Kaiser Permanente - Mid-Atlantic States

www.kp.org/feds

Member Services 877-KP4-FEDS (877-574-3337) (TTY: 711)

KAISER PERMANENTE®

2027

A Health Maintenance Organization
(High Option, Standard Option and Prosper)

This Plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See FEHB Facts, page 8 for details. This Plan is accredited. See Section 1, page 13.

IMPORTANT
- Rates: Back Cover
- Changes for 2027: Page 16
- Summary of Benefits: Page 128

Serving: *Washington, DC, Northern Virginia, and Metropolitan Baltimore, Montgomery County, Prince George's County, and portions of Calvert, Charles, and Frederick Counties, Maryland Area*

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See pages 13 and 14 for requirements.

Postal Employees and Annuitants are no longer eligible for this plan (unless currently under Temporary Continuation of Coverage).

Enrollment codes for this Plan:

E31 High Option - Self Only
E33 High Option - Self Plus One
E32 High Option - Self and Family

E34 Standard Option - Self Only
E36 Standard Option - Self Plus One
E35 Standard Option - Self and Family

T71 Prosper - Self Only
T73 Prosper - Self Plus One
T72 Prosper - Self and Family

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-047

Important Notice from Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.'s prescription drug coverage meets the Centers for Medicare & Medicaid Services (CMS) requirements to be considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low-Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213 (TTY: 800-325-0778).

Additional Premium for Medicare's High-Income Members

Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your FEHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return.** You do not make any IRMAA payments to your FEHB plan. Refer to the Part D-IRMAA section of the Medicare website: https ://www. medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visitwww. medicare.gov for personalized help.
- Call 800-MEDICARE (800-633-4227), (TTY: 877-486-2048).

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Introduction

This brochure describes the benefits of Kaiser Permanente - Mid-Atlantic States under contract (CS 1763) between Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Member Services may be reached at 877-KP4-FEDS (877-574-3337) (TTY: 711) or through our website: www. kp.org/feds. If you are deaf, hearing impaired or speech impaired, you can contact our Customer Service at 877-KP4-FEDS (877-574-3337) (TTY: 711). If you need ASL providers see our website at kp.org. The address for Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., administrative office is:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
4000 Garden City Drive
Hyattsville, Maryland 20785

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2027, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2027, and changes are summarized in Section 2. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee and each covered family member, “we” or "Plan" means Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of healthcare for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOB) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 877-KP4-FEDS (877-574-3337) (TTY: 711) and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTHCARE FRAUD HOTLINE
877-499-7295
OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

Do not maintain as a family member on your policy:

- Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
- Your child age 26 or over (unless they are disabled and incapable of self-support prior to age 26)

We may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- If you have any questions about the eligibility of a family member, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, sex, pregnancy, or genetic information. We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, sex, pregnancy, or genetic information.

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions and understand answers.

2. Keep and bring a list of all the medications you take.

- Bring the actual medication or give your doctor and pharmacist a list of all the medications and dosages that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other drug allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understanding both the generic and brand names for all of your medication(s) is important. This helps ensure you do not receive double dosing from taking both a generic and a brand of the same medication. It also helps you avoid taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Do not assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:

- "Exactly what will you be doing?"
- "About how long will it take?"
- "What will happen after surgery?"
- "How can I expect to feel during recovery?"

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www. jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www. jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www. ahrq.gov/patients-consumers/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- www. bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medication.
- www. leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www. ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.
- https://psnet.ahrq.gov/issue/national-patient-safety-foundation. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter a Plan hospital for a covered service, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events." (See Section 10. *Definitions of Terms We Use in This Brochure*).

We have a benefit payment policy that encourages Plan hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error. If you are charged a cost share for a never event that occurs while you are receiving an inpatient covered service, or for treatment to correct a never event that occurred at a Plan provider, please notify us.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, give you other plans' brochures and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - When you may change your enrollment
  - How you can cover your family members
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
  - What happens when your enrollment ends
  - When the next Open Season for enrollment begins

  We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for updates and questions about your benefit coverage.

- **Enrollment types available for you and your family**

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse and your children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married. We may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your employing or retirement office if you want to change from Self Only to Self Plus One or Self and Family. If you have a Self and Family enrollment, you may contact us to add a family member.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

- **Family Member Coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described below. A Self Plus One enrollment covers you and your spouse, or one eligible family member as described below.

Natural children, adopted children, and stepchildren

Coverage: Natural children, adopted children and stepchildren are covered until their 26th birthday.

Foster children

Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support

Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children

Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance

Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM implements the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP)

Our PDP EGWP is only available to FEHB annuitants who are Medicare Part D-eligible and their covered Medicare Part D-eligible family members. Our PDP EGWP is limited to FEHB annuitants enrolled in this plan and their eligible family members. If you are an active FEHB employee, or covered family member, and become eligible to enroll in Medicare Part D, you are not eligible to enroll in our PDP EGWP. Please, contact CMS for assistance at 800-MEDICARE (800-633-4227), (TTY: 877-486-2048), or you can contact Member Services at 877-KP4-FEDS (877-574-3337).

- **When benefits and premiums start**

  The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2027 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2026 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

  If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you, or a family member, are no longer eligible to use your health insurance coverage.

- **When you retire**

  When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

  You will receive an additional 31 days of coverage, for no additional premium, when:

  - Your enrollment ends, unless you cancel your enrollment; or
  - You are a family member no longer eligible for coverage.

  Any person covered under the 31-day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31-day temporary extension.

  You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

  If you are an enrollee, and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment.

  You must contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

  If you are married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you.

However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You can also visit OPM's website at www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, or if you are a covered child and you turn 26.

You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must contact us in writing within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 877-574-3337 (TTY: 711) or visit our website at www.kp.org/feds.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO). OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Kaiser Foundation Health Plan, Mid-Atlantic States, Inc. holds the following accreditation(s): National Committee for Quality Assurance (NCQA). To learn more about this plan's accreditation, please visit the following website: www. ncqa.org. We require you to use specific physicians, hospitals, and other providers. Our plan providers will coordinate your healthcare services, including among other things, when care is medically necessary and what treatment is appropriate. You choose a plan provider to be your Primary Care Provider (PCP). You will receive most of your care through these providers and at our facilities unless we have issued you a referral to another Plan provider. We are solely responsible for the selection of providers in your area. Contact us for a copy of our most recent provider directory. We give you a choice of enrollment in a High Option, a Standard Option, or Prosper plan.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. We follow the procedures for determining whether a service is medically necessary and a covered benefit described in this brochure when reviewing any prescribed course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance and deductibles described in this brochure. When you receive emergency or other authorized services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available, and/or remain under contract with us.

Questions regarding what protections apply may be directed to us at 877-KP4-FEDS (877-574-3337). You can also read additional information from the U.S. Department of Health and Human Services at www. healthcare.gov.

General features of our High Option, Standard Option and Prosper

How we pay providers

For the majority of our services, we contract with the Plan providers, and select hospitals to provide the benefits in this brochure. In addition, we may contract with a limited number of other physicians. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

Your rights and responsibilities

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayments, to no more than $4,800 for Self Only enrollment, and $9,600 for a Self Plus One or Self and Family. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed that amount.

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our providers, and our facilities. OPM's FEHB website www. opm.gov/healthcare-insurance lists the specific types of information that we must make available to you. Some of the required information is listed below.

- We are a health maintenance organization that has provided healthcare services to the Washington, DC and Baltimore, Maryland metropolitan areas since 1972.
- This medical benefit plan is provided by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. Medical, hospital and administrative services are provided through our integrated healthcare delivery organization known as Kaiser Permanente. Kaiser Permanente is composed of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (a Maryland-based non-profit/not-for-profit organization) and the Mid-Atlantic Permanente Medical Group, PC (a for-profit Maryland-based corporation) which provides services in Plan medical offices throughout the Washington, DC and Baltimore, Maryland metropolitan areas.

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our Kaiser Permanente Mid-Atlantic States website at www. kp.org/feds. You can also contact us to request that we mail a copy to you.

If you want more information, please call us at 877-KP4-FEDS (877-574-3337) (TTY: 711), or write to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Member Services Department, 4000 Garden City Drive, Hyattsville, Maryland, 20785. You may also visit our website at www. kp.org/feds.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www. kp.org/feds to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Language interpretation services

Language interpretation services are available to assist non-English speaking members. When you call Kaiser Permanente to make an appointment or talk with a medical advice nurse or member services representative, if you need an interpreter, we will provide language assistance.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area is:

- **The District of Columbia**
- **Virginia - The following cities and counties:** Alexandria City, Arlington, Fairfax City, Fairfax, Falls Church City, Fredericksburg City, King George, Loudoun, Manassas City, Manassas Park City, Prince William, Spotsylvania, Stafford
  - Portions of the following Virginia counties, as indicated by the ZIP codes below, are also within the service area:
    - Caroline - 22408, 22446, 22535, 22538, 22546, 22580 and 23015
    - Culpeper - 22407, 22736
    - Fauquier - 20115, 20116, 20117, 20119, 20128, 20137, 20138, 20139, 20140, 20144, 20181, 20184, 20185, 20186, 20187, 20188, 20198, 22406, 22556, 22639, 22642, 22643, 22720, 22728 and 22739
    - Hanover - 22546, 23015 and 23024
    - Louisa - 23015, 23024, 23117 and 23170
    - Orange - 22508, 22551, 22567 and 22960
    - Westmoreland - 22443 and 22485
- **Maryland - The following cities and counties**: Anne Arundel, Baltimore City, Baltimore, Carroll, Harford, Howard, Montgomery, Prince Georges
  - Portions of the following Maryland counties, as indicated by the ZIP codes below, are also within the service area:
  - Calvert - 20610, 20639, 20678, 20689, 20714, 20732, 20736, 20754, and 20758
  - Charles - 20601, 20602, 20603, 20604, 20607, 20612, 20613, 20616, 20617, 20637, 20640, 20643, 20645, 20646, 20658, 20675, 20677 and 20695
  - Frederick - 20842, 20871, 21701, 21702, 21703, 21704, 21705, 21709, 21710, 21714, 21716, 21717, 21718, 21754, 21755, 21757, 21758, 21759, 21762, 21769, 21770, 21771, 21774, 21775, 21776, 21777, 21790, 21791, 21792 and 21793

Ordinarily, you must receive your care from the Plan provider and select hospitals. In a limited number of circumstances other physicians and providers may be providing care for you under the direction of the Plan provider. However, we are part of the Kaiser Permanente Medical Care Program, and when you are visiting a Kaiser Permanente medical office or affiliated Plan provider outside our service area, you can receive visiting member care from designated providers in that area. See Section 5(h) *Wellness and Other Special Features*, for more details. We also pay for certain follow-up services or continuing care services while you are traveling outside the service area, as described in Section 5(h); and for emergency care obtained from any non-Plan provider, as described in Section 5(d). *Emergency Services/Accidents*. We will not pay for any other healthcare services out of our service area unless the services have prior Plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your covered family members live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2027

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to High Option, Standard Option, and Prosper

- **Premium.** Your share of the premium rate may increase or decrease depending on your Plan option and enrollment type. For details, see page 131.
- **Clinically Administered Medicine.** We added a copayment for clinically administered medicine in a clinical setting or office visit. See Section 5(a) *Clinically Administered Medicine (CAM)*, page 31.
- **In Vitro Fertilization (IVF).** We updated coverage for in vitro fertilization (IVF) for a maximum of three attempts per live birth, per calendar year. See Section 5(a) *Infertility Services: In Vitro Fertilization (IVF*), page 45.
- **Durable Medical Equipment - Scalp Cooling System.** We added coverage of 50% of our allowance. See Section 5(a) *Durable medical equipment - Scalp Cooling System*, page 56.
- **Catastrophic Protection Out-of-Pocket Maximum.** We increased the catastrophic out-of-pocket maximum. See Section 4 *Your Catastrophic Out-of-Pocket Maximum*, page 24.
- **Ambulance.** We increased the cost share for ambulance services when medically necessary. See Sections 5(c) and 5(d) *Ambulance*, pages 75 and 79.
- **Sex-Trait Modification**. We removed the exception process for coverage of excluded Sex-Trait Modification services for members age 19 and over who are mid-treatment within a surgical and/or hormonal regimen for diagnosed gender dysphoria.
- **Cervical Cancer Screening.** We added, without cost sharing, additional follow-up testing to the initial cervical cancer screening. See section 5(a) *Preventive care, adult - Cervical Cancer Screening, Additional Testing*, page 33.

Changes to High Option and Standard Option

- **Outpatient Surgery.** We increased the copayment for outpatient surgery for services performed in an outpatient hospital setting or ambulatory surgical center, per surgery or procedure. See Sections 5(c) and 9 *Outpatient Surgery*, pages 74 and 108.
- **Inpatient Surgery**. For High Option, we added a $200 copayment per inpatient maternity admission. For Standard Option, we eliminated the inpatient admission copayment for mental health and substance use disorder. See Sections 5(c), 5(e) and 5(g) *Inpatient Hospital*, pages 72, 83 and 93.
- **X-Ray.** We added a cost share, per procedure. See Section 5(a) *Lab, X-ray and other diagnostic tests – X-Ray*, page 33.
- **Primary Care Office Visit.** We increased the cost share amounts for primary care office visits, individual therapy visits, group therapy visits for mental health and substance use, and primary care dental visits. See Section 5(a) *Primary Care office visits*, page 33.

Changes to Standard Option and Prosper

- **Emergency Room.** We increased outpatient emergency care services in a hospital setting. See Section 5(d) *Emergencyservices/Accidents - Emergency Room*, page 78.

Changes to Prosper Only

- **Deductible.** We increased the calendar year deductible to $150 per person and $300 per family. See Section 4 *Your Cost for Covered Services - Deductible,* page *24.*

Changes to Medicare Advantage High Option, Standard Option, and Prosper

- **Medicare Advantage Prescription Drug Coverage (Part D) Out-of-Pocket (OOP) Maximum.** We increased the Part D prescription drug OOP maximum to $2,400. See your Kaiser Permanente Medicare Advantage for Federal Members Evidence of Coverage for more information.
- **PDP EGWP Prescription Drugs Benefit (Part D) Out-of-Pocket (OOP) Maximum**. We increased the Part D prescription drugs out-of-pocket (OOP) maximum from $2,100 to $2,400. See Section 4 *PDP EGWP Prescription Drugs Benefit (Part D) Out-of-Pocket(OOP) Maximum*, page 24.
- **Medicare Advantage Prescription Drug Dispensing Limit**. We increased the dispensing limit for prescription drugs from a 90-day supply to a 100-day supply for most medications through our retail pharmacies or our mail order pharmacy programs. See your Kaiser Permanente Medicare Advantage for Federal Members Evidence of Coverage for more information.
- **PDP EGWP Prescription Drugs Benefit – Prescription Drug Dispensing Limit**. We are increasing the dispensing limit for prescription drugs from a 90-day supply to a 100-day supply for most medications dispensed through our retail pharmacies or our mail order pharmacy programs. See your Kaiser Permanente Medicare Advantage for Federal Members Evidence of Coverage for more information.
- **Durable Medical Equipment - Scalp Cooling System.** We added coverage of 20% of our allowance. See your Kaiser Permanente Medicare Advantage for Federal Members Evidence of Coverage for more information.

Changes to Medicare Advantage High Option and Standard Option

- In our High Option Medicare Advantage 2 and our Standard Option Medicare Advantage 2 plans, we increased the Medicare Part B premium to $250 per month. See Section 9, *Medicare Advantage - Part B Reimbursement*, page 108.

- **Identification cards**

  We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Providers may request photo identification together with your ID card to verify identity. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

  If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call our Member Services Department at 877-KP4-FEDS (877-574-3337) (TTY: 711) or write to us at: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Attention: Member Services Department, 4000 Garden City Drive, Hyattsville, Maryland, 20785. After registering on our website at www.kp.org/feds, you may also request replacement cards electronically.

- **Where you get covered care**

  You get care from "Plan providers" and "Plan facilities." You will only pay cost-sharing as defined in Section 10. *Definitions of Terms We Use in This Brochure*.

- **Balance Billing Protection**

  FEHB Carriers must have clauses in their Plan provider agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the Plan provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If a Plan provider bills you for covered services over your normal cost share (deductible, copay, co-insurance), contact your Carrier to enforce the terms of its provider contract.

- **Plan providers**

  Plan providers are physicians and other healthcare professionals in the Mid-Atlantic Permanente Medical Group, PC in our service area that we employ or contract with to provide covered services to our members. Services by Plan providers are covered when acting within the scope of their license or certification under applicable state law. We credential Plan providers according to national standards.

  Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state’s designation as a medically underserved area.

  We list covered providers in our network provider directory, which we update periodically, and available on our website. Directories are available at the time of enrollment or upon request by calling our Member Services Department at 877-KP4-FEDS (877-574-3337) (TTY: 711).

  Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex, pregnancy or genetic information.

  This plan provides Care Coordinators for complex conditions and can be reached at 877-574-3337 (TTY: 711) for assistance.

- **Plan facilities**

  Plan facilities are hospitals, medical offices, and other facilities in our service area with which we contract and to which the Plan provider refers members to receive covered services. Kaiser Permanente offers comprehensive healthcare at Plan facilities conveniently located throughout our service area.

  We list Plan facilities in our physician directory, with their locations and phone numbers. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling our Member Services Department at 877-KP4-FEDS (877-574-3337) (TTY: 711). The list is also on our website at www.kp.org/feds.

You must receive your health services at Plan facilities, except if you have an emergency, authorized referral, or out-of-area urgent care. If you are visiting another Kaiser Permanente or allied plan service area, you may receive healthcare services at those Kaiser Permanente facilities. See Section 5(h). *Wellness and Other Special Features*, for more details. Under the circumstances specified in this brochure you may receive follow-up or continuing care while you travel anywhere.

- **What you must do to get covered care**

You and each covered family member choose a primary care provider from a list of the Plan providers that practice at Kaiser Permanente medical facilities. This decision is important since your primary care provider provides or arranges for most of your healthcare.

- **Primary care**

We encourage you to choose a primary care provider when you enroll. Your primary care provider will provide most of your healthcare. You may select a primary care provider from any of our available Plan providers who practice as generalists in these specialties: internal medicine, pediatrics, or family practice. If you do not select a primary care provider, one may be selected for you. Parents may choose a pediatrician as the Plan physician for their child. In the event you require services of a specialist, please refer to the section below.

To choose or change your primary care provider, you can either select one from our Provider Directory, from our website, www.kp.org/feds, or you can call our Federal Member Services Department at 877-KP4-FEDS (877-574-3337) (TTY: 711).

Please notify us of the primary care provider you choose. If you need help choosing a primary care provider, call us. You may change your primary care provider at any time. You are free to see other Plan primary care providers if your primary care provider is not available, and to receive care at Kaiser Permanente medical facilities other than the one where your primary care provider practices.

- **Specialty care**

Specialty care is care you receive from providers other than a primary care provider. When your primary care provider believes you may need specialty care, they will request authorization from us. If specialty care is necessary, we will authorize a referral to a particular specialist for an initial consultation and/or for a certain number of visits. If we authorize a referral, you may seek that care from the specialist to whom you were referred. Unless we have authorized additional visits without the need to obtain another referral you must return to your primary care provider after the consultation. Do not go to a specialist for return visits unless we have given you an authorized referral for visits beyond the initial consultation. You may see the following Plan providers without first obtaining authorization: obstetrical and gynecologists, optometrists, or mental health and substance use. You may obtain mental health and substance use services from the Plan's mental health or substance use disorder treatment providers without a primary care referral by directly calling our Behavioral Health Access Unit at 866-530-8778 to arrange for services.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care provider in consultation with us and your attending specialist may develop a treatment plan that allows you to see the specialist for visits without additional referrals. Your primary care provider must contact us and use our criteria when creating your treatment plan (the physician will have to get authorization beforehand).
- If you are seeing a specialist when you enroll in our Plan, in almost all cases you will be required to switch to a Plan specialist. Generally, we will not pay for you to see a specialist who is not a member of the Plan unless you have an authorized referral.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care provider, who will request permission from us for you to see another specialist. Under certain circumstances for certain conditions, you may receive authorized services from your current specialist until we can make arrangements for you to see a Plan specialist.
- You may continue seeing your specialist for up to 90 days if you are undergoing treatment for a chronic or disabling condition and you lose access to your specialist because:
  - we terminate our contract with your specialist for a reason other than cause;
  - we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
  - we reduce our service area and you enroll in another FEHB plan;

Contact us at 877-KP4-FEDS (877-574-3337) or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 day period.

Note: If you lose access to your specialist because you changed your carrier or plan option enrollment, contact your new plan.

- **Hospital care**

If you require emergency care, please go to the nearest hospital. After your condition has stabilized, we may choose to move you to a hospital where Plan physicians are on duty 24 hours a day, 7 days a week.

For non-emergency admissions, your care will be coordinated through the Plan. This includes admission to a skilled nursing or other facility. The Plan determines the most appropriate facility for care for any admission to a non-hospital facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Member Services Department immediately at 877-KP4-FEDS (877-574-3337) (TTY: 711). If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

- **You need prior Plan approval for certain services**

Your primary care provider arranges most referrals to specialists. For certain services your physician must obtain approval from us. Before we approve a referral, we may consider if the service or item is medically necessary and meets other coverage requirements. We call this review and approval process “prior authorization” although we often use the term “referral” for this process as well. Once the referral is approved, we will notify you that we have authorized your referral.

