Kaiser Permanente - Fresno California - PSHB

www.kp.org/postal

Member Services Call Center 800-464-4000 (TTY: 711)

KAISER PERMANENTE®

2025

A Health Maintenance Organization (High and Standard Option)

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: *Northern California: Fresno service area*

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:

NNA High Option - Self Only
NNC High Option - Self Plus One
NNB High Option - Self and Family

NND Standard Option - Self Only
NNF Standard Option - Self Plus One
NNE Standard Option - Self and Family

IMPORTANT

PSHB

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-919

Important Notice for Medicare-eligible Active Employees from Kaiser Foundation Health Plan, Inc., Northern California Region: Fresno
About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the Kaiser Foundation Health Plans Inc.'s prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is 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 percent 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 percent 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 http://ssa.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).

Table of Contents

Introduction

This brochure describes the benefits of Kaiser Permanente – Fresno California under contract (CS 1044-D PS) between Kaiser Foundation Health Plan, Inc. Northern California Region: Fresno 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 800-464-4000 or through our website: www.kp.org. The address for Northern California Region: Fresno PSHB administrative offices is:

Kaiser Foundation Health Plan, Inc.
1 Kaiser Plaza
Oakland, CA 94612

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, 2025, 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, 2025. 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, Inc., Northern California Region: Fresno.
- 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. 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 our Member Service Call Center at 800-464-4000 (TTY: 711) and explain the situation.

If we do not resolve the issue:

CALL - THE HEALTHCARE FRAUD HOTLINE
877-499-7295
OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/
The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.
You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

Do not maintain family members on your policy:

- Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
- Your child aged 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 dependent, 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, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

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, for example a member's gender identity or the fact that the covered benefit is sought in connection with gender-affirming care, 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.**

1. Ask questions and make sure you understand the answers.

2. Choose a doctor with whom you feel comfortable talking.

3. 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 medicines and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask your pharmacist about the medication 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.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

2. **Get the results of any test or procedure.**

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

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

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

4. **Make sure you understand what will happen if you need surgery.**

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

- "About how long will it take?
- "What will happen after the surgery?"
- "How can I expect to feel during recovery?"

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

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- 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 contact your carrier directly for address updates and questions about your benefit coverage.
• **Enrollment types available for you and your family**	Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support. If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member.

You enroll in a PSHB Program Plan and make enrollment changes in the PSHB System located at https://health-benefits.opm.gov/PSHB/. For assistance with the PSHB System, call the PSHBP Helpline at (844) 451-1261. 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 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 and their covered Medicare Part D-eligible family members. Our PDP EGWP is not an open market Medicare Part D Plan. If you are an active Postal Service employee, or covered family member, and become eligible to enroll in Medicare Part D, you are not eligible to enroll in our PDP EGWP. Please contact CMS for assistance at www.Medicare.gov or call 800 - MEDICARE (800) 633-4227, TTY (877) 486-2048 or call Members Services at 800-464-4000.

- **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 800-464-4000 (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 800-464-4000 (TTY: 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

Kaiser Foundation Health Plan, Inc. (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, Inc. Fresno County PSHB Region 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. Our Plan providers coordinate your healthcare services. We are solely responsible for the selection of Plan providers in your area. Contact us for a copy of our most recent provider directory. We 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. We give you a choice of enrollment in a High Option or Standard Option.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments and coinsurance described in this brochure. When you receive emergency services or services covered under the travel benefit 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 and Standard Options

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

Your rights and responsibilities

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

- We are a health maintenance organization that has provided healthcare services to Californians since 1945.
- This medical benefit plan is provided by Kaiser Foundation Health Plan, Inc. Medical and hospital services are provided through our integrated healthcare delivery organization known as Kaiser Permanente. Kaiser Permanente is composed of Kaiser Foundation Health Plan, Inc. (a not-for-profit organization), Kaiser Foundation Hospitals (a not-for-profit organization), and the Permanente Medical Group, Inc. (a for-profit California-based corporation) which operates Plan medical offices throughout Northern California.

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 website, Kaiser Permanente Fresno PSHB at 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 800-464-4000, or write to Kaiser Foundation Health Plan, Inc., Customer Service Center, 1950 Franklin St., Oakland, CA 94612. You may also visit our website at www.kp.org/postal.

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

Language interpretation services

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

Your medical and claims records are confidential

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

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our Fresno - PSHB service area consists of the following ZIP Codes:

- Fresno: 93242, 93602, 93606-07, 93609, 93611-13, 93616, 93618-19, 93624-27, 93630-31, 93646, 93648-52, 93654, 93656-57, 93660, 93662, 93667-68, 93675, 93701-12, 93714-18, 93720-30, 93737, 93740-41, 93744-45, 93747, 93750, 93755, 93760-61, 93764-65, 93771-79, 93786, 93790-94, 93844, 93888
- Kings: 93230, 93232, 93242, 93631, 93656
- Madera: 93601-02, 93604, 93614, 93623, 93626, 93636-39, 93643-45, 93653, 93669, 93720
- Mariposa: 93601, 93623, 93653
- Tulare: 93618, 93631, 93646, 93654, 93666, 93673

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 if you are visiting another Kaiser Permanente 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.

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

Section 2. New for 2025

This is the first year for the Postal Service Health Benefits Program (PSHBP). This Section is not an official statement of benefits. For that, go to Section 5. Benefits.

Section 3. How You Get Care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider or fill a prescription at a Plan pharmacy. Providers may request photo identification together with your ID card to verify identity. Until you receive your ID card, use your copy of the PSHB System enrollment confirmation.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call our Member Service Call Center at 800-464-4000 (TTY: 711). After registering on our website at www.kp.org/postal, you may also request replacement cards electronically.

Where you get covered care

You get care from "Plan providers" and "Plan facilities". You will only pay cost-sharing as described in Section 4. *Your Cost for Covered Services.*

Balance billing protection

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

Plan providers

Plan providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. Services by Plan Providers are covered when acting within the scope of their license or certification under applicable state law. We contract with The Permanente Medical Group, Inc. (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 Call Center at 800-464-4000 (TTY: 711). The list is also on our website at www.kp.org/postal.

This plan recognizes that transgender, non-binary, and other gender diverse members require health care delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

Kaiser Permanente primary care providers provide care coordination for complex conditions, for assistance please contact your provider or Member Service Call Center at 800-464-4000 (TTY: 711).

Plan facilities

Plan facilities are hospitals, medical offices, and other facilities in our service area that we own or contract with to provide covered services to our members. Kaiser Permanente offers comprehensive healthcare 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, out-of-area urgent care or COVID-19 services from non-Plan providers as described in Sections 5(a) and 5(f). 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

It depends on the type of care you need. First, you and each family member must choose a primary care provider. This decision is important since your primary care provider provides or arranges for most of your health care.

To choose or change your primary care provider, you can either select one from our Provider Directory, from our website, www.kp.org/postal, or you can call our Member Services Call Center at 800-464-4000 (TTY: 711).

Primary care

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

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

Specialty care

Specialty care is care you receive from providers other than a primary care provider. When your primary care provider believes you may need specialty care, they will request authorization from the Plan to refer you to a specialist for an initial consultation and/or for a certain number of visits. If the Plan approves the referral, you may seek the initial consultation from the specialist to whom you were referred. You must then return to your primary care provider after the consultation, unless your referral authorizes a certain number of additional visits without the need to obtain another referral. The primary care provider must provide or obtain authorization for a specialist to provide all follow-up care. Do not go to the specialist for return visits unless your primary care provider gives you an approved referral. However, you may see Plan gynecologists, obstetricians, optometrists, audiologists, urologists (limited to vasectomies), and health education, mental health and substance use disorder treatment providers without a referral. You may make appointments directly with these providers.

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

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care provider, in consultation with you and your attending specialist, may develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care provider will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

If you are seeing a specialist when you enroll in our Plan, talk to your primary care provider. Your primary care provider will decide what treatment you need. If they decide to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care provider, who will arrange for you to see another specialist. You may receive approved services from your current specialist until we can make arrangements for you to see a Plan specialist.
- If you have a chronic and disabling condition and
  - lose access to your specialist because your coverage changed from the FEHB to the PSHB and your health plan does not participate in the PSHB; or
  - lose access to your specialist because we drop out of the Postal Service Employees Health Benefits (PSHB) Program, and you enroll in another PSHB program plan; or:
  - lose access to your specialist because we terminate our contract with your specialist for other than cause; or
  - lose access to your specialist because we reduce our service area and you enroll in another PSHB plan

You may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan. If you are pregnant 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. If you are being treated for a maternal mental health condition, you can continue to see your specialist for up to 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.

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 Service Call Center immediately at 800-464-4000 (TTY: 711). If you are new to the PSHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

You need prior Plan approval for certain services

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

Your Plan physician must obtain prior authorization for:

- Certain prescription medications as identified on our formulary
- Durable medical equipment (DME)
- Home health services (If your Plan Physician makes a written referral for at least eight continuous hours of home health nursing or other care, the Medical Group's designee Plan Physician or committee will authorize the Services if the designee determines that they are Medically Necessary and that they are not the types of Services that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training)
- Organ/tissue transplants and related services
- Orthopedic and prosthetic devices
- Outpatient surgery and procedures
- Gender Affirming surgery
- Services or items from non-Plan providers or at non-Plan facilities (we cover these services and items only if they are not available from Plan providers)

To confirm if a referral has been approved for a service or item that requires prior authorization, please call our Member Service Call Center at 800-464-4000 (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.

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 at least 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 800-464-4000 (TTY: 711). You may also call OPM's Postal Service Insurance Operations (PSIO) at 202-936-0002 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 800-464-4000 (TTY: 711). If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

Concurrent care claims

A concurrent care claim involves care provided over 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.

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.

Emergency services/accidents and post-stabilization care

Emergency services do not require prior authorization. However, if you are admitted to a non-Kaiser Permanente facility, you or your family member must notify the Plan within 48 hours, or as soon as reasonably possible, or your claims may be denied.

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

See Section 5(d), *Emergency services/accidents* for more information.

What happens when you do not follow the precertification rules

You must receive your health services at Plan facilities, except if you have an emergency, authorized referral, out-of-area urgent care or COVID-19 services from non-Plan providers as described in Sections 5(a) and 5(f). Your primary care provider will provide most of your healthcare or give you a referral to see a specialist. If you do not obtain a referral from us for services or items that require a referral, we will not pay any amount for those services or items, and you may be liable for the full price of those services or items. This also includes any residual amounts, such as deductibles, copayments or coinsurance that are not covered or not paid by any other insurance plan you use to pay for those services or items.

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our prior approval decision, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call our Member Service Call Center at 800-464-4000 (TTY: 711).

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

To reconsider a non-urgent care claim

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

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

1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply.

2. Ask you or your provider for more information.

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

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

3. Write to you and maintain our denial.

To reconsider an urgent care claim

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

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

To file an appeal with OPM

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

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 or Standard Option, the type of provider, and the service or supply that you receive.

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

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

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

The Plan may allow you to designate a specialist as the physician who provides most of your healthcare (including services that primary care providers provide, such as referrals to specialists). If you choose to receive most of your healthcare from a physician designated as a specialist, the specialty care office visit copayment, rather than the primary care office visit copayment, will apply.

Deductible

We do not have a deductible.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for certain services you receive. Example: In our Plan, you pay 50% of our allowance for infertility services.

Paying cost-sharing amounts

Cost-sharing is due when you receive the services, except for the following:

Before starting or continuing a course of infertility services, you may be required to pay one or more deposits toward some or the entire course of services. Any unused portion of your deposit will be returned to you. When a deposit is not required, before you can schedule an infertility procedure, you must pay the copayment or coinsurance for the procedure.

For items ordered in advance, you pay the copayment or coinsurance in effect on the order date (although we will not cover the item unless you still have plan coverage for it on the date you receive it) and you may be required to pay the copayment or coinsurance before the item is ordered.

Your catastrophic protection out-of-pocket maximum

After your cost-sharing total is $2,000 per person up to $4,000 per family enrollment (High Option) or $3,000 per person up to $6,000 per family enrollment (Standard Option) in any calendar year, you do not have to pay any more for certain covered services. This includes any services required by group health plans to count toward the catastrophic protection out-of-pocket maximum by federal healthcare reform legislation (the Affordable Care Act and implementing regulations).

