Kaiser Permanente - Washington Core - PSHB

www.kp.org/postal

Member Services 888-901-4636

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 page 8 for details. This Plan is accredited. See page 14.

Serving: Most of Washington State and Northern Idaho

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 14 for requirements.

Only Postal Employees and Annuitants may enroll in this plan.

Enrollment codes for this Plan:

PRA High Option - Self Only
PRC High Option - Self Plus One
PRB High Option - Self and Family

PRD Standard Option - Self Only
PRF Standard Option - Self Plus One
PRE Standard Option - Self and Family

DWD Prosper - Self Only
DWF Prosper - Self Plus One
DWE 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

RI 73-924

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

The Office of Personnel Management (OPM) has determined that the Kaiser Foundation Health Plan of Washington's Plan prescription drug coverage for active employees meets the Center 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 and 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 800-325-0778.

Additional Premium for Medicare's High Income Members
Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your 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 - Washington Core-PSHB under contract (CS1043 PS) between Kaiser Foundation Health Plan of Washington 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 888-901-4636 or through our website: www.kp.org/postal.

The address for Kaiser Foundation Health Plan of Washington's administrative office is:

Kaiser Foundation Health Plan of Washington
2715 Naches Ave., SW
Renton, WA 98057

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/Medicare 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 this 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 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 Washington.
- 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 Health Care 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 888-901-4636 and explain the situation.

If we do not resolve the issue:

CALL - THE HEALTHCARE FRAUD HOTLINE
877-499-7295
OR go towww. 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)

A carrier 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, or sex, pregnancy, or genetic information.

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

Preventing Medical Mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

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

3. Get the results of any test or procedure.

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

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

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

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

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

  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www. jointcommission.org/speakup.aspx. The Joint Commission’s Speak Up™ patient safety program.
- www. jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www. ahrq.gov/patients-consumers. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- 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. 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. 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. 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. A carrier 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 covered 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 www.Medicare.gov or call 800 - MEDICARE (800) 633-4227, TTY (877) 486-2048 or call Members Services at 888-901-4636 (TTY: 711).

- **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 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 PSHB 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 PSHB 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/#url=Health. 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 888-901-4636 (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 800-833-6388 or 711 or visit our website at www.kp.org/postal.

- **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 Washington holds the following accreditations: National Committee for Quality Assurance (NCQA). To learn more about this Plan's accreditation(s), please visit the following websites: www. ncqa.org. We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care 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, a Standard Option, a Consumer Driven Health Plan (CDHP), or a High Deductible Health Plan (HDHP).

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

On High Option, Standard Option and Prosper, when you receive covered services, you will be responsible for a copayment or a coinsurance unless the service is covered in full. There is no dental coverage on this Plan. See Section 5 for Plan specifics.

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).

Who provides my healthcare?

Kaiser Foundation Health Plan of Washington is a Mixed Model Prepayment (MMP) Plan. The Plan provides medical care by doctors, nurse practitioners, and other skilled Medical personnel working as medical teams. Specialists are available as part of the medical teams for consultation and treatment.

In some of the Kaiser Foundation Health Plan of Washington Service areas, participating providers are practitioners who provide routine care within their private office settings in the community.

The first and most important decision each member must make is the selection of a primary care provider. The decision is important since it is usually through this provider that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care provider to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other providers are covered only when there has been a Plan approved written referral by the member's primary care provider, with the following exception: a member may see a participating General and Family Practitioner, Physician's Assistant, Gynecologist, Certified Nurse Midwife, Doctor of Osteopathy, Obstetrician or Advanced Registered Nurse Practitioner who provide healthcare services directly, without a referral from their primary care provider, for medically appropriate maternity care, reproductive health services, preventive care and general examination, gynecological care and medically appropriate follow-up visits for the above services. If your chosen provider diagnoses a condition that requires referral to other specialists or hospitalization, you or your chosen provider must obtain preauthorization and care coordination in accordance with applicable Plan requirements.

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 to Washingtonians since 1947.
- This medical benefit Plan is provided by Kaiser Foundation Health Plan of Washington. Medical, hospital and administrative services are provided through our integrated healthcare delivery organization known as Kaiser Permanente. Kaiser Permanente is composed of Kaiser Foundation Health Plan, Inc. (a not-for-profit organization), and the Washington Permanente Medical Group (a for-profit Washington-based partnership) which operates Plan medical offices throughout Washington.

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 Washington Core 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 888-901-4636, or write to Kaiser Foundation Health Plan of Washington, Member Services, P.O. Box 34590, Seattle WA 98124-1590. 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 Kaiser Permanente Washington Core website at www. 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.

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:

Western Washington (entire counties): Island, King, Kitsap, Lewis, Mason, Pierce, Skagit, Snohomish, Thurston, and Whatcom.

In Grays Harbor County, the following cities, by Zip Code:

- Elma (98541)
- Malone (98559)
- McCleary (98557)
- Oakville (98568)

In Jefferson County, the following cities, by Zip Code:

- Brinnon (98320)
- Chimacum (98325)
- Hadlock (98339)
- Nordland (98358)
- Port Ludlow (98365)
- Port Townsend (98368)
- Quilcene (98376)

Central and Eastern Washington (entire counties): Benton, Columbia, Franklin, Kittitas, Spokane, Walla Walla, Whitman, and Yakima.

Northern Idaho (entire counties): Kootenai and Latah

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 care from designated providers in that area. See Section 5(h), *Special features*, for more details. We also pay for certain follow-up services or continuing care services while you are traveling outside the service area, as described in Section 5(h); and for emergency care obtained from any non-Plan provider, as described in Section 5(d), *Emergency services/accidents*. We will not pay for any other healthcare services out of our service area unless the services have prior Plan approval.

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 Page 125.
- **Preventive care, adult: Cervical cancer screening.** We added follow-up testing after an initial cervical cancer screening, including cytology, biopsy, pathology, extended genotyping, and dual stain testing when needed at no cost to members. See Section 5(a), Page 32.
- **Emergency services/Accidents.** We increased the amount you pay for emergency care See Section 5(d), Page 67.
  - High Option: $200 per visit.
  - Standard Option: $250 per visit.
  - Prosper: $300 per visit after the deductible.
- **Sex-Trait Modification.** We removed the exception process for coverage of excluded Sex-Trait Modification services for members age 19 and older who are mid-treatment within a surgical and/or hormonal regimen for diagnosed gender dysphoria. See Sections 3, 5(b), 5(f), and 6, Pages 21, 54, 74, and 95.
- **Non-emergency medical transportation (NEMT).** We added no-cost coverage for non-emergency medical transportation using stretcher/gurney or wheelchair vans when medically necessary, authorized, and ordered by a Plan provider. See Section 5(c), Page 65.
- **Hormone therapy.** We increased the supply limit for prescription hormone therapy to 12 months when dispensed at one-time. See Section 5(f), Page 74.
- **Orthopedic and prosthetic devices.** We removed the current limit of two externally worn breast prostheses and surgical bras every six months following a mastectomy. See Section 5(a), Page 49.

Changes to High Option and Standard Option

- **Catastrophic out-of-pocket maximum.** We increased the catastrophic maximums. See Section 4, Page 26.
  - High Option: $4,000 per person up to $8,000 per family enrollment.
  - Standard Option: $10,000 per family enrollment.

Changes to Standard Option

- **Primary care.** We increased the copayment to $30 per office visit while continuing to provide no charge for children through age 17. We also increased the primary care group office visit copayment to $15 per visit for physical therapy, occupational therapy, and speech therapy group visits. See Section and 5(a), Page 31.

Changes to Prosper

- **Deductible.** We increased the calendar year deductible to $350 per person and $700 under the Self Plus One or Self and Family. See Sections 4, 5 and 9, Pages 25, 30, and 30.
- **Inpatient hospital: delivery.** We increased inpatient admission copayment to $750 per admission for delivery. See Section 5(c), Page 62.
- **Inpatient hospital.** We increased the copayment members pay for inpatient admission to $750 per day up to $2,250 per admission after the deductible. See Section 5(c), Page 62.

Changes to Prescription Drug Plan (PDP) EGWP

- **Hormone therapy drugs.** We increased the supply limit a member may obtain at once for prescriptions for hormone therapy drugs. You may obtain up to a 12-month supply of drugs for hormone replacement therapy at a Plan pharmacy or through the mail-delivery program. See Section 5(f)(a), Page 82.
- **PDP 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), Page 82.
- **PDP Part D out-of-pocket maximum.** We increased the Part D prescription drug out-of-pocket maximum (OOP) to $2,400 per calendar year to align with CMS guidelines. See Section 5(f)(a), Page 82.

Changes to Medicare Advantage:

- **Medicare Advantage hormone therapy drugs.** We increased the supply limit to up to a 12-month supply for prescriptions for hormone therapy drugs at a Plan pharmacy or through the mail-delivery program.
- **Medicare Advantage prescription drug dispensing limit.** We increased the dispensing limit for prescription drugs from up to a 90-day supply to up to a 100-day supply for most medications dispensed through our retail pharmacies or our mail order pharmacy programs.
- **Non-emergency medical transportation (NEMT).** We added no-cost coverage for non-emergency medical transportation (NEMT) using stretcher/gurney or wheelchair vans when medically necessary, authorized, and ordered by a Plan provider.
- **Medicare Advantage Part D out-of-pocket maximum.** We increased the Part D prescription drug out-of-pocket maximum (OOP) to $2,400 per calendar year to align with CMS guidelines.
- **Transportation services.** We increased the number of covered round trips available each calendar year from six to ten when transportation is provided by a designated transportation provider.

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, please call Member Services at 888-901-4636. 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 copayments, deductibles, and/or coinsurance as described in Section 4. *Your Cost for Covered Services.*

Balance billing protection

PSHB Carriers must have clauses in their in-network (participating) 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 in-network 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 an in-network 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 Washington Permanente Medical Group (Medical Group) 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. 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. Directories are available at the time of enrollment or upon request by calling our Member Service at 888-901-4636 (TTY: 711). The list is also on our website at www.kp.org/postal.

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.

Kaiser Permanente primary care providers provide care coordination for complex conditions. For assistance, please contact your provider or member services at 888-901-4636 (TTY: 711).

Plan facilities

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. Kaiser Permanente offers comprehensive healthcare at Plan facilities conveniently located throughout our service areas.

We list Plan facilities in the facility directory, with their locations and phone numbers. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling our Member Service Call Center at 800-464-4000 (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), *Special features*, for more details. Under the circumstances specified in this brochure, you may receive follow-up or continuing care while you travel anywhere.

What you must do to get covered care

You and each family member should choose a primary care provider. This decision is important since your primary care provider provides or arranges for most of your healthcare. There are several ways to select a physician; you may contact Member Services at 888-901-4636 or your chosen Plan facility for assistance.

Primary care

Your primary care provider (such as family practitioner or pediatrician) will arrange for most of your healthcare, or give you a referral to see a specialist.

If you want to change primary care providers or if your primary care provider leaves the Plan, call Member Services at 888-901-4636 or contact your chosen Plan facility. We will help you select a new one.

Specialty care

Your primary care provider will refer you to a specialist for needed care. When you receive a referral from your primary care provider, you must return to the primary care provider after the consultation, unless your primary care provider authorized a certain number of visits without additional referrals. The primary care provider must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care provider gives you a referral.

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 will 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 physician may have to get an authorization or approval beforehand).

Your primary care provider will create your treatment plan. The provider may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care provider. 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 arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- 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 program Plan (or become covered as a family member under an FEHB enrollment); or
  - we terminate our contract with your specialist for other than cause;
  - we reduce our service area and you enroll in another PSHB Plan;

Contact our Member Services Department at 888-901-4636 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 888-901-4636. 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.

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.

You need prior Plan approval for certain services

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

- Specialty care
- Inpatient hospital
- Surgical treatment of morbid obesity
- Certain prescription medications as identified on our formulary
- Non-emergency ambulance
- Durable Medical Equipment
- Infusion therapy

To confirm if a referral has been approved for a service or item that requires prior authorization, please call Member Service at 888-901-4636 (TTY: 711). 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.

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 888-901-4636 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

Non-urgent care claims

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

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

Urgent care claims

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

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide 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 888-901-4636. 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 888-901-4636. 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 inpatient admission

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

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 when using non-Plan facilities

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

Circumstances beyond our control

Under certain 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 888-901-4636.

