Kaiser Permanente - Colorado - PSHB

www.kp.org/postal

Member Services: (303)-338-3800 or toll-free (800)-632-9700

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 PSHB Facts, page 10 for details. This Plan is accredited. See Section 1, page 16.

Serving: Metropolitan Denver/Boulder, northern Colorado, and southern Colorado areas

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

Only Postal Employees and Annuitants may enroll in this Plan.

Enrollment codes for this Plan:

M8A High Option - Self Only
M8C High Option - Self Plus One
M8B High Option - Self and Family

M8D Standard Option - Self Only
M8F Standard Option - Self Plus One
M8E Standard Option - Self and Family

NCA Prosper - Self Only
NCC Prosper - Self Plus One
NCB Prosper - Self and Family

IMPORTANT
- Rates: Back Cover
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PSHB

Authorized for distribution by the:

United States
Office of Personnel Management

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

Important Notice

Important Notice for Medicare-eligible Active Employees from Kaiser Foundation Health Plan of Colorado About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that Kaiser Foundation Health Plans of Colorado's prescription drug coverage for active employees meets the Centers for Medicare and Medicaid Services (CMS) requirements to be considered Creditable Coverage. This means active employees and their covered family members do not need to enroll in an open market Medicare Part D Plan 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 PSHB coverage as an active employee.

However, if you (as an active employee and your covered Medicare Part D-eligible family members) choose to enroll in an open market Medicare Part D Plan, you can keep your PSHB coverage and your PSHB Plan will coordinate benefits with Medicare.

Please be advised

If you lose or drop your PSHB 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: 711).

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 PSHB 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 PSHB 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 open market Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www. 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 - Colorado under contract (CS 1268 PS) between Kaiser Foundation Health Plan of Colorado, as a legal entity, and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits (FEHB) law, as amended by the Postal Service Reform Act, which created the Postal Service Health Benefits (PSHB) Program. Member Services may be reached at (303)-338-3800 or toll-free at (800)-632-9700 (TTY: 711) or through our website: www. kp.org. If you are deaf, hearing impaired or speech impaired, you can contact Member Services (303)-338-3800, (TTY: 711). If you require ASL providers, see our website at www.kp.org. The address for Kaiser Foundation Health Plan of Colorado's administrative office is:

Kaiser Foundation Health Plan of Colorado
2500 South Havana Street
Aurora, Colorado 80014-1622

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. If you are a Postal Service annuitant and you are eligible for Medicare Part D, or a covered Medicare Part D-eligible family member of a Postal Service annuitant, your prescription drug benefits are provided under our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP) or our Medicare Advantage Prescription Drug (MAPD) EGWP if you choose to enroll in our Senior Advantage Plan for Postal Service Members. You do not have a right to benefits that were available before January 1, 2027, under the FEHB Program unless those benefits are also shown in the PSHB Plan brochure.

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

Plain Language

All Postal Service Health Benefits (PSHB) 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” means Kaiser Foundation Health Plan of Colorado.
- We limit acronyms to ones you know. OPM is the United States Office of Personnel Management. The FEHB Program is the Federal Employees Health Benefits Program administered by OPM and established under 5 U.S.C. chapter 89. The PSHB Program is the Postal Service Health Benefits Program established within the FEHB Program under 5 U.S.C. section 8903c. PSHB Plan means a health benefits plan offered under the PSHB Program. PSHB means Postal Service Health Benefits. If we use others, we tell you what they mean.
- Our brochure and other PSHB Plans’ brochures have the same format and similar descriptions to help you compare Plans.

Stop Healthcare Fraud!

Fraud increases the cost of healthcare for everyone and increases your Postal Service Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the PSHB 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 health care 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 (EOBs) 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 (303)-338-3800 or toll-free (800)-632-9700, (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 family members 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 PSHB 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 PSHB 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:

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.

1. 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 medicines and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other 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 your pharmacist about the medication.
- 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.

2. 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?
- Don't 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.

3. 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.

4. 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:

- https ://www. jointcommission.org/en-us/knowledge-library/for-patients/speak-ups 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.
- 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.
- 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.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, 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 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 PSHB 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.

PSHB 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 (MEC). 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 PSHB Program	See https://health-benefits.opm.gov/PSHB/ for enrollment information as well as: • Information on the PSHB Program and plans available to you • A health plan comparison tool Note: Contact the USPS for information on how to enroll in a PSHB Program Plan through the PSHB System. 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 PSHB 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. You will be responsible for making changes to your enrollment status through the PSHB System. In some cases, your employing or retirement office may need to submit documentation. For information on your premium deductions, you must also contact your employing or retirement office. Once enrolled in your PSHB Program Plan, you should make any enrollment changes in the PSHB System located at https://health-benefits.opm.gov/pre-auth/landing. If you are unable to access your PSHB account online contact your employing office at (877)-477-3273 or retirement office at (888)-767-6738. If you have questions about your benefit coverage, contact us directly.
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.

You enroll in a PSHB Program Plan and make enrollment changes in the PSHB System located at https://health-benefits.opm.gov/PSHB/. If you are unable to access your PSHB account online contact your employing office at (877)-477-3273 or retirement office at (888)-767-6738. 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 request. 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 PSHB enrollment.

Use the PSHB System if you want to change from Self Only to Self Plus One or Self and Family, and to add or remove a family member.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits. Please report changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26 through the PSHB System. 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 PSHB Plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another PSHB or 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 PSHB Program, change your enrollment, or cancel coverage using the PSHB System. For a complete list of QLEs, visit the PSHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, 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 in the chart below. A Self Plus One enrollment covers you and your spouse, or one other 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 PSHB 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 PSHB 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 PSHB 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 PSHB coverage, you must continue your PSHB 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.

For annuitants who are required to be enrolled in Medicare Part B as a condition to continue PSHB coverage in retirement: If you enroll in Medicare Part B and continue PSHB coverage in retirement, the child equity law applies to you and you cannot cancel your coverage, change to Self Only, or change to a Plan that does not serve the area in which your child(ren) live as long as the court/administrative order is in effect. You cannot be compelled to enroll or remain enrolled in Medicare Part B to maintain your PSHB enrollment as a condition to satisfy a court/administrative order. However, if you do not enroll (or remain enrolled) in Medicare Part B as required to continue your PSHB coverage in retirement (notwithstanding an existing court/administrative order), you will not be able to continue your PSHB coverage in retirement.

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

Our PDP EGWP is only available to Postal Service annuitants who are Medicare Part D-eligible, enrolled in this Plan and their covered Medicare Part D-eligible family members. Our PDP EGWP is not an open market Medicare Part D Plan. If you are an active Postal Service 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 https://www.medicare.gov/ or call (800)-MEDICARE, (800) 633-4227, TTY (877) 486-2048 or call Member Services at (800)-632-9700.

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office or retirement 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 PSHB Program. Generally, you must have been enrolled in the FEHB and/or PSHB 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 PSHB 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.

If you are eligible for coverage under spouse equity, you are only eligible to enroll in the FEHB Program. If you are not eligible for coverage under spouse equity and you are otherwise eligible for Temporary Continuation of Coverage (TCC), then you could enroll in TCC under the PSHB Program.

- **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** enter the date of the divorce or annulment and remove your ex-spouse in the PSHB System. We may ask for a copy of the divorce decree as proof. If you need to change your enrollment type, you must use the PSHB System. A change will not automatically be made.

If you were 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 coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). Former spouses eligible for coverage under the spouse equity law are not eligible to enroll in the PSHB Program. However, former spouses eligible for coverage under the spouse equity law may enroll in the FEHB Program. (Former Spouses seeking but not yet adjudicated as eligible for Spouse Equity may be entitled to TCC under a PSHB Plan in the interim).

Former spouses not meeting the spouse equity requirements may be eligible for TCC under the PSHB Program provided you otherwise meet the eligibility requirements for TCC. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get information about your coverage choices. You can also visit OPM's website at https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

Medicare PDP EGWP

When a Postal Service annuitant who is Medicare Part D-eligible or their covered Medicare-eligible family member opts out of or disenrolls from our PDP EGWP, they will not have our prescription drug coverage under this Plan. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for additional information at (800)-632-9700, (TTY: 711).

Temporary Continuation of Coverage (TCC)

If you leave Federal service, 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 PSHB enrollment after you retire, if you lose your Federal job, or if you are a covered child and you turn 26.

You may not elect TCC if you are fired from your Federal 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 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 PSHB Program coverage.

Converting to individual coverage

You may convert to a non-PSHB 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 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 PSHB 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 (303)-338-3800 or (800)-632-9700, or visit our website at www.kp.org.

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 PSHB Plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Kaiser Foundation Health Plan of Colorado holds the following accreditations: 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 see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your healthcare services. We are solely responsible for the selection of these 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, Standard Option, or Prosper.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any 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 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.

General features of our High Option, Standard Option, and Prosper

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. 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

OPM requires that all PSHB Plans provide certain information to their PSHB members. You may get information about us, our networks, and our providers. OPM's PSHB 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 in the Colorado area since 1969.
- This medical benefit plan is provided by Kaiser Foundation Health Plan of Colorado. Medical and hospital services are provided through our integrated healthcare delivery organization known as Kaiser Permanente. Kaiser Permanente is composed of Kaiser Foundation Health Plan of Colorado (a not-for-profit organization) and Colorado Permanente Medical Group, P.C., (a for-profit Colorado-based corporation) which operates Plan medical offices throughout the Denver/ Boulder, northern Colorado, and southern Colorado areas. We also offer you services through participating providers.

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 Colorado website at www. kp.org/postal. You can also contact us to request that we mail a copy to you.

If you want more information about us, call (303)-338-3800 or toll-free (800)-632-9700, (TTY: 711), or write to Kaiser Foundation Health Plan of Colorado, Member Services Department, P.O. Box 378066, Denver, Colorado 80237-8066. You may also visit our website at www. kp.org/postal.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at kp.org/postal 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 non-English speaking members. Please ask an English-speaking friend or relative to call Member Services at (303)-338-3800 or toll-free at (800)-632-9700, (TTY: 711).

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 following Colorado counties: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Jefferson, Larimer, Park, Pueblo, Teller, and Weld.

Ordinarily, you must receive your care from physicians, hospitals, and other providers who contract with us. 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 services from designated providers in that area. See Section 5(h), Wellness and Other Special Features, for more details. We also pay for certain services while you are 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 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 your dependent is temporarily outside any Kaiser Permanente service area, they may qualify for the dependent out-of-area benefit. See Section 5(h), Wellness and Other Special Features. 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. New 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 *2027 Rate Information*, page 144.
- **Catastrophic Protection Out-of-Pocket Maximum.** We increased the annual out-of-pocket maximum to $5,000 per person and $10,000 per family under the High Option; $6,500 per person and $13,000 per family under the Standard Option; $8,000 per person and $16,000 per family under Prosper. See Section 4, *Your Cost for Covered Services*, page 30.
- **Clinically Administered Drugs.** We increased the cost share for clinically administered drugs up to $200 per visit under the High Option, up to $250 per visit after the deductible under the Standard Option, and up to $350 per visit after the deductible under Prosper. See Section 5(a) *Medical Services and Supplies by Physicians and Other Healthcare Professionals*, page 36.
- **IVF Coverage.** We removed the limit of three completed egg retrievals for in vitro fertilization (IVF) Egg retrievals are unlimited while you remain enrolled. See Section 5(a) *Infertility services - IVF Coverage*, page 50.
- **IVF Coverage.** We changed the IVF benefit limit to three attempts per live birth, per calendar year. See Section 5(a) *Infertility services - IVF Coverage*, page 50.
- **Outpatient Rehabilitation.** We removed the annual visit limits for covered rehabilitative, habilitative, and pulmonary therapy services. Covered visits are unlimited for each therapy. See Section 5(a) *Physical and occupational therapies*, page 53.
- **Dependent, Out-of-Area Telehealth.** We added, at no charge, video visits (telehealth) and phone visits as an option for out-of-area dependents for primary care, specialty care, outpatient mental health, and substance use disorder care, gynecology care, and preventive care services. See Section 5(h), *Wellness and Other Special Features – Dependent out-of-area telehealth options*, page 107.
- **Diabetic Supplies for Out-of-Area Dependents.** We decreased the coinsurance to 20% of our allowance for diabetic supplies, for up to 12 prescription drug fills. See Section 5(h) *Wellness and Other Special Features - Dependent out-of-area benefit (Diabetic Supplies),* page 107.
- **Non-emergency medical transportation (NEMT)**. We added, at no cost share, coverage for NEMT trips using stretcher/gurney or wheelchair vans. The NEMT rides are unlimited and require prior authorization. See Section 5(c) *Ambulance - non-emergency medical transportation*, page 76.
- **Self-referrals.** We now require your primary care provider to request prior authorization for referrals for sleep medicine, orthopedics, cardiology, We established a new requirement whereby a member's primary care provider needs to request authorization from the Plan to refer the member for specialty services. See Section 3, *Specialty Care - Self-referrals*, page 22.
- **Brand name prescription drugs.** We increased the preferred brand name prescription drugs copay dollar amount. See Sections 5 and 5(f) *Covered medication and supplies - Preferred-brand drugs,* pages 34 and 90.
- **Specialty drugs.** We increased the specialty drugs copay dollar amount. See Sections 5 and 5(f) *Covered medication and supplies - Specialty drugs,* pages 34 and 90.
- **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,* page 38.
- **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.

Changes to High Option and Standard Option

- **Inpatient Hospital.** We increased the inpatient cost share up to a per day per admission. See Sections 5(c) and 5(e) *Hospital and Ambulatory Services- Inpatient Hospital,* pages 73 and 86.
- **X-ray.** We added a cost share of $20 in the High Option and $30 in the Standard Option, per visit. See Section 5(a) *Lab, X-ray and other diagnostic tests - X-ray*, page 37.

Changes to Standard Option and Prosper

- **Emergency Room.** We increased outpatient emergency care services to $400 after the deductible under the Standard Option, and $450 after the deductible under Prosper in a hospital setting, both inside and outside the services area. See Section 5(d) *Emergency/Accidents - Emergency*, page 79.

Changes to Prosper only

- **Deductible.** We increased the annual deductible to $350 per person, $700 per family. See Sections 4 and 5, *Your Cost for Covered Services - Deductible,* pages 29 and 34.

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

- **Senior 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 Senior Advantage for Federal Members Evidence of Coverage for more information.
- **PDP EGWP Prescription Drugs Benefit – 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 dispensed through our retail pharmacies or our mail order pharmacy programs. See Section 5(f)(a), *PDP EGWP Prescription Drug Benefits*, page 97.
- **Senior Advantage Non-emergency medical transportation (NEMT)**. We added, at no cost share, coverage for NEMT trips using stretcher/gurney or wheelchair vans when authorized by a Plan provider. See your Kaiser Permanente Senior Advantage for Federal Members Evidence of Coverage for more information.
- **Senior 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 Senior 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 OOP maximum from $2,100 to $2,400. *See Section 5(f)(a), PDP EGWP Prescription Drug Benefits,* page 97.
- **Senior Advantage Rewards and Incentives.** We added a Senior Advantage rewards for completing a hemoglobin A1c test, a blood-pressure reading, and an annual wellness exam. See the Kaiser Permanente Senior Advantage Evidence of Coverage for additional information.
- **Senior Advantage Advanced Care at Home.** We added, at no cost share, coverage for advanced care at home. See your Kaiser Permanente Senior Advantage for Federal Members Evidence of Coverage for more information.

Section 3. How You Get Care

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 PSHB System enrollment confirmation.

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 Member Services at (303)-338-3800 or toll-free (800)-632-9700, (TTY: 711) or write to us at: Kaiser Foundation Health Plan of Colorado, Member Services, P.O. Box 378066, Denver, Colorado 80237-8066. After registering on our website at www.kp.org/postal, 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 4, *Your Cost for Covered Services*.