Example: Your plan has a $2,000 per person up to $4,000 per family maximum out-of-pocket limit. If you or one of your covered family members has out-of-pocket qualified medical expenses of $2,000 in a calendar year, any cost-sharing for qualified medical expenses for that individual will be covered fully by your health plan for the remainder of the calendar year. With a family enrollment, the out-of-pocket maximum will be satisfied once two or more family members have out-of-pocket qualified medical expenses of $4,000 in a calendar year, and any cost–sharing for qualified medical expenses for all enrolled family members will be covered fully by your health plan for the reminder of the calendar year.

However, cost-sharing for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay cost-sharing for these services:

- Chiropractic services
- Dental services
- Durable medical equipment, except the following items: blood glucose monitors and their supplies; infusion pumps and supplies to operate the pump; standard curved handle or quad cane and replacement supplies; standard or forearm crutches and replacement supplies; dry pressure pad for a mattress; nebulizer and supplies; peak flow meters; IV pole; bone stimulator; cervical traction (over door); and phototherapy blankets for treatment of jaundice in newborns
- Hearing aids
- Infertility services and fertility drugs
- Travel benefit
- COVID-19 services received from non-Plan providers as described in Sections 5 (a) and 5(f)

For members enrolled in our Plan's associated MA-PD or PDP EGWP, we are required to accumulate all members' actual out-of-pocket costs for Medicare-covered drugs, services and supplies toward the PSHB catastrophic maximum(s), unless specifically excluded as indicated in Section 5(f)(a), *PDP EGWP Prescription Drug Benefits*.

If you are enrolled in our Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP), the prescription drug out-of-pocket maximum is $2,000. After this maximum 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 prior option to the catastrophic protection limit of your new option.

When Government facilities bill us

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

Important notice about surprise billing – know your rights

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

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 California and Cal. Health and Safety Code §§ 1371.30, 1371.31, and 1371.9, and §§ 10112.8, 10112.81 and 10112.82(a) of the Insurance Code.

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 and Standard Option Benefits

Page 112 and page 113 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. High and Standard Option Benefits Overview

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

The High and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High and Standard Option benefits, contact us at 800-464-4000 (TTY: 711) or on our website at www.kp.org/postal.

Since 1945, Kaiser Foundation Health Plan, Inc., Northern California Region: Fresno has offered quality integrated healthcare to PSHB members. Our delivery system offers convenient, comprehensive care all under one roof. You can come to almost any one of our medical facilities and see a primary care provider or specialist, fill prescriptions, have mammograms, complete lab work, get X-rays and more. Also, our sophisticated health technology gives you the opportunity 24 hours a day, 7 days a week to schedule appointments, send secure messages to your provider, refill prescriptions, or research medical conditions.

This Plan offers two benefit options: the High and Standard Options. Both Options are designed to include preventive and acute care services provided by our Plan providers but offer different levels of benefits and services for you to choose between to best fit your healthcare needs.

High Option

The High Option includes the most comprehensive benefits. Our PSHB High Option includes:

- Primary care office visit copayment – $15
- Specialty care office visit copayment – $25
- Copayment on inpatient admissions – $250
- Copayment for most adult preventive care services and immunizations provided at no charge
- Drug cost-sharing – $10 for generic drugs, $40 for preferred and non-preferred brand name drugs, and specialty drugs $100 per prescription for up to a 30-day supply at a Plan pharmacy
- Chiropractic office visit copayment – $15 for up to 20 visits per calendar year

Standard Option

We also offer a Standard Option. With the Standard Option your copayments (and coinsurance, if appropriate) may be higher than for the High Option, but the biweekly premium is lower. Specific benefits of our PSHB Standard Option include:

- Primary care office visit copayment – $30
- Specialty care office visit copayment – $40
- Copayment on inpatient admissions – $500
- Copayment for most adult preventive care services and immunizations provided at no charge
- Drug cost-sharing – $15 for generic drugs, $50 for preferred and non-preferred brand name drugs, and specialty drugs $150 per prescription for up to a 30-day supply at a Plan pharmacy
- Chiropractic office visit copayment – $15 for up to 20 visits per calendar year

Please review this brochure carefully to learn which of our Kaiser Foundation Health Plan of California PSHB options is best for you. If you would like more information about our benefits, please contact us at 800-464-4000 (TTY: 711) or visit our website at www.kp.org.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, Your Costs for Covered Services, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- You pay one-half of the individual office visit copayment for certain group office visits, rounded down to the nearest dollar. You pay the primary care office visit copayment for visits with a non-physician specialist (such as nurse practitioners, physician assistants, optometrists, podiatrists and audiologists).
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care, including birthing doula support services. 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 the benefits in this Section. We say "(No deductible)" when it does not apply.		
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians and other healthcare professionals • In a physician's office • Office medical consultations • Second surgical opinions • Advance care planning • At home	$15 per primary care office visit $25 per specialty care office visit	$30 per primary care office visit $40 per specialty care office visit
Professional services of physicians and other healthcare professionals • During a hospital stay • In a skilled nursing facility	Nothing	Nothing
Telehealth services	**High Option**	**Standard Option**
Professional services of physicians and other healthcare professionals delivered through telehealth, such as: • Interactive video visits • Phone visits • Email Note: Visits may be limited by provider type, location and benefit specific limitations, such as visit limits.	Nothing	Nothing

Benefit Description	You pay	
Lab, X-ray, and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood test • Urinalysis • Non-routine Pap test • Pathology • X-rays • Non-routine mammogram • Ultrasound • Electrocardiogram and EEG • Nuclear medicine	Nothing	$10 per office visit
• Laboratory tests to diagnose or screen for COVID-19 obtained from Plan providers • Over-the-counter COVID-19 tests obtained from Plan Providers (up to a total of 8 tests from Plan Providers and non-Plan Providers per calendar month, not to exceed $12 per test, including fees and taxes, if you obtain the test from a non-Plan Provider)	Nothing	Nothing
• Laboratory tests to diagnose or screen for COVID-19 obtained from non-Plan providers (except for providers of Emergency Services or Out-of-Area Urgent Care) • Over-the-counter COVID-19 tests obtained from non-Plan Providers (up to a total of 8 tests from Plan Providers and non-Plan Providers per calendar month, not to exceed $12 per test, including fees and taxes, if you obtain the test from a non-Plan Provider)	50% coinsurance	50% coinsurance
• Routine laboratory tests to monitor the effectiveness of dialysis	Nothing	Nothing
• CT/CAT scan • MRI • PET scan	Nothing	$50 per procedure
• Procedures requiring licensed staff to monitor your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort.	$50 per procedure	$200 per procedure

Benefit Description	You pay	
Preventive care, adult	**High Option**	**Standard Option**
Routine physical exam, including screenings such as hearing and vision 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 for breast cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of A and B recommended screenings go to the website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • 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 and domestic violence. 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. • Services such as routine prostate specific antigen (PSA) test and retinal photography screening • We cover other preventive services required by federal healthcare reform legislation (the Affordable Care Act and implementing regulations) and additional services that we include in our preventive services benefit. For a complete list of Kaiser Permanente preventive services visit our website at www.kp.org/prevention • To build your personalized list of preventive services go to https://health.gov/myhealthfinder	Nothing	Nothing
• Routine mammogram	Nothing	Nothing
• Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
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. 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 as indicated by the FDA obesity medication treatment guidelines, see Section 5(f) or 5(f)(a) for cost share requirements for anti-obesity medications. • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity, see section 5(b) for surgery requirements and cost share.	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
• Immunizations (including the vaccine) for COVID-19 administered by non-Plan Providers (except for providers of Emergency Services or Out-of-Area Urgent Care).	50% coinsurance	50% coinsurance
Not covered: • *Physical exams required for:* *- Obtaining or continuing employment* *- Insurance or licensing* *- Participating in employee programs* *- Court ordered parole or probation* • *If you obtain a COVID-19 immunization from a non-Plan Provider (except for providers of Emergency Services or Out-of-Area Urgent Care), we do not cover an office visit or any other services from the non-Plan Provider other than administration of the vaccine.*	*All charges*	*All charges*

Benefit Description	You pay	
Preventive care, children	**High Option**	**Standard Option**
• 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 visit https://brightfutures.aap.org/ • Children's immunization's endorsed by the Centers for Disease Control (CDC) including DTaP, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the website at www.cdc.gov/vaccines/schedules/index.html • You can also find a complete list of A and B recommended preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) online at www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • We cover other preventive services required by federal healthcare reform legislation (the Affordable Care Act and implementing regulations) and additional services that we include in our preventive services benefit. For a complete list of Kaiser Permanente preventive services visit our website at www.kp.org/prevention • To build your personalized list of preventive services go to https://health.gov/myhealthfinder Notes: • You may pay cost-sharing for any procedure, injection, diagnostic service, laboratory or X-ray service that is provided in conjunction with a routine physical exam and is not included in the recommended list of preventive services. • Hearing screenings are provided by a primary care provider as part of a well-child care visit. For other hearing exams or tests, see Section 5(a), Diagnostic and treatment services or Section 5(a), Hearing services.	Nothing	Nothing
Note: 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.	Applies to this benefit	Applies to this benefit

Preventive care, children - continued on next page

Benefit Description	You pay	
Preventive care, children (cont.)	**High Option**	**Standard Option**
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. 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 as indicated by the FDA obesity medication treatment guidelines, see Section 5(f) for cost share requirements for anti-obesity medications. • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity, see section 5(b) for surgery requirements and cost share.	Nothing	Nothing
Immunizations (including the vaccine) for COVID-19 administered by non-Plan Providers (except for providers of Emergency Services or Out-of-Area Urgent Care).	50% coinsurance	50% coinsurance
Not covered: • *Physical exams required for:* *- Obtaining or continuing employment* *- Insurance or licensing* *- Participating in employee program* *- Court ordered parole or probation* • *All other hearing testing, except as may becovered in Section 5(a), Diagnostic and treatment services and Section 5(a), Hearing services* • *If you obtain a COVID-19 immunization from a non-Plan Provider (except for providers of Emergency Services or Out-of-Area Urgent Care), we do not cover an office visit or any other services from the non-Plan Provider other than administration of the vaccine.*	*All charges*	*All charges*

Benefit Description	You pay	
Maternity care	**High Option**	**Standard Option**
Routine maternity (obstetrical) care, such as: • Prenatal and postpartum care • Screening for gestational diabetes • Screening and counseling for prenatal and postpartum depression	Nothing	Nothing
• Breastfeeding and lactation support, supplies and counseling for each birth • An initial visit with a birthing doula and up to 8 additional visits in any combination of prenatal and postpartum visits. We will cover support during labor and delivery. Up to 2 additional postpartum visits may be available. Note: We cover breastfeeding pumps and supplies under Durable Medical Equipment (DME).	Nothing	Nothing
• As part of your coverage, you have access to in-network certified nurse midwives and board-certified lactation specialists during the prenatal and post-partum period.	Nothing	Nothing
• Delivery Notes: • Routine maternity care is covered after confirmation of pregnancy. • Your Plan provider does not have to obtain prior approval from us for your vaginal delivery. See Section 3, You need prior Plan approval for certain services, for prior approval guidelines. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. • When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • You pay cost-sharing for other services, including:	Nothing for inpatient professional delivery services	Nothing for inpatient professional delivery services

Maternity care - continued on next page

Benefit Description	You pay	
Maternity care (cont.)	**High Option**	**Standard Option**
- Diagnostic and treatment services for illness or injury received during a non-routine maternity care as described in this section. - Lab, X-ray and other diagnostic tests (including ultrasounds), Durable medical equipment as described in this section. - Surgical services (including circumcision of an infant if performed after the mother's discharge from the hospital) as described in Section 5 (b). *Outpatient hospital or ambulatory surgical center.* - Hospitalization (including room and board and delivery) as described in Section 5(c). *Inpatient hospital.*	Nothing for inpatient professional delivery services	Nothing for inpatient professional delivery services
Not covered: Doula services that include: • Clinical or medical services (such as taking blood pressure or temperature, fetal heart tone checks, vaginal examination or postpartum clinical care • Assistance with activities of daily living • Alternative or complementary modalities (such as aromatherapy, childbirth education, massage therapy or placenta encapsulation) • Yoga • Birthing ceremonies • Over-the-counter supplies or drugs • Home birth	*All charges*	*All charges*
Family planning	**High Option**	**Standard Option**
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories on the HRSA list. This list includes: • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Contraceptive counseling • Family planning counseling • Voluntary 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

