected in advance	682	628
Medicare liabilities	33	45
Physicians' retirement plan liability	185	171
TBA commitments	136	149
Other	678	641
Total	$ 2,102	$ 2,027

At December 31, other long-term liabilities were as follows (in millions):

	2016	2015
Self-insured risks	$ 1,518	$ 1,500
Derivatives liability	323	324
Due to associated medical groups	202	289
Other	337	305
Total	$ 2,380	$ 2,418

(12) Debt

At December 31, debt was as follows (in millions):

	2016	2015
Tax-exempt revenue bonds and taxable bonds and notes:		
0.01% to 2.00% variable rate due through 2052	$ 5,107	$ 4,097
3.60% to 5.25% fixed rate due through 2045	2,329	3,468
Others at various rates due through 2026	7	2
Total	$ 7,443	$ 7,567
Other current debt:		
Commercial paper	$ 1,886	$ 654
Current portion of long-term debt	18	121
Long-term debt subject to short-term remarketing arrangements - net	785	732
Long-term debt classified as a long-term liability	4,754	6,060
Total	$ 7,443	$ 7,567

At December 31, 2016 and 2015, repurchase of variable rate bonds totaling $3.2 billion and $3.4 billion, respectively, may be required at earlier than stated maturity. These bonds may be remarketed rather than repurchased. Health Plans and Hospitals have provided self liquidity for the variable rate demand bonds with put options. Additionally, at December 31, 2016 and 2015, management had the ability to finance the acquisition of up to $2.4 billion of any unremarketed bonds that are put, using available credit facilities. At December 31, 2016 and 2015, $785 million and $732 million, respectively, of these variable rate demand bonds were classified in current liabilities, net of available long-term credit facilities of $2.4 billion.

At December 31, 2016 and 2015, $31 million and $52 million, respectively, of the above tax-exempt fixed-rate revenue bonds represented a net unamortized premium balance. At December 31, 2016 and 2015, $(23) million and $(29) million, respectively, of unamortized debt issuance cost was presented within long-term debt.

Scheduled principal payments for each of the next five years and thereafter considering obligations subject to short-term remarketing as due according to their long-term amortization schedule, except as described below, were as follows (in millions):

2017	$	1,904
2018		18
2019		247
2020		18
2021		18
Thereafter		5,230
Total	$	7,435

At December 31, 2016, Hospitals had certain bonds that require mandatory tender by the holder on a date certain in the amount of $275 million in 2017. Hospitals intends to remarket these bonds until final maturity of the bonds.

Credit Facility

Hospitals' credit facility of $2.4 billion terminates in September 2021. Various interest rate options are available under this facility. Any revolving borrowings mature on the termination date. Hospitals pays facility fees, which range from 0.05% to 0.15% per annum, depending upon Hospitals' long-term senior unsecured debt rating. At December 31, 2016, the facility fee was at an annual rate of 0.06%. At December 31, 2016 and 2015, no amounts were outstanding under this credit facility.

Hospitals' revolving credit facility contains a financial covenant. Under the terms of this facility, Hospitals is required to maintain a ratio of total debt to capital, as defined.

Taxable Commercial Paper Program

Hospitals maintains a commercial paper program providing for the issuance of up to $2.4 billion in aggregate maturity value of short-term indebtedness. The commercial paper is issued in denominations of $100,000 and will bear such interest rates, if interest-bearing, or will be sold at such discount from their face amounts, as agreed upon by Hospitals and the dealer acting in connection with the commercial paper program. The commercial paper may be issued with varying maturities up to a maximum of 270 days from the date of issuance. At December 31, 2016 and 2015, commercial paper of $1.9 billion and $654 million, respectively, was outstanding under this program and is included within other current debt.

(13) Pension Plans

(a) Defined Benefit Plan

Health Plans and Hospitals have a defined benefit pension plan (Plan) covering substantially all their employees. Benefits are based on age at retirement, years of credited service, and average

compensation for a specified period prior to retirement. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future.

For financial reporting purposes, the projected unit credit method is used. At December 31, 2016 and 2015, substantially all pension fund assets were held in a group trust. At December 31, 2016 and 2015, the trust's assets were invested primarily in fixed-income and equity securities, with approximately 21% and 22%, respectively, of trust assets, net of liabilities, invested in alternative investments.

At December 31, the funded status of the Plan was as follows (in millions):

	2016	2015
Change in projected benefit obligation (PBO):		
Benefit obligation at beginning of year	$ 16,536	$ 16,361
Service cost	1,079	1,130
Interest cost	772	713
Plan amendments	—	118
Net actuarial loss (gain)	1,058	(1,137)
Benefits paid	(867)	(649)
Benefit obligation at end of year	$ 18,578	$ 16,536
Accumulated benefit obligation at end of year	$ 14,316	$ 12,846
Change in Health Plans' and Hospitals' share of trust assets:		
Fair value of plan assets at beginning of year	$ 10,149	$ 9,374
Actual return on plan assets	758	(165)
Contributions	1,731	1,589
Benefits paid	(867)	(649)
Fair value of plan assets at end of year	$ 11,771	$ 10,149
Funded status	$ (6,807)	$ (6,387)
Amounts recognized in the balance sheet consist of:		
Noncurrent assets	$ —	$ —
Current liabilities	—	—
Pension and other retirement liabilities	(6,807)	(6,387)
	$ (6,807)	$ (6,387)
Amounts recognized in net worth:		
Net actuarial loss	$ 5,602	$ 4,701
Prior service cost	99	113
	$ 5,701	$ 4,814

The measurement date used to determine pension valuations was December 31.

For the years ended December 31, pension expense was as follows (in millions):

	2016	2015
Service cost	$ 1,079	$ 1,130
Interest cost	772	713
Expected return on plan assets	(810)	(678)
Amortization of net actuarial loss	209	386
Amortization of prior service cost	14	11
Net pension expense	1,264	1,562
Other changes in plan assets and PBO recognized in net worth:		
Net actuarial loss (gain)	1,110	(294)
Prior service cost	—	118
Amortization of net actuarial loss	(209)	(386)
Amortization of prior service cost	(14)	(11)
Total recognized in net worth	887	(573)
Total recognized in net periodic benefit cost and net worth	$ 2,151	$ 989

During 2017, $300 million and $10 million in estimated net actuarial loss and prior service cost, respectively, will be amortized from net worth into net pension expense.

Actuarial assumptions used were as follows:

	2016	2015
Weighted average discount rate at January 1 for calculating pension expense	4.70%	4.25%
Weighted average discount rate for calculating December 31 PBO	4.45%	4.70%
Weighted average salary scale for calculating pension expense	4.20%	4.20%
Weighted average salary scale for calculating December 31 PBO	4.20%	4.20%
Expected long-term rate of return on plan assets for calculating pension expense	7.25%	7.25%

During 2017, management expects to contribute approximately $2.0 billion to the Plan.

The following benefit payments, which reflect expected future service, are expected to be paid (in millions):

2017	$	727
2018		804
2019		889
2020		974
2021		1,062
2022 - 2026		6,316

Explanation of Investment Strategies and Policies

A total return investment approach is employed for the Plan whereby the Plan invests in a mix of equity, fixed-income, and alternative asset classes to maximize the long-term return of plan assets for a prudent level of risk. The intent of this strategy is to minimize plan expenses by outperforming plan liabilities over the long run. Risk tolerance is established through consideration of plan liabilities, plan funded status, and corporate financial condition. The investment portfolio will consist over time of a varying but diversified blend of equity, fixed-income, and alternative investments. Diversification includes such factors as geographic location, equity capitalization size and style, placement in the capital structure, and security type. Investment risk is measured and monitored on an ongoing basis through annual liability measurements, periodic asset/liability studies, and quarterly investment portfolio reviews. The Plan's investment policy has restrictions relating to credit quality, industry/sector concentration, duration, concentration of ownership, and use of derivatives.

Capital Market Assumption Methodology

To determine the long-term rate of return assumption for plan assets, management incorporates historical relationships among the various asset classes and subclasses to be accessed over the investment horizon. Management's intent is to maximize portfolio efficiency. This will be accomplished by seeking the highest returns prudently available among the available asset classes. Overall portfolio volatility is managed through diversification among asset classes. Current market factors such as inflation and interest rates are evaluated before long-term capital market assumptions are determined. From time to time, management reviews its long-term investment strategy and reconciles that strategy with the long-term liabilities of the Plan. This asset-liability study produces a range of expected returns over medium and long-term time periods. Those intermediate and long-term investment projections form the basis for the expected long-term rate of return on assets.

At December 31, 2016, the estimated fair value of total pension trust assets - net by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Significant unobservable inputs level 3	Total
Assets:				
Cash and cash equivalents	$ 117	$ 1,018	$ —	$ 1,135
Broker receivables	—	355	—	355
Securities lending collateral	—	979	—	979
U.S. equity securities	5,212	510	—	5,722
Foreign equity securities	4,679	1,834	—	6,513
Global equity funds	—	253	—	253
Debt securities issued by the U.S. government	—	1,036	—	1,036
Debt securities issued by U.S. government agencies and corporations	—	56	—	56
Debt securities issued by U.S. states and political subdivisions of states	—	201	—	201
Foreign government debt securities	—	492	—	492
U.S. corporate debt securities	—	4,256	—	4,256
Non-U.S. corporate debt securities	—	1,037	—	1,037
U.S. agency mortgage-backed securities	—	189	—	189
Non-U.S. agency mortgage-backed securities	—	44	—	44
Other	—	666	—	666
Alternative investments:				
Absolute return	—	496	1,174	1,670
Private equity	—	—	3,241	3,241
Risk parity	—	—	752	752
Total assets	10,008	13,422	5,167	28,597
Liabilities:				
Broker payables	—	508	—	508
Securities lending payable	—	979	—	979
Other liabilities	19	631	—	650
Total liabilities	19	2,118	—	2,137
Fair value of pension trust assets - net	$ 9,989	$ 11,304	$ 5,167	$ 26,460

At December 31, 2016, Health Plans' and Hospitals' share of pension trust assets was 44.5%, or $11.8 billion. The remaining share of pension trust assets is for Medical Groups and a related party associated with Medical Groups.

At December 31, 2015, the estimated fair value of total pension trust assets - net by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Significant unobservable inputs level 3	Total
Assets:				
Cash and cash equivalents	$ 110	$ 1,082	$ —	$ 1,192
Broker receivables	—	156	—	156
Securities lending collateral	—	1,332	—	1,332
U.S. equity securities	4,219	365	—	4,584
Foreign equity securities	4,125	1,616	—	5,741
Global equity funds	—	187	—	187
Debt securities issued by the U.S. government	—	841	—	841
Debt securities issued by U.S. government agencies and corporations	—	70	—	70
Debt securities issued by U.S. states and political subdivisions of states	—	199	—	199
Foreign government debt securities	—	486	—	486
U.S. corporate debt securities	—	3,722	—	3,722
Non-U.S. corporate debt securities	—	957	—	957
U.S. agency mortgage-backed securities	—	159	—	159
Non-U.S. agency mortgage-backed securities	—	40	—	40
Other	1	569	—	570
Alternative investments:				
Absolute return	—	900	1,249	2,149
Private equity	—	—	2,339	2,339
Risk parity	—	—	597	597
Total assets	8,455	12,681	4,185	25,321
Liabilities:				
Broker payables	—	282	—	282
Securities lending payable	—	1,332	—	1,332
Other liabilities	12	117	—	129
Total liabilities	12	1,731	—	1,743
Fair value of pension trust assets - net	$ 8,443	$ 10,950	$ 4,185	$ 23,578

At December 31, 2015, Health Plans' and Hospitals' share of pension trust assets was 43.0%, or $10.1 billion. The remaining share of pension trust assets is for Medical Groups and a related party associated with Medical Groups.

For the years ended December 31, reconciliations of alternative investments with fair value measurements using significant unobservable inputs (level 3) were as follows (in millions):

	2016	2015
Beginning balance	$ 4,185	$ 3,103
Transfers into level 3	—	—
Changes related to actual return on plan assets	195	22
Purchases, sales, and settlements - net	787	1,060
Ending balance	$ 5,167	$ 4,185
Total year-to-date net gains related to assets held at end of period	$ 196	$ 21

During the years ended December 31, 2016 and 2015, there were no significant transfers of assets with inputs with quoted prices in active markets for identical assets (level 1) and assets with inputs with significant other observable inputs (level 2).

The target asset allocation and expected long-term rate of return on assets (ELTRA) for calculating pension expense were as follows:

	2016 and 2015 target range	2016 and 2015 ELTRA
Cash and cash equivalents	0%-3%	3.00%
Equity securities	43%-55%	8.65%
Debt securities	28%-45%	5.50%
Alternative investments	10%-25%	7.60%
Total	100%	7.25%

Alternative investments, which include absolute return, risk parity, and private equity, held in the pension trust are reported at net asset value as a practical expedient for fair value. Absolute return investments use advanced investment strategies, including derivatives, to generate positive long-term risk adjusted returns. Private equity investments consist of funds that make direct investments in private companies. Risk parity funds use risk as the primary factor to allocate investments among asset classes. At December 31, 2016, the trust had original commitments related to alternative investments of $6.7 billion, of which $3.4 billion was invested, leaving $3.3 billion of remaining commitments. At December 31, 2015, the trust had original commitments related to alternative investments of $5.4 billion, of which $2.4 billion was invested, leaving $3.0 billion of remaining commitments.

Absolute return, risk parity, and private equity investments include redemption restrictions. Absolute return and risk parity investments require 10 to 90 day written notice of intent to withdraw and are

often subject to the approval and capital requirements of the fund manager. At December 31, 2016, absolute return and risk parity investments of $809 million are subject to lock-up periods of up to 3 years. Private equity agreements do not include provisions for redemption. Distributions will be received as the underlying investments of the funds are liquidated, which is expected over the next 11 years.

The majority of debt and equity securities can be redeemed within 10 days. Debt and equity investment funds of $1.5 billion are redeemable between 10 and 30 days. Equity investment funds of $166 million have a redemption period of up to 120 days. No debt or equity investments require a redemption period of greater than 120 days.

