Kaiser Permanente Washington Options Federal-PSHB

www.kp.org/postal

Member Services: 888-901-4636

KAISER PERMANENTE®

2025

A Prepaid Comprehensive Medical Plan (Standard Option) with a Point of Service product, and a High Deductible Health Plan

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: All of Washington state, except San Juan County

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:

H9A Standard Option – Self Only
H9C Standard Option – Self Plus One
H9B Standard Option – Self and Family

H9D High Deductible Health Plan (HDHP) – Self Only
H9F High Deductible Health Plan (HDHP) – Self Plus One
H9E High Deductible Health Plan (HDHP) – Self and Family

IMPORTANT
- Rates: Back Cover
- Changes for 2025: Page 18
- Summary of Benefits: Page 182

PSHB

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-925

Important Notice for Medicare-eligible Active Employees from Kaiser Permanente Washington Options Federal
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% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

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

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

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

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

Table of Contents

Introduction

This brochure describes the benefits of Kaiser Permanente Washington Options Federal under contract (CS1767 PS) between Kaiser Foundation Health Plan of Washington Options, Inc. 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 800-901-4636 or through our website: www.kp.org/postal. The address for Kaiser Permanente Washington Options Federal administrative offices is:

Administrative Office:
Kaiser Foundation Health Plan of Washington Options, Inc.
2715 Naches Ave., SW
1300 SW 27th Street
Renton, Washington 98057

Mailing Address:
Kaiser Permanente
P.O. Box 9010
Seattle, Washington 98057-9010

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). 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 Permanente Washington Options Federal, Options Federal or Kaiser Permanente.
- 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 us at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711 and explain the situation.

If we do not resolve the issue:

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

Do not maintain family members on your policy:

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

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.

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

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

- Bring the actual medication or give your doctor and pharmacist a list of all the 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.

3. Get the results of any test or procedure.

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

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

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

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.

- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.

- 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." 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 enrollment request. Benefits will not be available to your spouse until you are married. We may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

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

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

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

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

- **Family Member Coverage**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Our PDP EGWP is only available to Postal Service annuitants who are Medicare Part D-eligible 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 Medicare.gov or call 800 - MEDICARE (800) 633-4227, TTY (877) 486-2048 or call Members Services at 888-901-4636 (TTY: 711).

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage and premiums begin on January 1. If you joined at any other time during the year, your employing or retirement office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When PSHB coverage ends**

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

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

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

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

- **Upon divorce**

If you are an enrollee and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You must enter the date of the divorce or annulment and remove your ex-spouse in the PSHB System. We may ask for a copy of the divorce decree as proof. If you need to change your enrollment type, you must use the PSHB System. A change will not automatically be made.

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

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

Medicare PDP EGWP

When a Postal Service annuitant who is Medicare Part D-eligible or their covered Medicare-eligible family member opts out of or disenrolls from our PDP EGWP, they will not have our prescription drug coverage under this plan. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for additional information at 888-901-4636 (TTY: 711).

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

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

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

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

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing PSHB 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 toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711 or visit our website at www.kp.org/postal.

- **Health Insurance Marketplace**

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

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO). OPM requires that PSHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Kaiser Foundation Health Plan Washington Options, Inc. holds the following accreditations: National Committee for Quality Assurance (NCQA), a private, non-profit organization dedicated to improving healthcare quality. To learn more about this plan's accreditation, please visit the following website: www.ncqa.org. We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory. We give you a choice of enrollment in a Standard Option or a High Deductible Health Plan (HDHP).

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

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

Questions regarding what protections apply may be directed to us toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

General features of our Standard Option

The Standard Option provides comprehensive medical, surgical and hospitalization benefits in addition to coverage for alternative care providers, preventive dental benefits, mental healthcare, and an open drug formulary prescription benefit.

We have Point of Service (POS) benefits

Our Plan offers POS benefits. This means you can receive covered services from a non-Plan provider. However, out-of-network benefits may have higher out-of-pocket costs than our in-network benefits. Please see Standard Option Section 5(i), 87, for POS benefit details.

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 (deductible, copayments, coinsurance and non-covered services and supplies). We pay dental providers based on a scheduled allowance amount, and you will only be responsible for charges over and above the scheduled allowance amount.

We emphasize comprehensive medical and surgical care received from Plan providers. A Plan provider is any facility or licensed practitioner who contracts with the Plan, the First Choice Health Network (FCHN), or First Health Network. A Plan pharmacy is a pharmacy contracted with our pharmacy benefit management company and a Plan dentist is any licensed dentist within Washington state.

To receive the highest level of benefits, you must use Plan providers, pharmacies, and dentists.

When you reside outside the state of Washington under any of the following conditions, 1) part-time, 2) as a dependent child, or 3) on Temporary Duty Assignment; in Alaska, Idaho, Montana, and Oregon, a Plan provider is a First Choice Health Network provider; or in a different Kaiser Foundation Health Plan service area, a designated Kaiser Permanente provider. If you are in an area where Plan providers are difficult to access (e.g., 50 miles from home or work), please contact us to confirm that we will pay a non-Plan provider at the non-Plan provider rate based on the billed amount rather than our allowed amount, which will eliminate the non-Plan provider "balance billing" you. You can reach us toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711.

General features of our High Deductible Health Plan (HDHP)

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of PSHB plans. PSHB Program HDHPs also offer health savings accounts or health reimbursement arrangements. Please see below for more information about these savings features.

Preventive care services: Preventive care services are generally covered with no cost-sharing and are not subject to copayments, deductibles or annual limits when received from a Plan provider. Preventive dental care is paid on a fee basis and may result in "balance billing" by your dentist.

Annual deductible: The annual deductible must be met before Plan benefits are applied, except for preventive medical care services, preventive dental care, and tobacco cessation treatment and medications when received through the Quit For Life® program.

Health Savings Account (HSA):

You are eligible for an HSA if you:

- Are enrolled in an HDHP;
- Are not covered by any other health plan that is not an HDHP (including a spouse's health plan, excluding specific injury insurance and accident, disability, dental care, vision care, or long-term coverage);
- Are not enrolled in Medicare;
- Have not received VA (except for veterans with a service-related disability) or Indian Health Service (IHS) benefits within the last three months;
- Are not covered by your own or your spouse's flexible spending account (FSA); and
- Are not claimed as a dependent on someone else's tax return.

You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.

Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by an HDHP.

You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.

For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health Plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.

You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA): If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.

Catastrophic protection: We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayments, to no more than $7,000 for Self Only enrollment, or $14,000 for a Self Plus One or Self and Family enrollment. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed that amount.

Health education resources and accounts management tools: Kaiser Permanente Washington Options Federal has chosen HealthEquity® to be our HSA and HRA administrator. As a Kaiser Permanente Washington Options Federal HDHP enrollee, you will have the following health education resources and account management tools provided or made available to you:

- A HealthEquity® new enrollee welcome letter with your account information will be mailed to you shortly after enrolling.
- Convenient access to funds is made available through a HealthEquity® Visa® account.
- At the HealthEquity® website (www.healthequity.com) you can easily view account balances and information, change investment options, download forms and link to a list of covered expenses.
- Through the HealthEquity® toll-free customer service line at 866-346-5800 you can access automated information, or speak with a helpful customer service representative.

Other important tools and information are available by visiting the Kaiser Permanente Washington Options Federal website at www.kp.org/postal.

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 healthcare service contractor that has provided healthcare services to Washingtonians since 1946.
- Kaiser Foundation Health Plan of Washington Options, Inc. is a for-profit organization.

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

If you want more information about us, call 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711, or write to P.O. Box 34803, Seattle, Washington 98124-1803. You may also visit our Kaiser Permanente Washington Options Federal 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 www.kp.org/postal to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Language interpretation services

Language interpretation services are available to assist non-English speaking members. Please call our Language interpretation services line at 888-901-4636 (TTY: 771).

Your medical and claims records are confidential

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

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area is all of Washington state except for San Juan County.

If you receive care from non-Plan providers in our service area, as described in How we pay providers on page 12, we will pay benefits based on our contracted rates for Plan providers. You will be responsible for any copayments, coinsurance, deductible, and any additional balance billed by a non-Plan provider. For details regarding out-of-network services, please see Section 5(i), Point of Service (POS) benefits for Standard Option, page 87, and page xxx for the HDHP Out-of-network services.

If you or a covered family member move outside of our service area, you can enroll in another plan. 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. 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 us at 888-901-4636. For the deaf and hearing-impaired, use Washington state's relay line by dialing either 800-833-6388 or 711 or write to us at P.O. Box 34803, Seattle, Washington 98124-1803. You may also request replacement cards through our website: www.kp.org/postal.

Where you get covered care

In Washington state, you get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims. If you use our Point of Service program, you also can get care from non-Plan providers in Washington state, but it will cost you more.

You get dental care from any licensed dentist within Washington state.

Balance Billing Protection

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

- **Plan providers**

Plan providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. We contract with Washington Permanente Medical Group (Medical Group) to provide or arrange covered services for our members. Medical care is provided through physicians, nurse practitioners, physician assistants, and other skilled medical personnel. Specialists in most major specialties are available as part of the medical teams for consultation and treatment. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. Directories are available at the time of enrollment or upon request by calling our Member Service at 888-901-4636 (TTY: 711). The list is also on our website at www.kp.org/postal.

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 at 888-901-4636 (TTY: 711).

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. Kaiser Permanente offers comprehensive healthcare at Plan facilities conveniently located throughout our service areas. We list Plan facilities in the facility directory, with their locations and phone numbers. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling our Member Service Call Center at 800-464-4000 (TTY: 711). The list is also on our website at kp.org/postal.

What you must do to get covered care

It depends on the type of care you need. You can go to any provider you want but we must approve some care in advance.

- **Primary care**

Primary care providers are family practitioners, general practitioners, pediatricians, obstetricians/gynecologists, naturopaths, physician assistants (under the supervision of a physician), or advanced registered nurse practitioners (ARNPs). If your primary care provider is no longer a Plan provider, the same time frames described on page 20 under Specialty care will apply for you to transfer to a new primary care Plan provider.

- **Specialty care**

Specialists are listed in our provider directory. No referral is required.

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

- If you are seeing a specialist and your specialist leaves the Plan, you will be allowed 60 days from the date we notify you that the specialist has left the Plan to either (i) complete your course of treatment, or (ii) appropriately transfer your care to another Plan provider. If, after 60 days, you have not completed your course of treatment or transferred your care to another Plan provider, your benefits will be paid at the lower Point of Service (POS) rate described in Section 5(i), Point of Service (POS) benefits, page 75, for Standard Option and page 78 for HDHP Out-of-network services.
  - 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 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 in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Complementary care**

The term "complementary care" refers to services provided by the following licensed providers when those services are within the scope of their licenses:

- East Asian Medicine Practitioner (Acupuncturist)
- Chiropractor
- Massage therapist

When receiving services from these providers, you are subject to the same benefit conditions and limitations that exist for other Plan providers. In addition, spinal and extremity manipulations, acupuncture needle treatments; except for the treatment of substance use disorder, and massage therapy are each limited to 20 treatments per calendar year.

The non-Plan provider reduction in benefits applies (see Standard Option Section 5(i), Point of Service benefits, page 87 and HDHP Section 5, High Deductible Health Plan Benefits Overview, Out-of-network services, page 91.

- **Hospital care**

Your physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Member Services department immediately toll-free at 888-901-4636. For the deaf and hearing-impaired, use Washington state's relay line by dialing either 800-833-6388 or 711. If you are new to the PSHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another PSHB plan to 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

Since we do not have a primary care provider or a referral requirement, and we allow you to use non-Plan providers, you need to obtain our approval before you receive certain services. The pre-service claim approval processes for inpatient hospital admissions (called precertification) and for other services and equipment, are detailed in this section. A pre-service claim is any claim, in whole or in part, that requires approval from us in advance of obtaining medical care, services, or equipment. In other words, a pre-service claim for benefits (1) requires a precertification or prior approval and (2) will result in a denial or reduction of benefits if you do not obtain precertification or prior approval.

- **Inpatient hospital admission**

Precertification is the process by which - prior to your inpatient hospital admission - we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition. The authorization is valid for 30 days. Approval for each admission or re-admission is required. We will provide coverage only for the number of hospital days that are medically necessary and appropriate for your condition. If your hospital stay is extended due to complications, your provider must obtain benefit authorization for the extension.

After your doctor notifies you that hospitalization or skilled nursing care is necessary, ask your doctor to obtain precertification. Your doctor or care facility must request precertification before admission. This is a feature that allows you to know, prior to admission, which services are considered medically necessary and eligible for payment under this Plan.

We will send you written confirmation of the approved admission, once certification is obtained.

- **Other services**

For certain services or equipment your physician must obtain prior approval from us. Before giving approval, we consider if the service or equipment is covered, medically necessary, and follows generally accepted medical practice. Your physician or medical equipment supplier must obtain prior approval for the services, treatments, or items listed below.

Note: The list is not all inclusive and is subject to change upon notification to physicians. Please call Member Services at 888-901-4636 to verify if your procedure/ services require preauthorization.

- Bariatric Surgery
- Certain prescription medications as indicated on our formulary

- Clinical trials
- Cochlear implants
- High end radiology services, such as CAT scan, MRI, PET and SPECT scans
- Inpatient facility services, such as hospital, rehabilitation, skilled nursing, mental health and substance use disorder treatment facilities
- Non-emergent air transportation
- Organ transplants
- Reconstructive breast surgery
- Gender Affirming services
- Surgeries for sleep disorders
- Temporomandibular joint (TMJ) surgery
- Infusion therapy

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

First, your physician, your hospital, you, or your representative, must call us toll-free at 888-901-4636. For the deaf and hearing-impaired, use Washington state's relay line by dialing either 800-833-6388 or 711 before admission, services, or equipment requiring prior authorization are rendered.

Member Services will confirm that the service, treatment, or equipment requires preauthorization. If it does, your physician or care facility must submit a preauthorization request. All requests for prior authorization must include the following information:

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

A staff nurse will review the request and send you and your provider notification in writing of the decision. The same process applies when the service or treatment is received from a non-Plan provider; or if an extension to the prior authorization is required.

- **Non-urgent care claims**

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

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

- **Urgent care claims**

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

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

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

  You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us toll-free at 888-901-4636. You may also call OPM's Postal Service Insurance Operations (PSIO) at (202) 936-0002 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us toll-free at 888-901-4636. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

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

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

- **Emergency inpatient admission**

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

- **Maternity care**

  Maternity care does not require preauthorization.

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

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

What happens when you do not follow the precertification rules

If a service or treatment that requires precertification is performed either by a Plan provider/facility or a non-Plan provider/facility without obtaining the authorization, a retro-review may be done to determine if it is a covered benefit and if it was medically necessary. We will not pay for services or treatments that are not covered or that are not medically necessary.

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 888-901-4636.

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

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

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

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

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

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

If we do not receive the information within 60 days, we will decide within 30 days of the date the information 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 requests 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.

Help us control costs

Outpatient Surgery: Hospitalization is no longer necessary for many surgical and diagnostic procedures. These procedures can be performed safely and less expensively on an outpatient basis without sacrificing quality of care.

The elective surgeries and diagnostic procedures listed below must be performed in a hospital outpatient unit, surgical center, or doctor's office. These facilities are more convenient than a hospital because surgery can be scheduled easily and quickly, and the patient can return home sooner. The cost of surgery is reduced because hospital room and board charges are eliminated.

If circumstances indicate that it is medically necessary to perform a procedure on an inpatient basis, full Plan benefits will be provided.

If a procedure is performed on an inpatient basis when hospitalization is not medically necessary, benefits for the surgical fee will be reduced by 20% and benefits for the hospital stay will be denied. No reduction in benefits will occur for emergency admissions.

The procedures listed below must be performed on an outpatient basis.

Note: The list is not all inclusive and is subject to change at any time for physicians.

To obtain information regarding procedures that must be performed on an outpatient basis, please contact Member Services toll-free at 888-901-4636. For the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711.

- Biopsy procedures
- Breast surgery (minor) (However, anyone who undergoes a mastectomy may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.)
- Diagnostic examination with scopes
- Dilation and curettage (D&C)
- Ear surgery (minor)
- Facial reconstruction surgery
- Hemorrhoid surgery
- Inguinal hernia surgery
- Knee surgery
- Nose surgery
- Removal of bunions, nails, hammertoes, etc.
- Removal of cataracts
- Removal of cysts, ganglions, and lesions
- Sterilization procedures
- Tendon, bone, and joint surgery of the hand and foot
- Tonsillectomy and adenoidectomy

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.

Example:

Under Standard Option, you pay a copayment of $25 (no deductible) for primary care per office visit and $35 (no deductible) for specialty care per office visit. You pay a $20 copayment for Tier 1 drugs, a $40 copayment for Tier 2 drugs and a $60 copayment for Tier 3 drugs. (Coinsurance amounts apply to Tier 4 and 5 drugs).

Under the High Deductible Health Plan (HDHP), once you have met the annual deductible, you pay a $20 copayment for Tier 1 drugs, a $40 copayment for Tier 2 drugs, and a $60 copayment for Tier 3 drugs. (Coinsurance amounts apply to Tier 4 and Tier 5 drugs.).

Deductible

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

- **The Standard Option** calendar year deductible is $350 per person.
- **Under Standard Option Self Only enrollment**, the deductible is considered satisfied and benefits are payable for you when your covered expenses for in- and out-of-network services applied to the calendar year deductible reach $350.
- **Under Standard Option Self Plus One enrollment**, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses for in- and out-of-network services applied to the calendar year deductible for your enrollment reach $700.
- **Under Standard Option Self and Family Enrollment**, the deductible is considered satisfied for all family members when their combined covered expenses for in- and out-of-network services applied to the calendar year deductible for family members reach $700.
- **The Standard Option deductible** is waived for preventive care.
- **The High Deductible Health Plan (HDHP)** calendar year deductible is $1,650 for Self Only enrollment and $1,650 per person for Self Plus One or Self and Family enrollment not to exceed a total family deductible of $3,300 (each applies separately for services received from Plan providers and non-Plan providers).

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 the new deductible starts on January 1. If you change plans at another time during the year, you must begin a new deductible under your new plan.

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible. You pay 20% coinsurance in-network or 40% out-of-network for most services, except for infertility services that have a 50% coinsurance.

See Your catastrophic protection out-of-pocket maximum, page 27, for more information regarding coinsurance.

Differences between our Plan allowance and the bill

Our "Plan allowance" is the amount we use to calculate our payment for covered services. As a general rule, you may receive care from any licensed or certified healthcare provider or hospital. We do not require a referral for specialty care. However, your choice of providers and hospitals affects the level of benefit coverage you receive, as well as your out-of-pocket costs.

When you choose a Plan provider, your out-of-pocket costs are the least. Plan providers agree to limit what they will bill you. Because of that, when you use a Plan provider, your share of covered charges consists only of your deductible (if applicable), coinsurance, or copayment. For non-emergency surgical or ancillary services performed at an in-Plan hospital or ambulatory surgical facility in Washington, under Washington law a non-Plan provider may not charge you more than our allowance.

If you choose a non-Plan provider, we pay 60% of our allowed amount for covered services. It is your responsibility to pay the difference between the amount billed by the non-Plan provider and the amount allowed by us. This is called "balance billing."

In certain instances, the care you receive from a non-Plan provider or facility is not subject to the reduction in the level of benefit coverage described above. Those instances are:

- **Medical Emergency.** Emergency care is covered in full after you have met any applicable deductible, copayment, or coinsurance. If you are admitted to a non-Plan hospital as a result of your emergency, we reserve the right to arrange for your transportation to a Plan hospital (see Section 5(d), Emergency Services/Accidents, 64 and 65).
- **Services Not Available from Plan Providers/Facilities**. We have the right to determine whether care and services are, or are not, available from a Plan provider or facility. If you believe the care or service you require is not available from a Plan provider or facility, please contact Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711 before obtaining the care or service and ask for a review to determine if it is appropriate for you to see a non-Plan provider. If we determine that the care or service you require can only be obtained from a non-Plan provider, your care will be covered in full (if it is a medically necessary/covered benefit) after you have met any applicable deductible, copayment, or coinsurance.

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

Your catastrophic protection out-of-pocket maximum

After your cost-sharing total is $5,000 per person up to $10,000 per family enrollment 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).

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*.

Example: Your plan has a $5,000 per person up to $10,000 per family maximum out-of-pocket limit. If you or one of your covered family members has out-of-pocket qualified medical expenses of $5,000 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 $10,000 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.

For Standard Option: 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:

- Services of non-Plan providers and facilities
- Dental services
- Expenses in excess of the Plan's allowable amount or benefit maximum (e.g., preventive dental care fee schedule amounts)

For HDHP Option: 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:

- Expenses in excess of the Plan’s allowable amount or benefit maximum (e.g., preventive dental care fee schedule amounts)

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 Washington and RCW 48.49.030(2).
For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.kp.org/postal or contact the health plan at 888-901-4636.

