Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

http://kp.org/feds

1-877-KP4-FEDS (1-877-574-3337) (TTY: 711)

2016

A Health Maintenance Organization (High and Standard Options)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details.

Serving: *Washington, DC, Northern Virginia, and Metropolitan Baltimore, Maryland Area*

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 11 for requirements.

IMPORTANT
- Rates: Back Cover
- Changes for 2016: Page 14
- Summary of benefits: Page 100

This Plan has excellent accreditation from the NCQA.

Enrollment codes for this Plan:

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

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

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

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

RI 73-047

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

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

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare, but you still need to follow the rules in this brochure for us to cover your prescriptions. We will only cover your prescription if it is written by a Plan provider and obtained at a Plan pharmacy, affiliated network pharmacy, or through our Plan mail service delivery program, except in an emergency or urgent care situation.

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's 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 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY: 1-800-325-0778).

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

- Visit www.medicare.gov for personalized help,
- Call **1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048).**

Table of Contents

Introduction

This brochure describes the benefits of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., under our contract (CS 1763) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. If you want more information about us, you can call Member Services Department at 1-877-KP4-FEDS (1-877-574-3337) (TTY: 711) or through our website: http://kp.org/feds. The address for Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.'s administrative offices is:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street
Rockville, Maryland 20852

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 and Family coverage, each eligible family member is also entitled to these benefits. If you enroll in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2016, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2016, and changes are summarized on page 14. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Indivdual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

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

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

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, or authorized health benefits plan or OPM representatives.
- 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 (EOB) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that 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 1-877-KP4-FEDS (1-877-574-3337) (TTY: 711) and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE
877-499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form
The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

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

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)
- 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.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. 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. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. 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 ask questions and understand answers.

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other drug allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

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

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

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

- www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- 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 health care professionals working to improve patient safety.

Never Events

When you enter a Plan hospital for a covered service, you don't 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, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

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 reduce medical errors that should never happen. These conditions and errors are called "Never Events" (See Section 10, Definitions of terms we use in this brochure). When a Never Event occurs you may not incur cost-sharing. If you are charged a cost share for a never event that occurs at a Plan provider while you are receiving an inpatient covered service, or for treatment to correct a never event that occurred at a Plan provider, please notify the Plan.

You may no longer be billed a cost share at Plan providers for inpatient covered services related to never events and treatment needed to correct never events, if you use Kaiser Permanente providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Indivdual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

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

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

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

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

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

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

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

- **Types of coverage available for you and your family**

  Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, 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. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

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

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and one eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	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	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	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	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

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

- **Children's Equity Act**

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- 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 Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't 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.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2016 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2015 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You can also download visit OPM's website at, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides.

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

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance/healthcare/plan-information/guides. 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 new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **Converting to individual coverage**

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

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

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must apply in writing to us 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 apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the Affordable Care Act'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). We require you to use specific physicians, hospitals, and other providers. Through the Mid-Atlantic Permanente Medical Group, PC (Medical Group), we will coordinate your health care services, including among other things, when care is medically necessary and what treatment is appropriate. You have the ability to choose your Primary Care Physician (PCP) within the Medical Group. You will receive most of your care through these providers and at our facilities unless we have issued you a referral to another Plan provider. The Plan is solely responsible for the selection of providers in your area. Contact the Plan for a copy of the most recent provider directory. We give you a choice of enrollment in a High Option or a Standard Option.

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

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

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

Questions regarding what protections apply may be directed to us at 1-877-KP4-FEDS (1-877-574-3337). You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

General features of our High and Standard Options

How we pay providers

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

Your rights

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

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

If you want more information, please call us at 1-877-KP4-FEDS (1-877-574-3337) (TTY: 711), or write to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Member Services Department, 2101 East Jefferson Street, Rockville, Maryland, 20852. You may also contact us by fax at 301-816-6192 or visit our website at http://kp.org/feds.

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.

Language interpretation services

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

Service Area

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

- **The District of Columbia**
- **The following Virginia cities and counties:**
  - Alexandria City
  - Arlington
  - Fairfax City
  - Fairfax
  - Falls Church City
  - Fredericksburg City
  - King George
  - Loudoun
  - Manassas City
  - Manassas Park City
  - Prince William
  - Spotsylvania
  - Stafford
- Portions of the following Virginia counties, as indicated by the ZIP codes below, are also within the service area:
  - Caroline - 22446, 22535, 22538, 22546 and 22580
  - Culpepper - 22736
  - Fauquier - 20119, 22720, and 22728
  - Hanover - 23015
  - Louisa - 23024, 23117, and 23170
  - Orange - 22508, 22567, and 22960
  - Westmoreland - 22443
- **The following Maryland counties:**
  - Anne Arundel
  - Baltimore
  - Carroll
  - Harford
  - Howard
  - Montgomery
  - Prince Georges
- Portions of the following Maryland counties, as indicated by the ZIP codes below, are also within the service area:
  - Calvert – 20610, 20639, 20678, 20689, 20714, 20732, 20736, and 20754
  - Charles – 20601, 20602, 20603, 20604, 20612, 20616, 20617, 20637, 20640, 20643, 20645, 20646, 20658, 20675, 20677, and 20695
  - Frederick – 21701, 21702, 21703, 21704, 21705, 21709, 21710, 21714, 21716, 21717, 21718, 21754, 21755, 21758, 21759, 21762, 21769, 21770, 21771, 21774, 21775, 21777, 21790, 21792, and 21793
  - **Baltimore City, MD**

Ordinarily, you must receive your care from Medical Group and select hospitals. In a limited number of circumstances other physicians and providers may be providing care for you under the direction of the Medical Group. However, we are part of the Kaiser Permanente Medical Care Program, and if you are visiting another Kaiser Permanente or allied plan service area, you can receive visiting member care from designated providers in that area. See Section 5(h), *Special features*, for more details. We also pay for certain follow-up services or continuing care services while you are traveling outside the service area, as described in Section 5(h); and for emergency care obtained from any non-Plan provider, as described in Section 5(d), *Emergency services/accidents*. We will not pay for any other health care services.

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

Section 2. Changes for 2016

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

Program-wide changes

- Self Plus One enrollment type has been added effective January 1, 2016.

Changes to High Option only

- Your share of the non-Postal premium will decrease for Self Only or Self and Family. See page xxx.
- We have added a specialty drug tier with 20% coinsurance up to $100 per prescription or refill obtained at a Plan medical office pharmacy, and 30% coinsurance up to $150 per prescription or refill obtained at an affiliated network pharmacy. See page 64.

Changes to Standard Option only

- Your share of the non-Postal premium will increase for Self Only or Self and Family. See page xxx.
- We have added a specialty drug tier with 30% coinsurance up to $150 per prescription or refill obtained at a Plan medical office pharmacy, and 40% coinsurance up to $200 per prescription or refill obtained at an affiliated network pharmacy. See page 64.
- We have decreased your copayment for interventional radiology from $150 to $100 per procedure. See page 27.

Changes to both High and Standard Options

- We have increased the cost share for up to a 90-day supply filled at a Plan pharmacy or an affiliated network pharmacy from two copayments to three. The mail service delivery program will continue to apply two copayments for up to a 90-day supply. See page 63.
- We will cover intracytoplasmic sperm injection (ICSI), as part of covered infertility services when medically appropriate, and preimplantation genetic diagnosis (PGD). See page 32.
- We will cover in vitro fertilization for same sex married couples. See page 32.
- We have removed the 90-day limit on visiting member care when temporarily visiting a Kaiser Foundation Health Plan or allied plan service area. See page 71.
- We have reduced the cost share to no charge for services as required by the Affordable Care Act, including screening for Hepatitis B virus for persons at high risk, the application of fluoride varnish for children under the age of 5, and low-dose aspirin for women at risk for preeclampsia. See page 28.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call our Member Services Department at 1-877-KP4-FEDS (1-877-574-3337) (TTY: 711) or write to us at: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Attention: Member Services Department, 2101 East Jefferson Street, Rockville, Maryland, 20852. After registering on our website at http://kp.org/feds, you may also request replacement cards electronically.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay cost-sharing as defined in Section 10, *Definitions of terms we use in this brochure*.

- **Plan providers**

Plan providers are physicians and other health care professionals in the Mid-Atlantic Permanente Medical Group, P.C. (Medical Group) that we contract with to provide or arrange for covered services to our members. Medical care is provided through physicians, nurse practitioners, physician assistants, and other skilled medical personnel. Consultation and treatment in most major specialties will be provided through the Medical Group. Other necessary medical services, such as physical therapy, laboratory and radiology will also be provided primary at Kaiser Permanente medical facilities.

We list certain 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 Services Department at 1-877-KP4-FEDS (1-877-574-3337) (TTY: 711). The list is also on our website at http://kp.org/feds.

- **Plan facilities**

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

We list Plan facilities in our physician directory, with their locations and phone numbers. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling our Member Services Department at 1-877-KP4-FEDS (1-877-574-3337) (TTY: 711). The list is also on our website at http://kp.org/feds.

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

What you must do to get covered care

You and each covered family member should choose a primary care physician from a list of the Medical Group physicians that practice at Kaiser Permanente medical facilities. If you do not choose a primary care physician, one will be chosen for you. This decision is important since your primary care physician provides or arranges for most of your health care.

- **Primary care**

  To choose or change your primary care physician from the Medical Group, you can either select one from our Provider Directory, from our website, http://kp.org/feds, or you can call our Federal Member Services Department at 1-877-KP4-FEDS (1-877-574-3337) (TTY: 711). Your primary care physician must be a member of the Medical Group, unless we designate otherwise.

  You may choose any primary care Plan physician who is available to accept you. Parents may choose a pediatrician as the Plan physician for their child. Your primary care physician will provide most of your health care. In the event you require services of a specialist, please refer to the section below.

  You may change your primary care physician to another Medical Group primary care physician at any time. You are free to see other Medical Group primary care physicians if your primary care physician is not available, and to receive care at Kaiser Permanente medical facilities other than the one where your primary care physician practices.

- **Specialty care**

  Specialty care is care you receive from providers other than a primary care physician. When your primary care physician believes you may need specialty care, he or she will request authorization from us. If specialty care is necessary, we will authorize a referral to a particular specialist for an initial consultation and/or for a certain number of visits. If we authorize a referral, you may seek that care from the specialist to whom you were referred. Unless we have authorized additional visits without the need to obtain another referral you must return to your primary care physician after the consultation. Do not go to a specialist for return visits unless we have given you an authorized referral for visits beyond the initial consultation. You may see the following Medical Group providers without first obtaining authorization: obstetrical and gynecologists, optometrists, or mental health and substance abuse. You may obtain mental health and substance abuse services from Medical Group mental health or substance abuse providers without a primary care referral by directly calling our Behavioral Health Access Unit at 1-866-530-8778 to arrange for services.

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

  - If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician in consultation with us and your attending specialist may develop a treatment plan that allows you to see the specialist for visits without additional referrals. Your primary care physician must contact us and use our criteria when creating your treatment plan (the physician will have to get authorization beforehand).
  - If you are seeing a specialist when you enroll in our Plan, in almost all cases you will be required to switch to a Medical Group specialist. Generally, we will not pay for you to see a specialist who is not a member of the Medical Group unless you have an authorized referral.
  - If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will request permission from us for you to see another specialist. Under certain circumstances for certain conditions, you may receive authorized services from your current specialist until we can make arrangements for you to see a Medical Group specialist.
  - If you have a chronic and disabling condition and lose access to your specialist because we:
    - terminate our contract with your specialist for a reason other than cause;
    - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan; or
    - reduce our service area and you enroll in another FEHB 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 day period.

- **Hospital care**

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

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

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Member Services Department immediately at 1-877-KP4-FEDS (1-877-574-3337) (TTY: 711). If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

You need prior Plan approval for certain services

For certain services your physician must obtain prior approval from us. Before giving approval, we may consider if the service or item is medically necessary and meets other coverage requirements. We call this review and approval process "authorization" although we often use the term "referral" for this process as well.