Your physician must obtain authorization for all covered items or services, except:

- Routine primary care services
- Routine obstetrical and gynecological services (excluding infertility diagnosis and treatment; treatment and management of gynecological malignancies; urogynecology; prenatal diagnostic tests performed outside of the doctor's office; and other specialized gynecological services)
- Care received in an emergency room, designated Kaiser Permanente urgent care centers, or designated Kaiser Permanente minor injury clinics
- Emergency ambulance transport
- Certain prescription medications as identified on our formulary
- Self-referrals to designated Plan Behavioral Health (mental health and substance use disorder care) providers
- Optometry services

To confirm if a referral has been approved for a service or item that requires prior authorization, please call our Member Services Department at 877-KP4-FEDS (877-574-3337) (TTY: 711).

We must provide or arrange for your mental health and substance use disorder care. Call our Behavioral Health Access Unit at 866-530-8778 to make arrangements.

Finally, except for services from Plan primary care providers, all services performed by non-Plan providers and non-Kaiser Permanente facilities must be authorized in advance.

You should call our Member Services Department if you have not been notified of the outcome of our review. If we do not authorize a request, you have the right to ask us in writing to reconsider our initial decision (see Section 8. *The Disputed Claims Process*).

Prior authorization determinations are made based on the information available at the time the service or item is requested. We will not cover a service or item unless you are a Plan member on the date you receive the service or item. Prior authorization is a certification of medical necessity. In order for the Plan to pay for an authorized service, the service must be a covered service.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 877-KP4-FEDS (877-574-3337) (TTY: 711). You may also call OPM's FEHB 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 877-KP4-FEDS (877-574-3337) (TTY: 711). If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

- **Emergency services/ accidents and post-stabilization care**

Emergency services do not require authorization. However, if you are admitted to a hospital or other facility, you or your family member must notify us within 48 hours, or as soon as reasonably possible, or your claims may be denied.

You must also obtain authorization from us for post-stabilization care you receive from non-Plan providers.

See Section 5(d). *Emergency Services/Accidents* for more information.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

- **Maternity care**

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, your physician or the hospital must contact us for precertification of additional days for your baby.

Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **What happens when you do not follow the precertification rules**

  You must receive your health services at Plan facilities, except if you have an emergency, authorized referral, or out-of-area urgent care. Your primary care provider will provide most of your healthcare or give you a referral to see a specialist. If you do not obtain a referral from us for services or items that require a referral, we will not pay any amount for those services or items, and you may be liable for the full price of those services or items. This also includes any residual amounts, such as deductibles, copayments or coinsurance that are not covered or not paid by any other insurance plan you use to pay for those services or items.

- **Circumstances beyond our control**

  Under certain circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

- **If you disagree with our pre-service claim decision**

  If you have a **pre-service claim** and you do not agree with our prior approval decision, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call our Member Services Department at 877-KP4-FEDS (877-574-3337) (TTY:711).

  If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

  Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to do one of the following:

  1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply.
  2. Ask you or your provider for more information.
     - You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.
     - If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
  3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

  In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written request for appeals and the exchange of information by phone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

  After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your Cost for Covered Services

This is what you will pay out-of-pocket for covered care:

- **Cost-sharing**

  Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

- **Copayments**

  A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. The amount of copayment will depend upon whether you are enrolled in the High Option, Standard Option or Prosper, the type of provider, and the service or supply that you receive.

  You pay a primary care provider copayment when you visit any primary care provider as described in Section 3. *How You Get Care*. You pay a specialist copayment when you receive care from a specialist as described in Section 3.

  For example, for diagnostic and treatment services as described in Section 5(a):

  - Under the High Option, you pay a $15 copayment when you receive diagnostic and treatment services from a primary care provider and a $20 copayment when you receive these services from a specialty care provider.
  - Under the Standard Option, you pay a $25 copayment when you receive diagnostic and treatment services from a primary care provider and a $30 copayment when you receive these services from a specialty care provider.
  - Under Prosper, you pay a $30 copayment when you receive diagnostic and treatment services from a primary care provider and a $40 copayment when you receive these services from a specialty care provider.

- **Deductible**

  A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

  The High and Standard Options have no deductible. The calendar year deductible is $150 per person for Prosper. Under a Self Plus One or Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $300.

  Note: If you change plans during Open Season, you do not have to start a new deductible under your prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

  If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

- **Coinsurance**

  Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible. Example: In our Plan, you pay 50% of our allowance for infertility services, ovulation stimulants, oxygen, and equipment for home use.

- **Your catastrophic protection out-of-pocket maximum**

  After your (deductible, copayments, and coinsurance) reaches the out-of-pocket maximum, you do not have to pay any more for covered services, with the exception of certain cost-sharing for the services below, which do not count toward your catastrophic protection out-of-pocket maximum.

  Your out-of-pocket maximum for services rendered during the 2027 calendar year is:

  High Option

$3,750 per person, up to $7,500 per family enrollment

Standard Option

$4,500 per person, up to $9,000 per family enrollment

Prosper

$5,300 per person, up to $10,600 per family enrollment

For members enrolled in our Plan's associated MA-PD or PDP EGWP, we are required to accumulate all members' actual out-of-pocket costs for Medicare-covered drugs, services and supplies toward the FEHB catastrophic maximum(s).

If you are enrolled in our Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP), the prescription drug true out-of-pocket cost (TrOOP) is $2,400. After this is met, we pay 100% of all eligible covered prescription drug benefits.

- **Carryover**

If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your prior plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your prior plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your prior plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your prior plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your prior option to the catastrophic protection limit of your new option.

- **When Government facilities bill us**

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

- **Important Notice About Surprise Billing - Know Your Rights**

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services. We use "Plan providers" and "Plan facilities" to refer to "in-network" services.

A surprise bill is an unexpected bill you receive for

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by non-Plan providers with respect to patient visits to Plan health care facilities, or for
- air ambulance services furnished by non-Plan providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills.

In addition, we will pay for services obtained at a nonparticipating hospital in the State of Maryland based on Title 19, Subtitle 2, Part II (Health Care Facility Rate Setting) and § 19-710.1 of Maryland's Health-General Article and § 14-205.2 of the Maryland Insurance Article.

- **The Federal Flexible Spending Account Program – *FSAFEDS***
  - **Healthcare FSA (HCFSA)** – Reimburses an FSA participant for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, over-the-counter drugs and medications, vision and dental expenses, and much more) for their tax dependents, and their adult children (through the end of the calendar year in which they turn 26).
  - **FSAFEDS** – offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

Section 5. High Option, Standard Option and Prosper Benefits

See Section 2 for how our benefits changed this year. The Summary of Benefits is a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. High Option, Standard Option and Prosper Benefits Overview

This Plan offers High Option, Standard Option and Prosper. These benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High Option, Standard Option and Prosper Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High Option, Standard Option and Prosper benefits, contact us at 877-KP4-FEDS (877-574-3337) (TTY: 711). You can also visit our website at www. kp.org/feds.

Since 1972, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Permanente) has offered quality integrated healthcare to the FEHB Program. We contract with the Mid-Atlantic Permanente Plan providers to provide our members with quality care and attention, to coordinate your care with the appropriate provider or providers, and to assist us in determining what services, supplies and items are medically necessary. Because we are an integrated system, your care will almost always be rendered by one of Plan provider's primary care providers or specialists, or the contracted hospital that we determine is appropriate for the care you need. Our delivery system offers convenient, comprehensive care all under one roof. You can come to many of our medical facilities and see a primary care provider, pediatrician, Ob/Gyn or specialist, fill prescriptions, have mammograms, complete lab work, get X-rays and more. Also, our sophisticated health technology gives you the opportunity 24 hours a day, 7 days a week to schedule appointments with Plan provider physicians, refill prescriptions at Kaiser Permanente pharmacies, research medical conditions and view your medical information on line.

This Plan offers three options: High Option, Standard Option and Prosper. These Options are designed to include preventive and acute care services provided by our Plan providers, but offer different levels of benefits and services for you to choose between to best fit your healthcare needs. Each option offers unique features.

High Option

Our High Option provides comprehensive benefits. It includes:

- No copayment for all primary care visits for children from infancy through age 4
- No copayment for most preventive care for adults and children
- $15 per visit to your primary care provider (PCP) for diagnostic services
- $20 per visit to a specialist for diagnostic services
- $200 per admission for inpatient admissions, and $200 for inpatient maternity care
- $7 per prescription or refill for covered preferred generic drugs obtained at a Plan medical center pharmacy; $17 per prescription or refill for covered preferred generic drugs obtained at an affiliated network pharmacy up to a 30-day supply
- $30 per prescription or refill for preferred brand-name drugs obtained at a Plan medical center pharmacy; $50 per prescription or refill for preferred brand-name drugs obtained at an affiliated network pharmacy up to a 30-day supply
- $45 per prescription or refill for non-preferred drugs obtained at a Plan medical center pharmacy; $65 per prescription or refill for non-preferred drugs obtained at an affiliated network pharmacy up to a 30-day supply
- $100 per prescription or refill for specialty drugs obtained at a Plan medical center pharmacy; $150 per prescription or refill for specialty drugs obtained at an affiliated network pharmacy up to a 30-day supply
- $30 per office visit for preventive dental care

Standard Option

With the Standard Option your copayments may be higher than the High Option, but the bi-weekly premium is lower. Specific benefits of our FEHB Standard Option include:

- No copayment for all primary care visits for children from infancy through age 17
- No copayment for most preventive care for adults and children
- $25 per visit to your primary care provider (PCP) for diagnostic services

- $30 per visit to a specialist for diagnostic services
- $500 per admission for inpatient admissions, except no charge for inpatient maternity care and inpatient mental health and substance use care
- $10 per prescription or refill for covered preferred generic drugs obtained at a Plan medical center pharmacy; $20 per prescription or refill for covered preferred generic drugs obtained at an affiliated network pharmacy up to a 30-day supply
- $40 per prescription or refill for preferred brand-name drugs obtained at a Plan medical center pharmacy; $60 per prescription or refill for preferred brand-name drugs obtained at an affiliated network pharmacy up to a 30-day supply
- $60 per prescription or refill for non-preferred drugs obtained at a Plan medical center pharmacy; $80 per prescription or refill for non-preferred drugs obtained at an affiliated network pharmacy up to a 30-day supply
- $150 per prescription or refill for specialty drugs obtained at a Plan medical center pharmacy; $200 per prescription or refill for specialty drugs obtained at an affiliated network pharmacy up to a 30-day supply
- $30 per office visit for preventive dental care

Prosper

With Prosper, you will pay a deductible for certain services and higher copayments but the premium is the lowest. Specific benefits of our FEHB Prosper include:

- Calendar year deductible of $150 per person up to $300 per family.
- No copayment for all primary care visits for children from infancy through age 4.
- No copayment for most preventive care for adults and children.
- $30 per visit to your primary care provider (PCP) for diagnostic services.
- $40 per visit to a specialist for diagnostic services.
- $750 per admission after deductible for inpatient admissions.
- $10 per prescription or refill for covered preferred generic drugs obtained at a Plan medical center pharmacy; $20 per prescription or refill for covered preferred generic drugs obtained at an affiliated network pharmacy, up to a 30-day supply.
- $45 per prescription or refill for preferred brand-name drugs obtained at a Plan medical center pharmacy; $65 per prescription or refill for preferred brand-name drugs obtained at an affiliated network pharmacy, up to a 30-day supply.
- $65 per prescription or refill for non-preferred drugs obtained at a Plan medical center pharmacy; $85 per prescription or refill for non-preferred drugs obtained at an affiliated network pharmacy, up to a 30-day supply.
- $200 per prescription or refill for specialty drugs obtained at a Plan medical center pharmacy; $250 per prescription or refill for specialty drugs obtained at an affiliated network pharmacy, up to a 30-day supply.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Our integrated system and the care teams we have developed provide care in a collaborative model. That model pervades all of the care provided and in many ways our care is, in its entirety, a collaborative care model. These collaborative systems for care delivery are included across care teams such as primary care, chronic conditions management, hospital-based care, post discharge care, healthy living resources, and specialty care including mental health and substance use disorder services. This is facilitated by our integration of care and coverage, our shared electronic health record, and our whole-person approach to care. Our clinicians work together with patients using our shared decision-making model to develop treatment plans. All care is documented in our electronic health record and all clinicians have access to a patient's chart, facilitating a seamless patient experience and better health outcomes.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- Unless you receive prior approval from us, Plan providers must provide or arrange your care.
- There is no calendar year deductible for the High and Standard Options.
- Under Prosper the calendar year deductible is $150 per person ($300 per Self Plus One enrollment, or $300 per Self and Family enrollment). The calendar year deductible applies to some benefits in this Section. We added "(after the deductible)" when the calendar year deductible applies.
- Be sure to read Section 4. *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9, Coordinating Benefits with Medicare and Other Coverage. Different copayments apply for primary care visits and specialty care visits.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(*c*) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You pay		
Note: The calendar year deductible applies to some benefits under Prosper in this Section. We say "after the deductible" when the calendar year deductible applies.			
Diagnostic and treatment services	**High Option**	**Standard Option**	**Prosper**
Professional services of physicians and other healthcare professionals • In physician's office • Office medical consultations • Second surgical opinion • Advance care planning Notes: You will not be charged the following clinically administered medications in connection with your care: • Immunizations • Allergen serum and related injection supplies • Pregnancy and postpartum-related administered medications/services	$15 per primary care office visit (nothing from infancy through age 4) $20 per specialty care office visit Note: You pay up to $50 per encounter for drugs administered in connection with your care	$25 per primary care office visit (nothing from infancy through age 17) $30 per specialty care office visit Note: You pay up to $75 per encounter for drugs administered in connection with your care	$30 per primary care office visit (nothing from infancy through age 4) $40 per specialty care office visit Note: You pay up to $100 per encounter for drugs administered in connection with your care

Diagnostic and treatment services - continued on next page

Benefit Description	You pay		
Diagnostic and treatment services (cont.)	**High Option**	**Standard Option**	**Prosper**
• Services rendered in the following care setting: - Inpatient hospital - Outpatient hospital - Ambulatory surgery centers • Drugs required for radiology procedures and other diagnostic tests	$15 per primary care office visit (nothing from infancy through age 4) $20 per specialty care office visit Note: You pay up to $50 per encounter for drugs administered in connection with your care	$25 per primary care office visit (nothing from infancy through age 17) $30 per specialty care office visit Note: You pay up to $75 per encounter for drugs administered in connection with your care	$30 per primary care office visit (nothing from infancy through age 4) $40 per specialty care office visit Note: You pay up to $100 per encounter for drugs administered in connection with your care
Not covered: • Drugs administered in a clinical setting, such as androgen blockers, estrogen, progesterone, and testosterone, to align an individual's physical appearance with an identity that differs from his or her sex • Drugs administered in a clinical setting for the purpose of delaying the onset or progression of normally timed puberty (including GnRH agonists)	*All charges*	*All charges*	*All charges*
Professional services of physicians and other healthcare professionals • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child • In a rehabilitation facility • At home	Nothing	Nothing	Nothing
Telehealth services	**High Option**	**Standard Option**	**Prosper**
Professional services of physicians and other healthcare professionals delivered through telehealth, such as: • Interactive video visits • Phone visits • Email Note: Visits may be limited by provider type, location and benefit specific limitations, such as visit limits.	Nothing	Nothing	Nothing

Benefit Description	You pay		
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**	**Prosper**
Tests, such as: • Blood test • Urinalysis • Non-routine Pap test • Pathology • Non-routine mammogram • Ultrasound • Electrocardiogram and EEG Note: You pay the diagnostic and treatment cost-sharing for diagnostic tests when received as a part of a non-invasive vascular diagnostic study or echocardiogram. See Section 5(a), *Diagnostic and treatment services*.	Nothing	Nothing	Nothing
• X-ray	$15 per procedure	$25 per procedure	$40 per procedure
• Breast MRI	Nothing	Nothing	Nothing
• CT/CAT scan • MRI • Nuclear medicine • PET scan • Sleep lab • Interventional radiology procedures Note: Interventional radiology uses guided imagery to visualize, treat, or diagnose organ or circulatory function.	$75 per procedure	$100 per procedure	$100 per procedure after the deductible
Preventive care, adult	**High Option**	**Standard Option**	**Prosper**
Routine physical exam, including for school and camp **The following preventive services are covered at the time interval recommended at each of the links below:** • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings, visit the U.S. Preventive Services Task Force (USPSTF) website at https ://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks	Nothing	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay		
Preventive care, adult (cont.)	**High Option**	**Standard Option**	**Prosper**
• Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal, intimate partner, and domestic violence. For a complete list of preventive care benefits for women, please visit the Health and Human Services (HHS) website at www. hrsa.gov/womens-guidelines • Routine use of adult immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and adopted by the Centers for Disease Control and Prevention (CDC) are covered. A recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention. For the current immunization schedule, visit https ://www.cdc.gov/vaccines/imz-schedules/index.html • Services such as routine prostate specific antigen (PSA) test • We cover other preventive services required by federal healthcare reform legislation (the Affordable Care Act and implementing regulations) and additional services that we include in our preventive services benefit. For a complete list of Kaiser Permanente preventive services visit our website at www.kp.org/prevention • To build your personalized list of preventive services go to www. health.gov/myhealthfinder	Nothing	Nothing	Nothing
• Routine mammogram	Nothing	Nothing	Nothing
Travel consultations, immunizations, and vaccines	$15 per primary care office visit $20 per specialty care office visit	$25 per primary care office visit $30 per specialty care office visit	$30 per primary care office visit $40 per specialty care office visit
Obesity counseling, screening, and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family-centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy.	Nothing	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay		
Preventive care, adult (cont.)	**High Option**	**Standard Option**	**Prosper**
Kaiser Permanente's unique integrated model of care and coverage enables us to provide whole-person care that meets the unique needs of each individual patient, without coverage limitations or strict eligibility criteria. Our approach to weight management with our patients includes lifestyle modification programs when clinically appropriate. All Kaiser Permanente regions offer lifestyle programs that align with USPSTF recommendations for program duration, including providing the required 26 or more contact hours over 3 to 12 months, to support members in their weight management journey. Additionally, our physicians work with patients to determine the appropriate length of program participation to meet their unique needs. We offer several aspects of an Intensive Behavioral Treatment program to our adolescent and pediatric members, including: medical nutritional therapy by registered dieticians, behavioral therapy by a pediatric psychologist, and supervised physical activity by a pediatric physical therapist. Members are offered individual or group-based training. • Family-centered programs when medically identified to support obesity prevention and management by an in-network provider. Family-centered programs include The Healthy Eating, Active Living (HEAL) program offered by Kaiser Permanente to help children and teens aged 3-17 years old and their families make lasting healthy lifestyle choices to help maintain a healthy weight. HEAL offers 6–12-month programs on healthy lifestyle changes, healthy cooking courses, and recommended physical activity. The HEAL program is available to any patient with a BMI>85%. Kaiser Permanente physicians work with our members using a shared decision-making model to develop individualized treatment plans to address clinical condition(s) and personal goals, and provide access to other weight management experts when needed, including dieticians and behavioral health coaches. Kaiser Permanente also offers healthy weight, nutrition, and exercise programs and resources to instill healthy lifestyle behaviors and promote good health. Program offerings may include: • In-person and virtual classes	Nothing	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay		
Preventive care, adult (cont.)	**High Option**	**Standard Option**	**Prosper**
• Wellness coaching by phone • Healthy lifestyle programs • Fitness programs • Intensive Behavioral Therapy (IBT) for Cardiovascular Risk Factors While we do not have a formal IBT program, we do have the components of Intensive Behavioral Therapy available to our patients; these components are offered within our integrated model and all care team members have access to our electronic medical record to coordinate and oversee care plans. Our programs focus on assessing readiness to change and supporting effective and sustained behavior change. Patients with cardiovascular risk factors (e.g. smoking, elevated blood pressure, high cholesterol, obesity, diabetes, and physical inactivity) receive targeted recommendations from wellness coaches, health educators, and other clinicians as appropriate to identify behavioral and lifestyle modifications for better health outcomes. Additionally, patients diagnosed with cardiovascular conditions and/or other co-morbidities are automatically enrolled in the relevant disease management program within our system and will receive personalized support to manage their condition. Visit kp.org/classes for more information, or see Section 5(h), *Wellness and Other Special Features,* for nutritional and behavioral lifestyle support details. Visit www. kp.org/feds to review additional information on Kaiser Permanente's requirements for weight loss medications and weight loss programs. Notes: • See Section 5(h) *Wellness and Other Special Features* and *Non-FEHB Benefits Available to Plan Members* for details on our nutritional and physical activity support for members. • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) • When anti-obesity medication is prescribed. See Section 5(f).	Nothing	Nothing	Nothing
Notes:	Applies to this benefit	Applies to this benefit	Applies to this benefit