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), *Medicare PDP EGWP Disputed Claims Process* for information about the PDP EGWP appeal process.

Section 4. Your Cost for Covered Services

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

Cost-sharing

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

Copayments

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

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

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

- Under the High Option, you pay a $25 copayment when you receive diagnostic and treatment services in a physician's office.
- Under the Standard Option, you pay a $30 copayment when you receive diagnostic and treatment services from a primary care provider or a $35 copayment when you receive diagnostic and treatment services from a specialty care provider.
- Under Prosper, you pay a $15 copayment when you receive diagnostic and treatment services from a primary care provider and a $40 copayment when you receive these services from a specialty care provider.

Deductible

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

- We do not have a deductible for the High Option and 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.

Annual Deductible Carryover: Under Prosper, charges from the last 3 months of the prior year which were applied toward the individual annual deductible will also apply to the current year individual annual deductible. The individual annual deductible carryover will apply only when expenses incurred have been paid in full. The Family deductible does not carry over into the next year.

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

We have different coinsurance percentages for some benefits, and in those cases, we specify the percentage that you must pay. For example, there is a 50% coinsurance for certain types of infertility services. Durable medical equipment and ambulance services are other services that require you to pay a coinsurance.

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 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

$4,000 per person up to $8,000 per family enrollment

Standard Option

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

Prosper

$6,000 per person up to $12,000 per family enrollment

Your out-of-pocket maximum may differ if you changed plans at Open Season.

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 indicated in Section 5(f)(a), PDP EGWP Prescription Drug Benefits.

If you are enrolled in our Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP), the prescription drug true out-of-pocket (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 that 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 old option to the catastrophic protection limit of your new option.

When Government facilities bill us

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

Important Notice About Surprise Billing – Know Your Rights

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

A surprise bill is an unexpected bill you receive for:

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

Balance billing happens when you receive a bill from the non-Plan provider, facility, or air ambulance service for the difference between the non-Plan 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 Washington and RCW 48.49.030(2).

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 800-464-4000.

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 and Standard Option Benefits Overview

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

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 our benefits, contact us at 888-901-4636 or on our website at www. kp.org/postal.

Each option offers unique features.

High Option

The High Option covers most outpatient services subject to a copayment. Select services are covered subject either to a copayment or to a coinsurance and some services are covered in full. See Section 5 for Plan specifics.

Specific benefits of our PSHB High Option include:

- No deductible
- Primary care office visit copayment is $25
- Specialty care office visit copayment is $25
- Drug cost-sharing: $20 for preferred generic drugs, $60 for non-preferred generic drugs, $40 for preferred brand name drugs, $60 for non-preferred brand name drugs, and 25% of our allowance up to $200 for preferred specialty drugs per prescription or refill for up to a 30-day supply at a Plan pharmacy.
- $25 for Chiropractic services - 20 visits per year

Standard Option

The Standard Option covers some services, such as specialty care and hospital services, at a higher copayment than on the High Option. Select services are covered subject either to a copayment or to a coinsurance and some services are covered in full. See Section 5 for Plan specifics.

Specific benefits of our PSHB Standard Option include:

- Primary care office visit copayment is $30, and nothing for children through age 17.
- Specialty care office visit copayment is $35
- Drug cost-sharing: $20 for preferred generic drugs, $60 for non-preferred generic drugs, $40 for preferred brand name drugs, $60 for non-preferred brand name drugs, and 25% of our allowance up to $200 for preferred specialty drugs per prescription or refill for up to a 30-day supply at a Plan pharmacy.
- $25 for Chiropractic services - 20 visits per year. Nothing for children through age 17.

Prosper

With Prosper, there is a calendar year deductible of $350 per person ($700 per Self Plus One or Self and Family) and your cost-sharing may be higher than for the Standard Option; however, your bi-weekly premium contribution is lower.

Specific benefits to Prosper:

- Primary care office visit copayment is $15
- Specialty care office visit copayment is $40
- Drug cost-sharing: $20 for preferred generic drugs, $100 for non-preferred generic drugs, $60 for preferred brand name drugs, $100 for non-preferred brand name drugs, and 35% of our allowance up to $300 for preferred specialty drugs per prescription or refill for up to a 30-day supply at a Plan 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:

- Kaiser Permanente is inherently a collaborative care model; this is facilitated by our integration of care and coverage, our shared electronic health record (EHR), 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 EHR 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.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible for High Option and Standard Option.
- The calendar year deductible for Prosper 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 Costs for Covered Services,* for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.
- 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 almost all benefits in this Section. We say "(No deductible)" when it does not apply.			
Diagnostic and treatment services	**High Option**	**Standard Option**	**Prosper**
Professional services of physicians and other healthcare professionals • In provider's office • In an urgent care center • Office medical consultation • Second surgical opinion	$25 per office visit	$30 per primary care office visit (nothing for children through age 17) $35 per specialty care office visit	$15 per primary care office visit $40 per specialty care office visit
Procedures received during an office visit	Nothing after you pay the office visit copayment	Nothing after you pay the office visit copayment	Nothing after the deductible
Professional services of physicians • During a hospital stay • In a skilled nursing facility • Advanced care planning • At home	Nothing	Nothing	Nothing

Benefit Description	You pay		
Telehealth services	**High Option**	**Standard Option**	**Prosper**
Professional services of physicians and other healthcare professionals delivered through telehealth, such as: • Interactive videos • 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	Nothing	Nothing	Nothing
• X-ray, including diagnostic mammography and digital breast tomosynthesis/3D mammography following a breast cancer diagnosis • Ultrasound, including breast ultrasound following a breast cancer diagnosis • Electrocardiogram, EEG and echocardiogram	Nothing	Nothing	$50 per visit
• CT/CAT scan • MRI, including breast magnetic resonance imaging (MRI) following a breast cancer diagnosis • PET scan	Nothing	$100 per visit	$150 per visit
Preventive care, adult	**High Option**	**Standard Option**	**Prosper**
Routine physical according to the Plan's adult well-care schedule **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 screening. For a complete list of screenings go to the website at https ://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations	Nothing	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay		
Preventive care, adult (cont.)	**High Option**	**Standard Option**	**Prosper**
• Screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https ://www. uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Services such as routine prostate specific antigen (PSA) test and retinal photography screening • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal, intimate partner, and domestic violence. 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, including preventive mammography, digital breast tomosynthesis/3D mammography, breast magnetic resonance imaging (MRI), or breast ultrasound • Diagnostic and supplemental breast imaging preceding a breast cancer diagnosis, including preventive mammography, digital breast tomosynthesis/3D mammography, breast magnetic resonance imaging (MRI), or breast ultrasound	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:	Nothing	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay		
Preventive care, adult (cont.)	**High Option**	**Standard Option**	**Prosper**
• 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. • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. Family-centered programs include Healthy Eating, Active Living (HEAL) program offered by Kaiser Permanente to help children and teens aged 3-17 years old and their families make lasting healthy lifestyle choices to help maintain a healthy weight. HEAL offers 6–12-month programs on healthy lifestyle changes, healthy cooking courses, and recommended physical activity. The HEAL program is available to any patient with a BMI>85%.	Nothing	Nothing	Nothing

Preventive care, adult - continued on next page

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

Preventive care, adult - continued on next page

Benefit Description	You pay		
Preventive care, adult (cont.)	**High Option**	**Standard Option**	**Prosper**
Notes: • There are no frequency/visit limitations, services are based on medical necessity • See Section 5(h) for additional optional programs under Wellness and Other Special Features • When anti-obesity medication is prescribed, see Section 5(f) or Section 5(f)(a) • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity, see Section 5(b)	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 Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing	Nothing	Nothing
Notes: • You may pay cost-sharing for any procedure, injection, diagnostic service, laboratory or X-ray service that is provided in conjunction with a routine physical exam and not included in the preventive recommended listing of services. • You should consult with your physician to determine what is appropriate for you.	Applies to this benefit	Applies to this benefit	Applies to this benefit
Not covered: • *Physical exams and immunizations required for:* - *obtaining or continuing employment or insurance* - *attending schools or camp* - *athletic exams* • *Immunizations, boosters, and medications for travel or work-related exposure*	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
Preventive care, children	**High Option**	**Standard Option**	**Prosper**
• 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/imz-schedules/index.html • You can also find a complete list of A and B recommended preventive care services under the U.S. Preventive Services Task Force (USPSTF) online at www.uspreventiveservicestaskforce.org • We cover other preventive services required by federal healthcare reform legislation (the Affordable Care Act and implementing regulations) and additional services that we include in our preventive services benefit. For a complete list of Kaiser Permanente preventive services visit our website at www. kp.org/prevention • To build your personalized list of preventive services go to www. health.gov/myhealthfinder 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 not included in the preventive recommended listing of 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, children - continued on next page

Benefit Description	You pay		
Preventive care, children (cont.)	**High Option**	**Standard Option**	**Prosper**
Kaiser Permanente's unique integrated model of care and coverage enables us to provide whole-person care that meets the unique needs of each individual patient, without coverage limitations or strict eligibility criteria. Our approach to weight management with our patients includes lifestyle modification programs when clinically appropriate. All Kaiser Permanente regions offer lifestyle programs that align with USPSTF recommendations for program duration, including providing the required 26 or more contact hours over 3 to 12 months, to support members in their weight management journey. Additionally, our physicians work with patients to determine the appropriate length of program participation to meet their unique needs. We offer several aspects of an Intensive Behavioral Treatment program to our adolescent and pediatric members, including: medical nutritional therapy by registered dieticians, behavioral therapy by a pediatric psychologist, and supervised physical activity by a pediatric physical therapist. Members are offered individual or group-based training. 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.	Nothing	Nothing	Nothing

Preventive care, children - continued on next page

Benefit Description	You pay		
Preventive care, children (cont.)	**High Option**	**Standard Option**	**Prosper**
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 co-morbidities are automatically enrolled in the relevant disease management program within our system and will receive personalized support to manage their condition. Visit kp.org/classes for more information, or see Section 5(h), Wellness and Other Special Features, for nutritional and behavioral lifestyle support details. • Visit www. kp.org/postal to review additional information on Kaiser Permanente's requirements for weight loss medications and weight loss programs. Notes: • There are no frequency/visit limitations, services are based on medical necessity • See Section 5(h) for additional optional programs under Wellness and Other Special Features • 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**
Routine maternity (obstetrical) care, such as: • Prenatal and postpartum care • Screening for gestational diabetes • Delivery • Screening and counseling for prenatal and postpartum depression • Breastfeeding and lactation support, supplies and counseling for each birth Note: We cover breastfeeding pumps and supplies under Durable Medical Equipment (DME).	Nothing for routine prenatal and postpartum care Non-routine care: $25 per office visit Nothing for inpatient professional delivery services	Nothing for routine prenatal and postpartum care Non-routine care: $30 per primary care office visit (nothing for children through age 17) $35 per specialty care office visit Nothing for inpatient professional delivery services	Nothing for routine prenatal and postnatal care Non-routine care:$15 per primary care office visit $40 per specialty care office visit Nothing for inpatient professional delivery services
• As part of your coverage, you have access to in-network certified nurse midwives, home nurse visits and board-certified lactation specialists during the prenatal and post-partum period.	Nothing	Nothing	Nothing
Notes: Here are some things to keep in mind: • 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. • 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. We cover routine circumcision under Preventive care, children. • 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 (delivery) and non-maternity care the same as for illness and injury.	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**
• Hospital services are covered under Section 5(c) and Surgery benefits Section 5(b). • See *Section 5(a), Diagnostic and treatment services*, Procedures received during an office visit. • 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.	Applies to this benefit	Applies to this benefit	Applies to this benefit
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: • Contraceptive counseling • Voluntary female sterilization • Intrauterine devices (IUDs) - insertion • Diaphragms - fittings • Oral contraceptives • Implantable contraceptives • Injectable contraceptives (such as Depo Provera) • Voluntary male sterilization Notes: • See Section 5(b), Surgical and Anesthesia Services for coverage of voluntary sterilization and section 5(f), Prescription Drug Benefits for oral contraceptives and devices such as diaphragms.	Nothing	Nothing	Nothing