Family planning - continued on next page

Benefit Description	You pay	
Family planning (cont.)	**High Option**	**Standard Option**
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. Information on contraceptive coverage is available to PSHB members on www.kp.org/postal and www.kp.org/health-wellness. • If you are having problems accessing contraceptive coverage or need more information about contraception, email OPM at contraception@opm.gov or visit OPM's website at Contraception Coverage at www.opm.gov/healthcare-insurance/healthcare/contraception-coverage/.	Nothing	Nothing
• Genetic counseling	$15 per primary care office visit $25 per specialty care office visit	$30 per primary care office visit $40 per specialty care office visit
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
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)	50% of our allowance	50% of our allowance

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**High Option**	**Standard Option**
- Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Semen analysis • Hysterosalpingogram • Hormone evaluation Notes: • See Section 5(a) *Lab, X-ray, and other diagnostic tests*, for coverage of diagnostic pre-screening testing associated with infertility services, such as an Electrocardiogram (EKG). • See Section 5(f) or 5(f)(a), *Prescription Drug Benefits*, for coverage of fertility drugs. • A Plan physician will determine the appropriate treatment and number of attempts for infertility treatment.	50% of our allowance	50% of our allowance
Standard fertility preservation for iatrogenic infertility, such as: • Retrieval of sperm and eggs • Cryopreservation • Storage for preserved specimen for 1 year after a covered preservation procedure even if your enrollment ends Note: You pay cost-sharing for other services associated with fertility preservation for iatrogenic infertility, including: • Lab, X-ray and other diagnostic tests, as described in Section 5(a) • Surgical services as described in Section 5(b) • Outpatient hospital or ambulatory surgical center as described in Section 5(c) • Prescription drugs as described in Section 5(f)	$25 per specialty care office visit	$40 per specialty care office visit
Not covered: *These exclusions apply to fertile as well as infertile individuals or couples:* • *Assisted reproductive technology (ART) procedures, including related services and supplies, such as:* - *in vitro fertilization (IVF)* - *embryo transfer, gamete intra-fallopian transfer (GIFT), and zygote intra-fallopian transfer (ZIFT)* • *Any charges associated with donor eggs, donor sperm or donor embryos*	*All charges*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**High Option**	**Standard Option**
• *Any charges associated with cryopreservation, unless listed as covered for iatrogenic infertility* • *Any charges associated with thawing and storage of frozen sperm, eggs and embryos, unless listed as covered for iatrogenic infertility* • *Ovum transplants* • *Infertility services when either member of the family has been voluntarily, surgically sterilized* • *Services to reverse voluntary, surgically induced infertility* • *Services related to surrogate arrangements*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
• Testing and treatment	$25 per specialty care office visit	$40 per specialty care office visit
• Injections	$5 per office visit	$5 per office visit
• Serum	Nothing	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy Note: High-dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Section 5(b), *Organ/ Tissue transplants.* • Intravenous (IV)/Infusion therapy— Home IV and antibiotic therapy • Radiation therapy	$25 for services provided by a physician Nothing for services provided by a non-physician provider	$40 for services provided by a physician Nothing for services provided by a non-physician provider
• Cardiac rehabilitation following a qualifying event/ condition	$15 per primary care office visit $25 per specialty care office visit	$30 per primary care office visit $40 per specialty care office visit
• Respiratory and inhalation therapy		$40 per specialty care office visit $10 per office visit for services provided by a non-physician provider
• Outpatient dialysis performed in a doctor's office or facility - hemodialysis and peritoneal dialysis • Growth hormone therapy (GHT) Notes:	$25 per specialty 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**
• Growth hormone is covered under the prescription drug benefit. See Section 5(f), *Prescription drug benefits*. • See section 5(e) *Professional services*, for coverage of Applied Behavior Analysis (ABA).	$25 per specialty care office visit	$40 per specialty care office visit
• Ultraviolet light treatments • Home dialysis – hemodialysis and peritoneal dialysis Note: After you receive appropriate training at a dialysis facility we designate, we also cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis inside our service area. Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. We decide whether to rent or purchase the equipment and supplies, and we select the vendor. You must return the equipment and any unused supplies to us or pay us the fair market price of the equipment and any unused supplies when we are no longer covering them.	Nothing	Nothing
Physical and occupational therapies	**High Option**	**Standard Option**
• Physical habilitative and rehabilitative therapy by qualified physical therapists to attain or restore bodily function when you have a total or partial loss of bodily function due to illness or injury. • Occupational habilitative and rehabilitative therapy by occupational therapists to assist you in attaining or resuming self-care and improved functioning in other activities of daily life when you have a total or partial loss of bodily function due to illness or injury. • Multidisciplinary outpatient rehabilitation includes diagnostic and restorative services comprising a program of physical, speech, occupational, and respiratory therapy, as well as certain other items and services that are medically necessary for rehabilitation.	$15 per visit	$30 per visit
Not covered: • *Exercise programs*	*All charges*	*All charges*

Benefit Description	You pay	
Speech therapy	**High Option**	**Standard Option**
Habilitative and rehabilitative services for: • Visits to a speech therapist	$15 per visit	$30 per visit
Not covered: • *Services to treat social, behavioral, or cognitive delays in speech or language development, unless medically necessary.*	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies	**High Option**	**Standard Option**
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 Note: For coverage of hearing screenings, see Section 5(a), *Preventive care, adult and Preventive care, children*, for any other hearing testing, see Section 5 (a), *Diagnostic and treatment services.*	$15 per primary care office visit $25 per specialty care office visit	$30 per primary care office visit $40 per specialty care office visit
Hearing aids for children through age 17, including testing and examinations Notes: • We will cover hearing aids for both ears only if both aids are required to provide significant improvement that is not obtainable with only one hearing aid. • Coverage is limited to the types and models of hearing aids furnished by the provider or vendor we select. • For coverage of Audible prescription reading and speech generating devices, see Section 5(a), *Durable medical equipment.*	All charges in excess of $1,000 for each hearing impaired ear every 36 months	All charges in excess of $1,000 for each hearing impaired ear every 36 months
Not covered: • *All other hearing testing, except as may be covered in Section 5(a), Diagnostic and treatment services and Section 5(a), Preventive care, children* • *Hearing aids, including testing and examinations for them, for all persons age 18 and over* • *Internally implanted hearing aids* • *Replacement parts and batteries, repair of hearing aids, and replacement of lost or broken hearing aids*	*All charges*	*All charges*

Benefit Description	You pay	
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Diagnosis and treatment of diseases of the eye	$15 per primary care office visit $25 per specialty care office visit	$30 per primary care office visit $40 per specialty care office visit
• Routine eye exam with a Plan optometrist to determine the need for vision correction and provide a prescription for eyeglasses • Therapeutic contact lenses for the condition of aniridia for up to two lenses per eye, per calendar year • Up to a total of six medically necessary aphakic contact replacement lenses per eye, per calendar year to treat aphakia (absence of the crystalline lens of the eye)	Nothing	Nothing
Not covered: • *Eyeglass lenses or frames* • *Contact lenses, examinations for contact lenses or the fitting of contact lenses, except for the condition of aniridia or to treat aphakia* • *Eye surgery solely for the purpose of correcting refractive defects of the eye*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**
• Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	$15 per primary care office visit $25 per specialty care office visit	$30 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 (unless the treatment is by open cutting surgery)*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
External prosthetic and orthotic devices , such as: • Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy	Nothing	Nothing

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Ostomy and urological supplies that are consistent with our Plan Soft Goods Formulary guidelines. • Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan physician • Special footwear for foot disfigurement due to disease, injury, or developmental disability • Enteral formula for members who require tube feeding per Medicare guidelines • Tracheostomy tube and supplies • Enteral pump and supplies • External devices used for the treatment of sexual dysfunction	Nothing	Nothing
Internal prosthetic devices, such as: • Artificial joints • Pacemakers • Cochlear implants • Osseointegrated external hearing devices • Surgically implanted breast implants following a mastectomy • Monofocal intraocular lenses following cataract removal • Repairs and replacements resulting from normal use Note: See Section 5(b), *Surgery benefits,* for coverage of the surgery to insert the device and Section 5(c), *Hospital benefits*, for inpatient hospital benefits.	Nothing	Nothing
Notes: • Orthopedic and prosthetic equipment or services must be prescribed by a Plan physician; obtained through sources designated by the Plan; and primarily and customarily used to serve a medical or therapeutic purpose in the treatment of an illness or injury. • We cover only those standard items that are adequate to meet the medical needs of the member. • For coverage of hearing aids, see Section 5(a), *Hearing services*. • See Section 3 *How you get care* for services that need prior Plan approval.	Applies to this benefit	Applies to this benefit
Not covered:	*All charges*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
• *Orthopedic and prosthetic devices and corrective shoes, except as described above* • *Foot orthotics and podiatric use devices, such as arch supports, heel pads and heel cups, except as described above* • *Multifocal intraocular lenses and intraocular lenses to correct astigmatism* • *Nonrigid supplies, such as elastic stockings and wigs* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Comfort, convenience, or luxury equipment or features* • *Repairs, adjustments, or replacements due to misuse, theft or loss*	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen and oxygen dispensing equipment • Hospital beds • Wheelchairs, including motorized wheelchairs when medically necessary • Crutches • Walkers • Speech generating devices • Blood glucose monitors and related supplies • Insulin pumps • Infant apnea monitors	20% of our allowance	50% of our allowance
• One breastfeeding pump and supplies per delivery, including equipment that is required for pump functionality • Ultraviolet light treatment equipment	Nothing	Nothing
• During a covered stay in a Plan hospital or skilled nursing facility	Nothing	Nothing
Notes:	Applies to this benefit	Applies to this benefit

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
• Durable medical equipment (DME) is equipment that is prescribed by a Plan physician; obtained through sources designated by the Plan; consistent with our Plan DME formulary guidelines; intended for repeated use; primarily and customarily used to serve a medical or therapeutic purpose in the treatment of an illness or injury; designed for prolonged use; and appropriate for use in the home. • We cover only those standard items that are adequate to meet the medical needs of the member. • We may require you to return the equipment to us, or pay us the fair market price of the equipment, when it is no longer prescribed. • We only provide DME in the Plan's service areas, except we cover the following DME items if you live outside our service area when the item is dispensed at a Plan facility: - Standard curved handle cane - Standard crutches - For diabetes blood testing, blood glucose monitors and their supplies from a Plan Pharmacy - Insulin pumps and supplies to operate the pump (but not including insulin or any other drugs), after completion of training and education on the use of the pump - Nebulizers and their supplies for the treatment of pediatric asthma - Peak flow meters from a Plan Pharmacy • Diabetes urine-testing supplies and insulin-administration devices other than insulin pumps are covered under your prescription drug benefit. See Section 5(f), *Prescription drug benefits.* • See Section 3 *How you get care* for services that need prior Plan approval.	Applies to this benefit	Applies to this benefit
Not covered: • *Audible prescription reading devices* • *Comfort, convenience, or luxury equipment or features* • *Non-medical items such as sauna baths or elevators* • *Exercise and hygiene equipment* • *Electronic monitors of the heart, lungs, or other bodily functions, except for infant apnea monitors* • *Devices to perform medical testing of bodily fluids, excretions or substances, except diabetic blood testing equipment and supplies*	*All charges*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
• *Modifications to the home or vehicle* • *Dental appliances* • *More than one piece of durable medical equipment serving essentially the same function* • *Spare or alternate use equipment* • *Repairs, adjustments, or replacements due to misuse, theft or loss*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
• Home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), physical or occupational therapist, speech therapist or home health aide • Services include oxygen therapy, intravenous therapy, and medications Notes: • We only provide these services in the Plan's service areas. • The services are covered only if you are homebound and a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home. • Services of a home health aide must be part of covered home healthcare and home health aide services are not covered unless you are also getting covered home healthcare from a licensed provider that only a licensed provider can provide. • See Section 3 *How you get care* for services that need prior Plan approval.	Nothing	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Custodial care* • *Personal care and hygiene items* • *Care of a type that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training. This care is excluded even if we would cover the care if it were provided by a qualified medical professional in a hospital or a skilled nursing facility.*	*All charges*	*All charges*