Preventive care, adult - continued on next page

Benefit Description	You pay		
Preventive care, adult (cont.)	**High Option**	**Standard Option**	**Prosper**
• You may pay cost-sharing for any procedure, injection, diagnostic service, laboratory or X-ray service that is provided in conjunction with a routine physical exam and is not included in the preventive recommended listing of services. • You should consult with your physician to determine what is appropriate for you.	Applies to this benefit	Applies to this benefit	Applies to this benefit
Not covered: • *Physical exams and immunizations required for:* - *Obtaining or continuing employment* - *Insurance or licensing* - *Participating in employee programs* - *Court ordered parole or probation*	*All charges*	*All charges*	*All charges*
Preventive care, children	**High Option**	**Standard Option**	**Prosper**
Annual routine physical	Nothing	Nothing	Nothing
• Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to www. brightfutures.aap.org. For preventive immunizations see guidance below. • Routine use of children's immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) schedule and adopted by the Centers for Disease Control and Prevention (CDC) are covered. A recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention. For the current immunization schedule, visit https ://www. cdc.gov/vaccines/imz-schedules/index.html • You can also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at https :// www. uspreventiveservicestaskforce.org/ uspstf/recommendation-topics/uspstf-a-and-b-recommendations	Nothing	Nothing	Nothing

Preventive care, children - continued on next page

Benefit Description	You pay		
Preventive care, children (cont.)	**High Option**	**Standard Option**	**Prosper**
• We cover other preventive services required by federal healthcare reform legislation (the Affordable Care Act and implementing regulations) and additional services that we include in our preventive services benefit. For a complete list of Kaiser Permanente preventive services visit our website at www.kp.org/prevention • To build your personalized list of preventive services go to https://health.gov/myhealthfinder	Nothing	Nothing	Nothing
Travel consultations, immunizations, and vaccines	$15 per primary care office visit (nothing from infancy through age 4) $20 per specialty care office visit	$25 per primary care office visit (nothing from infancy through age 17) $30 per specialty care office visit	$30 per primary care office visit (nothing from infancy through age 4) $40 per specialty care office visit
Obesity counseling, screening, and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family-centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy. Kaiser Permanente's unique integrated model of care and coverage enables us to provide whole-person care that meets the unique needs of each individual patient, without coverage limitations or strict eligibility criteria. Our approach to weight management with our patients includes lifestyle modification programs when clinically appropriate. All Kaiser Permanente regions offer lifestyle programs that align with USPSTF recommendations for program duration, including providing the required 26 or more contact hours over 3 to 12 months, to support members in their weight management journey. Additionally, our physicians work with patients to determine the appropriate length of program participation to meet their unique needs.	Nothing	Nothing	Nothing

Preventive care, children - continued on next page

Benefit Description	You pay		
Preventive care, children (cont.)	**High Option**	**Standard Option**	**Prosper**
We offer several aspects of an Intensive Behavioral Treatment program to our adolescent and pediatric members, including: medical nutritional therapy by registered dieticians, behavioral therapy by a pediatric psychologist, and supervised physical activity by a pediatric physical therapist. Members are offered individual or group-based training. Our Adolescent Lifestyle Medicine program is recognized as an intensive, longitudinal intervention designed to support sustainable health behavior change in youth. The program spans six months or more, with monthly physician visits that include a 60-minute initial consultation followed by 30-minute follow-ups throughout the course of the program. Our Teen Mindfulness virtual workshop is another valuable offering for members between the ages of 12 and 17 years old. This workshop consists of 6 weekly sessions where members can expect to learn about the mind/body connection, emotions, and thoughts, and build their strengths. This workshop is open to all our interested pediatric members, and there are no specific BMI criteria for participating in the workshops. • Family-centered programs when medically identified to support obesity prevention and management by an in-network provider. Family-centered programs include The Healthy Eating, Active Living (HEAL) program offered by Kaiser Permanente to help children and teens aged 3-17 years old and their families make lasting healthy lifestyle choices to help maintain a healthy weight. HEAL offers 6–12-month programs on healthy lifestyle changes, healthy cooking courses, and recommended physical activity. The HEAL program is available to any patient with a BMI>85%.	Nothing	Nothing	Nothing

Preventive care, children - continued on next page

Benefit Description	You pay		
Preventive care, children (cont.)	**High Option**	**Standard Option**	**Prosper**
Kaiser Permanente physicians work with our members using a shared decision-making model to develop individualized treatment plans to address clinical condition(s) and personal goals, and provide access to other weight management experts when needed, including dieticians and behavioral health coaches. Kaiser Permanente also offers healthy weight, nutrition, and exercise programs and resources to instill healthy lifestyle behaviors and promote good health. Program offerings may include: • In-person and virtual classes • Wellness coaching by phone • Healthy lifestyle programs • Fitness programs • Intensive Behavioral Therapy (IBT) for Cardiovascular Risk Factors While we do not have a formal IBT program, we do have the components of Intensive Behavioral Therapy available to our patients; these components are offered within our integrated model and all care team members have access to our electronic medical record to coordinate and oversee care plans. Our programs focus on assessing readiness to change and supporting effective and sustained behavior change. Patients with cardiovascular risk factors (e.g. smoking, elevated blood pressure, high cholesterol, obesity, diabetes, and physical inactivity) receive targeted recommendations from wellness coaches, health educators, and other clinicians as appropriate to identify behavioral and lifestyle modifications for better health outcomes. Additionally, patients diagnosed with cardiovascular conditions and/or other co-morbidities are automatically enrolled in the relevant disease management program within our system and will receive personalized support to manage their condition. Visit kp.org/classes for more information, or see Section 5(h), *Wellness and Other Special Features,* for nutritional and behavioral lifestyle support details. • Visit www. kp.org/feds to review additional information on Kaiser Permanente's requirements for weight loss medications and weight loss programs.	Nothing	Nothing	Nothing

Preventive care, children - continued on next page

Benefit Description	You pay		
Preventive care, children (cont.)	**High Option**	**Standard Option**	**Prosper**
Notes: • See Section 5(h) *Wellness and Other Special Features* and *Non-FEHB Benefits Available to Plan Members* for details on our nutritional and physical activity support for members. • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) • When anti-obesity medication is prescribed. See Section 5(f).	Nothing	Nothing	Nothing
Notes: • You may pay cost-sharing for any procedure, injection, diagnostic service, laboratory or X-ray service that is provided in conjunction with a routine physical exam and is not included in the recommended listing of services. • Hearing Screenings are provided by a primary care provider as part of a well-child care visit. For other hearing exams or tests, see Section 5(a), *Diagnostic and treatment services* or Section 5(a), *Hearing services*.	Applies to this benefit	Applies to this benefit	Applies to this benefit
Not covered: • *Physical exams required for:* - *Obtaining or continuing employment* - *Insurance or licensing* - *Participating in employee programs* - *Court ordered parole or probation* • *All other hearing testing, except as may be covered in Section 5(a), Diagnostic and treatment services or Section 5(a), Hearing services*	*All charges*	*All charges*	*All charges*
Maternity care	**High Option**	**Standard Option**	**Prosper**
Routine maternity (obstetrical) care, such as: • Prenatal and Postpartum care • Screening for gestational diabetes • Screening and counseling for prenatal and postpartum depression Note:	Nothing	Nothing	Nothing

Maternity care - continued on next page

Benefit Description	You pay		
Maternity care (cont.)	**High Option**	**Standard Option**	**Prosper**
Early intervention is a hallmark of Kaiser Permanente's prenatal care program. Prenatal care screenings can help detect or prevent many adverse health outcomes and identify members with high-risk pregnancies. In Kaiser Permanente's patient-centered model of care, the care plan for patients with high-risk pregnancies is determined based on the patient's unique needs and condition. This may include ultrasounds, fetal monitoring, and/or additional in-person prenatal visits, and supportive touchpoints with nurses or other care coordinators.	Nothing	Nothing	Nothing
• Delivery	Nothing for inpatient professional delivery services	Nothing for inpatient professional delivery services	Nothing for inpatient professional delivery services
• Breastfeeding and lactation support, supplies, and counseling for each birth Note: We cover milk pumps and supplies under Durable Medical Equipment (DME).	Nothing	Nothing	Nothing
Notes: • Routine maternity care is covered after confirmation of pregnancy. • Your Plan provider does not have to obtain prior approval from us for your vaginal delivery. See Section 3, *You need prior Plan approval for certain services*. • As part of your coverage, you have access to in-network Certified Nurse Midwives (CNM) within our service area and board-certified lactation specialists during the prenatal and post-partum period. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Note:	Applies to this benefit	Applies to this benefit	Applies to this benefit

Maternity care - continued on next page

Benefit Description	You pay		
Maternity care (cont.)	**High Option**	**Standard Option**	**Prosper**
• When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • You pay cost-sharing for other services, including: - Diagnostic and treatment services for illness or injury received during a non-routine maternity care as described in this section - Lab, X-ray and other diagnostic tests (including ultrasounds), Durable medical equipment as described in this section - Surgical services described in Section 5 (b). *Outpatient hospital or ambulatory surgical center* - Hospitalization (including room and board and delivery) as described in Section 5(*c*). *Inpatient hospital*	Applies to this benefit	Applies to this benefit	Applies to this benefit
Clinically Administered Medication Notes: You will not be charged for the following medications in connection with your care: • Immunizations • Allergen serum and related injection supplies • Pregnancy and postpartum-related administered medications/services • Services rendered in the following care setting: - Inpatient hospital - Outpatient hospital - Ambulatory surgery centers • Drugs required for radiology procedures and other diagnostic tests	Note: You pay $50 per encounter for drugs administered in connection with your care	Note: You pay $75 per encounter for drugs administered in connection with your care	Note: You pay $100 per encounter for drugs administered in connection with your care

Benefit Description	You pay		
Family planning	**High Option**	**Standard Option**	**Prosper**
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories in the HRSA-supported guidelines. This list includes: • Voluntary female sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms • Family planning counseling • Contraceptives counseling Notes: • See Section 5(b), *Surgical and Anesthesia Services* • See additional Family Planning and Prescription drug coverage in Section 5(f) Note: • Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below. • Kaiser Permanente physicians prescribe the appropriate level of medically necessary contraceptive medications to FEHB members. To ensure physicians can make appropriate exceptions, they have the authority to prescribe brand-name or non-formulary contraceptive drugs for members without administrative review if their opinion is that a particular drug is medically necessary and would be more beneficial for an individual member. Members pay their regular prescription drug copayment for medically necessary brand-name drugs. Information on contraceptive coverage is available to FEHB members on kp.org/feds and kp.org/health-wellness.	Nothing	Nothing	Nothing

Family planning - continued on next page

Benefit Description	You pay		
Family planning (cont.)	**High Option**	**Standard Option**	**Prosper**
• Kaiser Permanente does not have any coverage exceptions for surgical contraception methods. If surgical contraception procedures are performed for the purpose of contraception, they are covered without cost-sharing. • Once we have been contacted with exception request information sufficient for us to make a determination, you will receive a response within 24 hours or the next business day. Contraceptive exception requests are not subject to Section 8. The Disputed Claims Process. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.	Nothing	Nothing	Nothing
Voluntary male sterilization	Nothing	Nothing	Nothing
• Genetic counseling	$15 per primary care office visit $20 per specialty care office visit	$25 per primary care office visit $30 per specialty care office visit	$30 per primary care office visit $40 per specialty care office visit
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**	**Prosper**
Infertility is the inability of an individual to conceive or produce conception during a period of 1 year if the female is age 35 or younger, or during a period of 6 months if the individual is over the age of 35, or having a medical or other demonstrated condition that is recognized by a Plan Physician as a cause of infertility. Diagnosis and treatment of infertility: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Semen analysis • Hysterosalpingogram • Hormone evaluation	50% of our allowance	50% of our allowance	50% of our allowance after the deductible
• In vitro fertilization (IVF) • Coverage for in vitro fertilization (IVF) is limited to a maximum of three attempts per live birth, per calendar year	50% of our allowance	50% of our allowance	50% of our allowance after the deductible

Infertility services - continued on next page

Benefit Description	You pay		
Infertility services (cont.)	**High Option**	**Standard Option**	**Prosper**
• Covered for an annual benefit maximum of $50,000. • Assisted reproductive technology (ART) procedures • Embryo transfer Notes: • The use of in vitro fertilization (IVF) is available for: - Unmarried or married members or married member's spouse who have been unable to attain a successful pregnancy through a less costly infertility treatment - The infertility of the unmarried or married member or married member's spouse is associated with the following: • Endometriosis; • Exposure in utero to diethylstilbestrol, commonly known as DES; • Blockage of, or surgical removal of, one (1) or both fallopian tubes (lateral or bilateral salpingectomy); or • Abnormal male factors, including oligospermia, contributing to the infertility; • Unmarried members and same sex couples using donor sperm that have attempted three Intrauterine Insemination (IUI), procedures prior to attempting IVF treatment	50% of our allowance	50% of our allowance	50% of our allowance after the deductible
Notes: • See Section 5(f). Prescription Drug Benefits, for coverage of fertility drugs. • See Section 3, *You need prior Plan approval for certain services*. • A Plan physician will determine the appropriate treatment and number of attempts for infertility treatment.	Applies to this benefit	Applies to this benefit	Applies to this benefit
Fertility preservation for iatrogenic infertility: • Procurement of sperm or eggs including medical, surgical, and pharmacy claims associated with retrieval • Unlimited embryo transfer when recommended and medically appropriate • Cryopreservation of sperm and mature oocytes	$20 per specialty care office visit	$30 per specialty care office visit	$40 per specialty care office visit

Infertility services - continued on next page

Benefit Description	You pay		
Infertility services (cont.)	**High Option**	**Standard Option**	**Prosper**
• Cryopreservation storage for preserved specimen for 1 year after a covered preservation procedure even if your enrollment ends Note: You pay cost-sharing for other services associated with fertility preservation for iatrogenic infertility including: • Lab, X-ray and other diagnostic tests, as described in Section 5(a) • Surgical services as described in Section 5(b) • Outpatient hospital or ambulatory surgical center as described in Section 5(*c*) • Prescription drugs as described in Section 5 (f)	$20 per specialty care office visit	$30 per specialty care office visit	$40 per specialty care office visit
Not covered: *These exclusions apply to fertile as well as infertile individuals or couples:* • *Gamete intra- fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Any charges associated with obtaining donor eggs, donor sperm or donor embryos* • *Any charges associated with cryopreservation, except for standard fertility preservation for iatrogenic infertility* • *Any charges associated with thawing and storage of frozen sperm, eggs, and embryos, unless listed as covered above for iatrogenic infertility* • *Ovum transplants* • *Infertility services when either member of the family has been voluntarily, surgically sterilized* • *Services to reverse voluntary, surgically induced infertility* • *Services related to surrogate arrangements*	*All charges*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**	**Prosper**
• Testing and treatment Notes: You will not be charged for the following clinically administered medications in connection with your care: • Immunizations • Allergen serum and related injection supplies	$15 per primary care office visit (nothing from infancy through age 4) $20 per specialty care office visit	$25 per primary care office visit (nothing from infancy through age 17) $30 per specialty care office visit	$30 per primary care office visit (nothing from infancy through age 4) $40 per specialty care office visit

Allergy care - continued on next page

Benefit Description	You pay		
Allergy care (cont.)	**High Option**	**Standard Option**	**Prosper**
• Pregnancy and postpartum-related administered medications/services • Services rendered in the following care setting: - Inpatient hospital - Outpatient hospital - Ambulatory surgery centers • Drugs required for radiology procedures and other diagnostic tests	$15 per primary care office visit (nothing from infancy through age 4) $20 per specialty care office visit Note: You pay up to $50 per encounter for drugs administered in connection with	$25 per primary care office visit (nothing from infancy through age 17) $30 per specialty care office visit Note: You pay up to $75 per encounter for drugs administered in connection with your care	$30 per primary care office visit (nothing from infancy through age 4) $40 per specialty care office visit Note: You pay up to $100 per encounter for drugs administered in connection with your care
• Allergy injections Notes: You will not be charged for the following clinically administered medications in connection with your care: • Immunizations • Allergen serum and related injection supplies • Pregnancy and postpartum-related administered medications/services • Services rendered in the following care setting: - Inpatient hospital - Outpatient hospital - Ambulatory surgery centers • Drugs required for radiology procedures and other diagnostic tests	$15 per office visit Note: You pay up to $50 per encounter for drugs administered in connection with your care	$25 per office visit Note: You pay up to $75 per encounter for drugs administered in connection with your care	$30 per office visit Note: You pay up to $100 per encounter for drugs administered in connection with your care
• Allergy serum	Nothing	Nothing	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**	**Prosper**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Section 5(b), *Organ/Tissue transplants*. • Respiratory and inhalation therapy • Cardiac rehabilitation following a qualifying event/condition is provided for up to 12 weeks or 36 sessions, whichever is less.	$15 per primary care office visit (nothing from infancy through age 4) $20 per specialty care office visit	$25 per primary care office visit (nothing from infancy through age 17) $30 per specialty care office visit	$30 per primary care office visit (nothing from infancy through age 4) $40 per specialty care office visit

Treatment therapies - continued on next page

Benefit Description	You pay		
Treatment therapies (cont.)	**High Option**	**Standard Option**	**Prosper**
• Dialysis – hemodialysis performed in a doctor's office or Plan facility • Intravenous (IV)/Infusion Therapy – Home (IV) and antibiotic therapy • Ultraviolet light treatments • Qualified medical clinical trials that provide treatment for life-threatening conditions or for preventive, early detection, or treatment studies of cancer for Phases I, II, III and IV • Growth hormone therapy (GHT) Notes: • GHT requires our prior approval and is covered under the prescription drug benefit. See Section 3, *You need prior Plan approval for certain services,* and Section 5 (f), *Prescription Drug Benefits.* • We will cover dialysis at a non-Plan provider while traveling outside the service area for up to 26 sessions per calendar year. • You will not be charged for the following clinically administered medications in connection with your care: - Immunizations - Allergen serum and related injection supplies - Pregnancy and postpartum-related administered medications/services - Services rendered in the following care setting: - Inpatient hospital - Outpatient hospital - Ambulatory surgery centers - Drugs required for radiology procedures and other diagnostic tests	$15 per primary care office visit (nothing from infancy through age 4) $20 per specialty care office visit Note: You pay up to $50 per encounter for drugs administered in connection wit h	$25 per primary care office visit (nothing from infancy through age 17) $30 per specialty care office visit Note: You pay up to $75 per encounter for drugs administered in connection with your care	$30 per primary care office visit (nothing from infancy through age 4) $40 per specialty care office visit Note: You pay up to $100 per encounter for drugs administered in connection with your care
• Peritoneal Dialysis - Training in a doctor's office or Plan facility - Provided at home • Multidisciplinary nephrology team visits	Nothing	Nothing	Nothing
• Applied Behavior Analysis (ABA) Note: Applied Behavior Analysis treatment requires prior authorization. See *Section 3. You need prior Plan approval for certain services,* for more information.	$15 per visit	$25 per visit	$30 per visit

Treatment therapies - continued on next page

Benefit Description	You pay		
Treatment therapies (cont.)	**High Option**	**Standard Option**	**Prosper**
Not covered: • *Cognitive therapy* • *Sleep therapy* • *Thermography and related services*	*All charges*	*All charges*	*All charges*
Physical and occupational therapies	**High Option**	**Standard Option**	**Prosper**
We cover up to 30 visits per condition per calendar year each for rehabilitative and habilitative physical therapy and occupational therapy, except we cover habilitative services with no visit limits. Notes: • Physical therapy must be provided by a qualified Plan therapist in consultation with a Plan physician to attain or restore bodily function when you have a total or partial loss of bodily function due to illness or injury. • Occupational therapy must be provided by a Plan therapist in consultation with a Plan physician to assist you in attaining or resuming self-care and other activities of daily life when you have a total or partial loss of bodily function due to illness or injury.	$20 per specialty care office visit	$30 per specialty care office visit	$40 per specialty care office visit
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Maintenance therapy* • *Cognitive rehabilitative programs* • *Vocational rehabilitative programs* • *Therapies done primarily for education purposes* • *Services provided by local, state, and federal government agencies, including schools*	*All charges*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**	**Prosper**
We cover up to 30 visits for rehabilitative and habilitative speech therapy per condition per calendar year, except we cover habilitative services with no visit limits.	$20 per specialty care office visit	$30 per specialty care office visit	$40 per specialty care office visit
Not covered: • *Therapies done primarily for educational purposes* • *Therapy for tongue thrust in the absence of swallowing problems*	*All charges*	*All charges*	*All charges*

Speech therapy - continued on next page

Benefit Description	You pay		
Speech therapy (cont.)	**High Option**	**Standard Option**	**Prosper**
• *Training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation* • *Voice therapy for occupation or performing arts* • *Services provided by local, state, and federal government agencies including schools*	*All charges*	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**	**Prosper**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., audiologists or other provider in a physician's office • Otologic and audiological services needed as a result of the congenital defect known as cleft lip and/or cleft palate. Note: For coverage of hearing screenings, see Section 5(a), *Preventive care, children* and, for any other hearing testing, see Section 5(a), *Diagnostic and treatment services.*	$15 per primary care office visit (nothing from infancy through age 21) $20 per specialty care office visit	$25 per primary care office visit (nothing from infancy through age 21) $30 per specialty care office visit	$30 per primary care office visit (nothing from infancy through age 21) $40 per specialty care office visit
Hearing aids, for children through the end of the month they turn age 19, if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist or a licensed hearing aid dispenser. Hearing aids, for members ages 19 and over, if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist or a licensed hearing aid dispenser. Notes: • A single hearing aid providing hearing to both ears (binaural hearing aid) is considered two hearing aids for purposes of this benefit. • For coverage of audible prescription reading and speech generating devices, see Section 5 (a), *Durable medical equipment.* • There are no annual or lifetime dollar limits placed on hearing aids.	Nothing (limited to one hearing aid for each hearing impaired ear every 36 months)	Nothing (limited to one hearing aid for each hearing impaired ear every 36 months)	Nothing (limited to one hearing aid for each hearing impaired ear every 36 months)
Not covered: • *All other hearing testing, except as may be covered in Section 5(a), Diagnostic and treatment services, Section 5(a), Preventive care, children and Section 5(a), Hearing services*	*All charges*	*All charges*	*All charges*