(b) Defined Contribution Plans

Health Plans and Hospitals have defined contribution plans for eligible employees. Employer contributions and costs are typically based on a percentage of covered employees' eligible compensation. During 2016 and 2015, there were no required employee contributions. For the years ended December 31, 2016 and 2015, plan expense, primarily employer contributions, was $257 million and $247 million, respectively.

(c) Multi-Employer Plans

Health Plans and Hospitals participate in a number of multi-employer defined benefit pension plans under the terms of collective bargaining agreements that cover some union-represented employees. Some risks of participating in these multi-employer plans that differ from single-employer plans include:

- Assets contributed to the multi-employer plan by one employer may be used to provide benefits to employees of other participating employers.
- If a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers.
- Employers that choose to stop participating in a multi-employer plan may be required to pay the plan an amount based on the underfunded status of the plan, referred to as a withdrawal liability.

Health Plans' and Hospitals' participation in these plans for the year ended December 31, 2016 is outlined in the table below. The "EIN/PN" column provides the Employee Identification Number (EIN) and the three-digit plan number (PN), if applicable. Unless otherwise noted, the most recent Pension Protection Act (PPA) zone status available in 2016 and 2015 is for the plan's year-end in 2015 and 2014, respectively. The zone status is based on information that Health Plans and Hospitals obtained from publicly available information provided by the United States Department of Labor. Among other factors, plans in the red zone are generally less than 65% funded, plans in the yellow zone are between 65% and 80% funded, and plans in the green zone are at least 80% funded. The

"FIP/RP Status Pending/Implemented" column indicates plans for which a financial improvement plan (FIP) or a rehabilitation plan (RP) is either pending or has been implemented. The "Health Plans' and Hospitals' Contributions to Plan Exceeded More Than 5% of Total Contributions" columns represent those plans where Health Plans and Hospitals were listed in the plans' Forms 5500 as providing more than 5% of the total contributions for the plan years listed. The last column lists the expiration dates of the collective bargaining agreements to which the plans are subject. There have been no significant changes that affect the comparability of 2016 and 2015 employer expense.

Pension Fund	EIN-PN	Pension Protection Act Zone Status 2016	Pension Protection Act Zone Status 2015	FIP/RP Status Pending / Implemented	(in millions) Health Plans' and Hospitals' Contributions December 31, 2016	(in millions) Health Plans' and Hospitals' Contributions December 31, 2015	Surcharge Imposed	Health Plans' and Hospitals' Contributions to Plan Exceeded More Than 5% of Total Contributions [1] 2015	Health Plans' and Hospitals' Contributions to Plan Exceeded More Than 5% of Total Contributions [1] 2014	Expiration Date of Collective Bargaining Agreement
IUOE Stationary Engineers Local 39 Pension Fund	946118939 -001	Green	Green	N/A	$ 11	$ 10	No	Yes	Yes	9/17/2018
Southern California United Food and Commercial Workers Unions and Drug Employers Pension Fund	516029925 -001	Red	Red	Implemented	5	5	No	Yes	Yes	2/1/2020
Oregon Retail Employees Pension Trust[2]	936074377 -001	Red	Red	Implemented	4	4	No	Yes	Yes	9/30/2018-10/31/2018
Carpenters Pension Trust Fund for Northern California	946050970 -001	Red	Red	Implemented	7	6	No	No	No	6/30/2019
Other	Various	Green	Green		14	13		No	No	9/30/2017-12/31/2020
Other	Various	Yellow	Yellow		4	3		No	No	6/30/2017-6/30/2019
Total Expense					$ 45	$ 41				

(1) Forms 5500 information was available for all plan years ended in 2015. The majority of plans have a plan year end of December 31.

(2) Includes UFCW Local 555 Pharmacy Techs and Radiologists expiring September 30, 2018 and October 31, 2018, respectively.

(14) Postretirement Benefits Other than Pensions

(a) Defined Benefit Plan

Certain employees may become eligible for postretirement health care and life insurance benefits while working for Health Plans and Hospitals. Benefits available to retirees, through both affiliated and unaffiliated provider networks, vary by employee group. Postretirement health care benefits available to retirees include subsidized Medicare premiums, medical and prescription drug benefits, dental benefits, and vision benefits.

In January 2015, Health Plans and Hospitals modified postretirement health care benefits for certain union represented employees. Under the terms of the agreement, cost sharing will increase for plan participants and future employer-paid monthly premiums will be fixed. The impact of the agreement resulted in a negative plan amendment and a reduction in liabilities of $477 million.

At December 31, the accrued liability for postretirement benefits was as follows (in millions):

	2016	2015
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 5,503	$ 7,193
Service cost	156	192
Interest cost	235	256
Plan amendments	7	(756)
Benefits paid or provided	(133)	(136)
Net actuarial gain	(332)	(1,246)
Benefit obligation at end of year	$ 5,436	$ 5,503
Change in plan assets:		
Fair value of plan assets at beginning of year	$ 1,365	$ 400
Actual return on plan assets	130	(35)
Contributions	1,733	1,136
Benefits paid or provided	(133)	(136)
Fair value of plan assets at end of year	$ 3,095	$ 1,365
Funded status	$ (2,341)	$ (4,138)
Amounts recognized in the balance sheet consist of:		
Noncurrent assets	$ —	$ —
Current liabilities	—	—
Pension and other retirement liabilities	(2,341)	(4,138)
	$ (2,341)	$ (4,138)
Amounts recognized in net worth:		
Net actuarial loss	$ 2,201	$ 2,671
Prior service credit	(2,286)	(2,724)
	$ (85)	$ (53)

The measurement date used to determine postretirement benefits valuations was December 31.

For the years ended December 31, postretirement benefits expense was as follows (in millions):

	2016	2015
Service cost	$ 156	$ 192
Interest cost	235	256
Expected return on plan assets	(100)	(28)
Amortization of net actuarial loss	108	224
Amortization of prior service credit	(431)	(439)
Postretirement benefits expense	(32)	205
Other changes in plan assets and benefit obligations recognized in net worth:		
Net actuarial gain	(362)	(1,183)
Prior service cost (credit)	7	(756)
Amortization of net actuarial loss	(108)	(224)
Amortization of prior service credit	431	439
Total recognized in net worth	(32)	(1,724)
Total recognized in net periodic benefit cost and net worth	$ (64)	$ (1,519)

During 2017, $104 million and $(429) million in estimated net actuarial loss and prior service credit, respectively, will be amortized from net worth into postretirement benefits expense.

During 2016, the employer contributions and benefits paid or provided were $1,733 million and $133 million, respectively. During 2015, the employer contributions and benefits paid or provided were $1,136 million and $136 million, respectively. During 2016 and 2015, there were no participant contributions from active employees.

Actuarial assumptions used were as follows:

	2016	2015
Weighted average discount rate used for calculating non-union plan postretirement benefits expense from January 1 to December 31	4.75%	4.35%
Weighted average discount rate for calculating union plan postretirement benefits expense from January 1 to January 24	4.75%	4.35%
Weighted average discount rate for calculating union plan postretirement benefits expense from January 25 to December 31	4.75%	3.90%
Weighted average discount rate for calculating December 31 accumulated postretirement benefit obligation	4.45%	4.75%
Expected long-term rate of return on plan assets for calculating benefits expense	7.00%	7.00%

The following were the assumed health care cost trend rates used to determine the December 31, 2016 and 2015 benefit obligation and postretirement benefits expense for the years ended December 31, 2016 and 2015:

	Basic medical Pre-65/Post-65	Prescription drug Pre-65/Post-65	Medicare Part D	Dental	Medicare Part A&B	Medicare Part C	Supplemental medical Pre-65/Post-65
Initial trend rate - 2015	5.50% / 5.25%	8.00% / 8.00%	4.00%	4.50%	5.25%	2.00%	5.50% / 5.25%
Initial trend rate - 2016	5.50% / 5.25%	7.00% / 7.00%	4.00%	4.50%	5.25%	3.25%	5.50% / 5.25%
Ultimate trend rate	4.50% / 4.50%	4.50% / 4.50%	4.50%	4.50%	4.50%	4.50%	4.50% / 4.50%
First year at ultimate trend rate	2026 / 2022	2025 / 2025	2026	2015	2022	2018	2026 / 2022

A 1% increase in the health care medical trend rate would increase the benefit obligation by $701 million and the service cost plus interest by $52 million. A decrease of 1% in the health care medical trend rate would decrease the benefit obligation by $574 million and the service cost plus interest by $41 million.

The following benefit payments, which reflect expected future service, are expected to be paid or provided (in millions):

2017	$ 155
2018	166
2019	182
2020	200
2021	220
2022 - 2026	1,420

Explanation of Investment Strategies and Policies

A total return investment approach is employed for the retirement benefit trust whereby the assets are invested in various asset classes to maximize the long-term return of plan assets for a prudent level of risk. The intent of this strategy is to minimize plan expenses by outperforming plan liabilities over the long run. Risk tolerance is established through consideration of plan liabilities, plan funded status, and corporate financial condition. The investment portfolio will consist over time of a varying but diversified blend of equity, fixed-income, and alternative investments. Diversification includes such factors as geographic location, equity capitalization size and style, placement in the capital structure, and security type. Investment risk is measured and monitored on an ongoing basis through annual liability measurements, periodic asset/liability studies, and quarterly investment portfolio reviews. The retirement benefit trust investment policy has restrictions relating to credit quality, industry/sector concentration, duration, concentration of ownership, and use of derivatives.

Capital Market Assumption Methodology

To determine the long-term rate of return assumption for plan assets, management incorporates historical relationships among the various asset classes and subclasses to be accessed over the investment horizon. Management's intent is to maximize portfolio efficiency. This will be accomplished by seeking the highest returns prudently available among the available asset classes. Overall portfolio volatility is managed through diversification among asset classes. Current market factors such as inflation and interest rates are evaluated before long-term capital market assumptions are determined. From time to time, management reviews its long-term investment strategy and reconciles that strategy with the long-term liabilities of the Plan. This asset-liability study produces a range of expected returns over medium and long-term time periods. Those intermediate and long-term investment projections form the basis for the expected long-term rate of return on assets.

At December 31, 2016, the estimated fair value of retirement benefit trust assets by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Significant unobservable inputs level 3	Total
Assets:				
Cash and cash equivalents	$ —	$ 201	$ —	$ 201
Alternative investments:				
Absolute return	—	949	206	1,155
Risk parity	—	851	886	1,737
Other	—	2	—	2
Total assets	$ —	$ 2,003	$ 1,092	$ 3,095

At December 31, 2015, the estimated fair value of retirement benefit trust assets by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Significant unobservable inputs level 3	Total
Assets:				
Cash and cash equivalents	$ —	$ 650	$ —	$ 650
Alternative investments:				
Risk parity	—	375	340	715
Total assets	$ —	$ 1,025	$ 340	$ 1,365

At December 31, reconciliations of alternative investments with fair value measurements using significant unobservable inputs (level 3) were as follows (in millions):

	2016	2015
Beginning balance	$ 340	$ —
Transfers into level 3	—	—
Changes related to actual return on plan assets	56	(10)
Purchases, sales, and settlements - net	696	350
Ending balance	$ 1,092	$ 340
Total year-to-date net gains (losses) related to assets held at end of period	$ 56	$ (10)

The target asset allocation and expected long-term rate of return on assets (ELTRA) for calculating postretirement benefits expense were as follows:

	2016 and 2015 target range	2016 and 2015 ELTRA
Alternative investments	100%	7.00%
Total	100%	7.00%

Absolute return and risk parity investments include redemption restrictions. Absolute return and risk parity investments require 10 to 90 day written notice of intent to withdraw and are often subject to the approval and capital requirements of the fund manager. At December 31, 2016, absolute return and risk parity investments of $429 million are subject to lock-up periods of up to 3 years.

(b) Multi-Employer Plans

Health Plans and Hospitals participate in multi-employer union-administered retiree medical health and welfare plans that provide benefits to some union employees. Benefits for retirees under these plans are negotiated as part of the collective bargaining process. For the years ended December 31, 2016 and 2015, Health Plans' and Hospitals' employer expense for both current and retiree benefits was $81 million and $77 million, respectively.

(15) Physicians' Retirement Plan

Kaiser Foundation Health Plan, Inc. provides defined retirement benefits for physicians associated with certain Medical Groups. Benefits are determined based on the length of service and level of compensation of each participant. The plan is unfunded and is not subject to the Employee Retirement Income Security Act.

At December 31, the accrued liability for physicians' retirement plan was as follows (in millions):

	2016	2015
Change in projected benefit obligation:		
Physicians' retirement plan liability at January 1	$ 5,901	$ 6,078
Service cost	317	327
Interest cost	283	258
Net actuarial loss (gain)	414	(608)
Benefits paid	(164)	(154)
Physicians' retirement plan liability at December 31	$ 6,751	$ 5,901
Accumulated benefit obligation at end of year	$ 5,306	$ 4,624
Change in plan assets:		
Fair value of plan assets at the beginning of year	$ —	$ —
Company contributions	164	154
Benefits paid	(164)	(154)
Fair value of plan assets at end of year	$ —	$ —
Funded status	$ (6,751)	$ (5,901)
Amounts recognized in the balance sheet consist of:		
Noncurrent assets	$ —	$ —
Current liabilities	(185)	(171)
Noncurrent liability	(6,566)	(5,730)
	$ (6,751)	$ (5,901)
Amounts recognized in net worth:		
Net actuarial loss	$ 1,733	$ 1,373

The measurement date used to determine physicians' retirement valuation was December 31.

A portion of the investments of Health Plans has been designated by management for the liabilities of the physicians' retirement plan. These investments are not held in trust or otherwise legally segregated and are not restricted even though it has been intended that these assets be used to pay the obligations of the physicians' retirement plan.

For purposes of the physicians' retirement plan expense, the expected return on assets is the portion of investment income that represents the expected return on the investments designated for the physicians' retirement plan. This amount is recorded as a reduction in the expense for the physicians' retirement plan and is excluded from investment income - net, as described below and in the *Summary of Significant Accounting Policies - Investments* note.

For the years ended December 31, physicians' retirement plan provision was as follows (in millions):

	2016	2015
Service cost	$ 317	$ 327
Interest cost	283	258
Amortization of net actuarial loss	54	92
Total benefit expense	654	677
Expected return on assets - investment income included in operating expenses	(427)	(435)
Net benefit expense	227	242
Other changes in projected benefit obligations recognized in net worth		
Net actuarial loss (gain)	414	(608)
Amortization of net actuarial loss	(54)	(92)
Total recognized in net worth	360	(700)
Total recognized in net periodic benefit cost and net worth	$ 587	$ (458)

During 2017, $70 million in estimated net actuarial loss will be amortized from net worth into net benefit expense.