Balance Billing Protection

PSHB 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 our service area that we contract with to provide covered services to our members. We contract with the Colorado Permanente Medical Group, P.C. (Medical Group) to provide or arrange covered services for our members. In addition, we contract with a panel of affiliated primary care providers, specialists, and other healthcare professionals to provide or arrange covered services for our members. Medical care is provided through physicians, nurse practitioners, physician assistants, and other skilled medical personnel. Specialists in most major specialties are available as part of the medical teams for consultation and treatment. 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 Plan providers in the provider directory, which we update periodically. The list is also on our website. Directories are available at the time of enrollment or upon request by calling Member Services at (303)-338-3800 or toll-free (800)-632-9700, (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 (800)-632-9700, (TTY: 711) for assistance.

Plan facilities

Members may get covered routine care from any Plan provider at any Kaiser Permanente medical office and from any affiliated Plan provider in our service area.

Plan facilities are hospitals, medical offices, and other facilities in our service area that we own or contract with to provide covered services to our members. Kaiser Permanente offers comprehensive healthcare with Plan providers conveniently located throughout our service area.

We list Plan facilities in the provider 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 Member Services at (303)-338-3800) or toll-free (800)-632-9700) (TTY 711). The list is also on our website at www.kp.org/postal.

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

It depends on the type of care you need. First, you and each family member must choose a primary care provider. 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. You may select a primary care provider from any of our available Plan providers who practice 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 primary care provider for their child. Your primary care provider will provide most of your healthcare or request a referral for you to see a specialist.

To choose your primary care provider, you can either select one from our provider directory, from our website, www.kp.org/postal, or you can call Appointments and Medical Advice at (303)-338-4545 or toll-free (800)-218-1059, (TTY: 711). If you want to receive care from a specific provider who is listed in the directory, call Appointments and Medical Advice to verify that the provider still participates with the Plan and is accepting new patients.

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 providers if your primary care provider is not available, and to receive care at other Kaiser Permanente facilities.

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 the Plan to refer you to a specialist for an initial consultation and/or for a certain number of visits. If the Plan approves the referral, you may seek the initial consultation from the specialist to whom you were referred. You must then return to your primary care provider after the consultation unless your referral authorizes a certain number of additional visits without the need to obtain another referral. The primary care provider must provide or obtain authorization for a specialist to provide all follow-up care. Do not go to the specialist for return visits unless your primary care provider gives you a referral that has been approved by us. However, you may see Plan gynecologists, obstetricians, optometrists, ophthalmologists, mental health, and substance use providers without a referral. You may make appointments directly with these providers.

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 you and your attending specialist, may develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care provider will use our criteria when creating your treatment plan (the provider may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care provider. Your primary care provider will decide what treatment you need. If they decide to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care provider, who will request for you to see another specialist. You may receive approved 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 drop out of the PSHB Program and you enroll in another PSHB Plan (or become covered as a family member under a FEHB enrollment); or
  - We terminate our contract with your specialist for other than cause; or
  - We reduce our service area, and you enroll in another PSHB Plan

Contact us at (800)-632-9700, or if we drop out of the PSHB 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 days.

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

Hospital care

Your Plan primary care provider or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of 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 (303)-338-3800 or toll-free at (800)-632-9700, (TTY: 711). If you are new to the PSHB 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 PSHB 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 PSHB 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 referral requests to specialists. For certain services, your Plan provider must obtain approval from us. Before we approve a referral request, 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". If the referral request is approved, we will notify you that we have authorized your referral request.

Your Plan provider must obtain prior authorization for:

- Inpatient hospital care services, surgery, and procedures
- Outpatient surgery, related services, and procedures
- Ambulance transport (non-emergency)
- Anesthesia
- Applied Behavior Analysis (ABA) Therapy and autism treatment
- Bariatric surgery, Lap band (adjustable gastric band fills), and related services
- Biofeedback
- Biomarker Testing
- Cardiology
- Certain prescription medications as identified on our formulary
- Child Development Unit and Concussion Clinic at Children's Hospital Colorado
- Community behavioral health program, behavior identification and treatment
- Developmental screening and assessment
- Dietary consultations
- Durable medical equipment (DME) and orthopedic and prosthetic devices
- Electroconvulsive therapy
- Endocrinology
- Enuresis Encopresis clinic
- Epilepsy Monitoring Unit
- Gastroenterology Eosinophilic Esophagitis clinic
- Genetic testing
- GI capsule endoscopy
- Hemophilia center
- Home health services
- Initial evaluation for eligibility and acceptance into a clinical trial
- Injections/Infusions
- Implantable devices
- Infectious disease
- Infertility diagnosis and treatment
- Insulin pumps/supplies and continuous glucose monitoring
- Intensive in-home or intensive outpatient treatment
- Interventional radiology

- Laboratory services not on our formulary
- Long Term Acute Care, acute rehabilitation, partial hospitalization, or residential treatment
- Medical dental services including oral maxillary services and temporomandibular joint treatment
- Mental health service plan
- Neurobehavioral status
- Neurology
- Neuromonitoring
- Neuropsychological evaluation and testing, psychological testing
- Neurosurgery
- Observation services
- Organ/tissue transplants and related services
- Orthopedics
- Outpatient alcohol or drug services, outpatient detoxification
- Outpatient physical therapy, occupational therapy, speech therapy
- All perinatal monitoring services
- Photopheresis
- Physical Medicine and Rehabilitation
- Pulmonary rehabilitation, cardiac rehabilitation
- Pulmonary Medicine
- The following radiology services:
  - MRI and MRA
  - PET scans
  - CT scans
  - Nuclear imaging studies
- Prenatal diagnostic tests outside of the doctor’s office
- Rheumatology
- Skilled nursing care
- Sleep Medicine
- Sleep studies
- Surgery - General
- Surgery - Head & Neck
- The following treatment therapies:
  - Dermatology light therapy
  - Enteral/parenteral therapy
  - Esketamine
  - Extracorporeal shock wave
  - Infusion therapy
  - Hyperbaric oxygen therapy
  - Pain management services
  - Radiation/oncology therapy, gamma, and CyberKnife
  - Sclerotherapy for varicose veins

- Transcranial magnetic stimulation
- Weight loss clinic
- Wound care
- Services or items from a non-Colorado Permanente Medical Group provider, a non-Plan provider or at non-Plan facilities

To confirm if a referral request has been approved for a service or item that requires prior authorization, please call our Member Services Department at (303)-338-3800 or toll-free (800)-632-9700, (TTY: 711).

Your Plan provider submits the request for the services above with supporting documentation. You should call Member Services if you have not been notified of the outcome of the review within 15 calendar days. If your referral request is not approved, 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 the service or item unless you are a Plan member on the date you receive the service or item.

Non-urgent care claims

For non-urgent care claims, we will tell the provider 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 (303)- 338-3800 or toll-free at (800)-632-9700: (TTY: 711). You may also call OPM's Postal Service Insurance Operations PSIO at (202)-936-0002 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 (303)-338-3800 or toll-free at (800)-632-9700: (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 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 prior authorization. However, if you are admitted to a facility, you or your family member must notify the Plan within 48 hours, or as soon as reasonably possible, or your claims may be denied.

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

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

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.

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.

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 extraordinary 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 decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call (303)-338-3800.

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

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; or
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.
3. 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.

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 requests for appeals and the exchange of information by telephone, 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.

Note: If you are enrolled in our Medicare PDP EGWP and do not agree with our benefit coverage decision you have the right to appeal. See Section. 8(a) for information about the PDP EGWP appeal process.

Section 4. Your Cost for Covered Services

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, under the High Option for diagnostic and treatment services as described in Section 5(a), you pay a $20 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 the Standard Option, 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.

Under Prosper, you pay a $10 copayment when you receive diagnostic and treatment services from a primary care provider and a $35 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 Option has no deductible.
- The calendar year deductible for the Standard Option is $150 per person. 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 under the Standard Option.
- The calendar year deductible for Prosper is $350 per person. 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 $700 under Prosper.

Note: If you change PSHB Plans during Open Season, the effective date of your new PSHB Plan is January 1 of the next year, and a new deductible starts on January 1. 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 High Option, you pay 10% of our allowance for durable medical equipment.

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

$5,000 per person, up to $10,000 per family enrollment

Standard Option

$6,500 per person, up to $13,000 per family enrollment

Prosper

$8,000 per person, up to $16,000 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 PSHB catastrophic maximum(s), unless specifically excluded as indicated in Section 5(f)(a).

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 PSHB Plan during Open Season from a Plan with a catastrophic protection benefit the effective date of the change is January 1, and covered expenses apply to this Plan's catastrophic protection benefit starts on January 1.

Note: If you change PSHB Plans during Open Season the effective date of your new PSHB Plan is January 1 of the next year, and a new catastrophic protection accumulation starts on January 1. If you change Plans at another time during the year, you must begin a new catastrophic protection accumulation under your new Plan.

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 Service 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 nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating 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, your health plan complies with the surprise billing laws of Colorado and C.R. S. § 10-16-704(3)(d)(II), § 10-16-704(5.5), and § 10-16-704(15).S. § 10-16-704(3)(d)(II), § 10-16-704(5.5), and § 10-16-704(15).

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.kp.org/postal or contact the health Plan at (303)-338-3800.

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 a High Option, Standard Option, and Prosper. The 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 (303)-338-3800, toll-free (800)-632-9700, (TTY: 711) or on our website at www. kp.org/postal.

Since 1969, Kaiser Foundation Health Plan of Colorado has offered quality integrated healthcare to Federal programs. As a part of our commitment to keep pace with your healthcare needs, we are continually improving and enhancing your ability to manage your health online at www. kp.org.

Each option offers unique features.

High Option

Our High Option provides the most comprehensive benefits. Highlights of our PSHB High Option include:

- The High Option has no deductible
- $20 primary care and $30 specialty care office visit copayments
- Inpatient hospital services covered at $325 per day up to $1,300 maximum per admission
- Outpatient hospital services covered at $250 per visit
- Key preventive services at no charge, including annual well-checks for adults and children, routine mammograms, pre/postnatal office visits and childhood immunizations
- $15 generic, $50 preferred brand name, $75 non-preferred, and $175 specialty prescription drug copayments
- A dependent out-of-area benefit, limited to 10 office visits, 10 diagnostic services, 10 therapy visits, and 12 prescription refills each calendar year, which provides coverage for dependents under the age of 26 who are temporarily outside any Kaiser Permanente service area.
- $0 opioid rescue drug coverage when filled through a participating pharmacy

Standard Option

We also offer a Standard Option. With the Standard Option your copayments and coinsurance may be higher than for the High Option, but your premium is lower. Highlights of our PSHB Standard Option include:

- Calendar year deductible of $150 per person and $300 per family
- $30 primary care (no charge for children through age 17) and $40 specialty care office visit copayments
- Inpatient hospital services covered at $375 per day up to $1,500 per admission after you have met your calendar year deductible
- Outpatient hospital services covered at $300 per visit after you have met your calendar year deductible
- Key preventive services at no charge, including annual well-checks for adults and children, routine mammograms, pre/postnatal office visits and childhood immunizations
- $5 preventive maintenance drugs, $15 generic, $60 preferred brand name, $80 non-preferred, and $250 specialty prescription drug copayments

- A dependent out-of-area benefit, limited to 10 office visits, 10 diagnostic services, 10 therapy visits, and 12 prescription refills each calendar year, which provides coverage for dependents under the age of 26 who are temporarily outside any Kaiser Permanente service area.
- $0 opioid rescue drug coverage when filled through a participating pharmacy

Prosper

We also offer Prosper. With Prosper, some cost-sharing may be higher than for the High and Standard Options, but your premium is lower. Highlights of PSHB Prosper include:

- Calendar year deductible of $350 per person and $700 per family
- $10 primary care and $35 specialty care office visit copayments
- Inpatient hospital services covered at 20% of our allowance after you have met your calendar year deductible
- Outpatient hospital services covered at $375 per visit after you have met your calendar year deductible
- Key preventive services at no charge, including annual well-checks for adults and children, routine mammograms, pre/postnatal office visits and childhood immunizations
- $5 preventive maintenance drugs, $15 generic, $70 preferred brand name, $100 non-preferred, and $350 specialty prescription drug copayments
- A dependent out-of-area benefit, limited to 10 office visits, 10 diagnostic services, 10 therapy visits, and 12 prescription refills each calendar year, which provides coverage for dependents under the age of 26 who are temporarily outside any Kaiser Permanente service area.
- $0 opioid rescue drug coverage when filled through a participating pharmacy

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.
- Plan providers must provide or arrange your care.
- The Standard Option's calendar year deductible is $150 per person ($300 per family). Prosper's calendar year deductible is $350 per person ($700 per family). The calendar year deductible applies to some benefits in this Section. We added "after the deductible" when the calendar year deductible applies.
- There is no deductible for the High Option.
- If the cost for a drug administered in connection with your care is less than the copayment, you will pay the lesser amount.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- 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 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 a physician's office • Office medical consultations • Second surgical opinion • At home • Advance care planning	$20 per primary care office visit $30 per specialty care office visit Note: You pay up to $200 for drugs administered in connection with your care.	$30 per primary care office visit (nothing for children through age 17) $40 per specialty care office visit Note: You pay up to $250 after the deductible for drugs administered in connection with your care.	$10 per primary care office visit $35 per specialty care office visit Note: You pay up to $350 after the deductible 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**
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*
Procedures received during an office visit Note: Surgical procedures require prior approval. See Section 3, You need prior Plan approval for certain services.	Nothing after you pay the office visit copayment	Nothing after you pay the primary care copayment Specialty care office copayment plus 10% of our allowance after the deductible	Nothing after you pay the primary care copayment Specialty care office copayment plus 20% of our allowance after the deductible
Professional services of physicians and other healthcare professionals • During a hospital stay • In a skilled nursing facility • In a rehabilitation facility	Nothing	Nothing after the deductible	20% of our allowance after the deductible
Telehealth services	**High Option**	**Standard Option**	**Prosper**
Professional services of physicians and other healthcare professionals delivered through telehealth, such as: • Interactive video • Phone visits • Email Note: Visits may be limited by provider type, location, and benefit-specific limitations, such as visit limits.	Nothing	Nothing	Nothing
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**	**Prosper**
Tests, such as: • Blood test • Urinalysis • Non-routine Pap test • Pathology • Electrocardiogram	Nothing	Nothing	Nothing
• X-ray	$20 per visit	$30 per visit after the deductible	Nothing
• Non-routine mammogram	Nothing	Nothing	Nothing

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay		
Lab, X-ray and other diagnostic tests (cont.)	**High Option**	**Standard Option**	**Prosper**
• Ultrasound • EEG	Nothing	Nothing	Nothing
• CT/CAT scan • MRI • PET scan • Nuclear medicine	$125 per procedure per body part	$150 per procedure per body part after the deductible	$250 per procedure per body part after the deductible
Note: See Section 3, *You need prior Plan approval for certain services.*	Applies to this benefit	Applies to this benefit	Applies to this benefit
Preventive care, adult	**High Option**	**Standard Option**	**Prosper**
Annual behavioral health screening Annual routine physical	Nothing	Nothing	Nothing
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 go to the U.S. Preventive Services Task Force (USPSTF) website at www. uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • 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	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, annual counseling for sexually transmitted infections, contraceptive methods, screening for interpersonal, intimate partner, and domestic violence, and well-women visits. Well-women visits also include prepregnancy, prenatal, postpartum, and interpregnancy visits. For a complete list of preventive care benefits for women go to the Health and Human Services (HHS) website at https ://www. hrsa.gov/womens-guidelines • To build your personalized list of preventive services go to https://health.gov/myhealthfinder	Nothing	Nothing	Nothing
• Routine mammogram	Nothing	Nothing	Nothing
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 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 preventive recommended listing of services. • You should consult with your provider to determine what is appropriate for you. • See Section 3, *You need prior Plan approval for certain services*.	Nothing	Nothing	Nothing
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 dietitians, 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 comorbidities 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/postal 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-PSHB Benefits Available to Plan Members* for details on our nutritional and physical activity support for members. • When anti-obesity medication is prescribed. See Section 5(f) or 5(f)(a), if applicable. • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity, see Section 5(b).	Nothing	Nothing	Nothing
Not covered:	*All charges*	*All charges*	All charges