Hearing services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay		
Hearing services (testing, treatment, and supplies) (cont.)	**High Option**	**Standard Option**	**Prosper**
• *Replacement parts, batteries, repair of hearing aids, and replacement of lost or broken hearing aids*	*All charges*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**	**Prosper**
• Diagnosis and treatment of diseases of the eye with a Plan ophthalmologist Notes: You will not be charged for the following clinically administered medications in connection with your care: • Immunizations • Allergen serum and related injection supplies • Pregnancy and postpartum-related administered medications/services • Services rendered in the following care setting: - Inpatient hospital - Outpatient hospital - Ambulatory surgery centers Drugs required for radiology procedures and other diagnostic tests	$20 per specialty care office visit Note: You pay up to $50 per encounter for drugs administered in connection with your care	$30 per specialty care office visit Note: You pay up to $75 per encounter for drugs administered in connection with your care	$40 per specialty care office visit Note: You pay up to $100 per encounter for drugs administered in connection with your care
For members age 19 and older: Routine eye exam and medical treatment of the eye with a Plan optometrist to determine the need for vision correction and provide a prescription for eyeglasses For children through the end of the month they turn age 19: One routine eye exam and medical treatment of the eye each year with a Plan optometrist to determine the need for vision correction and provide a prescription for eyeglasses	$15 per primary care office visit Note: You pay up to $50 per encounter for drugs administered in connection with your care	$25 per primary care office visit Note: You pay up to $75 per encounter for drugs administered in connection with your care	$30 per primary care office visit Note: You pay up to $100 per encounter for drugs administered in connection with your care
For children through the end of the month they turn age 19: • At Plan optical shops: - One pair of eyeglasses (lenses and frames) or regular contact lenses (in lieu of lenses and frames) every calendar year; or - Up to 2 pairs of medically necessary contact lenses per eye (includes the evaluation, fitting and follow-up) every calendar year; and	Nothing	Nothing	Nothing

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay		
Vision services (testing, treatment, and supplies) (cont.)	**High Option**	**Standard Option**	**Prosper**
- Unlimited low vision aids from available supply Notes: • Coverage for eyeglasses and contact lenses are limited to a specified collection. • Medically necessary contact lenses are to treat conditions including keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism or astigmatism	Nothing	Nothing	Nothing
For all members at Plan optical shops: • Eyeglass frames and lenses • Contact lenses package, including: initial fitting for contact lenses; initial pair of contact lenses; insertion and removal of contact lens training; three months of follow-up office visits. These services are provided only as a total package.	*All charges* in excess of $100 for eyeglasses and $50 for contact lenses package every 12 months	*All charges* in excess of $100 for eyeglasses and $50 for contact lenses package every 12 months	*All charges* in excess of $100 for eyeglasses and $50 for contact lenses package every 12 months
Not covered: • *Non-refractive eyeglasses* • *Non-corrective contact lenses, including fitting and follow-up* • *Eye surgery solely for the purpose of correcting refractive defects of the eye* • *Vision therapy, including orthoptics, visual training and eye exercises*	*All charges*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**	**Prosper**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Notes: You will not be charged for the following clinically administered medications in connection with your care: • Immunizations • Allergen serum and related injection supplies • Pregnancy and postpartum-related administered medications/services • Services rendered in the following care setting: - Inpatient hospital - Outpatient hospital	$15 per primary care office visit (nothing from infancy through age 4) $20 per specialty care office visit Note: You pay up to $50 for drugs administered in connection with your care	$25 per primary care office visit (nothing from infancy through age 17) $30 per specialty care office visit Note: You pay up to $75 for drugs administered in connection with your care	$30 per primary care office visit (nothing from infancy through age 4) $40 per specialty care office visit Note: You pay up to $100 for drugs administered in connection with your care

Foot care - continued on next page

Benefit Description	You pay		
Foot care (cont.)	**High Option**	**Standard Option**	**Prosper**
- Ambulatory surgery centers • Drugs required for radiology procedures and other diagnostic tests	$15 per primary care office visit (nothing from infancy through age 4) $20 per specialty care office visit Note: You pay up to $50 for drugs administered in connection with your care	$25 per primary care office visit (nothing from infancy through age 17) $30 per specialty care office visit Note: You pay up to $75 for drugs administered in connection with your care	$30 per primary care office visit (nothing from infancy through age 4) $40 per specialty care office visit Note: You pay up to $100 for drugs administered in connection with your care
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (except for surgical treatment)*	*All charges*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**	**Prosper**
External prosthetic devices, such as: • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy (limited to a maximum of four surgical bras per calendar year) • One hair prosthesis • Ostomy and urological supplies • Replacements for legs, arms or eyes, and their components and repair • Prosthetic sleeve or sock	Nothing	Nothing	Nothing
External orthotic devices, such as: • Therapeutic shoes required for conditions associated with diabetes or other vascular disease • Braces	20% of our allowance	50% of our allowance	50% of our allowance
Internal prosthetic devices, such as • Artificial joints • Pacemakers • Cochlear implants • Osseointegrated external hearing devices • Surgically implanted breast implants following mastectomy	Nothing	Nothing	Nothing after the deductible

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay		
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**	**Prosper**
• Monofocal intraocular implants following cataract removal Note: See 5(b), *Surgery benefits*, for coverage of the surgery to insert the device and Section 5 (*c*), *Hospital benefits*, for inpatient hospital benefits.	Nothing	Nothing	Nothing after the deductible
Notes: • Orthopedic and prosthetic equipment or services must be prescribed by a Plan physician; obtained through sources designated by the Plan; medically necessary; and primarily and customarily used to serve a medical or therapeutic purpose in the treatment of an illness or injury. • We cover only those standard items that are adequate to meet the medical needs of the member • For coverage of hearing aids, see Section 5 (a), *Hearing services*.	Applies to this benefit	Applies to this benefit	Applies to this benefit
Not covered: • *Orthopedic devices and corrective shoes, except as listed above* • *Foot orthotics and podiatric use devices, such as arch supports, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Comfort, convenience, or luxury equipment or features* • *Prosthetic devices, equipment and supplies related to sexual dysfunction* • *Dental prostheses, devices and appliances, except for appliances used for the treatment of temporomandibular joint (TMJ) disorder, or oral and maxillofacial surgery* • *Repairs, adjustments, or replacements due to misuse, theft or loss*	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
Durable medical equipment (DME)	**High Option**	**Standard Option**	**Prosper**
We cover rental or purchase of prescribed durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen and oxygen dispensing equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Portable commodes • Canes • Bilirubin lights and apnea monitors for a period not to exceed 6 months • Continuous Positive Airway Pressure (CPAP) and Bilevel Positive Airway Pressure device (BIPAP) equipment • Asthma-related equipment (spacers, peak-flow meters, and nebulizers) for adults and children • Home Prothrombin Time (PT)/International Normalized Ratio (INR) testing machines • Scalp Cooling Systems	50% of our allowance	50% of our allowance	50% of our allowance after the deductible Note: Deductible waived for asthma-related equipment dispensed by the pharmacy.
• One breastfeeding pump per delivery, including any equipment and supplies that are required for pump functionality • Additional breastfeeding supplies	Nothing for retail-grade pump and breastfeeding supplies 50% of our allowance for hospital-grade pump	Nothing for retail-grade pump and breastfeeding supplies 50% of our allowance for hospital-grade pump	Nothing for retail-grade pump and breastfeeding supplies 50% of our allowance for hospital-grade pump
• Home ultraviolet light treatment equipment	Nothing	Nothing	Nothing
We cover diabetic equipment and supplies when obtained from sources designated by the Plan including: • Diabetic equipment • Insulin pumps • Disposable needles and syringes (up to 3 boxes) • Blood glucose monitor • Control solutions • Lancets • Test tape and acetone test tablets	20% of our allowance	20% of our allowance	20% of our allowance
• Glucose test strips (up to 6 boxes of 50 count)	Nothing	Nothing	Nothing
Notes:	Applies to this benefit	Applies to this benefit	Applies to this benefit

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay		
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**	**Prosper**
• Durable medical equipment (DME) is equipment that is prescribed by a Plan physician; obtained through sources designated by the Plan; medically necessary; intended for repeated use; primarily and customarily used to serve a medical or therapeutic purpose in the treatment of an illness or injury; designed for prolonged use; and appropriate for use in the home. • We cover only those standard items that are adequate to meet the medical needs of the member. • We may require you to return the equipment to us, or pay us the fair market price of the equipment, when it is no longer prescribed. • Your Plan physician must certify your medical need for oxygen and oxygen equipment. • DME does not include coverage for prosthetic devices such as artificial eyes or legs or orthotic devices such as braces or therapeutic shoes. • Refer to Section 5(a), Orthopedic and Prosthetic devices, for coverage of internal prosthetic devices and breast prostheses. • Refer to Section 5(f). Prescription Drug Benefits, for information about insulin coverage.	Applies to this benefit	Applies to this benefit	Applies to this benefit
Not covered: • *Audible prescription reading devices* • *Speech generating devices* • *Comfort, convenience, or luxury equipment or features* • *Non-medical items such as sauna baths or elevators* • *Exercise and hygiene equipment* • *Electronic monitors of the heart, lungs, or other bodily functions, except for apnea monitors, bilirubin blankets, and blood glucose monitors* • *Devices, equipment, and supplies related to the treatment of sexual dysfunction disorders* • *Modifications to the home or vehicle* • *Dental appliances, except for the treatment of cleft lip and/or cleft palate*	*All charges*	*All charges*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay		
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**	**Prosper**
• *More than one piece of durable medical equipment serving essentially the same function* • *Disposable supplies* • *Replacement batteries for glucose meters* • *Oxygen tents* • *Repairs, adjustments, or replacements due to misuse, theft or loss*	*All charges*	*All charges*	*All charges*
Medical supplies	**High Option**	**Standard Option**	**Prosper**
Amino acid-based elemental formula (drugs, supplies and supplements), regardless of delivery method, for the diagnosis and treatment of: • Congenital errors of amino acid metabolism; • Immunoglobulin E and non-Immunoglobulin E mediated allergies to multiple food proteins; • Severe food protein induced enterocolitis syndrome; • Eosinophilic disorders, as evidenced by the results of a biopsy; and • Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract	25% of our allowance	25% of our allowance	Nothing after the deductible Note: Deductible waived for pharmacy-dispensed items only.
Notes: • Coverage shall be provided if the ordering physician has issued a written order stating that amino acid-based elemental formula is medically necessary for the treatment of a disease or disorder listed above. • The Plan may review the ordering physician's determination of the medical necessity of the amino acid-based elemental formula for the treatment of a disease or disorders listed above.	Applies to this benefit	Applies to this benefit	Applies to this benefit
Home health services	**High Option**	**Standard Option**	**Prosper**
• Home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.) physical therapist, occupational therapist, speech and language pathologist, or home health aide • Services include:	Nothing	Nothing	Nothing after the deductible

Home health services - continued on next page

Benefit Description	You pay		
Home health services (cont.)	**High Option**	**Standard Option**	**Prosper**
- Oxygen therapy, intravenous therapy and medications - A home visit within 24 hours after discharge from the hospital or outpatient facility, and additional home visits if prescribed by the patient's attending physician, for enrollees who receive less than 48 hours of inpatient hospitalization following a mastectomy or the surgical removal of a testicle, or who undergo a mastectomy or surgical removal of a testicle on an outpatient basis	Nothing	Nothing	Nothing after the deductible
Notes: • We only provide these services in the Plan's service areas. • Your Plan physician will periodically review the home health services for continuing appropriateness and medical need. • The services are covered only if you are homebound and a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home.	Applies to this benefit	Applies to this benefit	Applies to this benefit
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Custodial care* • *Private duty nursing* • *Personal care and hygiene items* • *Care that a Plan provider determines may be appropriately provided in a Plan facility, hospital, skilled nursing facility, or other facility we designate and we provide* • *General maintenance care of colostomy, ileostomy, and ureterostomy* • *Medical supplies or dressings applied by you or a family caregiver* • *Transportation and delivery service costs of durable medical equipment, medications, drugs, medical supplies, and supplements to the home*	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
Chiropractic	**High Option**	**Standard Option**	**Prosper**
Up to 20 visits per calendar year, including: • Diagnosis and treatment of neuromusculoskeletal disorders • Plain film X-rays associated with diagnosis and treatment • Adjunctive therapies Note: Your Plan physician must determine that such care will result in improvement in your condition. Chiropractic services require our prior approval. See Section 3, *You need prior Plan approval for certain services.*	$20 per office visit	$30 per office visit	$40 per office visit
Not covered: • *Hypnotherapy, behavior training, sleep therapy and weight programs* • *Thermography* • *Any radiological exam other than plain film studies such as magnetic resonance imaging, CT scans, bone scans, nuclear radiology* • *Treatment for non-neuromusculoskeletal disorders* • *Chiropractic appliances, except as covered in Section 5(a), Durable medical equipment and Prosthetics and orthotic devices* • *Laboratory services*	*All charges*	*All charges*	*All charges*
Alternative treatments	**High Option**	**Standard Option**	**Prosper**
Acupuncture – by a doctor of medicine or osteopathy, or licensed or certified acupuncture practitioner. Covered up to 20 acupuncture visits per calendar year. Services include: • Diagnosis and treatment of chronic pain and nausea • Adjunctive acupuncture therapy Note: You receive these services when your Plan physician determines that such care will result in improvement in your condition. Acupuncture services require our prior approval. See Section 3, *You need prior Plan approval for certain services.*	$20 per office visit	$30 per office visit	$40 per office visit
Not covered: • *All other form of alternative treatment, such as naturopathic services, behavior training, sleep therapy, weight programs and adjunctive therapy not associated with acupuncture*	*All charges*	*All charges*	*All charges*

Alternative treatments - continued on next page

Benefit Description	You pay		
Alternative treatments (cont.)	**High Option**	**Standard Option**	**Prosper**
• *Thermography* • *Any radiological exam including plain film studies such as magnetic resonance imaging, CT scans, bone scans, nuclear radiology* • *Laboratory services*	*All charges*	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**	**Prosper**
Individual health education discussions, including: • Diabetes • Post-coronary • Nutritional counseling	$15 per primary care office visit (nothing from infancy through age 4) $20 per specialty care office visit	$25 per primary care office visit (nothing from infancy through age 17) $30 per specialty care office visit	$30 per primary care office visit (nothing from infancy through age 4) $40 per specialty care office visit
Health education classes, including: • Most group classes • Tobacco Cessation programs, including individual/group/telephone counseling, over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing	Nothing	Nothing
Notes: • Kaiser Permanente's approach to diabetes prevention is intertwined with our overall care delivery model; our diabetes prevention services meet or exceed the elements of the CDC-recognized Diabetes Prevention Program (DPP), including support for lifestyle changes such as weight loss, healthy diet, increasing physical activity levels, and A1c testing.	Applies to this benefit	Applies to this benefit	Applies to this benefit

Educational classes and programs - continued on next page

Benefit Description	You pay		
Educational classes and programs (cont.)	**High Option**	**Standard Option**	**Prosper**
• Our teams work to ensure that all members with pre-diabetes and other comorbidities that put them at risk for developing diabetes receive high-quality and comprehensive preventative care, regardless of whether or not they meet the CDC's DPP eligibility criteria. Members at risk of developing diabetes receive care through multiple pathways, including in-person and virtual visits with clinicians on their care team, health education classes, and online self-management tools. In addition to the CDC certified DPP, our primary care physicians and health education services offer diabetes prevention support that is available to our members beyond the 1-year limit of the DPP. The flexibility of our diabetes prevention programs and services facilitates continued patient engagement and optimized health outcomes. • Kaiser Permanente offers a variety of tobacco cessation resources including individual and group visits with wellness coaches, health educators and dieticians to help instill healthy lifestyle behaviors and promote good health. We also prescribe both over-the-counter and prescription medicines to members when indicated. We also provide patients with a comprehensive suite of educational materials via our kp.org website and app (more information provided at this link). • Please call our Member Services Department at 877-KP4-FEDS (877-574-3337) (TTY: 711) for information on classes near you. • See Section 5(f). *Prescription Drug Benefits*, for important information about coverage of tobacco cessation and other drugs.	Applies to this benefit	Applies to this benefit	Applies to this benefit

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Our integrated system and the care teams we have developed provide care in a collaborative model. That model pervades all of the care provided and in many ways our care is, in its entirety, a collaborative care model. These collaborative systems for care delivery are included across care teams such as primary care, chronic conditions management, hospital-based care, post discharge care, healthy living resources, and specialty care including mental health and substance use disorder services. This is facilitated by our integration of care and coverage, our shared electronic health record, and our whole-person approach to care. Our clinicians work together with patients using our shared decision-making model to develop treatment plans. All care is documented in our electronic health record and all clinicians have access to a patient's chart, facilitating a seamless patient experience and better health outcomes.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Unless you receive prior approval from us, Plan providers must provide or arrange your care.
- There is no calendar year deductible for the High and Standard Options.
- The Prosper calendar year deductible is $150 per person ($300 per Self Plus One enrollment, or $300 per Self and Family enrollment). The calendar year deductible applies to some benefits in this Section. We added "(after the deductible)" when the calendar year deductible applies.
- Be sure to read Section 4. *Your Cost for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9, Coordinating Benefits with Medicare and Other Coverage, including with Medicare.
- The cost-sharing listed below applies to services billed by a physician or other healthcare professional for your surgical care. See Section 5(a) for cost-sharing you pay for services performed during an office visit or 5(*c*) for cost-sharing you pay for services in an inpatient hospital, outpatient hospital or ambulatory surgical center facility.
- **YOUR PROVIDER MUST GET PRIOR APPROVAL FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay		
Note: The calendar year deductible applies to some benefits under Prosper in this Section. We say "after the deductible" when the calendar year deductible applies.			
Surgical procedures	**High Option**	**Standard Option**	**Prosper**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Routine pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Diagnostic colonoscopy procedures • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts	Nothing	Nothing	Nothing