Benefit Description	You pay	
Chiropractic	**High Option**	**Standard Option**
Up to 20 visits per calendar year, limited to: • Diagnosis and treatment of neuromusculoskeletal disorders • Laboratory tests and plain film X-rays associated with diagnosis and treatment Notes: • You may only self-refer to a participating American Specialty Health (ASH) network chiropractor. The participating chiropractor must provide, arrange or prescribe your care and appliances. • Participating chiropractors are listed in the ASH Participating Provider Directory. For a list of ASH Participating Providers, call 800-678-9133.	$15 per visit	$15 per visit
• Chiropractic appliances	*All charges* over $50 per calendar year	*All charges* over $50 per calendar year
Not covered: • *Hypnotherapy, behavior training, sleep therapy and weight programs* • *Thermography* • *Any radiological exam other than plain film studies such as magnetic resonance imaging, CT scans, bone scans, nuclear radiology* • *Treatment for non-neuromusculoskeletal disorders, including adjunctive therapy*	*All charges*	*All charges*
Alternative treatments	**High Option**	**Standard Option**
• Acupuncture services, primarily for the treatment of chronic pain and nausea	$15 per visit	$30 per visit
Not covered: • *Massage therapy*	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
Health education classes including: • 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. • Stress reduction • Chronic conditions, such as diabetes and asthma • Individual health education visits • Childhood obesity screening programs and treatment interventions Notes:	Nothing	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay	
Educational classes and programs (cont.)	**High Option**	**Standard Option**
• Please call your local Health Education department or Member Services at 800-464-4000 for information on classes near you. • See Section 5(f), *Prescription drug benefits*, for important information about coverage of tobacco cessation and other drugs.	Nothing	Nothing

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and will also determine the most medically appropriate setting for provision of care. Consult with your physician to determine what is appropriate for you.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The cost-sharing listed below applies to services billed by a physician or other healthcare professional for your surgical care. See Section 5(a) for cost-sharing you pay for services performed during an office visit or 5(c) for cost-sharing you pay for services in an inpatient hospital, outpatient hospital or ambulatory surgical center facility.
- **YOUR PROVIDER MUST GET PRIOR APPROVAL FOR SOME SURGICAL PROCEDURES**. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay	
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and postoperative 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*) • Treatment of burns • Insertion of other implanted time-release drugs Notes: • We cover the cost of these drugs and devices under the prescription drug benefit (see Section 5(f)). • See Section 3, *How you get care* for services that need prior Plan approval	Nothing	Nothing
• Surgical treatment of severe obesity (bariatric surgery). Notes:	Nothing	Nothing

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
• Visit www.kp.org/postal to get a list of criteria you must meet to qualify for bariatric surgery. You should consult with your physician to determine what is appropriate for you. • A Plan physician, who is a specialist in bariatric care, must determine that the surgery is medically necessary. • If you live 50 miles or more from the facility to which you are referred for a covered bariatric surgery, we will reimburse you for certain authorized and documented travel and lodging expenses as follows if: - The Medical Group gives you prior written authorization for travel and lodging reimbursement and - You send us adequate documentation including receipts. • Reimbursement benefits are subject to certain limits. Please call our Member Services Call Center at 800-464-4000 for more information.	Nothing	Nothing
• Voluntary sterilization, including anesthesia and confirmation testing following tubal occlusion and vasectomy • Insertion of surgically implanted time-release contraceptive drugs and intrauterine devices (IUDs)	Nothing	Nothing
• Surgical and any other procedures requiring licensed staff to monitor your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort.	Nothing	Nothing
• Insertion of internal prosthetic devices. See Section 5(a) *Orthopedic and prosthetic devices,* for device coverage information. Notes: • The following contraceptive devices and drugs are provided at no charge: intrauterine devices (IUDs), implanted time-release contraceptive drugs and injectable contraceptive drugs. We cover oral contraceptives, cervical caps, and diaphragms under the prescription drug benefit. • For female surgical family planning procedures see Family Planning Section 5(a) Note: For male surgical family planning procedures see Family Planning Section 5(a).	Nothing	Nothing

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
• 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.	Nothing	Nothing
Not covered: • *Reversal of voluntary surgical sterilization* • *Services for the promotion, prevention, or other treatment of hair loss or hair growth* • *Cosmetic surgery - any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**
• 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; webbed fingers and toes Note: We cover dental extractions, dental procedures necessary to prepare the mouth for an extraction and orthodontic services that are an integral part of reconstructive surgery for cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery and reconstruction on the other breast to produce a symmetrical appearance. - treatment of any physical complications, such as lymphedemas. - breast prostheses and surgical bras and replacements (see *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. • Gender Affirming Surgery	Nothing	Nothing

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
Notes: • Visit kp.org/postal to get a list of criteria you must meet to qualify for gender affirming surgery and the surgeries available. You should consult with your primary care physician to determine what is appropriate for you. • Your primary care physician will introduce you to specialists and other caregivers familiar with the unique challenges of transitioning. Care teams collaborate to provide medical, psychological, and emotional support throughout the process.	Nothing	Nothing
• Reconstructive surgical and any other procedures requiring licensed staff to monitor your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort.	Nothing	Nothing
Not covered: • *Cosmetic surgery—any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury and mental health conditions*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaw or facial bones • Surgical correction of cleft lip, cleft palate, or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Medical and surgical treatment of temporomandibular joint **(**TMJ**)** disorder (non-dental); and • Other surgical procedures that do not involve the teeth or their supporting structures	Nothing	Nothing
• Oral surgical procedures requiring licensed staff to monitor your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort.	Nothing	Nothing
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*

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay	
Oral and maxillofacial surgery (cont.)	**High Option**	**Standard Option**
• *Dental services associated with medical treatment such as surgery, except for services related to accidental injury of teeth (See Section 5(g))*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to Section 3, *How you get care,* for authorization procedures. Solid organ tissue transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart-lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung: Single/bilateral/lobar • Pancreas	Nothing	Nothing
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
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	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- 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 - 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

Organ/tissue transplants - continued on next page

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

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Hemoglobinopathy - Marrow Failure and Related Disorders (i.e. Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	Nothing	Nothing
Transplant services requiring licensed staff to monitor your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort.	Nothing	Nothing
Notes: • We cover related medical and hospital expenses of the donor when we cover the recipient. • We cover donor screening tests for potential donors for solid organ transplants. We cover human leukocyte antigen (HLA) typing for potential donors for a bone marrow/stem cell transplant only for parents, children and siblings of the recipient.	Applies to this benefit	Applies to this benefit

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• We cover computerized national and international search expenses for prospective unrelated bone marrow/stem cell transplant donors conducted through the National Marrow Donor Program, and the testing of blood relatives of the recipient. • We cover medically necessary routine dental services required in preparation for a transplant. Covered services may include a routine oral examination, cleaning (prophylaxis), extractions, and X-rays. You pay cost-sharing listed in Section 5(a) for services performed during an office visit. • Please refer to Section 5(h), *Special features,* for information on our Centers of Excellence. • See Section 3 *How you get care* for services that need prior Plan approval.	Applies to this benefit	Applies to this benefit
	All charges	*All charges*
Anesthesia	**High Option**	**Standard Option**
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgery center • Office	Nothing	Nothing

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Sections 5 (a) or (b).

Benefit Description	You pay	
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$250 per admission	$500 per admission
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Blood and blood products • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services Note: You may receive covered hospital services for certain dental procedures if a Plan physician determines you need to be hospitalized for reasons unrelated to the dental procedure. The need for anesthesia, by itself, is not such a condition.	Nothing	Nothing
Not covered: • *Custodial care and care in an intermediate care facility* • *Non-covered facilities, such as nursing homes* • *Personal comfort items, such as barber services, and guest meals and beds*	*All charges*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• *Private nursing care, except when medically necessary* • *Inpatient dental procedures*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Lab, X-rays, and other diagnostic tests • Blood and blood products • Pre-surgical testing • Dressing, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics and anesthesia services Notes: • 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.	$50 per admission	$200 per admission
• Voluntary sterilization	Nothing	Nothing
Skilled nursing care facility benefits	**High Option**	**Standard Option**
Up to 100 days per benefit period when you need full-time skilled nursing care. A benefit period begins when you enter a hospital or skilled nursing facility and ends when you have not been a patient in either a hospital or skilled nursing facility for 60 consecutive days. All necessary services are covered, including: • Room and board • General nursing care • Medical social services • Prescribed drugs, biological supplies, and equipment, including oxygen, ordinarily provided or arranged by the skilled nursing facility	Nothing	Nothing
Not covered: • *Custodial care and care in an intermediate care facility* • *Personal comfort items, such as phone, television, barber services, and guest meals and beds*	*All charges*	*All charges*

Benefit Description	You pay	
Hospice care	**High Option**	**Standard Option**
Supportive and palliative care for a terminally ill member: • The Services are provided inside our Service Area or inside California but within 15 miles or 30 minutes from our Service Area (including a friend's or relative's home even if you live there temporarily) • Services are provided in the home, when a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home. • Services include inpatient care under limited circumstances, outpatient care and family counseling. A Plan physician must certify that you have a terminal illness, with a life expectancy of approximately twelve months or less.	Nothing	Nothing
Not covered: • *Independent nursing (private duty nursing)*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
• Local licensed ambulance service when medically necessary Note: See Section 5(d) for emergency services.	$50 per trip	$150 per trip
Not covered: • *Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van), even if it is the only way to travel to a Plan provider*	*All charges*	*All charges*

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- 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.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is an 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.
- A psychiatric emergency is a mental disorder that manifests itself by acute symptoms of sufficient severity such that either you are in immediate danger to yourself or others, or you are not immediately able to provide for, or use, food, shelter, or clothing, due to the mental disorder.

Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies—what they all have in common is the need for quick action.

What to do in case of emergency:

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

Emergencies within our service area:

If you think you have a medical emergency, call **911** or go to the nearest hospital. To better coordinate your emergency care, we recommend that you go to a Plan hospital if it is reasonable to do so considering your condition or symptoms. Please refer to *Your Guidebook to Kaiser Permanente Services (Guidebook)* for the location of Plan hospitals that provide emergency care.

Post-stabilization care is the services you receive after your treating physician determines that you are clinically stable. We cover post-stabilization care if a Plan provider provides it or if you obtain authorization from us to receive the care from a non-Plan provider.

When you are sick or injured, you may have an urgent care need. An urgent care need is one that requires prompt medical attention, but is not a medical emergency. If you think you may need urgent care, call the appropriate appointment or advice nurse number at a Plan facility. Please refer to the *Guidebook* for advice nurse and Plan facility phone numbers.

Emergencies outside our service area:

If you think you have a medical emergency, call **911** or go to the nearest hospital.

Post-stabilization care is the services you receive after your treating physician determines that you are clinically stable. We cover post-stabilization care if a Plan provider provides it or if you obtain authorization from us to receive the care from a non-Plan provider.

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

You may obtain emergency and urgent care services from Kaiser Permanente medical facilities and providers when you are in the service area of another Kaiser Permanente plan. The facilities will be listed in the local phone book under "Kaiser Permanente". These numbers are available 24 hours a day, seven days a week. You may also obtain information about the location of facilities by calling 800-227-2415.

How to Obtain Authorization

You must call us at 800-225-8883 (the phone number is also on your ID card) to:

- Request authorization for post-stabilization care *before* you obtain the care from a non-Plan provider if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible).
- Notify us that you have been admitted to a non-Plan Hospital.

We understand that extraordinary circumstances can delay your ability to call us, for example, if you are unconscious or a young child without a parent or guardian. In these cases, you must call us as soon as it is reasonably possible. Please keep in mind that anyone can call us. We do not cover any care you receive from non-Plan providers after you're clinically stable unless we authorize it, so if you don't call us as soon as reasonably possible you increase the risk that you will have to pay for this care.