Preventive care, adult - continued on next page

Benefit Description	You pay		
Preventive care, adult (cont.)	**High Option**	**Standard Option**	**Prosper**
• *Physical exam required for obtaining or continuing employment or insurance, attending schools or camp, court ordered parole or probation, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*	*All charges*	All charges
Preventive care, children	**High Option**	**Standard Option**	**Prosper**
Annual behavioral health screening 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 https://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/hcp/imz-schedules/child-adolescent-age.html	Nothing	Nothing	Nothing
• You can also find a complete list of U.S. Preventive Services Task Force (USPSTF) online at www. uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • 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 [#PAGEBREAK#]	Nothing	Nothing	Nothing

Preventive care, children - continued on next page

Benefit Description	You pay		
Preventive care, children (cont.)	**High Option**	**Standard Option**	**Prosper**
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 preventive 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*.	Nothing	Nothing	Nothing
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. 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.	Nothing	Nothing	Nothing

Preventive care, children - continued on next page

Benefit Description	You pay		
Preventive care, children (cont.)	**High Option**	**Standard Option**	**Prosper**
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%. 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	Nothing	Nothing	Nothing

Preventive care, children - continued on next page

Benefit Description	You pay		
Preventive care, children (cont.)	**High Option**	**Standard Option**	**Prosper**
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 comorbidities 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/postal 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-PSHB Benefits Available to Plan Members* for details on our nutritional and physical activity support for members. • When anti-obesity medication is prescribed. See Section 5(f). • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity, see Section 5(b).	Nothing	Nothing	Nothing

Benefit Description	You pay		
Maternity care	**High Option**	**Standard Option**	**Prosper**
Complete maternity (obstetrical) care, such as: • Prenatal and Postpartum care • Screening for gestational diabetes • Screening and counseling for prenatal and postpartum depression Note: 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 Note: You pay nothing for inpatient professional delivery services.	Nothing	Nothing	20% of our allowance after the deductible
• 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
• Office administered drugs	Note: You pay up to $200 for drugs administered in connection with your care.	Note: You pay up to $250 after the deductible for drugs administered in connection with your care.	Note: You pay up to $350 after the deductible for drugs administered in connection with your care.
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*, for prior approval guidelines. • 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.	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**
• 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. • 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 visit as described in this section. - Lab, X-ray and other diagnostic tests (including ultrasounds), durable medical equipment as described in this section. - Surgical services as described in Section 5 (c) *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
• As part of your coverage, you have access to in-network Certified Nurse Midwives (CNM) within our service area, in person doula coverage, and board-certified lactation specialists during the prenatal and post-partum period. • An initial visit with a birthing doula, and up to 11 additional visits in any combination of pre-natal and postpartum visits within our service area.	Nothing	Nothing	Nothing
Not covered: Doula services that include:	*All charges*	*All charges*	*All charges*

Maternity care - continued on next page

Benefit Description	You pay		
Maternity care (cont.)	**High Option**	**Standard Option**	**Prosper**
• Clinical or medical services (such as taking blood pressure or temperature, fetal heart tone checks, vaginal examination or postpartum clinical care) • Assistance with activities of daily living • Alternative or complementary modalities (such as aromatherapy, childbirth education, massage therapy, or placenta encapsulation) • Yoga • Birthing ceremonies • Over-the-counter supplies or drugs • Home birth	*All charges*	*All charges*	*All charges*
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 • Contraceptive counseling Notes: • See Section 5(b), *Surgical and Anesthesia Services* • See additional Family Planning and Prescription drug coverage in Section 5(f) or 5(f)(a), if applicable • 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.	Nothing	Nothing	Nothing

Family planning - continued on next page

Benefit Description	You pay		
Family planning (cont.)	**High Option**	**Standard Option**	**Prosper**
• Kaiser Permanente physicians prescribe the appropriate level of medically necessary contraceptive medications to PSHB 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 PSHB members on www. kp.org/postal and www. kp.org/health-wellness. • 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. 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. • 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 are having problems accessing contraceptive coverage or need more information about contraception, you can email contraception@opm.gov or visit Member Resources at kp.org/postal or OPM's website at Contraception Coverage at www. opm.gov/healthcare-insurance/healthcare/contraception-coverage/. • If you are having problems accessing contraceptive coverage or need more information about contraception, email OPM at contraception@opm.gov or visit OPM's website at Contraception Coverage at opm.gov/healthcare-insurance/healthcare/contraception-coverage/.	Nothing	Nothing	Nothing

Family planning - continued on next page

Benefit Description	You pay		
Family planning (cont.)	**High Option**	**Standard Option**	**Prosper**
Voluntary male sterilization	Nothing	Nothing	Nothing
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*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 female is over the age of 35, or having a medical or other demonstrated condition that is recognized by a Plan provider as a cause of infertility. See Section 3, *You need prior Plan approval for certain services*, for more information. Diagnosis and treatment of infertility, such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Semen analysis • Hysterosalpingogram • Hormone evaluation	50% coinsurance	50% coinsurance after deductible	50% coinsurance after deductible
• In vitro fertilization (IVF) - You are covered for an annual benefit maximum of $50,000 - Unlimited egg retrievals while member is enrolled - Services are limited to 3 attempts per live birth, per calendar year	50% coinsurance	50% coinsurance after deductible	50% coinsurance after deductible
Fertility preservation for iatrogenic infertility: • Unlimited embryo transfers when recommended and medically appropriate • Procurement of sperm or eggs, including medical office visits, procurement procedures, and Infertility prescription drugs; • Cryopreservation of sperm and mature oocytes; • Cryopreservation storage for preserved specimen for 1 year after a covered preservation procedure, even if your enrollment ends; and	50% coinsurance	50% coinsurance after deductible	50% coinsurance after deductible

Infertility services - continued on next page

Benefit Description	You pay		
Infertility services (cont.)	**High Option**	**Standard Option**	**Prosper**
• Assisted reproductive technology (ART) procedures, including related services and supplies, such as embryo transfer, gamete intra-fallopian transfer (GIFT), and zygote intra-fallopian transfer (ZIFT)	50% coinsurance	50% coinsurance after deductible	50% coinsurance after deductible
• Fertility drugs (See Section 5(f) or 5(f)(a), *Prescription Drug Benefits*), if applicable	Applies to this benefit	Applies to this benefit	Applies to this benefit
Notes: The following services are covered as part of the retrieval of sperm and eggs: You pay cost-sharing for other services, including: • Procedures received during an office visit, as described in Section 5(a), Diagnostic and treatment services. • Lab, X-ray, and other diagnostic tests, as described in Section 5(a) • Surgical services as described in Section 5(b) • Outpatient hospital, ambulatory surgical • Center, or inpatient hospital as described in Section 5(c • Prescription drugs as described in Section 5 (f) or 5(f)(a), if applicable	Applies to this benefit	Applies to this benefit	Applies to this benefit
Not covered: *These exclusions apply to fertile as well as infertile individuals or couples:* • *Any charges associated with donor eggs, donor sperm, or donor embryos* • *Any charges associated with cryopreservation or 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*

Benefit Description	You pay		
Allergy care	**High Option**	**Standard Option**	**Prosper**
Referrals are required by your Primary Care Physician for allergy specialty care services. The bellow services are covered: • Testing and treatment	$20 per primary care office visit $30 per specialty care office visit Note: You pay up to $200 for drugs administered in connection with your care.	$30 per primary care office visit (nothing for children through age 17) $40 per specialty care office visit Note: You pay up to $250 after the deductible for drugs administered in connection with your care.	$10 per primary care office visit $35 per specialty care office visit Note: You pay up to $350 after the deductible for drugs administered in connection with your care.
Injections	$20 per office visit Note: You pay $200 for drugs administered in connection with your care (other than allergy injections & serum).	$30 per office visit Note: You pay $250 after the deductible for drugs administered in connection with your care (other than allergy injections & serum).	$10 per office visit Note: You pay $350 after the deductible for drugs administered in connection with your care (other than allergy injections & serum).
Allergy serum	Nothing	Nothing	Nothing
Note: For coverage of procedures received during an office visit, see Section 5(a), Diagnostic and treatment services.	Applies to this benefit	Applies to this benefit	Applies to this benefit
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**	**Prosper**
Chemotherapy Notes: • High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Section 5(b), *Organ/Tissue transplants*. • For coverage of procedures received during an office visit, see Section 5(a), *Diagnostic and treatment services.*	$30 per office visit Note: You pay up to $200 for drugs administered in connection with your care.	$40 per office visit Note: You pay up to $250 after the deductible for drugs administered in connection with your care.	$35 per office visit Note: You pay up to $350 after the deductible for drugs administered in connection with your care.
• Radiation therapy • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy	$30 per office visit Note: You pay up to $200 for drugs administered in connection with your care.	$40 per office visit Note: You pay up to $250 after the deductible for drugs administered in connection with your care.	$35 per office visit Note: You pay up to $350 after the deductible for drugs administered in connection with your care.

Treatment therapies - continued on next page

Benefit Description	You pay		
Treatment therapies (cont.)	**High Option**	**Standard Option**	**Prosper**
Cardiac rehabilitation program following a qualifying event/condition	$20 per office visit	$30 per office visit	$10 per office visit
Ultraviolet light treatments	Nothing	Nothing	Nothing
Notes: • IV and antibiotic therapy require our prior approval and are covered under the prescription drug benefit. See Section 3, *You need prior Plan approval for certain services* and Section 5(f) or 5(f)(a), *Covered medications and supplies,* if applicable. • For coverage of growth hormone therapy, see Section 5(f) of 5(f)(a), *Covered medications and supplies*, if applicable. • See Section 5(e) *Professional services*, for coverage of Applied Behavior Analysis (ABA). • For coverage of procedures received during an office visit, see Section 5(a), *Diagnostic and treatment services*. • We waive office visit charges for dialysis if you enroll in Medicare Part B and assign your Medicare benefits to us. • See Section 3, *You need prior Plan approval for certain services*.	Applies to this benefit	Applies to this benefit	Applies to this benefit
Physical and occupational therapies	**High Option**	**Standard Option**	**Prosper**
We cover outpatient rehabilitative and outpatient habilitative visits of each therapy, with no visit limitations. Coverage for rehabilitative and habilitative services includes: • Physical therapy by qualified physical therapists to attain or restore bodily function when you have a total or partial loss of bodily function due to illness or injury • Occupational therapy by occupational therapists to assist you in attaining or resuming self-care and improved functioning in other activities of daily life when you have a total or partial loss of bodily function due to illness or injury Note: See Section 3, *You need prior Plan approval for certain services.*	$20 per office visit	$30 per office visit	$10 per office visit
We cover pulmonary rehabilitation with no visit limitations.	$20 per office visit	$30 per office visit	$10 per office visit
Not covered: • *Long-term therapy, excluding treatment of autism spectrum disorders*	*All charges*	*All charges*	*All charges*

Physical and occupational therapies - continued on next page

Benefit Description	You pay		
Physical and occupational therapies (cont.)	**High Option**	**Standard Option**	**Prosper**
• *Exercise programs* • *Maintenance therapy, excluding treatment of autism spectrum disorders* • *Vocational rehabilitation programs* • *Therapies done primarily for educational 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 20 outpatient habilitative and up to 20 outpatient rehabilitative visits per year, except we cover habilitative and rehabilitative services with no visit limits with a diagnosis of autism spectrum disorders (ASD) or treatment of cleft lip or cleft palate. Note: See Section 3, *You need prior Plan approval for certain services.*	$20 per office visit	$30 per office visit	$10 per office visit
Not covered: • *Therapies done primarily for educational purposes* • *Therapy for tongue thrust in the absence of swallowing problems* • *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., or other provider in a physician's office	$20 per primary care office visit $30 per specialty care office visit	$30 per primary care office visit (nothing for children through age 17) $40 per specialty care office visit	$10 per primary care office visit $35 per specialty care office visit
• Audiologist	$20 per visit	$30 per visit	$10 per visit
• Hearing aids, fitting, and recheck visits for children through age 17 Note: Alterations to existing hearing aids are covered when the hearing aids cannot adequately meet the needs of the child.	$20 per office visit $20 per hearing aid	10% of our allowance after the deductible	20% of our allowance after the deductible
Notes: For coverage of:	Applies to this benefit	Applies to this benefit	Applies to this benefit

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**
• Hearing screenings, see Section 5(a), *Preventive care, children* • Procedures received during an office visit and any other hearing testing, see Section 5 (a), *Diagnostic and treatment services.*	Applies to this benefit	Applies to this benefit	Applies to this benefit
Not covered: *All other hearing testing, except as may be covered in Section* 5(a), *Diagnostic and treatment services* and Section 5 (a), *Preventive care, children* • *Hearing aids, including testing and examinations for them, for all persons age 18 and over* • *Batteries for 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	$20 per primary care office visit $30 per specialty care office visit Note: You pay up to $200 for drugs administered in connection with your care.	$30 per primary care office visit (nothing for children through age 17) $40 per specialty care office visit Note: You pay up to $250 after the deductible for drugs administered in connection with your care.	$10 per primary care office visit $35 per specialty care office visit Note: You pay up to $350 after the deductible for drugs administered in connection with your care.
Routine eye exam with a Plan optometrist or ophthalmologist to determine the need for vision correction and provide a prescription for eyeglasses.	$20 per primary care office visit $30 per specialty care office visit	$30 per primary care office visit $40 per specialty care office visit	$10 per primary care office visit $35 per specialty care office visit
Note: One pair of medically necessary eyeglasses or contact lenses to correct an impairment directly cause by accidental ocular injury or intraocular surgery (such as for cataracts)	$20 per primary care office visit $30 per specialty care office visit Note: You pay up to $200 for drugs administered in connection with your care.	$30 per primary care office visit $40 per specialty care office visit Note: You pay up to $250 after the deductible for drugs administered in connection with your care.	$10 per primary care office visit $35 per specialty care office visit Note: You pay up to $350 after the deductible for drugs administered in connection with your care.