Section 5. Standard Option Benefits

Page 182 and page 183 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. Standard Option Benefits Overview

This Plan offers a Standard Option. The benefit package is described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The 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 Standard Option benefits, contact us toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711, or on our website at www.kp.org/postal.

Unique features:

- Preventive dental benefit
- Alternative care provider coverage

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 are payable only when we determine they are medically necessary.
- The calendar year deductible is: $350 per person ($700 per Self Plus One or Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9, Coordinating benefits with Medicare and other coverage.
- For the non-Plan provider benefit see Section 5(i), Point of Service (POS) benefits, page 87.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You pay After the calendar year deductible...
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Diagnostic and treatment services	**Standard Option**
Professional services of physicians and other healthcare professionals • In physician's office • In an urgent care center • Office medical consultations • Second surgical opinion Note: You pay a copayment for office visits billed with codes corresponding to these services.	In-network: $25 per primary care office visit or $35 per specialty care office visit (no deductible) Out-of-network: $25 per primary care office visit or $35 per specialty care office visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible)
Procedures received during an office visit Note: Procedures include lab, X-ray, other diagnostic procedures and surgical services. For more information, see Sections 5(a), *Lab, X-ray and other diagnostic tests,* and 5(b)*, Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals.*	In-network: 20% of Plan allowance Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount
Professional services of physicians and other healthcare professionals • At a hospital - inpatient and outpatient visits • In a skilled nursing facility • At home	In-network: 20% of Plan allowance Out-of-Network: 40% of Plan allowance and any difference between our allowance and the billed amount

Benefit Description	You pay After the calendar year deductible...
Telehealth services	**Standard Option**
Professional services of physicians and other healthcare professionals delivered through telehealth, such as: • Interactive video • Phone visits • Email Note: Visits may be limited by provider type, location and benefit specific limitations, such as visit limits.	In-network: Nothing (no deductible) Out-of-network: $25 per primary care office visit or $35 per specialty care office visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible)
Lab, X-ray and other diagnostic tests	**Standard Option**
Tests, such as: • Blood test • Urinalysis • Non-routine Pap test • Pathology • X-ray • CT/CAT Scan • MRI • Ultrasound • Electrocardiogram and EEG	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
• Breast imaging	In-network: Nothing (No deductible) Out-of-network: Nothing (No deductible)
• Urine drug screening	In-network: Nothing (no deductible) for the first 2 tests per year, then 20% of Plan allowance after the deductible Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Preventive care, adult	**Standard Option**
• One annual routine physical • One annual routine eye exam **The following preventive services are covered at the time interval recommended at each of the links below:** Including:	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible...
Preventive care, adult (cont.)	**Standard Option**
• U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the website at 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, medically necessary postpartum visits, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. Well-women visits also include prepregnancy, prenatal, postpartum, and interpregnancy visits. For a complete list of preventive care benefits for women please visit 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 www.health.gov/myhealthfinder	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)
• Routine mammogram	In-network: Nothing Out-of-network: Nothing (No deductible)
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.	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible...
Preventive care, adult (cont.)	**Standard Option**
• Family centered programs when medically identified to support obesity prevention and management by an in-network provider. 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	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)
• 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/.	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)
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
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending camp, athletic exams or travel.*	*All Charges*

Benefit Description	You pay After the calendar year deductible...
Preventive care, children	**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 www.brightfutures.aap.org • Children's immunization's endorsed by the Centers for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the website at www.cdc.gov/vaccines-children/index.html • You can also find a complete list of A and B recommendations 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 www.health.gov/myhealthfinder	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)
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.	Applies to this benefit
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. • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. Notes:	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)

Preventive care, children - continued on next page

Benefit Description	You pay After the calendar year deductible...
Preventive care, children (cont.)	**Standard Option**
• 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	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending camp, athletic exams or travel.*	*All charges*
Maternity care	**Standard Option**
Complete maternity (obstetrical) care by a physician, certified nurse midwife, or licensed midwife for: • Prenatal and Postpartum care • Screening for gestational diabetes • Delivery (including home births) • Screening and counseling for prenatal and postpartum depression	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)
Breastfeeding and lactation support, supplies and counseling for each birth Note: We cover breastfeeding pumps and supplies under *Durable Medical Equipment (DME)*.	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)
• 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
Notes: Here are some things to keep in mind: • When seen in an emergency room for any reason, the **Emergency services/accidents** benefit cost-share will apply. • Your Plan provider does not have to obtain prior approval from us for your vaginal delivery. See Section 3, You need prior Plan approval for certain services, for prior approval guidelines. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery. We will extend your inpatient stay if medically necessary.	Applies to this benefit

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible...
Maternity care (cont.)	**Standard Option**
• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. See Section 5(b) for circumcision benefits. We cover routine circumcision under Preventive care, children. • When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits. • Hospital/birthing center costs, see Section 5(c) and Surgical benefits Section 5(b).	Applies to this benefit
Family planning	**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: • Voluntary female sterilization • Surgically implanted contraceptives • Injectable contraceptives (such as Depo Provera) • Intrauterine devices (IUDs) • Contraceptive methods and counseling Notes: • See Section 5(b), Surgical and Anesthesia Services for coverage of voluntary sterilization for males and females and section 5 (f), Prescription Drug Benefits for oral contraceptives and devices such as diaphragms.	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)

Family planning - continued on next page

Benefit Description	You pay After the calendar year deductible...
Family planning (cont.)	**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 nonformulary 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 kp.org/health-wellness. • If you are having problems accessing contraceptive coverage, contact contraception@opm.gov. For more information about contraception, you can visit the OPM website at Contraception Coverage (www.opm.gov) or email contraception@opm.gov.	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)
Not covered: • *Reversal of voluntary surgical sterilization*	*All Charges*
Infertility services	**Standard Option**
Diagnosis & treatment of infertility such as: • Artificial insemination (AI): - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Semen analysis • Hysterosalpingogram • Hormone evaluation Notes:	In-network: 50% of Plan allowance Out-of-network: 50% of Plan allowance and any difference between our allowance and the billed amount

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible...
Infertility services (cont.)	**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. • For coverage of fertility drugs, see Section 5(f), *Covered medications and supplies*.	In-network: 50% of Plan allowance Out-of-network: 50% of Plan allowance and any difference between our allowance and the billed amount
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	In-network: 50% of Plan allowance Out-of-network: 50% of Plan allowance and any difference between our allowance and the billed amount
Not covered: These exclusions apply to fertile as well as infertile individuals or couples: • *Services related to surrogate arrangements* • *Assisted reproductive technology (ART) procedures, such as:* *- In vitro fertilization (IVF)* *- Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* *- Zygote transfer* • *Services and supplies related to excluded ART procedures* • *Any charges associated with donor eggs or donor sperm* • *Any charges associated with cryopreservation, unless listed as covered above for iatrogenic infertility* • *Any charges associated with thawing and storage of frozen sperm, eggs and embryos, unless listed as covered above for iatrogenic infertility*	*All Charges*
Allergy care	**Standard Option**
• Testing and treatment • Allergy injections	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Allergy serum	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between the Plan's allowed amount and the billed charges (No deductible)

Allergy care - continued on next page

Benefit Description	You pay After the calendar year deductible...
Allergy care (cont.)	**Standard Option**
Not covered: • *Provocative food testing and sublingual allergy desensitization.*	*All Charges*
Treatment therapies	**Standard Option**
• Chemotherapy and radiation therapy – some types of chemotherapy require preauthorization. Your physician should call Member Services toll-free at 888-901-4636 prior to you receiving therapy. Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Section 5(b), *Organ/tissue transplants*. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Cardiac rehabilitation following a qualifying event/condition • Infusion therapy in a medical office or outpatient hospital facility: Professional services of physicians and other healthcare professionals, equipment and supplies • Ultraviolet light treatments Notes: • Growth hormone therapy (GHT) is covered under the prescription drug benefit and requires preauthorization. • We only cover GHT when we preauthorize the treatment. Your physician must obtain preauthorization before you begin treatment. See *Other services* under *Section 3, You need prior Plan approval for certain services*. • See *Section 5(e)*, *Professional services*, for coverage of Applied Behavior Analysis (ABA).	In-network: $25 per primary care office visit or $35 per specialty care office visit (no deductible) Out-of-network: $25 per primary care office visit or $35 per specialty care office visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible)
• Infusion therapy in a medical office or outpatient hospital facility: Medication	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
• Infusion therapy at home: Professional services of physicians and other healthcare professionals, equipment and supplies	In-network: Nothing (No deductible) Out-of-network: *All Charges*
• Infusion therapy at home: Medication	In-network: 20% of Plan allowance Out-of-network: *All Charges*

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Treatment therapies (cont.)	**Standard Option**
Note: You must obtain infusion medications for the home setting at a preferred specialty Plan pharmacy, and a Plan provider we identify must administer the medications.	In-network: 20% of Plan allowance Out-of-network: *All Charges*
• Enteral and parenteral supplements and formula when it is the sole source, or an essential source, of nutrition Note: See Section 5(a), *Durable medical equipment (DME)* for coverage of equipment and supplies.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
• Amino acid modified products for the treatment of inborn errors of metabolism, such as phenylketonuria (PKU)	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)
Neurodevelopmental therapies	**Standard Option**
Coverage for the restoration and improvement of function in a neurodevelopmentally disabled individual includes: • Inpatient and outpatient physical, speech and occupational therapy; and • Ongoing maintenance care in cases where significant deterioration of the child's condition would occur without the care All therapy treatments must be performed by a physician, registered physical therapist (PT), ASHA-certified speech therapist or an occupational therapist certified by the American Occupational Therapy Association. Coverage does not duplicate coverage for therapy services provided under any other benefit of this Plan.	In-network: $25 per primary care office visit or $35 per specialty care office visit (no deductible) Out-of-network: $25 per primary care office visit or $35 per specialty care office visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible)
Physical and occupational therapies	**Standard Option**
Up to 60 combined visits for rehabilitative or habilitative care per condition per calendar year for physical, occupational, and speech therapy and pulmonary rehabilitation. This limit does not apply to rehabilitative or habilitative care for the treatment of mental health conditions. Services must be provided by qualified physical, occupational, respiratory, speech therapists or other provider. Notes:	In-network: $25 per primary care visit or $35 per specialty care individual office visit (no deductible) Out-of-network: $25 per primary care office visit or $35 per specialty care individual office visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible) Note: You pay one-half of the individual office visit copayment for group office visits, rounded down to the nearest dollar

Physical and occupational therapies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Physical and occupational therapies (cont.)	**Standard Option**
• Outpatient therapies that are provided in a rehabilitation unit that is part of an acute-care hospital, a stand-alone rehabilitation hospital, or an extended care/skilled nursing facility apply toward the maximum 60 combined visits per condition. See Speech therapy, and Home health services. • For inpatient therapy benefit, see Section 5(c).	In-network: $25 per primary care visit or $35 per specialty care individual office visit (no deductible) Out-of-network: $25 per primary care office visit or $35 per specialty care individual office visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible) Note: You pay one-half of the individual office visit copayment for group office visits, rounded down to the nearest dollar
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Reflexology* • *Rolfing*	*All Charges*
Pulmonary rehabilitation	**Standard Option**
Up to 60 combined visits for rehabilitative or habilitative care per condition per calendar year for physical, occupational, and speech therapy and pulmonary rehabilitation. This limit does not apply to rehabilitative or habilitative care for the treatment of mental health conditions. Services must be provided by qualified respiratory therapists. Notes: • Outpatient therapy services that are provided in a rehabilitation unit that is part of an acute-care hospital, a stand-alone rehabilitation hospital, or an extended care/skilled nursing facility apply toward the maximum 60 combined visits per condition. • For inpatient therapy benefit, see Section 5(c).	In-network: $25 per primary care visit or $35 per specialty care individual office visit (no deductible) Out-of-network: $25 per primary care office visit or $35 per specialty care individual office visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible) Note: You pay one-half of the individual office visit copayment for group office visits, rounded down to the nearest dollar
Speech therapy	**Standard Option**
Up to 60 combined visits for rehabilitative or habilitative care per condition per calendar year for physical, occupational, and speech therapy and pulmonary rehabilitation. This limit does not apply to rehabilitative or habilitative care for the treatment of mental health conditions. Services must be provided by qualified speech therapists. Notes: • Outpatient therapy services that are provided in a rehabilitation unit that is part of an acute-care hospital, a stand-alone rehabilitation hospital, or an extended care/skilled nursing facility apply toward the maximum 60 combined visits per condition. • For inpatient therapy benefit, see Section 5(c).	In-network: $25 per primary care visit or $35 per specialty care individual office visit (no deductible) Out-of-network: $25 per primary care office visit or $35 per specialty care individual office visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible) Note: You pay one-half of the individual office visit copayment for group office visits, rounded down to the nearest dollar

Benefit Description	You pay After the calendar year deductible...
Hearing services (testing, treatment, and supplies)	**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. • Testing and examinations for hearing aids. Note: For coverage of hearing screenings, see Section 5(a), *Preventive care, children*, and for any other hearing testing, see Section 5(a), *Diagnostic and treatment services.*	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Hearing aids, including auditory osseointegrated implants/bone anchored hearing systems (BAHS). Notes: • For audible prescription reading and speech generating devices, see Section 5(a), Durable medical equipment. • Covered hearing aids will include bone conduction hearing devices but will not include over-the-counter hearing aids. • Coverage for minors under the age of 18 is available after they have received medical clearance within the last six (6) months from either an otolaryngologist for an initial evaluation of hearing loss or from a licensed physician when it is determined there has not been a significant change in clinical status after the initial evaluation by an otolaryngologist.	All charges in excess of $3,000 for one hearing aid per ear every 36 months
Not covered: • *Hearing services that are not shown as covered* • *Replacement parts and batteries, repair of hearing aids, and replacement of lost or broken hearing aids* • *Over-the-counter hearing aids*	*All Charges*
Cochlear implants – requires preauthorization • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Benefit Description	You pay After the calendar year deductible...
Vision services (testing, treatment, and supplies)	**Standard Option**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
• Diagnostic eye exams provided by an optometrist or ophthalmologist to determine the need for vision correction. For routine screening eye exam benefit see *Preventive care, adult* and *Preventive care, children.*	In-network: $25 per primary care office visit or $35 per specialty care office visit (no deductible) Out-of-network: $25 per primary care office visit or $35 per specialty care office visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible)
• Annual routine eye exam for adults	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)
Not covered: • *Eyeglasses or contact lenses, except as related to accidental ocular injury or intraocular surgery* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All Charges*
Foot care	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See *Orthopedic and prosthetic devices*, for information on podiatric shoe inserts.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
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*

Benefit Description	You pay After the calendar year deductible...
Diabetic education, equipment and supplies	**Standard Option**
• Health Education and training - Nutritional guidance	In-network: $25 per primary care office visit or $35 per specialty care office visit (no deductible) Out-of-network: $25 per primary care office visit or $35 per specialty care office visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible)
• Medical Equipment - Dialysis equipment - Insulin pumps - Insulin infusion devices - Medically necessary orthopedic shoes and inserts • Supplies other than those covered under Prescription drug benefits such as: - Orthopedic and corrective shoes - Arch supports - Foot orthotics - Heel pads and heel cups - Elastic stockings, support hose - Prosthetic replacements	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
• Glucometers	In-network: 20% of Plan allowance (no deductible) Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Orthopedic and prosthetic devices	**Standard Option**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Osseointegrated implants/bone anchored hearing aids (BAHA); preauthorization is required. Please refer to the preauthorization information provided in Section 3. • Cochlear implants - requires preauthorization • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Notes:	Applies to this benefit

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible...
Orthopedic and prosthetic devices (cont.)	**Standard Option**
• For information on the professional charges for the surgery to insert an implant, see Section 5(b), Surgical and anesthesia services. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c), Services provided by a hospital or other facility, and ambulance services. • For information on external hearing aids, see Section 5(a), Hearing services. • Orthopedic and prosthetic devices must be obtained from a Medicare certified provider. Purchases made through the Internet generally do not meet this requirement and are not covered under this Plan. If you have questions about a provider you are considering, please contact us before obtaining the device(s).	Applies to this benefit
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 3 years after the last one we covered (except for externally worn breast prostheses and surgical bras)* • *Devices and supplies purchased through the Internet* • *Replacement of devices, equipment and supplies due to loss, theft, breakage or damage*	*All Charges*
Durable medical equipment (DME)	**Standard Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Hospital beds • Wheelchairs • Crutches • Walkers • Motorized wheelchairs • Audible prescription reading device • Speech generating device	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible...
Durable medical equipment (DME) (cont.)	**Standard Option**
Note: For more details please contact Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
• Peak flow meters	In-network: 20% of Plan allowance (no deductible) Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
• One breastfeeding pump and supplies per delivery, including equipment that is required for pump functionality • Ultraviolet light treatment equipment	In-network: Nothing (no deductible) Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Note: DME must be obtained from a Medicare certified provider. Purchases made through the Internet generally do not meet this requirement and are not covered under this Plan. If you have questions about a provider you are considering, please contact us before obtaining the equipment.	Applies to this benefit
Not covered: • *Exercise equipment such as Nordic Track and/or exercise bicycles* • *Equipment which is primarily used for non-medical purposes such as hot tubs and massage pillows* • *Convenience items* • *DME purchased through the Internet* • *Wigs and hair prostheses* • *Replacement of devices, equipment and supplies due to loss, theft, breakage or damage*	*All Charges*
Home health services	**Standard Option**
• Home healthcare ordered by a physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), master of social work (M.S.W.), or home health aide. - Up to two hours per visit. • Services include oxygen therapy, intravenous therapy and assistance with medications. IV therapy supplies and medications are covered separately under the *Treatment therapies* benefit. Oxygen is covered separately under the *Durable medical equipment (DME)* benefit. Note: These services require preauthorization. Please refer to the preauthorization information shown in Section 3.	In-network: 20% of Plan allowance per visit Out-of-network: 40% of Plan allowance per visit and any difference between our allowance and the billed amount

Home health services - continued on next page

Benefit Description	You pay After the calendar year deductible...
Home health services (cont.)	**Standard Option**
Note: Therapy (physical, occupational, speech) received in your home is paid under the Physical and occupational therapies benefit and applies towards your therapy maximum of 60 visits per condition. See Physical and occupational therapies.	In-network: 20% of Plan allowance per visit Out-of-network: 40% of Plan allowance per visit and any difference between our allowance and the billed amount
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.*	*All Charges*
Chiropractic	**Standard Option**
• Up to 20 treatments per calendar year for manipulation of the spine and extremities	In-network: $25 per primary care treatment (no deductible) Out-of-network: $25 per primary care treatment, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible)
Not covered: • *Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application*	*All Charges*
Alternative treatments	**Standard Option**
• Massage therapy - up to 20 treatments per calendar year when treatment prescribed by a qualified provider and received from a licensed massage therapist • Acupuncture – up to 20 treatments per calendar year when treatment is received from a licensed provider for: - anesthesia - pain relief - substance use disorder - unlimited • • Naturopathic services	In-network: $25 per primary care office visit or $35 per specialty care office visit (no deductible) Out-of-network: $25 per primary care office visit or $35 per specialty care office visit, then 40% of the Plan allowance and any difference between our Plan allowance and the billed amount (no deductible)
Not covered: • *Herbs prescribed by an East Asian Medicine Practitioner (acupuncturist) or naturopath* • *Hypnotherapy* • *Biofeedback* • *Reflexology* • *Rolfing*	*All Charges*

Benefit Description	You pay After the calendar year deductible...
Educational classes and programs	**Standard Option**
Coverage is provided for: • Tobacco Cessation when participating in the Quit For Life® program. You will receive up to two (2) quit attempts per year and a minimum of four (4) counseling sessions that include individual, group, and phone counseling, along with physician prescribed over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco cessation. Call 866-784-8454 toll-free or visit the Quit For Life® website at www.quitnow.net for information on how to enroll.	Nothing for two quit attempts per calendar year through the Quit For Life® program. Nothing for physician prescribed over-the-counter and prescription drugs authorized by the Quit For Life® program and approved by the FDA to treat tobacco dependence. (No deductible)
• Outpatient nutritional guidance counseling services by a certified dietitian or certified nutritionist for conditions such as: - Cancer - Endocrine conditions - Swallowing conditions after stroke - Hyperlipidemia - Colitis - Coronary artery disease - Dysphagia - Gastritis - Inactive colon - Anorexia - Bulimia - Short bowel syndrome (post surgery) - Food allergies or intolerances - Obesity	In-network: $25 per primary care office visit or $35 per specialty care office visit (no deductible) Out-of-network: $25 per primary care office visit or $35 per specialty care office visit, then 40% of the Plan allowance and any difference between our Plan allowance and the billed amount (no deductible)
Not covered: • *Over-the-counter drugs, except for physician prescribed tobacco cessation medications received through the Quit For Life® program and approved by the FDA for treatment of tobacco dependence*	*All Charges*
Sleep disorders	**Standard Option**
Coverage under this benefit is limited to sleep studies, including provider services, appropriate durable medical equipment, and surgical treatments. No other benefits for the purposes of studying, monitoring and/or treating sleep disorders, other than as described below, is provided. **Sleep studies** – Coverage for sleep studies includes: • Polysomnographs • Multiple sleep latency tests	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Sleep disorders - continued on next page

Benefit Description	You pay After the calendar year deductible...
Sleep disorders (cont.)	**Standard Option**
• Continuous positive airway pressure (CPAP) studies • Related durable medical equipment and supplies, including CPAP machines • The condition giving rise to the sleep disorder (such as narcolepsy or sleep apnea) must be diagnosed by your provider. Preauthorization of sleep studies is not required; however, you must be referred to the sleep studies program by your provider.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Any service not listed above for the purpose of studying, monitoring and/or treating sleep disorders*	*All Charges*

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

Important things you should keep in mind about these benefits

- 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.
- The calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment). The calendar year deductible applies to all benefits in this Section.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing Also, read Section 9, Coordinating benefits with Medicare and other coverage.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e., hospital, surgical center).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION 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. Contact Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711 to be sure which services require preauthorization and identify which surgeries require preauthorization.