Actuarial assumptions used were as follows:

	2016	2015
Weighted average discount rate at January 1 for calculating benefit expense	4.80%	4.30%
Weighted average discount rate for calculating December 31 PBO	4.55%	4.80%
Weighted average salary scale for calculating pension expense	4.40%	4.40%
Weighted average salary scale for calculating December 31 PBO	4.40%	4.40%
Expected long-term rate of return on designated investments for calculating benefit expense	7.25%	7.25%

The following benefit payments, which reflect expected future service, are expected to be paid (in millions):

2017	$	185
2018		203
2019		223
2020		243
2021		265
2022 - 2026		1,618

(16) Commitments and Contingencies

(a) Lease and Purchase Commitments

Health Plans and Hospitals lease primarily office space, medical facilities, and equipment under various leases that expire through 2048. Certain leases contain rent escalation clauses and renewal options for additional periods.

At December 31, 2016, minimum commitments under noncancelable leases extending beyond one year were as follows (in millions):

2017	$	316
2018		293
2019		224
2020		192
2021		157
Thereafter		406
Total	$	1,588

Minimum payments above have not been reduced by minimum sublease rentals of $2 million due in the future under noncancelable subleases.

For the years ended December 31, 2016 and 2015, total lease expense for all leases was $464 million and $459 million, respectively.

Health Plans and Hospitals have entered into long-term agreements that require certain minimum purchases of goods and services. These commitments are at levels that are consistent with normal business requirements. Health Plans has committed to directing most of its purchasing volume for selected products through an outside agency and has committed to at least $1 billion in purchasing per annum through March 31, 2017. During 2016 and 2015, Health Plans' total purchases through this outside agency exceeded $1 billion. Should the $1 billion level not be achieved, financial penalties would be assessed at an established percentage of any shortfalls. In management's judgment, there is a remote probability of material financial penalties under this contract.

At December 31, 2016, minimum purchase commitments, excluding contracts that count towards the $1 billion per annum commitment noted above, extending beyond one year were as follows (in millions):

2017	$	361
2018		236
2019		176
2020		65
2021		8
Thereafter		16
Total	$	862

During 2016 and 2015, Health Plans' and Hospitals' total purchases under contracts with minimum purchase commitments, excluding those purchases which count towards the $1 billion per annum commitment noted above, were $552 million and $542 million, respectively.

(b) Renewable Energy Contracts

Hospitals has entered into 20 year renewable energy contracts to reduce the financial risk of unexpected increases in utility prices and help achieve its renewable energy goals. Under the renewable energy contracts, Hospitals will net settle with the counterparty based on 100% of the output of two renewable energy sites and also realize renewable energy credits from the production of energy from wind and solar sites. The wind site started its production in December 2015 and the solar site began its production in May 2016. To the extent that the price of electrical energy varies from the fixed amounts in the contracts, Hospitals will pay more or less than the current value of electrical energy over the term of the contracts. Management cannot reasonably estimate the future financial impact of these contracts as they are subject to market fluctuations in energy prices and to the actual production volume of the sites. In addition, Health Plans and Hospitals have entered into multiple on-site renewable energy contracts ranging between 10 and 20 years that are recorded as either contingent operating leases or purchase agreements.

(c) Surety Instruments and Standby Letters of Credit

In the normal course of business, Health Plans and Hospitals contract to perform certain financial obligations that require a guarantee from a third party. This guarantee creates a contingent liability to the entity that provides that guarantee. At December 31, 2016 and 2015, Health Plans and Hospitals had entered into surety instruments and standby letters of credit that totaled $87 million and $81 million, respectively.

Health Plan, Inc. and Hospitals also guarantee payment of workers' compensation liabilities of certain Medical Groups under self-insurance programs. The majority of such liabilities are recorded as other long-term liabilities of Health Plan, Inc., as payment is provided for under the applicable medical service agreements. In addition to amounts accrued, at December 31, 2016 and 2015, pursuant to such

guarantees, Health Plan, Inc. and Hospitals are contingently liable for approximately $180 million and $200 million, respectively, of certain Medical Groups' self-insured workers' compensation liabilities.

(d) Regulatory

Health Plans is required to periodically file financial statements with regulatory agencies in accordance with statutory accounting and reporting practices. Health Plans must comply with the various states' minimum regulatory net worth requirements generally under the regulation of the California Department of Managed Health Care and various state departments of insurance. Such requirements are generally based on tangible net equity or risk-based capital, and for California are calculated on the basis of combined net worth of Health Plans and Hospitals. At December 31, 2016 and 2015, the regulatory net worth, so defined, exceeded the aggregate regulatory minimum requirements by approximately $25 billion and $23 billion, respectively.

Health Plans' regulated subsidiaries maintain investments in various states where they are licensed. At December 31, 2016 and 2015, $6 million and $5 million, respectively, in securities were held to satisfy various state regulatory requirements.

Health Plans and Hospitals are subject to numerous and complex laws and regulations of federal, state, and local governments, and accreditation requirements. Compliance with such laws, regulations, and accreditation requirements can be subject to retrospective review and interpretation, as well as regulatory actions. These laws and regulations include, but are not necessarily limited to, requirements of tax exemption, government reimbursement, government program participation, privacy and security, false claims, anti-kickback, accreditation, healthcare reform, controlled substances, facilities, and professional licensure. In recent years, government activity has increased with respect to compliance and enforcement actions.

In the ordinary course of business operations, Health Plans and Hospitals are subject to periodic reviews, investigations, and audits by various federal, state, and local regulatory agencies and accreditation agencies, including, without limitation, CMS, Department of Managed Health Care, Office of Personnel Management, Occupational Safety and Health Administration, Drug Enforcement Administration, State Boards of Pharmacy, Food and Drug Administration, IRS, National Committee for Quality Assurance, and state departments of insurance.

Health Plans' and Hospitals' compliance with the wide variety of rules and regulations and accreditation requirements applicable to their business may result in certain remediation activities and regulatory fines and penalties, which could be substantial. Where appropriate, reserves have been established for such sanctions. While management believes these reserves are adequate, the outcome of legal and regulatory matters is inherently uncertain, and it is possible that one or more of the legal or regulatory matters currently pending or threatened could have a material adverse effect on the combined financial position or results of operations.

(e) Litigation

Health Plans and Hospitals are involved in lawsuits and various governmental investigations, audits, reviews, and administrative proceedings arising, for the most part, in the ordinary course of business operations. Lawsuits have been brought under a wide range of laws and include, but are not limited to, business disputes, employment and retaliation claims, claims alleging professional liability, improper disclosure of personal information, labor disputes, administrative regulations, the False Claims Act, information privacy and HIPAA laws, mental health parity laws, and consumer protection laws. In addition, Health Plans indemnifies the Medical Groups against various claims, including professional liability claims.

Health Plans and Hospitals record reserves for legal proceedings and regulatory matters where available information indicates that at the date of the combined financial statements a loss is probable and the amount can be reasonably estimated. While such reserves reflect management's best estimate of the probable loss for such matters, Health Plans' and Hospitals' recorded amounts may differ materially from the actual amount of any such losses.

In September 2015, a lawsuit was filed seeking to have the State of California impose the gross premiums tax on Health Plan, Inc. In the opinion of management, strong defenses exist regarding this claim. However, an unfavorable outcome could have a material adverse effect. No reserves have been provided related to this lawsuit.

Pursuant to a civil subpoena, Health Plans and Hospitals have provided documents and information to the Department of Justice and Department of Health and Human Services - Office of Inspector General relating to Medicare Part C risk adjustment practices, policies, and programs. This matter could result in a False Claims Act litigation, in which an unfavorable outcome could have a material adverse effect. No reserves have been provided related to this matter.

In the opinion of management, based upon current facts and circumstances, the resolution of these matters is not expected to have a material adverse effect on the combined financial position or combined results of operations of Health Plans and Hospitals. The outcome of litigation and other legal and regulatory matters is inherently uncertain, however, and it is possible that one or more of the legal or regulatory matters currently pending or threatened could have a material adverse effect.

KPMG LLP
Suite 1400
55 Second Street
San Francisco, CA 94105

Independent Auditors' Report on Credit Group Financial Information

The Boards of Directors
Kaiser Foundation Health Plan, Inc.
and Kaiser Foundation Hospitals:

We have audited the combined financial statements of Kaiser Foundation Health Plan, Inc. and Subsidiaries (Health Plans) and Kaiser Foundation Hospitals and Subsidiaries (Hospitals) as of and for the years ended December 31, 2016 and 2015, and have issued our report thereon dated February 14, 2017 which contained an unmodified opinion on those combined financial statements. Our audits were performed for the purpose of forming an opinion on the combined financial statements as a whole. The supplementary information included in pages 57-59 is presented for the purposes of additional analysis and is not a required part of the combined financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the combined financial statements. The information has been subjected to the auditing procedures applied in the audit of the combined financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the combined financial statements or to the combined financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the combined financial statements as a whole.

KPMG LLP

San Francisco, California
February 14, 2017

KAISER FOUNDATION HEALTH PLAN, INC.,
KAISER HEALTH PLAN ASSET MANAGEMENT, INC.,
KAISER FOUNDATION HOSPITALS AND
KAISER HOSPITALS ASSET MANAGEMENT, INC.
(CREDIT GROUP)[1]

Combined Balance Sheets

December 31, 2016 and 2015

(In millions)

Assets	2016	2015
Current assets:		
Cash and cash equivalents	$ 336	$ 79
Current investments	4,404	4,253
Securities lending collateral	631	1,068
Broker receivables	764	814
Accounts receivable - net	1,549	1,529
Due from affiliated organizations	1,160	1,085
Inventories and other current assets	1,128	1,172
Total current assets	9,972	10,000
Noncurrent investments	24,580	23,127
Land, buildings, equipment, and software - net	22,314	21,883
Investments in subsidiaries	1,856	1,741
Noncurrent portion of due from affiliated organizations	3,201	3,150
Other long-term assets	121	147
Total assets	$ 62,044	$ 60,048
Liabilities and Net Worth		
Current liabilities:		
Accounts payable and accrued expenses	$ 3,270	$ 2,556
Medical claims payable	1,675	1,554
Due to associated medical groups	791	718
Payroll and related charges	1,579	1,474
Securities lending payable	631	1,068
Broker payables	843	1,153
Long-term debt subject to short-term remarketing arrangements - net	785	732
Other current debt	1,904	775
Other current liabilities	1,743	1,683
Total current liabilities	13,221	11,713
Noncurrent portion of due to affiliated organizations	1,329	1,328
Long-term debt	4,754	6,060
Physicians' retirement plan liability	6,566	5,730
Pension and other retirement liabilities	7,743	8,874
Other long-term liabilities	2,049	2,103
Total liabilities	35,662	35,808
Net worth	26,382	24,240
Total liabilities and net worth	$ 62,044	$ 60,048

[1] Entities which are obligated to make payments under various debt and guarantee agreements.

Certain reclassifications have been made in the 2015 statement to conform to the 2016 presentation.

See accompanying independent auditors' report on credit group financial information.

KAISER FOUNDATION HEALTH PLAN, INC.,
KAISER HEALTH PLAN ASSET MANAGEMENT, INC.,
KAISER FOUNDATION HOSPITALS AND
KAISER HOSPITALS ASSET MANAGEMENT, INC.
(CREDIT GROUP)[1]

Combined Statements of Operations and Changes in Net Worth

Years ended December 31, 2016 and 2015

(In millions)

	2016	2015
Revenues:		
Members' dues	$ 33,844	$ 32,238
Contract revenue from Health Plans	2,252	2,101
Medicare	12,889	12,084
Copays, deductibles, fees, and other	5,395	4,884
Total operating revenues	54,380	51,307
Expenses:		
Medical services	23,987	21,729
Hospital services	16,702	16,393
Outpatient pharmacy and optical services	5,524	5,287
Other benefit costs	3,289	3,113
Total medical and hospital services	49,502	46,522
Health Plan administration	2,992	2,924
Total operating expenses	52,494	49,446
Income before equity in net income of subsidiaries	1,886	1,861
Equity in net income (loss) of subsidiaries	130	(27)
Operating income	2,016	1,834
Other income and expense:		
Investment income - net	1,300	245
Interest expense	(211)	(227)
Total other income and expense	1,089	18
Net income	3,105	1,852
Change in pension and other retirement liability charges	(1,215)	2,997
Change in net unrealized gains on investments	299	(793)
Change in due from affiliated organizations	(36)	(53)
Change in restricted donations	(1)	(2)
Change in noncontrolling interest	(10)	—
Change in net worth	2,142	4,001
Net worth at beginning of year	24,240	20,239
Net worth at end of year	$ 26,382	$ 24,240

[1] Entities which are obligated to make payments under various debt and guarantee agreements.

See accompanying independent auditors' report on credit group financial information.