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**
Note: For coverage of procedures received during an office visit, see Section 5(a), Diagnostic and treatment services.	Applies to this benefit	Applies to this benefit	Applies to this benefit
Not covered: • *Eyeglass lenses or frames, unless noted above* • *Contact lenses, examinations for contact lenses or the fitting of contact lenses* • *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. Note: For coverage of procedures received during an office visit, see Section 5(a), *Diagnostic and treatment services.*	$20 per primary care office visit $30 per specialty care office visit Note: You pay up to $200 for drugs administered in connection with your care.	$30 per primary care office visit (nothing for children through age 17) $40 per specialty care office visit Note: You pay up to $250 after the deductible for drugs administered in connection with your care.	$10 per primary care office visit $35 per specialty care office visit Note: You pay up to $350 after the deductible 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 and orthotic devices, such as: • Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy	10% of our allowance	10% of our allowance	20% of our allowance

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay		
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**	**Prosper**
• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Additional prostheses when deemed medically necessary for engaging in recreational activities, team, and individual sports	10% of our allowance	10% of our allowance	20% of our allowance
Internal prosthetic devices, such as: • Artificial joints • Pacemakers • Cochlear implants • Surgically implanted breast implants following mastectomy Note: See Section 5(b), *Surgical procedures*, for coverage of the surgery to insert the device and Section 5(c), *Services Provided by a Hospital or other Facility*, for inpatient hospital benefits.	Nothing	Nothing	Nothing
Notes: • Orthopedic and prosthetic equipment or services must be prescribed by a Plan physician; obtained through sources designated by the Plan; consistent with our Plan DME formulary guidelines; 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. • See Section 3, *You need prior Plan approval* for certain services. • 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 and prosthetic devices and corrective shoes, except as described above* • *Foot orthotics and podiatric use devices, such as arch supports, heel pads and heel cups* • *Comfort, convenience, or luxury equipment or features* • *Prosthetic devices, equipment, and supplies related to treatment of sexual dysfunction*	*All charges*	*All charges*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay		
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**	**Prosper**
• *Dental prostheses, devices, and appliances; except, we will provide medically necessary orthodontic and prosthodontic treatment for cleft lip or cleft palate for the repair of congenital anomalies, unless these services are covered under a dental insurance policy* • *Spare or alternate use devices* • *Repairs, adjustments, or replacements due to misuse, theft, or loss*	*All charges*	*All charges*	*All charges*
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 • Oxygen dispensing equipment • Insulin pumps • Infant apnea monitors • Dialysis equipment • Hospital beds • Wheelchairs, including motorized wheelchairs when medically necessary • Crutches • Walkers • Speech generating devices • Blood glucose monitors • Commodes • Respirators	10% of our allowance	10% of our allowance	20% of our allowance
Ultraviolet light therapy equipment	Nothing	Nothing	Nothing
• One breastfeeding pump and supplies per delivery, including equipment that is required for pump functionality	Nothing for retail-grade pump 10% of our allowance for hospital-grade pump	Nothing for retail-grade pump 10% of our allowance for hospital-grade pump	Nothing for retail-grade pump 20% of our allowance for hospital-grade pump
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; consistent with our Plan DME formulary guidelines; 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. • When outside the service area, you must obtain your oxygen supplies and services from our designated vendor. • See Section 3, *You need prior Plan approval for certain services*.	Applies to this benefit	Applies to this benefit	Applies to this benefit
Not covered: • *Audible prescription reading 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 infant apnea monitors* • *Devices to perform medical testing of bodily fluids, excretions, or substances* • *Devices, equipment, and supplies related to the treatment of sexual dysfunction disorders* • *Modifications to the home or vehicle* • *Dental appliances* • *More than one piece of durable medical equipment serving essentially the same function* • *Spare or alternate use equipment* • *Disposable supplies* • *Replacement batteries* • *Repairs, adjustments, or replacements due to misuse, theft, or loss*	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
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.), or home health aide, physical or occupational therapist, and speech and language pathologist. • Services include oxygen therapy, intravenous therapy and medications. Notes: • We only provide these services in the Plan's service area. • 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. • See Section 3, *You need prior Plan approval for certain services*.	Nothing	10% of our allowance after the deductible	20% of our allowance after the deductible
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* • *Homemaker services* • *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*	*All charges*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**	**Prosper**
Chiropractic services are considered the manipulation of the spine and extremities, adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application. Coverage up to 20 visits per calendar year limited to: • Diagnosis and treatment of neuromusculoskeletal disorders	$30 per office visit	$40 per office visit	$40 per office visit

Chiropractic - continued on next page

Benefit Description	You pay		
Chiropractic (cont.)	**High Option**	**Standard Option**	**Prosper**
• Laboratory tests and plain film X-rays associated with diagnosis and treatment	$30 per office visit	$40 per office visit	$40 per office visit
Notes: • You may only self-refer to a participating provider. The participating provider must provide, arrange or prescribe your care. • For a list of participating providers call Member Services at (303)-338-3800 or toll-free (800)-632-9700, (TTY: 711).	Applies to this benefit	Applies to this benefit	Applies to this benefit
Not covered: • *Hypnotherapy, behavior training, sleep therapy and weight programs* • *Thermography* • *Any radiological exam other than plain file studies such as magnetic resonance imaging, CT scans, bone scans, nuclear radiology* • *Treatment for non-neuromusculoskeletal disorders, including adjunctive therapy* • *Chiropractic appliances, except as covered in Section 5(a), Durable medical equipment and Prosthetics and orthotic devices*	*All charges*	*All charges*	*All charges*
Alternative treatments	**High Option**	**Standard Option**	**Prosper**
Not covered, including acupuncture	*All charges*	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**	**Prosper**
Coverage is provided for services such as • Diabetes self-management • Nutritional counseling	$20 per primary care office visit $30 per specialty care office visit	$30 per primary care office visit (nothing for children through age 17) $40 per specialty care office visit	$10 per primary care office visit $35 per specialty care office visit
Tobacco cessation programs, including individual, group, and phone counseling, prescribed 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. • For information on the cost and classes near you, please call Member Services at (303)-338-3800, or toll-free (800)-632-9700, (TTY: 711). • See Section 5(f) or 5(f)(a), *Prescription Drug Benefits*, if applicable, for important information about coverage of tobacco cessation and other drugs. • For coverage of procedures received during an office visit, see Section 5(a), *Diagnostic and treatment services.* • 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*https://healthy.kaiserpermanente.org/health-wellness/health-encyclopedia/he.quitting-smoking.center1045).*	Applies to this benefit	Applies to this benefit	Applies to this benefit

Benefit Description	You pay		
Early childhood intervention services	**High Option**	**Standard Option**	**Prosper**
Through age two (2), early intervention services (EIS) are covered for children with significant delays in development or a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by Colorado state law. Limitations: The amount of coverage required by state law does not apply to: • Rehabilitation or therapeutic services that are necessary as the result of an acute medical condition • Services provided to a child who is not participating in an early intervention program for infants and toddlers under Part C of the federal "Individuals with Disabilities Education Act" and that are not provided pursuant to an Individualized Family Service Plan	All charges in excess of the amount of coverage required by state law.	All charges in excess of the amount of coverage required by state law.	All charges in excess of the amount of coverage required by state law.
Not covered: • *Respite care* • *Non-emergency medical transportation* • *Service coordination, as defined by law* • *Assistive technology, not to include durable medical equipment that is otherwise covered*	*All charges*	*All charges*	*All charges*

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 we cover them only when we determine they are medically necessary.
- Plan providers must provide or arrange your care. Consult with your provider to determine what is appropriate for you. Services may be covered provided that established Plan criteria are met.
- There is no deductible for the High Option.
- The Standard Option's calendar year deductible is $150 per person ($300 per family). Prosper's calendar year deductible is $350 per person ($700 per family). 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 about coordinating benefits with other coverage, including with Medicare.
- If the cost for a drug administered in connection with your care is less than the copayment, you will pay the lesser amount.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(a) for charges associated with office visits and Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- **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 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 • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts	Nothing	Nothing, except 10% of our allowance after the deductible for procedures in a specialist's office	Nothing, except 20% of our allowance after the deductible for professional services while inpatient or for procedures in a specialist's office

Surgical procedures - continued on next page

Benefit Description	You pay		
Surgical procedures (cont.)	**High Option**	**Standard Option**	**Prosper**
• Correction of congenital anomalies (see Reconstructive surgery) • Epidural steroid injections • Insertion of internal prosthetic devices. See 5 (a), *Orthopedic and prosthetic devices* for device coverage information • Treatment of burns • Iatrogenic infertility procedures related to the retrieval of sperm and eggs and embryo transfer • Surgical treatment of severe obesity (bariatric surgery) Visit www. kp.org/postal to get a list of criteria you must meet to qualify for bariatric surgery. You will need to meet the qualifications before your Plan provider will refer you to our bariatric surgery program. This program may refer you to other Plan providers to determine if you meet the additional criteria necessary for bariatric surgery, including nutritional, psychological, medical and social readiness for surgery. Final approval for surgical treatment will be required from the Colorado Permanente Medical Group's designated physician Note: For female surgical family planning procedures, see *Family Planning* Section 5(a) Note: For male surgical family planning procedures, see *Family Planning* Section 5(a)	Nothing	Nothing, except 10% of our allowance after the deductible for procedures in a specialist's office	Nothing, except 20% of our allowance after the deductible for professional services while inpatient or for procedures in a specialist's office
Notes: • See Section 3, *You need prior Plan approval for certain services*, for more information • Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker	Applies to this benefit	Applies to this benefit	Applies to this benefit
Male voluntary sterilization	Nothing	Nothing	Nothing
Female voluntary sterilization, including anesthesia and confirmation testing following tubal occlusion	Nothing	Nothing	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Implants or devices related to the treatment of sexual dysfunction* • *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; birthmarks; and webbed fingers and toes. • Surgery for treatment of a form of congenital hemangioma known as port wine stains. • 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, except 10% of our allowance after the deductible for procedures in a specialist's office	Nothing, except 20% of our allowance after the deductible for professional services while inpatient or for procedures in a specialist's office
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through a change in bodily form, except repair of accidental injury* (See Section 5(d) Accidental injury) • Surgery for Sex-Trait Modification to treat gender dysphoria	*All charges*	*All charges*	*All charges*
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;	Nothing	Nothing, except 10% of our allowance after the deductible for procedures in a specialist's office	Nothing, except 20% of our allowance after the deductible for professional services while inpatient or for procedures in a specialist's office

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay		
Oral and maxillofacial surgery (cont.)	**High Option**	**Standard Option**	**Prosper**
• Excision of cysts and incision of abscesses when done as independent procedures • Medical and surgical treatment of temporomandibular joint (TMJ) disorder (non-dental); and • Other surgical procedures that do not involve the teeth or their supporting structures. Note: See Section 3, *You need prior Plan approval for certain services.*	Nothing	Nothing, except 10% of our allowance after the deductible for procedures in a specialist's office	Nothing, except 20% of our allowance after the deductible for professional services while inpatient or for procedures in a specialist's office
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Shortening of the mandible or maxillae for cosmetic purposes* • *Correction of any malocclusion not listed above* • *Dental care involved in treatment of the temporomandibular joint (TMJ) pain dysfunction syndrome* • *Dental services associated with medical treatment such as radiation treatment (See Section 5(g).)*	*All charges*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**	**Prosper**
These **solid organ and tissue transplants** are covered and subject to medical necessity and experimental/investigational review by the Plan. Refer to Section 3, *How You Get Care* for prior authorization procedures. Solid organ tissue transplants are covered and limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis] • Cornea • 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	Nothing	Nothing, except 10% of our allowance after the deductible for procedures in a specialist's office	Nothing, except 20% of our allowance after the deductible for professional services while inpatient or for procedures in a specialist's office

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Prosper**
• Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas	Nothing	Nothing, except 10% of our allowance after the deductible for procedures in a specialist's office	Nothing, except 20% of our allowance after the deductible for professional services while inpatient or for procedures in a specialist's office
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, except 10% of our allowance after the deductible for procedures in a specialist's office	Nothing, except 20% of our allowance after the deductible for professional services while inpatient or for procedures in a specialist's office
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 - 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)	Nothing	Nothing, except 10% of our allowance after the deductible for procedures in a specialist's office	Nothing, except 20% of our allowance after the deductible for professional services while inpatient or for procedures in a specialist's office

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Prosper**
- 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 macroglobulin	Nothing	Nothing, except 10% of our allowance after the deductible for procedures in a specialist's office	Nothing, except 20% of our allowance after the deductible for professional services while inpatient or for procedures in a specialist's office
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)	Nothing	Nothing, except 10% of our allowance after the deductible for procedures in a specialist's office	Nothing, except 20% of our allowance after the deductible for professional services while inpatient or for procedures in a specialist's office

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Prosper**
• 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, except 10% of our allowance after the deductible for procedures in a specialist's office	Nothing, except 20% of our allowance after the deductible for professional services while inpatient or for procedures in a specialist's office
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i. e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia	Nothing	Nothing, except 10% of our allowance after the deductible for procedures in a specialist's office	Nothing, except 20% of our allowance after the deductible for professional services while inpatient or for procedures in a specialist's office

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Prosper**
- 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, except 10% of our allowance after the deductible for procedures in a specialist's office	Nothing, except 20% of our allowance after the deductible for professional services while inpatient or for procedures in a specialist's office
Notes: • We cover related medical and hospital expenses of the donor when we cover the recipient. • We cover services related to living organ donation without cost-sharing or limitations to coverage for a member providing a living organ donation. • 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. • 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) for services performed during an office visit. • See Section 3, *You need prior Plan approval for certain services.*	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**
• Please refer to Section 5(h), *Wellness and Other 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*
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of 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 and outpatient) • Ambulatory surgical center • Skilled nursing facility • Office	Nothing	Nothing, except 10% of our allowance after the deductible for procedures in a specialist's office	Nothing, except 20% of our allowance after the deductible for professional services while inpatient or for procedures in a specialist's office
Not covered: • *Anesthesia for dental services, other than general anesthesia for a dependent child with physical, mental, or behavior problems*	*All charges*	*All charges*	*All charges*

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 we cover them only when we determine they are medically necessary.
- Plan providers must provide or arrange your care and you must be hospitalized in a Plan facility.
- The Standard Option's calendar year deductible is $150 per person ($300 per family). Prosper's calendar year deductible is $350 per person ($700 per family). The calendar year deductible applies to some benefits in this Section. We added "after the deductible" when the calendar year deductible applies.
- There is no deductible for the High Option.
- 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.
- 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 covered 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 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 Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$325 per day up to $1,300 maximum per admission Includes maternity care delivery	$375 per day up to $1,500 per admission after you have met your calendar year deductible Nothing for maternity care delivery	20% of our allowance after the deductible
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays	Nothing	Nothing	20% of our allowance after the deductible

Inpatient hospital - continued on next page

Benefit Description	You pay		
Inpatient hospital (cont.)	**High Option**	**Standard Option**	**Prosper**
• Blood and blood products • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services	Nothing	Nothing	20% of our allowance after the deductible
Note: You may receive covered hospital services for certain dental procedures if a Plan physician determines you need to be hospitalized for reasons unrelated to the dental procedure. The need for anesthesia, by itself, is not such a condition. We cover general anesthesia for dental services for a dependent child with physical, mental, or behavior problems. Note: See Section 3, Y*ou need prior Plan approval for certain services.*	Nothing	Nothing	20% of our allowance after the deductible
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, and guest meals and beds* • *Private nursing care, except when medically necessary* • *Inpatient dental procedures, except for reasons noted above*	*All charges*	*All charges*	*All charges*
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 • Blood and blood products • Pre-surgical testing • Dressings, casts and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics and anesthesia service	$150 in an ambulatory surgical center 10% coinsurance of our allowable amount in an outpatient hospital	$200 after the deductible in an ambulatory surgical center $300 after the deductible in an outpatient hospital	$275 after the deductible in an ambulatory surgical center $375 after the deductible in an outpatient hospital

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay		
Outpatient hospital or ambulatory surgical center (cont.)	**High Option**	**Standard Option**	**Prosper**
Notes: • You may receive covered outpatient hospital services for certain dental procedures if a Plan physician determines you need outpatient hospital services for reasons unrelated to the dental procedure. The need for anesthesia, by itself, is not such a condition. See Section 5(g) for details of your dental benefits. • We cover general anesthesia for dental services for a dependent child with physical, mental, or behavior problems. • See Section 3, *You need prior Plan approval for certain services*. • We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Applies to this benefit	Applies to this benefit	Applies to this benefit
Skilled nursing care 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: See Section 3, *You need prior Plan approval for certain services.*	Nothing	Nothing after the deductible	20% of our allowance after the deductible
Not covered: • *Custodial care and care in an intermediate care facility* • *Personal comfort items, such as phone, television, barber services, and guest meals and beds*	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
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 for home-based hospice services 10% of our allowance after the deductible for inpatient admission	Nothing for home-based hospice services 20% of our allowance after the deductible for inpatient admission
Special Services Program Hospice-eligible members who have not yet elected hospice care are eligible to receive home visits by Plan special service hospice providers. Note: See Section 3, *You need prior Plan approval for certain services.*	Nothing	Nothing	Nothing
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 Notes: • See Section 3, *You need prior Plan approval for certain services.* • See Section 5(d), *Emergency Services/ Accidents.*	$150 per trip	$200 per trip	$250 per trip after the deductible
• Unlimited non-emergency medical transportation (NEMT) by stretcher/gurney or wheelchair vans when medically necessary, authorized, and ordered by a Plan provider	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 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*
Rehabilitation facility	**High Option**	**Standard Option**	**Prosper**
Up to 60 days per condition of multidisciplinary rehabilitation services program in a designated rehabilitation facility. Note: See Section 3, *You need prior Plan approval for certain services.*	$325 per day up to $1,300 maximum per admission	$375 per day up to $1,500 maximum per admission after the deductible	20% of our allowance after the deductible

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 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.
- The Standard Option's calendar year deductible is $150 per person ($300 per family). Prosper's calendar year deductible is $350 per person ($700 per family). The calendar year deductible applies to some benefits in this Section. We added "after the deductible" when the calendar year deductible applies.
- There is no deductible for the High Option.
- If you receive special procedures (MRIs, CT scans, PET scans and nuclear medicine) while in the hospital emergency room, you pay the amount specified in Section 5(a). Your copayment for the special procedures performed in a hospital emergency room will be waived if you are admitted to the hospital as an inpatient.
- If you receive additional services (such as laboratory tests, X-rays, MRIs, CT scans) while in urgent care, you pay the amount specified in Section 5(a), *Lab, X-ray and other diagnostic tests.*
- 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.