Surgical procedures - continued on next page

Benefit Description	You pay		
Surgical procedures (cont.)	**High Option**	**Standard Option**	**Prosper**
• Foot surgery including open cutting surgery to remove bunions and spurs • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of severe obesity (bariatric surgery). Notes: • Visit www. kp.org/feds to get a list of criteria you must meet to qualify for bariatric surgery. • See Section 3, *You need prior Plan approval for certain services*, for more information. • Insertion of internal prosthetic devices. See Section 5(a), *Orthopedic and prosthetic devices,* for device coverage information • Treatment of burns • Insertion of implanted time-release drugs except for contraceptive drugs and IUDs. • We cover the cost of the implanted time-release drugs under the prescription drug benefit (see Section 5(f)). • Insertion of surgically implanted time-release contraceptive drugs and intrauterine devices (IUDs) • We cover the cost of these drugs and devices under the prescription drug benefit (see Section 5(f)). Note: • For female surgical family planning procedures, see Family Planning Section 5 (a) • For male surgical family planning procedures, see Family Planning Section 5 (a)	Nothing	Nothing	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Services for the promotion, prevention, or other treatment of hair loss or hair growth*	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
Reconstructive surgery	**High Option**	**Standard Option**	**Prosper**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance; and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. Note: We cover orthodontia services as a result of cleft lip and/or cleft palate. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery and reconstruction on the other breast to produce a symmetrical appearance; - Treatment of any physical complications, such as lymphedemas; - Breast prostheses and surgical bras and replacements (see Section 5(a) *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing	Nothing	Nothing
Not covered: • *Cosmetic surgery - any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury if repair is initiated within a year of the injury* • *Surgery for Sex-Trait Modification to treat gender dysphoria*	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
Oral and maxillofacial surgery	**High Option**	**Standard Option**	**Prosper**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Medical and surgical treatment of temporomandibular joint (TMJ) disorder (non-dental) • Medically necessary oral and maxillofacial restoration after major reconstructive surgery; and • Other surgical procedures that do not involve the teeth or their supporting structures	Nothing	Nothing	Nothing
Not covered: • *Oral implants and transplants, unless covered due to medically necessary major reconstructive surgery* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone) except as covered under the accidental dental benefit, oral restoration after major reconstructive surgery or for orthodontia services as a result of cleft lip and/or cleft palate* • *Shortening of the mandible or maxillae for cosmetic purposes and* • *Correction of any malocclusion not listed above*	*All charges*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**	**Prosper**
These **solid organ and tissue transplants** are subject to medical necessity and experimental/ investigational review by the Plan. Refer to Section 3, *How you get care,* for authorization procedures. Solid organ tissue transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea	Nothing	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Prosper**
• Heart • Heart-lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung: Single/bilateral/lobar • Pancreas	Nothing	Nothing	Nothing
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to Section 3 for prior authorization procedures. • Autologous tandem transplants for: - AL Amyloidosis - Hematopoietic stem cell transplant (HSCT) - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	Nothing	Nothing	Nothing
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous [myeloid]) leukemia - Hodgkin's lymphoma (relapsed) - Non-Hodgkin's lymphoma (relapsed) - Advanced neuroblastoma - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hematopoietic stem cell transplant (HSCT) - Hemoglobinopathies (e.g., thalassemias, Sickle cell disease) - Infantile malignant osteopetrosis - Kostmann's syndrome	Nothing	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Prosper**
- Leukocyte adhesion deficiencies - Marrow Failure and Related Disorders (i.e., Fanconi's, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Myeloproliferative disorders - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe Aplastic Anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for: - Hodgkin's lymphoma (relapsed) - Non-Hodgkin's lymphoma (relapsed) - Amyloidosis - Ewing sarcoma - Immune deficiency diseases other than SCID (e.g., Wiskott-Aldrich syndrome, Kostmann's Syndrome, Leukocyte Adhesion Deficiencies) not amenable to more conservative treatments - Medulloblastoma - Multiple myeloma - Neuroblastoma - Phagocytic/Hemophagocytic deficiency diseases - Pineoblastoma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Waldenstrom's macroglobulinemia	Nothing	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Prosper**
Limited benefits The following autologous blood or bone marrow stem cell transplants may be provided in a National Cancer Institute (NCI) or National Institutes of Health (NIH)-approved clinical trial at a Plan-designated Center of Excellence. These limited benefits are not subject to medical necessity. • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Beta Thalassemia Major • Breast cancer • Childhood rhabdomyosarcoma • Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) • Chronic lymphocytic leukemia • Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) relapsed/refractory disease • Chronic myelogenous leukemia • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Epithelial ovarian cancer • High-grade (Aggressive) non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) • High-risk Ewing sarcoma • High risk childhood kidney cancers • Hodgkin's lymphoma • Multiple myeloma • Multiple sclerosis • Myeloproliferative Disorders • Myelodysplasia/Myelodysplastic Syndromes • Non-Hodgkin's lymphoma • Sarcomas • Sickle Cell • Systemic lupus erythematosus • Systemic sclerosis • Scleroderma • Scleroderma-SSc (severe, progressive)	Nothing	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Prosper**
Mini-transplants performed in a Clinical Trial Setting (non-myeloblative, reduced intensity conditioning). • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow Failure and Related Disorders (i.e. Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	Nothing	Nothing	Nothing
Notes: • We cover related medical and hospital expenses of the donor when we cover the recipient. • We cover donor screening tests for potential donors for solid organ transplants. We cover human leukocyte antigen (HLA) typing for potential donors for a bone marrow/stem cell transplant only for parents, children and siblings of the recipient.	Applies to this benefit	Applies to this benefit	Applies to this benefit

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Prosper**
• We cover computerized national and international search expenses for prospective unrelated bone marrow/stem cell transplant donors conducted through the National Marrow Donor Program, and the testing of blood relatives of the recipient. • We cover medically necessary routine dental services required in preparation for a transplant. Covered services may include a routine oral examination, cleaning (prophylaxis), extractions, and X-rays. You pay cost-sharing listed in Section 5 (a) and Section 5 (g) for services performed during an office visit. • Please refer to Section 5(h), *Special features,* for information on our Centers of Excellence.	Applies to this benefit	Applies to this benefit	Applies to this benefit
Not covered: • *Donor screening tests and donor search expenses, except those listed above* • *Implants of non-human artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**	**Prosper**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing	Nothing	Nothing

Section 5(c.). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Our integrated system and the care teams we have developed provide care in a collaborative model. That model pervades all of the care provided and in many ways our care is, in its entirety, a collaborative care model. These collaborative systems for care delivery are included across care teams such as primary care, chronic conditions management, hospital-based care, post discharge care, healthy living resources, and specialty care including mental health and substance use disorder services. This is facilitated by our integration of care and coverage, our shared electronic health record, and our whole-person approach to care. Our clinicians work together with patients using our shared decision-making model to develop treatment plans. All care is documented in our electronic health record and all clinicians have access to a patient's chart, facilitating a seamless patient experience and better health outcomes.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Unless you receive prior approval from us, Plan providers must provide or arrange your care and you must be hospitalized in a Plan facility.
- There is no calendar year deductible for the High and Standard Options.
- The Prosper calendar year deductible is $150 per person ($300 per Self Plus One enrollment, or $300 per Self and Family enrollment). The calendar year deductible applies to some benefits in this Section. We added "(after the deductible)" when the calendar year deductible applies.
- Be sure to read Section 4. *Your Cost for Covered Services* for valuable information about how cost-sharing works. Also read Section 9, Coordinating Benefits with Medicare and Other Coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PROVIDER MUST GET PRIOR APPROVAL FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay		
Note: The calendar year deductible applies to some benefits under Prosper in this Section. We say "after the deductible" when the calendar year deductible applies.			
Inpatient hospital	**High Option**	**Standard Option**	**Prosper**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Notes: • If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$200 per inpatient admission $200 for maternity care	$500 per inpatient admission Nothing for maternity care	$750 per inpatient admission after the deductible

Inpatient hospital - continued on next page

Benefit Description	You pay		
Inpatient hospital (cont.)	**High Option**	**Standard Option**	**Prosper**
• You may receive covered medical hospital services for certain dental procedures if a Plan physician determines that you need to be hospitalized. Section 5(g), *Dental benefits*, includes more information on the requirements.	$200 per inpatient admission $200 for maternity care	$500 per inpatient admission Nothing for maternity care	$750 per inpatient admission after the deductible
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays, and pathology services • Blood and blood products • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics and anesthesia services • Procurement and storage for approved medically necessary cord blood for a designated recipient	Nothing	Nothing	Nothing
Not covered: • *Custodial care and care in an intermediate care facility* • *Non-covered facilities, such as nursing homes* • *Personal comfort items, such as phone, television, barber services, guest meals, and beds* • *Private nursing care except when medically necessary* • *Cord blood procurement and storage for possible future need or for yet to be determined Member recipient*	*All charges*	*All charges*	*All charges*
Rehabilitation facility	**High Option**	**Standard Option**	**Prosper**
• Up to 60 days of physical and occupational therapy per condition • Up to two months of speech therapy per condition Note: The admission charge is waived if you have been admitted directly from a hospital inpatient stay.	$200 per inpatient admission	$500 per inpatient admission	$750 per inpatient admission after the deductible

Benefit Description	You pay		
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**	**Prosper**
• Operating, recovery, and other treatment rooms • Observation care • Prescribed drugs and medications • Lab, X-ray and other diagnostic tests • Procurement and storage of cord blood for approved medically necessary procedures requiring cord blood for a designated recipient • Blood and blood products • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. Section 5 (g), *Dental benefits*, includes more information on the requirements.	$125 per surgery or procedure in an outpatient hospital or ambulatory surgery center	$200 per surgery or procedure in an outpatient hospital or ambulatory surgery center	$300 per surgery or procedure in an outpatient hospital or ambulatory surgery center after the deductible
• Breast biopsy • Lung biopsy	Nothing	Nothing	Nothing
Not covered: • *Procurement and storage of cord blood for possible future need or for yet to be determined Member recipient*	*All charges*	*All charges*	*All charges*
Skilled nursing care facility benefits	**High Option**	**Standard Option**	**Prosper**
Up to 100 days per calendar year when you need full-time skilled nursing care. All necessary services are covered, including: • Room and board • General nursing care • Medical social services • Prescribed drugs, biologicals, supplies, and equipment, including oxygen, ordinarily provided or arranged by the skilled nursing facility Note: We waive the additional admission charge if you are admitted to an extended care or skilled nursing facility directly from a hospital inpatient stay.	$200 per inpatient admission	$500 per inpatient admission	$750 per inpatient admission after the deductible

Skilled nursing care facility benefits - continued on next page

Benefit Description	You pay		
Skilled nursing care facility benefits (cont.)	**High Option**	**Standard Option**	**Prosper**
Not covered: • *Custodial care and care in an intermediate care facility* • *Personal comfort items, such as phone, television, barber services, guest meals, and beds*	*All charges*	*All charges*	All charges
Hospice care	**High Option**	**Standard Option**	**Prosper**
Supportive and palliative care for a terminally ill member: • You must reside in the service area • Services are provided: - in the home, when a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home, or - in a Plan-approved hospice facility if approved by the hospice interdisciplinary team. Services include inpatient care, outpatient care, and family counseling. A Plan physician must certify that you have a terminal illness, with a life expectancy of approximately six months or less.	Nothing	Nothing	Nothing after the deductible
Not covered: • *Independent nursing (private duty nursing)* • *Homemaker services*	*All charges*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**	**Prosper**
• Local licensed ambulance service when medically necessary	No charge when we transfer you from an emergency room or hospital to a Plan facility $75 per service for all other ambulance services	No charge when we transfer you from an emergency room or hospital to a Plan facility $125 per service for all other ambulance services	No charge when we transfer you from an emergency room or hospital to a Plan facility $200 per service for all other ambulance services after the deductible
• Non-emergent transportation services via stretcher/gurney or wheelchair vans to or from medical appointments when medically necessary and ordered by a Plan Provider Note: See Section 5(d) for emergency services	Nothing	Nothing	Nothing
Not covered:	*All charges*	*All charges*	*All charges*

Ambulance - continued on next page

Benefit Description	You pay		
Ambulance (cont.)	**High Option**	**Standard Option**	**Prosper**
• *Transportation by car, taxi, bus, and any other type of transportation (other than ambulette or a licensed ambulance), even if it is the only way to travel to a Plan Provider* • *Non-emergent transportation services that are not medically appropriate and that have not been ordered by a Plan provider*	*All charges*	*All charges*	*All charges*

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Our integrated system and the care teams we have developed provide care in a collaborative model. That model pervades all of the care provided and in many ways our care is, in its entirety, a collaborative care model. These collaborative systems for care delivery are included across care teams such as primary care, chronic conditions management, hospital-based care, post discharge care, healthy living resources, and specialty care including mental health and substance use disorder services. This is facilitated by our integration of care and coverage, our shared electronic health record, and our whole-person approach to care. Our clinicians work together with patients using our shared decision-making model to develop treatment plans. All care is documented in our electronic health record and all clinicians have access to a patient's chart, facilitating a seamless patient experience and better health outcomes.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There is no calendar year deductible for the High and Standard Options.
- The Prosper calendar year deductible is $150 per person ($300 per Self Plus One enrollment, or $300 per Self and Family enrollment). The calendar year deductible applies to some benefits in this Section. We added "(after the deductible)" when the calendar year deductible applies.
- Be sure to read Section 4. *Your Cost for Covered Services,* for valuable information about how cost-sharing works. Also read Section 9, Coordinating Benefits with Medicare and Other Coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

In a life-threatening emergency-call the local emergency system (e.g., the local 911 phone system). When the operator answers, stay on the phone and answer all questions. If you are not sure whether you are experiencing a medical emergency, please contact our Emergency Line at 800-677-1112.

Emergencies within our service area:

Emergency care is provided at Plan Hospitals 24 hours a day, seven days a week.

If you think you have a medical emergency condition and you cannot safely go to a Plan Hospital, call 911 or go to the nearest hospital. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify us within 48 hours, or as soon as is reasonably possible, by calling 703-359-7878 inside the Washington, DC metropolitan area or toll free 800-777-7904 (TTY: 711).

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify us within that time. If you are in non-Plan facilities and we believe care can be better provided in a Plan facility, we will transfer you when medically feasible.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

When you are sick or injured, you may have an urgent care need. An urgent care need is one that requires prompt medical attention, but is not a medical emergency. If you think you may need urgent care, call the appointment or advice nurse number.

Emergencies outside our service area:

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified within 48 hours or as soon as is reasonably possible. If we believe care can be better provided in a Plan Hospital, we will transfer you when medically feasible, with any ambulance charges covered in full.

When you are sick or injured, you may have an urgent care need. An urgent care need is one that requires prompt medical attention, but is not a medical emergency. If you think you may need urgent care, call the appointment or advice nurse number. If you are temporarily outside the service area and have an urgent care need due to an unforeseen illness or injury, we cover the medically necessary services and supplies you receive from a non-Plan provider if we find that the services and supplies were necessary to prevent serious deterioration of your health and they could not be delayed until you returned to the service area.

You may obtain emergency and urgent care services from Kaiser Permanente medical facilities and providers when you are in the service area of another Kaiser Permanente plan. The facilities will be listed in the local phone book under Kaiser Permanente. These numbers are available 24 hours a day, seven days a week. You may also obtain information about the location of facilities by calling the dedicated Federal Membership Services Department at 877-KP4-FEDS 877-574-3337 (TTY: 711).

Benefit Description	You pay		
Note: The calendar year deductible applies to some benefits under Prosper in this Section. We say "after the deductible" when the calendar year deductible applies.			
Emergency within our service area	**High Option**	**Standard Option**	**Prosper**
• Emergency care at a Plan urgent care center • Urgent care at a Plan urgent care center	$20 per visit	$30 per visit	$40 per visit
• Emergency care as an outpatient at a hospital, including physicians' services • Urgent care at an emergency room Note: • If you receive emergency care and then are transferred to observation care, you pay the emergency services cost-sharing. If you are admitted as an inpatient, we will waive your emergency room copayment and you will pay your cost-sharing related to your inpatient hospital stay.	$200 per visit	$200 per visit	$200 per visit after the deductible
Not covered: • *Elective care or non-emergency care* • *Urgent care at a non-Plan urgent care center*	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
Emergency outside our service area	**High Option**	**Standard Option**	**Prosper**
• Emergency care at an urgent care center • Urgent care at an urgent care center	$20 per visit	$30 per visit	$40 per visit
• Emergency care as an outpatient at a hospital, including physicians' services • Urgent care at an emergency room	$200 per visit	$200 per visit	$200 per visit after the deductible
Notes: • If you receive emergency care and then are transferred to observation care, you pay the emergency services cost-sharing. If you are admitted as an inpatient, we will waive your emergency room copayment and you will pay your cost-sharing related to your inpatient hospital stay. • See Section 5(h) for travel benefit coverage of continuing or follow-up care.	Applies to this benefit	Applies to this benefit	Applies to this benefit
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**	**Prosper**
Licensed ambulance service, including air ambulance, when medically necessary. Notes: • Coverage is also provided for medically necessary transportation or services rendered as the result of a 911 call, whether or not transport is required. • See Section 5(*c*) for non-emergency service. • Service means any time an ambulance is summoned on your behalf.	$75 per service	$125 per service	$200 per service after the deductible
Not covered: • *Ambulance services we determine are not medically necessary* • *Transportation by car, bus, gurney van, wheelchair van, minivan, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a provider or facility*	*All charges*	*All charges*	*All charges*

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Our integrated system and the care teams we have developed provide care in a collaborative model. That model pervades all of the care provided and in many ways our care is, in its entirety, a collaborative care model. These collaborative systems for care delivery are included across care teams such as primary care, chronic conditions management, hospital-based care, post discharge care, healthy living resources, and specialty care including mental health and substance use disorder services. This is facilitated by our integration of care and coverage, our shared electronic health record, and our whole-person approach to care. Our clinicians work together with patients using our shared decision-making model to develop treatment plans. All care is documented in our electronic health record and all clinicians have access to a patient's chart, facilitating a seamless patient experience and better health outcomes.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There is no calendar year deductible for the High and Standard Options.
- The Prosper calendar year deductible is $150 per person ($300 per Self Plus One enrollment, or $300 per Self and Family enrollment). The calendar year deductible applies to some benefits in this Section. We added "(after the deductible)" when the calendar year deductible applies.
- Be sure to read Section 4. *Your Cost for Covered Services,* for valuable information about how cost-sharing works. Also read Section 9, Coordinating Benefits with Medicare and Other Coverage, including with Medicare.
- Unless you receive prior approval from us, Plan providers must provide or arrange your care. Call our Behavioral Health Access Unit at 866-530-8778 to make arrangements.
- If we are unable to provide services in our Plan facilities, you may request a referral to a network provider. If a network provider requests additional visits/time beyond those/that authorized by us, then we must approve a treatment plan.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay		
Note: The calendar year deductible applies to some benefits under Prosper in this Section. We say "after the deductible" when the calendar year deductible applies.			
Professional services	**High Option**	**Standard Option**	**Prosper**
We cover professional services recommended by a Plan mental health and substance use disorder treatment provider that are covered services, drugs, and supplies described in this brochure. Notes: • We cover the services only when we determine that the care is clinically appropriate to treat your condition.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.

Professional services - continued on next page

Benefit Description	You pay		
Professional services (cont.)	**High Option**	**Standard Option**	**Prosper**
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Outpatient services include: Outpatient office visits: • Diagnostic evaluation • Medication, evaluation, and management (pharmacotherapy) • Treatment and counseling (including individual and group therapy visits) • Professional charges for intensive outpatient treatment in a provider's office or other professional setting	$15 per individual therapy visit $7 per group therapy visit (nothing from infancy through age 4)	$25 per individual therapy visit $12 per group therapy visit (nothing from infancy through age 17)	$30 per individual therapy visit $15 per group therapy visit (nothing from infancy through age 4)
Diagnosis and treatment of substance use disorders. Outpatient services include: Outpatient office visits: • Detoxification (medical management of withdrawal from the substance) • Treatment and counseling (including individual and group therapy visits) • Intensive day treatment • Medication evaluation and management (pharmacotherapy)	$15 per individual therapy visit $7 per group therapy visit (nothing from infancy through age 4)	$25 per individual therapy visit $12 per group therapy visit (nothing from infancy through age 17)	$30 per individual therapy visit $15 per group therapy visit (nothing from infancy through age 4)
• Methadone treatment	$15 per week (nothing from infancy through age 4)	$25 per week (nothing from infancy through age 17)	$30 per week (nothing from infancy through age 4)
All other outpatient services (office)	$15 per individual therapy visit $7 per group therapy visit (nothing from infancy through age 4)	$25 per individual therapy visit $12 per group therapy visit (nothing from infancy through age 17)	$30 per individual therapy visit $15 per group therapy visit (nothing from infancy through age 4)
All other outpatient services (non-office) • Crisis intervention and stabilization for acute episodes • Electroconvulsive therapy (ECT) • Partial hospitalization treatment • Psychological and neuropsychological testing is necessary to determine the appropriate psychiatric treatment	Nothing	Nothing	Nothing
Notes:	Applies to this benefit	Applies to this benefit	Applies to this benefit

Professional services - continued on next page

Benefit Description	You pay		
Professional services (cont.)	**High Option**	**Standard Option**	**Prosper**
• Kaiser Permanente offers mental health care within our integrated model; when indicated, this may include visits with a therapist who may practice modalities such as psychotherapy and cognitive behavioral therapy (CBT). Patients seeking support with managing their stress or other mental health needs can self-refer to our behavioral health services, or they may be connected directly by their primary care physician or other care teams. When our behavioral health teams determine that visits with a therapist are appropriate for the patient's specific needs, members are connected directly to an available therapist within our network without needing to navigate siloed external systems or search through long lists of practitioners. All Kaiser Permanente clinicians have access to our shared electronic medical record to coordinate and oversee care plans, including for patients receiving psychotherapy and CBT. • Kaiser Permanente's behavioral health services are integrated within our overall system. All Kaiser Permanente clinicians have access to our shared electronic medical record to coordinate and oversee care plans, creating a seamless patient experience and facilitating better outcomes. Specific examples of how behavioral health is integrated within our system include: • Outpatient mental health departments are usually co-located in the same medical facilities as our primary care, pharmacy, and specialty services, making it easy for primary care physicians to make referrals. • In many locations, behavioral health clinicians are embedded in primary care, allowing them to provide one-on-one consultations and other services in the primary care setting. • Our primary care physicians are trained to look for signs of mental health and substance use disorder needs when they are treating members in the primary care setting. • Routine screenings for depression, anxiety, and psychological distress are built into the care experience at key points, such as when a member is being screened for a chronic condition.	Applies to this benefit	Applies to this benefit	Applies to this benefit

Professional services - continued on next page

Benefit Description	You pay		
Professional services (cont.)	**High Option**	**Standard Option**	**Prosper**
• You may see a Plan mental health and substance use disorder treatment provider for outpatient services without a referral from your primary care provider. See Section 3. *How You Get Care,* for information about services requiring our prior approval. • Your Plan mental health and substance use disorder treatment provider will develop a treatment plan to assist you in improving or maintaining your condition and functional level, or to prevent relapse and will determine which diagnostic and treatment services are appropriate for you. • See Section 5(a), *Treatment therapy*, for coverage of Applied Behavior Analysis (ABA)	Applies to this benefit	Applies to this benefit	Applies to this benefit
Diagnostics	**High Option**	**Standard Option**	**Prosper**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Your cost-sharing responsibilities are no greater than for other illness or condition. See Section 5(a) Lab, X-ray and other diagnostic tests and Section 5(*c*) Services provided by a hospital or other facility, and Ambulance Services.	Your cost-sharing responsibilities are no greater than for other illness or condition. See Section 5(a) Lab, X-ray and other diagnostic tests and Section 5(*c*) Services provided by a hospital or other facility, and Ambulance Services.	Your cost-sharing responsibilities are no greater than for other illness or condition. See Section 5(a) Lab, X-ray and other diagnostic tests and Section 5(*c*) Services provided by a hospital or other facility, and Ambulance Services.
Inpatient hospital or other covered facility	**High Option**	**Standard Option**	**Prosper**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Inpatient psychiatric care • Inpatient detoxification • Acute inpatient substance use rehabilitation • Services in an inpatient residential treatment center Notes:	$200 per inpatient admission	Nothing	$750 per inpatient admission after the deductible

