

Kaiser Foundation Health Plan of Colorado

my.kp.org/federalempleyees

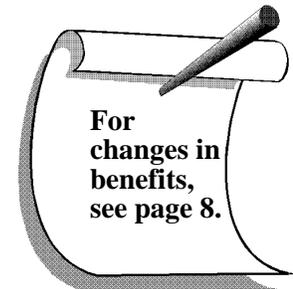


KAISER PERMANENTE®

2007

A Health Maintenance Organization (High and Standard Options)

Serving: *Metropolitan Denver/Boulder and the Colorado Springs areas*



Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 6 for requirements.

*This Plan has excellent accreditation from the NCQA.
See the 2007 Guide for more information on accreditation.*

Enrollment codes for this Plan:

651 High Option Self Only
652 High Option Self and Family

654 Standard Option Self Only
655 Standard Option Self and Family

Authorized for distribution by the:



**United States
Office of Personnel Management**
Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

Important Notice from Kaiser Foundation Health Plan of Colorado About Our Prescription Drug Coverage and Medicare

OPM has determined that Kaiser Foundation Health Plan of Colorado'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. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit 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 or through our Plan mail service delivery program, except in an emergency or urgent care situation.

Remember: If you are an annuitant and you terminate 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 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'll 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 (November 15th through December 31st) 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 users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of Kaiser Foundation Health Plan of Colorado under our contract (CS 1268) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Kaiser Foundation Health Plan of Colorado's administrative office is:

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

This brochure is the official statement of benefits. No oral 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. You do not have a right to benefits that were available before January 1, 2007, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2007, and changes are summarized on page 8. Rates are shown on the last page of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- 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 Colorado.
- 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 first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let us know. Visit OPM’s “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Program, Program Planning & Evaluation Group, 1900 E Street NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits (FEHB) 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 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, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOB) statements that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 303-338-3800 in Denver/Boulder or 1-888-681-7878 in Colorado Springs and explain the situation.

If we do not resolve the issue:

**CALL - THE HEALTH CARE FRAUD HOTLINE
202-418-3300**

OR WRITE TO:

**United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC20415-1100**

- 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); or
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- 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.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

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 that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- 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 you are taking.

Visit these Web sites for more information about patient safety.

- www.ahrq.gov/path/beactive.htm. 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.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1 Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of our 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. Our providers follow generally accepted medical practice when prescribing any course of treatment.

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

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

General features of our High and Standard Options

How we pay providers

We contract with the Colorado Permanente Medical Group (Plan physicians) in the Denver/Boulder area to provide care in our Plan Medical Offices and network physicians (Plan physicians) in the Colorado Springs area. These Plan physicians are paid in a number of ways, including salary, capitation, per diem rates, case rates, fee-for-service, and incentive payments, for services they provide and services that are referred. If you would like further information about the way we pay Plan physicians to provide or arrange medical and hospital care in your service area, please call Member Services at 303-338-3800, or for Colorado Springs members, 1-888-681-7878.

Language Interpretation Services

Interpreters are available to assist members who do not speak English. For free language interpretation services, or information about providers who speak foreign languages, call 303-338-3800 (Denver/Boulder members) or 1-888-681-7878 (Colorado Springs members).

Your rights

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

We have provided health care services to the Denver, Colorado area since 1969. Kaiser Foundation Health Plan of Colorado is a Colorado not-for-profit organization. This Plan is part of the Kaiser Permanente Medical Care Program, a group of not-for-profit organizations and contracting medical groups that serve over 8 million members nationwide. Our Medical Group, the Colorado Permanente Medical Group, P.C., (a for-profit Colorado corporation) operates Plan medical offices in the Denver/Boulder area. For the Colorado Springs area, we offer you services through participating providers.

If you want more information about us, call Member Services at 303-338-3800 for Denver members or 1-888-681-7878 for Colorado Springs members, or write to Kaiser Foundation Health Plan of Colorado, Member Services, 2500 South Havana Street, Aurora, Colorado 80014-1622. You may also visit our Web site at my.kp.org/federalemplee.

Service Area

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

Denver/Boulder. These zip codes in Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld counties: 80001-7, 80010-22, 80024-28, 80030-31, 80033-34, 80036-38, 80040-42, 80044-47, 80102, 80104, 80107-12, 80116-17, 80120-31, 80134-35, 80137-38, 80150-51, 80154-55, 80160-63, 80201-12, 80214-39, 80241, 80243-44, 80246-52, 80255-56, 80259-66, 80270-71, 80273-75, 80279-81, 80290-95, 80299, 80301-10, 80314, 80321-23, 80328-29, 80401-3, 80421-22, 80425, 80427, 80433, 80437, 80439, 80452-55, 80457, 80465-66, 80470-71, 80474, 80481, 80501-4, 80510, 80513-14, 80516, 80520, 80530, 80533-34, 80537-40, 80542-44, 80601-3, 80614, 80621, 80623, 80640, 80642-43, 80651.