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:

You are covered for medical emergencies anywhere in the world. In a life-threatening emergency, call 911 or go to the nearest emergency room. If you call 911, when the operator answers, stay on the phone and answer all questions.

Emergencies within our service area

If you think you have a life- or limb-threatening emergency, call 911 or go to the nearest emergency room. Please refer to the Provider Directory on www. kp.org for the locations of Plan facilities that provide emergency care.

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 appropriate appointment or advice nurse number at a Plan facility. Please refer to the Provider Directory on www. kp.org for advice nurse and Plan facility phone numbers. A Plan provider will determine if care can be provided at home or in an urgent care center. Call (303)-338-4545 or toll-free (800)-218-1059, (TTY: 711) for advice, 24 hours a day, seven days a week. For an appointment, call your PCP's office. Visit kp.org/postal to find locations and hours of accessibility for a designated Plan urgent care center.

Emergencies outside our service area

We cover emergency situations, such as myocardial infarction, appendicitis or premature delivery, outside the service area. Post-stabilization care is the services you receive after your treating physician determines that you are clinically stable. We cover post-stabilization care if a Plan provider provides it or if you obtain authorization from us to receive the care from a non-Plan provider.

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 appropriate appointment or advice nurse number at a Plan facility. Please refer to the Provider Directory on kp.org for advice nurse and Plan facility phone numbers. If you are temporarily outside the service area and have an urgent care need due to 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 are listed on www. kp.org, available 24 hours a day, seven days a week. You may also obtain information about the location of facilities by calling Member Services at (303)-338-3800 or toll-free (800)-632-9700, (TTY: 711).

How to obtain authorization

You or someone on your behalf must call us at (303)-338-3800 or toll-free (800)-632-9700, (TTY: 711) (these phone numbers are also on the back of your ID card) to:

- Request authorization for post-stabilization care before you obtain the care from a non-Plan provider if it is reasonable to do so (otherwise, call us as soon as reasonably possible).
- Notify us that you have been admitted to a non-Plan hospital or a hospital with whom we have contracted for emergency services.

We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. By notifying us of your hospitalization as soon as possible, you will protect yourself from potential liability for payment for services you receive after transfer to one of our facilities would have been possible.

Benefit Description	You pay		
Note: The calendar year deductible applies to some benefits in this Section. We say "after the deductible" when the calendar year deductible applies.			
Emergencies within our service area	**High Option**	**Standard Option**	**Prosper**
• Emergency care at an urgent care center • Urgent care at an urgent care center • Urgent care delivered through interactive video • Urgent care provided in your home	$30 per visit	$40 per visit	$35 per visit
• Emergency care as an outpatient at a hospital, including physicians' services • Urgent care at a Plan emergency room	$300 per visit	$400 per visit after the deductible	$450 per visit after the deductible

Emergencies within our service area - continued on next page

Benefit Description	You pay		
Emergencies within our service area (cont.)	**High Option**	**Standard Option**	**Prosper**
Notes: • Interactive video visits may be limited by provider type and/or location. • If you receive emergency care and then are transferred to observation care, you pay the outpatient hospital copayment. If you are admitted as an inpatient, we will waive your emergency room copayment (High and Standard Options) and you will pay your cost-sharing related to your inpatient hospital stay.	$300 per visit	$400 per visit after the deductible	$450 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*
Emergency outside our service area	**High Option**	**Standard Option**	**Prosper**
• Emergency care at an urgent care center • Urgent care at an urgent care center	$30 per visit	$40 per visit	$35 per visit
• Emergency care as an outpatient at a hospital, including physicians' services • Urgent care at an emergency room Notes: • If you receive emergency care and then are transferred to observation care, you pay the outpatient hospital copayment. If you are admitted as an inpatient, we will waive your emergency room copayment (High and Standard Options) 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.	$300 per visit	$400 per visit after the deductible	$450 per visit after the deductible
Not covered: • *Elective care or non-emergency care* • *Follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *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*

Benefit Description	You pay		
Ambulance	**High Option**	**Standard Option**	**Prosper**
Licensed ambulance service when medically necessary. Notes: • See Section 5(c), for non-emergency services. • Trip means any time an ambulance is summoned on your behalf.	$150 per trip	$200 per trip	$250 per trip after the deductible
Not covered: • *Trips we determine are not medically necessary* • *Transportation by car, taxi, 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 we cover them only when we determine they are clinically appropriate to treat your condition.
- Plan providers must provide or arrange your care.
- Please call our Behavioral Health Department at (303)-471-7700 or toll-free at (866)-359-8299, (TTY: 711) if you have urgent mental health concerns. In southern Colorado, call (866)-702-9026, (TTY: 711).
- The Standard Option's calendar year deductible is $150 per person ($300 per family). Prosper's calendar year deductible is $350 per person ($700 per family). The calendar year deductible applies to some benefits in this Section. We added "after the deductible" when the calendar year deductible applies.
- There is no deductible for the High Option.
- If the cost for a drug administered in connection with your care is less than the copayment, you will pay the lesser amount.
- 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.
- 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 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 or substance use disorder treatment provider that are covered services, drugs, and supplies described in this brochure. Notes:	Your cost-sharing responsibilities are not greater than for other illnesses or conditions.	Your cost-sharing responsibilities are not greater than for other illnesses or conditions.	Your cost-sharing responsibilities are not 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**
We cover the services only when we determine that the care is clinically appropriate to treat your condition.	Your cost-sharing responsibilities are not greater than for other illnesses or conditions. *Note*: You pay up to $200 for drugs administered in connection with your care.	Your cost-sharing responsibilities are not greater than for other illnesses or conditions. *Note*: You pay up to $250 after the deductible for drugs administered in connection with your care.	Your cost-sharing responsibilities are not greater than for other illnesses or conditions. *Note*: You pay up to $350 after the deductible for drugs administered in connection with your care.
Note: See Section 3, *You need prior Plan approval for certain 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.*	Your cost-sharing responsibilities are no greater than for other illness or condition. See Section 5(a) *Lab, X-ray and other diagnostic tests.*	Your cost-sharing responsibilities are no greater than for other illness or condition. See Section 5(a) *Lab, X-ray and other diagnostic tests.*
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Treatment and counseling (including group and individual therapy visits) • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Applied Behavior Analysis (ABA) Therapy for the treatment of autism spectrum disorder • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Electroconvulsive therapy • Diagnosis and treatment of substance use disorders. Services include: • Detoxification (medical management of withdrawal from the substance) • Treatment and counseling (including individual and group therapy visits) • Rehabilitative care Notes:	$20 per individual therapy office visit $10 per group therapy office visit Note: You pay up to $100 for drugs administered in connection with your care.	$30 per individual therapy office visit (nothing for children through age 17) $15 per group therapy office visit (nothing for children through age 17) Note: You pay up to $200 after the deductible for drugs administered in connection with your care.	$10 per individual therapy office visit $5 per group therapy office visit Note: You pay up to $300 after the deductible for drugs administered in connection with your care.

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:	$20 per individual therapy office visit $10 per group therapy office visit Note: You pay up to $100 for drugs administered in connection with your care.	$30 per individual therapy office visit (nothing for children through age 17) $15 per group therapy office visit (nothing for children through age 17) Note: You pay up to $200 after the deductible for drugs administered in connection with your care.	$10 per individual therapy office visit $5 per group therapy office visit Note: You pay up to $300 after the deductible for drugs administered in connection with your care.

Professional services - continued on next page

Benefit Description	You pay		
Professional services (cont.)	**High Option**	**Standard Option**	**Prosper**
• 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. • You may see a Plan mental health or substance use provider for these 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 or substance use 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.	$20 per individual therapy office visit $10 per group therapy office visit Note: You pay up to $100 for drugs administered in connection with your care.	$30 per individual therapy office visit (nothing for children through age 17) $15 per group therapy office visit (nothing for children through age 17) Note: You pay up to $200 after the deductible for drugs administered in connection with your care.	$10 per individual therapy office visit $5 per group therapy office visit Note: You pay up to $300 after the deductible for drugs administered in connection with your care.
Procedures received during an office visit	Nothing after you pay the office visit copayment	Nothing after you pay the office visit copayment	Nothing after you pay the office visit copayment
Methadone/Suboxone treatment program	$20 every thirty days	$30 every thirty days (nothing for children through age 17)	$10 every thirty days

Benefit Description	You pay		
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.	Your cost-sharing responsibilities are no greater than for other illness or condition. See Section 5(a) Lab, X-ray and other diagnostic tests.	Your cost-sharing responsibilities are no greater than for other illness or condition. See Section 5(a) Lab, X-ray and other diagnostic tests.
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 or substance use care • Inpatient psychiatric or substance use care • Psychiatric and substance use care in a residential treatment center Note: All inpatient admissions require approval by a Plan mental health or substance use physician.	$325 per day up to $1,300 maximum per admission	$375 per day up to $1,500 maximum per admission after the deductible	20% of our allowance 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 • Partial hospitalization, day treatment and intensive outpatient psychiatric treatment programs • Day treatment programs for substance use Note: All psychiatric and substance use treatment programs require approval by a Plan mental health or substance use physician.	Nothing	Nothing	Nothing
Not covered: • *Care that is not clinically appropriate for the treatment of your condition* • *Intelligence, IQ, aptitude ability, learning disorders, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition*	*All charges*	*All charges*	*All charges*

Outpatient hospital or other covered facility - continued on next page

Benefit Description	You pay		
Outpatient hospital or other covered facility (cont.)	**High Option**	**Standard Option**	**Prosper**
• *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* • *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 page 89.
- 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 authorization must be renewed periodically.
- There is no 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.
- **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 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, for the dependent out-of-area benefit as described in Section 5(h), or as stated in this section.
- **Where you can obtain them.** You may obtain all prescriptions at a Plan pharmacy or through the Plan mail order program. You may obtain a non-maintenance prescription or a first fill of your maintenance prescription at a network pharmacy, then you must obtain all refills of your maintenance prescription at a Plan medical office pharmacy or through the Plan mail order program only. Maintenance medications are taken regularly for ongoing conditions. Non-maintenance medications are typically prescribed for one-time or urgent conditions, such as antibiotics or for pain.

Regardless of where you receive your care, you may order prescription refills through our website at www. kp.org/rxrefill if the prescription was originally filled by a Kaiser Permanente pharmacy, or by calling (866)-523-6059, (TTY: 711) if the prescription was originally filled by a network pharmacy. If you order through the Plan mail order program, your refills will be mailed by First Class U.S. Mail at no charge to you for postage and handling. You should receive your prescription within 7-10 days. Prescribed over-the-counter medications must be filled at a Kaiser Permanente pharmacy. You can get information about our mail order program on www. kp.org or Member Services at (303)-338-3800 or toll-free at (800)-632-9700, (TTY: 711).

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 contact our Clinical Pharmacy Call Center at (303)-338-4503. Your refills will be mailed by First Class U.S. Mail at no charge to you for postage and handling. You should receive your prescription within 7-10 days.

- **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 who participate in pharmacy and therapeutics committees. The committees meet 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 PSHB 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.

Your provider may request an exception for us to cover non-formulary drugs (those not listed on our drug formulary for your condition). You will be charged your applicable non-formulary drug copayment. Please see our online formulary and drug pricing search tools at the following www. kp.org/formulary or call Member Services at (303)-338-3800 or toll-free (800)-632-9700, (TTY: 711).

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

- **Expanded preventive maintenance drugs** (Standard Option and Prosper). We categorize some drugs used to treat specific chronic conditions as preventive maintenance drugs. Not all drugs used for the treatment of chronic conditions are considered preventive maintenance drugs.
  - **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 drugs**. Brand name drugs are produced and sold under the original manufacturer's brand name. Preferred brand name drugs are listed on our drug formulary.
  - **Tier 3: Non-preferred generic and brand name drugs.** Non-preferred generic and brand name 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 tiers, 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 prescribed and obtained from a Plan pharmacy. Refills of prescribed maintenance drugs may be obtained in a Plan pharmacy up to a 90-day supply for three copayments or through our mail order program for two copayments. For prescribed contraceptives, you may obtain up to a three-month supply for the first dispensing and up to a twelve-month supply for refills, or a prescribed vaginal contraceptive ring intended to last for a three-month period, at a Plan pharmacy or through our mail-order 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 state of Colorado) 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 Plan provider specifically requires a brand name drug. If you request a brand name drug on the formulary when your Plan provider has prescribed an approved generic drug, you pay your brand name drug copayment plus the difference in price between the generic drug and your requested brand name drug.

- **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 have 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 and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Disposable needles and syringes for the administration of covered medications, other than insulin as specified below • Growth hormone • Chemotherapy drugs • Fertility drugs, including drugs for in vitro fertilization • Immunosuppressant drugs after a transplant Notes: • For information about mail order discounts, see "These are the dispensing limitations" in the introduction to Section 5(f). • You will be charged your applicable generic or brand name drug copayment depending on the compound drug'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 to meet the requirements of a prescription. • Growth hormone requires our prior approval. See Section 3, *You need prior Plan approval for certain services.* • There are some bona fide medical conditions, such as precocious puberty, or therapy subsequent to a traumatic injury where hormone treatments for individuals may be medically necessary and covered • For in vitro *fertilization,* we cover fertility drugs prescribed by non-Plan providers when obtained at a Plan pharmacy.	$15 for preferred generic drugs; $50 for preferred brand name drugs; $75 for non-preferred drugs; $175 for specialty drugs for up to a 30-day supply at a Plan pharmacy *Note*: For up to a 30-day supply of one or more insulin prescriptions, you pay the standard prescription copayment up to $100.	$5 for preventive maintenance drugs; $15 for preferred generic drugs; $60 for preferred brand name drugs; $80 for non-preferred drugs; $250 for specialty drugs for up to a 30-day supply at a Plan pharmacy *Note*: For up to a 30-day supply of one or more insulin prescriptions, you pay the standard prescription copayment up to $100.	$5 for preventive maintenance drugs; $15 for preferred generic drugs; $70 for preferred brand name drugs; $100 for non-preferred drugs; $350 for specialty drugs for up to a 30-day supply at a Plan pharmacy *Note*: For up to a 30-day supply of one or more insulin prescriptions, you pay the standard prescription copayment up to $100.