KAISER FOUNDATION HEALTH PLAN, INC.,
KAISER HEALTH PLAN ASSET MANAGEMENT, INC.,
KAISER FOUNDATION HOSPITALS AND
KAISER HOSPITALS ASSET MANAGEMENT, INC.
(CREDIT GROUP)[1]

Combined Statements of Cash Flows

Years ended December 31, 2016 and 2015

(In millions)

	2016	2015
Cash flows from operating activities:		
Net income	$ 3,105	$ 1,852
Adjustments to reconcile net income to net cash provided from operating activities:		
Depreciation and software amortization	2,111	1,976
Other amortization	(78)	(8)
Loss (gain) recognized on investments - net	(761)	143
Loss on land, buildings, equipment, and software - net	29	58
Changes in assets and liabilities:		
Accounts receivable - net	(20)	(92)
Investments in subsidiaries	(115)	(321)
Due from affiliated organizations	(89)	(86)
Other assets	47	(167)
Accounts payable and accrued expenses	667	(43)
Medical claims payable	121	340
Due to associated medical groups	(14)	(216)
Payroll and related charges	105	(138)
Pension and other retirement liabilities	(1,987)	(615)
Other liabilities	(47)	329
Net cash provided from operating activities	3,074	3,012
Cash flows from investing activities:		
Additions to land, buildings, equipment, and software	(2,481)	(2,449)
Proceeds from sales of land, buildings, and equipment	5	1
Proceeds from investments	32,230	37,311
Investment purchases	(32,712)	(36,308)
Decrease in securities lending collateral	437	460
Broker receivables / payables	(260)	17
Other investing	24	28
Physicians' retirement plan liability	491	524
Increase in long-term affiliated receivable	(66)	(2,143)
Net cash used in investing activities	(2,332)	(2,559)
Cash flows from financing activities:		
Issuance of debt	3,261	1,454
Prepayment and repayment of debt	(3,298)	(1,472)
Decrease in securities lending payable	(437)	(460)
Change in restricted donations	(1)	(2)
Change in noncontrolling interest	(10)	—
Net cash used in financing activities	(485)	(480)
Net change in cash and cash equivalents	257	(27)
Cash and cash equivalents at beginning of year	79	106
Cash and cash equivalents at end of year	$ 336	$ 79
Supplemental cash flows disclosure:		
Cash paid for interest - net of capitalized amounts	$ 210	$ 209
Noncash changes in accounts payable related to purchases of fixed assets	$ 47	$ —
Noncash change in due from Health Plans	$ (36)	$ (53)

[1] Entities which are obligated to make payments under various debt and guarantee agreements.

See accompanying independent auditors' report on credit group financial information.

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APPENDIX B

SUMMARY OF PRINCIPAL DOCUMENTS

Following are summaries of certain provisions of the Indenture and the Guarantee Agreement relating to the Bonds not described elsewhere in this Offering Memorandum. These summaries are not complete recitals of the terms of those documents and reference should be made to the Indenture and Guarantee Agreement for their complete terms. Words and terms used in the following summaries and not defined herein have the same meanings as in the Indenture and Guarantee Agreement.

DEFINITIONS

"Accountant" means any independent certified public accountant or firm of such accountants selected by the Corporation.

"Additional Bonds" means bonds issued under the Indenture subsequent to the initial issuance of the Kaiser Permanente Taxable Bonds, Series 2017 that are consolidated with such bonds.

"Affiliated Corporations" means the Corporation, the Guarantors and each Subsidiary of either the Corporation or a Guarantor.

"Attributable Debt" means, as to any lease required to be capitalized under generally accepted accounting principles as in effect as of the date of the Indenture, the liability with respect to such lease on the lessee's balance sheet for the most recent Fiscal Year for which audited financial statements are available.

"Bond Fund" means the fund by that name established pursuant to the Indenture.

"Bonds" means the Kaiser Permanente Taxable Bonds, Series 2017 authorized by, and at any time Outstanding pursuant to, the Indenture, including any Additional Bonds.

"Business Day" means any day on which banks located in the State of California or New York, New York and the city in which the Corporate Trust Office of the Trustee is located are not required or authorized to be closed and on which The New York Stock Exchange is open.

"Consolidated Net Tangible Assets" means as of any particular time the aggregate amount of assets of the Affiliated Corporations after deducting therefrom (a) all current liabilities (excluding any such liability that by its terms is extendable or renewable at the option of the debtor thereon to a time more than twelve (12) months after the time as of which the amount thereof is being computed) and (b) all goodwill, patents, copyrights, trademarks, trade names, unamortized debt discount and expense and other like intangibles, all as shown in the most recent combined financial statements of the Affiliated Corporations prepared in accordance with generally accepted accounting principles.

"Corporation" means Kaiser Foundation Hospitals, a California nonprofit public benefit corporation, or any corporation which is the surviving, resulting or transferee corporation in any merger, consolidation or transfer of substantially all the assets of the Corporation permitted under the Indenture.

"Default" means any event which is or after notice or lapse of time or both would become an Event of Default.

"Fiscal Year" means the period beginning on January 1 of each year and ending on the next succeeding December 31, or any other twelve-month or fifty-two week period selected and designated as the official fiscal year period of the Corporation.

"Fitch" means Fitch, Inc., dba Fitch Ratings, a corporation organized and existing under the laws of the State of Delaware, its successors and their assigns, or, if such corporation shall be dissolved or liquidated or shall no

longer perform the functions of a securities rating organization, any other nationally recognized securities rating organization designated by the Corporation by notice to the Trustee.

"Government Obligations" means:

(a) direct obligations of, or obligations the payment of principal and interest on which is unconditionally guaranteed by, the United States of America;

(b) certificates, trust receipts, or similar instruments evidencing ownership of principal payments or interest payments due on bonds of the United States of America if held in the custody of a commercial bank or lead bank of a parent holding company whose obligations are rated in one of the two highest Rating Categories of S&P and Moody's;

(c) direct, general obligations of any state or territory of the United States of America, or of any political subdivision of any such state, to the payment of principal of and interest on which the full faith and credit of the issuer thereof is pledged; provided that such obligations are rated within one of the two highest Rating Categories of S&P and Moody's and with respect to obligations of a political subdivision, are payable from taxes levied on all the taxable property therein without limitation as to rate or amount;

(d) any other obligations of any such state, territory or political subdivision, provided that the payment of principal of and interest on such obligations has been insured through the issuance of any irrevocable municipal bond insurance policy and that such obligations are rated in one of the two highest Rating Categories of S&P and Moody's;

(e) any obligations of any such state, territory or political subdivision the payment of principal of and interest on which is secured by an escrow fund constituted of obligations described in clauses (a), (b), (c), or (d) of this definition; and

(f) obligations of any agency, department, or instrumentality of the United States, or obligations guaranteed directly or indirectly by any such agency, department, or instrumentality, provided that such obligations are rated in one of the two highest Rating Categories by S&P and Moody's.

"Guarantee Agreement" means that certain guarantee agreement relating to the Bonds among the Trustee and the Guarantors, as originally executed and as it may be supplemented, modified or amended in accordance with the terms thereof and of the Indenture.

"Guarantors" means Kaiser Foundation Health Plan, Inc., Kaiser Hospital Asset Management, Inc. and Kaiser Health Plan Asset Management, Inc., each a California nonprofit public benefit corporation, or any corporation which is the surviving, resulting or transferee corporation in any merger, consolidation or transfer of substantially all of the assets of any Guarantor permitted under the Guarantee Agreement.

"Holder" or "Bondholder," whenever used with respect to a Bond, means the Person in whose name such Bond is registered.

"Indebtedness" means, with respect to any Person, all indebtedness for borrowed money (including any installment purchase obligation and Attributable Debt) of such Person (other than indebtedness of one Affiliated Corporation to another Affiliated Corporation) which in accordance with generally accepted accounting principles is classified as a liability on a balance sheet, and twenty percent (20%) of the aggregate principal amount of all indebtedness for borrowed money for which such Person is a guarantor except for any guarantee by any Affiliated Corporation of indebtedness of any other Affiliated Corporation. In determining the amount of Indebtedness outstanding as of any date of calculation, there shall be deducted from the aggregate principal amount of such Indebtedness an amount equal to the amount then on deposit in any trustee-held reserve account or trustee-held escrow fund and available for the payment of the principal of such Indebtedness.

"Indenture" means that certain Indenture relating to the Bonds, between the Corporation and the Trustee, as originally executed or as it may be supplemented, modified or amended by any Supplemental Indenture.

"Indenture Fund" means the fund by that name established pursuant to the Indenture.

"Investment Agreement" means an agreement or contract providing for the deposit or loan of funds pursuant to which the principal thereof is payable upon demand by the Trustee for application when and as required or permitted under the Indenture, with a financial institution (including an insurance company) whose unsecured obligations at the time of investment are rated in one of the three highest Rating Categories by a Rating Agency or Moody's.

"Investment Securities" means any of the following: (1) Government Obligations; (2) repurchase agreements with banks (including the Trustee or any of its affiliates), lead banks of parent holding companies, or security dealers provided that (a) the underlying securities of such agreement are rated in one of the three highest Rating Categories by a Rating Agency, (b) the underlying securities are required to be continuously maintained at a market value (valued at least quarterly) not less than the amount of the repurchase price from time to time payable with respect thereto and (c) the underlying securities are held by the Trustee or a third party agent for the Trustee and not subject to claims of third parties; (3) interest-bearing demand or time deposits (including certificates of deposit) in banks (including the Trustee or any of its affiliates) rated in one of the three highest Rating Categories by a Rating Agency; (4) banker's acceptances or certificates of deposit of, or time deposits in, any bank (including the Trustee or any of its affiliates), lead bank of a parent holding company, or savings and loan association whose unsecured obligations are rated in one of the three highest Rating Categories by a Rating Agency; (5) Investment Agreements; (6) commercial paper which at the time of purchase is of "prime" quality of the two highest rankings or one of the two highest Rating Categories of a Rating Agency or Moody's and issued by corporations organized and operating within the United States; (7) notes or medium term notes rated within one of the three highest Rating Categories by a Rating Agency or Moody's; and (8) money market funds invested in Government Obligations, including such funds for which the Trustee, its affiliates or subsidiaries provide investment advisory or other management services.

"Moody's" means Moody's Investors Service, a corporation organized and existing under the laws of the State of Delaware, its successors and their assigns, or, if such corporation shall be dissolved or liquidated or shall no longer perform the functions of a securities rating organization, any other nationally recognized securities rating organization designated by the Corporation, by notice to the Trustee.

"Outstanding," when used as of any particular time with reference to Bonds, means (subject to the provisions of the Indenture relating to disqualified Bonds) all Bonds theretofore, or thereupon being, authenticated and delivered by the Trustee under the Indenture except (1) Bonds theretofore cancelled by the Trustee or surrendered to the Trustee for cancellation; (2) Bonds with respect to which all liability of the Corporation shall have been discharged in accordance with the Indenture, including Bonds (or portions of Bonds) referred to in the section of the Indenture relating to money held for particular Bonds; and (3) Bonds for the transfer or exchange of or in lieu of or in substitution for which other Bonds shall have been authenticated and delivered by the Trustee pursuant to the Indenture.

"Payment Date" means an Interest Payment Date or a Principal Payment Date.

"Permitted Encumbrances," with respect to the property of any Affiliated Corporation, means and includes:

(1) undetermined liens and charges incident to construction or maintenance, and liens and charges incident to construction or maintenance filed of record as of or after the date of the Indenture, which are being contested in good faith and have not proceeded to final judgment (and for which all applicable periods for appeal or review have not expired);

(2) notices of lis pendens or other notices of pending actions which are being contested in good faith and have not proceeded to final judgment (and for which all applicable periods for appeal or review have not expired);

(3) the lien of taxes and assessments which are not delinquent, or which are being contested in good faith;

(4) minor defects and irregularities in title which in the aggregate do not materially adversely affect the value or operation of such Affiliated Corporation's facilities for the purposes for which they are or may reasonably be expected to be used;

(5) easements, exceptions or reservations for the purpose of pipelines, telephone lines, telegraph lines, power lines and substations, roads, streets, alleys, highways, railroad purposes, drainage and sewerage purposes, dikes, canals, laterals, ditches, the removal of oil, gas, coal or other minerals, and other like purposes, or for the joint or common use of real property, facilities and equipment, which in the aggregate do not materially interfere with or impair the operation of such Affiliated Corporation's facilities for the purposes for which they are or may reasonably be expected to be used;

(6) rights reserved to or vested in any municipality or governmental or other public authority to control or regulate or use in any manner any portion of the property which do not materially impair the operation of such Affiliated Corporation's facilities for the purposes for which they are or may reasonably be expected to be used;

(7) present or future valid zoning laws and ordinances;

(8) liens securing indebtedness for the payment, redemption or satisfaction of which money (or evidences of indebtedness) in the necessary amount shall have been deposited in trust with a trustee or other holder of such indebtedness;

(9) purchase money security interests and security interests existing on any property prior to the time of its acquisition through purchase, merger, consolidation or otherwise, whether or not assumed by the purchaser thereof, or placed upon property being acquired to secure a portion of the purchase price thereof, or lessor's interests in leases (other than with respect to Sale and Leaseback Transactions) required to be capitalized in accordance with generally accepted accounting principles; provided that the aggregate principal amounts secured by any such interests shall not exceed at the time of incurrence the fair market value of the property so encumbered;

(10) statutory liens arising in the ordinary course of business which are not delinquent or are being contested in good faith;

(11) the lease or license of the use of property for use in performing professional or other services necessary for the proper and economical operation of such property;

(12) liens securing Indebtedness incurred and existing prior to the date of delivery of the Bonds and which liens secure such Indebtedness and are either (a) existing as of the date of delivery of the Bonds or (b) created pursuant to any loan agreement, mortgage, deed of trust, indenture or similar instrument entered into on or before the date of delivery of the Bonds;

(13) liens securing Indebtedness of such Affiliated Corporation if on or before one hundred twenty (120) days after the date of incurrence of such Indebtedness, the principal amount of such Indebtedness, together with all other secured Indebtedness of the Affiliated Corporations (exclusive of Indebtedness described in clauses (8), (9) and (12) of this definition), does not exceed ten percent (10%) of Consolidated Net Tangible Assets;

(14) liens arising by reason of good faith deposits by any Affiliated Corporation in the ordinary course of business (for other than borrowed money), deposits by any Affiliated Corporation to secure public or statutory obligations, or deposits to secure, or in lieu of, surety, stay or appeal bonds, and deposits as security for the payment of taxes or assessments or other similar charges;

(15) any lien arising by reason of deposits with, or the giving of any form of security to, any governmental agency or any body created or approved by law or governmental regulation for any purpose at any

time as required by law or governmental regulation as a condition to the transaction of any business or the exercise of any privilege or license, or to enable any Affiliated Corporation to maintain self-insurance or to participate in any funds established to cover insurance risks or in connection with worker's compensation, unemployment insurance, pension, or profit-sharing plans or other similar social security plans, or to share in the privileges or benefits required for companies participating in such arrangements;

(16) any judgment lien against any Affiliated Corporation so long as such judgment is being contested in good faith and execution thereon is stayed;

(17) liens on property received by any Affiliated Corporation through gifts, grants or bequests, such liens being due to restrictions on such gifts, grants or bequests of property or the income thereon up to the fair market value of such property;

(18) liens on property due to rights of third party payers for recoupment of amounts paid to any Affiliated Corporation; and

(19) any lien in favor of a trustee on the proceeds of Indebtedness prior to the application of such proceeds.