Inpatient hospital or other covered facility - continued on next page

Benefit Description	You pay		
Inpatient hospital or other covered facility (cont.)	**High Option**	**Standard Option**	**Prosper**
• All inpatient admissions and hospital alternative services treatment programs require approval by a Plan mental health and substance use disorder treatment physician. • Inpatient services will only be part of a treatment plan when services cannot be provided safely on an outpatient basis or in a less intensive setting than an acute care hospital.	$200 per inpatient admission	Nothing	$750 per inpatient admission after the deductible
Outpatient hospital or other covered facility	**High Option**	**Standard Option**	**Prosper**
Outpatient services provided and billed by a hospital or other covered facility • Hospital alternative services: partial hospitalization, intensive outpatient psychiatric treatment programs and residential crisis services.	$15 per visit; or $200 per inpatient admission if your treatment is more than 24 continuous hours	$25 per visit; or nothing per inpatient admission if your treatment is more than 24 continuous hours	$30 per visit; or $750 per inpatient admission after the deductible if your treatment is more than 24 continuous hours
Not covered	**High Option**	**Standard Option**	**Prosper**
Not covered: • *Care that is not clinically appropriate for the treatment of your condition* • *Intelligence, IQ, aptitude ability, learning disabilities, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition* • *Evaluation or therapy on court order or as a condition of parole or probation, or otherwise required by the criminal justice system, unless determined by a Plan physician to be medically necessary and appropriate* • *Services that are custodial in nature* • *Marital, family, or educational services* • *Services rendered or billed by a school or a member of its staff* • *Services provided under a federal, state, or local government program* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms*	*All charges*	*All charges*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- Our integrated system and the care teams we have developed provide care in a collaborative model. That model pervades all of the care provided and in many ways our care is, in its entirety, a collaborative care model. These collaborative systems for care delivery are included across care teams such as primary care, chronic conditions management, hospital-based care, post discharge care, healthy living resources, and specialty care including mental health and substance use disorder services. This is facilitated by our integration of care and coverage, our shared electronic health record, and our whole-person approach to care. Our clinicians work together with patients using our shared decision-making model to develop treatment plans. All care is documented in our electronic health record and all clinicians have access to a patient's chart, facilitating a seamless patient experience and better health outcomes.
- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- We have no calendar year pharmacy deductible.
- Federal or state laws may prevent the pharmacy from accepting unused drugs.
- Be sure to read Section 4. *Your Cost for Covered Services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- A PDP EGWP provides prescription drug coverage only, while an MAPD EGWP combines prescription drug, physician, and hospital coverage. Enrollees are encouraged to review their options under the plan to choose what best serves their needs as the PDP EGWP or MAPD EGWP may not offer the same coverage or pricing.
- See Section 9 for the PDP EGWP opt-out process.
- **The exclusion for hormone treatments for Sex-Trait Modification for gender dysphoria** only pertains to chemical and surgical modification of an individual's sex traits (including as part of "gender transition" services). **We do not exclude coverage for entire classes of pharmaceuticals,** e.g., GnRH agonists may be prescribed during IVF, for reduction of endometriosis or fibroids, and for cancer treatment or prostate cancer/tumor growth prevention.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed Plan provider or licensed Plan dentist must prescribe your medication. We cover prescriptions written by a non-Plan provider or filled at a non-Plan pharmacy only for emergencies or out-of-area urgent care (see Section 5(d), *Emergency services/accidents*), or as stated in this section.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy, an affiliated network pharmacy, online at www. kp.org/rxrefillor by the Plan mail order program for certain maintenance medication as specified below. We cover prescriptions written by a non-Plan provider or filled at a non-Plan pharmacy only for covered emergencies as specified in Section 5(d). *Emergency Services/Accidents*. Plan members called to active military duty (or members in time of national emergency), who need to obtain prescribed medications, should call a Plan pharmacy.
- **We use a managed formulary.** The medications included in our drug formulary are chosen by a group of Kaiser Permanente physicians, pharmacists and other Plan providers known as the Pharmacy and Therapeutics Committee. The committee meets regularly to consider adding and removing prescription drugs on the drug formulary based on new information or drugs that become available. We describe any additional coverage requirements and limits in our FEHB formulary. These may include step therapy, prior authorization, quantity limits, drugs that can only be obtained at certain specialty pharmacies, or other requirements and limits described in our formulary.

Drugs on our formulary are called, “preferred drugs”. We cover non-preferred prescription drugs (those not listed on our drug formulary for your condition) prescribed by a Plan provider if they would otherwise be covered and 1) a Plan provider believes that a non-preferred drug best treats your medical condition; a preferred drug has been ineffective in the treatment of your medical condition; or a preferred drug causes, or is reasonably expected to cause, a harmful reaction, and 2) a Plan provider receives an approved drug formulary exception from us. For information about drug formulary exceptions, see Section 3, *You need prior Plan approval for certain services*. You pay higher cost-sharing for non-preferred drugs prescribed by a Plan provider. If you request a non-preferred generic or brand-name drug when your Plan provider has prescribed a preferred drug, the non-preferred drug is not covered. However, you may purchase the non-preferred drug from a Plan pharmacy at prices charged to members for non-covered drugs. For more information on our prescription drug FEHB formulary, visit kp.org/formulary or call our Federal Member Services Department at 877-KP4-FEDS (877-574-3337) (TTY: 711).

You pay applicable drug cost-sharing based on the tier a drug is in. Our drugs are categorized into four tiers:

- **Tier 1: Preferred generic drugs.** Generic drugs are produced and sold under their generic names after the patent of the brand-name drug expires. Although the price is usually lower, the quality of generic drugs is the same as brand-name drugs. Generic drugs are also just as effective as brand-name drugs. The Food and Drug Administration (FDA) requires that a generic drug contain the same active drug ingredient in the same amount as the brand-name drug. Preferred generic drugs are listed on our drug formulary.
- **Tier 2: Preferred brand-name and high-cost generic drugs.** Brand-name drugs are produced and sold under the original manufacturer's brand name. Preferred brand-name and high-cost generic drugs are listed on our drug formulary.
- **Tier 3: Non-preferred drugs.** Non-preferred drugs are not listed on our drug formulary.
- **Tier 4: Specialty drugs.** Specialty drugs are high-cost drugs that are on our specialty drug list.

If our allowance for the drug, supply, or supplement is less than the copayment, you will pay the lesser amount. Items can change tier, in accord with formulary guidelines, which may impact the cost-sharing you pay (for example, if a brand-name drug is added to the specialty drug list, you will pay the cost-sharing that applies to drugs on the specialty drug tier, not the cost-sharing for drugs on the brand-name drug tier).

- **These are the dispensing limitations**. We provide up to a 30-day supply for most drugs dispensed in a Plan pharmacy for one copayment based upon (a) the prescribed quantity, (b) the standard manufacturer’s package size, (*c*) specified dispensing limits, (d) the type of drug, and (e) the place of purchase. Maintenance medications may be obtained for up to a 90-day supply when dispensed in a Plan pharmacy for three copayments or through our mail order program for two copayments. A maintenance drug is a drug that your Plan provider anticipates you will require for 6 months or more to treat a chronic condition. For prescribed contraceptives, you may obtain up to a 12-month supply at a Plan pharmacy or through our mail-delivery program. We cover episodic drugs prescribed to treat sexual dysfunction disorders up to a maximum of 8 doses in any 30-day period or 24 doses in any 90-day period. Most drugs can be mailed from our mail order pharmacy. Some drugs (for example, drugs that are extremely high cost, require special handling, have standard packaging or requested to be mailed outside the states of Maryland and Virginia, and the District of Columbia) may not be eligible for mailing and/or a mail order discount. The pharmacy may reduce the day supply dispensed if the pharmacy determines that the item is in limited supply in the market or for specific drugs (your Plan pharmacy can tell you if a drug you take is one of these drugs). You will pay the lesser amount of the total cost of the drug based on the dispensed day’s supply (prorated copay) or the full copay if full supply is available.
- **A generic equivalent will be dispensed if it is available,** unless your physician specifically requires a brand-name . If you receive a brand-name drug when an FDA approved generic drug is available, and your physician has not specified Dispense as Written for the brand-name drug, you have to pay the difference in cost between the brand-name drug and the generic.
- **Why use generic drugs?** Typically generic drugs cost you and us less money than a brand-name drug. Under federal law, generic and brand-name drugs must meet the same standards for safety, purity, strength, and effectiveness.
- **When you do have to file a claim.** You do not need to file a claim when you receive drugs from a Plan pharmacy. You have to file a claim when you receive drugs from a non-Plan pharmacy for a covered out-of-area emergency as specified in Section 5(d). *Emergency Services/Accidents*. For information about how to file a claim, see Section 7. *Filing a Claim for Covered Services*.

Benefit Description	You pay		
Covered medications and supplies	**High Option**	**Standard Option**	**Prosper**
We cover the following medications and supplies prescribed by a Plan physician or Plan dentist and obtained from a Plan pharmacy, an affiliated network pharmacy, or through the Plan's mail service delivery program: • Drugs and medications that, by Federal law of the United States, require a Plan's physician's prescription for their purchase, except those listed as *Not covered* • Insulin • Other implanted time-release drugs • Self-injectable drugs, other than ovulation stimulants • Self-administered post-surgical immunosuppressant outpatient drugs required as a result of a covered transplant • Growth hormone therapy (GHT) – for treatment of growth hormone deficiency • Disposable needles and syringes for the administration of covered medications, except disposable needles and syringes for the administration of insulin (See Section 5 (a). *Durable medical equipment*) • Fertility drugs, including drugs for in vitro fertilization	**For up to a 30-day supply:** • At a Plan medical center pharmacy: $7 preferred generic; $30 preferred brand-name and high-cost generic; $45 non-preferred; $100 specialty • At an affiliated network pharmacy: $17 preferred generic; $50 preferred brand-name and high-cost generic; $65 non-preferred; $150 specialty • Through our mail service: $5 preferred generic; $28 preferred brand-name and high-cost generic; $43 non-preferred; $100 specialty Note: You pay the standard prescription drug cost-sharing for insulin up to a maximum of $30 and for drugs for the treatment of diabetes, HIV, or AIDS up to a maximum of $150.	**For up to a 30-day supply:** • At a Plan medical center pharmacy: $10 preferred generic; $40 preferred brand-name and high-cost generic; $60 non-preferred; $150 specialty • At an affiliated network pharmacy: $20 preferred generic; $60 preferred brand-name and high-cost generic; $80 non-preferred; $200 specialty • Through our mail service: $8 preferred generic; $38 preferred brand-name and high cost generic; $58 non-preferred; $150 specialty Note: You pay the standard prescription drug cost-sharing for insulin up to a maximum of $30 and for drugs for the treatment of diabetes, HIV, or AIDS up to a maximum of $150.	**For up to a 30-day supply:** • At a Plan medical center pharmacy: $10 preferred generic; $45 preferred brand-name and high-cost generic; $65 non-preferred; $200 specialty • At an affiliated network pharmacy: $20 preferred generic; $65 preferred brand-name and high-cost generic; $85 non-preferred; $250 specialty • Through our mail service: $8 preferred generic; $43 preferred brand-name and high-cost generic; $63 non-preferred; $200 specialty Note: You pay the standard prescription drug cost-sharing for insulin up to a maximum of $30 and for drugs for the treatment of diabetes, HIV, or AIDS up to a maximum of $150.
• Medications prescribed to treat obesity	50% of our allowance	50% of our allowance	50% of our allowance

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	**High Option**	**Standard Option**	**Prosper**
Contraceptive drugs and devices as listed in the Health Resources and Services Administration https ://www. hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. • We cover contraceptive drugs and devices, including implanted contraceptive devices, diaphragms, contraceptive gels, hormonal contraceptive methods, and prescribed FDA approved over-the-counter women's contraceptives and devices • We cover over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. • We cover prescribed FDA approved over-the-counter women's contraceptives and devices when prescribed by a Plan provider and obtained at a Plan pharmacy • We cover non-preferred contraceptives if they would otherwise be covered, and a Plan provider receives an approved drug formulary exception Providers have the authority to prescribe non-formulary, contraceptive drugs for their patients if it is medically necessary and would be more beneficial for an individual patient. Members pay no cost share for medically necessary, approved non-formulary contraceptive drugs. For more information on contraceptive coverage and the prescription exception process, please go to https ://www. kp.org/feds. Kaiser Permanente does not have any coverage exceptions for surgical contraception methods. If surgical contraception procedures are performed for the purpose of contraception, they are covered without cost-sharing.	Nothing	Nothing	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	**High Option**	**Standard Option**	**Prosper**
As an integrated care delivery system, our providers are contracted with us. They can assess the need for surgical contraception based on ACA requirements and medical necessity. Therefore, we do not have exception forms for our members to complete or a review process to follow. Our coverage is based on required guidelines and clinical necessity. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. Note: For additional Family Planning benefits see Section 5(a)	Nothing	Nothing	Nothing
• Fertility drugs, including drugs for in vitro fertilization	50% of our allowance (If it is medically necessary to administer medication during an office visit, the medication is included in the office visit copayment.)	50% of our allowance (If it is medically necessary to administer medication during an office visit, the medication is included in the office visit copayment.)	50% of our allowance (If it is medically necessary to administer medication during an office visit, the medication is included in the office visit copayment.)
• Sexual dysfunction drugs	50% of our allowance	50% of our allowance	50% of our allowance
Notes: • For information about mail order discounts, see “These are the dispensing limitations” in the introduction to Section 5(f) • The brand-name drug copayment will apply to single-source generic products. For compound drugs, you will be charged your applicable generic or brand-name drug copayment depending on the compounded product’s main ingredient, whether the main ingredient is a generic or brand-name drug. • A compound drug is one in which two or more drugs or pharmaceutical agents are combined together. We limit coverage to products listed in our drug formulary or when one of the ingredients requires a prescription by law. • Non-maintenance self-injectables are limited to a dispensing limit of 30 days.	Applies to this benefit	Applies to this benefit	Applies to this benefit

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	**High Option**	**Standard Option**	**Prosper**
• Home IV and growth hormone require our prior approval. See Section 3, You need prior Plan approval for certain services. • For in vitro fertilization only, we cover fertility drugs prescribed by non-Plan providers when obtained at a Plan pharmacy. • Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a) • There are medically necessary conditions outside of gender dysphoria that also utilize similar hormone treatments and medications	Applies to this benefit	Applies to this benefit	Applies to this benefit
Not covered: • *Drugs or supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Prescriptions filled at a non-Plan pharmacy, except for out-of-area emergencies as described in Section 5(d). Emergency Services/Accidents* • *Vitamins, nutritional and herbal supplements that can be purchased without a prescription, unless they are included in our drug formulary or listed as covered above or below* • *Over-the-counter (nonprescription) drugs, including prescription drugs for which there is an over-the-counter drug equivalent available* • *Prescription drugs not on our drug formulary, unless approved through an exception process* • *Over-the-counter drugs, unless they are included in our drug formulary or listed as covered above* • *Medical supplies such as dressings and antiseptics, except as listed above* • *Drugs to shorten the duration of the common cold* • *Any requested packaging of drugs other than the dispensing pharmacy's standard packaging* • *Replacement of lost, stolen, or damaged prescription drugs and accessories*	*All charges*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	**High Option**	**Standard Option**	**Prosper**
• *Drugs related to non-covered services, except as stated above* • *Drugs for the promotion, prevention, or other treatment of hair loss or growth* • *Dental prescriptions other than those prescribed for pain relief or antibiotics* • *Drugs prescribed in connection with Sex-Trait Modification for treatment of gender dysphoria*	*All charges*	*All charges*	*All charges*
Preventive care medications	**High Option**	**Standard Option**	**Prosper**
The following are covered: • Aspirin to reduce the risk of heart attack • Oral fluoride for children to reduce the risk of tooth decay • Folic acid for women to reduce the risk of birth defects • Medication to reduce the risk of breast cancer • Preventive medications with USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to https ://www. uspreventiveservicestaskforce.org/ BrowseRec/Index/browse-recommendations	Nothing	Nothing	Nothing
Opioid rescue agents are covered under this Plan with no cost sharing when obtained with a prescription from a Plan pharmacy, affiliated pharmacy in any over-the-counter or clinical setting, or prescription form available, such as nasal sprays and intramuscular injections. For more information, consult the FDA guidance at https ://www. fda.gov/consumers/ consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https ://www. findtreatment.samhsa.gov/.	Nothing	Nothing	Nothing
Not covered: • *Prescriptions filled at a non-Plan pharmacy, except for emergencies as described in Section 5(d). Emergency Services/Accidents*	*All charges*	*All charges*	*All charges*

Preventive care medications - continued on next page

Benefit Description	You pay		
Preventive care medications (cont.)	**High Option**	**Standard Option**	**Prosper**
• *Vitamins, nutritional and herbal supplements that can be purchased without a prescription, unless they are included in our drug formulary or listed as covered above* • *Over-the-counter, unless they are included in our drug formulary or listed as covered above* • *Prescription drugs not on our drug formulary, unless approved through an exception process* • *Any requested packaging of drugs other than the dispensing pharmacy's standard packaging* • *Replacement of lost, stolen or damaged prescription drugs and accessories* • *Drugs related to non-covered services* • *Drugs and supplies for cosmetic purposes* • *Nonprescription medications*	*All charges*	*All charges*	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Our integrated system and the care teams we have developed provide care in a collaborative model. That model pervades all of the care provided and in many ways our care is, in its entirety, a collaborative care model. These collaborative systems for care delivery are included across care teams such as primary care, chronic conditions management, hospital-based care, post discharge care, healthy living resources, and specialty care including mental health and substance use disorder services. This is facilitated by our integration of care and coverage, our shared electronic health record, and our whole-person approach to care. Our clinicians work together with patients using our shared decision-making model to develop treatment plans. All care is documented in our electronic health record and all clinicians have access to a patient's chart, facilitating a seamless patient experience and better health outcomes.
- Please remember that all benefits are subject to this brochure's definitions, limitations, and exclusions and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan, your FEHB plan preventive and comprehensive dental coverage is the primary payor of any benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9, *Coordinating Benefits with Medicare and Other Coverage*.
- Plan dentists must provide or arrange your care, except as described under the Accidental injury benefit below. LIBERTY Dental Plan (LIBERTY) will provide or arrange for the provision of covered dental services to you through participating dental providers.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(*c*), *Services Provided by a Hospital or Other Facility, and Ambulance Services*, for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- There is no calendar year deductible for the High and Standard Options.
- The Prosper calendar year deductible is $150 per person ($300 per Self Plus One enrollment, or $300 per Self and Family enrollment). The calendar year deductible applies to some benefits in this Section. We added "(after the deductible)" when the calendar year deductible applies.
- Be sure to read Section 4. *Your Costs for Covered Services*, for valuable information about how cost-sharing works.