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

- Routine primary care services
- Routine obstetrical and gynecological services (excluding infertility diagnosis and treatment; treatment and management of gynecological malignancies; urogynecology; prenatal diagnostic tests performed outside of the doctor's office; and other specialized gynecological services)
- Care received in an emergency room, designated Kaiser Permanente urgent care centers, or designated Kaiser Permanente minor injury clinics
- Emergency ambulance transport
- Formulary drugs (excluding Growth Hormone Therapy, amino-acid based elemental formula and Botox)
- Self-referrals to designated Medical Group Behavioral Health (mental health and substance abuse care) providers

To confirm if your service or item requires authorization, please call our Member Services Department at 1-877-KP4-FEDS (1-877-574-3337) (TTY: 711).

We must provide or arrange for your mental health and substance abuse care. Call our Behavioral Health Access Unit at 1-866-530-8778 to make arrangements.

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

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

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

- **Non-urgent care claims**

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

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

- **Urgent care claims**

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

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

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-877-KP4-FEDS (1-877-574-3337) (TTY: 711). You may also call OPM's Health Insurance 3 at (202) 606-0755 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 1-877-KP4-FEDS (1-877-574-3337) (TTY: 711). If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

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

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

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

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

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

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

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

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

What happens when you do not follow the precertification rules

If you or your Plan physician do not obtain prior authorization from us for services or items that require prior authorization, we will not pay any amount for those services or items and you may be liable for the full price of those services or items. This also includes any residual amounts, such as deductibles, copayments or coinsurance, that are not covered or not paid by any other insurance plan you use to pay for those services or items.

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our prior approval decision, you may request a review in accord with the procedures detailed below.

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

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

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

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

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

2. Ask you or your provider for more information.

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

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

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Section 4. Your cost for covered services

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

Cost-sharing

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

Copayments

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

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

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

- Under the High Option, you pay $10 copayment when you receive diagnostic and treatment services from a primary care provider and a $20 copayment when you receive these services from a specialty care provider.
- Under the Standard Option, you pay a $20 copayment when you receive diagnostic and treatment services from a primary care provider and a $30 copayment when you receive these services from a specialty care provider.

Deductible

There is no deductible.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Example: In our Plan, you pay 50% of our allowance for infertility services, ovulation stimulants, weight management drugs, and oxygen and equipment for home use.

Your catastrophic protection out-of-pocket maximum

After your cost-sharing total $2,250 per person up to $4,500 per family enrollment (High Option) or $3,500 per person up to $7,000 per family enrollment (Standard Option) in any calendar year, you do not have to pay any more for certain covered services. This includes any services required by group health plans to count toward the catastrophic protection out-of-pocket maximum by federal health care reform legislation (the Affordable Care Act and implementing regulations).

Example: Your plan has a $2,250 per person up to $4,500 per family maximum out-of-pocket limit. If you or one of your covered family members has out-of-pocket qualified medical expenses of $2,250 in a calendar year, any cost-sharing for qualified medical expenses for that individual will be covered fully by your health plan for the remainder of the calendar year. With a family enrollment, the out-of-pocket maximum will be satisfied once two or more family members have out-of-pocket qualified medical expenses of $4,500 in a calendar year, and any cost–sharing for qualified medical expenses for all enrolled family members will be covered fully by your health plan for the reminder of the calendar year.

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

- Acupuncture services
- Dental services, except accidental injury dental benefit services
- Orthopedic devices
- Travel benefit

Be sure to keep accurate records and receipts of your copayments and coinsurance since you are responsible for informing us when you reach the maximum.

Carryover

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

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

When Government facilities bill us

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

Section 5. High and Standard Option Benefits

See page 14 for how our benefits changed this year. Pages 100 and 101 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. High and Standard Option Benefits Overview

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

The High and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High and Standard Option benefits, contact us at 1-877-KP4-FEDS (1-877-574-3337) (TTY: 711). You can also visit our website at http://kp.org/feds.

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

For 2015-2016, Kaiser Permanente's Commercial HMO and Medicare HMO received "Excellent Accreditation" - the highest level of accreditation possible - from the National Committee for Quality Assurance (NCQA), a private, non-profit organization dedicated to improving health care quality.

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

High Option

Our High Option provides comprehensive benefits. It includes:

- No copayment for all primary care visits for children from infancy through age 4
- No copayment for most preventive care for adults and children
- $10 per visit to your primary care physician (PCP) for diagnostic services
- $20 per visit to a specialist for diagnostic services
- $100 per admission for inpatient admissions
- $7 per prescription or refill for covered generic drugs obtained at a Plan medical center pharmacy; $17 per prescription or refill for covered generic drugs obtained at an affiliated network pharmacy up to a 30-day supply
- $30 per prescription or refill for preferred brand name drugs obtained at a Plan medical center pharmacy; $50 per prescription or refill for preferred brand name drugs obtained at an affiliated network pharmacy up to a 30-day supply
- $45 per prescription or refill for non-preferred brand-name drugs obtained at a Plan medical center pharmacy; $65 per prescription or refill for non-preferred brand-name drugs obtained at an affiliated network pharmacy up to a 30-day supply
- 20% up to $100 per prescription or refill for specialty drugs obtained at a Plan medical center pharmacy; 30% up to $150 per prescription or refill for specialty drugs obtained at an affiliated network pharmacy up to a 30-day supply
- $30 per office visit for preventive dental care

Standard Option

We also offer a Standard Option. With the Standard Option your co-payments may be higher than the High Option, but the bi-weekly premium is lower. Specific benefits of our FEHB Standard Option include:

- No copayment for all primary care visits for children from infancy through age 4
- No copayment for most preventive care for adults and children
- $20 per visit to your primary care physician (PCP) for diagnostic services
- $30 per visit to a specialist for diagnostic services
- $250 per day for inpatient admissions ($750 maximum per admission)
- $12 per prescription or refill for covered generic drugs obtained at a Plan medical center pharmacy; $22 per prescription or refill for covered generic drugs obtained at an affiliated network pharmacy up to a 30-day supply
- $35 per prescription or refill for preferred brand name drugs obtained at a Plan medical center pharmacy; $55 per prescription or refill for preferred brand name drugs obtained at an affiliated network pharmacy up to a 30-day supply
- $50 per prescription or refill for non-preferred brand-name drugs obtained at a Plan medical center pharmacy; $70 per prescription or refill for non-preferred brand-name drugs obtained at an affiliated network pharmacy up to a 30-day supply
- 30% up to $150 per prescription or refill for specialty drugs obtained at a Plan medical center pharmacy; 40% up to $200 per prescription or refill for specialty drugs obtained at an affiliated network pharmacy up to a 30-day supply
- $30 per office visit for preventive dental care

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- Unless you receive prior approval from us, Medical Group must provide or arrange your care.
- We have no calendar year deductible for Medical services and supplies.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also read Section 9, Coordinating benefits with other coverage, including with Medicare. Different copayments apply for primary care visits and specialty care visits.
- **YOUR PHYSICIAN MUST GET PRIOR APPROVAL FOR MOST MEDICAL SERVICES AND SUPPLIES PROVIDED BY PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS**. Please refer to the prior approval information shown in Section 3 to be sure which services and supplies require prior approval.
- **WHEN YOUR PHYSICIAN REQUESTS PRIOR APPROVAL, THE PLAN WILL DETERMINE WHETHER THE SERVICE IS MEDICALLY NECESSARY AND WHETHER IT SHOULD BE PROVIDED BY A PARTICULAR PROVIDER OR FACILITY.**

Benefit Description	You pay	
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians and other health care professionals • In physician's office • Office medical consultations • Second surgical opinion	$10 per primary care office visit (nothing from infancy through age 4) $20 per specialty care office visit	$20 per primary care office visit (nothing from infancy through age 4) $30 per specialty care office visit
Professional services of physicians and other health care professionals • Delivered through interactive telemedicine • During a hospital stay • In a skilled nursing facility Note: Interactive telemedicine is covered only when determined medically appropriate by a Plan provider	Nothing	Nothing
• At home	Nothing	Nothing
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	Nothing	Nothing

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

Benefit Description	You pay	
Lab, X-ray and other diagnostic tests (cont.)	**High Option**	**Standard Option**
Note: You pay the diagnostic and treatment cost-sharing for diagnostic tests when received as a part of a non-invasive vascular diagnostic study or echocardiogram. See Section 5(a), *Diagnostic and treatment services*.	Nothing	Nothing
• CT scans/MRI • Nuclear medicine • PET scans • Sleep lab • Interventional radiology procedures Note: Interventional radiology uses guided imagery to visualize, treat, or diagnose organ or circulatory function.	$75 per procedure	$100 per procedure
Preventive care, adult	**High Option**	**Standard Option**
Routine physical exam	Nothing	Nothing
Routine screenings, such as: • Total blood cholesterol • Colorectal cancer screening, including - Fecal occult blood test - Sigmoidoscopy screening – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 • Bone mass measurement to determine risk for osteoporosis • Chlamydia screenings – women under age 20 who are sexually active and women over age 20 with multiple risk factors • Human Papillomavirus Screening at testing intervals recommended for cervical cytology screening by the American College of Obstetricians and Gynecologists	Nothing	Nothing
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing	Nothing
Well woman care, including but not limited to: • Routine Pap test • Human papillomavirus testing for women age 30 and up • Counseling for sexually transmitted infections • Counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
Routine mammogram covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • At age 40 and older, one every calendar year	Nothing	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	Nothing	Nothing
Travel consultations, immunizations, and vaccines	$10 per primary care office visit $20 per specialty care office visit	$20 per primary care office visit $30 per specialty care office visit
Preventive services required to be covered by group health plans at no cost share by federal health care reform legislation (the Affordable Care Act and implementing regulations). Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available (USPSTF) is available online at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-aand-b-recommendations/ and HHS at www.healthcare.gov/preventive-care-benefits/	Nothing	Nothing
Notes: • You should consult with your physician to determine what is appropriate for you • We cover preventive care services if you have average risk factors based on age, sex, and other relevant information, consistent with national preventive health care standards. • Examinations and test to diagnose a specific disease for which you are at high risk, to monitor chronic disease, or to follow up after you are diagnosed with a disease are covered under "Lab, X-ray and other diagnostic tests" and "Surgical procedures". • You pay cost-sharing for diagnostic and treatment services for illness or injury received during a preventive care exam. See Section 5(a), *Diagnostic and treatment services*.		
Not covered: • *Physical exams and immunizations required for:* - *Obtaining or continuing employment* - *Insurance or licensing* - *Attending schools or camp* - *Participating in employee programs* - *Court ordered parole or probation*	*All charges*	*All charges*

Benefit Description	You pay	
Preventive care, children	**High Option**	**Standard Option**
We cover preventive care services if you have average risk factors based on age, sex, and other relevant information, consistent with national preventive health care standards. • Well-child care including routine examinations and immunizations (through age 21)	Nothing	Nothing
• Childhood immunizations recommended by the American Academy of Pediatrics • Examinations, such as: - Eye exam through age 21 to determine the need for vision correction - Hearing screening through age 21 to determine the need for hearing correction Note: Hearing screenings are provided by a primary care physician as part of a well-child care visit. For other hearing exams or tests, see Section 5(a), *Diagnostic and treatment services* or Section 5(a), *Hearing services*.	Nothing	Nothing
Travel consultations, immunizations, and vaccines	$10 per primary care office visit (nothing from infancy through age 4) $20 per specialty care office visit	$20 per primary care office visit (nothing from infancy through age 4) $30 per specialty care office visit
Preventive services required to be covered by group health plans at no cost share by federal health care reform legislation (the Affordable Care Act and implementing regulations). Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available (USPSTF) is available online at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-aand-b-recommendations/ and HHS at www.healthcare.gov/preventive-care-benefits/	Nothing	Nothing
Note: Should you receive services for an illness, injury or condition during a preventive care examination, you may be charged the cost share for professional services in a physician's office. See Section 5(a), *Diagnostic and treatment services*.		
Not covered: • *Physical exams and immunizations required for:* - *Obtaining or continuing employment* - *Insurance or licensing* - *Participating in employee programs* - *Attending school or camp* - *Court ordered parole or probation*	*All charges*	*All charges*