Benefit Description	You pay	
Emergencies within our service area	**High Option**	**Standard Option**
• Urgent care at a Plan urgent care center	$15 per visit	$30 per visit
• Emergency room visits at a Plan hospital, including physicians' services • Emergency care as an outpatient at a non-Plan hospital, including physicians' services • Urgent care at a Plan emergency room Notes: • If you receive emergency care and then are transferred to observation care, you pay the emergency services cost-sharing. If you are admitted as an inpatient, we will waive your emergency room copayment and you will pay your cost-sharing related to your inpatient hospital stay.	$100 per visit	$150 per visit
Not covered: • *Elective care or non-emergency care (unless you receive prior authorization)* • *Urgent care at a non-Plan urgent care center*	*All charges*	*All charges*
Emergency outside our service area	**High Option**	**Standard Option**
• Urgent care at an urgent care center	$15 per visit	$30 per visit
• Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including physicians' services • Urgent care at an emergency room Note: See Section 5(h) for travel benefit coverage of continuing or follow-up care.	$100 per visit	$150 per visit
Not covered:	*All charges*	*All charges*

Emergency outside our service area - continued on next page

Benefit Description	You pay	
Emergency outside our service area (cont.)	**High Option**	**Standard Option**
• *Elective care or non-emergency care at non-Plan facilities (unless you receive prior authorization)*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Licensed ambulance services are covered when: • Your treating physician determines that you must be transported to another facility because your emergency medical condition is not stabilized and the care you need is not available at the treating facility. • You are not already being treated, and you reasonably believed that the medical condition was an emergency medical condition which required ambulance services. Notes: • See Section 5(c) for non-emergency service. • Trip means any time an ambulance is summoned on your behalf.	$50 per trip	$150 per trip
Not covered: • *Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van), even if it is the only way to travel to a provider or facility.*	*All charges*	*All charges*

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are clinically appropriate to treat your condition.
- Plan physicians must provide or arrange your care. In addition, we will cover behavioral health crisis services provided by a 988 center and mobile crisis team providers for treating a mental health or substance use disorder, as state law requires. You pay the same cost-sharing for services you receive from a Plan provider.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay	
Professional services	**High Option**	**Standard Option**
We cover professional services recommended by a Plan mental health or substance use disorder treatment provider that are covered services, drugs, and supplies described in this brochure. Notes: • We cover the services only when we determine that the care is clinically appropriate to treat your condition.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions	Your cost-sharing responsibilities are no greater than for other illnesses or conditions
Diagnosis and treatment of psychiatric conditions, mental illness, or disorders. Services include: • Diagnostic evaluation • Treatment and counseling (including individual and group therapy visits) • Crisis intervention and stabilization for acute episodes • Psychological and neuropsychological testing that is medically necessary to determine the appropriate psychiatric treatment • Medication evaluation and management (pharmacotherapy) • Electroconvulsive therapy	$15 per individual office visit $7 per group office visit	$30 per individual office visit $15 per group office visit
• Applied Behavior Analysis (ABA) program for the treatment of autism spectrum disorder	Nothing	$30 per day
Notes:	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**
• We cover behavioral health crisis services provided by 988 center and mobile crisis team providers, for medically necessary treatment of a mental health or substance use disorder without prior authorization until the condition is stabilized, as required by state law. After the mental health or substance use disorder condition has been stabilized, post-stabilization care from non-Plan providers is subject to prior authorization as described in section 5(d), *Emergency services/accidents.* You pay the same cost-sharing you pay for services you receive from a Plan provider. • You may see a Plan mental health or substance use disorder treatment provider for outpatient services without a referral from your primary care provider. See Section 3, *How you get care,* for information about services requiring our prior approval. • Your Plan mental health or substance use disorder treatment provider will develop a treatment plan to assist you in improving or maintaining your condition and functional level, or to prevent relapse and will determine which diagnostic and treatment services are appropriate for you. • The California Community Assistance, Recovery, and Empowerment ("CARE") Act established a system for individuals with severe mental illness to be evaluated and given a treatment plan developed by a county behavioral health agency ("CARE Plan"). If you have a court-approved CARE Plan, we cover the services required under that plan when provided by Plan providers or non-Plan providers at no charge, with the exception of prescription drugs.	Applies to this benefit	Applies to this benefit
Diagnostics	**High Option**	**Standard Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Your cost-sharing responsibilities are no greater than for other illness or condition. See Section 5 (a) *Lab, X-ray and other diagnostic tests.* *See Section 5 (c), Other Hospital Services and Supplies.*	Your cost-sharing responsibilities are no greater than for other illness or condition. See Section 5 (a) *Lab, X-ray and other diagnostic tests.* *See Section 5 (c), Other Hospital Services and Supplies.*

Benefit Description	You pay	
Inpatient hospital or other covered facility	**High Option**	**Standard Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Inpatient psychiatric care • Inpatient substance use disorder care Note: All inpatient admissions require approval by a Plan mental health or substance use disorder treatment physician	$250 per admission	$500 per admission
• Psychiatric and substance use disorder care in a residential treatment center Note: Residential treatment programs require approval by a Plan mental health or substance use disorder treatment physician.	$100 per stay	$100 per stay
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
Outpatient services provided and billed by a hospital or other covered facility • Hospital alternative services, such as partial hospitalization and intensive outpatient psychiatric treatment programs	Nothing	Nothing
• Intensive outpatient treatment program for substance use disorders	Nothing	$5 per day
Note: All hospital alternative services treatment programs require approval by a Plan mental health or substance use disorder treatment physician.	Applies to this benefit	Applies to this benefit
Not covered: • *Care that is not clinically appropriate for the treatment of your condition* • *Intelligence, IQ, aptitude ability, learning disorders, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition* • *Evaluation or therapy on court order or as a condition of parole or probation, or otherwise required by the criminal justice system, unless determined by a Plan physician to be medically necessary and appropriate* • *Services that are custodial in nature* • *Marital, family or educational services* • *Services rendered or billed by a school or a member of its staff* • *Services provided under a Federal, state, or local government program*	*All charges*	*All charges*

Outpatient hospital or other covered facility - continued on next page

Benefit Description	You pay	
Outpatient hospital or other covered facility (cont.)	**High Option**	**Standard Option**
• *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms*	*All charges*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- Your prescribers must obtain prior approval authorizations for certain prescription drugs and supplies from Medical Group before coverage applies. Prior approval/authorizations must be renewed periodically.
- We have no calendar year deductible.
- Federal law prevents the pharmacy from accepting unused medications.
- 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.

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

- **Who can write your prescription**. A licensed Plan provider or any dentist must prescribe your medication. Drugs prescribed by dentists are not covered if a Plan provider determines that they are not medically necessary. We cover prescriptions written by a non-Plan provider or filled at a non-Plan pharmacy only for emergencies or out-of-area urgent care (see Section 5(d), *Emergency services/accidents*), or as stated in this section.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy, another pharmacy that we designate, or through our mail order program for certain maintenance medication as specified below. You may be able to order refills from a Plan Pharmacy, our mail-order program or through our website at www.kp.org/rxrefill. A Plan Pharmacy or Your Guidebook can give you more information about obtaining refills, including the options available to you for obtaining refills. Plan members called to active military duty (or members in time of national emergency), who need to obtain prescribed medications, should contact our Member Service Call Center at 800-464-4000 (TTY: 711) for further information regarding dispensing limitations.
- **We use a managed formulary.** The medications included in our drug formulary are chosen by a group of Kaiser Permanente physicians, pharmacists and other Plan providers known as the Pharmacy and Therapeutics Committee. The committee meets regularly to consider adding and removing prescription drugs on the drug formulary based on new information or drugs that become available. We describe any additional coverage requirements and limits in our PSHB formulary. These may include step therapy, prior authorization, quantity limits, drugs that can only be obtained at certain specialty pharmacies, or other requirements and limits described in our formulary.

  We cover non-formulary drugs (those not listed on our drug formulary for your condition) prescribed by a Plan provider if they would otherwise be covered and a Plan provider determines that the drug is medically necessary. If you request the non-formulary drug when your Plan provider has prescribed a substitution, the non-formulary drug is not covered. However, you may purchase the non-formulary drug from a Plan pharmacy at prices charged to members for non-covered drugs. For more information on our prescription drug PSHB formulary, visit www.kp.org/formulary, or call our Member Service Contact Center at 800-464-4000 (TTY: 711).

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

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

- **Tier 4: Specialty drugs.** Specialty drugs are high-cost drugs that are on our specialty drug list.

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

- **These are the dispensing limitations.** We provide up to a 30-day supply for most drugs when dispensed in a Plan pharmacy at one copayment. We provide up to a 100-day supply for most drugs when dispensed in a Plan pharmacy for three copayments or through our mail order program for two copayments. For prescribed hormonal contraceptives, you may obtain up to a 12-month supply at a Plan pharmacy or through our mail-delivery program. We cover episodic drugs prescribed to treat sexual dysfunction disorders up to a maximum of 8 doses in any 30-day period or up to 27 doses in any 100-day period. When you are prescribed an oral or solid Schedule II drug (drugs with a high potential for abuse which may lead to severe psychological or physical dependence), you or the prescribing provider can request that the pharmacy dispense less than the prescribed amount. Your cost-sharing will be prorated based on the amount of the drug that is dispensed. Most drugs can be mailed from our mail order pharmacy. Some drugs (for example, drugs that are extremely high cost, or require special handling, have standard packaging or requested to be mailed outside the state of California) may not be eligible for mailing and/or mail order discount. The pharmacy may reduce the day supply dispensed if the pharmacy determines that the item is in limited supply in the market or for specific drugs (your Plan pharmacy can tell you if a drug you take is one of these drugs). You will pay the lesser amount of the total cost of the drug based on the dispensed day's supply (prorated copay) or the full copay if full supply is available.
- **A generic equivalent will be dispensed if it is available,** unless your Plan provider specifically requires a brand-name drug. If you request a brand-name drug when a FDA approved generic drug is available, and your Plan provider has not specified the brand-name drug must be dispensed, you have to pay the full cost of the brand-name drug.
- **Why use generic drugs?** Typically generic drugs cost you and us less money than a brand-name drug. Under federal law, generic and brand-name drugs must meet the same standards for safety, purity, strength, and effectiveness.
- **When you do have to file a claim.** You do not 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 as specified in Section 5 (d), *Emergency services/accidents.* For information about how to file a claim, see Section 7, *Filing a claim for covered services*.