Benefit Description	You pay		
Note: The calendar year deductible applies to some benefits under Prosper in this Section. We say "after the deductible" when the calendar year deductible applies.			
Accidental injury benefit	**High Option**	**Standard Option**	**Prosper**
We cover medically necessary dental services to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. Dental appliances required to diagnose or treat an accidental injury to the teeth, and the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face, are also covered. • Damage is due to an accidental injury from trauma to the mouth from violent contact with an external object, • The tooth has not been restored previously, and	$15 per primary care office visit $20 per specialty care office visit	$25 per primary care office visit $30 per specialty care office visit	$30 per primary care office visit $40 per specialty care office visit

Accidental injury benefit - continued on next page

Benefit Description	You pay		
Accidental injury benefit (cont.)	**High Option**	**Standard Option**	**Prosper**
• The tooth has not been weakened by decay, periodontal disease, or the existing dental pathology.	$15 per primary care office visit $20 per specialty care office visit	$25 per primary care office visit $30 per specialty care office visit	$30 per primary care office visit $40 per specialty care office visit
Not covered: • *Services for conditions caused by an accidental injury occurring before your eligibility date* • *Injury that results from chewing or biting*	*All charges*	*All charges*	*All charges*
Other dental benefits	**High Option**	**Standard Option**	**Prosper**
General anesthesia and associated hospital or ambulatory surgery facility charges, in conjunction with dental care, are covered for members: • 7 years of age or younger, who: - are developmentally disabled - for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition, - for whom a superior result can be expected from dental care provided under general anesthesia • 17 years of age or younger, and extremely uncooperative, fearful, or uncommunicative with dental needs of such magnitude that treatment should not be delayed or deferred; and whom a lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity • 17 and older, whose medical condition requires that dental service be performed in a hospital or ambulatory surgical center for their safety (e.g., heart disease and hemophilia) Note: Dental care must be provided by a fully accredited specialist in pediatric dentistry, a fully accredited specialist in oral and maxillofacial surgery, or a dentist for whom hospital privileges have been granted.	$15 per primary care office visit $20 per specialty care office visit $75 per outpatient surgery $200 per inpatient admission	$25 per primary care office visit $30 per specialty care office visit $150 per outpatient surgery $500 per inpatient admission	$30 per primary care office visit $40 per specialty care office visit $300 per outpatient surgery after the deductible $750 per inpatient admission after the deductible
Not covered:	*All charges*	*All charges*	*All charges*

Other dental benefits - continued on next page

Benefit Description	You pay		
Other dental benefits (cont.)	**High Option**	**Standard Option**	**Prosper**
• *The dentist's or specialist's professional services* • *Dental care for temporal mandibular joint (TMJ) disorders* • *Lab fees associated with cysts that are considered dental according to our medical guidelines*	*All charges*	*All charges*	*All charges*
Diagnostic and preventive benefit	**High Option**	**Standard Option**	**Prosper**
Diagnostic and preventive dental services when provided by a participating LIBERTY Dental Plan dentist, such as: • Routine oral examinations – twice per calendar year • Cleaning (prophylaxis) – twice per calendar year (excluding periodontal prophylaxis) • Topical application of fluoride – twice per calendar year • Bitewing X-rays – twice per calendar year	$30 per office visit	$30 per office visit	*All charges*
Other covered dental services when provided by a Plan dentist. Note: All dental procedures listed in the schedule of discounted fees are covered dental services. When you receive any of the listed procedures from a Participating Dental Provider, you will pay the fee listed next to the procedure description for that service. The Participating Dental Provider has agreed to accept that fee as payment in full for that procedure. Neither Kaiser Permanente nor LIBERTY are liable for payment of these fees or for any fees incurred as the result of receipt of non-covered dental services.	See Kaiser Permanente Dental Plan Provider Directory for schedule of discounted dental fees.	See Kaiser Permanente Dental Plan Provider Directory for schedule of discounted dental fees.	*All charges*
Dental emergencies outside our service area Notes: • We cover emergency dental treatment required to alleviate pain, bleeding, or swelling. • If post-emergency care is required, you must receive all post-emergency care from your Participating Dental Provider.	*All charges*, not to exceed $200 per incident	*All charges*, not to exceed $100 per incident	*All charges*
Notes:	Applies to this benefit	Applies to this benefit	Applies to this benefit

Diagnostic and preventive benefit - continued on next page

Benefit Description	You pay		
Diagnostic and preventive benefit (cont.)	**High Option**	**Standard Option**	**Prosper**
• You may select a Participating Dental Provider, who is a "general dentist", from whom you and your eligible family members will receive covered dental services. If your general dentist requires you to get covered services from a specialist, you may go directly to a specialist who is a participating dental provider. • For a complete list of covered dental services, a schedule of discounted dental fees, limitations, exclusions and a directory of Participating Dental Providers, refer to your Kaiser Permanente Dental Plan booklet. You can obtain a Dental Plan booklet by calling our Federal Member Services Department at 877-KP4-FEDS (877-574-3337), (TTY: 711). • For assistance concerning dental coverage questions or for help finding a participating dental provider: - Go to www. kp.org/feds - Call LIBERTY toll-free at 888-798-9868, (TTY: 877-855-8039), Monday through Friday from 8:00 a.m. to 8:00 p.m. (Eastern Time).	Applies to this benefit	Applies to this benefit	Applies to this benefit

Section 5(h). Wellness and Other Special Features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claims process (see Section 8).
Centers of Excellence	The Centers of Excellence program began in 1987. As new technologies proliferate and become the standard of care, Kaiser Permanente refers members to contracted "Centers of Excellence" for certain specialized medical procedures. We have developed a nationally contracted network of Centers of Excellence for organ transplantation, which consists of medical facilities that have met stringent criteria for quality care in specific procedures. A national clinical and administrative team has developed guidelines for site selection, site visit protocol, volume and survival criteria for evaluation and selection of facilities. The institutions have a record of positive outcomes and exceptional standards of quality.
Services for the deaf, hard of hearing or speech impaired	We provide TTY/text phone number TTY: 711. Sign language services are also available.
Services from other Kaiser Permanente regions	When you visit a different Kaiser Foundation Health Plan service area, you can receive visiting member services from designated providers in that area. Visiting member services are subject to the terms, conditions and cost-sharing described in this FEHB brochure. Certain services are not covered as a visiting member. For more information about receiving visiting member services, including provider and facility locations in other Kaiser Permanente service areas please call our Away from Home Travel Line at 951-268-3900 or visit www.kp.org/feds.

Travel benefit	Kaiser Permanente's travel benefits for Federal employees provides you with outpatient follow-up and/or continuing medical and mental health and substance use care when you are temporarily (for example, on a temporary work assignment or attending school) outside your home service area by more than 100 miles and outside of any other Kaiser Permanente service area. These benefits are in addition to your emergency services/accident benefit and include: • Outpatient follow-up care necessary to complete a course of treatment after a covered emergency. Services include removal of stitches, a catheter, or a cast. • Outpatient continuing care for covered services for conditions diagnosed and treated within the previous 12 months by a Kaiser Permanente healthcare provider or affiliated Plan provider. Services include prescription drug monitoring. You pay $25 for each follow-up or continuing care office visit. This amount will be deducted from the reimbursement we make to you or to the provider. We limit our payment for this travel benefit to no more than $1,200 each calendar year. For more information about this benefit you should contact the Plan's dedicated Federal Member Services Department at 877-KP4-FEDS (877-574-3337) (TTY: 711). File claims as shown in Section 7. *The following are a few examples of services not included in your travel benefits coverage:* • Non-emergency hospitalization • Infertility treatments • Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area • Transplants • Durable medical equipment (DME) • Prescription drugs • Home health services
Rewards	Take steps to improve your well-being by completing the Kaiser Permanente Total Health Assessment and a biometric screening. FEHB subscribers and their enrolled spouses (age 18 and over) are eligible for the following reward: **High Option, Standard Option, and Prosper** • $150 for completing a confidential, online, Total Health Assessment (available in English or Spanish) and being up to date on the following biometric screenings: blood glucose, blood pressure, Body Mass Index (BMI) and total cholesterol. To view and determine the status of your screenings, go to www.kp.org/feds. Both activities must be completed to be eligible. If you have not had these screenings recently, you may be required to contact your Kaiser Permanente doctor. You will get a picture of your overall health and a customized action plan with tips and resources to improve your well-being. **Program Guidelines (applies to High Option, Standard Option, and Prosper)** You must accept the Wellness Program Agreement to be eligible to earn rewards. Please go to www.kp.org/feds to learn how to earn your reward and how to view and track the status of your reward activities. You must complete reward activities (Total Health Assessment and a biometric screening) during the plan year. We will issue you a Kaiser Permanente Health Payment Card 4-6 weeks after you complete both activities. We will send each eligible member their own debit card.

	You may use your Health Payment Card to pay for certain qualified medical expenses, such as: • Copayments for office visits, prescription drugs and other services at Kaiser Permanente or other providers • Prescription eyeglasses or contacts • Dental services • Over-the-counter medication for certain diseases • Other medical expenses, as permitted by the IRS Please keep your card for use in the future. As you complete activities, we will add rewards to your card. We will not send you a new card until the card expires. Rewards you earn during this calendar year may be used until March 31 of the next calendar year. Funds are forfeited if you leave this plan. For more information, please go to www.kp.org/feds. If you have questions about completing a Total Health Assessment or biometric screenings, you may call us at **866-300-9867**. If you have questions about your account balance or what expenses the Health Payment Card can be used for, you may call the phone number on the back of your Health Payment Card.
Nutrition and behavioral lifestyle support	Kaiser Permanente is committed to investing in the total health of our members. Exercise, nutrition, and weight management resources such as wellness coaching and online Healthy Lifestyle Programs are all available at no cost. We offer our members the tools and resources they need to actively participate in their health at home, online, with their smartphone, and at our facilities. Our members can enroll in a variety of programs that are designed to help them take an active role in their health and make desired lifestyle changes. Unless otherwise noted, most of these programs are available at no additional costs to members because they are embedded within our integrated care delivery model as part of our core offerings. Examples of our wellness programs aimed at weight and nutrition are: • Nutrition counseling (such as weight loss and a healthy diet) • Stress reduction programs • Chronic disease self-management programs • Exercise counseling and cardiovascular fitness programs • Smoking Cessation program • Health risk assessments Members can access our Health and Wellness Programs at kp.org/healthyliving.
Non-pharmaceutical treatment options	Kaiser Permanente promotes and covers a wide variety of non-pharmaceutical treatment options to address pain, diabetes, hypertension, obesity, and many other chronic conditions. Our care teams focus on instilling healthy lifestyle behaviors for all patients, including those at risk of or diagnosed with chronic conditions. Our comprehensive network of practitioners includes nutritionists and health coaches in addition to primary care physicians and specialists, all working together to develop care plans for our members. Kaiser Permanente's non-pharmaceutical treatment options and approaches to care include the following offerings: **Medical Nutrition Therapy**

	Kaiser Permanente's cross-functional care teams include registered dietitians who work with patients to develop evidence-based nutrition plans to help manage their chronic conditions (e.g. diabetes, hypertension, obesity). Our dietitians support patients with identifying their dietary needs and preferences, building meal plans, and counseling them on behavioral and lifestyle modifications for better health outcomes. Patients are referred to medical nutrition therapy by their primary care physician or specialists as appropriate; these services are offered within our integrated model, and all care team members have access to our electronic medical record to coordinate and oversee care plans. **Obesity counseling** Patients at risk of or diagnosed with obesity are counseled by their primary care physician (PCP) to assess lifestyle factors or co-morbidities that may be impacting their weight and overall health. Patients work with their PCP and other clinicians as needed to develop care plans to achieve a healthy weight, which may include behavioral health support, wellness coaching, nutrition counseling, exercise regimens, prescribed medications, and other interventions as appropriate. **Tobacco cessation counseling** Kaiser Permanente offers a variety of tobacco cessation resources including individual and group visits with wellness coaches, health educators and dieticians to help instill healthy lifestyle behaviors and promote good health. We also prescribe both over-the-counter and prescription medicines to members when indicated. We also provide patients with a comprehensive suite of educational materials via our kp.org website and app (more information provided at this link). **Remote Physiologic Monitoring** Kaiser Permanente offers a suite of digital health devices and remote monitoring options. These programs and devices minimize the need for members to travel to a medical center for care and enhance our clinicians' ability to monitor and manage their patient's clinical conditions. Examples of these digital options include e-visits, remote glucose monitoring, remote blood-pressure monitoring, vagal nerve stimulators, responsive neurostimulator, and medical alert monitoring. Members must obtain prior authorization for Durable Medicare Equipment (DME). See Section 3 of the brochure for details. Please refer to Section 5(a) for any applicable cost sharing. **Remote Therapeutic Monitoring** Kaiser Permanente members can use our app or website to access their medical record and send secure messages to their physician. When indicated as part of their care plans, members may use the secure message functionality to provide their care teams with data for the purposes of remote therapeutic monitoring (RTM). This may include pain scores, updates on medication compliance and effectiveness, exercise plan logging, and other key communications from the patient to their care team regarding treatment plan compliance. Different RTM options may vary by service area, and all service areas have access to secure messaging. These services are available at no cost to members.

Non-FEHB Benefits Available to Plan Members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. The fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the plan at 877-KP4-FEDS (877-574-3337) (TTY: 711).

Gym Reimbursement

Member Services: 877-KP4-FEDS (877-574-3337) (TTY: 711) www. kp.org/feds

Kaiser Permanente Prosper includes a gym reimbursement program for members over the age of 18 up to $500 reimbursement for gym membership. To learn more about gym reimbursement, visit kp.org/feds or call the Member Services Department at 877-KP4-FEDS (877-574-3337) (TTY:711).

Health classes and programs - www. kp.org/classes

As a Kaiser Permanente member, you can sign up for in-person, over-the-phone, and online wellness programs and classes designed to help you achieve your health goals. All sessions are taught by your team of experts who walk you through how to make actionable lifestyle changes.

Fitness deals - www. kp.org/exercise

- **One Pass Select Affinity®.** As a Kaiser Permanente member, you get access to more than 20,000 gym locations and over 23,000 online classes. You can have groceries and household essentials delivered right to your door. Flexible fitness options and the ability to use multiple locations.
- **Affinity Musculoskeletal Program®** provides you with access to a variety of high-quality providers for complimentary and alternative medicine for therapies such as acupuncture, massage and chiropractic care. Go to https ://www. myoptumhealthphysicalhealth.com/ProviderDirectory to locate a provider near you.

Emotional Wellness and Coaching Apps - www. kp.org/selfcareapps

Kaiser Permanente members get access to wellness apps that can help you navigate life's challenges and receive support for emotional wellness. Get help with anxiety, stress, sleep, relationships, and more, anytime you need it.

- **Calm** is an app for meditation and sleep designed to lower stress, reduce anxiety, and more. You can choose from more than 100 programs and activities, including guided meditations, sleep stories, and mindful movement videos.
- **Headspace Care (formerly ginger)** allows you to text one-on-one with an emotional support coach anytime, anywhere, for up to 90 days each year. You can discuss goals, share challenges, and create an action plan with your coach.

Section 6. General Exclusions – Services, Drugs and Supplies We Do Not Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3, *You need prior Plan approval for certain services*.**

We do not cover the following:

- When a service is not covered, all services, drugs, or supplies related to the non-covered service are excluded from coverage, except when specifically stated as covered in this brochure or for services we would otherwise cover to treat complications of the non-covered service.
- Fees associated with non-payment (including interest), missed appointments and special billing arrangements.
- Care by non-Plan providers, except with prior approval of the Plan, emergencies, travel benefit, or services from other Kaiser Permanente plans (see Emergency services/accidents and Special features).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except, you pay nothing when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services or supplies we are prohibited from covering under the Federal Law.
- Any benefits or services required solely for your employment are not covered by this plan.
- Chemical or surgical modification of an individual's sex traits through medical interventions (to include “gender transition” services), other than mid-treatment exceptions, see Section 3. How You Get Care.
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.

Section 7. Filing a Claim for Covered Services

This section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on prior Plan approval and pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

You may need to file a claim when you receive a service or item from a non-Plan provider or at a non-Plan facility. This includes services such as out-of-network emergency services, out-of-area urgent care and services covered under the travel benefit. Check with the provider to determine if they can bill us directly. Filing a claim does not guarantee payment.

If you need to file the claim, here is the process:

Medical, hospital and drug benefits

In most cases, providers and facilities file HIPAA compliant electronic claims for you. Providers must file on the form CMS-1500, Health Insurance Claim Form. In cases where a paper claim must be used, the facility will file on the UB-04 form. For claims questions and assistance, call us at 877-KP4-FEDS (877-574-3337) (TTY:711) or at our website at www.kp.org/feds.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the provider or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

Mid-Atlantic Claims Administration
Kaiser Permanente
P.O. Box 371860
Denver, CO 80237-9998

Deadline for filing your claim

Send us all the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service.

Post-Service Claims

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Records

Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

Overseas claims

Filing Overseas Claims for Urgent or Emergent Care

Most overseas providers are under no obligation to file claims on behalf of our members. You may need to pay for the services at the time you receive them and then submit a claim to us for reimbursement. To file a claim for covered urgent or emergent care received outside the United States, send a completed Overseas Claim Form and itemized bills to:

Mid-Atlantic Claims Administration
Kaiser Permanente
P.O. Box 371860
Denver, CO 80237-9998

We will do the translation and currency conversion for you. You may obtain the Overseas Claim Form by calling Member Services toll-free at 877-KP4-FEDS (877-574-3337) or from our website at www.kp.org/feds, Members/Forms and Information.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a healthcare professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as phone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call Member Services at the phone number found on your ID card, Plan brochure, or Plan website.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3, *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Member Services Appeals Department by writing to Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305, Attn: Member Services Appeals Unit or calling 877-KP4-FEDS (877-574-3337) (TTY: 711).

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305, Attn: Member Services Appeals Unit; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or

b) Write to you and maintain our denial or

c) Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3

If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Postal Service Insurance Operations (PSIO), 1900 E Street NW, Room 5478, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim;
- Your daytime phone number and the best time to call; and
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4

OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of OPM’s review within 60 days. There are no other administrative appeals.

If you do not agree with OPM’s decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life-threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 877-KP4-FEDS (877-574-3337). We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's FEHB 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a family member is covered under this Plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays healthcare expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC website at www.kp.org/feds.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan processes the benefit, we will pay what is left of our allowance, up to our regular benefit, except Medicare-eligible members with Original Medicare as primary payor must pay cost-sharing described in this FEHB brochure (see Sections 4 and 5, members with Medicare should also see the Original Medicare Plan portion of this Section 9). We will not pay more than our allowance. If we are the secondary payor, and you received your services from Plan providers, we may bill the primary carrier.

- **TRICARE and CHAMPVA**

TRICARE is the healthcare program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar federal or state agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these state programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the state program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.

When others are responsible illness or injuries

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused or is responsible for an injury or illness for which you received covered healthcare services or benefits ("Services"), you must pay us Charges for those Services. "Charges" are: 1) for Services that we pay the provider on a fee-for-service basis, the payments that we made for the Services; and 2) for all other Services, the charges in the provider's schedule of charges for Services provided to Members less any cost share payments that you made to the provider. Our payments for Services in these circumstances are expressly conditioned on your agreement to comply with these provisions. You are still required to pay cost-sharing to the provider, even if a third party has allegedly caused or is responsible for the injury or illness for which you received Services.

You must also pay us Charges for such Services if you receive or are entitled to receive a recovery from any insurance for an injury or illness alleged to be based on a third party's or your own fault, such as from uninsured or underinsured motorist coverage, automobile or premises medical payments coverage, or any other first party coverage. You must also pay us Charges for such Services if you receive or are entitled to receive recovery from any Workers' Compensation benefits.

To secure our rights, we will have a lien on and reimbursement right to the proceeds of any judgment or settlement you or we obtain. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred. Our right to receive payment is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We are entitled to full recovery regardless of whether any liability for payment is admitted by any person, entity or insurer. We are entitled to full recovery regardless of whether the settlement or judgment received by you identifies the medical benefits provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. We are entitled to recover from any and all settlements, even those designated as for pain and suffering, non-economic damages and/or general damages only.

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney and any, insurer to pay us directly. You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent. You must cooperate in doing what is reasonably necessary to assist us with our right of recovery. You must notify us within 30 days of the date you or someone acting on your behalf notifies anyone, including an insurer or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury or illness. You must not take any action that may prejudice our right of recovery.

If your estate, parent, guardian, or conservator asserts a claim based on your injury or illness, that person or entity and any settlement or judgment recovered by that person or entity shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the party. We may assign our rights to enforce our liens and other rights.

We have the option of becoming subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney, but we will be subrogated only to the extent of the total of Charges for the relevant Services. Contact us if you need more information about recovery or subrogation.

Surrogacy Agreements

If you enter into a Surrogacy Agreement, you must reimburse us for covered services you receive related to conception, pregnancy, delivery, or postpartum care in connection with the Surrogacy Agreement, except that the amount you must pay will not exceed the payments or other compensation you and any other payee are entitled to receive under the Surrogacy Agreement. A "Surrogacy Agreement" is one in which a person agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), in exchange for payment or compensation for being a surrogate. The "Surrogacy Agreement" does not affect your obligation to pay your cost-sharing for services received, but we will credit any such payments toward the amount you must pay us under this paragraph. We will only cover charges incurred for any services when you have legal custody of the baby and when the baby is covered as a family member under your Self Plus One or Self and Family enrollment (the legal parents are financially responsible for any services that the baby receives).

By accepting services, you automatically assign to us your right to receive payments that are payable to you or any other payee under the Surrogacy Agreement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Within 30 days after entering into a Surrogacy Agreement, you must send written notice of the Agreement, a copy of the Agreement, including the names, addresses, and phone numbers of all parties involved in the Agreement. You must send this information to:

Kaiser Permanente
Attention: Patient Financial Services
4000 Garden City Drive
Hyattsville, MD 20785
Attn: Surrogacy Coordinator

You must complete and send us consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy Agreements" section and to satisfy those rights.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on the Surrogacy Agreement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on www.BENEFEDS.gov or by phone at 877-888-3337, (TTY 877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

We will cover routine care costs and may cover some extra care costs not provided by the clinical trial in accordance with Section 5 when Plan physicians provide or arrange for your care. We encourage you to contact us to discuss specific services if you participate in a clinical trial.

- Routine care costs are costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy. We cover routine care costs not provided by the clinical trial.
- Extra care costs are costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. We cover some extra care costs not provided by the clinical trial. We encourage you to contact us to discuss coverage for specific services if you participate in a clinical trial.
- Research costs are costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. The Plan does not cover research costs.

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 800-MEDICARE (800-633-4227), (TTY: 877-486-2048) or at www.medicare.gov.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us toll free, at 877-KP4-FEDS (877-574-3337) (TTY: 711), 7:30 a.m. to 9:00 p.m., Monday through Friday, or visit our website at www.kp.org/feds.

We do not waive any costs if the Original Medicare Plan is your primary payor.