Preventive care, children - continued on next page

Benefit Description	You pay	
Preventive care, children (cont.)	**High Option**	**Standard Option**
• *All other hearing testing, except as may be covered in Section 5(a), Diagnostic and treatment services or Section 5(a), Hearing services*	*All charges*	*All charges*
Maternity care	**High Option**	**Standard Option**
Routine maternity (obstetrical) care, such as: • Prenatal care visits • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk • Postpartum care	Nothing	Nothing
• Delivery	Nothing for inpatient professional delivery services	Nothing for inpatient professional delivery services
Notes: • You do not need prior approval for your normal 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 regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. • You pay cost-sharing for other services, including: - Diagnostic and treatment services for illness or injury received during a non-routine maternity care as described in this section - Lab, X-ray and other diagnostic tests (including ultrasounds), Durable medical equipment (including breastfeeding pumps) as described in this section - Surgical services (including circumcision of an infant if performed after the mother's discharge from the hospital) as described in Section 5(b). *Outpatient hospital or ambulatory surgical center* - Hospitalization (including delivery) as described in Section 5(c). *Inpatient hospital*		

Benefit Description	You pay	
Family planning	**High Option**	**Standard Option**
A range of family planning services for women, limited to: • Female voluntary sterilization (See Section 5(b), *Surgical procedures*) • Family planning counseling • Contraceptives counseling	Nothing	Nothing
Notes: • We cover contraceptive drugs, intrauterine devices (IUDs), and diaphragms under Prescription drug benefits. See Section 5(f). • For surgical costs associated with family planning, See Section 5(b), *Surgery benefits* • Male family planning services are covered in Primary and Specialty office visits. See Section 5 (a), *Diagnostic and treatment services.*		
• Genetic counseling	$10 per primary care office visit $20 per specialty care office visit	$20 per primary care office visit $30 per specialty care office visit
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility, such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Semen analysis • Hysterosalpingogram • Hormone evaluation	50% of our allowance	50% of our allowance
• Up to three in vitro fertilization procedures per live birth if you have been unable to become pregnant through a less costly infertility treatment for which coverage is available under the Plan and: - you and your Spouse have a history of involuntary infertility, which may be demonstrated as follows: • you and your spouse are of opposite sexes, your oocytes are fertilized with your spouse's sperm and intercourse of at least 2 years duration failed to result in pregnancy; or	50% of our allowance; Plan pays up to $100,000 in a member's lifetime	50% of our allowance; Plan pays up to $100,000 in a member's lifetime

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**High Option**	**Standard Option**
• you and your Spouse are of the same sex, and six attempts of artificial insemination over the course of 2 years failed to result in pregnancy; or - the infertility is associated with endometriosis, exposure in utero to diethylstilbestrol, commonly known as DES, blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy), or abnormal male factors, including oligospermia, contributing to the infertility.	50% of our allowance; Plan pays up to $100,000 in a member's lifetime	50% of our allowance; Plan pays up to $100,000 in a member's lifetime
Notes: • Each frozen embryo transfer procedure counts as one cycle of in vitro fertilization towards the limit of three procedures per live birth. • See Section 5(f), *Prescription drug benefits,* for coverage of fertility drugs. • Infertility is the inability of an individual to conceive or produce conception during a period of 1 year if the female is age 35 or younger, or during a period of 6 months if the individual is over the age of 35, or having a medical or other demonstrated condition that is recognized by a Plan Physician as a cause of infertility. • Infertility services are covered for individuals over the age of 18 who meet medically necessary criteria and are authorized by the Plan. See Section 3, *You need prior Plan approval for certain services*, for more information. • A Plan physician will determine the appropriate treatment and number of attempts for infertility treatment, except in vitro fertilization is limited to three as described above.		
Not covered: *These exclusions apply to fertile as well as infertile individuals or couples:* • *Assisted reproductive technology (ART) procedures, including related services and supplies, such as* - *gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Any charges associated with donor eggs, donor sperm or donor embryos* • *Any charges associated with cryopreservation, thawing, and storage of frozen s*perm, eggs, and embryos • *Ovum transplants*	*All charges*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**High Option**	**Standard Option**
• *Infertility services when either member of the family has been voluntarily, surgically sterilized* • *Services to reverse voluntary, surgically induced infertility* • *Services related to surrogate arrangements*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
• Testing and treatment	$10 per primary care office visit (nothing from infancy through age 4) $20 per specialty care office visit	$20 per primary care office visit (nothing from infancy through age 4) $30 per specialty care office visit
• Injections	$10 per office visit	$20 per office visit
• Serum	Nothing	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Section 5(b), *Organ/ Tissue transplants*. • Respiratory and inhalation therapy • Dialysis – hemodialysis performed in a doctor's office or Plan facility • Intravenous/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone requires our prior approval and is covered under the prescription drug benefit. See Section 3, *You need prior Plan approval for certain services*, and Section 5(f), *Prescription drug benefits*. • Qualified medical clinical trials that provide treatment for life-threatening conditions or for preventive, early detection, or treatment studies of cancer for Phases I, II, III and IV	$10 per primary care office visit (nothing from infancy through age 4) $20 per specialty care office visit	$20 per primary care office visit (nothing from infancy through age 4) $30 per specialty care office visit
• Peritoneal dialysis training in a doctor’s office or Plan facility	Nothing	Nothing
• Multidisciplinary nephrology team visits	Nothing	Nothing

Treatment therapies - continued on next page

Benefit Description	You pay	
Treatment therapies (cont.)	**High Option**	**Standard Option**
• Home dialysis –peritoneal dialysis	Nothing	Nothing
Not covered: • *Chemotherapy supported by a bone marrow transplant or with stem cell support, for any diagnosis not listed as covered under Section 5(b), Organ/Tissue transplants* • *Long-term rehabilitative therapy* • *Cognitive therapy* • *Sleep therapy* • *Thermography and related services*	*All charges*	*All charges*
Physical and occupational therapies	**High Option**	**Standard Option**
Up to 60 days of therapy, per condition, of inpatient multidisciplinary rehabilitation in a prescribed, organized program in a plan facility or skilled nursing facility for up to 60 days for all covered rehabilitation services and supplies you may receive at different sites for the same condition. Note: The skilled nursing facility admission charge is waived if you are admitted directly from a hospital inpatient stay.	$100 per inpatient admission	$250 per day up to $750 maximum per inpatient admission
• Up to 30 office visits or 60 consecutive days, whichever is greater, per condition of out-patient physical habilitative and rehabilitative therapy by a qualified Plan therapist in consultation with a Plan physician to attain or restore bodily function when you have a total or partial loss of bodily function due to illness or injury • We cover up to 90 consecutive days per condition of out-patient occupational habilitative and rehabilitative therapy by a Plan therapist in consultation with a Plan physician to assist you in attaining or resuming self-care and other activities of daily life when you have a total or partial loss of bodily function due to illness or injury • Habilitative services are covered with no visit limits for children up to age 19 for the treatment of congenital and genetic birth defects to help a child function age-appropriately within his or her environment and enhance his or her functional ability without an effective cure • Up to 12 weeks or 36 sessions, whichever is less, for cardiac rehabilitation provided or coordinated by a hospital or other facility approved by a physician following coronary surgery or a myocardial infarction	$20 per specialty care office visit	$30 per specialty care office visit

Physical and occupational therapies - continued on next page

Benefit Description	You pay	
Physical and occupational therapies (cont.)	**High Option**	**Standard Option**
Physical therapy for the prevention of falls as required to be covered by group health plans at no cost share by federal health care reform legislation (the Affordable Care Act and implementing regulations). Includes: • Balance/gait training • Endurance/strength training	Nothing	Nothing
Not covered: • *Long-term therapy* • *Exercise programs* • *Maintenance therapy* • *Cognitive rehabilitative programs* • *Vocational rehabilitative programs* • *Therapies done primarily for education purposes* • *Services provided by local, state, and federal government agencies, including schools*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**
Up to two months of inpatient therapy per condition by a Plan therapist, in consultation with a Plan physician, for habilitative or rehabilitative purposes Note: The admission charge is waived if you have been admitted directly from a hospital inpatient stay	$100 per inpatient admission	$250 per day up to a $750 maximum per inpatient admission
• Up to 90 consecutive days of outpatient habilitative and rehabilitative therapy per condition per year • Habilitative services are covered with no visit limits for children up to age 19 for the treatment of congenital and genetic birth defects to help a child function age-appropriately within his or her environment and enhance his or her functional ability without an effective cure • Speech and language treatment needed as a result of the congenital defect known as cleft lip and/or cleft palate	$20 per specialty care office visit	$30 per specialty care office visit
Not covered: • *Therapies done primarily for educational purposes* • *Therapy for tongue thrust in the absence of swallowing problems* • *Training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation* • *Voice therapy for occupation or performing arts* • *Services provided by local, state, and federal government agencies including schools*	*All charges*	*All charges*

Benefit Description	You pay	
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Hearing aids, for children through age 17, if the hearing aids are prescribed, fitted and dispensed by a licensed audiologist Note: A single hearing aid providing hearing to both ears (binaural hearing aid) is considered two hearing aids for purposes of this benefit.	Nothing (limited to one hearing aid for each hearing impaired ear every 36 months)	Nothing (limited to one hearing aid for each hearing impaired ear every 36 months)
• Otologic and audiological services needed as a result of the congenital defect known as cleft lip and/or cleft palate.	$10 per primary care office visit (nothing from infancy through age 21) $20 per specialty care office visit	$20 per primary care office visit (nothing from infancy through age 21) $30 per specialty care office visit
Notes: For coverage of: • Hearing screenings, see Section 5(a), *Preventive care, children* and, for any other hearing testing, see Section 5(a), *Diagnostic and treatment services.* • Audible prescription reading and speech generating devices, see Section 5(a), *Durable medical equipment.*		
Not covered: • *All other hearing testing, except as may be covered in Section 5(a), Diagnostic and treatment services, Section 5(a), Preventive care, children and Section 5(a), Hearing services* • *Hearing aids, including testing and examinations for them, for all persons age 18 and over*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Diagnosis and treatment of diseases of the eye	$20 per specialty care office visit	$30 per specialty care office visit
• Routine eye exam with a Plan optometrist to determine the need for vision correction and provide a prescription for eyeglasses	$10 per office visit	$20 per office visit
At Plan optical shops: • Eyeglass frames and lenses • Contact lenses package, including: initial fitting for contact lenses; initial pair of contact lenses; insertion and removal of contact lens training; three months of follow-up office visits. These services are provided only as a total package	75% of our allowance	75% of our allowance
Not covered: • *Non-refractive eyeglasses*	*All charges*	*All charges*

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

Benefit Description	You pay	
Vision services (testing, treatment, and supplies) (cont.)	**High Option**	**Standard Option**
• *Non-corrective contact lenses, including fitting and follow-up* • *Eye surgery solely for the purpose of correcting refractive defects of the eye* • *Vision therapy, including orthoptics, visual training and eye exercises*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$10 per primary care office visit $20 per specialty care office visit	$20 per primary care office visit $30 per specialty care office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
External prosthetic and orthotic devices, such as: • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy (limited to a maximum of two surgical bras per contract year)	Nothing	Nothing
• Ostomy and urological supplies	50% of our allowance	50% of our allowance
• Replacements for legs, arms or eyes, and their components and repair	$10 per device	$20 per device
Other external prosthetic and orthotic devices, such as: • Stump hose • Therapeutic shoes required for conditions associated with diabetes • Braces • Monofocal intraocular implants following cataract removal	20% of our allowance	50% of our allowance
Internal prosthetic devices, such as • Artificial joints • Pacemakers, • Cochlear implants	Nothing	Nothing