"Person" means an individual, corporation, firm, association, partnership, trust, limited liability company or other legal entity or group of entities, including a governmental entity or any agency or political subdivision thereof.

"Principal Payment Date" means the date of final maturity of any of the Bonds and any Additional Bonds.

"Rating Agency" means Fitch, Moody's, S&P or any other national rating organization, if then rating the Bonds at the request of the Corporation.

"Rating Category" means a generic securities rating category of any Rating Agency, without regard to any refinement or gradation of such rating category by a numerical modifier or otherwise.

"Redemption Fund" means the fund by that name established pursuant to the Indenture.

"S&P" means S&P Global Ratings, a business of Standard & Poor's Financial Services LLC, a limited liability company organized and existing under the laws of the State of Delaware, its successors and their assigns, or, if such limited liability company shall be dissolved or liquidated or shall no longer perform the functions of a securities rating organization, any other nationally recognized securities rating organization designated by the Corporation by notice to the Trustee.

"Sale and Leaseback Transaction" means any arrangement or transaction whereby assets are sold or transferred and thereupon or within one year thereafter are rented or leased by the original transferor except for any arrangement or transaction between Affiliated Corporations.

"Subsidiary" means a corporation, partnership, joint venture, association, business trust or similar entity organized under the laws of the United States of America or a state thereof which is directly or indirectly controlled by, or under common control by the same Person as, the Corporation, or any Guarantors or any other Subsidiary. For purposes of this definition, control means the power to direct the management and policies of a Person through the ownership of a majority of its voting securities, the right to designate or elect a majority of its board of directors or other governing board or body or by contract or otherwise.

"Supplemental Indenture" means any indenture duly authorized and entered into between the Corporation and the Trustee, authorizing the issuance of Additional Bonds or supplementing, modifying or amending the Indenture; but only if and to the extent that such Supplemental Indenture is specifically authorized under the Indenture.

"Trustee" means Wilmington Trust, National Association, a national banking association organized and existing under the laws of the United States of America, or its successor, as Trustee under the Indenture.

"Uniform Commercial Code" means the Uniform Commercial Code as in effect in the State of California from time to time.

INDENTURE

The following is a summary of certain provisions of the Indenture not described elsewhere in this Offering Memorandum. This summary should not be considered as a complete recital of the terms of the Indenture. Reference is made to the Indenture for complete details of the Indenture and the security for the Bonds.

Pledge of Indenture Fund

The Indenture Fund (which includes the Bond Fund and the Redemption Fund) and all amounts held therein are pledged, assigned and transferred by the Corporation to the Trustee for the benefit of the Bondholders to secure the full payment of the principal or redemption price, including Make-Whole Redemption Price, if any, of and interest on the Bonds in accordance with their terms and the provisions of the Indenture. The Corporation grants to the Trustee a security interest in and acknowledges and agrees that the Indenture Fund and all amounts on deposit therein shall constitute collateral security to secure the full payment of the principal or redemption price, including Make-Whole Redemption Price, if any, of and interest on the Bonds in accordance with their terms and the provisions of the Indenture.

For purposes of creating, perfecting and maintaining the security interest of the Trustee on behalf of the Bondholders in and to the Indenture Fund and all amounts on deposit therein, the parties agree that: (1) the Indenture constitutes a "security agreement" for purposes of the Uniform Commercial Code; (2) the Trustee will maintain on its books records reflecting the interest, as set forth in the Indenture, of the Bondholders in the Indenture Fund and/or the amounts on deposit therein; and (3) the Indenture Fund and the amounts on deposit therein and any proceeds thereof will be held by the Trustee acting in its capacity as an agent of the Bondholders, and the holding of such items by the Trustee (including the transfer of any items among the funds and accounts in the Indenture Fund) is deemed possession of such items on behalf of the Bondholders.

Nothing in the Indenture or in the Bonds, expressed or implied, shall be construed to constitute a security interest under the Uniform Commercial Code or otherwise in the assets of the Corporation other than in any interest of the Corporation in the Indenture Fund and/or the amounts on deposit therein and as provided in the covenants in the Indenture.

Bond Fund

The Trustee shall immediately deposit all payments received from the Corporation and a draw under the Guarantee Agreement (if a deficiency exists after the application of payments pursuant to the Indenture) in a special fund designated the "Bond Fund" which the Trustee shall establish and maintain and hold in trust and which shall be disbursed and applied only as authorized in the Indenture.

The Trustee shall apply moneys in the Bond Fund to pay interest on and principal of the Bonds as it shall become due and payable.

Redemption Fund

All amounts deposited in the Redemption Fund shall be used and withdrawn by the Trustee solely for the purpose of redeeming Bonds.

Payments by the Corporation; Allocation of Funds

The Corporation shall pay to the Trustee a sum equal to pay interest on and principal of the Bonds on the Payment Dates established in the Indenture. Each payment shall at all times be sufficient to pay the total amount of interest and principal (whether at maturity or upon acceleration) becoming due and payable on the Bonds on such Payment Date. If on any Payment Date the amounts held by the Trustee in the accounts within the Bond Fund are insufficient to make any required payments of principal of (whether at maturity or upon acceleration) and interest on the Bonds as such payments become due, the Corporation shall pay such deficiency to the Trustee.

The obligations of the Corporation to make the payments as described in the immediately preceding paragraph and to perform and observe the other agreements on its part contained in the Indenture shall be a general obligation of the Corporation, absolute and unconditional, irrespective of any defense or any rights of set off, recoupment or counterclaim it might otherwise have against the Trustee, and during the term of the Indenture, the Corporation shall pay all payments required to be made under the Indenture, free of any deductions and without abatement, diminution or set off. Until the principal of and interest on the Bonds have been fully paid, the Corporation (i) will not suspend or discontinue any payments provided for the payment of principal and interest when due; (ii) will perform and observe all of its other covenants contained in the Indenture; and (iii) except as provided in the Indenture relating to redemption or defeasance of the Bonds, will not terminate the Indenture for any cause.

Investment of Moneys in Funds

All moneys in any of the funds established pursuant to the Indenture shall be invested solely in Investment Securities. Moneys in any funds established pursuant to the Indenture shall be invested in Investment Securities maturing not later than the date on which it is estimated that such moneys will be required by the Trustee.

Additional Bonds

Additional Bonds may be authorized by a Supplemental Indenture. Additional Bonds will mature on one of the same dates as the Bonds, bear interest at the same rates per annum for the Bonds corresponding to the applicable maturity date, and be subject to redemption at the same times and at the same redemption price, including Make-Whole Redemption Price, as the Bonds. As a condition to the issuance of Additional Bonds there shall be delivered to the Trustee a certificate of the Corporation, certifying that, after consultation with counsel experienced in federal securities and tax laws, the issuance and consolidation of such Additional Bonds will not cause (i) any adverse tax impact on the Holders of Outstanding Bonds, (ii) the Outstanding Bonds to be required to be registered under the Securities Act of 1933, as amended or (iii) the Indenture to be required to be qualified under the Trust Indenture Act of 1939, as amended.

Maintenance of Corporate Existence of the Corporation; Consolidation, Merger, Sale or Transfer of Assets Under Certain Conditions

The Corporation covenants and agrees that it will not dissolve, sell or otherwise dispose of all or substantially all of its assets nor consolidate with or merge into another corporation or permit one or more other corporations to consolidate with or merge into it; provided, that the Corporation may consolidate with or merge into another corporation, or permit one or more other corporations to consolidate with or merge into it, or sell or otherwise transfer to another corporation all or substantially all of its assets, if the surviving, resulting or transferee corporation, as the case may be (i) assumes in writing, if such corporation is not the Corporation or a Guarantor, all of the obligations of the Corporation under the Indenture; and (ii) is not, after such transaction, otherwise in default under any provisions of the Indenture.

Limitation on Encumbrances Including Sale and Leaseback Transactions

The Corporation covenants and agrees that it will not create, assume, or suffer to exist any mortgage, deed of trust, pledge, security interest, encumbrance, lien, or charge of any kind (each a "security interest") upon any property or revenues of any Affiliated Corporation, whether such property is owned or acquired, unless the

obligations of the Corporation under the Indenture shall be secured prior to or equally and ratably with any indebtedness or other obligation secured by such security interest, and the Corporation further covenants and agrees that if such a security interest is created or assumed by any Affiliated Corporation, it will make or cause to be made effective a provision whereby the obligations of the Corporation under the Indenture will be secured prior to or equally and ratably with such indebtedness or other obligation secured by such security interest; provided, however, that notwithstanding the foregoing provisions and without securing obligations of the Corporation under the Indenture, any Affiliated Corporation may create, suffer or assume Permitted Encumbrances.

Insurance Required

The Corporation covenants and agrees that it will keep all of its properties and operations adequately insured at all times and carry and maintain such insurance in amounts which are customarily carried and against such risks as are customarily insured against by other corporations of similar size in connection with the ownership and operation of health facilities. Such insurance may include alternative risk management programs, including self-insurance.

Limitation on Disposition of Assets

The Corporation agrees not to sell, lease or otherwise dispose of any of its assets (including cash), or permit any Affiliated Corporation to sell, lease or otherwise dispose of any of its assets (including cash), in any Fiscal Year with a net book value in excess of 10% of Consolidated Net Tangible Assets unless any assets in excess of such limitation are sold, leased or disposed of at a price equal to their fair market value and the Corporation, within 120 days of such disposition, applies (or causes an Affiliated Corporation to apply) the net proceeds of such sale, lease or disposition to either the redemption of long-term Indebtedness of the Corporation or of any other Affiliated Corporation or the acquisition of additional assets.

Events of Default

The following events shall be Events of Default under the Indenture:

(a) default in the due and punctual payment of the principal or redemption price, including Make-Whole Redemption Price, if any, of any Bond when and as the same shall become due and payable, whether at maturity as therein expressed, by proceedings for redemption, by acceleration or otherwise;

(b) default in the due and punctual payment of any interest on any Bond when and as such interest shall become due and payable;

(c) if the Corporation shall fail to observe or perform any covenant, condition, agreement or provision in the Indenture on its part to be observed or performed, other than as referred to in subsections (a) and (b) above, for a period of sixty (60) days after written notice specifying such failure or breach and requesting that it be remedied, has been given to the Corporation by the Trustee; except that, if such failure or breach can be remedied but not within such sixty-day period and if the Corporation has taken all action reasonably possible to remedy such failure or breach within such sixty-day period, such failure or breach shall not become an Event of Default for so long as the Corporation shall diligently proceed to remedy same in accordance with and subject to any directions or limitations of time established by the Trustee;

(d) certain incidents of bankruptcy, insolvency or similar conditions; and

(g) if any event of default under the Guarantee Agreement shall occur and is continuing.

Acceleration upon Default

If an Event of Default shall occur, then, and in each and every such case during the continuance of such Event of Default, the Trustee may, upon notice in writing to the Corporation, declare the principal of all the Bonds then Outstanding, and the interest accrued thereon, to be due and payable immediately, and upon any such

declaration by the Trustee the same shall become and shall be immediately due and payable, anything in the Indenture or in the Bonds contained to the contrary notwithstanding.

Any such declaration, however, is subject to the condition that if, at any time after such declaration and before any judgment or decree for the payment of the moneys due shall have been obtained or entered, there shall be deposited with the Trustee a sum sufficient to pay all the principal or redemption price, including Make-Whole Redemption Price, if any, of and interest on the Bonds payment of which is overdue, with interest on such overdue principal at the rate borne by the Bonds, and the reasonable charges and expenses of the Trustee, and any and all other Defaults known to the Trustee (other than in the payment of principal of and interest on the Bonds due and payable solely by reason of such declaration) shall have been made good or cured to the satisfaction of the Trustee or provision deemed by the Trustee to be adequate shall have been made therefor, then, and in every such case, the Trustee shall, on behalf of the Holders of all of the Bonds, rescind and annul such declaration and its consequences and waive such Default; but no such rescission and annulment shall extend to or shall affect any subsequent Default, or shall impair or exhaust any right or power consequent thereon.

Application of Moneys After Default

If an Event of Default shall occur and be continuing, all moneys then held or thereafter received by the Trustee under any of the provisions of the Indenture shall be applied by the Trustee as follows and in the following order:

(1) To the payment of any expenses necessary in the opinion of the Trustee to protect the interests of the Holders of the Bonds and payment of reasonable fees and expenses of the Trustee (including reasonable fees and disbursements of its counsel) incurred in and about the performance of its powers and duties under the Indenture; and

(2) To the payment of the principal or redemption price, including Make-Whole Redemption Price, if any, of and interest then due on the Bonds (upon presentation of the Bonds to be paid, and stamping thereon of the payment if only partially paid, or surrender thereof if fully paid) subject to the provisions of the Indenture, as follows:

(i) Unless the principal of all of the Bonds shall have become or have been declared due and payable,

First: To the payment to the Persons entitled thereto of all installments of interest then due in the order of the maturity of such installments, and, if the amount available shall not be sufficient to pay in full any installment or installments due on the same date, then to the payment thereof ratably, according to the amounts due thereon, to the Persons entitled thereto, without any discrimination or preference; and

Second: To the payment to the Persons entitled thereto of the unpaid principal or redemption price, including Make-Whole Redemption Price, if any, of any Bonds which shall have become due, whether at maturity or by call for redemption, in the order of their due dates, with interest on the overdue principal at the rate borne by the Bonds, and, if the amount available shall not be sufficient to pay in full all the Bonds due on any date, together with such interest, then to the payment thereof ratably, according to the amounts of principal or redemption price, including Make-Whole Redemption Price, if any, due on such date to the Persons entitled thereto, without any discrimination or preference.

(ii) If the principal of all of the Bonds shall have become or have been declared due and payable, to the payment of the principal and interest then due and unpaid upon the Bonds, with interest on the overdue principal at the rate borne by the Bonds, and, if the amount available shall not be sufficient to pay in full the whole amount so due and unpaid, then to the payment thereof ratably, without preference or priority of principal over interest, or of interest over principal, or of any installment of interest over any other installment of interest, or of any Bond over any other Bond, according to the amounts due respectively for principal and interest, to the Persons entitled thereto without any discrimination or preference.