Benefit Description	You pay	
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician or dentist and obtained from a Plan pharmacy or through our mail order program: • Certain self-administered IV drugs and fluids requiring specific types of parenteral infusion, and the supplies required for their administration • Hematopoietic agents for dialysis • Amino acid-modified products used to treat congenital errors of amino acid metabolism • Diabetes urine-testing supplies limited to ketone test strips, test tape and acetone test tablets, up to a 100-day supply • Elemental dietary enteral formula when used as a primary therapy for regional enteritis Note: See Section 5(a), *Durable medical equipment*, for diabetes blood-testing equipment and supplies.	Nothing	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• Drugs and medication that, by federal law, require a prescription for their purchase, except those listed as *Not covered*. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary. • Insulin • Disposable needles and syringes for the administration of covered medications • Growth hormone • Vaccines and immunizations approved for use by the Food and Drug Administration • Drugs to treat gender dysphoria, including hormones and androgen blockers • Medications prescribed to treat obesity Notes: • For information about mail order discounts, see "These are the dispensing limitations" in the introduction to Section 5(f). • The preferred or non-preferred brand name or specialty drug cost share will apply to compound drugs. • A compound drug is one in which two or more drugs or pharmaceutical agents are combined together. We limit coverage to products listed in our drug formulary and when one of the ingredients requires a prescription by law.	$10 for generic drugs, $40 for preferred and non-preferred brand name drugs, and $100 for specialty drugs per prescription or refill for up to a 30-day supply at a Plan pharmacy *All charges* if you request a brand name drug in place of a generic drug	$15 for generic drugs, $50 for preferred and non-preferred brand name drugs, and $150 for specialty drugs per prescription or refill for up to a 30-day supply at a Plan pharmacy *All charges* if you request a brand name drug in place of a generic drug
• Therapeutics for COVID-19 obtained from Plan Providers	No charge for up to a 30-day supply	No charge for up to a 30-day supply
• Therapeutics for COVID-19 obtained from non-Plan Providers (except when prescribed as part of a covered Emergency Services or Out-of-Area Urgent Care) Note: If you obtain a prescription from a non-Plan Provider related to COVID-19 therapeutics, we do not cover an office visit or any other services from the non-Plan Provider.	50% coinsurance for up to a 30-day suppl	50% coinsurance for up to a 30-day supply
• Prescribed tobacco cessation medications, including prescribed over-the-counter medications, approved by the FDA to treat tobacco dependence	Nothing	Nothing
• Insulin administration devices, such as: - Disposable needles and syringes - Pen delivery devices - Visual aids required to ensure proper dosage (except eyewear)	Up to a 100-day supply at $10	Up to a 100-day supply at $15

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
Note: See Section 5(a), *Durable medical equipment*, for coverage of insulin pumps and supplies	Up to a 100-day supply at $10	Up to a 100-day supply at $15
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 non-formulary, 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 non-formulary contraceptive drugs when determined medically necessary. 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. 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 or OPM's website at Contraception Coverage at opm.gov/healthcare-insurance/healthcare/contraception-coverage/	Nothing *All charges* if you request a brand name drug in place of a generic drug	Nothing *All charges* if you request a brand name drug in place of a generic drug

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
We cover prescribed FDA approved over-the-counter women's contraceptives and devices when prescribed by a Plan provider and obtained at a Plan pharmacy. Note: • For additional Family Planning benefits see Section 5(a).	Nothing *All charges* if you request a brand name drug in place of a generic drug	Nothing *All charges* if you request a brand name drug in place of a generic drug
• 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	50% of our allowance
• Sexual dysfunction drugs Note: If a drug for which a prescription is required by law is excluded and we had been covering and providing it to you for a use approved by the FDA, we will continue to provide the drug upon payment of 50% of our allowance if a Plan physician continues to prescribe the drug for the same condition.	50% of our allowance up to a maximum of $50 for generic drugs; 50% of our allowance up to a maximum of $100 or preferred brand-name drugs	50% of our allowance up to a maximum of $50 for generic drugs; 50% of our allowance up to a maximum of $100 or preferred brand-name drugs
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Prescriptions filled at a non-Plan pharmacy, except for emergencies as described in Section 5(d), Emergency services/accidents* • *Vitamins, nutritional and herbal supplements that can be purchased without a prescription, unless they are included in our drug formulary or listed as covered above or below* • *Over-the-counter (nonprescription) drugs, including prescription drugs for which there is an over-the-counter equivalent available, unless listed as covered above.* • *Over-the-counter drugs, unless they are included in our drug formulary or listed as covered above* • *Prescription drugs not on our drug formulary, unless approved through an exception process* • *Medical supplies, such as dressings and antiseptics, except as listed above* • *Drugs that shorten the duration of the common cold* • *Any requested packaging of drugs other than the dispensing pharmacy's standard packaging* • *Replacement of lost, stolen or damaged prescription drugs and accessories*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• *Drugs related to non-covered services, except as stated above* • *Drugs for the promotion, prevention, or other treatment of hair loss or growth*	*All charges*	*All charges*
Preventive medications	**High Option**	**Standard Option**
The following are covered: • Aspirin to reduce the risk of heart attack • Oral fluoride for children to reduce the risk of tooth decay • Folic acid for women to reduce the risk of birth defects • Medication to reduce the risk of breast cancer Note: Preventive medications with a USPSTF recommendation 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
Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained in a clinical setting administered in a form such as 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
Not covered: • *Prescriptions filled at a non-Plan pharmacy, except for emergencies as described in Section 5(d), Emergency services/accidents* • *Vitamins, nutritional and herbal supplements that can be purchased without a prescription, unless they are included in our drug formulary or listed as covered above.* • *Over-the-counter drugs, unless they are included in our drug formulary or listed as covered above* • *Prescription drugs not on our drug formulary, unless approved through an exception process* • *Any requested packaging of drugs other than the dispensing pharmacy's standard packaging*	*All charges*	*All charges*

Preventive medications - continued on next page

Benefit Description	You pay	
Preventive medications (cont.)	**High Option**	**Standard Option**
• *Replacement of lost, stolen or damaged prescription drugs and accessories* • *Drugs related to non-covered services*	*All charges*	*All charges*

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

Important things you should keep in mind about these benefits:

- 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 (800) 464-4000.

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

There are advantages to being enrolled in our PDP EGWP:

- In our PDP EGWP, your cost-share for covered drugs, medications, and supplies will be equal to or better than the cost-share for those enrolled in our standard non-PDP EGWP Prescription Drug Program.
- In our PDP EGWP, you have a pharmacy network that may include pharmacies that are out-of-network or excluded for those enrolled in our standard non-PDP EGWP Prescription Drug Program. Go to www.kp.org/directory to use the *Pharmacy Directory* or contact Member Services at (800) 464-4000 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 law prevents the pharmacy from accepting unused medications.
- Be sure to read Section 4, *Your cost for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- If you choose to opt out of or disenroll from our PDP EGWP, see Section 9 for additional PDP EGWP information and for our opt-out and disenrollment process. Contact us for assistance with the PDP EGWP opt out and disenrollment process at 800-464-4000 (TTY: 711).

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

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

- Visit www.kp.org/postal to view benefit details, enroll online, download an enrollment application, or RSVP to attend a seminar.

- Call and speak to a Kaiser Permanente Medicare health plan specialist at 877-547-4909 (TTY 711), Monday through Friday, from 6 a.m. 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 800-464-4000 (TTY: 711).

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

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

- **Who can write your prescription**. A licensed Plan provider or any dentist must prescribe your medication. Drugs prescribed by dentists are not covered if a Plan provider determines that they are not medically necessary. We cover prescriptions written by a non-Plan provider or filled at a non-Plan pharmacy only for emergencies or out-of-area urgent care (see Section 5(d), *Emergency services/accidents*), or as stated in this section. Your prescribers must have Medicare-approved prescriptive authority.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy, another pharmacy that we designate, or through our mail order program for certain maintenance medication as specified below. You may be able to order refills from a Plan Pharmacy, our mail-order program or through our website at www.kp.org/rxrefill. A Plan Pharmacy or Your Guidebook can give you more information about obtaining refills, including the options available to you for obtaining refills. Plan members called to active military duty (or members in time of national emergency), who need to obtain prescribed medications, should contact our Member Service Call Center at 800-464-4000 (TTY: 711) for further information regarding dispensing limitations. For assistance locating a PDP EGWP network pharmacy, visit our website at www.kp.org, or call Member Services at 800-464-4000 (TTY: 711).
- **We use a managed formulary.** The medications included in our drug formulary are chosen by a group of Kaiser Permanente physicians, pharmacists and other Plan providers known as the Pharmacy and Therapeutics Committee. The committee meets regularly to consider adding and removing prescription drugs on the drug formulary based on new information or drugs that become available. We describe any additional coverage requirements and limits in our PSHB formulary. These may include step therapy, prior authorization, quantity limits, drugs that can only be obtained at certain specialty pharmacies, or other requirements and limits described in our formulary.

  We cover non-formulary drugs (those not listed on our drug formulary for your condition) prescribed by a Plan provider if they would otherwise be covered and a Plan provider determines that the drug is medically necessary. If you request the non-formulary drug when your Plan provider has prescribed a substitution, the non-formulary drug is not covered. However, you may purchase the non-formulary drug from a Plan pharmacy at prices charged to members for non-covered drugs. For more information on our prescription drug PSHB formulary, visit www.kp.org/formulary, or call our Member Service Contact Center at 800-464-4000 (TTY: 711).

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

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

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

- **These are the dispensing limitations.** We provide up to a 30-day supply for most drugs when dispensed in a Plan pharmacy at one copayment. We provide up to a 100-day supply for most drugs when dispensed in a Plan pharmacy for three copayments or through our mail order program for two copayments. For prescribed hormonal contraceptives, you may obtain up to a 12-month supply at a Plan pharmacy or through our mail-delivery program. We cover episodic drugs prescribed to treat sexual dysfunction disorders up to a maximum of 8 doses in any 30-day period or up to 27 doses in any 100-day period. When you are prescribed an oral or solid Schedule II drug (drugs with a high potential for abuse which may lead to severe psychological or physical dependence), you or the prescribing provider can request that the pharmacy dispense less than the prescribed amount. Your cost-sharing will be prorated based on the amount of the drug that is dispensed. Most drugs can be mailed from our mail order pharmacy. Some drugs (for example, drugs that are extremely high cost, or require special handling, have standard packaging or requested to be mailed outside the state of California) may not be eligible for mailing and/or 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.
- **A generic equivalent will be dispensed if it is available,** unless your Plan provider specifically requires a brand-name drug. If you request a brand-name drug when a FDA approved generic drug is available, and your Plan provider has not specified the brand-name drug must be dispensed, you have to pay the full cost of the brand-name drug.
- **Why use generic drugs?** Typically generic drugs cost you and us less money than a brand-name drug. Under federal law, generic and brand-name drugs must meet the same standards for safety, purity, strength, and effectiveness.
- **When you do have to file a claim.** You do not 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 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 and you want to appeal, you**, 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 Catastrophic Maximum.** When you (or those paying on your behalf) have spent a total of **$2,000** 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 (EOC) for Kaiser Permanente Medicare Part D Group Plan (PDP) for Postal Service Health Benefits (PSHB) Members.

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.		
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician or dentist and obtained from a Plan pharmacy or through our mail order program: • Certain self-administered IV drugs and fluids requiring specific types of parenteral infusion, and the supplies required for their administration • Hematopoietic agents for dialysis • Amino acid-modified products used to treat congenital errors of amino acid metabolism • Diabetes urine-testing supplies limited to ketone test strips, test tape and acetone test tablets, up to a 100-day supply • Elemental dietary enteral formula when used as a primary therapy for regional enteritis Note: See Section 5(a), Durable medical equipment, for diabetes blood-testing equipment and supplies.	Nothing	Nothing
Drugs and medication that, by federal law, require a prescription for their purchase, except those listed as Not covered. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary. • Insulin • Disposable needles and syringes for the administration of covered medications • Growth hormone • Vaccines and immunizations approved for use by the Food and Drug Administration • Drugs to treat gender dysphoria, including hormones and androgen blockers • Medications prescribed to treat obesity Notes: • For information about mail order discounts, see “These are the dispensing limitations” in the introduction to Section 5(f). • The preferred or non-preferred brand name or specialty drug cost share will apply to compound drugs. • A compound drug is one in which two or more drugs or pharmaceutical agents are combined together. We limit coverage to products listed in our drug formulary and when one of the ingredients requires a prescription by law.	$10 for generic drugs, $40 for preferred and non-preferred brand name drugs, and $100 for specialty drugs per prescription or refill for up to a 30-day supply at a Plan pharmacy All charges if you request a brand name drug in place of a generic drug	$15 for generic drugs, $45 for preferred and non-preferred brand name drugs, and $150 for specialty drugs per prescription or refill for up to a 30-day supply at a Plan pharmacy All charges if you request a brand name drug in place of a generic drug

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• Therapeutic for COVID-19 obtained from Plan Providers	No charge for up to a 30-day supply	No charge for up to a 30-day supply
• Therapeutics for COVID-19 obtained from non-Plan Providers (except when prescribed as part of covered Emergency Services or Out-of-Area Urgent Care) Note: If you obtain a prescription from a non-Plan Provider related to COVID-19 therapeutics, we do not cover an office visit or any other services from the non-Plan Provider.	50% coinsurance for up to a 30-day supply	50% coinsurance for up to a 30-day supply
Note: If you obtain a prescription from a non-Plan Provider related to COVID-19 therapeutics, we do not cover an office visit or any other services from the non-Plan Provider.	Applies to this benefit	Applies to this benefit
• Prescribed tobacco cessation medications, including prescribed over-the-counter medications, approved by the FDA to treat tobacco dependence	Nothing	Nothing
• Insulin administration devices, such as: - Disposable needles and syringes - Pen delivery devices - Visual aids required to ensure proper dosage (except eyewear) Note: See Section 5(a), Durable medical equipment, for coverage of insulin pumps and supplies	Up to a 100-day supply at $10	Up to a 100-day supply at $15
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, 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.	Nothing All charges if you request a brand name drug in place of a generic drug	Nothing All charges if you request a brand name drug in place of a generic drug