- **If you enroll in Medicare Part B**

If you enroll in Medicare Part B, we require you to assign your Medicare Part B benefits to the Plan for its services. Assigning your benefits means you give the Plan written permission to bill Medicare on your behalf for covered services you receive in network. You do not lose any benefits or entitlements as a result of assigning your Medicare Part B benefits.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Part B premium reimbursement**

We offer a program designed to help members with their Medicare Part B premium. This program is called "Medicare Advantage 2". For each month you are enrolled in Medicare Advantage 2, have Medicare Parts A and B or Part B only and are enrolled in Medicare Advantage for Federal Members, you will be reimbursed up to $250 (up to $3,000 per year) of your Medicare Part B monthly premium. In addition to reimbursing for the Part B monthly premium, we will cover additional benefits, including lower copayments for office visits, outpatient surgery, inpatient hospital care, emergency care, plus additional coverage for the One Pass® fitness program.

You may enroll in this program if:

- You enroll in the Plan's High Option or Standard Option,
- You live in our Medicare Advantage service area,
- You have Medicare Parts A and B, or Medicare Part B only, and you enroll in Medicare Advantage for Federal Members, and
- The FEHB subscriber completes an additional application for enrollment in Medicare Advantage 2.

Reimbursements will begin on the first of the month following receipt of your additional application for enrollment in Medicare Advantage 2 and verification of your Medicare Part B enrollment. During a calendar year, you may enroll in Medicare Advantage 2 only once. If the FEHB subscriber enrolls in Medicare Advantage 2, each family member who enrolls in Medicare Advantage for Federal Members is required to participate in Medicare Advantage 2. If, for any reason, you do not meet the enrollment requirements for Medicare Advantage 2, you will no longer be eligible to participate in the program. Your reimbursement will end and your regular FEHB High Option and Standard Option benefits will resume. You may be required to repay any reimbursements paid to you in error.

To learn more about Medicare Advantage 2 and how to enroll, call us at 877-547-4909 (TTY:711), 8 a.m. to 8 p.m., 7 days a week, or visit our website at www.kp.org/feds. We will send you additional information and an additional application for enrollment in Medicare Advantage 2.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at **800-MEDICARE (800-633-4227) (TTY: 877-486-2048)** or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage Plan: We offer a Medicare Advantage plan known as Kaiser Permanente Medicare Advantage for Federal Members. Kaiser Permanente Medicare Advantage for Federal Members enhances your FEHB coverage by lowering cost-sharing for some services and/or adding benefits. High and Standard Option Members can chose between 2 Medicare Advantage plans: "Medicare Advantage 1" (richest benefits) and "Medicare Advantage 2" (some rich benefits) and Part B premium reimbursement. If you live in our Medicare Advantage service area and you have Medicare Parts A and B, or Medicare Part B only, you can enroll in Medicare Advantage for Federal Members. Enrolling in Medicare Advantage for Federal Members does not change your FEHB premium. Your enrollment is in addition to your FEHB High Option, Standard Option or Prosper enrollment; however, your benefits will be provided under the Kaiser Permanente Medicare Advantage for Federal Members plan and are subject to Medicare rules. If you are already enrolled and would like to understand your additional benefits in more detail, please refer to your Medicare Advantage for Federal Members plan's Evidence of Coverage. If you are considering enrolling in our Medicare Advantage for Federal Members, please call us at 301-816-6143 (TTY:866-513-0008), 8:30 a.m. to 5 p.m., Monday through Friday, or visit our website at www.kp.org/feds.

This is a summary of the features of the Kaiser Permanente Medicare Advantage for Federal Members.

This is a summary of the features of the Kaiser Permanente Medicare Advantage for Federal Members. As a Medicare Advantage member, you are still entitled to coverage under the FEHB Program. All benefits are subject to the definitions, limitations, and exclusions set forth in this FEHB brochure and the Kaiser Permanente Medicare Advantage for Federal Members Evidence of Coverage.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

2027 Benefits and Services: Deductible
High Option without Medicare You pay: None
High Option Medicare Advantage 1 You pay: None
High Option Medicare Advantage 2 You pay: None
Standard Option without Medicare You pay: None
Standard Option Medicare 1 You pay: None
Standard Option Medicare Advantage 2 You pay: None
Prosper without Medicare You pay: $150 per person, up to $300 per family
Prosper Medicare Advantage You pay: None

2027 Benefits and Services: Primary care
High Option without Medicare You pay: $15
High Option Medicare Advantage 1 You pay: $0
High Option Medicare Advantage 2 You pay: $5
Standard Option without Medicare You pay: $25
Standard Option Medicare Advantage 1 You pay: $10
Standard Option Medicare Advantage 2 You pay: $15
Prosper without Medicare You pay: $30
Prosper Medicare Advantage You pay: $20

2027 Benefits and Services: Specialty care
High Option without Medicare You pay: $20
High Option Medicare Advantage 1 You pay: $0
High Option Medicare Advantage 2 You pay: $15
Standard Option without Medicare You pay: $30
Standard Option Medicare Advantage 1 You pay: $10
Standard Option Medicare Advantage 2 You pay: $20
Prosper without Medicare You pay: $40
Prosper Medicare Advantage You pay: $30

2027 Benefits and Services: Outpatient surgery
High Option without Medicare You pay: $125
High Option Medicare Advantage 1 You pay: $25
High Option Medicare Advantage 2 You pay: $50
Standard Option without Medicare You pay: $150
Standard Option Medicare Advantage 1 You pay: $200
Standard Option Medicare Advantage 2 You pay: $125
Prosper without Medicare You pay: $300*
Prosper Medicare Advantage You pay: $150

2027 Benefits and Services: Inpatient hospital care
High Option without Medicare You pay: $200, $200 for maternity care
High Option Medicare Advantage 1 You pay: $75, except nothing for maternity care
High Option Medicare Advantage 2 You pay: $100, except nothing for maternity care
Standard Option without Medicare You pay: $500, except nothing for maternity care
Standard Option Medicare Advantage 1 You pay: $150, except nothing for maternity care
Standard Option Medicare Advantage 2 You pay: $250
Prosper without Medicare You pay: $750*
Prosper Medicare Advantage You pay: $250

2027 Benefits and Services: Additional Benefits offered
High Option without Medicare: Not applicable
High Option Medicare Advantage 1: One Pass, hearing aid coverage
High Option Medicare Advantage 2: One Pass
Standard Option without Medicare: Not applicable
Standard Option Medicare Advantage 1: One Pass, hearing aid coverage
Standard Option Medicare Advantage 2: One Pass
Prosper without Medicare: Not applicable
Prosper Medicare Advantage: One Pass

2027 Benefits and Services: Medicare Part B premium reimbursement
High Option without Medicare: Not covered
High Option Medicare Advantage 1: Not covered
High Option Medicare Advantage 2: Up to $250 per month
Standard Option without Medicare: Not covered
Standard Option Medicare Advantage 1: Not covered
Standard Option Medicare Advantage 2: Up to $250 per month
Prosper without Medicare: Not covered
Prosper Medicare Advantage: Not covered

2027 Benefits and Services: Out-of-pocket maximum - Per person
High Option without Medicare You pay: $3,750
High Option Medicare Advantage 1 You pay: $2,250
High Option Medicare Advantage 2 You pay: $2,250
Standard Option without Medicare You pay: $4,500
Standard Option Medicare Advantage 1 You pay: $3,400
Standard Option Medicare Advantage 2 You pay: $3,400
Prosper without Medicare You pay: $5,300
Prosper Medicare Advantage You pay: $4,000

2027 Benefits and Services: Out-of-pocket maximum - Per family
High Option without Medicare You pay: $7,500
High Option Medicare Advantage 1 You pay: $4,500
High Option Medicare Advantage 2 You pay: $4,500
Standard Option without Medicare You pay: $9,000
Standard Option Medicare Advantage 1 You pay: $7,000
Standard Option Medicare Advantage 2 You pay: $7,000
Prosper without Medicare You pay: $10,600
Prosper Medicare Advantage You pay: $8,000

*You pay the deductible, then cost-sharing

- **Medicare prescription drug coverage (Part D)**

  When we are the primary payor, we process the claim first. If you enroll in another plan's Medicare Part D plan and we are the secondary payor, when you fill your prescription at a Plan pharmacy that is not owned and operated by Kaiser Permanente we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan. Our Kaiser Permanente owned and operated pharmacies will not consider another plan's Medicare Part D benefits. These Kaiser Permanente pharmacies will only provide your FEHB Kaiser Permanente benefits.

  You will still need to follow the rules in this brochure for us to cover your care. We will only cover your prescription if it is written by a Plan provider and obtained at a Plan pharmacy or through our Plan mail service delivery program, except in an emergency or urgent care situation.

  If you enroll in a Kaiser Permanente Medicare plan, you will get all of the benefits of Medicare Part D plus additional drug benefits covered under your FEHB plan.

Medicare Prescription Drug Plan Employer Group Waiver Plan (PDP EGWP)

If you are enrolled in Medicare Part A and/or Part B and are not enrolled in our Medicare Advantage Prescription Drug Plan (MAPD), you will be automatically group enrolled into our Medicare PDP EGWP. Our PDP EGWP is a prescription drug benefit for FEHB-covered annuitants and their FEHB-covered Medicare-eligible family members. This allows you to receive benefits that will never be less than the standard prescription drug coverage that is available to members with non-PDP EGWP prescription drug coverage. But more often, you will receive benefits that are better than members with standard non-PDP EGWP prescription drug coverage.

This Plan and our PDP EGWP:

You will be automatically enrolled in our PDP EGWP and continue to remain enrolled in our FEHB Plan. **Participation in the PDP EGWP is voluntary, and you have the choice to opt out of this enrollment at any time.**

The PDP EGWP opt out process:
If you were automatically group enrolled into our PDP EGWP and choose to opt out:

- You will receive FEHB commercial prescription drug coverage unless you are enrolling in a Medicare Advantage with Part D plan (MAPD) offered through the FEHB program.

You may be subject to a Medicare Part D Late Enrollment Penalty (LEP) if you re-enroll in a Medicare Part D plan at a later date. The LEP is a dollar amount that is permanently added to your Medicare Part D plan premium. You can opt out of the PDP EGWP by signing and returning the Opt-Out form in the automatic enrollment notice or contacting us at 877-KP4-FEDS (877-574-3337); TTY:711.

The PDP EGWP disenrollment process:
When you are enrolled in our PDP EGWP, you may choose to disenroll at any time.

- If you request disenrollment, your disenrollment effective date will be the first day of the month following our receipt of your written, signed, and dated disenrollment request.
- Send a written notice to the following address:

Kaiser Permanente
Medicare Department
P.O. Box 232400
San Diego, CA 92193-2400

- When your Medicare Part D Group plan coverage ends, you may continue your FEHB membership if you still meet the requirements for FEHB coverage.

For additional information, see Chapter 8. *Ending your membership in the plan* in the Evidence of Coverage for Kaiser Permanente Medicare Part D Group Plan (PDP) for Federal members, or contact us at 877-KP4-FEDS (877-574-3337); TTY:711.

Members with higher incomes may have a separate premium payment for their Medicare Part D Prescription Drug Plan (PDP) benefit. Please refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to an additional premium.

For people with limited income and resources, extra help is a Medicare program to help with Medicare prescription drug plan costs. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213, TTY 800-325-0778. You may also contact us at (800) 464-4000.

Note: If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll when and if you are eligible. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for assistance at 877-KP4-FEDS (877-574-3337); TTY:711.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation	✓*	
9) Are a Federal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of Terms We Use in This Brochure

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical trials cost categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

See Section 4, page 24

Copayment

See Section 4, page 24

Cost-sharing

See Section 4, page 24

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

(1) Assistance with activities of daily living, for example, walking, getting in and out of bed, dressing, feeding, toileting, and taking medication. (2) Care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Custodial care that lasts 90 days or more is sometimes known as long-term care.

Deductible

See Section 4, page 24

Experimental or investigational service

We do not cover a service, supply, item or drug that we consider experimental, except for the limited coverage specified in Section 9, Clinical trials. We consider a service, supply, item or drug to be experimental when the services, supply, item or drug:

1. has not been approved by the FDA; or
2. is the subject of a new drug or new device application on file with the FDA; or
3. is available as the result of a written protocol that evaluates the service's safety, toxicity, or efficacy; or
4. is subject to the approval or review of an Institutional Review Board; or
5. requires an informed consent that describes the service as experimental or investigational.

We carefully evaluate whether a particular therapy is safe and effective or offers a degree of promise with respect to improving health outcomes. The primary source of evidence about health outcomes of any intervention is peer-reviewed medical literature.

Group health coverage

Healthcare benefits that are available as a result of your employment, or the employment of your spouse, and that are offered by an employer or through membership in an employee organization. Healthcare coverage may be insured or indemnity coverage, self-insured or self-funded coverage, or coverage through health maintenance organizations or other managed care plans. Healthcare coverage purchased through membership in an organization is also "group health coverage."

Healthcare professional

A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.

Hospice care

Hospice is a program for caring for the terminally ill patient that emphasizes supportive services, such as home care and pain and symptom control, rather than curative care. If you make a hospice election, you are not entitled to receive other healthcare services that are related to the terminal illness. If you have made a hospice election, you may revoke that election at any time, and your standard health benefits will be covered.

Medically necessary

Covered services must be medically necessary. Medically necessary means that the service is all of the following: (i) medically required to prevent, diagnose or treat your condition or clinical symptoms; (ii) in accordance with generally accepted standards of medical practice; (iii) not solely for the convenience of you, your family and/or your provider; and, (iv) the most appropriate level of Service which can safely be provided to you. For purposes of this definition, "generally accepted standards of medical practice" means (a) standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; (b) physician specialty society recommendations; (*c*) the view of physicians practicing in the relevant clinical area or areas within the Kaiser Permanente Medical Care Program; and/or (d) any other relevant factors reasonably determined by us. Unless otherwise required by law, we decide if a service is medically necessary. You may appeal our decision as set forth in Section 8: The disputed claims process. The fact that one of our Plan providers has prescribed, recommended, or approved a service, item or supply does not, in itself, make it medically necessary or covered under this plan.

Never event/serious reportable event

Certain Hospital Acquired Conditions, as defined by Medicare, including things like wrong-site surgeries, transfusion with the wrong blood type, pressure ulcers (bedsores), falls or trauma, and nosocomial infections (hospital-acquired infections) associated with surgeries or catheters, that are directly related to the provision of an inpatient covered service at a Plan provider.

Observation care

Hospital outpatient services you get while your physician decides whether to admit you as an inpatient or discharge you. You can get observation services in the emergency department or another area of the hospital.

Our allowance

Our allowance is the amount we use to determine our payment and your coinsurance for covered services. We determine our allowance as follows:

- For services and items provided by Kaiser Permanente, the applicable charges in the Plan's schedule of Kaiser Permanente charges for services and items provided to Plan members.
- For services and items for which a provider (other than Kaiser Permanente) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider.
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Plan member for the item if a Plan member's benefit plan did not cover the item. This amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy services and items to Plan members, and the pharmacy program's contribution to the net revenue requirements of the Plan.
- For services subject to federal surprise billing laws, the amount that we are required to pay (see Section 4 for more information about surprise billing.)
- For non-Plan Providers rendering services in the state of Maryland, our allowance shall not be less than the amount the Health Plan must pay pursuant to §19-710.1 of the Health General Article of the Annotated Code of Maryland.
- For all other services and items, the payments that Kaiser Permanente makes for the services and items or, if Kaiser Permanente subtracts cost-sharing from its payment, the amount Kaiser Permanente would have paid if it did not subtract cost-sharing.

You should also see Important Notice About Surprise Billing – Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims

Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Reimbursement

A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier Charges for Covered Services out of the payment to the extent of the Covered Services provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Surprise bill

An unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by non-Plan providers with respect to patient visits to Plan health care facilities, or for
- air ambulance services furnished by non-Plan providers of air ambulance services.

Urgent care claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims involve Pre-service claims and not Post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Member Services Department at 877-KP4-FEDS (877-574-3337). You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

Us and We refer to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

You

You refers to the enrollee and each covered family member.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Summary of Benefits for the High Option of Kaiser Permanente - Mid-Atlantic States - 2027

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www. kp.org/feds.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan provider physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	$15 per primary care office visit (nothing from infancy through age 4) $20 per specialty care office visit	31
Services provided by a hospital: Inpatient	$200 per admission, $200 for maternity care	72
Services provided by a hospital: Outpatient	$125 per visit	74
Emergency benefits:	$200 per visit	77
Mental health and substance use treatment:	Regular cost-sharing	80
Prescription drugs (up to a 30-day supply): Plan Pharmacy	$7 preferred generic; $30 preferred brand-name; $45 non-preferred; $100 specialty.	85
Prescription drugs (up to a 30-day supply): Affiliated network pharmacy	$17 preferred generic; $50 preferred brand-name; $65 non-preferred; $150 specialty.	87
Prescription drugs (up to a 30-day supply): Mail service delivery	$5 preferred generic; $28 preferred brand-name; $43 non-preferred; $100 specialty. Up to a 90-day supply of maintenance drugs for 2 copays through our mail order program.	87
Dental care:	Various copayments based on procedure rendered	93
Vision care:	$15 per office visit	52
Special features: Flexible benefits option; Centers of Excellence; Services for the deaf, hard of hearing or speech impaired; Services from other Kaiser Permanente or allied plans; Travel benefit; Rewards	See Section 5(h) for more information.	97
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $3,750/Self Only or $7,500/ Family enrollment per year. Some costs do not count toward this protection.	24

Summary of Benefits for the Standard Option of Kaiser Permanente - Mid-Atlantic States - 2027

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www. kp.org/feds.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan provider physicians, except in emergencies.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	$25 per primary care office visit (nothing from infancy through age 17) $30 per specialty care office visit	31
Services provided by a hospital: Inpatient	$500 per admission, except nothing for maternity care and inpatient mental health and substance use care	72
Services provided by a hospital: Outpatient	$200 per visit	74
Emergency benefits:	$200 per visit	77
Mental health and substance use treatment:	Regular cost-sharing	80
Prescription drugs (up to a 30-day supply): Plan pharmacy	$10 preferred generic; $40 preferred brand-name; $60 non-preferred; $150 specialty.	87
Prescription drugs (up to a 30-day supply): Affiliated network pharmacy	$20 preferred generic; $60 preferred brand-name; $80 non-preferred; $200 specialty.	87
Prescription drugs (up to a 30-day supply): Mail service delivery	$8 preferred generic; $38 preferred brand-name; $58 non-preferred; $150 specialty. Up to a 90-day supply of maintenance drugs for 2 copays through our mail order program.	87
Dental care:	Various copayments based on procedure rendered	93
Vision care:	$25 per office visit	52
Special features: Flexible benefits option; Centers of Excellence; Services for the deaf, hard of hearing or speech impaired; Services from other Kaiser Permanente or allied plans; Travel benefit; Rewards	See Section 5(h) for more information.	97
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $4,500/Self Only or $9,000/ Family enrollment per year. Some costs do not count toward this protection.	24

Summary of Benefits for Prosper of Kaiser Permanente - Mid-Atlantic States - 2027

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www. kp.org/feds.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan provider physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the calendar year medical deductible.

Prosper Benefits	You Pay	Page
Calendar year deductible for covered services	$150 per person $300 per family	24
Medical services provided by physicians: Diagnostic and treatment services provided in the office	$30 per primary care office visit (nothing from infancy through age 4) $40 per specialty care office visit	31
Services provided by a hospital: Inpatient	$750 per admission*	72
Services provided by a hospital: Outpatient	$300 per visit*	74
Emergency benefits:	$200 per visit*	77
Mental health and substance use treatment:	Regular cost-sharing	80
Prescription drugs (up to a 30-day supply): Plan pharmacy	$10 preferred generic; $45 preferred brand-name; $65 non-preferred; $200 specialty.	87
Prescription drugs (up to a 30-day supply): Affiliated network pharmacy	$20 preferred generic; $65 preferred brand-name; $85 non-preferred; $250 specialty.	87
Prescription drugs (up to a 30-day supply): Mail service delivery	$8 preferred generic; $43 preferred brand-name; $63 non-preferred; $200 specialty. Up to a 90-day supply of maintenance drugs for 2 copays through our mail order program.	87
Dental care:	Various copayments based on procedure rendered	93
Vision care:	$30 per office visit	52
Special features: Flexible benefits option; Centers of Excellence; Services for the deaf, hard of hearing or speech impaired; Services from other Kaiser Permanente or allied plans; Travel benefit; Rewards	See Section 5(h) for more information.	97
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,300/Self Only or $10,600/ Family enrollment per year. Some costs do not count toward this protection.	24

2027 Rate Information for Kaiser Permanente - Mid-Atlantic States

To compare your FEHB health plan options please go to www. opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to **www. opm.gov/FEHBpremiums** or **www. opm.gov/Tribalpremium**.

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee pay is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
High Option Self Only	E31	$352.04	$138.93	$762.75	$301.02
High Option Self Plus One	E33	$767.53	$361.71	$1,662.98	$783.71
High Option Self and Family	E32	$843.82	$285.42	$1,828.28	$618.41
Standard Option Self Only	E34	$297.10	$99.03	$643.71	$214.57
Standard Option Self Plus One	E36	$683.33	$227.77	$1,480.54	$493.51
Standard Option Self and Family	E35	$683.33	$227.77	$1,480.54	$493.51
Prosper Self Only	T71	$186.98	$62.33	$405.13	$135.04
Prosper Self Plus One	T73	$446.72	$148.90	$967.88	$322.63
Prosper Self and Family	T72	$504.38	$168.13	$1,092.83	$364.28