Trustee to Represent Bondholders

The Trustee is irrevocably appointed as trustee and true and lawful attorney-in-fact of the Holders of the Bonds for the purpose of exercising and prosecuting on their behalf such rights and remedies as may be available to such Holders under the provisions of the Bonds, the Indenture and applicable provisions of any law. Upon the occurrence and continuance of an Event of Default or other occasion giving rise to a right in the Trustee to represent the Bondholders, the Trustee in its discretion may, and upon the written request of the Holders of not less than a majority in aggregate principal amount of the Bonds then Outstanding, and upon being indemnified to its satisfaction therefor, shall, proceed to protect or enforce its rights or the rights of such Holders by such appropriate action, suit, mandamus or other proceedings as it shall deem most effectual to protect and enforce any such right, at law or in equity, either for the specific performance of any covenant or agreement contained in the Indenture, or in aid of the execution of any power granted in the Indenture, or for the enforcement of any other appropriate legal or equitable right or remedy vested in the Trustee, or in such Holders under the Bonds, the Indenture or any applicable law; and upon instituting such proceeding, the Trustee shall be entitled, as a matter of right, to the appointment of a receiver of the amounts pledged under the Indenture, pending such proceedings. If more than one such request is received by the Trustee from the Holders, the Trustee shall follow the written request executed by the Holders of the greatest percentage (which percentage shall be, in any case, not less than a majority in aggregate principal amount) of the Bonds then Outstanding. All rights of action under the Indenture or the Bonds or otherwise may be prosecuted and enforced by the Trustee without the possession of any of the Bonds or the production thereof in any proceeding relating thereto, and any such suit, action or proceeding instituted by the Trustee shall be brought in the name of the Trustee for the benefit and protection of all the Holders of such Bonds, subject to the provisions of the Indenture.

Bondholders' Direction of Proceedings

The Holders of a majority in aggregate principal amount of the Bonds then Outstanding shall have the right, by an instrument or concurrent instruments in writing executed and delivered to the Trustee, and upon indemnifying the Trustee to its satisfaction therefor, to direct the method of conducting all remedial proceedings taken by the Trustee under the Indenture, provided that such direction shall not be otherwise than in accordance with law and the provisions of the Indenture, and that the Trustee shall have the right to decline to follow any such direction which in the opinion of the Trustee would be unjustly prejudicial to Bondholders not parties to such direction.

Limitation on Holders' Right to Sue

No Holder of any Bond shall have the right to institute any suit, action, or proceeding at law or in equity, for the protection or enforcement of any right or remedy under the Indenture or any other applicable law with respect to such Bond unless (1) the Holder has given the Trustee written notice of the occurrence of an Event of Default; (2) the Holders of not less than a majority in aggregate principal amount of the Bonds then Outstanding have made written request to the Trustee to exercise the powers granted to the Trustee or to institute such suit, action or proceeding in its own name; (3) such Holder or said Holders shall have tendered to the Trustee indemnity satisfactory to it against the costs, expenses and liabilities to be incurred in compliance with such request; and (4) the Trustee has refused or omitted to comply with such request for a period of 60 days after such written request shall have been received by, and said tender of indemnity shall have been made to, the Trustee.

Waiver of Past Defaults

The Trustee may, and upon request of the Holders of not less than a majority in aggregate principal amount of the Outstanding Bonds shall, on behalf of the Holders of all the Bonds waive any past Default hereunder and its consequences, except a Default:

(1) in the payment of the principal or redemption price, including Make-Whole Redemption Price, if any, of or interest on any Bond, or

(2) in respect of a covenant or other provision of the Indenture which, pursuant to the Indenture, cannot be modified or amended without the consent of the Holder of each Outstanding Bond affected.

Upon any such waiver, such Default shall cease to exist, and any Event of Default arising therefrom shall be deemed to have been cured, for every purpose of the Indenture, but no such waiver shall extend to any subsequent or other Default or impair any right consequent thereon.

Trustee May File Proofs of Claim

In case of the pendency of any receivership, insolvency, liquidation, bankruptcy, reorganization, arrangement, adjustment, composition or other judicial proceeding relative to the Corporation or any other obligor upon the Bonds or the property of the Corporation or of such other obligor or their creditors, the Trustee (irrespective of whether the principal of the Bonds shall then be due and payable as therein expressed or by declaration or otherwise and irrespective of whether the Trustee shall have made any demand on the Corporation for the payment of overdue principal or interest) shall be entitled and empowered, by intervention in such proceeding or otherwise:

(1) To file and prove a claim for the whole amount of principal or redemption price, including Make-Whole Redemption Price, if any, and interest owing and unpaid in respect of the Bonds and to file such other papers or documents as may be necessary or advisable in order to have the claims of the Trustee (including any claim for the reasonable compensation, expenses, disbursements and advances of the Trustee, its agents and counsel including expenses and fees of outside counsel and allocated costs of internal legal counsel) and of the Bondholders allowed in such judicial proceeding; and

(2) To collect and receive any moneys or other property payable or deliverable on any such claims and to distribute the same; and any receiver, assignee, trustee, liquidator or sequestrator (or other similar official) in any such judicial proceeding is authorized by each Bondholder to make such payments to the Trustee and, in the event that the Trustee shall consent to the making of such payments directly to the Bondholders, to pay to the Trustee any amount due to it for the reasonable compensation, expenses, disbursements and advances of the Trustee, its agents and counsel including expenses and fees of outside counsel and allocated costs of internal legal counsel, and any other amounts due the Trustee under the Indenture.

Nothing in the Indenture contained shall be deemed to authorize the Trustee to authorize or consent to or accept or adopt on behalf of any Bondholder any plan of reorganization, arrangement, adjustment or composition affecting the Bonds or the rights of any Holder thereof, or to authorize the Trustee to vote in respect of the claim of any Bondholder in any such proceeding.

Modification or Amendment of the Indenture

Without the consent of any of the Holders of the Bonds, the Corporation and the Trustee may at any time enter into supplemental indentures for the following purposes: (1) to add to the covenants and agreements of the Corporation contained in the Indenture other covenants and agreements thereafter to be observed, to pledge or assign additional security for the Bonds (or any portion thereof), or to surrender any right or power reserved to or conferred upon the Corporation in the Indenture, provided, that no such covenant, agreement, pledge, assignment or surrender shall materially adversely affect the interests of the Holders of the Bonds; (2) to make such provisions for the purpose of curing any ambiguity, inconsistency or omission, or of curing or correcting any defective provision, contained in the Indenture, or in regard to matters or questions arising under the Indenture, as the Corporation may deem necessary or desirable and not inconsistent with the Indenture, and which shall not materially adversely affect the interests of the Holders of the Bonds; (3) to modify, amend or supplement the Indenture in such manner as to permit the qualification of the Indenture under the Trust Indenture Act of 1939, as amended, or any similar federal statute, and to add such other terms, conditions and provisions as may be permitted by said act or similar federal statute, and which shall not materially adversely affect the interests of the Holders of the Bonds; (4) to provide for the procedures required to permit any Bondholder, at its option, to utilize an uncertificated system of registration of its Bond or to facilitate the registration of the Bonds in the name of a nominee of the Securities Depository in accordance with the Indenture; (5) to authorize the issuance of Additional Bonds; (6) to make any changes required

by a Rating Agency in order to obtain or maintain a rating for the Bonds; or (7) to make any other changes which will not materially adversely affect the interests of the Holders of the Bonds.

The Indenture and the rights and obligations of the Corporation and of the Holders of the Bonds and of the Trustee may be modified or amended from time to time and at any time by supplemental indentures, which the Corporation and the Trustee may enter into when the written consent of the Holders of not less than a majority in aggregate principal amount of the Bonds then Outstanding have been filed with the Trustee. No such modification or amendment shall (i) extend the stated maturity of, reduce the principal amount of, reduce the rate of interest on, or extend the time of payment of interest on, or reduce any premium payable upon the redemption of, any Bond, without the written consent of the Holder of each Bond so affected, or (ii) reduce the percentage of Bonds of which the consent of the Holders is required to effect any such modification or amendment, or permit the creation of any lien on the Indenture Fund or the amounts pledged under the Indenture prior to or on a parity with the lien created by the Indenture, or deprive the Holders of the Bonds of the lien created by the Indenture on the Indenture Fund and such amounts (except as expressly provided in the Indenture), without the consent of the Holders of all Bonds then Outstanding.

The Indenture describes the procedures to be used to give notice to and obtain the consents of the Holders of the Bonds whenever the Corporation and the Trustee propose to enter into a supplemental indenture requiring such consents.

Defeasance

The Bonds may be paid or discharged by the Corporation or the Trustee on behalf of the Corporation in any of the following ways:

(A) by paying or causing to be paid the principal or redemption price, including Make-Whole Redemption Price, if any, of and interest on all Bonds Outstanding, as and when the same become due and payable;

(B) by depositing with the Trustee, in trust, at or before maturity, moneys or securities in the necessary amount (as provided in the Indenture) to pay when due or redeem all Bonds then Outstanding; or

(C) by delivering to the Trustee, for cancellation by it, all Bonds then Outstanding.

If the Corporation shall also pay or cause to be paid all other sums payable under the Indenture by the Corporation, then and in that case at the election of the Corporation, and notwithstanding that any Bonds shall not have been surrendered for payment, the Indenture and the pledge of the Indenture Fund and all amounts held therein made under the Indenture and all covenants, agreements and other obligations of the Corporation under the Indenture (except as otherwise provided in the Indenture) shall cease, terminate, become void and be completely discharged and satisfied and the Bonds shall be deemed paid. In such event, upon the request of the Corporation, the Trustee shall cause an accounting for such period or periods as may be requested by the Corporation to be prepared and filed with the Corporation and shall execute and deliver to the Corporation all such instruments as may be necessary to evidence such discharge and satisfaction, and the Trustee shall pay over, transfer, assign or deliver to the Corporation all moneys or securities or other property held by it pursuant to the Indenture which are not required for the payment or redemption of Bonds not theretofore surrendered for such payment or redemption.

Discharge of Liability on Bonds

Upon the deposit with the Trustee, in trust, at or before maturity, of money or securities in the necessary amount (as provided in the Indenture) to pay or redeem any Outstanding Bond (whether upon or prior to its maturity or the redemption date of such Bond), provided that, if such Bond is to be redeemed prior to maturity, notice of such redemption shall have been given as provided in the Indenture or provision satisfactory to the Trustee shall have been made for the giving of such notice, then all liability of the Corporation in respect of such Bond shall cease, terminate and be completely discharged, and the Bonds shall be deemed paid, except only that thereafter the Holder thereof shall be entitled to payment of the principal or redemption price, including Make-Whole Redemption Price, if any, of and interest on such Bond by the Corporation, and the Corporation shall remain liable for such payments,

but only out of such money or securities deposited with the Trustee for their payment, subject, however, to the provisions of Indenture. The Corporation may at any time surrender to the Trustee for cancellation by it any Bonds previously issued and delivered, which the Corporation may have acquired in any manner whatsoever, and such Bonds, upon such surrender and cancellation, shall be deemed to be paid and retired.

Deposit of Money or Securities with Trustee

Whenever in the Indenture it is provided or permitted that there be deposited with or held in trust by the Trustee money or securities in the necessary amount to pay or redeem any Bonds, the money or securities so to be deposited or held may include money or securities held by the Trustee in the funds and accounts established pursuant to the Indenture and shall be:

(a) lawful money of the United States of America in an amount equal to the principal amount of such Bonds and all unpaid interest thereon to maturity; or

(b) Government Obligations (not callable by the holder thereof prior to maturity), the principal of and interest on which when due will provide money sufficient to pay the principal or redemption price, including Make-Whole Redemption Price, if any, of and all unpaid interest to maturity, or to the redemption date, as the case may be, on the Bonds to be paid or redeemed, as such principal or redemption price, including Make-Whole Redemption Price and interest become due.

GUARANTEE AGREEMENT

The following is a summary of certain provisions of the Guarantee Agreement not described elsewhere in this Offering Memorandum. This summary should not be considered as a complete recital of the terms of the Guarantee Agreement. Reference is made to the Guarantee Agreement for complete details thereof.

Guarantee of Obligations

The Guarantors unconditionally guarantee, jointly and severally, to the Trustee, for the benefit of the Holders from time to time of the Bonds, (a) the due and punctual payment, when and as the same shall become due, of any and all amounts due pursuant to the Indenture, including but not limited to the principal and redemption price, including Make-Whole Redemption Price, if any, of and interest on the Bonds, and (b) the full and prompt performance and observance by the Corporation of each and all of the covenants and agreements required to be performed and observed by the Corporation under the terms of the Indenture. Each and every default in payment of the amounts due under the Indenture or the Bonds shall give rise to a separate cause of action hereunder, and separate suits may be brought hereunder as each cause of action arises.

Payments to Trustee

If by 10:00 a.m., California time, on any Interest Payment Date or Principal Payment Date there are insufficient amounts in the Bond Fund to make the payments required on such Interest Payment Date or Principal Payment Date, the Trustee shall immediately notify the Guarantors by facsimile transmission. The notice shall state:

(1) that moneys held by the Trustee in the Bond Fund will be insufficient to pay in full the interest on and principal and redemption price, including Make-Whole Redemption Price, if any, of the Bonds becoming due on such Payment Date, as the case may be; and

(2) the amount by which the obligation to make such payment(s) exceeds the amount available therefor (the "Shortfall").

Upon receiving such notice the Guarantors shall, before the close of business on such Interest Payment Date and/or Principal Payment Date, pay to the Trustee in immediately available funds, for deposit in the Bond Fund, an amount equal to the Shortfall.

Maintenance of Corporate Existence of the Guarantors; Consolidation, Merger, Sale or Transfer Under Certain Conditions

The Guarantors covenant and agree that each will not dissolve, sell or otherwise dispose of all or substantially all of its assets nor consolidate with or merge into another corporation or permit one or more other corporations to consolidate with or merge into it; provided that each Guarantor may, without violating the covenants described in this paragraph, consolidate with or merge into another corporation, or permit one or more other corporations to consolidate with or merge into it, or sell or otherwise transfer to another corporation all or substantially all of its assets, if the surviving, resulting or transferee corporation, as the case may be:

(1) assumes in writing, if such corporation is not such Guarantor, all of the obligations of such Guarantor under the Guarantee Agreement; and

(2) is not, after such transaction, otherwise in default under any provisions of the Guarantee Agreement.