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• 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 non-formulary, 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 non-formulary contraceptive drugs when determined medically necessary.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.If you are having problems accessing contraceptive coverage or need more information, you can email OPM at contraception@opm.gov or visit Member Resources at www.kp.org/postal or OPM's website at Contraception Coverage at www.opm.gov/healthcare-insurance/healthcare/contraception-coverage/. We cover prescribed FDA approved over-the-counter women's contraceptives and devices when prescribed by a Plan provider and obtained at a Plan pharmacy. Note: - For additional Family Planning benefits see Section 5(a).	Nothing All charges if you request a brand name drug in place of a generic drug	Nothing All charges if you request a brand name drug in place of a generic drug
• 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	50% of our allowance
• Sexual dysfunction drugs Note: If a drug for which a prescription is required by law is excluded and we had been covering and providing it to you for a use approved by the FDA, we will continue to provide the drug upon payment of 50% of our allowance if a Plan physician continues to prescribe the drug for the same condition.	50% of our allowance up to a maximum of $50 for generic drugs; 50% of our allowance up to a maximum of $100 or preferred brand-name drugs	50% of our allowance up to a maximum of $50 for generic drugs; 50% of our allowance up to a maximum of $100 or preferred brand-name drugs

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Prescriptions filled at a non-Plan pharmacy, except for emergencies as described in Section 5(d), Emergency services/accidents* • *Vitamins, nutritional and herbal supplements that can be purchased without a prescription, unless they are included in our drug formulary or listed as covered above or below* • *Over-the-counter (nonprescription) drugs, including prescription drugs for which there is an over-the-counter equivalent available, unless listed as covered above.* • *Over-the-counter drugs, unless they are included in our drug formulary or listed as covered above* • *Prescription drugs not on our drug formulary, unless approved through an exception process* • *Medical supplies, such as dressings and antiseptics, except as listed above* • *Drugs that shorten the duration of the common cold* • *Any requested packaging of drugs other than the dispensing pharmacy's standard packaging* • *Replacement of lost, stolen or damaged prescription drugs and accessories* • *Drugs related to non-covered services, except as stated above* • *Drugs for the promotion, prevention, or other treatment of hair loss or growth*	*All charges*	*All charges*
Preventive medications	**High Option**	**Standard Option**
The following are covered: • Aspirin to reduce the risk of heart attack • Oral fluoride for children to reduce the risk of tooth decay • Folic acid for women to reduce the risk of birth defects • Medication to reduce the risk of breast cancer	Nothing	Nothing

Preventive medications - continued on next page

Benefit Description	You pay	
Preventive medications (cont.)	**High Option**	**Standard Option**
Note: Preventive medications with a USPSTF recommendation 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
Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained in a clinical setting administered in a form such as 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 www.findtreatment.samhsa.gov/	Nothing	Nothing
Not covered: *• Drugs and supplies for cosmetic purposes* *• Drugs to enhance athletic performance* *• Fertility drugs* *• Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* *• Nonprescription medications*	*All charges*	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your PSHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your PSHB Plan. See Section 9, *Coordinating benefits with other coverage*.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures at a Plan hospital we designate only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c), *Hospital benefits*, for inpatient hospital benefits. We do not cover the dental procedure except as described below.
- Be sure to read Section 4, *Your cost for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- No precertification is required for accidental injury to teeth. Accidental injury to teeth services may be obtained from a licensed dentist. Please submit claims for services related to accidental injury to teeth according to Section 7, *Filing a claim for covered services*, of this brochure.

Benefit Description	You pay	
Accidental injury benefit	**High Option**	**Standard Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound, natural teeth, if: • damage is due to an accidental injury from trauma to the mouth from violent contact with an external object, • the tooth has not been restored previously, except in a proper manner, and • the tooth has not been weakened by decay, periodontal disease, or other existing dental pathology. Note: Services will be covered only when provided within 72 hours following the accidental injury.	Nothing up to the benefit maximum of $500 of covered charges per accidental injury All charges after reaching the benefit maximum of $500 per accidental injury	Nothing up to the benefit maximum of $500 of covered charges per accidental injury All charges after reaching the benefit maximum of $500 per accidental injury
Not covered: • *Services for conditions caused by an accidental injury occurring before your eligibility date.*	*All charges*	*All charges*
Dental benefits	**High Option**	**Standard Option**
We have no other dental benefits	*All charges*	*All charges*

Section 5(h). Wellness and Other Special Features

Centers of Excellence	The Centers of Excellence program began in Fall 1987. As new technologies proliferate and become the standard of care, Kaiser Permanente refers members to contracted "Centers of Excellence" for certain specialized medical procedures. We have developed a nationally contracted network of Centers of Excellence for organ transplantation, which consists of medical facilities that have met stringent criteria for quality care in specific procedures. A national clinical and administrative team has developed guidelines for site selection, site visit protocol, volume and survival criteria for evaluation and selection of facilities. The institutions have a record of positive outcomes and exceptional standards of quality.
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).
High risk pregnancies	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.
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.
Rewards	Take steps to improve your well-being by completing the Kaiser Permanente Total Health Assessment and a healthy lifestyle program. PSHB subscribers and their enrolled spouses (age 18 and over) are eligible for the following rewards: • $50 for completing a confidential, online, Total Health Assessment (available in English or Spanish). You will get a picture of your overall health and a customized action plan with tips and resources to improve your well-being. • $25 for completing an online healthy lifestyle program of your choice. Personalized and self-paced, they can help you reduce stress, quit smoking, lose weight and more. You can complete as many of these online programs as you would like, but you will only earn a reward for one program completion. You must accept the Wellness Program Agreement to be eligible to earn rewards. Please go to www.kp.org/postal to learn how to earn your reward and to view and track the status of your reward activities. You must complete the Total Health Assessment and/or a healthy lifestyle program during the plan year. We will issue you a Kaiser Permanente Health Payment Card 4-6 weeks after you complete either activity. We will send each eligible member their own debit card. You may use your Health Payment Card to pay for certain qualified medical expenses, such as: • Copayments for office visits, prescription drugs and other services at Kaiser Permanente or other providers • Prescription eyeglasses or contacts • Dental services • Over-the-counter medication for certain diseases • Other medical expenses, as permitted by the IRS Please keep your card for use in the future. As you complete activities, we will add rewards to your card. We will not send you a new card until the card expires. Rewards you earn during this calendar year may be used until March 31 of the next calendar year. Funds are forfeited if you leave this plan. For more information, please go to www.kp.org/postal. If you have questions about completing a Total Health Assessment or class, you may call us at **1-866-300-9867**. If you have questions about your account balance or what expenses the Health Payment Card can be used for, you may call the phone number on the back of your Health Payment Card.
Services for the 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 different Kaiser Foundation Health Plan service area, you can receive visiting member services from designated providers in that area. Visiting member services are subject to the terms, conditions and cost-sharing described in his PSHB brochure. Certain services are not covered as a visiting member.

	For more information about receiving visiting member services, including provider and facility locations in other Kaiser Permanente service areas, please call our Away from Home Travel Line at 951-268-3900 or visit www.kp.org/travel.
Travel benefit	Kaiser Permanente 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 $25 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 $1,200 each calendar year. For more information about this benefit, call our Member Service Call Center at 800-464-4000 (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-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**. The fees you pay for these services do not count toward PSHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the plan at 800-464-4000 (TTY: 711).

Dental plans - Delta Dental 800-933-9312

- **KPIC's PPO Dental Insurance Plan (Plan ID 09874)** lets you see any licensed dentist of your choice. Your out-of-pocket costs will usually be lowest if you visit a Delta Dental PPO™ Dentist (PPO Dentist). There are approximately 47,000 participating dentist locations in California. There is an annual deductible of $50 per person up to $150 per family and the maximum coverage annually is $1,500 per person. The plan covers a full range of services including diagnostic and preventative (no deductible), restorative, endodontics, periodontics, oral surgery and prosthodontics.
- **DeltaCare USA (Plan ID 71114)** lets you select from more than 6,400 DeltaCare USA network dentists in California. You pay nothing or a copayment for most covered services. There is no deductible, no annual maximums (except for accidental injury) and no claim forms. DeltaCare USA provides a full range of services including diagnostic, preventive, restorative, endodontics, periodontics, oral surgery, prosthodontics and orthodontics.

Visit www.kp.org/postal to download our dental programs brochure for details about premium, coverage and how to enroll.

Eyewear discount - www.kp2020.org

Kaiser Permanente High Option members get a 25% discount on eyeglasses, contacts and sunglasses at **Vision Essentials by Kaiser Permanente**. Some limits and exclusions apply.

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.

- **ClassPass** makes it easier for you to work out from anywhere. ClassPass partners with 40,000 gyms and studios around the world and offers a range of classes including yoga, dance, cardio, boxing, Pilates, boot camp, and more. You can get unlimited on-demand video workouts at no cost and reduced rates on membership plans to book in-person fitness classes and reserve gym time.
- **One Pass Select Affinity®** As a Kaiser Permanente member, you get access to more than 20,000 gym locations and over 23,000 online classes. You can have groceries and household essentials delivered right to your door. Flexible fitness options and the ability to use multiple locations.
- **Affinity Musculoskeletal Program®** provides you with access to a variety of high-quality providers for complimentary and alternative medicine for therapies such as acupuncture, massage and chiropractic care. Go to https://www.myoptumhealthphysicalhealth.com/ProviderDirectory to locate a provider near you.

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

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

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

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

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

We do not cover the following:

- When a service is not covered, all services, drugs, or supplies related to the noncovered 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 noncovered service.
- Fees associated with non-payment (including interest), missed appointments and special billing arrangements.
- Care by non-Plan providers except for authorized referrals, emergencies, travel benefit, or services from other Kaiser Permanente plans (see “Emergency services/accidents and special features”).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs, or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except you pay nothing when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services, drugs, or supplies you receive from a provider or facility barred from the PSHB Program.
- Services or supplies we are prohibited from covering under the Federal law.

Section 7. Filing a Claim for Covered Services

This section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on prior Plan approval and pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures.

When you see Plan providers, receive services at Plan hospitals and facilities, or fill your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

You may need to file a claim when you receive a service from a non-Plan provider or at a non-Plan facility. This includes services such as out-of-network emergency services, our-of-area urgent care and services covered under the travel benefit, or COVID-19 testing, therapeutics, or immunization services. Check with the provider to determine if they can bill us directly. Filing a claim does not guarantee payment. If you need to file the claim, here is the process:

Medical, hospital and prescription drug benefits

In most cases, providers and facilities file claims for you. Providers must file on the form CMS-1500, Health Insurance Claim Form. Facilities will file on the UB-04 form. For claims questions and assistance, call our Member Service Call Center at 800-464-4000 (TTY: 711).

When you must file a claim - such as for services you receive 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
- Follow-up services rendered out-of-area
- A copy of the explanation of benefits, payments, or denial from any primary payor—such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

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

Submit your claims to:

Northern California: Fresno - PSHB service area:
Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 12923
Oakland, CA 94604-2923

Prescription drugs

Submit your claims to:

Northern California: Fresno - PSHB service area:
Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 12923
Oakland, CA 94604-2923

Deadline for filing your claim	Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.
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.
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.
Binding arbitration	If you have any claim or dispute that is not governed by the Disputed Claims Process with OPM described in Section 8, then all such claims and disputes of any nature between you and the Plan, including but not limited to malpractice claims, shall be resolved by binding arbitration, subject to the Plan's Arbitration procedures. For information that describes the arbitration process, contact our Member Service Call Center at 800-464-4000 for copies of our requirements. These will explain how you can begin the binding arbitration process.
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 Medicare's appeals process outlined in Section 8a. Medicare 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 Customer Service Department by writing to us at: Kaiser Permanente, Special Services Unit, P.O. Box 23280, Oakland, CA 94623 or calling 800-464-4000.