Family planning - continued on next page

Benefit Description	You pay		
Family planning (cont.)	**High Option**	**Standard Option**	**Prosper**
• Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA- supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below. • Kaiser Permanente physicians prescribe the appropriate level of medically necessary 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. • 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 have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. • 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
Not covered:	*All charges*	*All charges*	*All charges*

Family planning - continued on next page

Benefit Description	You pay		
Family planning (cont.)	**High Option**	**Standard Option**	**Prosper**
• *Reversal of voluntary or involuntary surgical sterilization*	*All charges*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**	**Prosper**
Infertility is the inability of an individual to conceive or produce conception during a period of 1 year if the female is age 35 or younger, or during a period of 6 months if the female is over the age of 35, or having a medical or other demonstrated condition that is recognized by a Plan physician as a cause of infertility. Diagnosis and treatment of infertility, such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Fertility preservation for iatrogenic infertility: - Procurement of sperm or eggs including medical, surgical, and pharmacy claims associated with retrieval; - Cryopreservation of sperm and mature oocytes; and - Cryopreservation storage costs for 1 year. • Semen analysis • Hysterosalpingogram • Hormone evaluation Notes: • See Section 5(f), *Prescription Drug Benefits*, for coverage of fertility drugs.	50% of our allowance	50% of our allowance	50% of our allowance after the deductible
• Fertility preservation for iatrogenic infertility, such as: - Procurement of sperm and eggs including medical, surgical, and pharmacy claims associated with retrieval; - Cryopreservation of sperm and mature oocytes; and - Cryopreservation storage costs for 1 year.	50% of our allowance	50% of our allowance	50% of our allowance after the deductible
Not covered: *These exclusions apply to fertile as well as infertile individuals or couples:*	*All charges*	*All charges*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay		
Infertility services (cont.)	**High Option**	**Standard Option**	**Prosper**
• *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization (IVF)* - *embryo transfer, gamete intra-fallopian transfer (GIFT), and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to excluded ART procedures* • *Any charges associated with donor eggs or donor sperm* • *Any charges associated with cryopreservation, unless listed as covered above for iatrogenic infertility* • *Any charges associated with thawing and storage of frozen sperm and eggs, unless listed as covered above for iatrogenic infertility* • *Services related to surrogate arrangements*	*All charges*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**	**Prosper**
• Testing and treatment • Note: See *Section 5(a), Diagnostic and treatment services,* Procedures received during an office visit.	$25 per office visit	$30 per primary care office visit (nothing for children through age 17) $35 per specialty care office visit	$15 per primary care office visit $40 per specialty care office visit
• Allergy injections • Allergy Serum	Nothing	Nothing	Nothing
Not covered: • *Any testing or treatment that does not meet Plan protocols*	*All charges*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**	**Prosper**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/ Tissue Transplants Section 5(b). • Respiratory and inhalation therapy • Cardiac rehabilitation following qualifying event/condition • Dialysis – hemodialysis and peritoneal dialysis • Infusion therapy in a medical office or outpatient hospital facility	$25 per office visit	$30 per primary care for individual office visit (nothing for children through age 17) $35 per specialty care office visit	$15 per primary care office visit $40 per specialty care office visit

Treatment therapies - continued on next page

Benefit Description	You pay		
Treatment therapies (cont.)	**High Option**	**Standard Option**	**Prosper**
• Ultraviolet light treatments Notes: • See *Section 5(a), Diagnostic and treatment services*, Procedures received during an office visit. • See *Section 5(f), Prescription drugs* for coverage of growth hormone therapy drugs. • See *Section 5(e), Professional services*, for coverage of Applied Behavior Analysis (ABA)	$25 per office visit	$30 per primary care for individual office visit (nothing for children through age 17) $35 per specialty care office visit	$15 per primary care office visit $40 per specialty care office visit
• Infusion therapy at home: Professional services of physicians and other healthcare professionals, equipment and supplies	Nothing	Nothing	Nothing
• Infusion therapy at home: Medication	Nothing	Nothing	Nothing after the deductible
• Amino acid modified products for the treatment of inborn errors of metabolism, such as phenylketonuria (PKU)	Nothing	Nothing	Nothing
• Enteral supplements and formula when it is the sole or an essential source of nutrition Note: See *Section 5(a), Durable medical equipment (DME)* for coverage of equipment and supplies.	20% of our allowance	20% of our allowance	20% of our allowance
• Parenteral supplements and formula when it is the sole source or essential source of nutrition Note: See *Section 5(a), Durable medical equipment (DME)* for coverage of equipment and supplies.	Nothing	Nothing	Nothing
Not covered: • *Over-the-counter formulas*	*All charges*	*All charges*	*All charges*
Physical and occupational therapies	**High Option**	**Standard Option**	**Prosper**
Up to 60 combined visits for rehabilitative or habilitative care per condition per calendar year for physical, occupational, massage, pulmonary, and speech therapy. Services must be provided by qualified physical, occupational, speech, pulmonary or massage therapists. This visit limit does not apply to rehabilitative or habilitative care for the treatment of mental health conditions, including neurodevelopmental therapy.	$25 per individual office visit $12 per group office visit See Section 5(c) for Hospital charges	$30 per primary care individual and $15 per primary care group office visit (nothing for children through age 17) $35 per specialty care individual and $17 per specialty care group office visit	$15 per primary care individual and $7 per primary care group office visit $40 per specialty care individual and $20 per specialty care group office visit

Physical and occupational therapies - continued on next page

Benefit Description	You pay		
Physical and occupational therapies (cont.)	**High Option**	**Standard Option**	**Prosper**
		See Section 5(c) for Hospital charges	See Section 5 (a), *Diagnostic and treatment services,* Procedures received during an office visit. See Section 5(c) for Hospital charges
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**	**Prosper**
Up to 60 combined visits for rehabilitative or habilitative care per condition per calendar year for physical, occupational and speech therapy. Services must be provided by qualified physical, occupational, speech or massage therapists. This visit limit does not apply to rehabilitative or habilitative care for the treatment of mental health conditions, including neurodevelopmental therapy.	$25 per individual office visit $12 per group office visit See Section 5(c) for Hospital charges	$30 per primary care individual and $15 per primary care group office visit (nothing for children through age 17) $35 per specialty care individual and $17 per specialty care group office visit See Section 5(c) for Hospital charges	$15 per primary care individual and $7 per primary care group office visit $40 per specialty care individual and $20 per specialty care group office visit See *Section 5(a), Diagnostic and treatment services,* Procedures received during an office visit. See Section 5(c) for hospital 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., audiologist, or other provider in a physician's office. • Testing and examinations for hearing aids Notes: For coverage of hearing screenings, see Section 5(a), *Preventive care, children*, and, for any other hearing testing, see Section 5(a), *Diagnostic and treatment services.*	$25 per office visit	$30 per primary care office visit (nothing for children through age 17) $35 per specialty care office visit	$15 per primary care office visit $40 per specialty care office visit
Hearing aids, including auditory osseointegrated implants/bone anchored hearing systems. Notes:	20% of our allowance per hearing aid per ear every 36 months	20% of our allowance per hearing aid per ear every 36 months	20% of our allowance per hearing aid per ear every 36 months

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**
• For audible prescription reading and speech generating devices, see Section 5(a), *Durable medical equipment.* • Covered hearing aids include bone conduction hearing devices but does not include over-the-counter hearing aids. • Coverage for minors under the age of 18 is available after they have received medical clearance within the last six (6) months from either an otolaryngologist for an initial evaluation of hearing loss or from a licensed physician when it is determined there has not been a significant change in clinical status after the initial evaluation by an otolaryngologist.	20% of our allowance per hearing aid per ear every 36 months	20% of our allowance per hearing aid per ear every 36 months	20% of our allowance per hearing aid per ear every 36 months
Not covered: • *Over-the-counter hearing aids*	*All charges*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**	**Prosper**
• Eye exam to determine the need for vision correction • Annual eye exams or refractions Notes: • See Section 5(a), *Preventive care, children* for eye exams for children. • See Section 5(a), *Diagnostic and treatment services*, Procedures received during an office visit.	$25 per office visit	$30 per primary care office visit (nothing for children through age 17) $35 per specialty care office visit	$15 per primary care office visit $40 per specialty care office visit
When dispensed through a Plan facility, contact lenses or eyeglasses are covered when medically necessary for eye pathology, including an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts). Note: Replacement lenses for eye pathology, including following cataract surgery will be provided only when needed due to change in your medical condition and will be replaced only one time within any 12-month period.	Nothing	Nothing	Nothing after the deductible
Not covered: • *Eyeglasses except as provided above* • *Contacts lenses and related supplies including examinations and fittings for them, except as provided above* • *Eye exercises and orthoptics*	*All charges*	*All charges*	*All charges*

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**
• *Evaluations and surgical procedures to correct refractions which are not related to eye pathology including complications*	*All charges*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**	**Prosper**
Routine foot care when you are under active treatment for clinical conditions that affect sensation and circulation to the feet, when approved by the Plan's medical director Notes: • See Orthopedic and prosthetic devices for information on podiatric shoe inserts • See *Section 5(a), Diagnostic and treatment services,* Procedures received during an office visit.	$25 per office visit	$30 per primary care office visit (nothing for children through age 17) $35 per specialty care office visit	$15 per primary care office visit $40 per specialty care office visit
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**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Ostomy supplies necessary for the removal of bodily secretions or waste through an artificial opening • Cochlear implants • Intraocular lenses • Occlusal splints (including fittings) for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Therapeutic shoe inserts for severe diabetic foot disease • Braces, such as back, knee, and leg braces, but not dental braces • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy.	20% of our allowance	20% of our allowance	20% of our allowance after the deductible

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay		
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**	**Prosper**
Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See Section 5(b) for coverage of the surgery to insert the device.	20% of our allowance	20% of our allowance	20% of our allowance after the deductible
Not covered: • *orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *cost of artificial or mechanical hearts* • *orthopedic and prosthetic replacements provided except when medically necessary* • *replacement of devices, equipment and supplies due to loss, theft, breakage or damage*	*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: • Hospital beds • Standard wheelchairs • Crutches • Walkers • Speech generating devices • Canes • Oxygen and oxygen equipment for home use • Nasal CPAP device • Blood glucose monitors • External insulin pumps • Medically necessary replacement of supplies	20% of our allowance	20% of our allowance	20% of our allowance after the deductible
• Peak flow meter • Glucometer	20% our allowance	20% our allowance	20% our allowance
• One breastfeeding pump and supplies per delivery, including equipment that is required for pump functionality Note: Equipment and supplies to support dyads with breastfeeding difficulties are also covered. • Ultraviolet light treatment equipment	Nothing	Nothing	Nothing

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay		
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**	**Prosper**
Not covered: • *Motorized wheelchairs except when approved by the medical director as medically necessary* • *Replacement of devices, equipment and supplies due to loss, theft, breakage or damage* • *Wigs/hair prosthesis*	*All charges*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**	**Prosper**
• Home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), physical therapist, occupational therapist or speech therapist. Home health services require the skill of one of the listed providers based on the complexity of the service and the condition of the patient. • Services may include oxygen therapy, intravenous therapy or services provided by a Social Worker, licensed practical nurse (L. P.N.), licensed vocational nurse (L.V.N.), or home health aide, when provided in connection with the skilled services described above	Nothing 20% for oxygen therapy	Nothing 20% for oxygen therapy	Nothing 20% for oxygen therapy 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, custodial care or maintenance care that is not diagnostic, therapeutic, or rehabilitative*	*All charges*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**	**Prosper**
Up to 20 treatments per calendar year for manipulation of spine and extremities Note: See *Section 5(a), Diagnostic and treatment services,* Procedures received during an office visit.	$25 per office visit	$30 per office visit (nothing for children through age 17)	$15 per primary care office visit $40 per specialty care office visit
Not covered: • *Maintenance therapy* • *Care given on a non-acute asymptomatic basis* • *Services provided for the convenience of the member*	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
Alternative treatments	**High Option**	**Standard Option**	**Prosper**
Acupuncture services – Self referral to a licensed or certified acupuncture practitioner for up to 8 visits per medical diagnosis per calendar year. Additional visits must meet Plan protocols and be authorized in advance by your Plan. • anesthesia • pain relief • substance use disorder - unlimited • dry needling Naturopathic services – Self referral to a Plan provider for up to 3 visits per medical diagnosis per calendar year. Additional visits must meet Plan protocols and be authorized in advance by your Plan. Note: See *Section 5(a), Diagnostic and treatment services,* Procedures received during an office visit.	$25 per office visit	$30 per primary care office visit (nothing for children through age 17) $35 per specialty care office visit	$15 per primary care office visit $40 per specialty care office visit
Not covered: • *Maintenance therapy* • *Vitamins* • *Food supplements* • *Care given on a non-acute asymptomatic basics* • *Services provided for the convenience of the member* • *Hypnotherapy* • *Biofeedback* • *Botanical and herbal medicines*	*All charges*	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**	**Prosper**
• Tobacco cessation programs, including individual, group and phone counseling, prescribed over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco cessation. Notes: • See Section 5(f), *Prescription Drug Benefits*, for important information about coverage of tobacco cessation and other drugs.	Nothing	Nothing	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay		
Educational classes and programs (cont.)	**High Option**	**Standard Option**	**Prosper**
• 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).	Nothing	Nothing	Nothing
• Diabetes self-management • Routine nutritional counseling Note: See *Section 5(a), Diagnostic and treatment services,* Procedures received during an office visit.	$25 per office visit	$30 per primary care office visit (nothing for children through age 17) $35 per specialty care office visit	$15 per primary care office visit $40 per specialty care office visit
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. • 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 preventive 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.	Applies to this benefit	Applies to this benefit	Applies to this benefit