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
• Osseointegrated external hearing devices • Surgically implanted breast implants following mastectomy Note: See 5(b), *Surgery benefits*, for coverage of the surgery to insert the device and Section 5(c), *Hospital benefits*, for inpatient hospital benefits.	Nothing	Nothing
• One hair prosthesis if your hair loss results from chemotherapy or radiation treatment for cancer	Nothing	Nothing
Notes: • Orthopedic and prosthetic equipment or services must be prescribed by a Plan physician; obtained through sources designated by the Plan; consistent with Medicare guidelines; and primarily and customarily used to serve a medical or therapeutic purpose in the treatment of an illness or injury. • We cover only those standard items that are adequate to meet the medical needs of the member • For coverage of hearing aids, see Section 5(a), *Hearing services.*		
Not covered: • *Orthopedic devices and corrective shoes, except as listed above* • *Foot orthotics and podiatric use devices, such as arch supports, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Comfort, convenience, or luxury equipment or features* • *Prosthetic devices, equipment and supplies related to sexual dysfunction* • *Dental prostheses, devices and appliances* • *Repairs, adjustments, or replacements due to misuse or loss*	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**
We cover rental or purchase, at our option, of durable medical equipment. Covered items include: • Oxygen and oxygen dispensing equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Portable commodes	50% of our allowance	50% of our allowance

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
• Canes • Bilirubin lights and apnea monitors for infants up to age 3 for a period not to exceed 6 months • Continuous Positive Airway Pressure (CPAP) and Bilevel Positive Airway Pressure device (BIPAP) equipment • Asthma-related equipment (spacers, peak-flow meters, and nebulizers) for adults and children	50% of our allowance	50% of our allowance
Notes: • Durable medical equipment (DME) is equipment that is prescribed by a Plan physician; obtained through sources designated by the Plan; consistent with our Medicare guidelines; intended for repeated use; primarily and customarily used to serve a medical or therapeutic purpose in the treatment of an illness or injury; designed for prolonged use; and appropriate for use in the home. • We cover only those standard items that are adequate to meet the medical needs of the member. • We may require you to return the equipment to us, or pay us the fair market price of the equipment, when it is no longer prescribed. • Your Plan physician must recertify your medical need for oxygen and oxygen equipment every 30 days.		
We cover diabetic equipment and supplies when obtained from sources designated by the Plan including: • Diabetic equipment • Insulin pumps • Disposable needles and syringes (up to 3 boxes) • Glucose test strips (up to 6 boxes of 50 count) • Blood glucose monitor • Control solutions • Lancets • Test tape and acetone test tablets	20% of our allowance	20% of our allowance
Notes: • DME does not include coverage for prosthetic devices such as artificial eyes or legs or orthotic devices such as braces or therapeutic shoes. • Refer to Section 5(a), *Orthopedic and Prosthetic devices*, for coverage of internal prosthetic devices and breast prostheses. • Refer to Section 5(f), *Prescription drug benefits*, for information about insulin coverage.		

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
Breastfeeding pump, including any equipment that is required for pump functionality	Nothing	Nothing
Not covered: • *Audible prescription reading devices* • *Speech generating devices* • *Comfort, convenience, or luxury equipment or features* • *Non-medical items such as sauna baths or elevators* • *Exercise and hygiene equipment* • *Electronic monitors of the heart, lungs, or other bodily functions, except for apnea monitors, bilirubin blankets, and blood glucose monitors* • *Devices, equipment, and supplies related to the treatment of sexual dysfunction disorders* • *Modifications to the home or vehicle* • *Dental appliances, except for the treatment of cleft lip and/or cleft palate* • *More than one piece of durable medical equipment serving essentially the same function* • *Disposable supplies* • *Replacement batteries for glucose meters* • *Oxygen tents* • *Motorized wheelchairs* • *Repairs, adjustments, or replacements due to misuse or loss*	*All charges*	*All charges*
Medical supplies	**High Option**	**Standard Option**
Amino acid-based elemental formula (drugs, supplies and supplements), regardless of delivery method, for the diagnosis and treatment of: • Congenital errors of amino acid metabolism; • Immunoglobulin E and non-Immunoglobulin E mediated allergies to multiple food proteins; • Severe food protein induced enterocolitis syndrome; • Eosinophilic disorders, as evidenced by the results of a biopsy; and • Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract	25% of our allowance	25% of our allowance

Medical supplies - continued on next page

Benefit Description	You pay	
Medical supplies (cont.)	**High Option**	**Standard Option**
Notes: • Coverage shall be provided if the ordering physician has issued a written order stating that amino acid-based elemental formula is medically necessary for the treatment of a disease or disorder listed above. • The Plan may review the ordering physician's determination of the medical necessity of the amino acid-based elemental formula for the treatment of a disease or disorders listed above.		
Home health services	**High Option**	**Standard Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.) physical therapist, occupational therapist, speech and language pathologist, or home health aide • Services include: - Oxygen therapy, intravenous therapy and medications - A home visit within 24 hours after discharge from the hospital or outpatient facility, and additional home visits if prescribed by the patient's attending physician, for enrollees who receive less than 48 hours of inpatient hospitalization following a mastectomy or the surgical removal of a testicle, or who undergo a mastectomy or surgical removal of a testicle on an outpatient basis Notes: • We only provide these services in the Plan's service areas. • Your Plan physician will periodically review the home health services for continuing appropriateness and medical need. • The services are covered only if you are homebound and a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home.	Nothing	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Custodial care* • *Private duty nursing*	*All charges*	*All charges*

Home health services - continued on next page

Benefit Description	You pay	
Home health services (cont.)	**High Option**	**Standard Option**
• *Personal care and hygiene items* • *Care that a Plan provider determines may be appropriately provided in a Plan facility, hospital or skilled nursing facility or other facility we designate and we provide, or offer to provide, that care in one of these facilities* • *General maintenance care of colostomy, ileostomy, and ureterostomy* • *Medical supplies or dressings applied by you or a family caregiver* • *Transportation and delivery service costs of durable medical equipment, medications, drugs, medical supplies, and supplements to the home*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**
Up to 20 visits per calendar year, including: • Diagnosis and treatment of neuromusculoskeletal disorders • Plain film X-rays associated with diagnosis and treatment • Adjunctive therapies Note: Your Plan physician must determine that such care will result in improvement in your condition. Chiropractic services require our prior approval. See Section 3, *You need prior Plan approval for certain services.*	$20 per office visit	$30 per office visit
Not covered: • *Hypnotherapy, behavior training, sleep therapy and weight programs* • *Thermography* • *Any radiological exam other than plain film studies such as magnetic resonance imaging, CT scans, bone scans, nuclear radiology* • *Treatment for non-neuromusculoskeletal disorders* • *Chiropractic appliances, except as covered in Section 5(a), Durable medical equipment and Prosthetics and orthotic devices* • *Laboratory services*	*All charges*	*All charges*

Benefit Description	You pay	
Alternative treatments	**High Option**	**Standard Option**
Up to 20 acupuncture visits per calendar year. Services include: • Diagnosis and treatment of chronic pain and nausea • Adjunctive acupuncture therapy Note: You receive these services when your Plan physician determines that such care will result in improvement in your condition. Acupuncture services require our prior approval. See Section 3, *You need prior Plan approval for certain services.*	$20 per office visit	$30 per office visit
Not covered: • *All other form of alternative treatment, such as naturopathic services, behavior training, sleep therapy, weight programs and adjunctive therapy not associated with acupuncture* • *Thermography* • *Any radiological exam including plain film studies such as magnetic resonance imaging, CT scans, bone scans, nuclear radiology* • *Laboratory services*	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
Health education classes, including: • Diabetes • Post-coronary • Nutritional counseling	$10 per primary care office visit $20 per specialty care office visit	$20 per primary care office visit $30 per specialty care office visit
Tobacco cessation programs, including individual, group and telephone counseling.	Nothing	Nothing
Notes: • Please call our Member Services Department at 1-877-KP4-FEDS (1-877-574-3337) (TTY: 711) for information on classes near you. • You pay nothing for over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. See Section 5(f), *Prescription drug benefits*, for important information about coverage of tobacco cessation and other drugs. • You can also participate in programs that are available through Kaiser Permanente as non-FEHB benefits. These programs may require that you pay a fee. See the end of Section 5, *Non-FEHB benefits available to Plan members.*		

Section 5(b). Surgical and anesthesia services provided by physicians and other health care 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.
- Unless you receive prior approval from us, Medical Group must provide or arrange your care.
- We have no calendar year deductible for Surgical and anesthesia services.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRIOR APPROVAL FOR MOST MEDICAL SERVICES AND SUPPLIES PROVIDED BY PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS**. Please refer to the prior approval information shown in Section 3 to be sure which surgeries, services and supplies require prior approval.
- **WHEN YOUR PHYSICIAN REQUESTS PRIOR APPROVAL, THE PLAN WILL DETERMINE WHETHER THE SERVICE IS MEDICALLY NECESSARY AND WHETHER IT SHOULD BE PROVIDED BY A PARTICULAR PROVIDER OR FACILITY.**

Benefit Description	You pay	
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Diagnostic colonoscopy procedures • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Transgender surgical services, limited to, genital surgery and mastectomy to treat gender dysphoria • Foot surgery including open cutting surgery to remove bunions and spurs • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery). You must: - be 18 years of age or older; and - satisfy the requirements of bariatric surgery nutrition preparation; and	\$20 per surgery or procedure in a medical office \$75 per surgery or procedure in an outpatient hospital or ambulatory surgery center \$100 per inpatient admission for hospital charges	\$30 per surgery or procedure in a medical office \$150 per surgery or procedure in an outpatient hospital or ambulatory surgery center \$250 per day up to \$750 maximum per inpatient admission for hospital charges

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
- not be excluded due to a history alcohol or drug abuse within the past 2 years or have certain behavioral health diagnoses; and - have a Body Mass Index (BMI) that is greater than 40; or a BMI that is equal to or greater than 35 with a co-morbid medical condition such as hypertension, a cardiopulmonary condition, sleep apnea or diabetes Note: See Section 3, *You need prior Plan approval for certain services*, for more information.	$20 per surgery or procedure in a medical office $75 per surgery or procedure in an outpatient hospital or ambulatory surgery center $100 per inpatient admission for hospital charges	$30 per surgery or procedure in a medical office $150 per surgery or procedure in an outpatient hospital or ambulatory surgery center $250 per day up to $750 maximum per inpatient admission for hospital charges
• Insertion of internal prosthetic devices. See Section 5(a), *Orthopedic and prosthetic devices,* for device coverage information • Male voluntary sterilization (e.g. Vasectomy) • Treatment of burns • Insertion of implanted time-release drugs except for contraceptive drugs and IUDs. Note: We cover the cost of the implanted time-release drugs under the prescription drug benefit (see Section 5(f)).	$20 per surgery or procedure in a medical office $75 per surgery or procedure in an outpatient hospital or ambulatory surgery center $100 per inpatient admission for hospital charges	$30 per surgery or procedure in a medical office $150 per surgery or procedure in an outpatient hospital or ambulatory surgery center $250 per day up to $750 maximum per inpatient admission for hospital charges
• Female voluntary sterilization, including anesthesia and a hysterosalpingogram following tubal occlusion • Insertion of surgically implanted time-release contraceptive drugs and intrauterine devices (IUDs) Note: We cover the cost of these drugs and devices under the prescription drug benefit (see Section 5(f)).	Nothing	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Services for the promotion, prevention, or other treatment of hair loss or hair growth* • *Cosmetic surgery - any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form* • *Transgender surgical services, other than genital surgery and mastectomy*	*All charges*	*All charges*