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	**High Option**	**Standard Option**	**Prosper**
• Medications prescribed to treat obesity	50% of our allowance	50% of our allowance	50% of our allowance
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https ://www. hrsa.gov/ womens-guidelines. Contraceptive coverage is available at no cost to PSHB 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, contraceptive gels, diaphragms, hormonal contraceptive methods, and prescribed FDA approved over-the-counter women's contraceptives and devices • 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 www. kp.org/postal under Member Resources. 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**
• 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 are having problems accessing contraceptive coverage or need more information about contraception, you can email contraception@opm.gov or visit Member Resources at kp.org/postal or OPM's website at Contraception Coverage at www. opm.gov/healthcare-insurance/healthcare/contraception-coverage/. • If you are having problems accessing contraceptive coverage or need more information about contraception, email OPM at contraception@opm.gov or visit OPM's website at Contraception Coverage at opm.gov/healthcare-insurance/healthcare/contraception-coverage/. 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. 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) Note: 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)	Nothing	Nothing	Nothing
Diabetic supplies, limited to: • Disposable needles and syringes for the administration of covered insulin • Glucose test strips • Home glucose monitoring supplies • Acetone test tablets	20% of our allowance up to $40	20% of our allowance up to $50	20% of our allowance up to $60
Medical foods for use in the home:	$3 per product per day	$3 per product per day	$3 per product per day

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	**High Option**	**Standard Option**	**Prosper**
• For individuals unable to absorb or digest food • Includes enteral and parenteral elemental dietary formulas and amino acid modified product for treatment of inborn errors of metabolism	$3 per product per day	$3 per product per day	$3 per product per day
• Sexual dysfunction drugs Note: If a drug for which a prescription is required by law is excluded and we had been covering and providing it to you for a use approved by the FDA, we will continue to provide the drug upon payment of 50% of our allowance if a Plan physician continues to prescribe the drug for the same condition.	50% of our allowance	50% of our allowance	50% of our allowance
• Intravenous fluids and medications for home use	Nothing	Nothing	Nothing
• Prescribed tobacco cessation medications, including prescribed over-the-counter medications, approved by the FDA to treat tobacco dependence Note: Over-the-counter medications require a prescription and must be filled at a Kaiser Permanente pharmacy.	Nothing	Nothing	Nothing
Not covered • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Prescriptions filled at a non-Plan pharmacy, except for 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* • *Over-the-counter (nonprescription) drugs, 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* • *Over-the-counter drugs, including prescription drugs for which there is an over-the-counter equivalent available* • *Medical supplies such as dressings and antiseptics, except as listed above*	*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 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* • *Drugs related to non-covered services, except as stated above* • *Drugs for the promotion, prevention, or other treatment of hair loss or growth* • *Certain drugs determined excluded by our Pharmacy and Therapeutics Committee*	*All charges*	*All charges*	*All charges*
Preventive 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 • Medications 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 www. uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations Notes: • Over-the-counter medications require a prescription and must be filled at a Kaiser Permanente pharmacy.	Nothing	Nothing	Nothing
Opioid rescue agents are covered under this Plan with no cost sharing when obtained with a prescription and filled through a participating pharmacy 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	Nothing	Nothing	Nothing

Preventive medications - continued on next page

Benefit Description	You pay		
Preventive medications (cont.)	**High Option**	**Standard Option**	**Prosper**
Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to 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* • *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 (non-prescription) drugs, 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, except as stated above*	*All charges*	*All charges*	*All charges*

Section 5(f)(a). PDP EGWP 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.
- These prescription drug benefits are for members enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP).
- If you are a Postal Service annuitant or a covered Medicare-eligible family member, you will be automatically group enrolled in our PDP EGWP. Contact us for additional information at (303)-338-3800 or toll-free (800)-632-9700, (TTY: 711).

Note: Notify us as soon as possible if you or your eligible family member is already enrolled in a Medicare Part D Plan. Enrollment in our PDP EGWP will cancel your enrollment in another Medicare Part D Plan.

There are advantages to being enrolled in our PDP EGWP:

- In our PDP EGWP, your cost-share for covered drugs, medications, and supplies will be equal to or better than the cost-share for those enrolled in our standard non-PDP EGWP Prescription Drug Program.
- In our PDP EGWP, you have a pharmacy network that may include pharmacies that are out-of-network or excluded for those enrolled in our standard non-PDP EGWP Prescription Drug Program. Go to www. kp.org/directory to use the *Pharmacy Directory* or contact Member Services at (800)-632-9700 for additional information or visit www. kp.org/seniorrx. See Chapter 3, Section 2.5 of the Evidence of Coverage for Kaiser Permanente Medicare Part D Group Plan (PDP) for Postal Service Health Benefits Members for information on when you can use pharmacies that are not in the Plan's network.
- We provide coverage of some drugs excluded by Medicare, for example, sexual dysfunction drugs and drugs used for treatment of weight loss.

We cover drugs, medications, and supplies as described below and on the following pages.

- **Prescription drug (Part D) out-of-pocket (OOP) maximum.** We increased the Part D prescription drug out of pocket maximum from $2,100 to $2,400. See your Kaiser Permanente Medicare Part D Group Plan (PDP) for Postal Service Health Members Evidence of Coverage for more information.
- 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 are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal or state law 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.
- If you choose to opt out of or disenroll from our PDP EGWP, see Section 9 for additional PDP EGWP information and for our opt-out and disenrollment process. Contact us for assistance with the PDP EGWP opt out and disenrollment process at (800)-632-9700, (TTY: 711).

Warning: If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage. However, you can enroll in our MAPD during Open Season or for a **qualifying life event (QLE)** and receive PSHB Program Prescription Drug Coverage.

To learn more about our MAPD plans or enroll you can:

- Visit kp.org/postal to view benefit details, enroll online, download an enrollment application, or RSVP to attend a seminar.
- Call and speak to a Kaiser Permanente Medicare health plan specialist at (877)-547-4909, (TTY: 711), Monday through Friday, from 6 a.m. to 7 p.m. Pacific Time.

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 during Open Season or for a QLE. 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 (800)-632-9700, (TTY: 711).

Each new enrollee will receive a description of our PDP EGWP Summary of Benefits, a combined prescription drug/Plan identification card, a mail order form/patient profile and a preaddressed reply envelope. You will be enrolled in a Kaiser Permanente Medicare Part D Group Plan (PDP) for Postal Service Health Benefits (PSHB) Members.

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

- **Who can write your prescription.** A licensed Plan provider or licensed 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, for the dependent out-of-area benefit as described in Section 5(h), or as stated in this section. Your prescribers must have Medicare-approved prescriptive authority.
- **Where you can obtain them.** You may obtain all prescriptions at a Plan pharmacy or through the Plan mail order program. You may obtain a non-maintenance prescription or a first fill of your maintenance prescription at a network pharmacy, then you must obtain all refills of your maintenance prescription at a Plan medical office pharmacy or through the Plan mail order program only. Maintenance medications are taken regularly for ongoing conditions. Non-maintenance medications are typically prescribed for one-time or urgent conditions, such as antibiotics or for pain.

Regardless of where you receive your care, you may order prescription refills through our website at www. kp.org/rxrefill if the prescription was originally filled by a Kaiser Permanente pharmacy, or by calling (866)-523-6059, (TTY: 711) if the prescription was originally filled by a network pharmacy. If you order through the Plan mail order program, your refills will be mailed by First Class U.S. Mail at no charge to you for postage and handling. You should receive your prescription within 7-10 days. Prescribed over-the-counter medications must be filled at a Kaiser Permanente pharmacy. You can get information about our mail order program on www. kp.org or Member Services at (303)-338-3800 or toll-free at (800)-632-9700, (TTY: 711).

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 contact our Clinical Pharmacy Call Center at (303)-338-4503. Your refills will be mailed by First Class U.S. Mail at no charge to you for postage and handling. You should receive your prescription within 7-10 days. For assistance locating a PDP EGWP network pharmacy, visit our website at www. kp.org, or call Member Services at (303)-338-3800 or toll-free at (800)-632-9700, (TTY: 711).

- **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 who participate in pharmacy and therapeutics committees. The committees meet 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 PSHB 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.

Your provider may request an exception for us to cover non-formulary drugs (those not listed on our drug formulary for your condition). You will be charged your applicable non-formulary drug copayment. For more information on our prescription drug PSHB formulary, visit www. kp.org/formulary or call Member Services at (303)-338-3800 or toll-free (800)-632-9700, (TTY: 711).

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

- **Expanded preventive maintenance drugs** (Standard Option and Prosper). We categorize some drugs used to treat specific chronic conditions as preventive maintenance drugs. Not all drugs used for the treatment of chronic conditions are considered preventive maintenance drugs.
  - **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 drugs**. Brand name drugs are produced and sold under the original manufacturer's brand name. Preferred brand name drugs are listed on our drug formulary.
  - **Tier 3: Non-preferred generic and brand name drugs.** Non-preferred generic and brand name 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 tiers, 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 prescribed and obtained from a Plan pharmacy. Refills of prescribed maintenance drugs may be obtained in a Plan pharmacy up to a 100-day supply for three copayments or through our mail order program for two copayments. For prescribed contraceptives, you may obtain up to a three-month supply for the first dispensing and up to a twelve-month supply for refills, or a prescribed vaginal contraceptive ring intended to last for a three-month period, at a Plan pharmacy or through our mail-order 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 state of Colorado) 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 a full supply is available.
- **You may request a Formulary Exception.** Kaiser Permanente physicians prescribe the appropriate level of medically necessary medications to PSHB members. To ensure physicians can make appropriate exceptions, they have the authority to prescribe brand name or non-formulary 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.
- **A generic equivalent will be dispensed if it is available,** unless your Plan provider specifically requires a brand name drug. If you request a brand name drug on the formulary when your Plan provider has prescribed an approved generic drug, you pay your brand name drug copayment plus the difference in price between the generic drug and your requested brand name drug.

- **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 have 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.*
- **If we deny your claim for a prescription drug and you want to appeal**, you, your representative, or your prescriber must request an appeal following the process described in Section 8(a). *Medicare PDP EGWP Disputed Claims Process*. The PDP EGWP appeals process has 5 levels. If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you'll get instructions in the decision letter on how to move to the next level of appeal.
- **PDP EGWP True Out-of-Pocket Cost (TrOOP)**. When you (or those paying on your behalf) have spent a total of **$2,400** in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage. For additional information, please refer to your Evidence of Coverage for Kaiser Permanente Senior Advantage Postal Service Members.

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 and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered*. • Insulin • Disposable needles and syringes for the administration of covered medications, other than insulin as specified below • Growth hormone • Chemotherapy drugs • Fertility drugs, including drugs for in vitro fertilization • Immunosuppressant drugs after a transplant Notes: • For information about mail order discounts, see "These are the dispensing limitations" in the introduction to Section 5(f). • You will be charged your applicable generic or brand name drug copayment depending on the compound drug's main ingredient, whether the main ingredient is a generic or brandname drug. • A compound drug is one in which two or more drugs or pharmaceutical agents are combined together to meet the requirements of a prescription.	$15 for preferred generic drugs; $40 for preferred brand name drugs; $60 for non-preferred drugs; $100 for specialty drugs for up to a 30-day supply at a Plan pharmacy *Note*: For up to a 30-day supply of one or more insulin prescriptions, you pay the standard prescription copayment up to $100.	$5 for preventive maintenance drugs; $15 for preferred generic drugs; $45 for preferred brand name drugs; $70 for non-preferred drugs; $200 for specialty drugs for up to a 30-day supply at a Plan pharmacy *Note*: For up to a 30-day supply of one or more insulin prescriptions, you pay the standard prescription copayment up to $100.	$5 for preventive maintenance drugs; $15 for preferred generic drugs; $45 for preferred brand name drugs; $80 for non-preferred drugs; $300 for specialty drugs for up to a 30-day supply at a Plan pharmacy *Note*: For up to a 30-day supply of one or more insulin prescriptions, you pay the standard prescription copayment up to $100.

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	**High Option**	**Standard Option**	**Prosper**
• Growth hormone requires our prior approval. See Section 3, *You need prior Plan approval for certain services.* • For in vitro fertilization, we cover fertility drugs prescribed by non-Plan providers when obtained at a Plan pharmacy.	$15 for preferred generic drugs; $40 for preferred brand name drugs; $60 for non-preferred drugs; $100 for specialty drugs for up to a 30-day supply at a Plan pharmacy *Note*: For up to a 30-day supply of one or more insulin prescriptions, you pay the standard prescription copayment up to $100.	$5 for preventive maintenance drugs; $15 for preferred generic drugs; $45 for preferred brand name drugs; $70 for non-preferred drugs; $200 for specialty drugs for up to a 30-day supply at a Plan pharmacy *Note*: For up to a 30-day supply of one or more insulin prescriptions, you pay the standard prescription copayment up to $100.	$5 for preventive maintenance drugs; $15 for preferred generic drugs; $45 for preferred brand name drugs; $80 for non-preferred drugs; $300 for specialty drugs for up to a 30-day supply at a Plan pharmacy *Note*: For up to a 30-day supply of one or more insulin prescriptions, you pay the standard prescription copayment up to $100.
• Medications prescribed to treat obesity Note: When you are prescribed drugs solely for the purpose of losing weight, we may require you to be enrolled in a covered comprehensive weight loss program, for a reasonable period of time prior to or concurrent with receiving the prescription drug.	50% of our allowance	50% of our allowance	50% of our allowance
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https ://www. hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to PSHB 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, hormonal contraceptive methods, and prescribed FDA approved over-the-counter women's contraceptives and devices	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**
• 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. Kaiser Permanente physicians prescribe the appropriate level of medically necessary contraceptive medications to PSHB 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 PSHB members on www. kp.org/postal and www. kp.org/health-wellness. 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. 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. Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. 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.	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**
Note: For additional Family Planning benefits see Section 5(a)	Nothing	Nothing	Nothing
Diabetic supplies, limited to: • Glucose test strips • Home glucose monitoring supplies • Acetone test tablets • Disposable needles and syringes for the administration of covered insulin	20% of our allowance up to $40	20% of our allowance up to $45	20% of our allowance up to $45
Medical foods for use in the home: • For individuals unable to absorb or digest food • Includes enteral and parenteral elemental dietary formulas and amino acid modified product for treatment of inborn errors of metabolism	$3 per product per day	$3 per product per day	$3 per product per day
• Sexual dysfunction drugs	50% of our allowance	50% of our allowance	50% of our allowance
• Intravenous fluids and medications for home use	Nothing	Nothing	Nothing
Note: 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).	Nothing	Nothing	Nothing
Not covered • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Prescriptions filled at a non-Plan pharmacy, except for 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* • *Over-the-counter (nonprescription) drugs, 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* • *Over-the-counter drugs, including prescription drugs for which there is an over-the-counter equivalent available*	*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**
• *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* • *Drugs related to non-covered services, except as stated above* • *Drugs for the promotion, prevention, or other treatment of hair loss or growth*	*All charges*	*All charges*	*All charges*
Preventive 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 • Medications to reduce the risk of breast cancer Notes: • 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 www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations • Over-the-counter medications require a prescription and must be filled at a Kaiser Permanente pharmacy.	Nothing	Nothing	Nothing
Opioid rescue agents are covered under this Plan with no cost sharing when filled through a participating pharmacy such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at www. fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose	Nothing	Nothing	Nothing

Preventive medications - continued on next page

Benefit Description	You pay		
Preventive medications (cont.)	**High Option**	**Standard Option**	**Prosper**
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* • *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 (nonprescription) drugs, 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, except as stated above*	*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 the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your PSHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your PSHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- There is no deductible for the High Option.
- The Standard Option's calendar year deductible is $150 per person ($300 per family). Prosper's calendar year deductible is $350 per person ($700 per family). The calendar year deductible applies to some benefits in this Section. We added "after the deductible" when the calendar year deductible applies.
- 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) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- 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.