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

Important things you should keep in mind about these benefits:

- Kaiser Permanente is inherently a collaborative care model; this is facilitated by our integration of care and coverage, our shared electronic health record (EHR), 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 EHR 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.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible for High Option and Standard Option.
- The calendar year deductible for Prosper 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, *Coordinating benefits with Medicare and other coverage.*
- The cost-sharing listed below are for charges billed by a physician or other healthcare professional for your surgical care. See 5(c) for charges associated with the 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 Prosper 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 • Correction of congenital anomalies (see *Reconstructive surgery*) • Insertion of internal prosthetic devices. See Section 5(a) – "*Orthopedic and prosthetic devices*" for device coverage information • Treatment of burns • Non-routine Circumcision	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per day. See Section 5(c) for hospital charges	$30 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $150 copayment per day. See Section 5(c) for hospital charges	$15 per primary care office or $40 per specialty care office visit Outpatient surgery is subject to a $250 per day after the deductible See Section 5(c) for hospital charges

Surgical procedures - continued on next page

Benefit Description	You pay		
Surgical procedures (cont.)	**High Option**	**Standard Option**	**Prosper**
Note: 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. Surgical treatment of severe obesity (bariatric surgery). Notes: Visit www. kp.org/postal to get a list of criteria you must meet to qualify for bariatric surgery. You must meet these 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 Kaiser Permanente clinical review physician. For female surgical family planning procedures see Family Planning Section 5(a) For male surgical family planning procedures see Family Planning Section 5(a)	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per day. See Section 5(c) for hospital charges	$30 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $150 copayment per day. See Section 5(c) for hospital charges	$15 per primary care office or $40 per specialty care office visit Outpatient surgery is subject to a $250 per day after the deductible See Section 5(c) for hospital charges
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; (see Section 5(a) Foot care)* • *Devices related to sexual dysfunction* • *Services for the promotion, prevention or other treatment of hair loss or hair growth* • *Cosmetic surgery, any surgery procedure (or any portion of the procedure) performed primarily to improve physical appearance through change in bodily form* • *Cost of an artificial or mechanical heart* • *Weight loss programs* • *Adjustable gastric banding, Laparoscopic or Open* • *Bilio-pancreatic bypass* • *Distal gastric bypass* • *Duodenal Switch* • *Mini-gastric bypass*	*All charges*	*All charges*	*All charges*

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

Benefit Description	You pay		
Oral and maxillofacial surgery	**High Option**	**Standard Option**	**Prosper**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of malignancies • Excision of non-dental cysts and incision of non-dental 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	Nothing	Nothing	Nothing after the deductible
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Correction of any malocclusion not listed above*	*All charges*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**	**Prosper**
These **solid organ and tissue transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to Section 3, *How you get care,* for authorization procedures and are 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 • Kidney-pancreas • Liver	Nothing	Nothing	Nothing after the deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Prosper**
• Lung: Single/bilateral/lobar • Pancreas	Nothing	Nothing	Nothing after the deductible
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 - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	Nothing	Nothing	Nothing after the deductible
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) - 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	Nothing	Nothing	Nothing after the deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Prosper**
- 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 - Hematopoietic stem cell transplant (HSCT) - 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	Nothing after the deductible
Limited benefits The following autologous blood or bone marrow stem cell transplants may be provided in a National Cancer Institute (NCI) or National Institutes of Health (NIH)-approved clinical trial at a Plan-designated Center of Excellence. These limited benefits are not subject to medical necessity. • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Beta Thalassemia Major • Breast cancer • Childhood rhabdomyosarcoma • Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) • Chronic lymphocytic leukemia • Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) relapsed/refractory disease • Chronic myelogenous leukemia • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma	Nothing	Nothing	Nothing after the deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Prosper**
• Epithelial ovarian cancer • High-grade (Aggressive) non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) • High-risk Ewing sarcoma • High risk childhood kidney cancers • Hodgkin's lymphoma • Multiple myeloma • Multiple sclerosis • Myeloproliferative Disorders • Myelodysplasia/Myelodysplastic Syndromes • Non-Hodgkin's lymphoma • Sarcomas • Sickle Cell • Systemic lupus erythematosus • Systemic sclerosis • Scleroderma • Scleroderma-SSc (severe, progressive)	Nothing	Nothing	Nothing after the deductible
Mini-transplants performed in a Clinical Trial Setting (non-myeloblative, reduced intensity conditioning). • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow Failure and Related Disorders (i.e. Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency	Nothing	Nothing	Nothing after the deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Prosper**
- Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	Nothing	Nothing	Nothing after the deductible
Notes: • We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members. • We cover medically necessary routine dental services in preparation for chemotherapy, radiation therapy, and transplants. 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.	Applies to this benefit	Applies to this benefit	Applies to this benefit
• *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) • Skilled nursing facility • Hospital outpatient department • Ambulatory surgical center • Provider's office	Nothing	Nothing	Nothing after the deductible

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

Important things you should keep in mind about these benefits:

- Kaiser Permanente is inherently a collaborative care model; this is facilitated by our integration of care and coverage, our shared electronic health record (EHR), 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 EHR 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.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible for High Option and Standard Option.
- The calendar year deductible for Prosper 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, *Coordinating benefits with Medicare and other coverage*.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PROVIDER MUST GET PRIOR APPROVAL FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay		
Note: The Prosper 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: • Semiprivate room accommodations • Special care units such as intensive care or cardiac units • 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.	$350 per admission	$750 per admission	$750 per day up to $2,250 per admission after the deductible ($750 per admission for delivery)
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood and blood derivatives • Donor human milk provided through a milk bank	Nothing	Nothing	Nothing after the deductible

Inpatient hospital - continued on next page

Benefit Description	You pay		
Inpatient hospital (cont.)	**High Option**	**Standard Option**	**Prosper**
• Dressing, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services	Nothing	Nothing	Nothing after the deductible
• Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	According to the benefit of the specific item you take home, i. e., hospital bed, pharmacy items, etc.	According to the benefit of the specific item you take home, i. e., hospital bed, pharmacy items, etc.	According to the benefit of the specific item you take home, i. e., hospital bed, pharmacy items, etc.
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care* • *Non-covered facilities, such as nursing home, schools* • *Personal comfort items, such as phone, television, barber services, guest meals and beds* • *Private nursing care, except when medically necessary*	*All charges*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**	**Prosper**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications administered at the facility • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood derivatives • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing See Section 5(b) for professional services	Nothing See Section 5(b) for professional services	Nothing See Section 5(b) for professional services

Benefit Description	You pay		
Rehabilitative facility	**High Option**	**Standard Option**	**Prosper**
Up to 2 months of physical therapy, occupational therapy, and speech therapy – per condition per calendar year	$350 per inpatient hospitalization per person	$750 per inpatient hospitalization per person	$750 per inpatient hospitalization per person per day up to $2,250 after the deductible
Not covered: • *Long-term rehabilitative therapy*	*All charges*	*All charges*	*All charges*
Skilled nursing care facility benefits	**High Option**	**Standard Option**	**Prosper**
Skilled nursing facility (SNF) benefit: • When full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and authorized by the Plan, you will receive up to 100 days per calendar year.	Nothing	Nothing	Nothing after the deductible
Not covered: • *Custodial care* • *Rest cures* • *Domiciliary or convalescent care* • *Personal comfort items such as phone or television*	*All charges*	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**	**Prosper**
Supportive and palliative care for a terminally ill member is covered in the home or a hospice facility. Services could include: • Inpatient and outpatient care • Drugs • Biologicals • Medical appliances and supplies that are used primarily for the relief of pain and symptom management • Family counseling These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately 6 months or less.	Nothing	Nothing	Nothing after the deductible
Not covered: • *Independent nursing, homemaker services*	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
Ambulance	**High Option**	**Standard Option**	**Prosper**
Local licensed ambulance services when medically necessary. Note: See Section 3, *You need prior Plan approval for certain services* and Section 5(d), *Emergency services/Accidents*	20% of our allowance	$100 per trip	20% of our allowance
• 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: • *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-emergency transportation services that are not medically appropriate and that have not been ordered and authorized by a Plan provider*	*All charges*	*All charges*	*All charges*

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Kaiser Permanente is inherently a collaborative care model; this is facilitated by our integration of care and coverage, our shared electronic health record (EHR), 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 EHR 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.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible for High Option and Standard Option.
- The calendar year deductible for Prosper 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, *Coordinating benefits with Medicare and other coverage*.

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:

Emergencies within our service area: If you are in an emergency situation, go to the nearest hospital emergency room. In extreme emergencies, contact the local emergency system (e.g., the 911 phone system) or go to the nearest hospital emergency room. Remember, it is your responsibility to notify the Plan.

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 48 hours by calling the Plan notification line at 888-457-9516, unless it was not reasonably possible to do so. If you are hospitalized in a non-Plan facility and a Plan doctor believes that better care can be provided in a Plan hospital, you will be transferred when medically feasible with ambulance charges covered in full. If you have questions about acute illnesses other than emergencies, you should call your primary care provider.

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

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

If you are admitted to an in-Plan hospital or designated facility directly from the emergency room, we will waive the Emergency Room copayment. An observation bed is an extension of the emergency room and is not considered an inpatient admission.