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 Permanente, Special Services Unit, P.O. Box 23280, Oakland, CA 94623; and* c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or

b) Write to you and maintain our denial or.

c) Ask you or your provider for more information

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

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

3

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

You must write to OPM within:

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

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Postal Service Insurance Operations (PSIO), 1900 E Street, room 3443, NW, Washington, DC 20415.

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.

4

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

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

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 800-464-4000. 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 through Medicare's appeals process. See Section 8a, *Medicare PDP EGWP Disputed Claims Process*.

Section 8(a). Medicare PDP EGWP Disputed Claims Process

When a claim is denied in whole or in part, you may appeal the denial.

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

What to do if you have a problem or concern

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

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

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

As a PSHB member, you also have additional dispute resolution rights and a different appeals process through the PSHB Program. For a complete statement of your drug benefits and rights under the PSHB Program, please read your PSHB brochure (RI 73-919). All PSHB Program benefits are subject to the definitions, limitations, and exclusions set forth in the PSHB brochure.

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

Making an appeal

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

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

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

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

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

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

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

- You can call Member Services at 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/postal.

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

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

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

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

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

We do not cover services that:

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

- **Medicaid**

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

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

When other Government agencies are responsible for your care

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

When third parties cause illness or injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

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

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

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

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

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

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

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

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

Contact us if you need more information about recovery or subrogation.

Surrogacy Agreements

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

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

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

Trover Solutions, Inc.
Kaiser Permanente Northern California Surrogacy Mailbox
9390 Bunsen Parkway
Louisville, KY 40220

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

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

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

Some 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.

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

- Routine care costs are costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient’s condition whether the patient is in a clinical trial or is receiving standard therapy. We cover routine care costs not provided by the clinical trial.
- Extra care costs are costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient’s routine care. We cover some extra care costs not provided by the clinical trial. We encourage you to contact us to discuss coverage for specific services if you participate in a clinical trial.

The Plan does not cover research costs.

- Research costs are costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. We do 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 us at 800-464-4000, TTY: 711.

- **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 800-443-0815 (TTY: 800-777-1370), 8 a.m. to 8 p.m., 7 days a week, or visit our website at www.kp.org/postal.

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

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

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

- **Tell us about your Medicare coverage**

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

- **Medicare Part B reimbursement**

We offer a plan designed to help High Option members with their Medicare Part B premium. This program is called, "Senior Advantage 2". For each month you are enrolled in Senior Advantage 2, have Medicare Parts A and B, or Part B only, and are enrolled in Senior Advantage for Postal Service Members, you will be reimbursed up to $250 of the Medicare Part B monthly premium you pay, including any amount added to your Part B premium for the Part B late enrollment penalty (LEP) or income related monthly adjustment amount (IRMAA). In addition to reimbursing for the Part B monthly premium, we will cover additional benefits, including lower office visit copayments, urgent care and emergency care, plus additional coverage for benefits, such as hearing aids and the One Pass fitness program.

You may enroll in this program if:

- You enroll in the plan's High or Standard Option
- You live in our Medicare Advantage Service Area
- You have Medicare Parts A and B, or Medicare Part B only, and you enroll in Senior Advantage for Postal Service Members
- The PSHB subscriber completes an additional application for enrollment in Senior Advantage 2

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

To learn more about Senior Advantage 2 and how to enroll, call us at 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. We will send you additional information and an additional application for enrollment in Senior Advantage 2.

- **Medicare Advantage (Part C)**

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

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

This Plan and our Medicare Advantage plan: We offer a Medicare Advantage plan known as Kaiser Permanente Senior Advantage for Postal Service Members. Senior Advantage for Postal Service Members enhances your PSHB coverage by lowering cost-sharing for some services and/or adding benefits. High Option members can choose between 2 Kaiser Permanente Senior Advantage plans: "Senior Advantage 1" (best benefits) and "Senior Advantage 2" (some better benefits and Part B premium reimbursement) and Senior Advantage for Standard Option. If you live in our Senior Advantage service area and you have Medicare Parts A and B, or Medicare Part B only, you can enroll in Senior Advantage for Postal Service Members. Enrolling in Senior Advantage for Postal Service members does not change your PSHB premium. Your enrollment is in addition to your PSHB High Option or Standard Option enrollment: however, your benefits will be provided under the Kaiser Permanente Senior Advantage for Postal Service Members plan and are subject to Medicare rules. If you are already a member of Senior Advantage for Postal Service Members and would like to understand your additional benefits in more detail, please refer to your Senior Advantage for Federal Members Evidence of Coverage. If you are considering enrolling in Senior Advantage for Postal Service Members, please call us at **800-443-0815 (TTY: 800-777-1370)**, 8 a.m. to 8 p.m., 7 days a week, or visit our website at www.kp.org/postal**.**

With Kaiser Permanente Senior Advantage for Postal Service Members, you'll get more coverage, such as lower cost sharing and additional benefits. This 2025 benefit summary allows you to make a comparison of your choices:

Benefits and Services: Deductible
High Option Without Medicare You Pay: None
High Option Senior Advantage 1 You Pay: None
High Option Senior Advantage 2 You Pay: None
Standard Option Without Medicare You Pay: None
Standard Option Senior Advantage You Pay: None

Benefits and Services: Primary care
High Option Without Medicare You Pay: $15
High Option Senior Advantage 1 You Pay: $5
High Option Senior Advantage 2 You Pay: $10
Standard Option Without Medicare You Pay: $30
Standard Option Senior Advantage You Pay: $15

Benefits and Services: Specialty care
High Option Without Medicare You Pay: $25
High Option Senior Advantage 1 You Pay: $5
High Option Senior Advantage 2 You Pay: $10
Standard Option Without Medicare You Pay: $40
Standard Option Senior Advantage You Pay: $15

Benefits and Services: Outpatient surgery
High Option Without Medicare You Pay: $50
High Option Senior Advantage 1 You Pay: $5
High Option Senior Advantage 2 You Pay: $50
Standard Option Without Medicare You Pay: $200
Standard Option Senior Advantage You Pay: $15

Benefits and Services: Inpatient hospital care
High Option Without Medicare You Pay: $250
High Option Senior Advantage 1 You Pay: $0
High Option Senior Advantage 2 You Pay: $250
Standard Option Without Medicare You Pay: $500
Standard Option Senior Advantage You Pay: $250

Benefits and Services: Additional benefits offered
High Option Without Medicare: Not applicable
High Option Senior Advantage 1: Eyeglasses and contact lenses allowance, dental cleaning, home-delivered meals, transportation, and One Pass
High Option Senior Advantage 2: Hearing aid allowance and One Pass
Standard Option Without Medicare: Not applicable
Standard Option Senior Advantage: Eyeglasses and contact lenses allowance, dental cleaning, and One Pass

Benefits and Services: Out-of-pocket maximum (2x per family)
High Option Without Medicare You Pay: $2,000 per person
High Option Senior Advantage 1 You Pay: $2,000 per person
High Option Senior Advantage 2 You Pay: $2,000 per person
Standard Option Without Medicare You Pay: $3,000 per person
Standard Option Senior Advantage You Pay: $2,000 per person

Benefits and Services: - Part B premium reimbursement
High Option Without Medicare: $0
High Option Senior Advantage 1: $0
High Option Senior Advantage 2: Up to $250 monthly
Standard Option Without Medicare: $0
Standard Option Senior Advantage: $0

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

This Plan and another plan's Medicare Advantage plan: You may enroll in another non-PSHB plan's Medicare Advantage plan and also remain enrolled in our PSHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers).

However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

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

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

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

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 plan, you will get all of the benefits of Medicare Part D plus additional drug benefits covered under your PSHB plan.

- **Medicare Prescription Drug Plan (PDP) 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 (800) 464-4000.

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

- You will lose your Kaiser Permanente prescription drug coverage unless you are enrolling in a Medicare Advantage with Part D plan offered through the PSHB program.
- You may be subject to a Medicare Part D Late Enrollment Penalty (LEP) if you re-enroll in a Medicare Part D plan at a later date. The LEP is a dollar amount that is permanently added to your Medicare Part D plan premium.

Contact us at (800) 464-4000; 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
  California Service Center
  P.O. Box 232400
  Oakland, CA 94612-2400

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

For additional information, see Chapter 8. *Ending your membership in the plan* in the Evidence of Coverage for Kaiser Permanente Medicare Part D Group Plan (PDP) for Postal Service Members or contact us at (800) 464-4000; 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, enroll online, download an enrollment application, or RSVP to attend a seminar. (For KPWA delete enroll online).
- 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 (800) 464-4000; 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 23.

Copayment

See Section 4, page 23.

Cost-sharing

See Section 4, page 23.

Covered services

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

Custodial care

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

Deductible

See Section 4, page 23.

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.

Medically necessary

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

Medicare Part A

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

Our allowance

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

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

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

If you believe your claim qualifies as an urgent care claim, please contact our Member Service Call Center at 800-464-4000. 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, Inc., Northern California - Fresno - PSHB Region.

You

You refers to the enrollee and each covered family member.

Index

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

Summary of Benefits for the High Option of Kaiser Permanente - Fresno Cailfornia PSHB - 2025

- **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	$15 per primary care office visit $25 per specialty care office visit	29
Services provided by a hospital: Inpatient	$250 per admission	58
Services provided by a hospital: Outpatient	$50 per admission	58
Emergency benefits	$100 per visit	61
Mental health and substance use disorder treatment	Regular cost-sharing	64
Prescription drugs	$10 Generic; $40 preferred and non-preferred brand; $100 specialty per prescription for up to a 30-day supply at a Plan pharmacy. Up to a 100-day supply of most drugs when dispensed through our program for two copayments.	69
Prescription drugs - PDP (EGWP)	$10 Generic; $40 preferred and non-preferred brand; $100 specialty per prescription for up to a 30-day supply at a Plan pharmacy. Up to a 100-day supply of most drugs when dispensed through our program for two copayments.	69
Dental care	No benefit	83
Vision care: Eye exam	Nothing	42
Special features: Flexible benefits option; Centers of Excellence; Services for the deaf, hard of hearing or speech impaired; Services from other Kaiser Permanente or allied plans; Travel benefit; Rewards.	See Section 5(h) for more information.	84
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):	Nothing after $2,000/Self Only or $4,000/ Family enrollment per year. Some costs do not count toward this protection.	23

Summary of Benefits for the Standard Option of Kaiser Permanente - Fresno California PSHB - 2025

- **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 office visit $40 per specialty care office visit	29
Services provided by a hospital: Inpatient	$500 per admission	58
Services provided by a hospital: Outpatient	$200 per admission	58
Emergency benefits	$150 per visit	61
Mental health and substance use disorder treatment	Regular cost-sharing	64
Prescription drugs	$15 Generic; $50 preferred and non-preferred brand; $150 specialty per prescription or refill for up to a 30-day supply at a Plan pharmacy. Up to a 100-day supply for most drugs when dispensed through our mail order program for two copayments.	68
Prescription drugs - PDP (EGWP)	$15 Generic; $45 preferred and non-preferred brand; $150 specialty per prescription or refill for up to a 30-day supply at a Plan pharmacy. Up to a 100-day supply for most drugs when dispensed through our mail order program for two copayments.	78
Dental care	No benefit	83
Vision care: Eye exam	Nothing	42
Special features: Flexible benefits option; Centers of Excellence; Services for the deaf, hard of hearing or speech impaired; Services from other Kaiser Permanente or allied plans; Travel benefit; Rewards.	See Section 5(h) for more information.	84
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):	Nothing after $3,000/Self Only or $6,000/Family enrollment per year. Some costs do not count toward this protection.	23

2025 Rate Information for Kaiser Permanente - Fresno California - 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	NNA	$286.09	$144.46	$619.86	$313.00
High Option Self Plus One	NNC	$618.40	$376.68	$1,339.87	$816.14
High Option Self and Family	NNB	$672.95	$322.13	$1,458.06	$697.95
Standard Option Self Only	NND	$244.10	$81.37	$528.89	$176.30
Standard Option Self Plus One	NNF	$564.16	$188.05	$1,222.34	$407.45
Standard Option Self and Family	NNE	$564.16	$188.05	$1,222.34	$407.45