Benefit Description	You pay		
Note: The calendar year deductible applies to some benefits in this Section. We say "after the deductible" when the calendar year deductible applies.			
Accidental injury to teeth	**High Option**	**Standard Option**	**Prosper**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound, natural teeth, if: • 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, except in a proper manner, and • The tooth has not been weakened by decay, periodontal disease, or other existing dental pathology. Note: The need for these services must result from an accidental injury.	$20 per visit	10% of our allowance after the deductible	20% of our allowance after the deductible

Benefit Description	You pay		
Dental benefits	**High Option**	**Standard Option**	**Prosper**
We have no other dental benefits	*All charges*	*All charges*	*All charges*

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 numbers at: 711. Sign language services are also available.
Services from other Kaiser Permanente regions	When you visit a Kaiser Permanente medical office or affiliated Plan provider outside our 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 PSHB 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/travel.
Dependent out-of-area benefit	We provide a limited benefit to dependents under the age of 26, who are temporarily outside Kaiser Permanente's service areas and within the United States. These benefits are in addition to your emergency benefits and will be applied before your travel benefit. We cover routine, continuing and follow-up medical care as follows:

	• Up to 10 office visits, phone visits or video visits per year (combined visit limit between primary care, specialty care, outpatient mental health and substance use disorder care, gynecology care, preventive care and immunizations, hearing exams, and allergy injections). You pay $20 (High Option) or $30 (Standard Option) or $10 (Prosper) per office visit. Telehealth visits via phone or video visit are no charge. • Up to 10 diagnostic X-rays per year. You pay 20% of our allowance (High Option) or 20% of our allowance after you have met the calendar year deductible (Standard Option and Prosper). • Up to 12 prescription drug fills and diabetic supplies. You pay cost-sharing of 20% of our allowance. • Up to 10 therapy visits per year (combined visit limit between physical, occupational, and speech therapy). You pay $20 (High Option) or $30 (Standard Option) or $10 (Prosper) per office visit. File claims as shown in Section 7. For more information about this benefit, call (303)-338-3800 or toll-free (800)-632-9700, (TTY: 711). *The following are not included in your dependent out-of-area benefit:* • *Dental services* • *Transplants and transplant follow-up care* • *Services provided outside the United States* • *Laboratory, office procedures and office administered drugs and devices, except for allergy injections and preventive immunizations* • *Allergy evaluation, routine prenatal and postpartum visits, chiropractic services, acupuncture services, applied behavior analysis (ABA), pediatric dental, hearing tests, hearing aids, home health visits, hospice services, and travel immunizations* • *Special diagnostic procedures such as CT, MRI, or PET scans* • *Any and all services not listed in "Coverage" section of this benefit*
Travel benefit	Kaiser Permanente's travel benefit for Postal employees provides you with outpatient follow-up and/or continuing medical and mental health and substance use disorder 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 dialysis and 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. We limit our payment for this travel benefit to no more than $1,200 each calendar year. For more information about this benefit call the Travel Benefit Information Line at (800-632-9700) (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. PSHB subscribers and their enrolled spouses (age 18 and over) are eligible for the following reward: $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/postal. 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. You must accept the Wellness Program Agreement to be eligible to earn rewards. Please go to www.kp.org/postal to learn how to earn your reward and to view and track the status of your reward activities. You must complete the Total Health Assessment and 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/postal If you have questions about completing a Total Health Assessment or class, 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 www.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. **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.

Non-PSHB Benefits Available to Plan Members

The benefits on this page are not part of the PSHB contract or premium, and you cannot file a PSHB disputed claim about them. The fees you pay for these services do not count toward PSHB 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 or (877)-574-3337, (TTY: 711).

Dental Plans - Delta Dental of Colorado
(877)-516-6512 (presale) or (800)-610-0201 (customer relations)

PSHB members enrolled in Kaiser Permanente may purchase dental services from Delta Dental of Colorado. You have two Plans to choose from and both allow you to choose any dentist you wish, but you usually pay less out of pocket when you visit a Delta Dental PPO dentist. You must submit a separate enrollment for dental benefits and pay an additional premium directly to Delta Dental of Colorado.

Contact Delta Dental of Colorado or visit www. kp.org/postal to download our dental programs brochure for information about how to enroll, premiums, coverage, deductibles, cost-sharing, exclusions, limitations, and waiting periods for major and orthodontic services.

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

As a Kaiser Permanente member, you can stay fit with a variety of reduced rates on studios, gyms, fitness gear, and online classes.

- **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 complementary and alternative medicine for therapies such as acupuncture, massage, and chiropractic care. Go to www. myoptumhealthphysicalhealth.com/ProviderDirectory to locate a provider near you.

Emotional Wellness or 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 *When 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 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 for authorized referrals, emergencies, travel benefit, services from other Kaiser Permanente Plans, or dependent coverage outside the service area (*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 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 from a provider or facility barred from the PSHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services provided or arranged by criminal justice institutions for members confined therein.
- 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).
- 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 fill your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

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 or the dependent out-of-area 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 (303)-338-3600 or toll-free (800)-382-4661, (TTY: 711) or visit www.kp.org/support/claims.

When you must file a claim - such as for services you received outside of 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
- Follow-up services rendered out-of-area
- 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:

Kaiser Permanente
National Claims Administration - Colorado
PO Box 373150
Denver, CO 80237

Deadline for filing your claim

Send us all of 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, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

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.

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.

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, a healthcare professional with knowledge of your medical condition will be permitted 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 telephone 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.

Binding arbitration

If you have any claim or dispute that is not governed by the Disputed Claims Process with OPM described in Section 8, then all such claims and disputes of any nature between you and the Plan, including but not limited to malpractice claims, shall be resolved by binding arbitration, subject to the Plan's Arbitration procedures. The Plan has the information that describes the arbitration process. Contact our Resolve Program at (303)-344-7298 for copies of our requirements. These will explain how you can begin the binding arbitration process.

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. For covered services you receive by providers and hospitals outside the United States and Puerto Rico, send a completed Overseas Claim Form and the itemized bills to:

Kaiser Permanente
National Claims Administration - Colorado
PO Box 373150
Denver, CO 80237

We will do the translation and currency conversion for you. You may obtain the Overseas Claim Form by calling Member Services toll-free at (800)-382-4661 or from our website at www.kp.org/postal, Members/Forms and Information.

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 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 your Plan's customer service representative at the phone number found on your enrollment card, Plan brochure, or Plan website. If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP) and you disagree with our **pre-service or post-service** decision about your prescription drug benefits, please follow the appeals process outlined in Section 8(a). Medicare MAPD/PDP EGWP Disputed Claims Process.

Please follow this Postal Service 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 Member Services by writing to Kaiser Foundation Health Plan of Colorado, Member Services Department, P.O. Box 378066, Denver, Colorado 80237-8066 or calling (303)-338-3800 or toll-free at (800)-632-9700, (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: Appeals Program, Kaiser Foundation Health Plan of Colorado, P.O. Box 378066, Denver, CO 80237-8066; 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. 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 20415-1100.

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; and
- Your daytime phone number and the best time to call.
- 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.

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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 (800)-632-9700, (TTY: 711). 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 PSIO at (202)-936-0002 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.

Reminder: If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D MAPD/PDP EGWP, you may appeal an adverse pre-service or post-service determination. See Section 8(a).

Section 8(a). Medicare MAPD/PDP EGWP Plan Sponsored Disputed Claims Process

When a Medicare Part D MAPD/PDP EGWP claim is denied in whole or in part, you may appeal the denial.

Our Plan follows the Medicare Part D appeals process. For coverage decisions and appeals, see Chapter 7 of the Evidence of Coverage for Kaiser Permanente Medicare Part D Employer Group Waiver Plan (MAPD/PDP EGWP) for Postal Service Health Benefits (PSHB) Members (EOC). A copy of your EOC is available at www. kp.org/postal.

What to do if you have a problem or concern

This section explains two types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints;** also called grievances.

Both of these processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

As a PSHB member, you also have additional dispute resolution rights and a different appeals process through the PSHB Program. For a complete statement of your drug benefits and rights under the PSHB Program, please read your PSHB brochure (RI 73-918). All PSHB Program benefits are subject to the definitions, limitations, and exclusions set forth in the PSHB brochure.

Note: If you have an issue relating to coverage of a drug that is not covered by Medicare, but is covered under your PSHB membership, please refer to your PSHB brochure for dispute resolution options because the Medicare appeal process does not apply.

Making an appeal

If we make a coverage decision, whether before or after a benefit is received, and you are not satisfied, you can *appeal* the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, you can request an expedited or *fast appeal* of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

Note: A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision.

In limited circumstances, a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we do not dismiss your case but say no to all or part of your Level 1 appeal, you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an independent review organization that is not connected to us. (Part D appeals are discussed further in Chapter 7, Section 5 of your Evidence of Coverage for Kaiser Permanente Medicare Part D Group Plan (PDP) for Postal Service Health Benefits (PSHB) Members. If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Chapter 7, Section 6 of your Evidence of Coverage explains the Level 3, 4, and 5 appeals processes).

How to get help when you are asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- You can call Member Services at (800)-632-9700 (long distance) (TTY: 711).
- You can get free help from your State Health Insurance Assistance Program.
- Your doctor or other prescriber can make a request for you. For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.
- You can ask someone to act on your behalf. If you want to, you can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.
- You also have the right to hire a lawyer. You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, you are not required to hire a lawyer to ask for any kind of coverage decision or appeal a decision.

What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service. Here are examples of the kinds of problems handled by the complaint process.

- **Quality of your care.** Are you unhappy with the quality of the care you have received?
- **Respecting your privacy.** Did someone not respect your right to privacy or share confidential information?
- **Disrespect, poor customer service, or other negative behaviors.** Has someone been rude or disrespectful to you? Are you unhappy with our Member Services? Do you feel you are being encouraged to leave the Plan?
- **Waiting times.** Have you been kept waiting too long by pharmacists? Or by our Member Services or other staff at the Plan? Examples include waiting too long on the phone, in the waiting room, or getting a prescription.
- **Cleanliness.** Are you unhappy with the cleanliness or condition of a pharmacy?
- **Timeliness.** If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness.

Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

The **deadline** for making a complaint is **60 calendar days** from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call.
- Most complaints are answered within **30 calendar days**. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- If you are making a complaint because we denied your request for a *fast coverage decision or* a *fast appeal*, we will automatically give you a ***fast complaint***. If you have a *fast complaint*, it means we will give you an answer within **24 hours**.
- If we do not agree with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

You can submit a complaint about our Plan directly to Medicare. To submit a complaint to Medicare, go to www. medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

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 our website at www.kp.org/postal.

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 PSHB 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.

Please see Section 4, *Your Costs for Covered Services*, for more information about how we pay claims.

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 PSHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant, you can suspend your PSHB coverage to enroll in one of these programs, eliminating your PSHB premium. (OPM does not contribute to any applicable Plan premiums.) For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB 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 or postal 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 PSHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant, you can suspend your PSHB coverage to enroll in one of these state programs, eliminating your PSHB premium. For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB 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 third parties cause illness or injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. 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 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 on 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.

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

Some PSHB Plans already cover some dental and vision services. When you are covered by more than one vision/dental Plan, coverage provided under your PSHB Plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision Plan on BENEFEDS.gov or by phone at (877)-888-3337, (TTY: 1-877-889-5680), you will be asked to provide information on your PSHB Plan so that your Plans can coordinate benefits. Providing your PSHB 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.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- 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.

When you have Medicare

For more detailed information on "What is Medicare?" and "When do I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048) or at www.medicare.gov.

Important Note: Subject to limited exceptions, Postal Service annuitants entitled to Medicare Part A and their eligible family members who are entitled to Medicare Part A are required to enroll in Medicare Part B to maintain eligibility for the PSHB Program in retirement.

If you are required to enroll in Medicare Part B and fail to do so at your first opportunity, you may be disenrolled (annuitants) and/or your family members removed from coverage.

For more information on these requirements, please contact (303)-338-3800.

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 at (303)-338-3600 (toll-free 800-382-4661) (TTY: 711), 9 a.m. to 4 p. m., Monday through Friday, or visit our website at www.kp.org/postal.

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

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.

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 Senior Advantage for Postal Service Members. Senior Advantage for Postal Service Members enhances your PSHB coverage by lowering cost-sharing for some services and/or adding benefits. High and Standard Option members can choose between 2 Medicare Advantage Plans: "Senior Advantage 1" (best benefits) and "Senior Advantage 2" (some better benefits and Part B premium reimbursement). Prosper members have one choice, called “Senior Advantage". 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 Senior Advantage for Postal Service Members. Enrolling in Senior Advantage for Postal Service Members does not change your PSHB premium. Your enrollment is in addition to your PSHB High Option, Standard Option, or Prosper enrollment; however, your benefits will be provided under the Kaiser Permanente Senior Advantage for Postal Service Members Plan and are subject to Medicare rules. If you are already a member of Senior Advantage for Postal Service Members and would like to understand your additional benefits in more detail, please refer to your Senior Advantage for Postal Workers Evidence of Coverage. If you are considering enrolling in Senior Advantage for Postal Service Members, please call us at (800)-476-2167, (TTY: 711), 8 a.m. to 8 p.m., 7 days a week, or visit our website at www.kp.org/postal.

With Kaiser Permanente Senior Advantage for Postal Service Members, you will get more coverage, such as lower cost-sharing and additional benefits. This 2027 benefit summary allows you to make a comparison of your choices:

Medicare Advantage (Part C)

2027 Benefits and Services: Deductible
High Option without Medicare You pay: None

High Option Senior Advantage 1 You pay: None

High Option Senior Advantage 2 You pay: None

Standard Option without Medicare You pay: $150

Standard Option Senior Advantage 1 You pay: None

Standard Option Senior Advantage 2 You pay: None

Prosper without Medicare You pay: $350

Prosper Senior Advantage You pay: None

2027 Benefits and Services: Primary care
High Option without Medicare You pay: $20

High Option Senior Advantage 1 You pay: $5

High Option Senior Advantage 2 You pay: $15

Standard Option without Medicare You pay: $30

Standard Option Senior Advantage 1 You pay: $20

Standard Option Senior Advantage 2 You pay: $30

Prosper without Medicare You pay: $10

Prosper Senior Advantage You pay: $10

2027 Benefits and Services: Specialty care
High Option without Medicare You pay: $30

High Option Senior Advantage 1 You pay: $15

High Option Senior Advantage 2 You pay: $25

Standard Option without Medicare You pay: $40

Standard Option Senior Advantage 1 You pay: $35

Standard Option Senior Advantage 2 You pay: $40

Prosper without Medicare You pay: $35

Prosper Senior Advantage You pay: $35

2027 Benefits and Services: Outpatient surgery
High Option without Medicare You pay: $150/10%

High Option Senior Advantage 1 You pay: $50

High Option Senior Advantage 2 You pay: $150

Standard Option without Medicare You pay: $200/$300 (You pay the deductible, then cost-sharing.)

Standard Option Senior Advantage 1 You pay: $200

Standard Option Senior Advantage 2 You pay: $200

Prosper without Medicare You pay: $275/$375 (You pay the deductible, then cost-sharing.)