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

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to do so. If you are hospitalized in a non-Plan facility and a Plan doctor believes that better care can be provided in a Plan hospital, you will be transferred when medically feasible with ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Benefit Description	You pay		
Emergencies within our service area	**High Option**	**Standard Option**	**Prosper**
• Emergency or urgent care at a Plan doctor's office • Emergency or urgent care at a Plan urgent care center Note: See Section 5(a), *Diagnostic and treatment services* for procedures received during an office visit	$25 per office visit	$30 per primary care office visit (nothing for children through age 17) $35 per specialty care office visit	$15 per primary care office visit $40 per specialty care office visit
• Emergency care at a Plan or Plan designated emergency department • Emergency care at a non-Plan facility, including doctors' services Notes: • If you receive emergency care and then are transferred to an observation bed or status, you pay the emergency services cost-sharing. • If you are admitted as an inpatient, we will waive your emergency room copayment and you will pay your cost-sharing related to your inpatient hospital stay.	$200 per member per visit	$250 per member per visit	$300 per member per visit after the deductible
Not covered: • *Elective care or non-emergency care*	*All charges*	*All charges*	*All charges*
Emergency outside our service area	**High Option**	**Standard Option**	**Prosper**
• Emergency or urgent care at a doctor's office • Emergency or urgent care at an urgent care center Note: See Section 5(a), *Diagnostic and treatment services* for procedures received during an office visit	$25 per member per visit	$30 per primary care services office visit (nothing for children through age 17) $35 per specialty care services office visit	$15 per primary care office visit $40 per specialty care office visit
• Emergency care at a hospital, including doctors' services Note: If you receive emergency care and then are transferred to an observation bed or status, you pay the emergency services cost-sharing. If you are admitted as an inpatient, we will waive your emergency room copayment and you will pay your cost-sharing related to your inpatient hospital stay.	$200 per member per visit	$250 per member per visit	$300 per member per visit after the deductible

Emergency outside our service area - continued on next page

Benefit Description	You pay		
Emergency outside our service area (cont.)	**High Option**	**Standard Option**	**Prosper**
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**	**Prosper**
Licensed ambulance service when medically necessary Notes: • See Section 5(c) for nonemergency service. • Trip means any time an ambulance is summoned on your behalf.	20% of charges	$100 per trip	20% of charges
Not covered: • *Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan provider* • *Air and sea ambulance when not medically necessary*	*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:

- Kaiser Permanente is inherently a collaborative care model; this is facilitated by our integration of care and coverage, our shared electronic health record (EHR), 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 EHR 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.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible for High Option and Standard Option.
- The calendar year deductible for Prosper 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, *Coordinating benefits with Medicare and other coverage.*
- 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		
Professional services	**High Option**	**Standard Option**	**Prosper**
We cover all diagnostic and treatment services for the treatment of mental health and substance use conditions that are clinically necessary and recommended by the member's primary physician and approved by the Plan Medical Director or designee.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnostic and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Consultation services • Psychiatric treatment (individual, family and group therapy) by providers such as psychiatrists, psychologists, or clinical social workers • Diagnosis, treatment and counseling for substance use disorders • Medication evaluation and management (pharmacotherapy) • Professional charges for intensive outpatient treatment in a provider's office or other professional setting	$25 per individual therapy office visit Nothing per group therapy office visit See Section 5(f) for mental health prescription drug coverage	$30 per individual therapy office visit (nothing for children through age 17) Nothing per group therapy office visit Nothing for diagnostic tests See Section 5(f) for mental health prescription drug coverage.	$15 per individual therapy office visit Nothing per group therapy office visit See Section 5(a), *Diagnostic and treatment services* for procedures received during an office visit See Section 5(f) for mental health prescription drug coverage

Professional services - continued on next page

Benefit Description	You pay		
Professional services (cont.)	**High Option**	**Standard Option**	**Prosper**
• Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Alcohol and drug education • Applied Behavioral Analysis (ABA) therapy for the treatment of autism spectrum disorder or a developmental disability • Electroconvulsive therapy • Crisis intervention and stabilization for acute episodes	$25 per individual therapy office visit Nothing per group therapy office visit See Section 5(f) for mental health prescription drug coverage	$30 per individual therapy office visit (nothing for children through age 17) Nothing per group therapy office visit Nothing for diagnostic tests See Section 5(f) for mental health prescription drug coverage.	$15 per individual therapy office visit Nothing per group therapy office visit See Section 5(a), *Diagnostic and treatment services* for procedures received during an office visit See Section 5(f) for mental health prescription drug coverage
Notes • 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:	Applies to this benefit	Applies to this benefit	Applies to this benefit

Professional services - continued on next page

Benefit Description	You pay		
Professional services (cont.)	**High Option**	**Standard Option**	**Prosper**
- Outpatient mental health departments are usually co-located in the same medical facilities as our primary care, pharmacy, and specialty services, making it easy for primary care physicians to make referrals. - In many locations, behavioral health clinicians are embedded in primary care, allowing them to provide one-on-one consultations and other services in the primary care setting. - Our primary care physicians are trained to look for signs of mental health and substance use disorder needs when they are treating members in the primary care setting. - Routine screenings for depression, anxiety, and psychological distress are built into the care experience at key points, such as when a member is being screened for a chronic condition.	Applies to this benefit	Applies to this benefit	Applies to this benefit
Diagnostics	**High Option**	**Standard Option**	**Prosper**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder 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	Nothing	Nothing	Nothing for lab $50 per visit for X-ray and imaging $150 per visit for MRI/CT/PET Scan
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 • Hospitalization (including inpatient professional services) • Detoxification • Diagnostic tests • Diagnostic evaluation • Consultation services • Residential treatment	$350 per person per hospitalization	$750 per person per hospitalization	$750 per day up to $2,250 per hospitalization after the deductible

Benefit Description	You pay		
Outpatient hospital or other covered facility	**High Option**	**Standard Option**	**Prosper**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization	$25 per office visit. $25 per day for partial hospitalization; no day limit.	$30 per primary care office visit (nothing for children through age 17) $35 per specialty care office visit. $30 per day for partial hospitalization; no day limit. (nothing for children through age 17)	$15 per primary care office visit $40 per specialty care office visit $15 per day for partial hospitalization
Not covered	**High Option**	**Standard Option**	**Prosper**
Not covered: *Mental health inpatient and outpatient treatment that the Plan excludes are:* • *Psychiatric evaluation or therapy that is court ordered as a condition of parole or probation unless determined by a Plan provider to be necessary and appropriate* • *Psychological testing that is not medically necessary* • *Services that are custodial in nature* • *Assessment and treatment services that are primarily vocational and academic in nature (i.e., educational testing)* • *Services provided under a Federal, state, or local government* • *Services rendered or billed by a school or a member of its staff* • *Treatment not authorized by a Plan provider, provided by the Plan, or specifically contracted for by the Plan*	*All charges*	*All charges*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- Kaiser Permanente is inherently a collaborative care model; this is facilitated by our integration of care and coverage, our shared electronic health record (EHR), 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 EHR and all clinicians have access to a patient's chart, facilitating a seamless patient experience and better health outcomes.
- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable 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.
- Federal or state laws may prevent the pharmacy from accepting unused drugs.
- We have no calendar year pharmacy deductible.
- Be sure to read Section 4, *Your Cost for Covered Services,* for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.
- 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 physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy**.**
- **We use a managed formulary.** Prescriptions written by Plan Provider are dispensed in accordance with the Plan's drug formulary. A drug formulary is a list of preferred pharmaceutical products that our pharmacists and physicians have developed to assure that you receive quality prescription drugs at a reasonable price. We describe any additional coverage requirements and limits in our PSHB drug 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. Non-formulary drugs will be covered only if based on medical necessity and if prescribed by a Plan provider. Please see our online formulary and drug pricing search tools at the following https://healthy.kaiserpermanente.org/washington/health-wellness/drug-formulary. For information about specific formulary drugs, please call Member Services at 888-901-4636.
- We classify MOST drugs into one of five "tier categories:
  - Tier 1 includes generic formulary drugs, including preventive generic drugs. Usually represents the lowest copays.
  - Tier 2 generally includes brand formulary and preferred brand drugs. Usually represents brand or middle-range copays.
  - Tier 3 may include all other covered drugs not on tiers 1 and 2 (i.e., non-formulary or non-preferred).
  - Tier 4 includes preferred specialty drugs.
  - Tier 5 includes non-preferred specialty drugs.

- **A generic equivalent to a brand name drug will be dispensed if it is available.** If your physician believes that a brand name product is medically necessary, or if there is no generic equivalent available, your physician may prescribe a brand name drug. You pay a higher copayment when a brand name drug is prescribed. If you elect to purchase a brand name drug instead of the generic equivalent (if available), you will be responsible for paying the difference in cost in addition to the prescription drug cost share.
- **These are the dispensing limitations.** Prescription drugs prescribed by Plan doctors and filled at Plan pharmacies will be dispensed for up to a 30-day supply. You will be required to pay a copayment for each 30-day supply. If your prescription is written for more than a 30-day supply, such as a 100-day supply, you are responsible for three copayments, one for each 30-day supply. For prescribed hormonal contraceptives, you may obtain up to a 12-month supply at a Plan pharmacy or through our mail-delivery program. For prescribed hormone therapy drugs, you may obtain up to a 12-month supply at a Plan pharmacy or through our mail-delivery program. You may obtain up to 120 condoms per 100-day period. We cover episodic drugs prescribed to treat sexual dysfunction disorder up to a maximum of 8 doses in any 30-day period or 24 in any 100-day period. If you have a new prescription for a chronic condition, you may request a coordination of medications so that medications for chronic conditions are refilled on the same schedule (synchronized). Cost-shares for the initial fill of the medication will be adjusted if the fill is less than the standard quantity. Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications should call Member Services at 888-901-4636. 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 of the state of Washington) 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.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells that drug. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Under Federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. Generic drugs cost you and your plan less money than a name-brand drug.

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: • Drugs (including injectables) for which a prescription is required by Federal law • Insulin • Diabetic supplies limited to: - Disposable needles, syringes, lancets, urine and blood glucose testing reagents; a copayment charge applies per item per each 30-day supply • Compound dermatological preparations • Disposable needles and syringes for the administration of covered prescribed medications Notes: • Intravenous fluids and medication for home use are covered under Section 5(a), *Treatment therapies* • Allergy serums are covered under Section 5 (a), *Allergy care*	$20 for preferred generic formulary drugs, $60 for non-preferred generic formulary drugs, $40 for preferred brand name formulary drugs (including insulin and diabetic supplies), per prescription unit or refill for up to a 30-day supply or 100-unit supply, whichever is less; or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin). $60 for non-preferred brand name formulary drugs when prescribed by a Plan doctor.	$20 for preferred generic formulary drugs, $60 for non-preferred generic formulary drugs, or $40 for preferred brand name formulary drugs (including insulin and diabetic supplies), per prescription unit or refill for up to a 30-day supply or 100-unit supply, whichever is less; or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin).	$20 for preferred generic formulary drugs, $100 for non-preferred generic formulary drugs, $60 for preferred brand name formulary drugs (including insulin and diabetic supplies), per prescription unit or refill for up to a 30-day supply or 100-unit supply, whichever is less; or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin).

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	**High Option**	**Standard Option**	**Prosper**
	25% coinsurance up to $200 per 30-day supply for preferred specialty drugs when prescribed by a Plan doctor. 50% coinsurance up to $500 per 30-day supply for non-preferred specialty drugs when prescribed by a Plan doctor. Notes: • You pay no more than $35 for up to a 30-day supply of insulin. • You pay no more than $35 for up to a 30-day supply of corticosteroid and corticosteroid combination inhalers. • You pay no more than $35 per prescription for epinephrine autoinjector products that contain at least two autoinjectors.	$60 for non-preferred brand name formulary drugs when prescribed by a Plan doctor. 25% coinsurance up to $200 per 30-day supply for preferred specialty drugs when prescribed by a Plan doctor. 50% coinsurance up to $500 per 30-day supply for non-preferred specialty drugs when prescribed by a Plan doctor. Notes: • You pay no more than $35 for up to a 30-day supply of insulin. • You pay no more than $35 for up to a 30-day supply of corticosteroid and corticosteroid combination inhalers. • You pay no more than $35 per prescription for epinephrine autoinjector products that contain at least two autoinjectors.	$100 for non-preferred brand name formulary drugs when prescribed by a Plan doctor. 35% coinsurance up to $300 per 30-day supply for preferred specialty drugs when prescribed by a Plan doctor. 50% coinsurance up to $500 per 30-day supply for non-preferred specialty drugs when prescribed by a Plan doctor. Notes: • You pay no more than $35 for up to a 30-day supply of insulin. • You pay no more than $35 for up to a 30-day supply of corticosteroid and corticosteroid combination inhalers. • You pay no more than $35 per prescription for epinephrine autoinjector products that contain at least two autoinjectors.
• 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