For non-Plan provider benefit see Section 5(i), Point of Service (POS) benefits, page 72.

Benefit Description	You pay After the calendar year deductible...
Surgical procedures	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. • Circumcision as medically necessary • Treatment of burns • Surgical treatment (bariatric surgery) and all services associated with the surgical treatment of severe obesity.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible...
Surgical procedures (cont.)	**Standard Option**
Note: Visit kp.org/postal to get a list of criteria you must meet to qualify for bariatric surgery. All inpatient and outpatient surgical treatment for morbid obesity must be preauthorized and performed through a bariatric surgery Center of Excellence. See Other services under You need prior Plan approval for certain services.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
• Voluntary sterilization (tubal ligation and vasectomy)	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No Deductible)
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; (see Foot care)* • *Services for the promotion, prevention or other treatment of hair loss or hair growth* • *Cosmetic surgery, any surgery procedure (or any portion of the procedure) performed primarily to improve physical appearance through change in bodily form* • *Services not listed above as covered*	*All Charges*
Reconstructive surgery	**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; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts - Treatment of any physical complications, such as lymphedemas - Breast prostheses and surgical bras and replacements (see *Prosthetic devices*)	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible...
Reconstructive surgery (cont.)	**Standard Option**
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	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
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	*All Charges*
Oral and maxillofacial surgery	**Standard Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Medical and surgical treatment of temporomandibular joint (TMJ) disorder (non-dental); and • Other surgical procedures that do not involve the teeth or their supporting structures.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
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*
Organ/tissue transplants	**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	In-network: 20% of Plan allowance Out-of-network: *All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	**Standard Option**
- 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	In-network: 20% of Plan allowance Out-of-network: *All charges*
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in 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)	In-network: 20% of Plan allowance Out-of-network: *All charges*
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous [myeloid]) leukemia - Hodgkin's lymphoma (relapsed) - Non-Hodgkin's lymphoma (relapsed) - Advanced neuroblastoma - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hematopoietic stem cell transplant (HSCT) - Hemoglobinopathies (e.g., thalassemias, Sickle cell disease) - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow Failure and Related Disorders (i.e., Fanconi's, Pure Red Cell Aplasia)	In-network: 20% of Plan allowance Out-of-network: *All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	**Standard Option**
- 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	In-network: 20% of Plan allowance Out-of-network: *All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	**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)	In-network: 20% of Plan allowance Out-of-network: *All charges*
Mini-transplants performed in a Clinical Trial Setting (non-myeloblative, reduced intensity conditioning). • Allogeneic transplants for:	In-network: 20% of Plan allowance Out-of-network: *All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	**Standard Option**
- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow Failure and Related Disorders (i.e. Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	In-network: 20% of Plan allowance Out-of-network: *All charges*
Notes: • *We cover related medical and hospital expenses of the donor when we cover the recipient.* • *We cover donor screening tests and donor search expenses for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.*	Applies to this benefit

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	**Standard Option**
• *We cover medically necessary routine dental services in preparation for chemotherapy, radiation therapy, and transplants. Covered services may include a routine oral examination, cleaning (prophylaxis), extractions, and X-rays. You pay cost-sharing listed in Section 5(a) for services performed during an office visit.*	Applies to this benefit
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Any transplant not specifically listed as a covered benefit*	*All Charges*
Sleep disorders	**Standard Option**
Surgical treatment – Coverage for the medically necessary surgical treatment of diagnosed sleep disorders is covered under this benefit. Preauthorization of surgical procedures for the treatment of sleep disorders is required. See Other services under You need prior Plan approval for certain services. Surgical treatment includes all professional and facility fees related to the surgical treatment including pre- and post-operative care and complications.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Anesthesia	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

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 are payable only when we determine they are medically necessary.
- The calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage.*
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) and (b).
- **YOUR PROVIDER MUST GET PRIOR APPROVAL FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification. Contact Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711 to be sure which services require preauthorization.

For non-Plan provider benefit see Section 5(i), *Point of Service (POS) benefits*, page 87.

Benefit Description	You pay After the calendar year deductible...
Inpatient hospital	**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. Note: Included under this benefit are admissions for inpatient physical, occupational, and speech therapies and pulmonary rehabilitation provided in a rehabilitation unit that is part of an acute-care hospital or standalone rehabilitation hospital. Other hospital services and supplies, such as: • Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood products, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items (except medications)	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference our allowance and the billed amount

Inpatient hospital - continued on next page

Benefit Description	You pay After the calendar year deductible...
Inpatient hospital (cont.)	**Standard Option**
• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home • Private nursing care	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference our allowance and the billed amount
• Maternity delivery charges in a hospital or birthing center • Donor human milk provided through a milk bank	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as phone, television, barber services, guest meals and beds* • *Take home medications*	*All Charges*
Outpatient hospital or ambulatory surgical center	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood products, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: • We cover hospital services and supplies related to dental procedures when necessitated by a non-dental, physical impairment. We do not cover the dental procedures. • See Section 5(a), for *Telehealth Services*.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Take home medications* • *Audio-only, phone, fax and e-mail communications*	*All Charges*

Benefit Description	You pay After the calendar year deductible...
Extended care benefits/Skilled nursing care facility benefits	**Standard Option**
When appropriate, as determined by a doctor and approved by us, we cover full-time skilled nursing care with no dollar or day limit. Intensive physical and occupational therapies in a skilled nursing facility apply toward the maximum 60 combined visits per condition. Extended care benefits require preauthorization by our medical director.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: *• Custodial care*	*All Charges*
Hospice care	**Standard Option**
Supportive and palliative care for a terminally ill member is covered when services are provided under the direction of a doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately 6 months or less. Services include: • Medical care • Family counseling • Inpatient hospice benefits are available only when services are preauthorized and determined necessary to: - Control pain and manage the patient's symptoms; or - Provide an interval of relief (respite) to the family not to exceed seven (7) consecutive days; each respite care admission must be preauthorized and separated by at least 21 days.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Independent nursing, homemaker services*	*All Charges*
Ambulance	**Standard Option**
Local licensed ambulance services when medically necessary Note: See Section 3, *You need prior Plan approval for certain services* and Section 5(d), *Emergency Services/Accidents*	20% of Plan allowance
Not covered: • *Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan provider*	*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 are payable only when we determine they are medically necessary.
- The calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, please call your doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 phone system) or go to the nearest hospital emergency room.

If you need to be hospitalized, you or a family member must notify us unless it is not reasonably possible to do so. If you are hospitalized in a non-Plan facility, we will work with your doctor to determine when and if it is medically feasible to transfer you to a Plan hospital. You will be transferred when medically feasible with any ambulance charges covered in full.

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

If you need to be hospitalized, you or a family member must notify us unless it is not reasonably possible to do so. If you are hospitalized in a non-Plan facility, we will work with your doctor to determine when and if it is medically feasible to transfer you to a Plan hospital. You will be transferred when medically feasible with any ambulance charges covered in full.

Follow-up care received from non-Plan providers and/or at a non-Plan facility when the care could be received from a Plan provider and/or at a Plan facility, will be covered at the Point of Service (POS) benefit level. See Section 5(i), *Point of Service (POS) Benefits*, page 87.

Benefit Description	You pay After the calendar year deductible...
Emergency within our service area	**Standard Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$25 per primary care visit or $35 per specialty care visit (no deductible)
• Emergency care as an outpatient, including doctor's services Note: If you receive emergency care and then are transferred to observation care, you pay the emergency services cost-sharing. If you are admitted as an inpatient, we will waive your emergency room copayment and you will pay your cost-sharing related to your inpatient hospital stay.	$150 copayment
Not covered: • *Elective care or non-emergency care*	*All Charges*
Emergency outside our service area	**Standard Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$25 copayment per primary care visit or $35 copayment per specialty care visit (no deductible)
• Emergency care as an outpatient, including doctor's services Note: If you receive emergency care and then are transferred to observation care, you pay the emergency services cost-sharing. If you are admitted as an inpatient, we will waive your emergency room copayment and you will pay your cost-sharing related to your inpatient hospital stay.	$150 copayment
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area*	*All Charges*
Ambulance	**Standard Option**
Licensed ambulance service when medically necessary Note: See Section 5(c), *Services Provided by a Hospital or Other Facility and Ambulance Services for non-emergency service.*	20% of Plan allowance
Not covered: • Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan provider • Air and sea ambulance when not medically necessary	*All Charges*

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 are payable only when we determine they are medically necessary.
- The calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating Benefits with Medicare and Other Coverage*.
- **YOU MUST GET PREAUTHORIZATION FOR INPATIENT SERVICES**. Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan:
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Note: Preauthorization is not required for treatment rendered by a state hospital when the member has been involuntarily committed.

- **For non-Plan provider benefit see Section 5(i), *Point of Service (POS) benefits*, page 72.**

Benefit Description	You pay After the calendar year deductible...
Professional services	**Standard Option**
We cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits)	In-network: $25 per individual visit (no deductible) Nothing for group therapy (No deductible) Out-of-network: $25 per individual visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible) Nothing for group therapy (No deductible)

Professional services - continued on next page

Benefit Description	You pay After the calendar year deductible...
Professional services (cont.)	**Standard Option**
• Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy • Applied Behavioral Analysis (ABA) therapy - for the treatment of autism spectrum disorder or a developmental disability	In-network: $25 per individual visit (no deductible) Nothing for group therapy (No deductible) Out-of-network: $25 per individual visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible) Nothing for group therapy (No deductible)
Diagnostics	**Standard Option**
• 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	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Inpatient hospital or other covered facility	**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 • Professional services of physicians	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Outpatient hospital or other covered facility	**Standard Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	In-Network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Physical, Occupational and Speech Therapies	**Standard Option**
Services must be provided by qualified physical, occupational, or speech therapists.	In-network: $25 per primary care visit or $35 per specialty care office visit (no deductible) Out-of-network: $25 primary care visit or $35 per specialty care office visit, then 40% of the Plan allowance and any difference between our allowance and the billed amount (no deductible)

Benefit Description	You pay After the calendar year deductible...
Not Covered	**Standard Option**
• *Services that, upon review, are determined to be inappropriate to treat your condition or are Plan exclusions.* • *Long-term rehabilitative therapy* • *Exercise programs*	*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 on page 71.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- The calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.

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

- **Who can write your prescription**. A licensed physician, dentist, and in states allowing it, licensed/certified providers with prescriptive authority within their scope of practice must prescribe your medication.

Note: Some drugs require prior authorization and may be limited to a specific quantity or day supply (see Section 3, Other services, regarding prior approval).

- **Where you can obtain them**. You must fill the prescription at a Plan retail pharmacy or through a Plan mail order program, except for emergencies. If you have any questions regarding your pharmacy benefit, please call Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711.
- **Mail Order Program**. Covered prescription drugs are available through the mail order program. Prescriptions ordered through this program are subject to the same copayments, guidelines, and limitations set forth above. Mail order issues up to a 90-day supply per fill. To begin using mail order, or to transfer an existing prescription from a retail pharmacy, ask your prescriber to send the prescription directly to the mail order pharmacy:

Kaiser Permanente
Mail Order Pharmacy
P.O. Box 34383
Seattle, WA 98124-1383

Phone: 800-245-7979
Fax: 206-901-4443

- **These are the dispensing limitations.** Prescription drugs will be dispensed for up to a 30-day supply per fill, except for certain drugs, which may be dispensed on a 90-day supply basis with two (2) copayments. For prescribed hormonal contraceptives, you may obtain up to a 12-month supply at a Plan pharmacy or through our mail-delivery program. You may obtain up to 120 condoms per 90-day period. We cover episodic drugs prescribed to treat sexual dysfunction disorder up to a maximum of 8 doses in any 30-day period or 24 in any 90-day period. If a drug is a Tier 4 or 5 drug, you will pay the applicable coinsurance. Refills for any prescription drug cannot be obtained until at least 75% of the drug has been used. Drugs designated as specialty may be covered for up to a 30-day supply per fill. If you have a new prescription for a chronic condition, you may request a coordination of medications so that medications for chronic conditions are refilled on the same schedule (synchronized). Cost-shares for the initial fill of the medication will be adjusted if the fill is less than the standard quantity. Most drugs can be mailed from our mail order pharmacy. Some drugs (for example, drugs that are extremely high cost, require special handling, have standard packaging or requested to be mailed outside of the state of Washington) may not be eligible for mailing and/or a mail order discount. The pharmacy may reduce the day supply dispensed if the pharmacy determines that the item is in limited supply in the market or for specific drugs (your Plan pharmacy can tell you if a drug you take is one of these drugs). You will pay the lesser amount of the total cost of the drug based on the dispensed day's supply (prorated copay) or the full copay if full supply is available.
- **A generic equivalent will be dispensed if it is available**. If your physician believes that a name brand product is medically necessary, or if there is no generic equivalent available, your physician may prescribe a name brand drug. If you elect to purchase a name brand instead of the generic equivalent you are responsible for paying the difference in cost in addition to the prescription drug cost share.

Plan members called to active military duty (or members in a time of national emergency) who need to obtain prescribed medications should call Member Services toll-free at 888-901-4636.

- **We have a managed drug formulary** (approved list of preferred drugs and pharmaceutical products). You pay applicable drug cost-sharing based on the tier a drug is in. Our drugs are categorized into five tiers:
- Tier 1 generally includes generic drugs but may include some brand formulary or preferred brands. Usually represents the lowest copays.
- Tier 2 generally includes brand formulary and preferred brand drugs but may include some generics and brands not included in Tier 1. Usually represents brand or middle-range copays.
- Tier 3 may include all other covered drugs not on tiers 1 and 2 (i.e., non-formulary or non-preferred).
- Tier 4 includes preferred specialty drugs.
- Tier 5 includes non-preferred specialty drugs.

Because of their lower cost to you, we recommend that you ask your provider to prescribe preferred drugs as the first choice of therapy. We describe any additional coverage requirements and limits in our PSHB Drug formulary. These may include step therapy, prior authorization, quantity limits, drugs that can only be obtained at certain specialty pharmacies, or other requirements and limits described in our formulary. To order a Drug Formulary, call us toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711. You may also access the Drug Formulary on our website at kp.org/postal.

Preferred drugs are branded, single source or multi-source agents, or generic drugs that are determined to be preferred by us.

Non-preferred drugs are branded, single source or multi-source agents, or generic drugs that are determined to be non-preferred by us.

Note: The Drug Formulary is continually reviewed and revised. We reserve the right to update this list per formulary guidelines. **For the most up-to-date information about our Drug Formulary, visit our website at www.kp.org/postal.**

- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Generic drugs must contain the same active ingredient and must be equivalent in strength and dosage to the original name brand product. Under Federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic drug costs you – and us – less than a name brand drug.

- **When you do have to file a claim**. When you use a Plan pharmacy, you will not be responsible for submitting a claim form to the Plan. In the event of an accidental injury or medical emergency, you may utilize the services of a non-Plan pharmacy. For reimbursement of pharmacy claims, please submit an itemized claim form with the following information:

  - Member's name and ID#
  - Drug name, quantity, prescription number
  - Cost of drug and amount you paid
  - NDC number
  - Drug strength
  - Pharmacy name
  - Pharmacy address
  - Pharmacy NABP number

Submit your request for reimbursement to:

Member Claims
P.O. Box 30766
Salt Lake City, UT 84130-0766

- **For additional information** on your pharmacy benefits, call Member Services toll-free at 888-901-4636.
- **Specialty medications**. Certain medications must be ordered only through our specialty drug pharmacy program. Your physician must obtain preauthorization for these medications. For a list of specialty drugs, please go to Drug Lists on our website at www.kp.org/postal or call Member Services toll-free at 888-901-4636 prior to receiving services.

Benefit Description	You pay
Covered medications and supplies	**Standard Option**
We cover the following medications and supplies prescribed by a physician and obtained from a Plan retail pharmacy or through the mail order program: • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as Not covered • Insulin • Diabetic supplies limited to: - Disposable needles and syringes for the administration of covered medications - Lancets, test strips and control solution • Sexual dysfunction drugs • Preauthorized compounded drugs • Hormone therapy • Drugs to treat gender dysphoria, including hormones and androgen blockers	**Tier 1** $20 per prescription/refill $60 per 90-day supply **Tier 2 - Preferred** $40 per prescription/refill $120 per 90-day supply **Tier 3- Non-Preferred** $60 per prescription/refill $180 per 90-day supply **Tier 4 – Preferred Specialty** 25% up to a maximum out of pocket of $200 per 30-day supply **Tier 5 – Non-Preferred Specialty** 35% up to a maximum out of pocket of $300 per 30-day supply (No deductible) Notes: • You pay no more than $35 for up to a 30-day supply of insulin. • You pay no more than $35 for up to a 30-day supply of corticosteroid or corticosteroid combination inhalers. • You pay no more than $35 per prescription of epinephrine autoinjector products that contain at least two autoinjectors.
• Opioid rescue agents For more information consult the FDA guidance at www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose	Nothing (No deductible)

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Standard Option**
Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to www.findtreatment.samhsa.gov/.	Nothing (No deductible)
• 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 after the deductible (If it is medically necessary to administer medication during an office visit, the medication is included in the office visit copayment.)
Post-exposure prophylaxis (PEP) drugs • One regimen of human immunodeficiency virus post-exposure prophylaxis	Nothing
Contraceptive drugs and devices as listed in the Health Resources and Services Administration 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 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. • Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. • We cover contraceptive drugs and devices, including implanted contraceptive devices, diaphragms, contraceptive gels, hormonal contraceptive methods, and prescribed FDA approved over-the-counter women's contraceptives and devices. • We cover non-preferred contraceptives 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. For more information on contraceptive coverage and the prescription exception process, please go to www.kp.org/postal under Member Resources. • 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.	Nothing (No deductible)

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Standard Option**
Mail Order Drug Program • Prescription medications mailed to your home by the Kaiser Permanente mail order pharmacy (mail order issues up to a 90-day supply per fill)	**Tier 1** $20 per prescription/refill $40 per 90-day supply **Tier 2 – Preferred** $40 per prescription/refill $80 per 90-day supply **Tier 3 – Non-Preferred** $60 per prescription/refill $120 per 90-day supply (No deductible) Mail order not available for specialty drugs
• Drugs to aid in tobacco cessation when prescribed and dispensed as part of the Plan's tobacco cessation program • Over-the-counter tobacco cessation drugs when obtained through the Kaiser Permanente mail order pharmacy and plan retail pharmacy	Nothing (No deductible)
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them, except treatment of phenylketonuria (PKU) as described elsewhere in this brochure* • *Over-the-counter (nonprescription) medications, except certain over-the-counter substances approved by the Plan* • *Medical supplies such as dressings and antiseptics* • *Drugs to enhance athletic performance* • *Drugs prescribed to treat any non-covered service, except as stated above* • *Drugs obtained at a non-Plan pharmacy, except for emergencies* • *Drugs that are not medically necessary according to accepted medical, dental, or psychiatric practice as determined by the Plan* • *Lost or stolen medications* *Note: Over-the-counter and prescription drugs authorized by the Quit For Life® program and approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation program benefit (see Educational classes and programs).*	*All Charges*

Benefit Description	You pay
Preventive medications	**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 • Liquid iron supplements for children age 0-1 year • Medications to reduce the risk of breast cancer • Statins for adults at risk of cardiovascular disease 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 network 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: when prescribed by a healthcare professional and filled by a network pharmacy.
Not covered: • *Prescriptions filled at a non-Plan pharmacy except for emergencies as described in Section 5(d), Emergency services/accidents* • *Vitamins, nutritional, herbal supplements that can be purchased without a prescriptions, unless they are included in our drug formulary or listed as covered above* • *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* • *Replacement of lost, stolen, damaged prescription, drugs, and accessories* • *Drugs related to non-covered services*	*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 888-901-4636 (TTY: 711).