Limitation on Encumbrances Including Sale and Leaseback Transactions

The Guarantors covenant and agree that each will not create, assume or suffer to exist any mortgage, deed of trust, pledge, security interest, encumbrance, lien or charge of any kind (a "security interest") upon any property or revenues of any Affiliated Corporation, whether such property is owned or acquired, unless the obligations of the Corporation under the Indenture shall be secured prior to or equally and ratably with any indebtedness or other obligation secured by such security interest and each Guarantor further covenants and agrees that if such a security interest is created or assumed by any Affiliated Corporation, it will make or cause to be made effective a provision whereby the obligations of the Corporation under the Indenture will be secured prior to or equally and ratably with such indebtedness or other obligation secured by such security interest; provided, however, that notwithstanding the foregoing provisions and without securing obligations of the Corporation under the Indenture, Affiliated Corporations may create, suffer or assume Permitted Encumbrances.

Insurance Required

The Guarantors covenant and agree that each will keep all of its properties and operations adequately insured at all times and carry and maintain such insurance in amounts which are customarily carried against such risks as are customarily insured against by other corporations of similar size in connection with the ownership and operation of health facilities. Such insurance may include alternative risk management programs, including self-insurance.

Limitation on Disposition of Assets

The Guarantors each covenant and agree not to sell, lease or otherwise dispose of any of their respective assets (including cash), or permit any Affiliated Corporation to sell, lease or otherwise dispose of any of their respective assets (including cash), in any Fiscal Year with a net book value in excess of ten percent (10%) of Consolidated Net Tangible Assets unless any assets in excess of such limitation are sold, leased or disposed of at a price equal to their fair market value and such Guarantor, within one hundred twenty (120) days of such disposition, applies (or causes an Affiliated Corporation to apply) the net proceeds of such sale, lease or disposition to either the redemption of long-term Indebtedness of the Guarantor or of any other Affiliated Corporation or the acquisition of additional assets.

Events of Default

The following events are "events of default" under the Guarantee Agreement:

(a) If any Guarantor shall fail to make any payments required under the Guarantee Agreement when due and payable;

(b) If any representation or warranty made by any Guarantor in the Guarantee Agreement or in any document, instrument or certificate furnished to the Trustee in connection with the issuance of the Bonds shall at any time prove to have been incorrect in any material respect as of the time made;

(c) If any Guarantor shall fail to observe or perform any covenant, condition, agreement or provision in the Guarantee Agreement on its part to be observed or performed, other than as referred to in subsection (a) of above, for a period of sixty (60) days after written notice, specifying such failure or breach and requesting that it be remedied, has been given to such Guarantor by the Trustee; except that, if such failure can be remedied but not within such sixty (60)-day period and if the Guarantor has taken all action reasonably possible to remedy such failure within such sixty (60)-day period, such failure shall not become an event of default for so long as the Guarantor shall diligently proceed to remedy same in accordance with and subject to any directions or limitations of time established by the Trustee; or

(d) If an Event of Default shall occur and is continuing.

Remedies on Default

If an event of default shall occur under the Guarantee Agreement, then, and in each and every such case during the continuance of such event of default, the Trustee may take whatever action, at law or in equity, as may appear necessary or desirable to collect any payments then due and thereafter to become due under the Guarantee Agreement or to enforce the performance and observance of any obligation, covenant, agreement or provision contained in the Guarantee Agreement to be observed or performed by each Guarantor.

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APPENDIX C

DTC BOOK-ENTRY SYSTEM AND GLOBAL CLEARANCE PROCEDURES

The information in this Appendix C is subject to any change in or reinterpretation of the rules, regulations and procedures of the Depository Trust Company ("DTC"), Euroclear Bank S.A./N.V. as operator of the Euroclear System ("Euroclear") or Clearstream Banking S.A. ("Clearstream Banking") (DTC, Euroclear and Clearstream Banking together, the "Clearing Systems") currently in effect. The information under this caption concerning the Clearing Systems has been obtained from sources that the Credit Group believes to be reliable, but none of the Credit Group or the Underwriters take any responsibility for the accuracy of the information under this caption. Investors wishing to use the facilities of any of the Clearing Systems are advised to confirm the continued applicability of the rules, regulations and procedures of the relevant Clearing System. None of the members of the Credit Group, the Trustee or the Underwriters will have any responsibility or liability for any aspect of the records relating to, or payments made on account of beneficial ownership interests in the Bonds held through the facilities of any Clearing System or for maintaining, supervising or reviewing any records relating to such beneficial ownership interests.

Clearing Systems

DTC Book-Entry Only System. The DTC will act as securities depository for the Bonds. The Bonds will be issued as fully-registered securities registered in the name of Cede & Co. (DTC's partnership nominee) or such other name as may be requested by an authorized representative of DTC. One fully-registered bond certificate will be issued for each maturity of the Fixed Rate Bonds and each maturity of the Floating Rate Bonds, in the aggregate principal amount of such Bonds, and will be deposited with DTC.

DTC is a limited-purpose trust company organized under the New York Banking Law, a "banking organization" within the meaning of the New York Banking Law, a member of the Federal Reserve System, a "clearing corporation" within the meaning of the New York Uniform Commercial Code, and a "clearing agency" registered pursuant to the provisions of Section 17A of the Securities Exchange Act of 1934. DTC holds and provides asset servicing for over 3.6 million issues of U.S. and non-U.S. equity issues, corporate and municipal debt issues, and money market instruments (from over 100 countries) that DTC's participants ("Direct Participants") deposit with DTC. DTC also facilitates the post-trade settlement among Direct Participants of sales and other securities transactions in deposited securities, through electronic computerized book-entry transfers and pledges between Direct Participants' accounts. This eliminates the need for physical movement of securities certificates. Direct Participants include both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, clearing corporations, and certain other organizations. DTC is a wholly-owned subsidiary of The Depository Trust & Clearing Corporation ("DTCC"). DTCC is the holding company of DTC, National Securities Clearing Corporation and Fixed Income Clearing Corporation, all of which are registered clearing agencies. DTCC is owned by the users of its regulated subsidiaries. Access to the DTC system is also available to others, such as both U.S. and non-U.S. securities brokers and dealers, banks, trust companies and clearing corporations that clear through or maintain a custodial relationship with a Direct Participant, either directly or indirectly ("Indirect Participants"). DTC has a S&P Global Ratings rating of AA+. The DTC rules applicable to its Participants are on file with the Securities and Exchange Commission. More information about DTC can be found at www.dtcc.com.

Purchases of the Bonds under the DTC system must be made by or through Direct Participants, which will receive a credit for the Bonds on DTC's records. The ownership interest of each actual

purchaser of each Bond ("Beneficial Owner") is in turn to be recorded on the Direct and Indirect Participants' records. Beneficial Owners will not receive written confirmation from DTC of their purchase. Beneficial Owners are, however, expected to receive written confirmations providing details of the transaction, as well as periodic statements of their holdings, from the Direct or Indirect Participant through which the Beneficial Owner entered into the transaction. Transfers of ownership interests in the Bonds are to be accomplished by entries made on the books of Direct and Indirect Participants acting on behalf of Beneficial Owners. Beneficial Owners will not receive certificates representing their beneficial ownership interests in the Bonds, except in the event that use of the book-entry system for the Bonds is discontinued.

To facilitate subsequent transfers, all Bonds deposited by Direct Participants with DTC are registered in the name of DTC's partnership nominee, Cede & Co., or such other name as may be requested by an authorized representative of DTC. The deposit of the Bonds with DTC and their registration in the name of Cede & Co. or such other DTC nominee do not affect any change in beneficial ownership. DTC has no knowledge of the actual Beneficial Owners of the Bonds; DTC's records reflect only the identity of the Direct Participants to whose accounts such Bonds are credited, which may or may not be the Beneficial Owners. The Direct and Indirect Participants will remain responsible for keeping account of their holdings on behalf of their customers.

Conveyance of notices and other communications by DTC to Direct Participants, by Direct Participants to Indirect Participants, and by Direct Participants and Indirect Participants to Beneficial Owners will be governed by arrangements among them, subject to any statutory or regulatory requirements as may be in effect from time to time. Beneficial Owners of the Bonds may wish to take certain steps to augment the transmission to them of notices of significant events with respect to the Bonds, such as redemptions, tenders, defaults, and proposed amendments to the bond documents. For example, Beneficial Owners of the Bonds may wish to ascertain that the nominee holding the Bonds for their benefit has agreed to obtain and transmit notices to Beneficial Owners. In the alternative, Beneficial Owners may wish to provide their names and addresses to the Bond Trustee and request that copies of notices be provided directly to them.

Redemption notices shall be sent to DTC. If less than all of the Bonds are being redeemed, DTC's practice is to determine by lot the amount of the interest of each Direct Participant to be redeemed.

Neither DTC nor Cede & Co. (nor any other DTC nominee) will consent or vote with respect to the Bonds unless authorized by a Direct Participant in accordance with DTC's MMI Procedures. Under its usual procedures, DTC mails an Omnibus Proxy to the Parent as soon as possible after the record date. The Omnibus Proxy assigns Cede & Co.'s consenting or voting rights to those Direct Participants to whose accounts such Bonds are credited on the record date (identified in a listing attached to the Omnibus Proxy).

Payments of principal or redemption price, including the Make-Whole Redemption Price, if any, of and interest on the Bonds will be made to Cede & Co., or such other nominee as may be requested by an authorized representative of DTC. DTC's practice is to credit Direct Participants' accounts upon DTC's receipt of funds and corresponding detail information from the Parent or the Bond Trustee, on the payment date in accordance with their respective holdings shown on DTC's records. Payments by Participants to Beneficial Owners will be governed by standing instructions and customary practices, as is the case with securities held for the accounts of customers in bearer form or registered in "street name," and will be the responsibility of such Participant and not of DTC nor its nominee, the Bond Trustee or the Parent, subject to any statutory or regulatory requirements as may be in effect from time to time. Payment of principal or redemption price, including the Make-Whole Redemption Price, if any, and interest to Cede & Co. (or such other nominee as may be requested by an

authorized representative of DTC) is the responsibility of the Bond Trustee, disbursement of such payments to Direct Participants will be the responsibility of DTC, and disbursement of such payments to Beneficial Owners will be the responsibility of Direct and Indirect Participants.

DTC may discontinue providing its services as securities depository with respect to the Bonds at any time by giving reasonable notice to Hospitals or the Bond Trustee. Under such circumstances, in the event that a successor depository is not obtained, Bond certificates are required to be printed and delivered.

Hospitals may decide to discontinue use of the system of book-entry-only transfers through DTC (or a successor securities depository). In that event, Bond certificates will be printed and delivered.

NONE OF THE UNDERWRITERS, THE TRUSTEE OR ANY MEMBER OF THE CREDIT GROUP WILL HAVE ANY RESPONSIBILITY OR OBLIGATION TO DTC PARTICIPANTS, INDIRECT PARTICIPANTS OR BENEFICIAL OWNERS WITH RESPECT TO THE PAYMENTS OR THE PROVIDING OF NOTICE TO DTC PARTICIPANTS, INDIRECT PARTICIPANTS OR BENEFICIAL OWNERS.

None of the Underwriters, the Trustee or any member of the Credit Group can give any assurances that DTC, DTC Participants, Indirect Participants or others will distribute payments of principal and interest on the Bonds paid to DTC or its nominee, as the registered Owner, or any notice, to the Beneficial Owners or that they will do so on a timely basis or that DTC will serve and act in a manner described in this Offering Memorandum.

Euroclear and Clearstream Banking. Euroclear and Clearstream Banking have advised Hospitals as follows:

Euroclear and Clearstream Banking each hold securities for their customers and facilitate the clearance and settlement of securities transactions by electronic book-entry transfer between their respective account holders. Euroclear and Clearstream Banking provide various services including safekeeping, administration, clearance and settlement of internationally traded securities and securities lending and borrowing. Euroclear and Clearstream Banking also deal with domestic securities markets in several countries through established depositary and custodial relationships. Euroclear and Clearstream Banking have established an electronic bridge between their two systems across which their respective participants may settle trades with each other.

Euroclear and Clearstream Banking customers are worldwide financial institutions, including underwriters, securities brokers and dealers, banks, trust companies and clearing corporations. Indirect access to Euroclear and Clearstream Banking is available to other institutions that clear through or maintain a custodial relationship with an account holder of either system, either directly or indirectly.

Clearing and Settlement Procedures

The Bonds sold in offshore transactions will be initially issued to investors through the book-entry facilities of DTC, or Clearstream Banking and Euroclear in Europe if the investors are participants in those systems, or indirectly through organizations that are participants in the systems. For any of such Bonds, the record holder will be DTC's nominee. Clearstream Banking and Euroclear will hold omnibus positions on behalf of their participants through customers' securities accounts in Clearstream Banking's and Euroclear's names on the books of their respective depositories.

The depositories, in turn, will hold positions in customers' securities accounts in the depositories' names on the books of DTC. Because of time zone differences, the securities account of a Clearstream Banking or Euroclear participant as a result of a transaction with a participant, other than a depository holding on behalf of Clearstream Banking or Euroclear, will be credited during the securities settlement processing day, which must be a business day for Clearstream Banking or Euroclear, as the case may be, immediately following the DTC settlement date. These credits or any transactions in the securities settled during the processing will be reported to the relevant Euroclear participant or Clearstream Banking participant on that business day. Cash received in Clearstream Banking or Euroclear as a result of sales of securities by or through a Clearstream Banking participant or Euroclear participant to a DTC Participant, other than the depository for Clearstream Banking or Euroclear, will be received with value on the DTC settlement date but will be available in the relevant Clearstream Banking or Euroclear cash account only as of the business day following settlement in DTC.