Benefit Description	You pay	
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - it 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 and reconstruction on the other breast to produce a symmetrical appearance; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Notes: • 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. • We cover orthodontia services as a result of cleft lip and/or cleft palate.	$20 per surgery or procedure in a medical office $75 per surgery or procedure in an outpatient hospital or ambulatory surgery center $100 per inpatient admission for hospital charges	$30 per surgery or procedure in a medical office $150 per surgery or procedure in an outpatient hospital or ambulatory surgery center $250 per day up to $750 maximum per inpatient admission for hospital charges
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**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	$20 per surgery or procedure in a medical office $75 per surgery or procedure in an outpatient hospital or ambulatory surgery center $100 per inpatient admission for hospital charges	$30 per surgery or procedure in a medical office $150 per surgery or procedure in an outpatient hospital or ambulatory surgery center $250 per day up to $750 maximum per inpatient admission for hospital charges

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay	
Oral and maxillofacial surgery (cont.)	**High Option**	**Standard Option**
• 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	$20 per surgery or procedure in a medical office $75 per surgery or procedure in an outpatient hospital or ambulatory surgery center $100 per inpatient admission for hospital charges	$30 per surgery or procedure in a medical office $150 per surgery or procedure in an outpatient hospital or ambulatory surgery center $250 per day up to $750 maximum per inpatient admission for hospital charges
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone) except as covered under the accidental dental benefit or for orthodontia services as a result of cleft lip and/or cleft palate* • *Shortening of the mandible or maxillae for cosmetic purposes and* • *Correction of any malocclusion not listed above*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**
These solid organ transplants are subject to medical necessity and experimental/investigational review by the Plan. Refer to Section 3, *How you get care* for authorization procedures. Solid organ tissue transplants are limited to: • 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 • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	$20 per surgery or procedure in a medical office $75 per surgery or procedure in an outpatient hospital or ambulatory surgery center $100 per inpatient admission for hospital charges	$30 per surgery or procedure in a medical office $150 per surgery or procedure in an outpatient hospital or ambulatory surgery center $250 per day up to $750 maximum per inpatient admission for hospital charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
The following blood or marrow stem cell transplants are not subject to medical necessity review. Our denial is limited to the cytogenetics, subtype or staging of the diagnosis (e.g. acute, chronic) as appropriate for the diagnosis. Blood or marrow stem cell transplants are limited to: • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - 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) - Amyloidosis - Neuroblastoma	$20 per surgery or procedure in a medical office $75 per surgery or procedure in an outpatient hospital or ambulatory surgery center $100 per inpatient admission for hospital charges	$30 per surgery or procedure in a medical office $150 per surgery or procedure in an outpatient hospital or ambulatory surgery center $250 per day up to $750 maximum per inpatient admission for hospital charges
The following blood or marrow stem cell transplants are not subject to medical necessity review. Blood or marrow stem cell transplants for: • Allogeneic transplants for: - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Autologous transplants for: - Multiple myeloma	$20 per surgery or procedure in a medical office $75 per surgery or procedure in an outpatient hospital or ambulatory surgery center $100 per inpatient admission for hospital charges	$30 per surgery or procedure in a medical office $150 per surgery or procedure in an outpatient hospital or ambulatory surgery center $250 per day up to $750 maximum per inpatient admission for hospital charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors	$20 per surgery or procedure in a medical office $75 per surgery or procedure in an outpatient hospital or ambulatory surgery center $100 per inpatient admission for hospital charges	$30 per surgery or procedure in a medical office $150 per surgery or procedure in an outpatient hospital or ambulatory surgery center $250 per day up to $750 maximum per inpatient admission for hospital charges
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. • Advanced Childhood kidney cancers • Advanced Ewing sarcoma • Aggressive non-Hodgkin's lymphomas • Childhood rhabdomyosarcoma • Epithelial ovarian cancer • Mantle Cell (Non-Hodgkin's lymphoma)	$20 per surgery or procedure in a medical office $75 per surgery or procedure in an outpatient hospital or ambulatory surgery center $100 per inpatient admission for hospital charges	$30 per surgery or procedure in a medical office $150 per surgery or procedure in an outpatient hospital or ambulatory surgery center $250 per day up to $750 maximum per inpatient admission for hospital charges
Mini-transplants performed in a Clinical Trial Setting (non-myeloblative, reduced intensity conditioning for member over 60 years of age). • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Hemoglobinopathy - Marrow Failure and Related Disorders (i.e. Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency	$20 per surgery or procedure in a medical office $75 per surgery or procedure in an outpatient hospital or ambulatory surgery center $100 per inpatient admission for hospital charges	$30 per surgery or procedure in a medical office $150 per surgery or procedure in an outpatient hospital or ambulatory surgery center $250 per day up to $750 maximum per inpatient admission for hospital charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- 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	$20 per surgery or procedure in a medical office $75 per surgery or procedure in an outpatient hospital or ambulatory surgery center $100 per inpatient admission for hospital charges	$30 per surgery or procedure in a medical office $150 per surgery or procedure in an outpatient hospital or ambulatory surgery center $250 per day up to $750 maximum per inpatient admission for hospital charges
Tandem transplants: Subject to medical necessity • Autologous tandem transplants for: - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	$20 per surgery or procedure in a medical office $75 per surgery or procedure in an outpatient hospital or ambulatory surgery center $100 per inpatient admission for hospital charges	$30 per surgery or procedure in a medical office $150 per surgery or procedure in an outpatient hospital or ambulatory surgery center $250 per day up to $750 maximum per inpatient admission for hospital charges
Notes: • We cover related medical and hospital expenses of the donor when we cover the recipient. • We cover donor screening tests for potential donors for solid organ transplants. We cover human leukocyte antigen (HLA) typing for potential donors for a bone marrow/stem cell transplant only for parents, children and siblings of the recipient. • We cover computerized national and international search expenses for prospective unrelated bone marrow/stem cell transplant donors conducted through the National Marrow Donor Program, and the testing of blood relatives of the recipient. • Please refer to Section 5(h), *Special features,* for information on our Centers of Excellence.		
Not covered: • *Donor screening tests and donor search expenses, except those listed above* • *Implants of non-human artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*

Benefit Description	You pay	
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing	Nothing

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Unless you receive prior approval from us, Medical Group must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible for Services provided by a hospital or other facility, and ambulance charges.
- Be sure to read Section 4, *Your cost for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRIOR APPROVAL FOR HOSPITAL STAYS** (except for Maternity stays). Please refer to Section 3 to be sure which services require prior approval.
- **FOR EACH REQUEST FOR PRIOR APPROVAL, THE PLAN WILL DETERMINE WHETHER THE SERVICE IS MEDICALLY NECESSARY AND WHETHER IT SHOULD BE PROVIDED BY A PARTICULAR PROVIDER OR FACILITY.**

Benefit Description	You pay	
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Blood and blood products • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics and anesthesia services • Procurement and storage for approved medically necessary cord blood for a designated recipient	$100 per inpatient admission	$250 per day up to $750 maximum per inpatient admission

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
Note: You may receive covered medical hospital services for certain dental procedures if a Plan physician determines that you need to be hospitalized. Section 5(g), *Dental benefits*, includes more information on the requirements.		
Not covered: • *Custodial care and care in an intermediate care facility* • *Non-covered facilities, such as nursing homes* • *Personal comfort items, such as telephone, television, barber services, and guest meals and beds* • *Private nursing care except when medically necessary* • *Cord blood procurement and storage for possible future need or for yet to be determined Member recipient*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Lab, X-ray and other diagnostic tests • Procurement and storage of cord blood for approved medically necessary procedures requiring cord blood for a designated recipient • Blood and blood products • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics and anesthesia service	$75 per surgery or procedure in an outpatient hospital or ambulatory surgery center	$150 per surgery or procedure in an outpatient hospital or ambulatory surgery center
Not covered: • *Procurement and storage of cord blood for possible future need or for yet to be determined Member recipient*	*All charges*	*All charges*
Skilled nursing care facility	**High Option**	**Standard Option**
Up to 100 days per calendar year when you need full-time skilled nursing care. All necessary services are covered, including: • Room and board • General nursing care • Medical social services • Prescribed drugs, biologicals, supplies, and equipment, including oxygen, ordinarily provided or arranged by the skilled nursing facility Note: We waive the additional admission charge if you are admitted to an extended care or skilled nursing facility directly from a hospital inpatient stay.	$100 per inpatient admission	$250 per day up to $750 maximum per inpatient admission

Skilled nursing care facility - continued on next page

Benefit Description	You pay	
Skilled nursing care facility (cont.)	**High Option**	**Standard Option**
Not covered: • *Custodial care and care in an intermediate care facility* • *Personal comfort items, such as telephone, television, barber services, and guest meals and beds*	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**
Supportive and palliative care for a terminally ill member: • You must reside in the service area • Services are provided: - in the home, when a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home, or - in a Plan-approved hospice facility if approved by the hospice interdisciplinary team. Services include inpatient care, outpatient care, and family counseling. A Plan physician must certify that you have a terminal illness, with a life expectancy of approximately six months or less. Note: 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. A person who is terminally ill may elect to receive hospice benefits. These palliative and supportive services include nursing care, medical social services, therapy services for purposes of safety and symptom control, physician services, palliative drugs in accord with our drug formulary guidelines, and short-term inpatient care for pain control and acute and chronic symptom management. We also provide inpatient respite care, counseling and bereavement services. If you make a hospice election, you are not entitled to receive other health care 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.	Nothing	Nothing
Not covered: • *Independent nursing (private duty nursing)* • *Homemaker services*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
• Local licensed ambulance service when medically necessary	Nothing	No charge when we transfer you from an emergency room or hospital to a Plan facility $100 per service for all other ambulance services

Ambulance - continued on next page

Benefit Description	You pay	
Ambulance (cont.)	**High Option**	**Standard Option**
• Non-emergent transportation services when medically necessary and ordered by a Plan Provider Note: See Section 5(d) for emergency services	Nothing	Nothing
Not covered: • *Transportation by car, taxi, bus, and any other type of transportation (other than ambulette or a licensed ambulance), even if it is the only way to travel to a Plan Provider* • *Non-emergent transportation services that are not medically appropriate and that have not been ordered by a Plan provider*	*All charges*	*All charges*

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

What is a medical emergency?

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

What to do in case of emergency:

In a life threatening emergency-call the local emergency system (e.g., the local 911 telephone system). When the operator answers, stay on the phone and answer all questions. If you are not sure whether you are experiencing a medical emergency, please contact our Emergency Line at 1-800-677-1112.

Emergencies within our service area:

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

If you think you have a medical emergency condition and you cannot safely go to a Plan Hospital, call 911 or go to the nearest hospital. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify us within 48 hours, or as soon as is reasonably possible, by calling 703-359-7878 inside the Washington, DC metropolitan area or toll free 1-800-777-7904 (TTY: 711).

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

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

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

Emergencies outside our service area:

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

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

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

You may obtain emergency and urgent care services from Kaiser Permanente medical facilities and providers when you are in the service area of another Kaiser Permanente plan. The facilities will be listed in the local telephone book under Kaiser Permanente. These numbers are available 24 hours a day, seven days a week. You may also obtain information about the location of facilities by calling the dedicated Federal Membership Services Department at 1-877-KP4-FEDS (1-877-574-3337) (TTY: 711).