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

There are advantages to being enrolled in our PDP EGWP:

- In our PDP EGWP, your cost-share for covered drugs, medications, and supplies will be equal to or better than the cost-share for those enrolled in our standard non-PDP EGWP Prescription Drug Program.
- In our PDP EGWP, you have a pharmacy network that may include pharmacies that are out-of-network or excluded for those enrolled in our standard non-PDP EGWP Prescription Drug Program. Go to www.kp.org/directory to use the *Pharmacy Directory* or contact Member Services at 888-901-4636 for additional information or visit www.kp.org/seniorrx. See Chapter 3, Section 2.5 of the Evidence of Coverage for Kaiser Permanente Medicare Part D Group Plan (PDP) for Postal Service Health Benefits Members for information on when you can use pharmacies that are not in the plan's network.
- We provide coverage of some drugs excluded by Medicare, for example, sexual dysfunction drugs and drugs used for treatment of weight loss

We cover prescribed drugs and medications, as described in the chart beginning on the following pages.

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure, and we cover them only when we determine they are medically necessary.
- Your prescribers must obtain prior approval authorizations for certain prescription drugs and supplies from Medical Group before coverage applies. Prior approval/authorizations must be renewed periodically.
- We have no calendar year deductible.
- Federal 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 888-901-4636 (TTY: 711).

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

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

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

		• Call and speak to a Kaiser Permanente Medicare health plan specialist at 877-547-4909 (TTY 711), Monday through Friday, from 6 a.m. to7 p.m. Pacific Time **Note: If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll during Open Season or for a QLE. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty**. Contact us for assistance at 888-901-4636. Each new enrollee will receive a description of our PDP EGWP Summary of Benefits, a combined prescription drug/Plan identification card, a mail order form/patient profile and a preaddressed reply envelope. You will be enrolled in a Kaiser Permanente Medicare Part D Group Plan (PDP) for Postal Service Health Benefits (PSHB) Members.		

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

- **Who can write your prescription**. A licensed physician, dentist, and in states allowing it, licensed/certified providers with prescriptive authority within their scope of practice must prescribe your medication. Your prescribers must have Medicare-approved prescriptive authority.
- **Where you can obtain prescription drugs**. You must fill the prescription at a Plan retail pharmacy or through a Plan mail order program, except for emergencies. If you have any questions regarding your pharmacy benefit, please call Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or TTY 711. For assistance locating a PDP EGWP network pharmacy, visit our website at www.kp.org, or call Member Services at 888-901-4636.
- **Mail Order Program**. Covered prescription drugs are available through the mail order program. Prescriptions ordered through this program are subject to the same copayments, guidelines, and limitations set forth above. Mail order issues up to a 90-day supply per fill. To begin using mail order, or to transfer an existing prescription from a retail pharmacy, ask your prescriber to send the prescription directly to the mail order pharmacy:

  Kaiser Permanente
  Mail Order Pharmacy
  P.O. Box 34383 Seattle, WA 98124-1383

  Phone: 800-245-7979
  Fax: 206-901-4443

- **These are the dispensing limitations.** Prescription drugs will be dispensed for up to a 30-day supply per fill, except for certain drugs, which may be dispensed on a 90-day supply basis with two (2) copayments. For prescribed hormonal contraceptives, you may obtain up to a 12-month supply at a Plan pharmacy or through our mail-delivery program. You may obtain up to 120 condoms per 90-day period. We cover episodic drugs prescribed to treat sexual dysfunction disorder up to a maximum of 8 doses in any 30-day period or 24 in any 90-day period. If a drug is a Tier 4 or 5 drug, you will pay the applicable coinsurance. Refills for any prescription drug cannot be obtained until at least 75% of the drug has been used. Drugs designated as specialty may be covered for up to a 30-day supply per fill. If you have a new prescription for a chronic condition, you may request a coordination of medications so that medications for chronic conditions are refilled on the same schedule (synchronized). Cost-shares for the initial fill of the medication will be adjusted if the fill is less than the standard quantity. Most drugs can be mailed from our mail order pharmacy. Some drugs (for example, drugs that are extremely high cost, require special handling, have standard packaging or requested to be mailed outside of the state of Washington) may not be eligible for mailing and/or a mail order discount. The pharmacy may reduce the day supply dispensed if the pharmacy determines that the item is in limited supply in the market or for specific drugs (your Plan pharmacy can tell you if a drug you take is one of these drugs). You will pay the lesser amount of the total cost of the drug based on the dispensed day's supply (prorated copay) or the full copay if full supply is available.
- **You may request a Formulary Exception.** Kaiser Permanente physicians prescribe the appropriate level of medically necessary medications to PSHB members. To ensure physicians can make appropriate exceptions, they have the authority to prescribe brand-name or non-formulary drugs for members without administrative review if their opinion is that a particular drug is medically necessary and would be more beneficial for an individual member. Members pay their regular prescription drug copayment for medically necessary brand-name drugs.

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

Plan members called to active military duty (or members in a time of national emergency) who need to obtain prescribed medications should call Member Services toll-free at 888-901-4636.

- **We have a managed drug formulary** (approved list of preferred drugs and pharmaceutical products). You pay applicable drug cost-sharing based on the tier a drug is in. Our drugs are categorized into five tiers:

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

  Because of their lower cost to you, we recommend that you ask your provider to prescribe preferred drugs as the first choice of therapy. We describe any additional coverage requirements and limits in our PSHB Drug formulary. These may include step therapy, prior authorization, quantity limits, drugs that can only be obtained at certain specialty pharmacies, or other requirements and limits described in our formulary. To order a Drug Formulary, call us toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711. You may also access the Drug Formulary on our website at www.kp.org/postal.

  Preferred drugs are branded, single source or multi-source agents, or generic drugs that are determined to be preferred by us.

  Non-preferred drugs are branded, single source or multi-source agents, or generic drugs that are determined to be non-preferred by us.

  Note: The Drug Formulary is continually reviewed and revised. We reserve the right to update this list per formulary guidelines. **For the most up-to-date information about our Drug Formulary, visit our website at www.kp.org/postal.**

- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Generic drugs must contain the same active ingredient and must be equivalent in strength and dosage to the original name brand product. Under Federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic drug costs you – and us – less than a name brand drug.

- **When you do have to file a claim**. When you use a Plan pharmacy, you will not be responsible for submitting a claim form to the Plan. In the event of an accidental injury or medical emergency, you may utilize the services of a non-Plan pharmacy. For reimbursement of pharmacy claims, please submit an itemized claim form with the following information:

  - Member's name and ID#
  - Drug name, quantity, prescription number
  - Cost of drug and amount you paid
  - NDC number
  - Drug strength
  - Pharmacy name
  - Pharmacy address
  - Pharmacy NABP number

  Submit your request for reimbursement to:

  Member Claims
  P.O. Box 30766
  Salt Lake City, UT 84130-0766

- **If we deny your claim and you want to appeal,** you, your representative, or your prescriber must request an appeal following the process described in Section 8(a). Medicare PDP EGWP Disputed Claims Process. The PDP EGWP appeals process has 5 levels. If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you'll get instructions in the decision letter on how to move to the next level of appeal.
- **For additional information** on your pharmacy benefits, call Member Services toll-free at 888-901-4636.
- **Specialty medications**. Certain medications must be ordered only through our specialty drug pharmacy program. Your physician must obtain preauthorization for these medications. For a list of specialty drugs, please go to Drug Lists on our website at www.kp.org/postal or call Member Services toll-free at 888-901-4636 prior to receiving services.
- **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 Senior Advantage Postal Service Members.

Benefit Description	You pay
Covered medications and supplies	**Standard Option**
We cover the following medications and supplies prescribed by a physician and obtained from a Plan retail pharmacy or through the mail order program: • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as Not covered • Insulin • Diabetic supplies limited to: - Disposable needles and syringes for the administration of covered medications - Lancets, test strips and control solution • Sexual dysfunction drugs • Preauthorized compounded drugs • Hormone therapy • Drugs to treat gender dysphoria, including hormones and androgen blockers	**Tier 1 Generic Preferred** $20 per prescription/refill $60 per 90-day supply **Tier 2 – Generic Non-Preferred** $20 per prescription/refill $60 per 90-day supply **Tier 3 – Brand Preferred** $40 per prescription/refill $120 per 90-day supply **Tier 4 – Non-Preferred Drugs** $40 per prescription/refill $120 per 90-day supply **Tier 5 – Specialty** $200 per prescription/refill (No deductible) Notes: • You pay no more than $35 for up to a 30-day supply of insulin. • You pay no more than $35 for up to a 30-day supply of corticosteroid or corticosteroid combination inhalers. • You pay no more than $35 per prescription of epinephrine autoinjector products that contain at least two autoinjectors.
• Opioid rescue agents	Nothing No deductible
• 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 after the deductible (If it is medically necessary to administer medication during an office visit, the medication is included in the office visit copayment.)
Post-exposure prophylaxis (PEP) drugs	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Standard Option**
• One regimen of human immunodeficiency virus post-exposure prophylaxis	Nothing
Contraceptive drugs and devices as listed in the ACA/HRSA site. Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in all methods of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. • We cover contraceptive drugs and devices, including implanted contraceptive devices, diaphragms, contraceptive gels, hormonal contraceptive methods, and prescribed FDA approved over-the-counter women's contraceptives and devices. • We cover non-preferred contraceptives 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. For more information on contraceptive coverage and the prescription exception process, please go to kp.org/postal under Member Resources. • 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.	Nothing (No deductible)
Mail Order Drug Program • Prescription medications mailed to your home by the Kaiser Permanente mail order pharmacy (mail order issues up to a 90-day supply per fill)	**Tier 1 Generic Preferred** $20 per prescription/refill $40 per 90-day supply **Tier 2 – Generic Non-Preferred** $20 per prescription/refill $80 per 90-day supply **Tier 3 – Brand Preferred** $40 per prescription/refill $80 per 90-day supply **Tier 4 – Non-Preferred Drugs** $40 per prescription/refill $80 per 90-day supply

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Standard Option**
	(No deductible) Mail order not available for specialty drugs
• Drugs to aid in tobacco cessation when prescribed and dispensed as part of the Plan's tobacco cessation program • Over-the-counter tobacco cessation drugs when obtained through the Kaiser Permanente mail order pharmacy and plan retail pharmacy	Nothing (No deductible)
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them, except treatment of phenylketonuria (PKU) as described elsewhere in this brochure* • *Over-the-counter (nonprescription) medications, except certain over-the-counter substances approved by the Plan* • *Medical supplies such as dressings and antiseptics* • *Drugs to enhance athletic performance* • *Drugs prescribed to treat any non-covered service, except as stated above* • *Drugs obtained at a non-Plan pharmacy, except for emergencies* • *Drugs that are not medically necessary according to accepted medical, dental, or psychiatric practice as determined by the Plan* • *Lost or stolen medications* *Note: Over-the-counter and prescription drugs authorized by the Quit For Life® program and approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation program benefit (see Educational classes and programs).*	*All Charges*
Preventive medications	**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 • Liquid iron supplements for children age 0-1 year • Medications to reduce the risk of breast cancer • Statins for adults at risk of cardiovascular disease	Nothing

Preventive medications - continued on next page

Benefit Description	You pay
Preventive medications (cont.)	**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 network 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
Not covered: • *Prescriptions filled at a non-Plan pharmacy except for emergencies as described in Section 5(d), Emergency services/accidents* • *Vitamins, nutritional, herbal supplements that can be purchased without a prescriptions, unless they are included in our drug formulary or listed as covered above* • *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* • *Replacement of lost, stolen, damaged prescription, drugs, and accessories* • *Drugs related to non-covered services*	*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 Medicare and other coverage*.
- Only those procedures that are part of a routine/preventive dental exam are covered.
- We cover hospitalization for dental procedures only when a non-dental, physical impairment exists, which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits.
- The dental procedures listed below are not all-inclusive and are subject to change. Please call us toll-free at 888-901-4636. For the deaf and hearing-impaired, use Washington state's relay line by dialing either 800-833-6388 or 711 for additions/changes to the list of covered American Dental Association (ADA) codes.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.

Benefit Description	You pay After the calendar year deductible...
Accidental injury benefit	**Standard Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. Sound natural teeth are those that do not have any restoration. (See Section 10, Definitions of Terms We Use in This Brochure.) The need for these services must result from an accidental injury (not biting or chewing). All services must be performed and completed within 12 months of the date of injury.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Dental Benefits	We pay scheduled allowance. No deductible. (you pay all excess charges)	
Preventive Dental Services	**Codes**	**Standard Option**
Diagnostic X-rays: intraoral - periapical first film	D0220	$20.00
Diagnostic X-rays: intraoral – periapical each additional film	D0230	$19.00
Diagnostic X-rays: intraoral – occlusal film	D0240	$41.00
Bitewing X-rays – single film (twice per calendar year)	D0270	$20.00
Bitewing X-rays – two films (twice per calendar year)	D0272	$31.00
Bitewing X-rays – four films (twice per calendar year)	D0274	$45.00
Full mouth or panorex X-rays: panoramic film (full mouth or panorex series limited to once every 3 calendar years)	D0330	$77.00

Preventive Dental Services - continued on next page

Dental Benefits	We pay scheduled allowance. No deductible. (you pay all excess charges)	
Preventive Dental Services (cont.)	**Codes**	**Standard Option**
Full mouth or panorex X-rays: intraoral complete series including bitewings (full mouth or panorex series limited to once every 3 calendar years)	D0210	$95.00
Periodic oral exam (twice per calendar year)	D0120	$41.00
Limited oral evaluation – problem focused	D0140	$58.00
Comprehensive oral evaluation	D0150	$57.00
Pulp vitality tests	D0460	$38.00
Prophylaxis (cleaning) – through age 13 (twice per calendar year)	D1120	$51.00
Prophylaxis (cleaning) – after age 13 (twice per calendar year)	D1110	$88.00
Fluoride – topical application of fluoride (twice per calendar year through age 17; prophylaxis not included)	D1208	$32.00
Application of sealants for permanent molars and bicuspids only (with a 3 year limitation per surface, sealant per tooth; through age 13)	D1351	$28.00
Space Maintenance - fixed - unilateral (Passive Appliances)	D1510	No benefit

Section 5(h). Wellness and Other Special Features

Flexible benefits option	In certain cases, Kaiser Permanente Washington Options Federal, at its sole discretion, may choose to authorize coverage for benefits or services that are not otherwise included as covered under this Plan. Such authorization is done on a case-by-case basis if a particular benefit or service is judged to be medically necessary, beneficial, and cost effective. However, our decision to authorize services in one instance does not commit us to cover the same or similar services for you in other instances or to cover the same or similar services in any other instance for any other enrollee. Our decision to authorize services does not constitute a waiver of our right to enforce the provisions, limitations, and exclusions of this Plan. 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.
Services for deaf, hard of hearing, or speech impaired	We provide a TTY/text number at: 711. Sign language services are also available.

Travel benefit/services overseas	If you are on Temporary Duty Assignment or reside temporarily outside of Washington state you are covered for all of the benefits described in this brochure. You pay the applicable cost-share per visit for services. For non-urgent and non-emergent services you should receive care from a Plan provider; in Idaho, Oregon, Montana and Alaska, a Plan provider is a First Choice Health Network provider; in all other states, a Plan provider is a First Health Network provider; or in a different Kaiser Foundation Health Plan service area, a designated Kaiser Permanente provider or facility. Designated Kaiser Permanente providers are members of a Permanente Medical Group or are employed at Kaiser Permanente medical facilities. If a Kaiser Permanente provider refers you to a provider who is not affiliated with the Permanente Medical Group, you may pay out-of-network cost-sharing. Medications obtained at a participating pharmacy in connection with non-urgent, non-emergent services will also be covered. See also Section 1. *How we pay providers*. If you need assistance while anywhere in the world, call Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711. **Filing Overseas Claims for Urgent or Emergent Care** Most overseas providers are under no obligation to file claims on behalf of our members. **You may need to pay for the services at the time you receive them and then submit a claim to us for reimbursement.** To file a claim for covered urgent or emergent care received outside the United States, send a completed Overseas Claim Form and itemized bills to: Member Claims P.O. Box 30766 Salt Lake City, UT 84130-0766 We will do the translation and currency conversion for you. You may obtain the Overseas Claim Form by calling Member Services toll-free at 888-901-4636 or from our website at www.kp.org/postal, Members/Forms and Information.
Nutrition and behavioral lifestyle support	Kaiser Permanente is committed to investing in the total health of our members. Exercise, nutrition, and weight management resources such as wellness coaching and online Healthy Lifestyle Programs are all available at no cost. We offer our members the tools and resources they need to actively participate in their health at home, online, with their smartphone, and at our facilities. Our members can enroll in a variety of programs that are designed to help them take an active role in their health and make desired lifestyle changes. Unless otherwise noted, most of these programs are available at no additional costs to members because they are embedded within our integrated care delivery model as part of our core offerings. Examples of our wellness programs aimed at weight and nutrition are: • Nutrition counseling (such as weight loss and a healthy diet) • Stress reduction programs • Chronic disease self-management programs • Exercise counseling and cardiovascular fitness programs • Smoking cessation program • Health risk assessments Members can access our Health and Wellness Programs at kp.org/healthyliving.

Services from other Kaiser Permanente regions	When you visit a different Kaiser Foundation Health Plan service area, you can receive visiting member services from designated providers in that area. Visiting member services are subject to the terms, conditions, and cost-sharing described in this PSHB brochure. Certain services are not covered as a visiting member. Visiting member services are described in our visiting member brochure. For more information about receiving visiting member services, including provider and facility locations in other Kaiser Permanente services areas, please call our Washington Visiting Member Services at 800-466-4296 or visit Travel Emergency Health Care and Coverage | Kaiser Permanente.

Section 5(i). Point of Service (POS) 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.
- The calendar year deductible is $350 per person ($700 per family).
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.

Facts about this Plan's POS option
You may choose to obtain benefits covered by this Plan from non-Plan doctors and hospitals whenever you need care. All copayments, coinsurance, and deductibles apply.

What is covered
All services/treatments listed in this brochure as covered.

What is not covered
All services/treatments listed in this brochure as not covered, including the following:

- Orthopedic and prosthetic devices/supplies and durable medical equipment (DME) purchased through the Internet.
- Expenses in excess of the Plan's allowable amount or benefit maximum (e.g., dental fee schedule amounts).
- The difference between the billed amount and the amount allowed by Kaiser Permanente Washington Options Federal.

Emergency benefits
Emergency care is always payable at the Plan provider level of benefit. Please see Section 5(d), *Emergency services/ accidents*, page 64, for benefit details.

What you pay
When you choose to obtain services from a non-Plan provider or hospital:

- We will determine what our allowable amount would have been for a Plan provider*.
- We will apply your appropriate cost-sharing (i.e., deductible and/or copayment) to the allowed amount.
- You pay the non-Plan provider 40% of the allowed amount balance after you have paid your appropriate cost-sharing.
- The non-Plan provider may balance bill you for the difference between what we pay and the original charges.

***Note: If our allowed amount is more than what the non-Plan provider or hospital bills, we will base our payment on their billed amount.**

Section 5. High Deductible Health Plan Benefits

HDHP

Section 5. High Deductible Health Plan Benefits Overview

This Plan offers a High Deductible Health Plan (HDHP). The HDHP benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read *Important things you should keep in mind about these benefits* at the beginning of each subsection. Also read the general exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711; or on our website at www.kp.org/postal

Our HDHP option provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your healthcare benefits.

Based on your eligibility, when you enroll in this HDHP, you can have either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) account. We automatically pass through a portion of your total health Plan premium to your HSA each month or credit an equal amount to your HRA.

The first year you enroll in this HDHP, funds will be prorated based on your enrollment effective date. If your enrollment is effective other than the first day of a month, your HSA funds (or HRA credit) will be prorated based on the first of the following month. **Before funding for either an HSA or HRA can occur, we must receive an HSA Eligibility Worksheet from you** (the worksheet is sent to you with your new member materials or is available on our website at **www.kp.org/postal).** If you are eligible for an HSA, in addition to the worksheet, you must complete the HSA enrollment process with HealthEquity®.

With this Plan, preventive care is covered in full. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefits described on 104. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

This HDHP includes five key components: preventive care; traditional medical coverage healthcare that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools.

Preventive care

The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), well-child care, child and adult immunizations, tobacco cessation programs and preventive dental care. These services, except for preventive dental, are covered at 100% if you use a network provider and the services are described in Section 5, page 90, ***Preventive Care. You do not have to meet the deductible before using these services***.

The Plan covers the Quit For Life® tobacco cessation program, obesity weight loss programs, and nutritional guidance under Educational classes and programs. Please see Section 5(a), page 51 for benefit details.