Transfers between participants will occur in accordance with DTC rules. Transfers between Clearstream Banking participants or Euroclear participants will occur in accordance with their respective rules and operating procedures. Cross-market transfers between persons holding directly or indirectly through DTC, on the one hand, and directly or indirectly through Clearstream Banking participants or Euroclear participants, on the other, will be affected in DTC in accordance with DTC rules on behalf of the relevant European international clearing system by the relevant depositories; however, cross-market transactions will require delivery of instructions to the relevant European international clearing system by the counterparty in the system in accordance with its rules and procedures and within its established deadlines in European time. The relevant European international clearing system will, if the transaction meets its settlement requirements, deliver instructions to its depository to take action to affect final settlement on its behalf by delivering or receiving securities in DTC, and making or receiving payment in accordance with normal procedures for same day funds settlement applicable to DTC. Clearstream Banking participants or Euroclear participants may not deliver instructions directly to the depositories.

Hospitals will not impose any fees in respect of holding the Bonds; however, holders of book-entry interests in the Bonds may incur fees normally payable in respect of the maintenance and operation of accounts in the Clearing Systems.

Initial Settlement

Interests in the Bonds will be in uncertified book-entry form. Purchasers electing to hold book-entry interests in the Bonds through Euroclear and Clearstream Banking accounts will follow the settlement procedures applicable to conventional Eurobonds. Book-entry interests in the Bonds will be credited to Euroclear and Clearstream Banking participants' securities clearance accounts on the business day following the date of delivery of the Bonds against payment (value as on the date of delivery of the Bonds). Direct Participants acting on behalf of purchasers electing to hold book-entry interests in the Bonds through DTC will follow the delivery practices applicable to securities eligible for DTC's Same Day Funds Settlement system. Direct Participants' securities accounts will be credited with book-entry interests in the Bonds following confirmation of receipt of payment to Hospitals on the date of delivery of the Bonds.

Secondary Market Trading

Secondary market trades in the Bonds will be settled by transfer of title to book-entry interests in the Clearing Systems. Title to such book-entry interests will pass by registration of the transfer within the records of Euroclear, Clearstream Banking or DTC, as the case may be, in accordance with their respective procedures. Book-entry interests in the Bonds may be transferred within Euroclear and within Clearstream Banking and between Euroclear and Clearstream Banking in accordance with procedures

established for these purposes by Euroclear and Clearstream Banking. Book-entry interests in the Bonds may be transferred within DTC in accordance with procedures established for this purpose by DTC. Transfer of book-entry interests in the Bonds between Euroclear or Clearstream Banking and DTC may be affected in accordance with procedures established for this purpose by Euroclear, Clearstream Banking and DTC.

General

None of Euroclear, Clearstream Banking or DTC is under any obligation to perform or continue to perform the procedures referred to above, and such procedures may be discontinued at any time.

Neither Hospitals nor any of their agents will have any responsibility for the performance by Euroclear, Clearstream Banking or DTC or their respective direct or indirect participants or account holders of their respective obligations under the rules and procedures governing their operations or the arrangements referred to above.

The information in this Appendix C concerning the Clearing Systems has been obtained from sources that the Underwriters and the Credit Group believe to be reliable, but the Underwriters and the Credit Group take no responsibility for the accuracy thereof.

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APPENDIX D

FORM OF CONTINUING DISCLOSURE CERTIFICATE

This Continuing Disclosure Certificate (the "Disclosure Certificate"), dated May 3, 2017, is executed and delivered by Kaiser Foundation Hospitals ("Hospitals"), Kaiser Foundation Health Plan, Inc. ("Health Plan, Inc."), Kaiser Hospital Asset Management, Inc. ("HAMI"), and Kaiser Health Plan Asset Management, Inc. ("HPAMI" and, together with Health Plan, Inc. and HAMI, the "Guarantors"), each a nonprofit public benefit corporation duly organized and existing under the laws of the State of California, in connection with the execution and delivery of the $2,075,000,000 Kaiser Permanente Taxable Bonds, Series 2017 (the "Bonds"). The Bonds are being issued pursuant to an indenture, dated as of May 1, 2017 (the "Indenture"), between Hospitals and Wilmington Trust, National Association, as trustee (the "Trustee"). Payment to be made by Hospitals pursuant to the Indenture is guaranteed by the Guarantors pursuant to a Guarantee Agreement, dated as of May 1, 2017 (the "Guarantee Agreement"), between Guarantors and the Trustee. Hospitals and the Guarantors are collectively referred to herein as the "Credit Group."

Pursuant to the Indenture and the Guarantee Agreement, the members of the Credit Group each covenant and agree as follows:

Section 1. Definitions. In addition to the definitions set forth in the Indenture and the Offering Memorandum, which apply to any capitalized term used in this Disclosure Certificate unless otherwise defined in this Section, the following capitalized terms shall have the following meanings:

"*Annual Report*" shall mean any Annual Report provided by the Credit Group pursuant to, and as described in, Sections 3 and 4 of this Disclosure Certificate.

"*Beneficial Owner*" shall mean any Person that has or shares the power, directly or indirectly, to make investment decisions concerning ownership of any of the Bonds (including Persons holding Bonds through nominees, depositories or other intermediaries).

"Combined System" shall have the meaning set forth in Section 4(A)(1) hereof.

"*Dissemination Agent*" shall mean any Dissemination Agent designated in writing by the Credit Group.

"*EMMA*" means the Electronic Municipal Market Access system of the Municipal Securities Rulemaking Board established pursuant to Section 15B(b)(1) of the Securities Exchange Act of 1934, or any successor thereto. Information regarding submissions to EMMA is available at http://emma.msrb.org.

"*Offering Memorandum*" shall mean the offering memorandum relating to the Bonds, dated April 25, 2017.

Section 2. Purpose of the Disclosure Certificate. This Disclosure Certificate is being executed and delivered by the Credit Group for the benefit of the Holders and Beneficial Owners of the Bonds.

Section 3. Provision of Reports.

(A) The Credit Group shall, not later than six months following the end of the fiscal year of each member of the Credit Group, commencing with the report for the fiscal year ending December 31, 2017 (due no later than June 30, 2018), provide to EMMA or through a website maintained

by Hospitals, Health Plan, Inc., HAMI and/or HPAMI an Annual Report that is consistent with the requirements of Section 4 of this Disclosure Certificate. In each case, the Annual Report may be submitted as a single document or as separate documents comprising a package, and may cross-reference other information as provided in Section 4 of this Disclosure Certificate; provided that the financial statements described in Section 4(A)(1) hereof may be submitted separately from the balance of the Annual Report and later than the date required above for the filing of the Annual Report if such financial statements are not available by that date. If the fiscal year of any of the members of the Credit Group changes, the Credit Group shall post notice of such change to EMMA or through a website maintained by Hospitals, Health Plan, Inc., HAMI and/or HPAMI.

(B) The Credit Group shall, not later than 60 days following the end of each of the first three fiscal quarters of each fiscal year, commencing with the report for the June 30, 2017 fiscal quarter, post to EMMA or through a website maintained by Hospitals, Health Plan, Inc., HAMI and/or HPAMI a report consistent with the requirements of Section 4(B) hereof.

Section 4. Content of Reports.

(A) The Annual Report shall contain or include by reference the following:

(1) The combined audited financial statements of Hospitals and its subsidiaries and Health Plan, Inc. and its subsidiaries (collectively, the "Combined System") for the prior fiscal year, ending December 31, prepared in accordance with generally accepted accounting principles as promulgated from time to time by the Financial Accounting Standards Board. If such audited financial statements are not available by the time the Annual Report is required to be filed pursuant to Section 3 hereof, the Annual Report shall contain unaudited financial statements in a format similar to the financial statements contained in the Offering Memorandum, and the combined audited financial statements shall be filed in the same manner as the Annual Report when they become available; and

(2) The unaudited summarized combined financial statements of the Credit Group.

(3) An update of the following information contained in the Offering Memorandum:

(a) Membership of each Health Plan Organization (as defined in the Offering Memorandum).

(b) To the extent not otherwise shown in the financial statements, the capitalization and selected historical debt service coverage information for the preceding fiscal year, in the form of the table under the headings "INFORMATION ABOUT KAISER — Combined Financial Information of Kaiser" in the Offering Memorandum.

(c) A summary of change in membership of Health Plan Organizations for the previous year.

(d) Approximate number of employees of Hospitals, Health Plan, Inc. and Affiliated Health Plans (as defined in the Offering Memorandum).

(e) Number of licensed hospitals, medical office buildings and other outpatient facilities owned and operated by Hospitals and Health Plan, Inc.

(4) Until the Green Bond Proceeds are fully allocated, the following information:

(a) The amount of Green Bond Proceeds allocated to Eligible Green Projects;

(b) A brief description of each such Eligible Green Project, and

(c) The LEED rating achieved for each such Eligible Green Project.

Once the Credit Group has allocated all of the Green Bond Proceeds and provided the disclosure required by this Section 4(A)(4), the Credit Group shall no longer be obligated to report the information required by this subsection (4).

Any or all of the items listed above may be included by specific reference to other documents, including official statements of debt issued for the benefit of any member of the Credit Group, which have been submitted to EMMA. The Credit Group shall clearly identify each such other document so included by reference.

(B) The quarterly reports required pursuant to Section 3(B) hereof shall contain or include by reference the unaudited summarized combined financial statements of the Combined System, including a balance sheet, a cash flow statement and a consolidated statement of operations.

Section 5. [Reserved].

Section 6. Termination of Reporting Obligation. The Credit Group's obligations under this Disclosure Certificate shall terminate upon the legal defeasance, prior redemption or payment in full of all of the Bonds. If the Credit Group's respective obligations, under the Indenture and the Guarantee Agreement are assumed in full by some other entity, such Person shall be responsible for compliance with this Disclosure Certificate in the same manner as if it were the respective member of the Credit Group and the original Credit Group member shall have no further responsibility hereunder. If such termination or substitution occurs prior to the final maturity of the Bonds, the respective Credit Group member shall give notice of such termination or substitution to EMMA or through a website maintained by Hospitals, Health Plan, Inc., HAMI and/or HPAMI.

The Credit Group's obligations under Section 4(A)(4) shall terminate once the Green Bond Proceeds have been fully allocated by the Credit Group and the disclosure required pursuant to Section 4(A)(4) has been made.

Section 7. Dissemination Agent. The Credit Group may, from time to time, appoint or engage a Dissemination Agent to assist them in carrying out their obligations under this Disclosure Certificate, and may discharge any such Dissemination Agent, with or without appointing a successor Dissemination Agent. The Dissemination Agent shall not be responsible in any manner for the content of any notice or report prepared by the Credit Group pursuant to this Disclosure Certificate. The Dissemination Agent may resign by providing 30 days written notice to the Credit Group. If at any time there is not any other designated Dissemination Agent, the Credit Group shall be the Dissemination Agent. The initial Dissemination Agent shall be the Credit Group.

Section 8. Amendment; Waiver. Notwithstanding any other provision of this Disclosure Certificate, the Credit Group may amend this Disclosure Certificate (and the Dissemination Agent shall agree to any amendment so requested by the Credit Group which does not impose any greater duties, nor greater risk of liability, on the Dissemination Agent) and any provision of this Disclosure Certificate may be waived, provided that the following conditions are satisfied:

(A) If the amendment or waiver relates to the provisions of Sections 3, 4 or 5 hereof, it may only be made in connection with a change in circumstances that arises from a change in legal requirements, change in law or change in the identity, nature or status of any member of the Credit Group with respect to the Bonds or the type of business conducted; and

(B) The amendment or waiver either (i) is approved by the Holders of the Bonds in the same manner as provided in the Indenture for amendments to the Indenture with the consent of Holders, or (ii) does not, in the opinion of nationally recognized bond counsel, materially impair the interests of the Holders or Beneficial Owners of the Bonds.

In the event of any amendment or waiver of a provision of this Disclosure Certificate, the Credit Group shall describe such amendment in the next Annual Report, and shall include, as applicable, a narrative explanation of the reason for the amendment or waiver and its impact on the type (or, in the case of a change of accounting principles, on the presentation) of financial information or operating data being presented by the Credit Group. In addition, if the amendment relates to the accounting principles to be followed in preparing financial statements, (i) notice of such change shall be posted to EMMA or through a website maintained by Hospitals, Health Plan, Inc., HAMI and/or HPAMI, and (ii) the Annual Report for the year in which the change is made should present a comparison (in narrative form and also, if feasible, in quantitative form) between the financial statements as prepared on the basis of the new accounting principles and those prepared on the basis of the former accounting principles.

Section 9. Additional Information. Nothing in this Disclosure Certificate shall be deemed to prevent the Credit Group from disseminating any other information, using the means of dissemination set forth in this Disclosure Certificate or any other means of communication, or including any other information in any Annual Report or Quarterly Report, in addition to that which is required by this Disclosure Certificate. If the Credit Group chooses to include any information in any Annual Report or Quarterly Report, in addition to that which is specifically required by this Disclosure Certificate, the Credit Group shall have no obligation under this Disclosure Certificate to update such information or include it in any future Annual Report or Quarterly Report.

Section 10. Default. In the event of a failure of the Credit Group to comply with any provision of this Disclosure Certificate, the Trustee (at the written request of the Holders of at least 25% aggregate principal amount of Outstanding Bonds) shall, or any Holder or Beneficial Owner of the Bonds may, take such actions as may be necessary and appropriate, including seeking mandate or specific performance by court order, to cause the Credit Group to comply with their obligations under this Disclosure Certificate. A default under this Disclosure Certificate shall not be deemed an Event of Default under the Indenture, and the sole remedy under this Disclosure Certificate in the event of any failure of the Credit Group to comply with this Disclosure Certificate shall be an action to compel performance.

Section 11. Notices. Any notices or communications to the Credit Group may be given as follows:

One Kaiser Plaza
Oakland, California 94612
Attention: Treasurer

Any of the Credit Group members or the Dissemination Agent may, by written notice, designate a different address to which subsequent notices or communications should be sent.

Section 12. Beneficiaries. This Disclosure Certificate shall inure solely to the benefit of the Credit Group, the Dissemination Agent, if any, and Holders and Beneficial Owners from time to time of the Bonds, and shall create no rights in any other Person.

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IN WITNESS WHEREOF, the undersigned has executed this Disclosure Certificate as of the date first written above.

KAISER FOUNDATION HOSPITALS
KAISER FOUNDATION HEALTH PLAN, INC.
KAISER HOSPITAL ASSET MANAGEMENT, INC.
KAISER HEALTH PLAN ASSET MANAGEMENT, INC.

By: _____
Authorized Signatory

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