Benefit Description	You pay	
Emergency within our service area	**High Option**	**Standard Option**
• Emergency care at a Plan urgent care center • Urgent care at a Plan urgent care center	$20 per visit	$30 per visit
• Emergency care as an outpatient at a hospital, including physicians' services • Urgent care at an emergency room Notes: • We waive your emergency room copayment if you are directly admitted to a hospital as an inpatient. Your inpatient admission copayment will still apply (See Section 5(c)). • Transfers to an observation bed or observation status do not qualify as an admission to a hospital and your emergency room visit copayment will not be waived.	$100 per visit	$125 per visit
Not covered: • *Elective care or non-emergency care* • *Urgent care at a non-Plan urgent care center*	*All charges*	*All charges*
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency care at an urgent care center • Urgent care at an urgent care center	$20 per visit	$30 per visit
• Emergency care as an outpatient at a hospital, including physicians' services • Urgent care at an emergency room Notes: • We waive your emergency room copayment if you are directly admitted to a hospital as an inpatient. Your inpatient admission copayment will still apply (See Section 5(c)).	$100 per visit	$125 per visit

Emergency outside our service area - continued on next page

Benefit Description	You pay	
Emergency outside our service area (cont.)	**High Option**	**Standard Option**
• Transfers to an observation bed or observation status do not qualify as an admission to a hospital and your emergency room visit copayment will not be waived. • See Section 5(h) for travel benefit coverage of continuing or follow-up care.	$100 per visit	$125 per visit
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Licensed ambulance service, including air ambulance, when medically necessary. Notes: • Coverage is also provided for medically necessary transportation or services rendered as the result of a 911 call, whether or not transport is required. • See Section 5(c) for non-emergency service. • Service means any time an ambulance is summoned on your behalf.	Nothing	$100 per service
Not covered: • *Ambulance services we determine are not medically necessary* • *Transportation by car, bus, gurney van, wheelchair van, minivan, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a provider or facility*	*All charges*	*All charges*

Section 5(e). Mental health and substance abuse 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 to treat your condition.
- We have no calendar year deductible for Mental health and substance abuse benefits.
- 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.
- Unless you receive prior approval from us, Medical Group must provide or arrange your care. Call our Behavioral Health Access Unit at 1-866-530-8778 to make arrangements.
- **YOUR PHYSICIAN MUST GET PRIOR APPROVAL FOR HOSPITAL STAYS**. Please refer to Section 3 to be sure which services require prior approval. All inpatient admissions and hospital alternative services treatment programs require prior approval by the Plan.
- **FOR EACH REQUEST FOR PRIOR APPROVAL, THE PLAN WILL DETERMINE WHETHER THE SERVICE IS MEDICALLY NECESSARY AND WHETHER IT SHOULD BE PROVIDED BY A PARTICULAR PROVIDER OR FACILITY.**
- If we are unable to provide services in our Plan facilities, you may request a referral to a network provider. If a network provider requests additional visits/time beyond those/that authorized by us, then we must approve a treatment plan.

Benefit Description	You pay	
Professional services	**High Option**	**Standard Option**
We cover professional services recommended by a Plan mental health or substance abuse provider that are covered services, drugs, and supplies described in this brochure. Notes: • We cover the services only when we determine that the care is clinically appropriate to treat your condition. • OPM will generally not order us to pay or provide one clinically appropriate treatment in favor of another.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Outpatient services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual and group therapy visits)	$10 per individual therapy visit $5 per group therapy visit	$20 per individual therapy visit $10 per group therapy visit

Professional services - continued on next page

Benefit Description	You pay	
Professional services (cont.)	**High Option**	**Standard Option**
Diagnosis and treatment of alcoholism and drug abuse. Outpatient services include: • Detoxification (medical management of withdrawal from the substance) • Treatment and counseling (including individual and group therapy visits) • Intensive day treatment • Medication evaluation and management	$10 per individual therapy visit $5 per group therapy visit	$20 per individual therapy visit $10 per group therapy visit
• Methadone treatment	$10 per week	$20 per week
Notes: • You may see a Plan mental health or substance abuse provider for outpatient services without a referral from your primary care physician. See Section 3, *How you get care,* for information about services requiring our prior approval. • Your Plan mental health or substance abuse provider will develop a treatment plan to assist you in improving or maintaining your condition and functional level, or to prevent relapse and will determine which diagnostic and treatment services are appropriate for you.		
Inpatient hospital or other covered facility	**High Option**	**Standard Option**
• Inpatient psychiatric care • Inpatient detoxification • Acute inpatient substance abuse rehabilitation • Services in an inpatient residential treatment center Notes: • All inpatient admissions and hospital alternative services treatment programs require approval by a Plan mental health or substance abuse physician. • Inpatient services will only be part of a treatment plan when services cannot be provided safely on an outpatient basis or in a less intensive setting than an acute care hospital.	$100 per inpatient admission	$250 per day up to $750 maximum per inpatient admission
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
• Hospital alternative services: partial hospitalization, intensive outpatient psychiatric treatment programs and residential crisis services.	$20 per visit; or $100 per inpatient admission if your treatment is more than 24 continuous hours	$30 per visit; or $250 per day up to $750 maximum per inpatient admission if your treatment is more than 24 continuous hours

Benefit Description	You pay	
Not covered	**High Option**	**Standard Option**
Not covered: • *Care that is not clinically appropriate for the treatment of your condition* • *Services we have not approved* • *Intelligence, IQ, aptitude ability, learning disabilities, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition* • *Evaluation or therapy on court order or as a condition of parole or probation, or otherwise required by the criminal justice system, unless determined by a Plan physician to be medically necessary and appropriate* • *Services that are custodial in nature* • *Marital, family, or educational services* • *Services rendered or billed by a school or a member of its staff* • *Services provided under a federal, state, or local government program* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms*	*All charges*	*All charges*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page 64.
- 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.
- Federal law prevents the pharmacy from accepting unused medications.
- **Your Physician must get prior approval for some drugs**. Please refer to Section 3 to be sure which drugs require prior approval.
- Be sure to read Section 4, *Your cost for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed Plan provider or licensed Plan dentist must prescribe your medication. We cover prescriptions written by a non-Plan provider or filled at a non-Plan pharmacy only for emergencies or out-of-area urgent care.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy, an affiliated network pharmacy, online at www.kp.org/rxrefill or by the Plan mail order program for certain maintenance medication as specified below. We cover prescriptions written by a non-Plan provider or filled at a non-Plan pharmacy only for covered emergencies as specified in Section 5(d), *Emergency services/accidents*. Plan members called to active military duty (or members in time of national emergency), who need to obtain prescribed medications, should call a Plan pharmacy.
- **We use a formulary.** The medications included in our drug formulary are chosen by a group of Kaiser Permanente physicians, pharmacists and other Plan providers known as the Pharmacy and Therapeutics Committee. The committee meets regularly to consider adding and removing prescription drugs on the drug formulary based on new information or drugs that become available. Drugs on our formulary are called, "preferred drugs". We cover non-preferred prescription drugs (those not listed on our drug formulary for your condition) if they would otherwise be covered and a Plan provider receives an approved drug formulary exception. For information about drug formulary exceptions, see Section 3, *You need prior Plan approval for certain services*. You pay higher cost-sharing for non-preferred brand-name drugs prescribed by a Plan provider. If you request a non-preferred generic or brand-name drug when your Plan provider has prescribed a preferred drug, the non-preferred drug is not covered. For more information on our prescription drug FEHB formulary, visit kp.org/formulary, or call our Federal Member Services Department at 1-877-KP4-FEDS (1-877-574-3337) (TTY: 711).

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

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

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

- **These are the dispensing limitations**. We provide up to a 30-day supply for most drugs dispensed in a Plan pharmacy for one copayment based upon (a) the prescribed quantity, (b) the standard manufacturer's package size, (c) specified dispensing limits, (d) the type of drug, and (e) the place of purchase. Maintenance medications may be obtained for up to a 90-day supply for two copayments when ordered through our mail-delivery program. A maintenance drug is a drug that your Plan provider anticipates you will require for 6 months or more to treat a chronic condition. We cover episodic drugs prescribed to treat sexual dysfunction disorders up to a maximum of 8 doses in any 30-day period or 24 doses in any 90-day period. Most drugs can be mailed from our mail order pharmacy. Some drugs (for example, drugs that are extremely high cost or require special handling) may not be eligible for mailing. Mail order drugs are available anywhere in the United States. The pharmacy may reduce the day supply dispensed to a 30-day supply in any 30-day period 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,** unless your Plan provider specifically requires a brand name drug.
- **Why use generic drugs?** Typically generic drugs cost you and us less money than a brand-name drug. Under federal law, generic and brand-name drugs must meet the same standards for safety, purity, strength, and effectiveness.
- **When you do have to file a claim.** You do not need to file a claim when you receive drugs from a Plan pharmacy. You have to file a claim when you receive drugs from a non-Plan pharmacy for a covered out-of-area emergency as specified in Section 5(d), *Emergency services/accidents*. For information about how to file a claim, see Section 7, *Filing a claim for covered services*.

Benefit Description	You pay	
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician or Plan dentist and obtained from a Plan pharmacy, an affiliated network pharmacy, or through the Plan's mail service delivery program: • Drugs and medicines that, by federal law, require a prescription for their purchase, except those listed as *Not covered* • Insulin • Other implanted time-release drugs • Self-injectable drugs, other than ovulation stimulants • Self-administered post-surgical immunosuppressant outpatient drugs required as a result of a covered transplant • Growth hormone therapy (GHT) – for treatment of children with growth hormone deficiency • Disposable needles and syringes for the administration of covered medications, except disposable needles and syringes for the administration of insulin (See Section 5(a). *Durable medical equipment*) Notes:	**30-day supply at a Plan medical center pharmacy:** $7 per prescription or refill for generic drugs; or $30 per prescription or refill for preferred brand-name drugs; or $45 per prescription or refill for non-preferred brand-name drugs; or 20% up to $100 per prescription or refill for specialty drugs **30-day supply at an affiliated network pharmacy**: $17 per prescription or refill for generic drugs; or $50 per prescription or refill for preferred brand-name drugs; or $65 per prescription or refill for non-preferred brand-name drugs; or 30% up to $150 per prescription or refill for specialty drugs	**30-day supply at a Plan medical center pharmacy:** $12 per prescription or refill for generic drugs; or $35 per prescription or refill for preferred brand-name drugs; or $50 per prescription or refill for non-preferred brand-name drugs; or 30% up to $150 per prescription or refill for specialty drugs **30-day supply at an affiliated network pharmacy**: $22 per prescription or refill for generic drugs; or $55 per prescription or refill for preferred brand-name drugs; or $70 per prescription or refill for non-preferred brand-name drugs; or 40% up to $200 per prescription or refill for specialty drugs

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• The brand name drug copayment will apply to single source generic products. For compound drugs, you will be charged your applicable generic or brand name drug copayment depending on the compounded product's main ingredient, whether the main ingredient is a generic or brand name drug. • A compound drug is one in which two or more drugs or pharmaceutical agents are combined together. We limit coverage to products listed in our drug formulary or when one of the ingredients requires a prescription by law. • Non-maintenance self-injectables are limited to a dispensing limit of 30 days. • Home IV and growth hormone requires our prior approval. See Section 3, *You need prior Plan approval for certain services.*	**30-day supply at a Plan medical center pharmacy:** $7 per prescription or refill for generic drugs; or $30 per prescription or refill for preferred brand-name drugs; or $45 per prescription or refill for non-preferred brand-name drugs; or 20% up to $100 per prescription or refill for specialty drugs **30-day supply at an affiliated network pharmacy**: $17 per prescription or refill for generic drugs; or $50 per prescription or refill for preferred brand-name drugs; or $65 per prescription or refill for non-preferred brand-name drugs; or 30% up to $150 per prescription or refill for specialty drugs **30-day supply through our mail service delivery program:** $5 per prescription or refill for generic drugs; or $28 per prescription or refill for preferred brand-name drugs; or $43 per prescription or refill for non-preferred brand-name drugs; or 20% up to $100 per prescription or refill for specialty drugs For information about mail order discounts, see "These are the dispensing limitations" in the introduction to Section 5(f)	**30-day supply at a Plan medical center pharmacy:** $12 per prescription or refill for generic drugs; or $35 per prescription or refill for preferred brand-name drugs; or $50 per prescription or refill for non-preferred brand-name drugs; or 30% up to $150 per prescription or refill for specialty drugs **30-day supply at an affiliated network pharmacy**: $22 per prescription or refill for generic drugs; or $55 per prescription or refill for preferred brand-name drugs; or $70 per prescription or refill for non-preferred brand-name drugs; or 40% up to $200 per prescription or refill for specialty drugs **30-day supply through our mail service delivery program:** $10 per prescription or refill for generic drugs; or $33 per prescription or refill for preferred brand-name drugs; or $48 per prescription or refill for non-preferred brand-name drugs; or 30% up to $150 per prescription or refill for specialty drugs For information about mail order discounts, see "These are the dispensing limitations" in the introduction to Section 5(f)
• Intravenous fluids and medications for home use	Nothing	Nothing
• Weight management drugs for treatment of morbid obesity • Fertility drugs for covered infertility treatments • Sexual dysfunction drugs	50% of our allowance	50% of our allowance