Traditional medical coverage

After you have paid the Plan's deductible, we pay benefits under traditional medical coverage described in Section 5, Traditional medical coverage subject to the deductible. The Plan typically pays 80% for in-network and 60% for out-of-network care.

Covered services include:

• Medical services and supplies provided by physicians and other healthcare professionals
• Surgical and anesthesia services provided by physicians and other healthcare professionals
• Hospital and other facility services
• Ambulance services
• Emergency services/accidents
• Mental health and substance use disorder benefits
• Prescription drug benefits
• Accidental dental injury benefits

Out-of-network services

You may choose to obtain benefits covered by this Plan either in-network from Plan providers or out-of-network from non-Plan providers whenever you need care.

When you use non-Plan providers, your benefits are significantly less than if you use Plan providers. Kaiser Permanente Washington Options Federal will pay 60% of our allowed amount or the non-Plan provider's billed amount, whichever is less. In addition, it is your responsibility to pay the difference between any amounts billed by the non-Plan provider and the amount allowed by Kaiser Permanente Washington Options Federal. This is called "balance billing."

What is covered
All services/treatments listed in this brochure as covered under the HDHP, except preventive care, including preventive dental care.

What is not covered
All services/treatments listed in this brochure as not covered including the following:

- Expenses in excess of the Plan's allowable amount or benefit maximum (e.g., preventive dental care fee schedule amounts).
- The difference between the billed amount and the amount allowed by Kaiser Permanente Washington Options Federal.

Emergency benefits
Emergency care is always payable at the in-network benefit level. Please see Section 5(d), *Emergency Services/Accidents*, page 132, for benefit details.

Savings

Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see page 94 for more details).

Health Savings Accounts (HSAs)

By law, HSAs are available to members who:

- Are not enrolled in Medicare;
- Cannot be claimed as a dependent on someone else's tax return;
- Have not received VA (except for veterans with a service-connected disability) and/or Indian Health Service (IHS) benefits within the last three months; or
- Do not have other health insurance coverage other than another High Deductible Health Plan.

In 2025, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $62.50 per month for a Self Only enrollment or $125 per month for a Self Plus One or Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is $3,600 for an individual and $7,200 for a family. See maximum contribution information on page 83. You can use funds in your HSA to help pay your health Plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

NOTE: When you enroll in this HDHP, we will send you an HSA Eligibility Worksheet and instructions on how to enroll in an HSA with HealthEquity®. The worksheet is sent to you with your new member materials or is available on our website at kp.org/postal. The first year you enroll in this HDHP, funds will be prorated based on your enrollment effective date. If your enrollment is effective other than the first day of a month, your HSA funds will be prorated based on the first of the following month. Before funding for an HSA can occur, we must receive the HSA Eligibility Worksheet. In addition to the worksheet, you must complete the HSA enrollment process with HealthEquity®.

Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don't deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

HSA features include:

- Your HSA is administered by HealthEquity®.
- Your contributions to the HSA are tax deductible.
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).
- Your HSA earns tax-free interest.
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS publication 502 for a complete list of eligible expenses).
- Your unused HSA funds and interest accumulate from year to year.
- It's portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire.
- When you need them, your funds are available up to the actual HSA balance.

Important consideration if you want to participate in a Healthcare Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a **HCFSA** healthcare flexible spending account, this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish a Health Reimbursement Arrangement (HRA) account for you.

Health Reimbursement Arrangements (HRA)

If you are not eligible for an HSA, for example you are enrolled in Medicare or are covered on another health plan, we will establish an HRA for you instead. You must notify us that you are ineligible for an HSA by returning the HSA Eligibility Worksheet from your new member materials; the worksheet also is available on our website at www.kp.org/postal.

In 2025, we will give you an HRA credit of $750 per year for a Self Only enrollment and $1,500 per year for a Self Plus One or Self and Family enrollment (these amounts may be prorated the first year you are enrolled in this HDHP). You can use funds in your HRA to help pay your Plan deductible and/or for certain expenses that do not count toward the deductible.

HRA features include:

- Your HRA is administered by HealthEquity®.

- When you need them, your funds are available up to the actual HRA balance. NOTE: If your enrollment in this HDHP becomes effective other than the first day of a month, your HRA credit will be available to you the first of the following month.
- The tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP.
- Unused credit carries over from year to year.
- The HRA credit does not earn interest.
- The HRA credit is forfeited if you leave Federal employment or switch health insurance plans.
- An HRA does not affect your ability to participate in a Healthcare Flexible Spending Account (HCFSA). However, you must meet HCFSA eligibility requirements.

Catastrophic protection for out-of-pocket expenses

Your annual maximum for out-of-pocket expenses (deductibles, coinsurance, and copayments) for covered services is limited to $5,000 for Self Only enrollment or $5,000 per person for Self Plus One or Self and Family enrollment not to exceed a total out-of-pocket maximum of $10,000 (each applies separately for services received from Plan providers and non-Plan providers). However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to Section 4, Y*our catastrophic protection out-of-pocket maximum*, for more details. If you are enrolled in our PDP EGWP, see page 144 for additional information about your out-of-pocket maximum.

Health education resources and account management tools

HDHP Section 5(i) describes the health education resources and account management tools available to you to help you manage your healthcare and your healthcare dollars.

Section 5. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	The Plan will establish an HSA with HealthEquity®, this HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.)	The Plan will establish an HRA with HealthEquity®, this HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.).
Fees	Monthly administration fee charged by the fiduciary is paid by the Plan.	Monthly administration fee charged by the fiduciary is paid by the Plan.
Eligibility	You must: • Enroll in this HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else's tax return • Not have received VA (except for veterans with a service-connected disability) and/or Indian Health Service (IHS) benefits in the last three months • Complete and return the HSA Eligibility Worksheet to the Plan	You must enroll in this HDHP. • Enroll in this HDHP • Complete and return the HSA Eligibility Worksheet to the Plan
Funding	If you are eligible for HSA contributions, a portion of your monthly health Plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP. In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).	HRA contributions are a portion of your monthly health plan premium which is credited to your HRA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP. **NOTE: If your enrollment effective date in this HDHP is other than the first day of a month, funding for your HRA will be prorated based on the first of the following month.**

	NOTE: If your enrollment effective date in this HDHP is other than the first day of a month, you will be eligible to receive the premium pass through contribution beginning the first of the following month.	
• **Self Only enrollment**	For 2025, a monthly premium pass through of $62.50 will be made by the HDHP directly into your HSA each month.	For 2025, a monthly premium pass through of $62.50 will be made by the HDHP directly into your HRA each month.
• **Self Plus One enrollment**	For 2025, a monthly premium pass through of $125 will be made by the HDHP directly into your HSA each month.	For 2025, a monthly premium pass through of $125 will be made by the HDHP directly into your HRA each month.
• **Self and Family enrollment**	For 2025, a monthly premium pass through of $125 will be made by the HDHP directly into your HSA each month.	For 2025, a monthly premium pass through of $125 will be made by the HDHP directly into your HRA each month.
Contributions/credits	The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of $3,600 for an individual and $7,200 for a family. If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution. You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year.	Your monthly premium pass through will be credited to your HRA each month. The HRA does not earn interest. **NOTE: If your enrollment effective date in this HDHP is other than the first day of a month, funding for your HRA will be prorated based on the first of the following month.**

	If you do not meet the 12-month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability. You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). HSAs earn tax-free interest (does not affect your annual maximum contribution). Additional contribution discussed on page 95.	
• **Self Only enrollment**	You may make an annual maximum contribution of $2,850 if your enrollment effective date is January 1.	You cannot contribute to the HRA.
• **Self Plus One enrollment**	You may make an annual maximum contribution of $5,700 if your enrollment effective date is January 1.	You cannot contribute to the HRA.
• **Self and Family enrollment**	You may make an annual maximum contribution of $5,700 if your enrollment effective date is January 1.	You cannot contribute to the HRA.
Access funds	You can access your HSA by the following methods: • HealthEquity® Visa® account • Online portal • Withdrawal form	You can access your HRA by the following methods: • HealthEquity® Visa® account • Online portal • Withdrawal form

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Distributions/withdrawals • **Medical**	You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA. See IRS Publication(s) 502 for information on eligible medical expenses.	You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See Availability of funds, page 97 for information on when funds are available in the HRA. See IRS Publication 502 for a list of eligible medical expenses. Over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.
• **Non-medical**	If you are under age 65, withdrawal of funds for non-medical expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds. When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty, however they will be subject to ordinary income tax.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses
Availability of funds	Funds are not available for withdrawal until all the following steps are completed: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • The Plan receives record of your enrollment. • The Plan sends you an HSA Eligibility Worksheet and instructions on how to enroll in an HSA with HealthEquity®.	Funds are not available for withdrawal until all the following steps are completed: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • The Plan receives record of your enrollment. • The Plan sends you an HSA Eligibility Worksheet for you to complete. • You return the completed worksheet to the Plan, showing you are not eligible for an HSA.

	• You return the HSA Eligibility Worksheet to the Plan, confirming you meet the HSA eligibility requirements. • You enroll in an HSA with HealthEquity®. • The Plan confirms your HSA enrollment with HealthEquity® • The Plan initiates premium pass through contributions to your HSA. **NOTE: If your enrollment effective date in this HDHP is other than the first day of a month, you will be eligible to receive funding for your HSA the first of the following month.**	• The Plan forwards your enrollment information to HealthEquity® and establishes your HRA • Your monthly premium pass through will be credited to your HRA each month, beginning the first of the month following the Plan's receipt of the HSA Eligibility Worksheet. Accumulated funds will be made available to you to pay for qualified medical expenses and Medicare Part B premium. **NOTE: If your enrollment effective date in this HDHP is other than the first day of a month, funding for your HRA will be prorated based on the first of the following month.**
Account owner	PSHB enrollee	HDHP
Portable	You can take this account with you when you change plans, separate or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 94 for HSA eligibility.	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If you have an HSA

- **Contributions**

All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions, or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. Your own HSA contributions are tax deductible. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.

If you newly enroll in an HDHP during Open Season your effective date is January 1st, or if you enroll at any other time and have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.

Contact HealthEquity® toll-free at 866-346-5800 for more details.

- **Over age 55 additional contributions**

  If you are age 55 or older, the IRS permits you to make additional contributions to your HSA. The allowable additional contribution is $1,000. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury website at www.irs.gov or request a copy of IRS Publication 969 by calling 1-800-829-3676.

- **If you die**

  If you have not named beneficiary and you are married, your HSA becomes your spouse's; otherwise, your HSA becomes part of your taxable estate.

- **Qualified expenses**

  You can pay for "qualified medical expenses," as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, over-the-counter drugs, LASIK surgery, and some nursing services.

  When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.

  For details of IRS-allowable expenses, request a copy of IRS Publication(s) 502 and 969 by calling 1-800-829-3676, or visit the IRS website at www.irs.gov and click on "Forms and Publications." Note: Although over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

- **Non-qualified expenses**

  You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.

- **Tracking your HSA balance**

  You will receive a periodic statement that shows the "premium pass through", withdrawals, and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA.

- **Minimum reimbursements from your HSA**

  You can request reimbursement in any amount.

If you have an HRA

- **Why an HRA is established**

  If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you become ineligible to contribute to an HSA.

- **How an HRA differs**

  Please review the chart on page 99 which details the differences between an HRA and an HSA. The major differences are:

  - you cannot make contributions to an HRA
  - funds are forfeited if you leave the HDHP
  - an HRA does not earn interest
  - HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. PSHB law does not permit qualified medical expenses to include services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.

Contact HealthEquity® toll-free at 866-346-5800 for more details.

Section 5. Preventive Care

Important things you should keep in mind about these benefits:

- Preventive care services listed in this Section are not subject to the deductible.
- You must use Plan providers.
- For all other covered expenses, please see Section 5 – *Traditional medical coverage subject to the deductible*, page 104.

Benefit Description	You pay
Preventive care, adult	**HDHP**
• One annual routine physical • One annual routine eye exam 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 visit 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, medically necessary postpartum visits, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. Well-women visits also include prepregnancy, prenatal, postpartum, and interpregnancy visits. For a complete list of preventive care benefits for women please visit 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 www.health.gov/myhealthfinder	Nothing
• Routine mammogram	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**HDHP**
• 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 www.cdc.gov/vaccines/?CDC_AAref_Val=https://www.cdc.gov/vaccines/schedules/	Nothing
• Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy. • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. Notes: • 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
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	
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending camp, athletic exams or travel.* • *Preventive services received from a non-Plan provider*	All Charges

Benefit Description	You pay
Preventive care, children	**HDHP**
• Well-child visits examinations, and immunizations 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 brightfutures.aap.org/Pages/default.aspx • Immunizations such as DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations visit the Centers for Disease Control (CDC) website at www.cdc.gov/vaccines/schedules/index.html • You can also find a complete list of A and B recommended preventive care services under the U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at: www.uspreventiveservicestaskforce.org • We cover other preventive services required by federal healthcare reform legislation (the Affordable Care Act and implementing regulations) and additional services that we include in our preventive services benefit. For a complete list of Kaiser Permanente preventive services visit our website at www.kp.org/prevention • To build you personalized list of preventative services go to www.health.gov/myhealthfinder • 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
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.	
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending camp, athletic exams or travel.* • *Preventive services received from a non-Plan provider*	*All Charges*

Section 5. Traditional Medical Coverage Subject to the Deductible

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.
- In-network preventive care is covered at 100% (see page 101) and is not subject to the calendar year deductible.
- The deductible is $1,650 per person for Self Only enrollment or $1,650 per person for Self Plus One or Self and Family enrollment not to exceed a total family deductible of $3,300 (each applies separately for services received from Plan providers and non-Plan providers). The deductible applies to all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, you are responsible for your coinsurance and copayments for covered expenses.
- You are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments, and deductibles total $5,000 per person up to $10,000 per family enrollment (each applies separately for services received from Plan providers and non-Plan providers) in any calendar year, you do not have to pay any more for covered services. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum or amounts in excess of the Plan allowance).
- Be sure to read Section 4, Y*our costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.

Benefit Description	You Pay After the calendar year deductible...
Deductible before Traditional medical coverage begins	**HDHP**
The deductible applies to almost all benefits in this Section. In the **You pay** column, we say "No deductible" when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of $1,650 per person for Self Only enrollment or $1,650 per person for Self Plus One or Self and Family enrollment, not to exceed a total family deductible of $3,300 (each applies separately for services received from Plan providers and non-Plan providers).
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	**In-network:** After you meet the deductible, you pay the indicated coinsurance or copayments for covered services. You may choose to pay the coinsurance and copayments from your HSA or HRA, or you can pay for them out-of-pocket. **Out-of-network:** After you meet the deductible, you pay the indicated coinsurance based on our Plan allowance and any difference between our allowance and the billed amount.

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 are payable only when we determine they are medically necessary.
- The deductible is $1,650 for Self Only enrollment or $1,650 per person for Self Plus One or Self and Family enrollment not to exceed a total family deductible of $3,300 (each applies separately for services received from Plan providers and non-Plan providers) each calendar year. The deductible applies to most benefits in this Section, unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You Pay After the calendar year deductible...
Diagnostic and treatment services	**HDHP**
Professional services of physicians • In physician's office • In an urgent care center • Office medical consultation • Second surgical opinion • At a hospital - inpatient & outpatient visits • In a skilled nursing facility • At home	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Telehealth Services	**HDHP**
Professional services of physicians and other healthcare professionals delivered through telehealth, such as: • Interactive video • Phone visits • Email Note: Visits may be limited by provider type, location and benefit specific limitations, such as visit limits.	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Benefit Description	You Pay After the calendar year deductible...
Lab, X-ray and other diagnostic tests	**HDHP**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CT/CAT Scans • MRI • Ultrasound • Electrocardiogram and EEG	In-network: 20% of Plan allowance Out-of-network: Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
• Breast imaging	In-network: Nothing Out-of-network: Nothing
• Urine drug screening	In-network: Nothing for the first 2 tests per year, then 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Maternity care	**HDHP**
Complete maternity (obstetrical) care by a physician, certified nurse midwife, or licensed midwife for: • Prenatal and postpartum care • Screening and counseling for prenatal and postpartum depression • Screening for gestational diabetes after 24 weeks	In-network: Nothing (No deductible) Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
• Delivery (including home births)	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Breastfeeding support, supplies and counseling for each birth Note: We cover breastfeeding pumps and supplies under Durable Medical Equipment (DME).	In-network: Nothing (No deductible) Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
• 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.	In-network: Nothing (No deductible) Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Note: Here are some things to keep in mind: • When seen in an emergency room for any reason, the Emergency services/accidents benefit cost-share will apply.	Applies to this benefit

Maternity care - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Maternity care (cont.)	**HDHP**
• Your Plan provider does not have to obtain prior approval from us for your vaginal delivery. See Section 3, *You need prior Plan approval for certain services*, for prior approval guidelines. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to medically necessary circumcision. See Section 5(b), for circumcision benefits. We cover routine circumcision under Preventive care, children. • When a newborn requires definitive treatment during or after the mother's confinement, 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. • Hospital services are covered under Section 5(c) and Surgical benefit under Section 5(b).	Applies to this benefit
Family planning	**HDHP**
A range of voluntary family planning services, limited to: • Surgically implanted contraceptives • Injectable contraceptives (such as Depo Provera) • Intrauterine devices (IUDs) • Contraceptive methods and counseling Notes: • See Section 5(b), Surgical and Anesthesia Services for coverage of voluntary sterilization for males and females and section 5 (f), Prescription Drug Benefits for oral contraceptives and devices such as diaphragms	In-networking: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Family planning - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Family planning (cont.)	**HDHP**
• 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 nonformulary 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, email contraception@opm.gov. For more information about contraception, you can visit the OPM website at Contraception Coverage (opm.gov).	In-networking: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization*	*All Charges*
Infertility services	**HDHP**
Diagnosis and treatment of infertility specific to: • Artificial insemination (AI) - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Semen analysts • Hysterosalpingogram • Hormone evaluation Notes:	In-network: 50% of Plan allowance Out-of-network: 50% of Plan allowance and any difference between our allowance and the billed amount

Infertility services - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Infertility services (cont.)	**HDHP**
• 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. • For coverage of fertility drugs, see Section 5(f), Covered medications and supplies.	In-network: 50% of Plan allowance Out-of-network: 50% of Plan allowance and any difference between our allowance and the billed amount
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	In-network: 50% of Plan allowance Out-of-network: 50% of Plan allowance and any difference between our allowance and the billed
Not covered These exclusions apply to fertile as well as infertile individuals or couples: • *Services related to surrogate arrangements* • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization (IVF)* - *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra- fallopian transfer (ZIFT)* - *Zygote transfer* • *Services and supplies related to excluded ART procedures* • *Any charges associated with donor eggs or donor sperm* • *Any charges associated with cryopreservation, unless listed as covered above for iatrogenic infertility* • *Any charges associated with thawing and storage of frozen sperm, eggs and embryos, unless listed as covered above for iatrogenic infertility*	*All Charges*
Allergy care	**HDHP**
• Testing and treatment • Allergy injections	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference
Allergy serum	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered:	*All Charges*

Allergy care - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Allergy care (cont.)	**HDHP**
• *Provocative food testing and sublingual allergy desensitization*	*All Charges*
Treatment therapies	**HDHP**
• Chemotherapy and radiation therapy – some types of chemotherapy require preauthorization. Your physician should call Member Services toll-free at 888-901-4636 prior to you receiving therapy. Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Section 5(b), *Organ/tissue transplants*. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Cardiac rehabilitation following a qualifying event/condition • Infusion therapy in a medical office or outpatient hospital facility: Professional services of physicians and other healthcare professionals, equipment, supplies and medication. • Ultraviolet light treatments Notes: • Growth hormone therapy (GHT) is covered under the prescription drug benefit and requires preauthorization. • We only cover GHT when we preauthorize the treatment. Your physician must obtain preauthorization before you begin treatment. *See Other services under Section 3, You need prior Plan approval for certain services*. • See Section 5(e), *Professional services*, for coverage of Applied Behavior Analysis (ABA).	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
• Infusion therapy at home: Professional services of physicians and other healthcare professionals, equipment and supplies	In-network: Nothing Out-of-network: *All Charges*
• Infusion therapy at home: Medication Note: You must obtain infusion medications for the home setting at a preferred specialty Plan pharmacy, and a Plan provider we identify must administer the medications.	In-network: 20% of Plan allowance Out-of-network: *All Charges*
• Enteral and parenteral supplements and formula when it is the sole source, or an essential source, of nutrition	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Treatment therapies - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Treatment therapies (cont.)	**HDHP**
• Amino acid modified products for the treatment of inborn errors of metabolism, such as phenylketonuria (PKU) Note: See Section 5(a), *Durable medical equipment (DME)* for coverage of equipment and supplies.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Neurodevelopmental therapies	**HDHP**
Coverage under this benefit for the restoration and improvement of function in a neurodevelopmentally disabled individual includes: • inpatient and outpatient physical, speech and occupational therapy; and • ongoing maintenance care in cases where significant deterioration of the child's condition would occur without the care. All therapy treatments must be performed by a physician, registered physical therapist (PT), ASHA-certified speech therapist or an occupational therapist certified by the American Occupational Therapy Association. Coverage under this benefit does not duplicate coverage for therapy services provided under any other benefit of this Plan.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Physical and occupational therapies	**HDHP**
Up to 60 combined visits for rehabilitative or habilitative care per condition per calendar year for physical, occupational and speech therapy and pulmonary rehabilitation. This limit does not apply to rehabilitative or habilitative care for the treatment of mental health conditions. Services must be provided by qualified physical, occupational, respiratory, speech therapists or other provider. Notes: • Outpatient therapies that are provided in a rehabilitation unit that is part of an acute-care hospital, a stand-alone rehabilitation hospital, or an extended care/skilled nursing facility apply toward the maximum 60 combined visits per condition. See *Speech therapy* and *Home health services*. • For inpatient therapy benefit, see Section 5(c).	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Reflexology* • *Rolfing*	*All Charges*