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	**High Option**	**Standard Option**	**Prosper**
Mail Order Drug Program • Prescription medications mailed to your home by the Kaiser Permanente mail order pharmacy. (Mail order issues up to a 90-day supply)	2 times the applicable prescription drug copayment for a supply of 90 days or less of each prescription or refill. Mail order not available for specialty drugs.	2 times the applicable prescription drug copayment for a supply of 90 days or less of each prescription or refill. Mail order not available for specialty drugs.	2 times the applicable prescription drug copayment for a supply of 90 days or less of each prescription or refill. Mail order not available for specialty drugs.
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, devices and products, including implanted contraceptive drugs, devices, and products, including implanted devices, diaphragms, contraceptive gels, hormonal contraceptive methods, and FDA approved over-the-counter contraceptive drugs, devices, and products. • We cover non-preferred contraceptive drugs, devices, and products if they would otherwise be covered, and a Plan provider receives an approved drug formulary exception. Providers may prescribe nonformulary, contraceptive drugs for their patients if they determine it is medically necessary and would be clinically appropriate for an individual patient. Members pay no cost share for nonformulary contraceptive drugs when determined medically necessary.	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**
• 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. • 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, you can email contraception@opm.gov or visit Member Resources at kp.org/postal. • Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. *Filing a Claim for Covered Services.* Note: For additional Family Planning benefits see Section 5(a) *Medical Services and Supplies Provided by Physicians and ither Healthcare Professionals.* 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) *Medical Services and Supplies Provided by Physicians and ither Healthcare Professionals.*	Nothing	Nothing	Nothing
Post-exposure prophylaxis (PEP) drugs • One regimen of human immunodeficiency virus post-exposure prophylaxis	Nothing	Nothing	Nothing
Limited benefits: • Drugs to aid in tobacco cessation when prescribed and dispensed as part of our designated tobacco cessation program. • Opioid rescue agents. See Section 5(f), Preventive medications	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**
• Sexual dysfunction drugs	50% coinsurance	50% coinsurance	50% coinsurance
• Fertility drugs, including drugs for in vitro fertilization Note: For in vitro fertilization only, we cover fertility drugs prescribed by non-Plan providers when obtained at a Plan pharmacy.	50% of our allowance (If it is medically necessary to administer medication during an office visit, the medication is included in the office visit copayment.)	50% of our allowance (If it is medically necessary to administer medication during an office visit, the medication is included in the office visit copayment.)	50% of our allowance after the deductible (If it is medically necessary to administer medication during an office visit, the medication is included in the office visit copayment.)
Not covered: • *Drugs available without a prescription or for which there is an over-the-counter (nonprescription) equivalent available* • *Drugs obtained at a non-Plan pharmacy except when due to an out-of-area emergency* • *Vitamins and nutritional substances not listed as a covered benefit even if a physician prescribes or administers them, including dietary formulas and special diets, except for the treatment of inborn errors of metabolism; total parenteral; and enteral nutrition therapy* • *Oral nutritional supplements* • *Medical supplies such as dressings, antiseptics, etc.* • *Experimental drugs, devices, and biological products* • *Drugs for cosmetic purposes* • *Drugs to enhance athletic performance* • *Replacement of lost or stolen drugs, medications, or devices* • *Drugs related to non-covered services, except as stated above* *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)*	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
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 Note: Preventive medications with USPSTF A and B recommendations are covered without cost-share when prescribed by a healthcare professional and filled by a Plan pharmacy. 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	Nothing	Nothing	Nothing
Opioid rescue agents are covered under this Plan with no cost sharing when obtained with a prescription from a Plan pharmacy in prescription form such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at https ://www. fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https ://www. findtreatment.samhsa.gov/.	Nothing	Nothing	Nothing
Not covered: • *Prescriptions filled at a non-Plan pharmacy except for emergencies as described in Section 5(d), Emergency services/accidents* • *Vitamins, nutritional, herbal supplements that can be purchased without a prescriptions, unless they are included in our drug formulary or listed as covered above or below* • *Over-the-counter, unless they are included in our drug formulary or listed as covered above* • *Prescription drugs not on our drug formulary, unless approved through an exception process*	*All charges*	*All charges*	*All charges*

Preventive medications - continued on next page

Benefit Description	You pay		
Preventive medications (cont.)	**High Option**	**Standard Option**	**Prosper**
• *Any requested packaging of drugs other than the dispensing pharmacy's standard packaging* • *Replacement of lost, stolen, damaged prescription, drugs, and accessories* • *Drugs related to non-covered services*	*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:

- Kaiser Permanente is inherently a collaborative care model; this is facilitated by our integration of care and coverage, our shared electronic health record (EHR), 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 EHR 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 and their covered Medicare-eligible family member, you will be automatically group enrolled in our PDP EGWP. Contact us for additional information at 888-901-4636 (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 888-901-4636 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 prescribed drugs and medications, as described in the chart beginning on the following pages.

- 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 from Medical Group before coverage applies. Prior approval/authorizations must be renewed periodically.
- We have no calendar year deductible.
- Federal or state laws 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 888-901-4636.

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 www. kp.org/postal to view benefit details, 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. to7 p.m. Pacific Time.

Changing coverage due to divorce, marriage, or having or adopting a child qualifies as a life-changing event. The enrollment change must be submitted within a certain number of days of the event, typically within 60 days.

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 888-901-4636 (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 physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice. Your prescribers must have Medicare-approved prescriptive authority.
- **Where you can obtain prescription drugs.** You must fill the prescription at a Plan pharmacy**.** For assistance locating a PDP EGWP network pharmacy, visit our website at www.kp.org, or call Member Services at 888-901-4636.
- **We use a managed formulary.** Prescriptions written by Plan physicians are dispensed in accordance with the Plan's drug formulary. A drug formulary is a list of preferred pharmaceutical products that our pharmacists and physicians have developed to assure that you receive quality prescription drugs at a reasonable price. We describe any additional coverage requirements and limits in our PSHB drug 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. Non-formulary drugs will be covered only if based on medical necessity and if prescribed by a Plan doctor. Please see our online formulary and drug pricing search tools at the following https://healthy.kaiserpermanente.org/washington/health-wellness/drug-formulary For information about specific formulary drugs, please call Member Services at 888-901-4636.
- We classify MOST drugs into one of five "tier categories"

  - Tier 1 includes generic formulary drugs, including preventive generic drugs. Usually represents the lowest copays.
  - Tier 2 generally includes brand formulary and preferred brand drugs. Usually represents brand or middle-range copays.
  - Tier 3 may include all other covered drugs not on tiers 1 and 2 (i.e., non-formulary or non-preferred).
  - Tier 4 includes preferred specialty drugs.
  - Tier 5 includes non-preferred specialty drugs.

- **A generic equivalent to a brand name drug will be dispensed if it is available.** If your physician believes that a name brand product is medically necessary, or if there is no generic equivalent available, your physician may prescribe a name brand drug. You pay a higher copayment when a brand name drug is prescribed. If you elect to purchase a brand name drug instead of the generic equivalent (if available), you will be responsible for paying the difference in cost in addition to the prescription drug cost share.

- **These are the dispensing limitations.** Prescription drugs prescribed by Plan doctors and filled at Plan pharmacies will be dispensed for up to a 30-day supply. You will be required to pay a copayment for each 30-day supply. If your prescription is written for more than a 30-day supply, such as a 100-day supply, you are responsible for three copayments, one for each 30-day supply. For prescribed hormonal contraceptives, you may obtain up to a 12-month supply at a Plan pharmacy or through our mail-delivery program. For prescribed hormone therapy drugs, you may obtain up to a 12-month supply at a Plan pharmacy or through our mail-delivery program. You may obtain up to 120 condoms per 100-day period. We cover episodic drugs prescribed to treat sexual dysfunction disorder up to a maximum of 8 doses in any 30-day period or 24 in any 100-day period. If you have a new prescription for a chronic condition, you may request a coordination of medications so that medications for chronic conditions are refilled on the same schedule (synchronized). Cost-shares for the initial fill of the medication will be adjusted if the fill is less than the standard quantity. Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications should call Member Services at 888-901-4636. 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 of the state of Washington) 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.
- **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.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells that drug. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Under Federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. Generic drugs cost you and your plan less money than a name-brand drug.
- **When do you file a claim.** You do not need to file a claim when you receive drugs from a Plan pharmacy. You have to file a claim when you receive drugs from a non-Plan pharmacy for a covered emergency or out-of-area urgent care 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 Medicare Part D Group Plan (PDP) for Postal Service Health Benefits (PSHB) 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: • Drugs (including injectables) for which a prescription is required by Federal law • Insulin • Diabetic supplies limited to: - Disposable needles, syringes, lancets, urine and blood glucose testing reagents; a copayment charge applies per item per each 30-day supply • Compound dermatological preparations • Disposable needles and syringes for the administration of covered prescribed medications • Drugs to treat gender dysphoria, including hormones and androgen blockers • Medical Foods Notes: • Intravenous fluids and medication for home use are covered under Section 5(a), *Treatment therapies* • Allergy serums are covered under Section 5 (a), *Allergy care*	$20 for generic preferred/non-preferred drugs or $40 for brand name preferred/non-preferred drugs (including diabetic supplies), per prescription unit or refill for up to a 30-day supply or 100-unit supply, whichever is less; or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin). $200 per 30-day supply for preferred specialty drugs when prescribed by a Plan doctor. Notes: • You pay no more than $35 for up to a 30-day supply of insulin. • You pay no more than $35 for up to a 30-day supply of corticosteroid and corticosteroid combination inhalers. • You pay no more than $35 per prescription for epinephrine autoinjector products that contain at least two autoinjectors.	$20 for generic preferred/non-preferred drugs, or $40 for brand name preferred and non-preferred drugs (including diabetic supplies), per prescription unit or refill for up to a 30-day supply or 100-unit supply, whichever is less; or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin). $200 per 30-day supply for preferred specialty drugs when prescribed by a Plan doctor. Notes: • You pay no more than $35 for up to a 30-day supply of insulin. • You pay no more than $35 for up to a 30-day supply of corticosteroid and corticosteroid combination inhalers. • You pay no more than $35 per prescription for epinephrine autoinjector products that contain at least two autoinjectors.	$20 for generic preferred/non-preferred drugs, or $40 for brand name preferred and non-preferred drugs (including diabetic supplies), per prescription unit or refill for up to a 30-day supply or 100-unit supply, whichever is less; or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin). $200 per 30-day supply for preferred specialty drugs when prescribed by a Plan doctor. Notes: • You pay no more than $35 for up to a 30-day supply of insulin. • You pay no more than $35 for up to a 30-day supply of corticosteroid and corticosteroid combination inhalers. • You pay no more than $35 per prescription for epinephrine autoinjector products that contain at least two autoinjectors.

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 • 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
Mail Order Drug Program • Prescription medications mailed to your home by the Kaiser Permanente mail order pharmacy. (Mail order issues up to a 90-day supply)	2 times the applicable prescription drug copayment for a supply of 90 days or less of each prescription or refill. Mail order not available for specialty drugs.	2 times the applicable prescription drug copayment for a supply of 90 days or less of each prescription or refill. Mail order not available for specialty drugs.	2 times the applicable prescription drug copayment for a supply of 90 days or less of each prescription or refill. Mail order not available for specialty drugs.
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 all methods of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. • We cover contraceptive drugs and devices, including implanted contraceptive devices, diaphragms, contraceptive gels, hormonal contraceptive methods, and prescribed FDA approved over-the-counter women's contraceptives and devices. • We cover non-preferred contraceptive drugs, devices, and products if they would otherwise be covered, and a Plan provider receives an approved drug formulary exception. Providers may prescribe nonformulary, contraceptive drugs for their patients if they determine it is medically necessary and would be clinically appropriate for an individual patient. Members pay no cost share for nonformulary contraceptive drugs when determined medically necessary.	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**
• 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. • 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, you can email contraception@opm.gov or visit Member Resources at kp.org/postal. • Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. *Filing a Claim for Covered Services.* Note: For additional Family Planning benefits see Section 5(a) *Medical Services and Supplies Provided by Physicians and ither Healthcare Professionals.* 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) *Medical Services and Supplies Provided by Physicians and ither Healthcare Professionals.*	Nothing	Nothing	Nothing
Post-exposure prophylaxis (PEP) drugs • One regimen of human immunodeficiency virus post-exposure prophylaxis	Nothing	Nothing	Nothing
Limited benefits: • Drugs to aid in tobacco cessation when prescribed and dispensed as part of our designated tobacco cessation program. • Opioid rescue agents. See Section 5(f)(a), Preventive care medications.	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**
• Sexual dysfunction drugs	50% coinsurance	50% coinsurance	50% coinsurance
• Fertility drugs, including drugs for in vitro fertilization Note: For in vitro fertilization only, we cover fertility drugs prescribed by non-Plan providers when obtained at a Plan pharmacy.	50% of our allowance (If it is medically necessary to administer medication during an office visit, the medication is included in the office visit copayment.)	50% of our allowance (If it is medically necessary to administer medication during an office visit, the medication is included in the office visit copayment.)	50% of our allowance after the deductible (If it is medically necessary to administer medication during an office visit, the medication is included in the office visit copayment.)
Not covered: • *Drugs available without a prescription or for which there is an over-the-counter (nonprescription) equivalent available* • *Drugs obtained at a non-Plan pharmacy except when due to an out-of-area emergency* • *Vitamins and nutritional substances not listed as a covered benefit even if a physician prescribes or administers them, including dietary formulas and special diets, except for the treatment of inborn errors of metabolism; total parenteral; and enteral nutrition therapy* • *Oral nutritional supplements* • *Medical supplies such as dressings, antiseptics, etc.* • *Experimental drugs, devices, and biological products* • *Drugs for cosmetic purposes* • *Drugs to enhance athletic performance* • *Replacement of lost or stolen drugs, medications, or devices* • *Drugs related to non-covered services, except as stated above* *Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (See Section 5(a))*	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
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 Note: Preventive medications with a USPSTF recommendations of A or B are covered without cost-share when prescribed by a healthcare professional and filled by a Plan pharmacy. 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	Nothing	Nothing	Nothing
Opioid rescue agents are covered under this Plan with no cost sharing when obtained with a prescription from a Plan pharmacy in prescription form such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at https ://www. fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https ://www. findtreatment.samhsa.gov/.	Nothing	Nothing	Nothing
Not covered: • *Prescriptions filled at a non-Plan pharmacy except for emergencies as described in Section 5(d), Emergency services/accidents* • *Vitamins, nutritional, herbal supplements that can be purchased without a prescriptions, unless they are included in our drug formulary or listed as covered above or below* • *Over-the-counter, unless they are included in our drug formulary or listed as covered above* • *Prescription drugs not on our drug formulary, unless approved through an exception process*	*All charges*	*All charges*	*All charges*