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
Prescribed tobacco cessation medications, including prescribed over-the-counter medications, approved by the FDA to treat tobacco dependence	Nothing	Nothing
Self-administered chemotherapeutic drugs and oral chemotherapeutic agents used to treat cancer	Nothing	Nothing
Women's contraceptive drugs and devices, including implanted contraceptive devices, hormonal contraceptive methods, barrier contraceptive methods, and prescribed FDA approved over-the-counter women's contraceptives and devices.	Nothing	Nothing
Prescribed medications, including prescribed over-the-counter medications, required to be covered by group health plans at no cost share by federal health care reform (the Affordable Care Act and implementing regulations). These include: • 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 • Iron supplements for children to reduce the risk of anemia • Vitamin D for adults to reduce the risk of falls • Medication to reduce the risk of breast cancer	Nothing	Nothing
Not covered: • *Drugs or supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Prescriptions filled at a non-Plan pharmacy, except for out-of-area emergencies as described in Section 5(d), Emergency services/accidents* • *Vitamins and nutritional supplements that can be purchased without a prescription, unless they are included in our drug formulary or listed as covered above* • *Nonprescription drugs, unless they are included in our drug formulary or listed as covered above* • *Medical supplies such as dressings and antiseptics, except as listed above* • *Drugs to shorten the duration of the common cold* • *Any requested packaging of drugs other than the dispensing pharmacy's standard packaging* • *Replacement of lost, stolen, or damaged prescription drugs and accessories* • *Drugs related to non-covered services*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• *Drugs for the promotion, prevention, or other treatment of hair loss or growth* • *Dental prescriptions other than those prescribed for pain relief or antibiotics*	*All charges*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9, *Coordinating benefits with other coverage.*
- Plan dentists must provide or arrange your care, except as described under emergency dental services. Dominion Dental Services USA, Inc. (DOMINION) will provide or arrange for the provision of covered dental services to you through Participating Dental Providers.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c), *Hospital benefits*, 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 about coordinating benefits with other coverage, including with Medicare.
- **YOUR DENTAL PROVIDER MUST GET PRIOR APPROVAL FOR DENTAL SERVICES COVERED UNDER THE MEDICAL PLAN.** Please refer to Section 3, *You need prior Plan approval for certain services*, to be sure which services require prior approval.

Benefit Description	You pay	
Accidental injury benefit	**High Option**	**Standard Option**
We cover services to promptly repair (but not replace) a sound, natural tooth if: • damage is due to an accidental injury from trauma to the mouth from violent contact with an external object, • the tooth has not been restored previously, and • the tooth has not been weakened by decay, periodontal disease, or the existing dental pathology. Note: Services will be covered when started within 60 days and provided within 12 months of the accidental injury.	$10 per primary care office visit $20 per specialty care office visit	$20 per primary care office visit $30 per specialty care office visit
Not covered: • *Services for conditions caused by an accidental injury occurring before your eligibility date*	*All charges*	*All charges*

Benefit Description	You pay	
Other dental benefits	**High Option**	**Standard Option**
General anesthesia and associated hospital or ambulatory surgery facility charges, in conjunction with dental care, are covered for members: • 7 years of age or younger, who: - are developmentally disabled - for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition, - for whom a superior result can be expected from dental care provided under general anesthesia • 17 years of age or younger, and extremely uncooperative, fearful, or uncommunicative with dental needs of such magnitude that treatment should not be delayed or deferred; and whom a lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity • 17 and older, whose medical condition requires that dental service be performed in a hospital or ambulatory surgical center for their safety (e.g., heart disease and hemophilia) Note: Dental care must be provided by a fully accredited specialist in pediatric dentistry, a fully accredited specialist in oral and maxillofacial surgery, or a dentist for whom hospital privileges have been granted.	$10 per primary care office visit $20 per specialty care office visit $75 per outpatient surgery $100 per inpatient admission	$20 per primary care office visit $30 per specialty care office visit $150 per outpatient surgery $250 per day up to $750 maximum per inpatient admission
Not covered: • *The dentist's or specialist's professional services* • *Dental care for temporal mandibular joint (TMJ) disorders* • *Lab fees associated with cysts that are considered dental according to our medical guidelines*	*All charges*	*All charges*
Diagnostic and preventive benefit	**High Option**	**Standard Option**
Diagnostic and preventive dental services when provided by a participating Dominion Dental dentist, such as: • Routine oral examinations – twice per calendar year • Cleaning (prophylaxis) – twice per calendar year (excluding periodontal prophylaxis) • Topical application of fluoride – twice per calendar year • Bitewing X-rays – twice per calendar year	$30 per office visit	$30 per office visit

Diagnostic and preventive benefit - continued on next page

Benefit Description	You pay	
Diagnostic and preventive benefit (cont.)	**High Option**	**Standard Option**
Other covered dental services when provided by a Plan dentist. Note: All dental procedures listed in the schedule of discounted fees are covered dental services. When you receive any of the listed procedures from a Participating Dental Provider, you will pay the fee listed next to the procedure description for that service. The Participating Dental Provider has agreed to accept that fee as payment in full for that procedure. Neither Kaiser Permanente nor DOMINION are liable for payment of these fees or for any fees incurred as the result of receipt of non-covered dental services.	See Kaiser Permanente Dental Plan Provider Directory for schedule of discounted dental fees	See Kaiser Permanente Dental Plan Provider Directory for schedule of discounted dental fees
Dental emergencies outside our service area Notes: • We cover emergency dental treatment required to alleviate pain, bleeding, or swelling. • If post-emergency care is required, you must receive all post-emergency care from your Participating Dental Provider.	*All charges*, not to exceed $50 per incident	*All charges*, not to exceed $50 per incident
Notes: • You may select a Participating Dental Provider, who is a "general dentist", from whom you and your eligible family members will receive covered dental services. For specialty care, your general dentist must refer you to a specialist who is a Participating Dental Provider. • For a complete list of covered dental services, a schedule of discounted dental fees, limitations, exclusions and a directory of Participating Dental Providers, refer to your Kaiser Permanente Dental Plan booklet. You can obtain a Dental Plan booklet by calling our Federal Member Services Department at 1-877-KP4-FEDS (1-877-574-3337), (TTY: 711). • For assistance concerning dental coverage questions or for help finding a Participating Dental Provider, contact DOMINION Member Services, Monday through Friday from 7:30 am to 6:00 pm at 703-518-5338 or toll-free at 1-888-518-5338 (TTY: 1-800-688-4889), or at www.IP-RELAY.com.		

Section 5(h). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claims process (see Section 8).
24 hour advice line	For any of your health concerns, 24 hours a day, 7 days a week, you may call 703-359-7878 inside the Washington, DC metropolitan area or 1-800-777-7904 (TTY: 711) outside the Washington, DC metropolitan area and talk with a registered nurse who can help assess medical symptoms and provide advice over the phone, when medically appropriate.
Centers of Excellence	The Centers of Excellence program began in 1987. As new technologies proliferate and become the standard of care, Kaiser Permanente refers members to contracted "Centers of Excellence" for certain specialized medical procedures. We have developed a nationally contracted network of Centers of Excellence for organ transplantation, which consists of medical facilities that have met stringent criteria for quality care in specific procedures. A national clinical and administrative team has developed guidelines for site selection, site visit protocol, volume and survival criteria for evaluation and selection of facilities. The institutions have a record of positive outcomes and exceptional standards of quality.
Services for the deaf, hard of hearing or speech impaired	We provide TTY/text telephone number TTY: 711. Sign language services are also available.
Services from other Kaiser Permanente or allied plans	When you visit a different Kaiser Foundation Health Plan or allied plan service area, you can receive visiting member care from designated providers in that area. Visiting member care is described in our visiting member brochure. Visiting member care and your out-of-pocket costs may differ from the covered services, copayments and coinsurance described in this FEHB brochure.

	Please call our dedicated Federal Member Services Department at 1-877-KP4-FEDS (1-877-574-3337) (TTY: 711) to receive more information about visiting member care, including facility locations in other service areas. Service areas and facilities where you may obtain visiting member care may change at any time.
Travel benefit	Kaiser Permanente's travel benefits for Federal employees provides you with outpatient follow-up and/or continuing medical and mental health and substance abuse care when you are temporarily (for example, on a temporary work assignment or attending school) outside your home service area by more than 100 miles and outside of any other Kaiser Permanente service area. These benefits are in addition to your emergency services/accident benefit and include: • Outpatient follow-up care necessary to complete a course of treatment after a covered emergency. Services include removal of stitches, a catheter, or a cast. • Outpatient continuing care for covered services for conditions diagnosed and treated within the previous 12 months by a Kaiser Permanente health care provider or affiliated Plan provider. Services include dialysis and prescription drug monitoring. You pay $25 for each follow-up or continuing care office visit. This amount will be deducted from the reimbursement we make to you or to the provider. We limit our payment for this travel benefit to no more than $1,200 each calendar year. For more information about this benefit you should contact the Plan's dedicated Federal Member Services Department at 1-877-KP4-FEDS (1-877-574-3337) (TTY: 711). File claims as shown in Section 7. *The following are a few examples of services not included in your travel benefits coverage:* • Non-emergency hospitalization • Infertility treatments • Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area • Transplants • Durable medical equipment (DME) • Prescription drugs • Home health services
Rewards	Take steps to improve your well-being by completing the Kaiser Permanente Total Health Assessment and a healthy lifestyle program. FEHB subscribers and their enrolled spouses (age 18 and over) are eligible for the following cash gift card rewards: • $50 for completing a confidential, online, Total Health Assessment (available in English or Spanish). You'll get a picture of your overall health and a customized action plan with tips and resources to improve your well-being. You will also have the option to save a summary of your results to your electronic health record so that you can discuss next steps with your personal physician. • $25 for completing an online healthy lifestyle program of your choice. Personalized and self-paced, they can help you reduce stress, quit smoking, lose weight and more. You can complete as many of these online programs as you would like, but you will only earn a reward for one program completion. You must complete the Total Health Assessment and/or a healthy lifestyle program during the calendar year. Rewards will be issued 4-6 weeks after you complete either activity.

	For more information, please go to www.kp.org/feds or call our HealthWorks customer service at 1-866-300-9867.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the plan, and all complaints must follow their guidelines. For additional information contact the plan at 1-877-KP4-FEDS (1-877-574-3337) (TTY: 711).

Medicare Prepaid Plan Enrollment

We offer Medicare recipients the opportunity to enroll in our Plan through Medicare. Annuitants and former spouses with FEHB coverage and Medicare Parts A and B or Part B only may elect to either drop their FEHB coverage and enroll in a Medicare prepaid plan or remain enrolled in the FEHB Program and simultaneously enroll in the Medicare prepaid plan when one is available in their area. If you choose to disenroll from the FEHB Program you may then later re-enroll in the FEHB Program. Before you drop your FEHB coverage and apply for coverage in the Medicare prepaid plan, please contact us at 301-816-6428.