Benefit Description	You Pay After the calendar year deductible...
Pulmonary rehabilitation	**HDHP**
Up to 60 combined visits for rehabilitative or habilitative care per condition per calendar year for physical, occupational, and speech therapy and pulmonary rehabilitation. This limit does not apply to rehabilitative or habilitative care for the treatment of mental health conditions. Services must be provided by qualified physical, occupational, respiratory, speech therapists or other provider. Notes: • Outpatient therapy services that are provided in a rehabilitation unit that is part of an acute-care hospital, a stand-alone rehabilitation hospital, or an extended care/skilled nursing facility apply toward the maximum 60 combined visits per condition. • For inpatient therapy benefit, see Section 5(c)	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Speech therapy	**HDHP**
Up to 60 combined visits for rehabilitative or habilitative care per condition per calendar year for physical, occupational and speech therapy and pulmonary rehabilitation, except we cover rehabilitative or habilitative therapy with no limits for the treatment of mental health conditions. Services must be provided by qualified physical, occupational, respiratory, speech therapists or other providers. Notes: • Outpatient therapy services that are provided in a rehabilitation unit that is part of an acute-care hospital, a stand-alone rehabilitation hospital, or an extended care/skilled nursing facility apply toward the maximum 60 combined visits per condition. • For inpatient therapy benefit, see Section 5(c)	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Hearing services (testing, treatment, and supplies)	**HDHP**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist, or other provider in a physician's office. • Testing and examination for hearing aids. Note: For routine hearing screenings, see Section 5 (a), *Preventive care, children*, and for any other hearing testing, see Section 5(a), *Diagnostic and treatment services*.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Hearing aids, including auditory osseointegrated implants/bone anchored hearing systems (BAHS). Note:	All charges in excess of $3,000 for one hearing aid per ear every 36 months

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

Benefit Description	You Pay After the calendar year deductible...
Hearing services (testing, treatment, and supplies) (cont.)	**HDHP**
• *For audible prescription reading and speech generating devices, see Section 5(a), Durable medical equipment.*	All charges in excess of $3,000 for one hearing aid per ear every 36 months
Not covered: • *Hearing services that are not shown as covered* • *Replacement parts and batteries, repair of hearing aids, and replacement of lost or broken hearing aids* • *Over-the-counter hearing aids*	*All Charges*
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Cochlear implants – requires preauthorization • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Vision services (testing, treatment, and supplies)	**HDHP**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Diagnostic eye exams provided by an optometrist or ophthalmologist to determine the need for vision correction. For routine screening eye exam benefits see *Preventive care, adult, and Preventive care, children.*	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses, except as related to accidental ocular injury of intraocular surgery* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All Charges*

Benefit Description	You Pay After the calendar year deductible...
Foot care	**HDHP**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
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*
Diabetic education, equipment and supplies	**HDHP**
• Health Education and Training - Nutritional guidance • Medical Equipment - Dialysis equipment - Insulin pumps - Insulin infusion devices - Medically necessary orthopedic shoes and inserts • Supplies other than those covered under P*rescription drug benefits* such as: - Orthopedic and corrective shoes - Arch supports - Foot orthotics - Heel pads and heel cups - Elastic stockings, support hose - Prosthetic replacements	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
• Glucometers	In-network: 20% of Plan allowance (no deductible) Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Orthopedic and prosthetic devices	**HDHP**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Orthopedic and prosthetic devices (cont.)	**HDHP**
• Osseointegrated implants/bone anchored hearing aids (BAHA); preauthorization is required. Please refer to the preauthorization information provided in Section 3. • Cochlear implants - requires preauthorization • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy Notes: • For information on the professional charges for the surgery to insert an implant, see Section 5(b), *Surgical and anesthesia services*. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c), *Services provided by a hospital or other facility, and ambulance services*. • For information on external hearing aids, see Section 5(a), *Hearing services*.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
• Orthopedic and prosthetic devices must be obtained from a Medicare certified provider. Purchases made through the Internet generally do not meet this requirement and are not covered under this Plan. If you have questions about a provider you are considering, please contact us before obtaining the devices.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than3 years after the last one we covered;(except for externally worn breast prostheses and surgical bras)* • *Devices and supplies purchased through the Internet* • *Replacement of devices, equipment and supplies due to loss, theft, breakage or damage*	*All Charges*

Benefit Description	You Pay After the calendar year deductible...
Durable medical equipment (DME)	**HDHP**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Hospital beds • Wheelchairs • Crutches • Walkers • Motorized wheelchairs • Audible prescription reading devices • Speech generating devices For more details please contact Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
• Peak flow meters	In-network: 20% of Plan allowance (no deductible) Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
• One breastfeeding pump and supplies per delivery, including equipment that is required for pump functionality • Ultraviolet light treatment equipment	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Note: DME must be obtained from a Medicare certified provider. Purchases made through the Internet generally do not meet this requirement and are not covered under this Plan. If you have questions about a provider you are considering, please contact us before obtaining the equipment.	Applies to this benefit
Not covered: • *Exercise equipment such as Nordic Track and/or exercise bicycles* • *Equipment which is primarily used for non-medical purposes such as hot tubs and massage pillows* • *Convenience items* • *DME purchased through the Internet* • *Wigs and hair prostheses* • *Replacement of devices, equipment and supplies due to loss, theft, breakage or damage*	*All Charges*

Benefit Description	You Pay After the calendar year deductible...
Home health services	**HDHP**
• 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.), master of social work (M.S.W.), or home health aide. - Up to two hours per visit. • Services include oxygen therapy and assistance with medications. IV therapy is covered separately under the *Treatment therapies* benefit. Oxygen is covered separately under the *Durable medical equipment (DME)* benefit. Note: These services require preauthorization. Please refer to the preauthorization information shown in Section 3. Note: Therapy (physical, occupational, speech) received in your home is paid under the *Physical and occupational therapies* benefit and applies towards your therapy maximum of 60 visits per condition. See *Physical and occupational therapies*.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
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*	*All Charges*
Chiropractic	**HDHP**
• Up to 20 treatments per calendar year for the manipulations of the spine and extremities	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application*	*All Charges*
Alternative treatments	**HDHP**
• Massage therapy - up to 20 treatments per calendar year when treatment prescribed by a qualified provider and received from a licensed massage therapist • Acupuncture – up to 20 treatments per calendar year when treatment is received from a licensed or certified acupuncture practitioner for: - anesthesia - pain relief - substance use disorder - unlimited - dry needling	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Alternative treatments - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Alternative treatments (cont.)	**HDHP**
• Naturopathic services	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* • *Reflexology* • *Rolfing*	*All Charges*
Educational classes and programs	**HDHP**
Coverage is provided for: • Tobacco Cessation when participating in the Quit For Life® program. You will receive up to two (2) quit attempts per year and a minimum of four (4) counseling sessions that include individual, group, and phone counseling, along with physician prescribed over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco cessation. Call 866-784-8454 toll-free or visit the Quit For Life® website at www.quitnow.net for information on how to enroll.	Nothing for two quit attempts per year through the Quit For Life® program. Nothing for physician prescribed over-the-counter and prescription drugs authorized by the Quit For Life® program and approved by the FDA to treat tobacco dependence. (No deductible)
• Outpatient nutritional guidance counseling services by a certified dietitian or certified nutritionist for conditions such as: - Cancer - Endocrine conditions - Swallowing conditions after stroke - Hyperlipidemia - Colitis - Coronary artery disease - Dysphagia - Gastritis - Inactive colon - Anorexia - Bulimia - Short bowel syndrome (post surgery) - Food allergies or intolerances - Obesity	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not Covered: • *Over-the-counter drugs, except for physician prescribed tobacco cessation medications received through the Quit For Life® program and approved by the FDA for treatment of tobacco dependence*	*All Charges*

Benefit Description	You Pay After the calendar year deductible...
Sleep disorders	**HDHP**
Coverage under this benefit is limited to sleep studies, including provider services, appropriate durable medical equipment, and surgical treatments. No other benefits for the purposes of studying, monitoring and/or treating sleep disorders, other than as described below, is provided. **Sleep studies** - Coverage for sleep studies includes: • Polysomnographs • Multiple sleep latency tests • Continuous positive airway pressure (CPAP) studies • Related durable medical equipment and supplies, including CPAP machines The condition giving rise to the sleep disorder (such as narcolepsy or sleep apnea) must be diagnosed by your provider. Preauthorization of sleep studies is not required; however, you must be referred to the sleep studies program by your provider.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Any service not listed above for the purpose of studying, monitoring and/or treating sleep disorders*	*All Charges*

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

Important things you should keep in mind about these benefits:

- 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.
- The deductible is $1,650 for Self Only enrollment, $1,650 per person for Self Plus One or Self and Family enrollment not to exceed a total family deductible of $3,300 (each applies separately for services received from Plan providers and non-Plan providers) each calendar year. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e., hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION 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. Contact Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711 to be sure which services and surgeries require preauthorization.

Benefit Description	You pay After the calendar year deductible...
Surgical procedures	**HDHP**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Insertion of internal prosthetic devices (See 5(a) *Orthopedic and prosthetic devices* for device coverage information) Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. • Circumcision as medically necessary • Treatment of burns	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible...
Surgical procedures (cont.)	**HDHP**
• Surgical treatment (bariatric surgery) and all services associated with the surgical treatment of severe obesity. Note: Visit kp.org/postal to get a list of criteria you must meet to qualify for bariatric surgery. All inpatient and outpatient surgical treatment for morbid obesity must be preauthorized and performed through a bariatric surgery Center of Excellence. See Other services under You need prior Plan approval for certain services.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Note: For female surgical family planning procedures see *Family Planning Section* 5(a) Note: For male surgical family planning procedures see *Family Planning Section 5*(a)	In-network: Nothing Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount (No deductible)
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot (see Foot care)* • *Services for the promotion, prevention or other treatment of hair loss or hair growth* • *Cosmetic surgery, any surgery procedure (or any portion of the procedure) performed primarily to improve physical appearance through change in bodily form* • *Services not listed above as covered*	*All Charges*
Reconstructive surgery	**HDHP**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as:	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible...
Reconstructive surgery (cont.)	**HDHP**
- surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedemas - breast prostheses and surgical bras and replacements (see Section 5(a), Orthopedic and 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	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
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*	*All Charges*
Oral and maxillofacial surgery	**HDHP**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Medical and surgical treatment of temporomandibular joint (TMJ) disorder (non-dental); and • Other surgical procedures that do not involve the teeth or their supporting structures.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
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*

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants	**HDHP**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. See *Other services* under *You need prior Plan approval for certain services*. • 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	In-network: 20% of Plan allowance Out-of-network: All charges
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in 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)	In-network: 20% of Plan allowance Out-of-network: All charges
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. • Allogeneic transplants for	In-network: 20% of Plan allowance Out-of-network: *All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	**HDHP**
- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hematopoietic stem cell transplant (HSCT) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • 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 - Breast cancer	In-network: 20% of Plan allowance Out-of-network: *All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	**HDHP**
- Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Hematopoietic stem cell transplant (HSCT) - Medulloblastoma - Multiple myeloma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	In-network: 20% of Plan allowance Out-of-network: *All charges*
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, 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)	In-network: 20% of Plan allowance Out-of-network: *All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	**HDHP**
- Amyloidosis - Neuroblastoma	In-network: 20% of Plan allowance Out-of-network: *All charges*
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myelodysplasia/Myelodysplastic Syndromes	In-network: 20% of Plan allowance Out-of-network: *All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	**HDHP**
- Multiple sclerosis - Myeloproliferative disorders (MDDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas (Mantel Cell lymphoma, adult T-cell leukemia/ lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) - Breast cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	In-network: 20% of Plan allowance Out-of-network: *All charges*
• National Transplant Program (NTP)	In-network: 20% of Plan allowance Out-of-network: *All charges*
Notes: • We cover related medical and hospital expenses of the donor when we cover the recipient. • We cover donor screening tests and donor search expenses for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	Applies to this benefit

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	**HDHP**
• We cover medically necessary routine dental services in preparation for chemotherapy, radiation therapy, and transplants. Covered services may include a routine oral examination, cleaning (prophylaxis), extractions, and X-rays. You pay cost-sharing listed in Section 5(a) for services performed during an office visit.	Applies to this benefit
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not specifically listed as a covered benefit*	*All Charges*
Sleep disorders	**HDHP**
Surgical treatment – Coverage for the medically necessary surgical treatment of diagnosed sleep disorders is covered under this benefit. Preauthorization of surgical procedures for the treatment of sleep disorders is required. See *Other services* under *You need prior Plan approval for certain services.* Surgical treatment includes all professional and facility fees related to the surgical treatment including pre- and post-operative care and complications.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Anesthesia	**HDHP**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

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 are payable only when we determine they are medically necessary.
- The deductible is $1,650 for Self Only enrollment, $1,650 per person for Self Plus One or Self and Family enrollment not to exceed a total family deductible of $3,300 (each applies separately for services received from Plan providers and non-Plan providers) each calendar year. The Self Plus One and Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, Your costs for covered services for valuable information about how cost-sharing works. Also, read Section 9, Coordinating benefits with Medicare and other coverage.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) and (b).
- YOUR PROVIDER MUST GET PRIOR APPROVAL FOR HOSPITAL STAYS. Please refer to Section 3 to be sure which services require precertification. Contact Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711 to be sure which services require preauthorization.

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital	**HDHP**
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. Note: Included under this benefit are admissions for inpatient physical, occupational, and speech therapies and pulmonary rehabilitation provided in a rehabilitation unit that is part of an acute-care hospital or stand-alone rehabilitation hospital. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood products, if not donated or replaced	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Inpatient hospital - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital (cont.)	**HDHP**
• Donor human milk provided through a milk bank • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items (except medications) • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home • Private nursing care	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as phone, television, barber services, guest meals and beds* • *Take home med*	*All Charges*
Outpatient hospital or ambulatory surgical center	**HDHP**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Notes: • 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. • See Section 5(a), for *Telehealth Services.*	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Take home medications*	*All Charges*

Benefit Description	You Pay After the calendar year deductible...
Extended care benefits/Skilled nursing care facility benefits	**HDHP**
When appropriate, as determined by a doctor and approved by us, we cover full-time skilled nursing care with no dollar or day limit. Intensive physical and occupational therapies in a skilled nursing facility apply toward the maximum 60 combined visits per condition. Extended care benefits require preauthorization by our medical director.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Custodial care*	*All Charges*
Hospice care	**HDHP**
Supportive and palliative care for a terminally ill member is covered when services are provided under the direction of a doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately 6 months or less. Services include: • Medical care • Family counseling Inpatient hospice benefits are available only when services are preauthorized and determined necessary to: • Control pain and manage the patient's symptoms; or • Provide an interval of relief (respite) to the family not to exceed seven (7) consecutive days; each respite care admission must be preauthorized and separated by at least 21 days.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Independent nursing, homemaker services*	*All Charges*
Ambulance	**HDHP**
Local professional ambulance service when medically necessary Note: See Section 3 Y*ou need prior Plan approval for certain services* and Section 5(d), *Emergency Services/Accident*	20% of Plan allowance
Not covered: • *Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan provider*	*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 are payable only when we determine they are medically necessary.
- The deductible is $1,650 for Self Only enrollment, $1,650 per person for Self Plus One or Self and Family enrollment not to exceed a total family deductible of $3,300 (each applies separately for services received from Plan providers and non-Plan providers) each calendar year. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also, read Section 9, Coordinating benefits with Medicare and other coverage

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: Emergencies within our service area: If you are in an emergency situation, please call your doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 phone system) or go to the nearest hospital emergency room.

If you need to be hospitalized, you or a family member must notify us unless it is not reasonably possible to do so. If you are hospitalized in a non-Plan facility, we will work with your doctor to determine when and if it is medically feasible to transfer you to a Plan hospital. You will be transferred when medically feasible with any ambulance charges covered in full.

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

If you need to be hospitalized, you or a family member must notify us unless it is not reasonably possible to do so. If you are hospitalized in a non-Plan facility, we will work with your doctor to determine when and if it is medically feasible to transfer you to a Plan hospital. You will

be transferred when medically feasible with any ambulance charges covered in full.
Follow-up care received from non-Plan providers and/or at a non-Plan facility when the care could be received from a Plan provider and/or at a Plan facility, will be covered at the out-of-network benefit level.

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Benefit Description	You pay After the calendar year deductible...
Emergency within our service area	**HDHP**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient, including doctors' services	20% of Plan allowance
Not covered: • *Elective care or non-emergency care*	*All Charges*
Emergencies outside our service area	**HDHP**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient, including doctors' services	20% of Plan allowance
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area*	*All Charges*
Ambulance	**HDHP**
Licensed ambulance service when medically necessary Note: See 5(c), *Services Provided by a Hospital or Other Facility and Ambulance Services* for non-emergency service.	20% of Plan allowance
Not covered: • Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan provider • Air and sea ambulance when not medically necessary	*All Charges*

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 are payable only when we determine they are medically necessary.
- The calendar year deductible is $1,650 for Self Only enrollment, $1,650 per person for Self Plus One or Self and Family enrollment not to exceed a total family deductible of $3,300 (each applies separately for services received from Plan providers and non-Plan providers). The deductible applies to all benefits in this Section.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.
- **YOU MUST GET PREAUTHORIZATION FOR INPATIENT SERVICES**. Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan:
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
  OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Note: Preauthorization is not required for treatment rendered by a state hospital when the member has been involuntarily committed.

Benefits Description	You pay After the calendar year deductible...
Professional services	**HDHP**
We cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits)	In-network: 20% of Plan allowance Nothing for group sessions Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount Nothing for group sessions

Professional services - continued on next page

Benefits Description	You pay After the calendar year deductible...
Professional services (cont.)	**HDHP**
• Diagnosis and treatment of substance use disorders, including detoxification alcoholism and drug use, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy • Applied Behavioral Analysis (ABA) therapy - for the treatment of autism spectrum disorder or a developmental disability	In-network: 20% of Plan allowance Nothing for group sessions Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount Nothing for group sessions
Diagnostics	**HDHP**
• 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	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Inpatient hospital or other covered facility	**HDHP**
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 • Professional services of physicians	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Outpatient hospital or other covered facility	**HDHP**
Outpatient services provided and billed by a hospital or other covered facility • Services such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount
Physical, Occupational and Speech Therapies	**HDHP**
Services must be provided by qualified physical, occupational, or speech therapists.	In-Network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Benefits Description	You pay After the calendar year deductible...
Not covered	**HDHP**
• *Services that, upon review, are determined to be inappropriate to treat your condition or are Plan exclusions.* • *Long-term rehabilitative therapy* • *Exercise programs*	*All Charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about thin mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart on page 138.
- 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.
- Federal law prevents the pharmacy from accepting unused medications.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- The deductible is $1,650 for Self Only enrollment, $1,650 per person for Self Plus One or Self and Family enrollment not to exceed a total family deductible of $3,300 (each applies separately for services received from Plan providers and non-Plan providers) each calendar year. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible prescriptions.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.

Note: Some drugs require prior authorization and may be limited to a specific quantity or day supply (see Section 3. Other services, regarding prior approval).

- **Where you can obtain them.** You must fill the prescription at a Plan retail pharmacy or through a Plan mail order program, except for emergencies. If you have any questions regarding your pharmacy benefit, please call Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711
- **Mail Order Program.** Covered prescription drugs are available through the mail order program. Prescriptions ordered through this program are subject to the same copayments, guidelines, and limitations set forth above. Mail order issues up to a 90-day supply per fill. To begin using mail order, or to transfer an existing prescription from a retail pharmacy, ask your prescriber to send the prescription directly to the mail order pharmacy.