Preventive medications - continued on next page

Benefit Description	You pay		
Preventive medications (cont.)	**High Option**	**Standard Option**	**Prosper**
• *Any requested packaging of drugs other than the dispensing pharmacy's standard packaging* • *Replacement of lost, stolen, damaged prescription, drugs, and accessories* • *Drugs related to non-covered services*	*All charges*	*All charges*	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Kaiser Permanente is inherently a collaborative care model; this is facilitated by our integration of care and coverage, our shared electronic health record (EHR), 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 EHR 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 payment and your FEDVIP Plan is secondary to your PSHB Plan. See Section 9, *Coordinating benefits with Medicare and other coverage*.
- 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.
- Be sure to read Section 4, *Your Cost for Covered Services,* for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.

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

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 claim process (see Section 8).
Nutrition and behavioral lifestyle support	Kaiser Permanente is committed to investing in the total health of our members. Exercise, nutrition, and weight management resources such as wellness coaching and online Healthy Lifestyle Programs are all available at no cost. We offer our members the tools and resources they need to actively participate in their health at home, online, with their smartphone, and at our facilities. Our members can enroll in a variety of programs that are designed to help them take an active role in their health and make desired lifestyle changes. Unless otherwise noted, most of these programs are available at no additional costs to members because they are embedded within our integrated care delivery model as part of our core offerings. Examples of our wellness programs aimed at weight and nutrition are: • Nutrition counseling (such as weight loss and a healthy diet) • Stress reduction programs • Chronic disease self-management programs • Exercise counseling and cardiovascular fitness programs • Smoking cessation program • Health risk assessments Members can access our Health and Wellness Programs at kp.org/healthyliving.
Services for deaf, hard of hearing, or speech impaired	We provide a TTY/text phone number 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.

Travel benefit	Kaiser Permanente's travel benefits for Postal Service employees provide 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 benefits 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 the applicable copayment for each follow-up and/or continuing care office visit. This amount will be deducted from the reimbursement we make to you or to the provider. We limit our payment for this travel benefit to no more than $2,000 each calendar year. For more information about this benefit, call our Member Services Call Center at 888-901-4636 (TTY: 711). File claims as shown in Section 7. The following are a few examples of services not included in your travel benefits coverage: • Nonemergency hospitalization • Infertility treatments • Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area • Durable medical equipment (DME) • Prescription drugs • Home health services
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 an PSHB disputed claim about them. 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 888-901-4636 or at www. kp.org/wa.

Eyewear Discount - www. kp.org/wa/eyecare

Vision hardware discount members get discounts on vision hardware including eyeglasses, prescription sunglasses and contact lenses once per year. Call Member Services at 888-901-4636 or go online to www. kp.org/wa/eyecare for more information**.**

Assisted reproductive technology (ART) discounted services

Kaiser Permanente offers discounted rates for certain non-covered Assisted Reproductive Technology (ART) services in our Washington Federal Options market where ART is not included as a covered benefit.

Members can search our provider directory at Kaiser Permanente for affiliated **Reproductive Endocrinology** providers who offer ART fertility services at a discounted rate. Members can also contact Member Services at (888) 901- 4636 (TTY: 711) for assistance or kp.org/postal for additional information.

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 classesdesigned 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 https ://www. myoptumhealthphysicalhealth.com/ProviderDirectory to locate a provider near you.

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

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

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

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

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 *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 for services we would otherwise cover to treat complications of the non-covered service or services from other Kaiser Permanente plans (see Emergency services/ accidents and special features).
- Fees associated with non-payment (including interest), missed appointments and special billing arrangements.
- Care by non-Plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except you pay nothing when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the PSHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.
- 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).

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 pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

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

Medical and hospital benefits

In most cases, providers and facilities file HIPAA computer electronic claims for you. Provider 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, contact us at 888-901-4636 or at our website at www.kp.org/wa.

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

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

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

Submit your claims to: Kaiser Foundation Health Plan of Washington, Claims Administration, P.O. Box 30766, Salt Lake City, UT 84130-0766

Phone: 888-901-4636

Prescription drugs

Outpatient drugs and medicines obtained at non-Plan pharmacies are not covered; except when due to an out of area emergency.

Submit your claims to: Kaiser Foundation Health Plan of Washington, Claims Administration, P.O. Box 30766, Salt Lake City, UT 84130-0766

Phone: 888-901-4636

Other supplies or services

Submit your claims to: Kaiser Foundation Health Plan of Washington, Claims Administration, P.O. Box 30766, Salt Lake City, UT 84130-0766

Phone: 888-901-4636

Post-service claims procedures

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

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

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

Records

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

Deadline for filing your claim

Send us all the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. Once we pay benefits, there is a year limitation on the re-issuance of uncashed checks.

Overseas claims

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 Foundation Health Plan of Washington
Claims Administration
P.O. Box 30766
Salt Lake City, UT 84130-0766

Obtain Overseas Claim Forms from: Member Services. If you have questions about the processing of overseas claims, contact Member Services at 888-901-4636.

When we need more information

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

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, 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.

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 Member Services at the phone number found on your ID 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 our Member Services Department by writing to P.O. Box 34593, Seattle, WA 98124-1593 or calling 866-458-5479.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

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

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Kaiser Foundation Health Plan of Washington, Member Appeal Department, P. O. Box 34593, Seattle, WA 98124-1593, 866-458-5479; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4. In the case of a post-service claim, we have 30 days from the date we receive your request to:

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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 20415-1000.

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 888-901-4636. 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 PDP EGWP, you may appeal an adverse pre-service or post-service determination. See Section 8a.

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 888-901-4636. 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 PDP EGWP, you may appeal an adverse pre-service or post-service determination. See Section 8(a) *Medicare PDP EGWP Disputed Claims Process*.

Section 8(a). The Medicare Part D 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 Part D drugs covered under the Plan's Medicare Part D MAPD/PDP Employer Group Waiver Plan.

If the denied drug is excluded by Medicare Part D but is covered under the PSHB Plan's non-Part D supplemental benefit, the denial must be appealed using the PSHB disputed claims process described in Section 8, not the Medicare Part D appeals process. Section 8 does not govern Medicare Part D appeals for the MAPD/PDP EGWP.

The denial notice will tell you which appeals process applies.

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 73-924). 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 will not 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 is not 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 888-865-5813 (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 do not 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/wa.

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 you must pay cost sharing described in this PSHB brochure (See Sections 4 and 5. Members with Medicare should also see Section 9). We will not pay more than our allowance.

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 others are responsible for injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

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

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement 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 may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

If you need more information, contact Member Services toll-free at 888-901-4636 for our subrogation procedures.

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 www.BENEFEDS.gov or by phone at 1-877-888-3337, (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. This plan does not cover these costs when provided as part of the clinical trial, except when Kaiser Foundation Health Plan of Washington's exception to clinical trial exclusion criteria are met.
- 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 888-901-4636.

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 888-901-4636.

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.

- **Medicare Part B premium reimbursement**

We offer two programs designed to help members with their Medicare Part B premium.

The first program is called, "Medicare Advantage 2." For each month you are enrolled in Medicare Advantage 2, have Medicare Parts A and B and are enrolled in Medicare Advantage for Postal Service Members, you will be reimbursed up to $175 (up to $2,100 per year) of your Medicare Part B monthly premium. Kaiser Permanente Medicare Advantage for Postal Service Members is a Medicare Advantage HMO plan approved by Medicare.

In addition to reimbursing you for the Part B monthly premium we will cover additional benefits, including lower copays for office visits and inpatient hospitalization.

You may enroll in the Medicare Advantage 2 program if:

- You enroll in the Plan's High Option or Standard Option
- You live in our Medicare Advantage service area
- You have Medicare Parts A and B and you enroll in Medicare Advantage for Postal Service Members
- The PSHB subscriber completes an additional application for enrollment in Medicare Advantage 2

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

The second program is called, "Medicare Choice for High Option." This program is for High Option members who reside outside Kaiser Permanente's Medicare Advantage service area. You will be reimbursed $50 of your Medicare Part B monthly premium (up to $600 per year). We will automatically enroll you in the Medicare Choice for High Option program if:

- You enroll in the Plan's High Option
- We can verify that you have Medicare Parts A and B and you are not enrolled in Medicare Advantage

We encourage you to contact us if you are a High Option member who is retired and have Medicare Parts A and B.

To start your monthly reimbursement, you must provide proof of the amount you pay for your Part B premium to our Health Reimbursement Arrangement (HRA) vendor. The Part B reimbursement will begin the month after you provide proof. If we can independently verify your Medicare Part B enrollment, we may send you an annual reimbursement automatically after the plan year ends.

To learn more about our Medicare programs and how to enroll, call us at 855-366-9013, 8 a.m. to 8 p.m., 7 days a week, or visit our website at www.kp.org/postal. For TTY for the deaf, hard of hearing, or speech impaired, call 711.

- **Medicare Advantage (Part C)**

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

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

This Plan and our Medicare Advantage plan: We offer a Medicare Advantage plan known as Kaiser Permanente Postal Service Employees Health Benefits Medicare Advantage plan. The Postal Service Employees Medicare Advantage and Medicare Choice plans enhance your PSHB coverage by lowering cost shares for certain services and/or adding benefits. High and Standard Option members can choose between 2 Medicare Advantage plans: "Medicare Advantage 1" (richest benefits) and "Medicare Advantage 2" (some rich benefits and Part B premium reimbursement). If you live in our Medicare Advantage service area, are a Medicare-eligible retiree, and have Medicare Parts A and B, you can enroll in our Postal Service Employees Medicare Advantage plan. Enrolling in Medicare Advantage for Postal Service Members does not change your PSHB premium. Your enrollment in our Postal service Employee Medicare Advantage plan is in addition to your PSHB High Option, Standard Option, or Prosper enrollment. If you are considering enrolling in the Postal Service Employees Medicare Advantage plan, please call us at 800-446-8882 (TTY: 711), 8 a.m. to 8 p.m., Monday through Friday. Note: you must complete an election form to enroll in the Postal Service Employees Medicare Advantage plan.