Prosper Senior Advantage You pay: $275

2027 Benefits and Services: Inpatient hospital care
High Option without Medicare You pay: $325 per day up to $1,300

High Option Senior Advantage 1 You pay: $100/admit

High Option Senior Advantage 2 You pay: $300/admit

Standard Option without Medicare You pay: $375 per day up to $1,500 (You pay the deductible, then cost-sharing.)

Standard Option Senior Advantage 1 You pay: $250 per day up to $750

Standard Option Senior Advantage 2 You pay: $250 per day up to $750

Prosper without Medicare You pay: 20% (You pay the deductible, then cost-sharing.)

Prosper Senior Advantage You pay: $275 per day up to $1,100

2027 Benefits and Services: Additional benefits offered
High Option without Medicare: Not applicable

High Option Senior Advantage 1: Eyeglasses and contact lenses allowance, hearing aid allowance, acupuncture, preventive dental with a comprehensive allowance, nonemergency transportation, over-the-counter drugs and wellness supplies allowance, and One Pass

High Option Senior Advantage 2: Nonemergency transportation, Eyeglasses and contact lenses allowance, hearing aid allowance, over-the-counter drugs and wellness supplies allowance, and One Pass

Standard Option without Medicare: Not applicable

Standard Option Senior Advantage 1: Nonemergency transportation, Eyeglasses and contact lenses allowance, hearing aid allowance, over-the-counter drugs and wellness supplies allowance, and One Pass

Standard Option Senior Advantage 2: Nonemergency transportation, Eyeglasses and contact lenses allowance, over-the-counter drugs and wellness supplies allowance, and One Pass

Prosper without Medicare: Not applicable

Prosper Senior Advantage: Nonemergency transportation, over-the-counter drugs and wellness supplies allowance, and One Pass

2027 Benefits and Services: Part B Reimbursement
High Option without Medicare: None

High Option Senior Advantage 1: None

High Option Senior Advantage 2: up to $200 monthly

Standard Option without Medicare: None

Standard Option Senior Advantage 1: None

Standard Option Senior Advantage 2: up to $200 monthly

Prosper without Medicare: None

Prosper Senior Advantage: None

2027 Benefits and Services: Out-of-pocket maximum (2x per family)

High Option without Medicare You pay: $5,000 per person

High Option Senior Advantage 1 You pay: $2,200 per person

High Option Senior Advantage 2 You pay: $2,950 per person

Standard Option without Medicare You pay: $6,500 per person

Standard Option Senior Advantage 1 You pay: $2,950 per person

Standard Option Senior Advantage 2 You pay: $3,300 per person

Prosper without Medicare You pay: $8,000 per person

Prosper Senior Advantage You pay: $3,600 per person

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

This Plan and another Plan's Medicare Advantage Plan: You may enroll in another non-PSHB Plan's Medicare Advantage Plan and also remain enrolled in our PSHB 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 PSHB coverage to enroll in a Medicare Advantage Plan: If you are an annuitant, you can suspend your PSHB coverage to enroll in a Medicare Advantage Plan, eliminating your PSHB premium. (OPM does not contribute to your Medicare Advantage Plan premium.) For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB 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.

Medicare prescription drug coverage (Part D)

When we are the primary payor, we process the claim first. If you (as an active employee eligible for Medicare Part D or their covered Medicare Part D-eligible family member) enroll in any open market Medicare Part D Plan and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by that Medicare Part D Plan and consider them for payment under the PSHB Plan.

Note: If you are a Postal Service annuitant or their covered Medicare-eligible family member enrolled in our Medicare Part D PDP EGWP, this does not apply to you because you may not be enrolled in more than one Medicare Part D Plan at the same time. If you opt out of or disenroll from our PDP EGWP you do not have our PSHB Program prescription drug coverage and we are not a secondary payor for prescription drug 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 our Kaiser Permanente Senior Advantage for Postal Workers Plan, you will get all of the benefits of Medicare Part D plus additional drug benefits covered under your PSHB Plan.

Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (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 Postal Service annuitants and their 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. **Note: You have the choice to opt out of or disenroll from our PDP EGWP at any time and may obtain prescription drug coverage outside of the PSHB Program.**

When you are enrolled in our Medicare PDP EGWP for your prescription drug benefits you continue to have our medical coverage.

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 (800)-632-9700.

The PDP EGWP opt out process:

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

- You will lose your Kaiser Permanente prescription drug coverage unless you are enrolling in a Medicare Advantage with Part D Plan offered through the PSHB 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.
- Contact us at (800)-632-9700 for additional information.

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 written notice to the following address:Kaiser Permanente
  California Service Center
  P.O. Box 232400
  San Diego, CA 92193-2400
- When your Medicare Part D Group plan coverage ends, you may continue your PSHB membership if you still meet the requirements for PSHB 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 Postal Service Members or contact us at (800)-632-9700.

Warning: If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage. However, you can enroll in our MAPD during Open Season or for a QLE and receive PSHB Program Prescription Drug Coverage.

To learn more about our MAPD Plans or enroll you can:

- Visit www.kp.org/postal to view benefit details, enroll online, download an enrollment application, or RSVP to attend a seminar.
- Call and speak to a Kaiser Permanente Medicare health plan specialist at (877)-547-4909, (TTY: 711), Monday through Friday, from 6 a.m. to 7 p.m. Pacific Time.

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 (800)-632-9700.

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.

Medicare Part B premium reimbursement

We offer a program designed to help High and Standard Option members with their Medicare Part B premium. This program is called "Senior Advantage 2." For each month you are enrolled in Senior Advantage 2, have Medicare Parts A and B, or Medicare Part B, and are enrolled in Senior Advantage for Postal Workers, you will be reimbursed up to $200 (up to $2,400 per year) of your Medicare Part B monthly premium you pay, including any amount added to your Part B premium for the Part B late enrollment penalty (LEP) or income-related monthly adjustment amount (IRMAA). 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 or Standard Option.
- You live in our Medicare Advantage service area.
- You enroll in Senior Advantage for Postal Workers.
- The PSHB subscriber completes an additional application for enrollment in Senior Advantage 2.

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

To learn more about Senior Advantage 2 and how to enroll, call us at (800)-476-2167, (TTY: 711), 8 a.m. to 8 p.m., 7 days a week, or visit our website at www.kp.org/postal. We will send you additional information and an additional application for enrollment in Senior Advantage 2.

Surrogacy Arrangements

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:

Patient Business Services
Kaiser Foundation Health Plan of Colorado
2500 South Havana Street
Aurora, CO 80014-1622

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.

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 PSHB coverage on your own as an active employee		✓
2) Have PSHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have PSHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Postal Service and your position is excluded from the PSHB (your employing office will know if this is the case) and you are not covered under PSHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Postal Service and your position is not excluded from the PSHB (your employing office will know if this is the case) and...		
• You have PSHB coverage on your own or through your spouse who is also an active employee		✓
• You have PSHB coverage through your spouse who is an annuitant	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a Postal employee receiving Workers' Compensation	✓*	
8) Are a Postal 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 PSHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have PSHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	

*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 cancer, 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 29.

Copayment

See Section 4, page 29.

Cost-sharing

See Section 4, page 29.

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 29.

Experimental or investigational services

We do not cover a service, supply, item or drug that we consider experimental. We consider a service, supply, item, or drug to be experimental when the service, 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 part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial; or is intended to evaluate the safety, toxicity, or efficacy of the service; or
4. is available as the result of a written protocol that evaluates the service's safety, toxicity, or efficacy; or
5. is subject to the approval or review of an Institutional Review Board; or
6. 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 reasonable degree of promise with respect to improving health outcomes. The primary source of evidence about health outcomes of any intervention is peer-reviewed medical or dental 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

All benefits need to be medically necessary in order for them to be covered benefits. Generally, if your Plan physician provides the service in accord with the terms of this brochure, it will be considered medically necessary. However, some services are reviewed in advance of you receiving them to determine if they are medically necessary. When we review a service to determine if it is medically necessary, a Plan physician will evaluate what would happen to you if you do not receive the service. If not receiving the service would adversely affect your health, it will be considered medically necessary. The services must be a medically appropriate course of treatment for your condition. If they are not medically necessary, we will not cover the services. In case of emergency services, the services that you received will be evaluated to determine if they were medically necessary.

Medicare Part A

Part A helps cover inpatient hospital stays, skilled nursing facility care, hospice care, and some health care.

Medicare Part B

Part B covers medically necessary services like doctors' services and tests, outpatient care, home health services, durable medical equipment, and other medical services.

Medicare Part C

Part C is a Medicare Advantage Plan that combines the coverage of Medicare Part A and Part B. Part C typically also covers additional benefits like, dental, vision, and hearing services. Some Part C Plans also include Medicare Part D coverage.

Medicare Part D	Medicare Part D Plans provide coverage for prescription drugs. Private insurers contract with CMS on an annual basis for the right to offer Part D Plans. Part D can be offered as a standalone Prescription Drug Plan (PDP) or as part of a Medicare Advantage Prescription Drug Plan (MAPD).
Medicare Part D EGWP	A Medicare Part D Employer Group Waiver Plan (EGWP) is a type of Medicare prescription drug plan that can be offered to employees and retirees of certain companies, unions, or government agencies, which allows for flexibility and enhanced coverage of traditional Medicare pharmacy benefits. Examples of Medicare Part D EGWPs are Medicare Advantage Prescription Drug (MAPD) Plan EGWPs that include both health and drug benefits, as well as Prescription Drug Plan (PDP) EGWPs, which only cover the prescription drug benefit.
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 or state surprise billing laws, the amount that we are required to pay (see Section 4 for more information about surprise billing). • 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.
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 out of the payment to the extent of the benefits initially paid or 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 nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating 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 usually 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 Member Services at (303)-338-3800 or toll-free (800)-632-9700 (TTY 711). 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 Colorado.

You

You refers to the enrollee and each covered family member.

Index

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 - Colorado- 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 PSHB 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/postal.

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 providers, except in emergencies.

The High Option has no deductible.

High Option Benefits	You pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	$20 per primary care office visit $30 per specialty care office visit	36
Services provided by a hospital: • Inpatient	$325 per day up to $1,300 maximum per admission	73
Services provided by a hospital: • Outpatient	10% coinsurance of our allowable amount	74
Emergency benefits: • Medical emergency	$300 per visit	79
Mental health and substance use disorder treatment**:**	Regular cost-sharing.	82
Prescription drugs (up to a 30-day supply)	$15 preferred generic drugs; $50 preferred brand name drugs; $75 non-preferred drugs; $175 specialty drugs. Up to a 90-day supply of maintenance drugs for 2 copays through our mail order program.	90
Prescription drugs - PDP (EGWP)	$15 preferred generic drugs; $40 preferred brand name drugs; $60 non-preferred drugs; $100 specialty drugs. Up to a 100-day supply of maintenance drugs for 2 copays through our mail order program.	99
Diagnostic and preventive dental care:	All charges	106
Vision care: • Eye exam	$20 per primary care office visit; $30 per specialty care office visit	55
Special features: Flexible benefits option; 24-hour advice line; Centers of Excellence; Services from other Kaiser Permanente regions; Dependent coverage outside the service area; Travel benefit; Rewards	See Section 5(h) for more information.	107
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after $5,000 per person or $10,000 per family enrollment per year. Some costs do not count toward this protection.	30

Summary of Benefits for the Standard Option of Kaiser Permanente - Colorado - 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 PSHB 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/postal.

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 providers, except in emergencies.

• Below, an asterisk (*) means the item is subject to the $150 per person ($300 per family) calendar year deductible.

Standard Option Benefits	You pay	Page
Calendar year deductible for covered services	$150 per person, up to $300 per family	29
Medical services provided by physicians: Diagnostic and treatment services provided in the office	$30 (nothing for children through age 17) per primary care visit $40 per specialty care visit	36
Services provided by a hospital: • Inpatient	$375 per day*, up to $1,500 per admission, except nothing for maternity care delivery	73
Services provided by a hospital: • Outpatient	$300*	74
Emergency benefits: • Medical emergency	$400*	79
Mental health and substance use disorder treatment:	Regular cost-sharing	82
Prescription drugs (up to a 30-day supply)	$5 preventive maintenance drugs; $15 preferred generic drugs; $60 preferred brand name drugs; $80 non-preferred drugs; $250 specialty drugs. Up to a 90-day supply of maintenance drugs for 2 copays through our mail order program.	90
Prescription drugs - PDP (EGWP)	$5 preventive maintenance drugs; $15 preferred generic drugs; $45 preferred brand name drugs; $70 non-preferred drugs; $200 specialty drugs. Up to a 100-day supply of maintenance drugs for 2 copays through our mail order program.	99
Diagnostic and preventive dental care:	All charges	106
Vision care: • Eye exam	$30 per primary care office visit; $40 per specialty care office visit	55
Special features: Flexible benefits option; 24-hour advice line; Centers of Excellence; Services from other Kaiser Permanente regions; Dependent coverage outside the service area; Travel benefit; Rewards	See Section 5(h) for more information.	107

Standard Option Benefits	You pay	Page
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after $6,500 per person or $13,000 per family enrollment per year. Some costs do not count toward this protection.	30

Summary of Benefits for Prosper Kaiser Permanente - Colorado - 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 PSHB 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/postal.

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 providers, except in emergencies.

Below, an asterisk (*) means the item is subject to the $350 per person ($700 per family) calendar year deductible.

Prosper Benefit Options	You pay	Page
Calendar year deductible for covered services	$350 per person, up to $700 per family	29
Medical services provided by physicians: Diagnostic and treatment services provided in the office	$10 per primary care visit $35 per specialty care visit	36
Services provided by a hospital: Inpatient	20% of our allowance*	73
Services provided by a hospital: Outpatient	$375*	74
Emergency benefits:	$450*	79
Mental health and substance use disorder treatment:	Regular cost-sharing	82
Prescription drugs (up to a 30-day supply):	$5 preventive maintenance drugs; $15 preferred generic drugs; $70 preferred brand name drugs; $100 non-preferred drugs; $350 specialty drugs. Up to a 90-day supply of maintenance drugs for 2 copays through our mail order program.	90
Prescription drugs - PDP (EGWP)	$5 preventive maintenance drugs; $15 preferred generic drugs; $45 preferred brand name drugs; $80 non-preferred drugs; $300 specialty drugs. Up to a 100-day supply of maintenance drugs for 2 copays through our mail order program.	99
Diagnostic and preventive dental care:	All charges	106
Vision care: Eye exam	$10 per primary care office visit; $35 per specialty care office visit	55
Special features: Flexible benefits option; 24-hour advice line; Centers of Excellence; Services from other Kaiser Permanente regions; Dependent coverage outside the service area; Travel benefit; Rewards	See Section 5(h) for more information.	107
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after $8,000 per person or $16,000 per family enrollment per year. Some costs do not count toward this protection.	30

2027 Rate Information for Kaiser Permanente - Colorado - PSHB

To compare your PSHB health plan options please go to https://health-benefits.opm.gov/PSHB/.

To review premium rates for all PSHB health plan options please go to **https ://www. opm.gov/healthcare-insurance/pshb/premiums/.**

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
High Option Self Only	M8A	$318.23	$122.21	$689.50	$264.79
High Option Self Plus One	M8C	$689.34	$306.04	$1,493.57	$663.09
High Option Self and Family	M8B	$748.55	$334.93	$1,621.86	$725.68
Standard Option Self Only	M8D	$251.30	$83.77	$544.49	$181.50
Standard Option Self Plus One	M8F	$567.95	$189.32	$1,230.56	$410.19
Standard Option Self and Family	M8E	$618.20	$206.07	$1,339.44	$446.48
Prosper Self Only	NCA	$176.60	$58.86	$382.62	$127.54
Prosper Self Plus One	NCC	$399.10	$133.03	$864.71	$288.24
Prosper Self and Family	NCB	$434.42	$144.81	$941.25	$313.75