Kaiser Permanente
Mail Order Pharmacy
P.O. Box 34383
Seattle, WA 98124-1383

Phone: 800-245-7979
Fax: 206-901-4443

- **These are the dispensing limitations**. Prescription drugs will be dispensed for up to a 30-day supply per fill, except for certain drugs, which may be dispensed on a 90-day supply basis with two (2) copayments. For prescribed hormonal contraceptives, you may obtain up to a 12-month supply at a Plan pharmacy or through our mail-delivery program. You may obtain up to 120 condoms per 90-day period. We cover episodic drugs prescribed to treat sexual dysfunction disorder up to a maximum of 8 doses in any 30-day period or 24 in any 90-day period. If a drug is a Tier 4 or Tier 5 drug, you will pay the applicable coinsurance. Refills for any prescription drug cannot be obtained until at least 75% of the drug has been used. Drugs designated as specialty may be covered for up to a 30-day supply per fill. If you have a new prescription for a chronic condition, you may request a coordination of medications so that medications for chronic conditions are refilled on the same schedule (synchronized). Cost-shares for the initial fill of the medication will be adjusted if the fill is less than the standard quantity. Most drugs can be mailed from our mail order pharmacy. Some drugs (for example, drugs that are extremely high cost, require special handling, have standard packaging or requested to be mailed outside of the state of Washington) may not be eligible for mailing and/or a mail order discount. The pharmacy may reduce the day supply dispensed if the pharmacy determines that the item is in limited supply in the market or for specific drugs (your Plan pharmacy can tell you if a drug you take is one of these drugs).
- **A generic equivalent will be dispensed if it is available.** If your provider believes that a name brand product is medically necessary, or if there is no generic equivalent available, your provider may prescribe a name brand drug. If you elect to purchase a name brand drug instead of the generic equivalent you are responsible for paying the difference in cost in addition to the prescription drug cost share.

Plan members called to active military duty (or members in the time of national emergency) who need to obtain prescribed medications should Call Member Services toll-free at 888-901-4636.

We have a managed drug formulary (approved list of preferred drugs and pharmaceutical products). You pay applicable drug cost-sharing based on the tier a drug is in. Our drugs are categorized into five tiers:

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

Because of their lower cost to you, we recommend that you ask your provider to prescribe preferred drugs as the first choice of therapy. We describe any additional coverage requirements and limits in our PSHB Drug formulary. These may include step therapy, prior authorization, quantity limits, drugs that can only be obtained at certain specialty pharmacies, or other requirements and limits described in our formulary. To order a Drug Formulary, call us toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711. You may also access the Drug Formulary on our website at www.kp.org/postal.

Preferred drugs are branded, single source or multi-source agents, or generic drugs that are determined to be preferred by us.

Non-preferred drugs are branded, single source or multi-source agents, or generic drugs that are determined to be non-preferred by us.

Note: The Drug Formulary is continually reviewed and revised. We reserve the right to update this list per formulary guidelines. **For the most up-to-date information about our Drug Formulary, visit our website at www.kp.org/postal**.

- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. They must contain the same active ingredient and must be equivalent in strength and dosage to the original brand name product. Under Federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic drug costs you – and us – less than a name brand drug.

- **When you do have to file a claim.** When you use a Plan pharmacy, you will not be responsible for submitting a claim form to the Plan. In the event of an accidental injury or medical emergency, you may utilize the services of a non-Plan pharmacy. For reimbursement of pharmacy claims, please submit an itemized claim form with the following information:
  - Member's name and ID#
  - Drug name, quantity, prescription number
  - Cost of drug and amount you paid
  - NDC number
  - Drug strength
  - Pharmacy name
  - Pharmacy address
  - Pharmacy NABP number

Submit your request for reimbursement to:

Member Claims
P.O. Box 30766
Salt Lake City, UT 84130-0766

For additional information on your pharmacy benefits, call Member Services at 888-901-4636.

Specialty medications. Certain medications must be ordered only through our specialty drug pharmacy program. Your physician must obtain preauthorization for these medications. For a list of specialty drugs, please go to Drug Lists on our website at www.kp.org/postal or call Member Services toll-free at 888-901-4636 prior to receiving services.

Benefits Description	You pay After the calendar year...
Covered medications and supplies	**HDHP Section 5(f)**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered* • Insulin • Diabetic supplies limited to: - Disposable needles and syringes for the administration of covered medications - Lancets, test strips and control solution • Sexual dysfunction drugs • Preauthorized compounded drugs • Hormone therapy • Drugs to treat gender dysphoria, including hormones and androgen blockers	Tier 1 $20 per prescription/refill $60 per 90-day supply Tier 2 – Preferred $40 per prescription/refill $120 per 90-day supply Tier 3 – Non-Preferred $60 per prescription/refill $180 per 90-day supply Tier 4 – Preferred Specialty 25% up to a maximum out of pocket of $200 per 30-day supply Tier 5 – Non-Preferred Specialty 35% up to a maximum out of pocket of $300 per 30-day supply Notes: • You will not be subject to the deductible for insulin, lancets, test strips, and control solution. • You pay no more than $35 for up to a 30-day supply of insulin and the cost-sharing you pay counts toward the deductible. • You will not be subject to the deductible for corticosteroid or corticosteroid combination inhalers. • You pay no more than $35 for up to a 30-day supply of corticosteroid or corticosteroid combination inhalers and the cost-sharing you pay counts toward the deductible.

Covered medications and supplies - continued on next page

Benefits Description	You pay After the calendar year...
Covered medications and supplies (cont.)	**HDHP Section 5(f)**
	• You pay no more than $35 per prescription for epinephrine autoinjector products that contain at least two autoinjectors and the cost-sharing you pay counts toward the deductible.
• Opioid rescue agents	Nothing (No deductible)
• 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 after the deductible (If it is medically necessary to administer medication during an office visit, the medication is included in the office visit copayment.)
Post-exposure prophylaxis (PEP) drugs • One regimen of human immunodeficiency virus post-exposure prophylaxis	Nothing after the deductible
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in all methods of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. • We cover contraceptive drugs and devices, including implanted contraceptive devices, diaphragms, contraceptive gels, hormonal contraceptive methods, and prescribed FDA approved over-the-counter women's contraceptives and devices. • We cover non-preferred contraceptives 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. For more information on contraceptive coverage and the prescription exception process, please go to kp.org/postal under Member Resources.	Nothing (No deductible)

Covered medications and supplies - continued on next page

Benefits Description	You pay After the calendar year...
Covered medications and supplies (cont.)	**HDHP Section 5(f)**
• 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.	Nothing (No deductible)
• Drugs to aid in tobacco cessation when prescribed and dispensed as part of the Plan's tobacco cessation program • Over-the-counter tobacco cessation drugs when obtained through the Kaiser Permanente Washington mail order pharmacy and Plan retail pharmacy	Nothing
Not covered • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them, except treatment of phenylketonuria (PKU) as described elsewhere in this brochure* • *Over-the-counter (nonprescription) medications, except certain over-the-counter substances approved by the Plan* • *Medical supplies such as dressings and antiseptics* • *Drugs to enhance athletic performance* • *Drugs prescribed to treat any non-covered service, except as stated above* • *Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies* • *Drugs that are not medically necessary according to accepted medical, dental or psychiatric practice as determined by the Plan* • *Lost or stolen medications*	*All Charges*
Preventive medications	**HDHP Section 5(f)**
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 • Liquid iron supplements for children age 0-1 year • Medications to reduce the risk of breast cancer • Statins for adults at risk of cardiovascular disease	Nothing (No deductible)

Preventive medications - continued on next page

Benefits Description	You pay After the calendar year...
Preventive medications (cont.)	**HDHP Section 5(f)**
• 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 (No deductible)
Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained from a Plan pharmacy in prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to www.findtreatment.samhsa.gov/	Nothing (No deductible)
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them, except treatment of phenylketonuria (PKU) as described elsewhere in this brochure* • *Over-the-counter (nonprescription) medications, except certain over-the-counter substances approved by the Plan* • *Medical supplies such as dressings and antiseptics* • *Fertility drugs* • *Drugs to enhance athletic performance* • *Drugs prescribed to treat any non-covered service* • *Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies* • *Compounded drugs for hormone replacement therapy* • *Drugs that are not medically necessary according to accepted medical, dental or psychiatric practice as determined by the Plan* • *Lost or stolen medications* • *Non-self administered medications (e.g., intramuscular, intravenous, intrathecal)*	*All Charges*

Preventive medications - continued on next page

Benefits Description	You pay After the calendar year...
Preventive medications (cont.)	**HDHP Section 5(f)**
Note: Over-the-counter and prescription drugs authorized by the Quit For Life® program and approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation program benefit (see Educational classes and programs).	*All Charges*

Section 5(f)(a). Prescription Drug Benefits with Part D

Important things to 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 888-901-4636 (TTY: 711).

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

There are advantages to being enrolled in our PDP EGWP:

- In our PDP EGWP, your cost-share for covered drugs, medications, and supplies will be equal to or better than the cost-share for those enrolled in our standard non-PDP EGWP Prescription Drug Program.
- In our PDP EGWP, you have a pharmacy network that may include pharmacies that are out-of-network or excluded for those enrolled in our standard non-PDP EGWP Prescription Drug Program. Go to www.kp.org/directory to use the *Pharmacy Directory* or contact Member Services at 888-901-4636 (TTY: 711) 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.

- **Prescription drug (Part D) out-of-pocket (OOP) maximum**. We decreased the Medicare Part D prescription drug calendar year out-of-pocket maximum from $8,000 to $2,000. See your Kaiser Permanente Senior Advantage for Postal Service Members Evidence of Coverage (EOC) for more information.
- 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.
- Federal law prevents the pharmacy from accepting unused medications.
- This plan does not have a deductible.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible prescriptions.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.
- If you choose to opt out of or disenroll from our PDP EGWP, see Section 9 for additional PDP EGWP information and for our opt-out and disenrollment process. Contact us for assistance with the PDP EGWP opt out and disenrollment process at 888-901-4636 (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, download an enrollment application, or RSVP to attend a seminar.
- Call and speak to a Kaiser Permanente Medicare health plan specialist at 877-547-4909 (TTY 711), Monday through Friday, from 6 a.m. to7 p.m. Pacific Time

Note: If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll 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 at 888-901-4636 (TTY: 711) for assistance.

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

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication. Your prescribers must have Medicare-approved prescriptive authority.

  Note: Some drugs require prior authorization and may be limited to a specific quantity or day supply (see Section 3, Other services, regarding prior approval).

- **Where you can obtain them**. You must fill the prescription at a Plan retail pharmacy or through a Plan mail order program, except for emergencies. If you have any questions regarding your pharmacy benefit, please call Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711. or assistance locating a PDP EGWP network pharmacy, visit our website at www.kp.org, or call Member Services at 800-833-6388 or 711.

- **Mail Order Program**. Covered prescription drugs are available through the mail order program. Prescriptions ordered through this program are subject to the same copayments, guidelines, and limitations set forth above. Mail order issues up to a 90-day supply per fill. To begin using mail order, or to transfer an existing prescription from a retail pharmacy, ask your prescriber to send the prescription directly to the mail order pharmacy.

  Kaiser Permanente
  Mail Order Pharmacy
  P.O. Box 34383
  Seattle, WA 98124-1383

  Phone: 800-245-7979
  Fax: 206-901-4443

- **These are the dispensing limitations**. Prescription drugs will be dispensed for up to a 30-day supply per fill, except for certain drugs, which may be dispensed on a 90-day supply basis with two (2) copayments. For prescribed hormonal contraceptives, you may obtain up to a 12-month supply at a Plan pharmacy or through our mail-delivery program. You may obtain up to 120 condoms per 90-day period. We cover episodic drugs prescribed to treat sexual dysfunction disorder up to a maximum of 8 doses in any 30-day period or 24 in any 90-day period. If a drug is a Tier 4 or Tier 5 drug, you will pay the applicable coinsurance. Refills for any prescription drug cannot be obtained until at least 75% of the drug has been used. Drugs designated as specialty may be covered for up to a 30-day supply per fill. If you have a new prescription for a chronic condition, you may request a coordination of medications so that medications for chronic conditions are refilled on the same schedule (synchronized). Cost-shares for the initial fill of the medication will be adjusted if the fill is less than the standard quantity. Most drugs can be mailed from our mail order pharmacy. Some drugs (for example, drugs that are extremely high cost, require special handling, have standard packaging or requested to be mailed outside of the state of Washington) may not be eligible for mailing and/or a mail order discount. The pharmacy may reduce the day supply dispensed if the pharmacy determines that the item is in limited supply in the market or for specific drugs (your Plan pharmacy can tell you if a drug you take is one of these drugs).
- **A generic equivalent will be dispensed if it is available**. If your physician believes that a name brand product is medically necessary, or if there is no generic equivalent available, your physician may prescribe a name brand drug. If you elect to purchase a name brand drug instead of the generic equivalent you are responsible for paying the difference in cost in addition to the prescription drug cost share.

  Plan members called to active military duty (or members in the time of national emergency) who need to obtain prescribed medications should Call Member Services toll-free at 888-901-4636.
- **We have a managed drug formulary** (approved list of preferred drugs and pharmaceutical products). You pay applicable drug cost-sharing based on the tier a drug is in. Our drugs are categorized into five tiers:

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

  Because of their lower cost to you, we recommend that you ask your provider to prescribe preferred drugs as the first choice of therapy. We describe any additional coverage requirements and limits in our PSHB Drug formulary. These may include step therapy, prior authorization, quantity limits, drugs that can only be obtained at certain specialty pharmacies, or other requirements and limits described in our formulary. To order a Drug Formulary, call us toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711. You may also access the Drug Formulary on our website at www.kp.org/postal.

  Preferred drugs are branded, single source or multi-source agents, or generic drugs that are determined to be preferred by us.

  Non-preferred drugs are branded, single source or multi-source agents, or generic drugs that are determined to be non-preferred by us.

  Note: The Drug Formulary is continually reviewed and revised. We reserve the right to update this list per formulary guidelines. For the most up-to-date information about our Drug Formulary, visit our website at www.kp.org/postal.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. They must contain the same active ingredient and must be equivalent in strength and dosage to the original brand name product. Under Federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic drug costs you – and us – less than a name brand drug.
- **When you do have to file a claim?** When you use a Plan pharmacy, you will not be responsible for submitting a claim form to the Plan. In the event of an accidental injury or medical emergency, you may utilize the services of a non-Plan pharmacy. For reimbursement of pharmacy claims, please submit an itemized claim form with the following information:

- Member's name and ID#
- Drug name, quantity, prescription number
- Cost of drug and amount you paid
- NDC number
- Drug strength
- Pharmacy name
- Pharmacy address
- Pharmacy NABP number

Submit your request for reimbursement to:

Member Claims
P.O. Box 30766
Salt Lake City, UT 84130-0766

- **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.
- **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 After the calendar year deductible...
Covered medications and supplies	**HDHP**
We cover the following medications and supplies prescribed by a physician and obtained from a Plan retail pharmacy or through the mail order program: • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as Not covered • Insulin • Diabetic supplies limited to: - Disposable needles and syringes for the administration of covered medications - Lancets, test strips and control solution • Sexual dysfunction drugs • Preauthorized compounded drugs • Hormone therapy • Drugs to treat gender dysphoria, including hormones and androgen blockers	**Tier 1 - Generic Preferred** $20 per prescription/refill $60 per 90-day supply **Tier 2 – Generic Non-Preferred** $20 per prescription/refill $60 per 90-day supply **Tier 3 – Brand Preferred** $40 per prescription/refill $120 per 90-day supply **Tier 4 – Non-Preferred Drugs** $40 per prescription/refill $120 per 90-day supply **Tier 5 – Specialty** $200 per prescription/refill (No deductible) Notes: • You pay no more than $35 for up to a 30-day supply of insulin. • You pay no more than $35 for up to a 30-day supply of corticosteroid or corticosteroid combination inhalers.

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies (cont.)	**HDHP**
	• You pay no more than $35 per prescription of epinephrine autoinjector products that contain at least two autoinjectors.
• Opioid rescue agents	Nothing (No deductible)
• 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 after the deductible (If it is medically necessary to administer medication during an office visit, the medication is included in the office visit copayment.)
Post-exposure prophylaxis (PEP) drugs • One regimen of human immunodeficiency virus post-exposure prophylaxis	Nothing after the deductible
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below: • We cover contraceptive drugs and devices, including implanted contraceptive devices, diaphragms, contraceptive gels, hormonal contraceptive methods, and prescribed FDA approved over-the-counter women's contraceptives and devices. • We cover non-preferred contraceptives 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. For more information on contraceptive coverage and the prescription exception process, please go to kp.org/postal under Member Resources.	Nothing (No deductible)

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies (cont.)	**HDHP**
• 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.	Nothing (No deductible)
Mail Order Drug Program • Prescription medications mailed to your home by the Kaiser Permanente Washington mail order pharmacy (mail order issues up to a 90-day supply per fill.)	**Tier 1 - Generic Preferred** $20 per prescription/refill $40 per 90-day supply **Tier 2 – Generic Non-Preferred** $20 per prescription/refill $40 per 90-day supply **Tier 3 – Brand Preferred** $40 per prescription/refill $180 per 90-day supply **Tier 4 – Non-Preferred Drugs** $40 per prescription/refill $180 per 90-day supply Mail order not available for specialty drugs
• Drugs to aid in tobacco cessation when prescribed and dispensed as part of the Plan's tobacco cessation program • Over-the-counter tobacco cessation drugs when obtained through the Kaiser Permanente Washington mail order pharmacy and Plan retail pharmacy	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them, except treatment of phenylketonuria (PKU) as described elsewhere in this brochure* • *Over-the-counter (nonprescription) medications, except certain over-the-counter substances approved by the Plan* • *Medical supplies such as dressings and antiseptics* • *Drugs to enhance athletic performance* • *Drugs prescribed to treat any non-covered service, except as stated above* • *Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies* • *Drugs that are not medically necessary according to accepted medical, dental or psychiatric practice as determined by the Plan* • *Lost or stolen medications*	*All Charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies (cont.)	**HDHP**
Note: Over-the-counter and prescription drugs authorized by the Quit For Life® program and approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation programs benefit (see Educational classes and programs).	*All Charges*
Preventive care medications	**HDHP**
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 • Liquid iron supplements for children age 0-1 year • Medications to reduce the risk of breast cancer • Statins for adults at risk of cardiovascular disease 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 network 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 (No deductible)
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them, except treatment of phenylketonuria (PKU) as described elsewhere in this brochure* • *Over-the-counter (nonprescription) medications, except certain over-the-counter substances approved by the Plan* • *Medical supplies such as dressings and antiseptics* • *Fertility drugs* • *Drugs to enhance athletic performance* • *Drugs prescribed to treat any non-covered service* • *Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies* • *Compounded drugs for hormone replacement therapy*	*All Charges*

Preventive care medications - continued on next page

Benefit Description	You pay After the calendar year deductible...
Preventive care medications (cont.)	**HDHP**
• *Drugs that are not medically necessary according to accepted medical, dental or psychiatric practice as determined by the Plan* • *Lost or stolen medications* • *Non-self administered medications (e.g., intramuscular, intravenous, intrathecal)* *Note: Over-the-counter and prescription drugs authorized by the Quit For Life® program and approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation program benefit (see Educational classes and programs).*	*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 the first/primary payor of any benefit payments and your FEDVIP plan is secondary to your PSHB Plan. See Section 9, *Coordinating benefits with Medicare and other coverage*.
- The deductible is $1,650 for Self Only enrollment, $1,650 per person for Self Plus One or Self and Family enrollment not to exceed a total family deductible of $3,300 (each applies separately for services received from Plan providers and non-Plan providers) each calendar year. The deductible only applies to the accidental injury benefit in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.