With Kaiser Permanente Postal Service Employees Medicare Advantage and Medicare Choice for High Option, you'll get more coverage, such as lower cost-sharing and additional benefits. This 2027 benefit summary allows you to make a comparison of your choices:

Benefit Description: Deductible
High Option You Pay Without Medicare: None
High Option Senior Advantage 1 You Pay: None
High Option Senior Advantage 2 You Pay: None
Standard Option You Pay Without Medicare: None
Standard Option Senior Advantage 1 You Pay: None
Standard Option Senior Advantage 2 You Pay: None
Prosper You Pay Without Medicare: $350 individual; $700 family
Prosper Senior Advantage You Pay: None

Benefit Description: Primary Care
High Option You Pay Without Medicare: $25
High Option Senior Advantage 1 You Pay: $0
High Option Senior Advantage 2 You Pay: $15
Standard Option You Pay Without Medicare: $30 (No charge for children through age 17)
Standard Option Senior Advantage 1 You Pay: $10 (No charge for children through age 17)
Standard Option Senior Advantage 2 You Pay: $20 (No charge for children through age 17)
Prosper You Pay Without Medicare: $15
Prosper Senior Advantage You Pay: $10

Benefit Description: Specialty Care
High Option You Pay Without Medicare: $25
High Option Senior Advantage 1 You Pay: $0
High Option Senior Advantage 2 You Pay: $15
Standard Option You Pay Without Medicare: $35
Standard Option Senior Advantage 1 You Pay: $10
Standard Option Senior Advantage 2 You Pay: $25
Prosper You Pay Without Medicare: $40
Prosper Senior Advantage You Pay: $35

Benefit Description: Outpatient Surgery
High Option You Pay Without Medicare: $75
High Option Senior Advantage 1 You Pay: $0
High Option Senior Advantage 2 You Pay: $75
Standard Option You Pay Without Medicare: $150
Standard Option Senior Advantage 1 You Pay: $50
Standard Option Senior Advantage 2 You Pay: $100
Prosper You Pay Without Medicare: $250*
Prosper Senior Advantage You Pay: $200

Benefit Description: Inpatient Hospital Care
High Option You Pay Without Medicare: $350 per admission
High Option Senior Advantage 1 You Pay: $0 per admission
High Option Senior Advantage 2 You Pay: $100 per admission
Standard Option You Pay Without Medicare: $750 per admission
Standard Option Senior Advantage 1 You Pay: $100 per admission
Standard Option Senior Advantage 2 You Pay: $250 per admission
Prosper You Pay Without Medicare: $750 per day up to $2,250*
Prosper Senior Advantage You Pay: $350 per day up to $1,050*

Benefit Description: Part B Reimbursement
High Option Without Medicare: Not Applicable
High Option Senior Advantage 1: None
High Option Senior Advantage 2: Up to $175 monthly
Standard Option Without Medicare: Not Applicable
Standard Option Senior Advantage 1: None
Standard Option Senior Advantage 2: Up to $175 monthly
Prosper Without Medicare: Not Applicable
Prosper Senior Advantage: None

Benefit Description: Additional Benefits Offered
High Option Without Medicare: Not applicable
High Option Senior Advantage 1: Eyeglasses and contact lenses allowance; One Pass; Transportation Allowance
High Option Senior Advantage 2: One Pass; Transportation Allowance
Standard Option Without Medicare: Not applicable
Standard Option Senior Advantage 1: Eyeglasses and contact lenses allowance; One Pass; Transportation Allowance
Standard Option Senior Advantage 2: One Pass; Transportation Allowance
Prosper Without Medicare: Not applicable
Prosper Senior Advantage: One Pass; Transportation Allowance

Benefit Description: Out-of-Pocket Maximum (2x per family)
High Option You Pay Without Medicare: $3,000 self only/$6,000 family
High Option Senior Advantage 1 You Pay: $1,000 self only
High Option Senior Advantage 2 You Pay: $2,000 self only
Standard Option You Pay Without Medicare: $5,000 self only or family
Standard Option Senior Advantage 1 You Pay: $1,000 self only
Standard Option Senior Advantage 2 You Pay: $3,000 self only
Prosper You Pay Without Medicare: $6,000 self only/$12,000 family
Prosper Senior Advantage You Pay: $5,000 self only

* You pay the deductible, then cost-sharing

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.

Our Kaiser Permanente owned and operated pharmacies will not consider another plan's Medicare Part D benefits. These Kaiser Permanente pharmacies will only provide your PSHB Kaiser Permanente benefits.

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

If you enroll in one of our Kaiser Permanente Senior Advantage for Postal Service Members plans, 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) Drug Plan 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 us at 888-901-4636.

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 888-901-4636 (TTY: 711) 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
  Medicare Department
  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 888-901-4636 (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 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, 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. to7 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 888-901-4636 (TTY: 711).

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

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have 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 25.

Copayment

See Section 4, page 25.

Cost-sharing

See Section 4, page 25.

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 medicine. (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 longer is sometimes known as long-term care.

Deductible

See Section 4, page 25.

Experimental or investigational services

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

Medical necessity

Medical services or hospital services which are determined by the Plan Medical Director or designee to be:

a) Rendered for the treatment or diagnosis of an injury or illness; and

b) Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and

c) Not furnished primarily for the convenience of the Member, the attending physician, or other provider of service.

Whether there is "sufficient scientific evidence" shall be determined by the Plan based on the following: peer-reviewed medical literature; publications, reports, evaluations, and regulations issued by state and federal government agencies; Medicare local carriers, and intermediaries; and such other authoritative medical sources as deemed necessary by the Plan.

Medicare Part A

Part A helps cover inpatient hospital stays, skilled nursing facility care, hospice care, and some home 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.
Plan 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 the Kaiser Permanente would have paid if it did not subtract cost-sharing. You should also see *Important notice about surprise billing – know your rights* in Section 4 that describes your protections against surprise billing under the No Surprises Act.
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Reimbursement

A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier 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 our Customer Service Department at 888-901-4636. 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 Washington.

You

You refers to the enrollee and each covered family member.

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

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Notes

Notes

Summary of Benefits for High Option Kaiser Permanente - Washington Core - PSHB - 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 physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	$25 per primary care or specialist office visit	31
Medical services provided by physicians: Diagnostic tests, lab and X-ray services	Nothing	32
Services provided by a hospital: Inpatient	$350 per person per hospitalization	62
Services provided by a hospital: Outpatient	$75 per day	63
Emergency benefits	$200 per visit	67
Mental health and substance use disorder treatment	Regular cost-sharing.	69
Prescription drugs	$20 for preferred generic formulary drugs; $40 for preferred brand name formulary drugs; $60 for non-preferred drugs; 25% up to $200 for preferred specialty drugs; 50% up to $500 for non-preferred specialty drugs. 2 times the applicable prescription drug copayment for a supply of 90 days or less of each prescription or refill. Mail order not available for specialty drugs.	74
Prescription drugs - PDP (EGWP)	$20 preferred; $40 non-preferred generic; $40 preferred and non-preferred brand; $200 specialty per prescription for up to a 30-day supply at a Plan pharmacy. 2 times the applicable prescription drug copayment for a supply of 100 days or less of each prescription or refill. Mail order not available for specialty drugs.	74
Dental care	Not covered	90
Vision care: Routine eye exam and refractions for eyeglasses	$25 per office visit	48
Special features: Flexible benefits option; services for the deaf, hard of hearing, or speech impaired; services from other Kaiser Permanente regions; and travel benefit	See Section 5(h) for more information	91
Protection against catastrophic costs (out-of-pocket maximum)	Nothing after $4,000 for Self Only or $8,000 for Self Plus One and Family enrollment per year. Some costs do not count toward this protection	26

Summary of Benefits for Standard Option Kaiser Permanente - Washington Core - PSHB 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 physicians, except in emergencies.

Standard Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	$30 per primary care services (nothing for children through age 17) $35 per specialty care services office visit	31
Medical services provided by physicians: Diagnostic lab and X-ray services	Nothing	32
Services provided by a hospital: Inpatient	$750 per person per hospitalization	62
Services provided by a hospital: Outpatient	$150 per day	63
Mental health and substance use disorder treatment:	In-Network: Regular cost-sharing. Out-of-Network: Benefits are limited	69
Emergency benefits	$250 copayment per visit	67
Prescription drugs	$20 for preferred generic formulary drugs; $60 for non-preferred generic formulary drugs; $40 for preferred brand name formulary drugs; $60 for non-preferred brand name formulary drugs; 25% up to $200 per 30-day supply for preferred specialty drugs; 50% up to $500 per 30-day supply for non-preferred specialty drugs. 2 times the applicable prescription drug copayment for a supply of 90 days or less of each prescription or refill. Mail order not available for specialty drugs.	74
Prescription drugs - PDP (EGWP)	$20 preferred; $40 non-preferred generic; $40 preferred and non-preferred brand; $200 specialty per prescription or refill for up to a 30-day supply at a Plan pharmacy. 2 times the applicable prescription drug copayment for a supply of 100 days or less of each prescription or refill. Mail order not available for specialty drugs.	84
Dental care	Not covered	90
Vision care: Routine eye exam and refractions for eyeglasses	$30 for primary care services (nothing for children through age 17) $35 for specialty care services per office visit	48

Standard Option Benefits	You pay	Page
Special features: Flexible benefits option; services for the deaf, hard of hearing, or speech impaired; services from other Kaiser Permanente regions; and travel benefit	See Section 5(h) for more information	91
Protection against catastrophic costs (out-of-pocket maximum)	Nothing after $5,000 for Self Only or $10,000 for Self and Family enrollment per year. Some costs do not count toward this protection.	26

Summary of Benefits for Prosper Kaiser Permanente - Washington Core - PSHB - 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 physicians, except in emergencies.
- Below an asterisk (*) means the item is subject to $250 per person ($500 per family) calendar year deductible.

Prosper Benefits	You pay	Page
Calendar year deductible for covered services	$350 per person $700 per family	25
Medical services provided by physicians: Diagnostic and treatment services provided in the office	$15 per primary care services $40 per specialty care services office visit	31
Medical services provided by physicians: Diagnostic lab and X-ray services	Nothing for lab services. $50 per visit for X-ray services	32
Services provided by a hospital: Inpatient	$750 per day up to $2,250*	62
Services provided by a hospital: Outpatient	$250 per day*	63
Emergency benefits	$300 per member per visit*	67
Mental health and substance use disorder treatment	Regular cost-sharing	69
Prescription drugs	$20 for preferred generic formulary drugs; $100 for non-preferred generic formulary drugs, $60 for preferred brand name formulary drugs; $100 for non-preferred brand name formulary drugs; 35% up to $300 per 30-day supply for preferred specialty drugs; 50% up to $500 per 30-day supply for non-preferred specialty drugs. 2 times the applicable prescription drug copayment for a supply of 90 days or less of each prescription or refill. Mail order not available for specialty drugs.	74
Prescription drugs - PDP (EGWP)	$20 preferred; $40 non-preferred generic; $40 preferred and non-preferred brand; $200 specialty per prescription for up to a 30-day supply at a Plan pharmacy. 2 times the applicable prescription drug copayment for a supply of 100 days or less of each prescription or refill. Mail order not available for specialty drugs.	84
Dental care	Not covered	90
Vision care: Routine eye exam and refractions for eyeglasses	$15 for primary care services $40 for specialty care services per office visit	48

Prosper Benefits	You pay	Page
Special features: Flexible benefits option; services for the deaf, hard of hearing, or speech impaired; services from other Kaiser Permanente regions; and travel benefit	See Section 5(h) for more information	91
Protection against catastrophic costs (out-of-pocket maximum)	Nothing after $6,000 for Self Only or $12,000 for Self and Family enrollment per year. Some costs do not count toward this protection	26

2027 Rate Information for Kaiser Permanente - Washington Core - 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	PRA	$318.23	$255.36	$689.50	$553.28
High Option Self Plus One	PRC	$689.34	$572.55	$1,493.57	$1,240.53
High Option Self and Family	PRB	$748.55	$513.34	$1,621.86	$1,112.24
Standard Option Self Only	PRD	$301.38	$100.46	$652.99	$217.66
Standard Option Self Plus One	PRF	$689.34	$234.89	$1,493.57	$508.93
Standard Option Self and Family	PRE	$693.17	$231.06	$1,501.88	$500.62
Prosper Self Only	DWD	$185.00	$61.66	$400.82	$133.61
Prosper Self Plus One	DWF	$367.47	$122.49	$796.19	$265.39
Prosper Self and Family	DWE	$424.78	$141.59	$920.36	$306.78