Healthy Living Programs

In order to maximize your overall health and wellness, we also offer you discounts on acupuncture, massage therapy services, health club memberships, chiropractic care, herbs, vitamins and supplements, and health and fitness books and videos. To search for a health club near you or for more information on these discount programs, visit www.kp.org/choosehealthy.

Health Education Classes

In order to aid members in their quest for better health, the Plan makes available a variety of general health education classes such as prenatal, weight management and stress management classes. To take advantage of these services, a member need only identify himself/herself as a Plan member by showing his/her ID card and pay the providers' fee at the time of service.

Section 6. General exclusions – services, drugs and supplies we do not cover

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

We do not cover the following:

- When a service is not covered, all services, drugs, or supplies related to the non-covered service are excluded from coverage, except services we would otherwise cover to treat complications of the non-covered service
- Fees associated with non-payment (including interest), missed appointments and special billing arrangements.
- Care by non-Medical Group providers, except with prior approval of the Plan, emergencies, travel benefit, or services from other Kaiser Permanente plans (see Emergency services/accidents and Special features)
- Services, drugs, or supplies you receive while you are not enrolled in this Plan
- Services, drugs, or supplies not medically necessary
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants)
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies you receive without charge while in active military service
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program
- Applied Behavior Analysis (ABA)

Section 7. Filing a claim for covered services

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

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

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

Medical, hospital and drug benefits

In most cases, providers and facilities file claims for you. Physicians 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, call us at 1-877-KP4-FEDS (1-877-574-3337) (TTY: 711).

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

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

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

Submit your claims to:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Attention: Claims Department
P.O. Box 6233
Rockville, Maryland 20849-6233

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

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, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent 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 health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit http://kp.org/feds.

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing 2101 East Jefferson Street, Rockville, MD 20852, Attn: Member Services Appeals Unit or calling 1-877-KP4-FEDS (1-877-574-3337) (TTY: 711).

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

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a health care 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 his/her subordinate, who made the initial decision.

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., 2101 East Jefferson Street, Rockville, MD 20852, Attn: Member Services Appeals Unit; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. 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.

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

3

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, Health Insurance 3, 1900 E Street NW, Washington, DC 20415-3630.

Send OPM the following information:

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

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

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care 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 within 60 days. There are no other administrative appeals.

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

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 1-877-KP4-FEDS (1-877-574-3337). We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at (202) 606-0755 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 dependent is covered under this Plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

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

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

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 pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. If we are the secondary payor, and you received your services from Plan providers, we may bill the primary carrier.

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

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.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

- **Medicaid**

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

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

When other Government agencies are responsible for your care

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

When third parties cause illness or injuries

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

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

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

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

To secure our rights, we will have a lien on the proceeds of any judgment or settlement you or we obtain against a third party. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred. We are entitled under our first priority lien to be paid Charges for Services even if you are not "made whole" for all of your damages in the recoveries that you receive. In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay us directly. You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent. You must cooperate in doing what is reasonably necessary to assist us with our right of recovery. You must notify us within 30 days of the date you or someone acting on your behalf notifies anyone, including an insurer or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury or illness. You must not take any action that may prejudice our right of recovery.

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

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

We will reduce our lien pro rata to share in your legal fees and costs under the common fund doctrine. This net lien will not be more than (1) one-third of your total gross recovery from all third-party sources if you engaged an attorney to obtain that recovery; or (2) one-half of such recovery if you did not.

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

Surrogacy Agreements

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

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

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

Kaiser Permanente
Attention: Patient Financial Services
2101 E. Jefferson Street, 4 East
Rockville, MD 20852
Attn: Surrogacy Coordinator

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

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

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

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

Clinical trials

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

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

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

When you have Medicare

- **What is Medicare?**

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983). Otherwise, if you are age 65 or older, or under age 65 and disabled, you may be able to buy it. Contact **1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048)** for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You may enroll in another plan's Medicare Advantage plan to get your Medicare benefits. We offer a Medicare managed care plan, Kaiser Permanente Medicare Plus for Federal Members (Medicare Cost). Please review the information about Medicare managed care plans on page 86 .
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. However, when you are enrolled in Kaiser Permanente Medicare Plus for Federal Members, Part D is included in your plan; no separate premium applies. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at **1-800-772-1213 (TTY: 1-800-325-0778)**.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number **1-800-772-1213 (TTY: 1-800-325-0778)** to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage or another Medicare managed care plan are the terms used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan or another Medicare managed care plan.

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

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

- **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 1-800-KP4-FEDS (1-877-574-3337) (TTY: 711), 7:30 a.m. to 9:00 p.m., Monday through Friday, or visit our website at http://kp.org/feds.

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

- **Tell us about your Medicare coverage**

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

- **Medicare Advantage (Part C)**

  If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage or a Medicare Managed Care plan. These are private health care 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 www.medicare.gov.

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

  This Plan and our Medicare Managed Care plan: We offer a Medicare Managed Care (Medicare Cost) plan known as Kaiser Permanente Medicare Plus for Federal Members. Medicare Plus for Federal Members enhances your FEHB coverage by lowering cost-sharing for some services and/or adding benefits. If you have Medicare Parts A and B, or Medicare Part B only, you can enroll in Medicare Plus for Federal Members with no increase to your FEHB or Kaiser Permanente premium. Your enrollment is in addition to your FEHB High Option or Standard Option enrollment; however, your benefits will be provided under the Kaiser Permanente Medicare Plus for Federal Members plan and are subject to Medicare rules. If you are already a member of Medicare Plus for Federal Members and would like to understand your additional benefits in more detail, please refer to your Medicare Plus for Federal Members Evidence of Coverage. If you are considering enrolling in Medicare Plus for Federal Members, please call us at 301-816-6143 (TTY: 1-866-513-0008), 8:30 a.m. to 5 p.m., Monday through Friday, or visit our website at http://kp.org/feds.

  With Kaiser Permanente Medicare Cost for Federal Members, you'll get more coverage, such as lower cost sharing and better benefits. This 2016 benefit summary allows you to make a side-by-side comparison of your choices:

2016 Benefits and Services	**High Option** You pay	**Standard Option** You pay	**Medicare Cost High Option** You pay	**Medicare Cost Standard Option** You pay
Deductible	None	None	None	None
Primary care	$10	$20	$0	$10
Specialty care	$20	$30	$0	$10
Outpatient surgery	$75	$150	$25	$100
Inpatient hospital care	$100	$250 per day up to $750 maximum per admission	$75	$150
Emergency care	$100	$125	$75	$75
Urgent care	$20	$30	$0	$10
Ambulance	$0	$100	$0	$50
Prescription drugs (up to a 30-day supply at Plan pharmacies)				
- Generic	$7	$12	$3.50	$10
- Preferred brand	$30	$35	$20	$30
- Non-preferred brand	$45	$50	$20	$30
-Specialty	20% up to $100	30% up to $150	20% up to $75	30% up to $125
Eyeglasses and contact lenses (every 24 months)	75% of our allowance	75% of our allowance	75% of our allowance	75% of our allowance
Out-of-pocket maximum				
- Per person	$2,250	$3,500	$2,250	$3,400
- Per family	$4,500	$7,000	$4,500	$7,000

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

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

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

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

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

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

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

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Clinical trials cost categories

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

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See Section 4.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See Section 4.

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.

Covered services

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

Custodial care

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

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See Section 4.

Experimental or investigational service

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

(1) has not been approved by the FDA; or

(2) is the subject of a new drug or new device application on file with the FDA; or

(3) is available as the result of a written protocol that evaluates the service's safety, toxicity, or efficacy; or

(4) is subject to the approval or review of an Institutional Review Board; or

(5) requires an informed consent that describes the service as experimental or investigational.

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

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

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

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

Never event 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.

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

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

Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier Charges for Covered Services out of the payment to the extent of the Covered Services provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Telemedicine	The delivery of health care services, through the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a site other than the site at which the patient is located. Telemedicine does not include audio only telephone conversation, electronic mail message or facsimile transmission between a health care provider and a patient.
Urgent care claims	A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts: • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact our Member Services Department at 1-877-KP4-FEDS (1-877-574-3337). You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.
Us/We	Us and We refer to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
You	You refers to the enrollee and each covered family member.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important Information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP**), provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose Self Only, Self Plus One, or Self and Family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,550 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** - Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

  FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan. (Note: This Plan does not currently participate in FSAFEDS paperless reimbursement. You must submit a manual claim to FSAFEDS with supporting documentation for reimbursement.)
- **Limited Expense Health Care FSA (LEX HCFSA)** - Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA (DCFSA)** - Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1, you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337) (TTY: 1-800-952-0450), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 12-month waiting period. Most **FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.**

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for your choice of either lenses and frames or for contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision. These sites also provide links to each plan’s website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY: 1-877-889-5680).

The Federal Long Term Care Insurance Program - *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHBP plans. Long term care is help you receive to perform activities of daily living - such as bathing or dressing yourself – or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY: 1-800-843-3557), or visit www.ltcfeds.com.

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

Notes

Notes

Notes

Summary of benefits for the High Option of the Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. - 2016

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Medical Group physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	$10 per primary care office visit (nothing from infancy through age 4); $20 per specialty care office visit	27
Services provided by a hospital:		
• Inpatient	$100 per admission	53
• Outpatient	$75 per visit	54
Emergency benefits:		
• In-area and Out-of-area	$100 per visit	58
Mental health and substance abuse treatment:	Regular cost-sharing	60
Prescription drugs:		
• Plan pharmacy	$7 generic; $30 preferred brand-name; $45 non-preferred brand-name; 20% up to $100 specialty	64
• Affiliated network pharmacy	$17 generic; $50 preferred brand-name; $65 non-preferred brand-name; 30% up to $150 specialty.	64
• Mail service delivery	$5 generic; $28 preferred brand-name; $43 non-preferred brand-name; 20% up to $100 specialty.	64
Dental care:	Various copayments based on procedure rendered	68
Vision care:	Eye exam in Optometry; $10 per office visit	37
Special features: Flexible benefits option; 24 hour advice line; Centers of Excellence; Services for the deaf, hard of hearing or speech impaired; Services from other Kaiser Permanente or allied plans; Travel benefit; Rewards		71
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $2,250/Self Only or $4,500/ Family enrollment per year. Some costs do not count toward this protection.	21

Summary of benefits for the Standard Option of the Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. - 2016

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Medical Group physicians, except in emergencies.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	$20 per primary care office visit (nothing from infancy through age 4); $30 per specialty care office visit	27
Services provided by a hospital:		
• Inpatient	$250 per day up to $750 maximum per admission	53
• Outpatient	$150 per visit	54
Emergency benefits:		
• In-area and Out-of-area	$125 per visit	58
Mental health and substance abuse treatment:	Regular cost-sharing	60
Prescription drugs:		
• Plan pharmacy	$12 generic; $35 preferred brand-name; $50 non-preferred brand-name; 30% up to $150 specialty.	64
• Affiliated network pharmacy	$22 generic; $55 preferred brand-name; $70 non-preferred brand-name; 40% up to $200 specialty.	64
• Mail service delivery	$10 generic; $33 preferred brand-name; $48 non-preferred brand-name; 30% up to $150 specialty.	64
Dental care:	Various copayments based on procedure rendered	68
Vision care:	Eye exam in Optometry; $20 per office visit	37
Special features: Flexible benefits option; 24 hour advice line; Centers of Excellence; Services for the deaf, hard of hearing or speech impaired; Services from other Kaiser Permanente or allied plans; Travel benefit; Rewards		71
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $3,500/Self Only or $7,000/ Family enrollment per year. Some costs do not count toward this protection.	21

2016 Rate Information for Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

For 2016 health premium information, please see: http://www.opm.gov/healthcare-insurance/indian-tribes/health-insurance/#url=Premiums or contact your tribe's Human Resources department.