Benefits Description	You pay After the calendar year deductible...
Accidental injury benefit	**Standard Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. Sound natural teeth are those that do not have any restoration. (See Section 10, *Definitions of terms we use in this brochure*.) The need for these services must result from an accidental injury (not biting or chewing). All services must be performed and completed within 12 months of the date of injury. Note: This benefit is not part of the Dental preventive care benefit.	In-network: 20% of Plan allowance Out-of-network: 40% of Plan allowance and any difference between our allowance and the billed amount

Dental Benefits	We pay scheduled allowance. No deductible. (you pay all excess charges)	
Preventative Dental Services	**Codes**	**Standard Option**
Diagnostic X-rays: intraoral - periapical first film	D0220	$20.00
Diagnostic X-rays: intraoral – periapical each additional film	D0230	$19.00
Diagnostic X-rays: intraoral – occlusal film	D0240	$41.00
Bitewing X-rays – single film (twice per calendar year)	D0270	$20.00
Bitewing X-rays – two films (twice per calendar year)	D0272	$31.00
Bitewing X-rays – four films (twice per calendar year)	D0274	$45.00

Preventative Dental Services - continued on next page

Dental Benefits	We pay scheduled allowance. No deductible. (you pay all excess charges)	
Preventative Dental Services (cont.)	**Codes**	**Standard Option**
Full mouth or panorex X-rays: panoramic film (full mouth or panorex series limited to once every 3 calendar years)	D0330	$77.00
Full mouth or panorex X-rays: intraoral complete series including bitewings (full mouth or panorex series limited to once every 3 calendar years)	D0210	$95.00
Periodic oral exam (twice per calendar year)	D0120	$41.00
Limited oral evaluation – problem focused	D0140	$58.00
Comprehensive oral evaluation	D0150	$57.00
Pulp vitality tests	D0460	$38.00
Prophylaxis (cleaning) – through age 13 (twice per calendar year)	D1120	$51.00
Prophylaxis (cleaning) – after age 13 (twice per calendar year)	D1110	$88.00
Fluoride – topical application of fluoride (twice per calendar year through age 17; prophylaxis not included)	D1208	$32.00
Application of sealants for permanent molars and bicuspids only (with a 3 year limitation per surface, sealant per tooth; through age 13)	D1351	$28.00
Space Maintenance - fixed - unilateral (Passive Appliances)	D1510	No benefit

Section 5(h). Wellness and Other Special Features

Flexible benefits option	In certain cases, Kaiser Permanente Washington Options Federal, at its sole discretion, may choose to authorize coverage for benefits or services that are not otherwise included as covered under this Plan. Such authorization is done on a case-by-case basis if a particular benefit or service is judged to be medically necessary, beneficial, and cost effective. However, our decision to authorize services in one instance does not commit us to cover the same or similar services for you in other instances or to cover the same or similar services in any other instance for any other enrollee. Our decision to authorize services does not constitute a waiver of our right to enforce the provisions, limitations, and exclusions of this Plan. 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).
Consulting Nursing Service	For urgent care information and after hours care 24 hours a day, 7 days a week, call toll-free 800-297-6877.
Services for deaf, hard of hearing, or speech impaired	We provide a TTY/text number at: 711. Sign language services are also available.
Travel benefit/services overseas	If you are on Temporary Duty Assignment or reside temporarily outside of Washington state you are covered for all of the benefits described in this brochure. You pay the applicable cost-share per visit for services. For non-urgent and non-emergent services you should receive care from a Plan provider; in Idaho, Oregon, Montana and Alaska, a Plan provider is a First Choice Health Network provider; in all other states, a Plan provider is a First Health Network provider; or in a different Kaiser Foundation Health Plan service area, a designated Kaiser Permanente provider or facility. Designated Kaiser Permanente providers are members of a Permanente Medical Group or are employed at Kaiser Permanente medical facilities. If a Kaiser Permanente provider refers you to a provider who is not affiliated with the Permanente Medical Group, you may pay out-of-network cost-sharing.

	Medications obtained at a participating pharmacy in connection with non-urgent, non-emergent services will also be covered. See also Section 1. *How we pay providers*. If you need assistance while anywhere in the world, call Member Services toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711. **Filing Overseas Claims for Urgent or Emergent Care** Most overseas providers are under no obligation to file claims on behalf of our members. **You may need to pay for the services at the time you receive them and then submit a claim to us for reimbursement**. To file a claim for covered urgent or emergent care received outside the United States, send a completed Overseas Claim Form and itemized bills to: Member Claims P.O. Box 30766 Salt Lake City, UT 84130-0766 We will do the translation and currency conversion for you. You may obtain the Overseas Claim Form by calling Member Services toll-free at 888-901-4636 or from our website at kp.org/postal, Members/Forms and Information.
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.

Services from other Kaiser Permanente regions	When you visit a different Kaiser Foundation Health Plan service area, you can receive visiting member services from designated providers in that area. Visiting member services are subject to the terms, conditions, and cost-sharing described in this PSHB brochure. Certain services are not covered as a visiting member. Visiting member services are described in our visiting member brochure. For more information about receiving visiting member services, including provider and facility locations in other Kaiser Permanente services areas, please call our Washington Visiting Member Services at 800-466-4296 or visit Travel Emergency Health Care and Coverage | Kaiser Permanente.

Section 5(i). Health Education Resources and Account Management Tools

Special features	Description
Health education resources	Through our website at kp.org/postal you will find information on: • General health topics • Links to healthcare news • Cancer and other specific diseases • Drugs/medication interactions • Kids' health • Patient safety information • Helpful website links
Account management tools	For each HSA and HRA account holder, complete payment history and balance information can be found online at www.MyHealthEquity.com. This information is also available by calling the HealthEquity® customer service line toll-free at 866-346-5800. You may view monthly statements, year-end statements and tax statements online at healthequity.com. If you have an HSA, you may also change your investment options online at www.MyHealthEquity.com.
Consumer choice information	As a member of this HDHP, you may choose any provider. However, you will pay less out-of-pocket when using a network provider. Directories are available online at www.kp.org/postal by clicking on Members/Find a Provider. See page 16 for further information. Pricing information for prescription drugs and a link to our online pharmacy are available at www.kp.org/postal by clicking on Pharmacy. Educational materials regarding HSAs and HRAs are available at www.myhealthequity.com.
Care support	Patient safety information is available online at www.kp.org/postal.

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 877-KP4-FEDS (877-574-3337) (TTY: 711).

Eyewear Discount - Member Services: 888-901-4636 www.kp.org/wa/eyecare

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

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

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

Fitness deals - www.kp.org/exercise

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

- **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.
- **'Active .** As a Kaiser Permanente member, you get access to more than 11,600 gyms with one membership when you sign up for an 'Active&Fit' Direct "standard network" membership., You can visit any of the participating fitness centers in the nationwide 'Active&Fit' Direct network. Additional "premium network" gyms may be available for additional costs.
- **ChooseHealthy®** provides you with reduced rates on a variety of fitness, health, and wellness products. This includes activity trackers, online tools to help manage your health, workout apparel, and exercise equipment.

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

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

Calm is an app for meditation and sleep designed to lower stress, reduce anxiety, and more. You can choose from more than 100 programs and activities, including guided meditations, sleep stories, and mindful movement videos.

myStrength allows you to build a personalized plan. You can set mental health goals, learn coping skills, track your progress over time, and make positive changes.

ginger allows you to text one-on-one with an emotional support coach anytime, anywhere, for up to 90 days each year. You can discuss goals, share challenges, and create an action plan with your coach.

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

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

We do not cover the following:

- When a service is not covered, all services, drugs, or supplies related to the non-covered service are excluded from coverage, except when specifically stated as covered in this brochure or for services we would otherwise cover to treat complications of non-covered service.
- Fees associated with non-payment (including interest), missed appointments and special billing arrangements.
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary as determined by the Plan.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except you pay nothing when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the PSHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services or supplies 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, equipment, or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs, equipment, or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible (if applicable).

You will only need to file a claim when you receive emergency services from non-Plan Provider. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical, hospital benefits, and prescription drugs

In most cases, providers and facilities file claims for you. Providers must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing 800-833-6388 or 711, or at our website at www.kp.org/postal.

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
- A copy of the explanation of benefits, payments, or denial from any primary payor such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services.

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

Submit your claims to:

Kaiser Permanente Washington Options Federal
Member Claims
PO Box 30766
Salt Lake City, UT 84130-0766

Prescription drugs

When you must file a claim – such as for prescriptions you receive from an out-of-state non-Plan pharmacy due to an emergency – submit it on a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Member’s name and ID number
- Drug name, quantity, prescription number
- Cost of drug and amount you paid
- NDC number
- Drug strength
- Pharmacy name
- Pharmacy address
- Pharmacy NABP number

Submit your claims to:

Claim Reimbursement
P.O. Box 30766
Salt Lake City, UT 84130-0766

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.

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 or to make an inquiry about situations in which you are entitled to immediate 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, equipment 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, equipment or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Member Services Department by writing to Kaiser Permanente Washington Options Federal, P.O. Box 34593, Seattle, WA 98124-1593 or calling 888-901-4636.

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.

Disagreements between you and the HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

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 Washington Options Federal Appeals Department PO Box 34593 Seattle, WA 98124-1593 or fax your request to: 206-901-7340; 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) e) Include your email address (optional), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

2 In the case of a post-service claim, we have 30 days from the date we receive your request to:

a) Pay the claim; or

b) Write to you and maintain our denial; or

c) Ask you or your provider for more information.

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

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

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

You must write to OPM within:

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

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, PSIO, 1900 E Street 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 preauthorization 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) 901-4636. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's PSIO at (202) 936-0002 between 8 a.m. and 5 p.m. Eastern Time.

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

Reminder: If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D PDP EGWP you may appeal an adverse pre-service or post-service determination 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 73-926). 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 don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

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

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

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

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

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

When we are the secondary payor, we will determine our allowance. After the primary plan processes the benefit, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. When we are the secondary payor, we will coordinate benefits with the primary payor allowing up to our Plan's benefit visit maximum.

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

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

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

We do not cover services that:

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

- **Medicaid**

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

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

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

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

Clinical trials

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

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

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this Plan.

- 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. This Plan covers some of these costs, providing the Plan determines the services are medically necessary. For more specific information, we encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials, this Plan does not cover these costs.

When you have Medicare

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

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

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

For more information on these requirements, please contact us at 888-901-4636.

The Original Medicare Plan (Part A or Part B)

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

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

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

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711, or see our website at www.kp.org/postal.

We waive some cost-sharing if Original Medicare Plan is your primary payor and you use a provider who accepts Medicare assignment.

When you have Medicare Parts A and B, Medicare is primary payor and you receive care from a provider that accepts Medicare, we waive some out-of-pocket costs as follows:

Benefit Description: Deductible
Standard Option without Medicare You pay: $350 Standard Option with Medicare You pay: $0

Benefit Description: Out-of-Pocket Maximum
Standard Option without Medicare You pay: $5,000 per person up to $10,000 per family
Standard Option with Medicare You pay: $5,000 per person up to $10,000 per family

Benefit Description: Primary Care Provider
Standard Option without Medicare You pay: $25 Standard Option with Medicare You pay: $0

Benefit Description: Specialist
Standard Option without Medicare You pay: $35 Standard Option with Medicare You pay: $0

Benefit Description: Inpatient Hospital
Standard Option without Medicare You pay: 20% Standard Option with Medicare You pay: $0

Benefit Description: Outpatient Hospital
Standard Option without Medicare You pay: 20% Standard Option with Medicare You pay: $0

If you have Medicare Part A <u>only</u>, and Original Medicare is your primary payor, we will waive deductible, coinsurance, and copayments for Part A services only (such as inpatient hospital care, home health, hospice, or skilled nursing care).

If you have Medicare Part B <u>only</u>, and Original Medicare is your primary payor, we will waive deductible, coinsurance, and copayments for Part B services only (such as outpatient medical or surgical care).

We will <u>not</u> waive the following:

- Cost-sharing for members who do not have Medicare Parts A or B, or, for whom Medicare is secondary payor
- Prescription drug cost-sharing
- Cost-sharing for HDHP members

- **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 family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **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 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at <u>www.medicare.gov</u>.

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

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our 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 or former spouse, 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.

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

If you are enrolled in Medicare Part A and/or Part B, you will be automatically group enrolled into our Medicare PDP EGWP. Our PDP EGWP is a prescription drug benefit for Postal Service annuitants and their covered Medicare-eligible family members. This allows you to receive benefits that will never be less than the standard prescription drug coverage that is available to members with non-PDP EGWP prescription drug coverage. But more often you will receive benefits that are better than members with standard non-PDP EGWP prescription drug coverage. **Note: You have the choice to opt out of or disenroll from our PDP EGWP at any time and may obtain prescription drug coverage outside of the PSHB Program.**

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

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

For people with limited income and resources, extra help is a Medicare program to help with Medicare prescription drug plan costs. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213, TTY 800-325-0778. You may also contact us at 888-901-4636 (TTY: 711).

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

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

Contact us at 888-901-4636 (TTY: 711) for additional information.

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

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

  Kaiser Permanente
  California Service Center
  P.O. Box 232400
  San Diego, CA 92193-2400

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

For additional information, see Chapter 8. *Ending your membership in the plan* in the Evidence of Coverage for Kaiser Permanente Medicare Part D Group Plan (PDP) for Postal Service Members or contact us at 888-901-4636 (TTY: 711).

Warning: If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage.

Note: If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll when and if you are eligible. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for assistance at 888-901-4636 (TTY: 711).

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

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

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

Section 10. Definitions of Terms We Use in This Brochure

Assignment

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

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

Calendar year

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

Clinical trials cost categories

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

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

Coinsurance

See Section 4, page 26

Copayment

See Section 4, page 26

Cost-sharing

See Section 4, page 26

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 26

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

Healthcare professional

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

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.

Hospice care

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

Medical necessity

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

- Rendered for the treatment or diagnosis of an injury or illness; and
- Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and

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

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

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

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

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

Medicare Part D — Medicare Part D plans provide coverage for prescription drugs. Private insurers contract with CMS on an annual basis for the right to offer Part D plans. Part D can be offered as a standalone Prescription Drug plan (PDP) or as part of a Medicare Advantage Prescription Drug plan (MAPD).

Medicare Part D EGWP — A Medicare Part D Employer Group Waiver Plan (EGWP) is a type of Medicare prescription drug plan that can be offered to employees and retirees of certain companies, unions, or government agencies, which allows for flexibility and enhanced coverage of traditional Medicare pharmacy benefits. Examples of Medicare Part D EGWPs are Medicare Advantage Prescription Drug (MAPD) plan EGWPs that include both health and drug benefits, as well as Prescription Drug Plan (PDP) EGWPs, which only cover the prescription drug benefit.

Never event/serious reportable event — Certain Hospital Acquired Conditions, as defined by Medicare, including things like wrong-site surgeries, transfusion with the wrong blood type, pressure ulcers (bedsores), falls or trauma, and nosocomial infections (hospital-acquired infections) associated with surgeries or catheters, that are directly related to the provision of an inpatient covered service at a Plan provider.

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

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

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

- For all other services and items, the payments that Kaiser Permanente makes for the services and items, or if Kaiser Permanente subtracts cost-sharing from its payment, the amount the Kaiser Permanente would have paid if it did not subtract cost-sharing.

You should also see *Important notice about surprise billing – know your rights* in Section 4 that describes your protections against surprise billing under the No Surprises Act.

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

Pre-service claims Those claims (1) that require precertification or prior approval and (2) where failure to obtain precertification or prior approval 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.

Sound natural tooth A sound natural tooth is a tooth that is whole or properly restored (restoration with amalgams/resin-based composites only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. A tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics is not considered a sound natural tooth.

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

Surprise bill An unexpected bill you receive for:

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

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

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

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

If you believe your claim qualifies as an urgent care claim, please contact our Member Services Department toll-free at 888-901-4636; for the deaf and hearing-impaired use Washington state's relay line by dialing either 800-833-6388 or 711. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We	Us and We refer to Kaiser Foundation Health Plan of Washington Options, Inc., Kaiser Permanente Washington Options Federal, Options Federal or Kaiser Permanente.
You	You refers to the enrollee and each covered family member.

High Deductible Health Plan (HDHP) Definitions

Calendar year deductible	The fixed amount of covered expenses you must incur during the calendar year for certain covered services and supplies before we start paying benefits for those services. See page 26 for more information.
Catastrophic limit	The maximum amount you will have to pay in a calendar year towards copayments, coinsurance, and deductible for certain covered services. See page 26 for more information.
Health Reimbursement Arrangement (HRA)	An HRA allows you to pay for certain medical expenses using funds contributed by the Plan. Money left at the end of the year may be rolled over to the following year as long as you remain with the Plan. See page 99 for more information.
Health Savings Account (HSA)	An HSA allows you to pay for certain medical expenses using funds contributed by the Plan and/or yourself as long as you are covered only by a High Deductible Health Plan (HDHP). Money left at the end of the year may be rolled over to the following year and remains yours even if you leave the Plan. See page 98 for more information.
Premium contribution to HSA/HRA	The amount of money from your premium payment that the Plan contributes to your HSA or HRA account. See page 95 for more information.

Index

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

Notes

Notes

Summary of Benefits for the Standard Option of Kaiser Permanente Washington Options Federal - 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.
- Below, an asterisk (*) means the item is subject to the $350 per person ($700 per family) calendar year deductible.

Standard Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	$25 for primary care office visit $35 for specialty care office visit	33
Services provided by a hospital: • Inpatient & outpatient	20% of Plan allowance*	61
Emergency benefits: • Accidental injury	Emergency Room: $150*	64
Emergency benefits: • Medical emergency	Regular benefits	64
Mental health and substance use disorder treatment:	Regular cost-sharing*	64
Prescription drugs	Tier 1: $20; Tier 2: $40; Tier 3: $60; Tier 4: 25% up to a maximum out of pocket of $200 per 30-day supply; Tier 5: 35% up to a maximum out of pocket of $300 per 30-day supply. 2 times the applicable prescription drug copayment for a supply of 90 days or less of each prescription or refill. Mail order not available for specialty drugs.	71
Prescription drugs - PDP (EGWP)	$15 preferred and non-preferred generic; $40 preferred and non-preferred brand; $200 specialty per prescription for up to a 30-day supply at a Plan pharmacy. 2 times the applicable prescription drug copayment for a supply of 90 days or less of each prescription or refill. Mail order not available for specialty drugs.	78
Dental care: Preventive dental care	All charges in excess of the fee schedule allowance.	82
Vision care: Annual eye exam	Nothing	46
Special features:	See Section 5(h) for more information	84
Point of Service benefits:	See Section 5(i)	87
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after $5,000/person or $10,000/ family per year. Some costs do not count toward this protection	27

Summary of Benefits for the HDHP of Kaiser Permanente Washington Options Federal - 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.

In 2025, for each month you are eligible for a Health Savings Account (HSA), we will deposit $62.50 per month for Self Only enrollment or $125 per month for Self Plus One or Self and Family enrollment into your HSA. For the High Deductible Health Plan (HDHP), you may use your HSA or pay out of pocket to satisfy your calendar year deductible of $1,650 for Self Only enrollment and $1,650 per person for Self Plus One or Self and Family enrollment not to exceed a total family deductible of $3,300 (each applies separately for services received from Plan providers and non-Plan providers). Once you satisfy your calendar year deductible, Traditional medical coverage begins.

If you are not eligible for an HSA, we will establish a Health Reimbursement Arrangement (HRA) account for you with an annual credit of $750 for Self Only enrollment and $1,600 for Self Plus One or Self and Family enrollment.

Below, an asterisk (*) means the item is subject to the $1,650 per person Self Only ($1,650 per person Self Plus One or Self and Family, not to exceed a total family deductible of $3,300) calendar year deductible.

HDHP Benefits	You pay	Page
In-network medical and dental preventive care	Nothing	101
Medical services provided by physicians: Diagnostic and treatment services provided in the office	In-network: 20% of Plan allowance* Out-of-network: 40% of Plan allowance*	105
Services provided by a hospital: Inpatient & outpatient	In-network: 20% of Plan allowance* Out-of-network: 40% of Plan allowance*	129
Emergency benefits:	20% of Plan allowance*	132
Mental health and substance use disorder treatment:	In-network: 20% of Plan allowance* Out-of-network: 40% of Plan allowance*	134
Prescription drugs	Tier 1: $20*; Tier 2: $40*; Tier 3: $60*; Tier 4: 25% up to a maximum out of pocket of $200 per 30-day supply*; Tier 5: 35% up to a maximum out of pocket of $300 per 30-day supply*. 2 times the applicable prescription drug copayment for a supply of 90 days or less of each prescription or refill. Mail order not available for specialty drugs.	147
Prescription drugs	$10 preferred and non-preferred generic; $40 preferred and non-preferred brand; $200 specialty per prescription for up to a 30-day supply. 2 times the applicable prescription drug copayment for a supply of 90 days or less of each prescription or refill. Mail order not available for specialty drugs.	147
Dental care: Accidental injury only:	In-network: 20% of Plan allowance* Out-of-network: 40% of Plan allowance*	82
Vision care: Annual eye exam	Nothing (included in Preventive Care)	113
Special features:	See Section 5(h) for more information.	154

HDHP Benefits	You pay	Page
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,000/person or $10,000/ family per year (each applies separately for services received from Plan providers and non-Plan providers). Some costs do not count toward this protection.	27
Preventive dental care:	All charges in excess of the dental fee schedule allowance	152

2025 Rate Information for Kaiser Permanente Washington Options Federal - 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
Standard Option Self Only	H9A	$244.58	$81.53	$529.93	$176.64
Standard Option Self Plus One	H9C	$542.97	$180.99	$1,176.44	$392.14
Standard Option Self and Family	H9B	$542.97	$180.99	$1,176.44	$392.14
HDHP Option Self Only	H9D	$215.88	$71.96	$467.74	$155.91
HDHP Option Self Plus One	H9F	$479.24	$159.74	$1,038.35	$346.11
HDHP Option Self and Family	H9E	$479.24	$159.74	$1,038.35	$346.11