Colorado Springs. These zip codes in Douglas, El Paso, Fremont, Park and Teller counties: 80106, 80118, 80132-33, 80808-09, 80813-14, 80816-17, 80819-20, 80827, 80829, 80831-33, 80840-41, 80860, 80863-64, 80866, 80901, 80903-22, 80925-26, 80928-37, 80940-47, 80949-50, 80960, 80962, 80970, 80977, 80995, 80997, 81007-08, 81212, 81240.

Ordinarily, you must receive your care from physicians, hospitals, and other providers who contract with us. However, we are part of the Kaiser Permanente Medical Care Program, and if you are visiting another Kaiser Permanente or allied plan service area, you can receive visiting member care from designated providers in that area. See Section 5(g), 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(g); and for emergency care obtained from any non-Plan provider, as described in Section 5(d). 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 How we change for 2007

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

Changes to this Plan

Changes to both High and Standard Options

- We revised the amount you pay and services that are covered when you temporarily visit another Kaiser Permanente or Allied Plan (see page 60).

Changes to High Option only

- Your share of the non-Postal premium will increase by 22.8% for Self Only or increase by 11.0% for Self and Family.
- Your copayment for primary care office visits has increased to \$20 per visit. Group mental health and substance abuse office visits have increased to \$10 (see pages 19 – 29 and 42 – 43).
- Your copayment for chiropractic visits has increased to \$20 per visit (see page 29).
- Your copayment for routine screening colonoscopies has increased to \$100 per procedure (see page 20).
- You now pay \$100 per procedure for epidural steroid injections (see page 30).
- You now pay a \$100 copayment for special procedures (MRIs, CAT scans, PET scans and nuclear medicine) performed in a hospital emergency room, in addition to paying your emergency room copayment. The copayment for special procedures performed in a hospital emergency room will be waived if you are admitted to the hospital as an inpatient (see pages 20 and 39).

Changes to Standard Option only

- Your share of the non-Postal premium will increase by 20.3% for Self Only or increase by 16.8% for Self and Family.
- Your copayment for primary care office visits has increased to \$25 per visit. Your copayment for specialty care office visits has increased to \$45 per visit. Group mental health and substance abuse office visits have increased to \$13 (see pages 19 – 29 and 42 – 43).
- Your copayment for chiropractic visits has increased to \$25 per visit (see page 29).
- Your copayment for routine screening colonoscopies has increased to 20% of our allowance after you have met your calendar year deductible (see page 20).

Section 3 How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the 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 Member Services. Member Services' numbers for ID issues are: Denver/Boulder: 303-338-3800, 303-338-3820 (TTY/TDD), and 1-800-632-9700 (toll-free). In Colorado Springs, the number is: 1-888-681-7878. Member Services hours are Monday – Friday, 8:00 a.m. – 5:00 p.m. (MST). Members with ID card issues can write to: Kaiser Foundation Health Plan of Colorado, Member Services, 2500 South Havana Street, Aurora, Colorado 80014-1622. You may also request replacement cards through our Web site at my.kp.org/federalempleyees.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, coinsurance, or deductibles and you will not have to file claims.

- **Plan providers**

Denver/Boulder area: We contract with the Colorado Permanente Medical Group, P.C., to provide or arrange all necessary health care services. Physicians, including specialists, and other health care professionals such as nurse practitioners, physician assistants, and other skilled medical personnel working as medical teams at our Plan facilities provide your medical care. You also receive other necessary medical services, such as physical therapy, laboratory and X-ray services at our Plan facilities.

We list Plan physicians in our provider directory, which we update periodically. The list is also on our Web site, my.kp.org/federalempleyees.

Colorado Springs area: We contract, through the Colorado Permanente Medical Group, P.C., with a panel of affiliated primary care physicians, specialists, and other health care professionals to provide medical services. You can identify these physicians, along with a listing of affiliated specialists and ancillary providers in the Affiliated Practitioner Directory. You may obtain a copy by calling Member Services at 1-888-681-7878 or going to our Web site, my.kp.org/federalempleyees and clicking on "locate our services", then on Colorado Springs.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in our provider directory, which we update periodically. The list is also on our Web site, my.kp.org/federalempleyees.

Denver/Boulder area: We offer health care at 17 Plan medical offices conveniently located throughout the Denver/Boulder metropolitan area. We list these in the provider directory, which we update periodically. The list is also on our Web site.

Colorado Springs area: When you select your primary care physician, you will receive your services at that physician's office.

You must receive your health services at affiliated Plan facilities, except if you have an emergency. 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(g), Special Features, for more details. Under the circumstances specified in this brochure, you may receive follow-up or continuing care while you travel anywhere.

What you must do to get covered care

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

Denver/Boulder area: Choose your primary care physician from our provider directory. If you want to receive care from a specific physician who is listed in the directory, call the physician to verify that he or she still participates with the Plan and is accepting new patients.

Colorado Springs area: Choose your primary care physician from our panel of affiliated primary care physicians. Our affiliated physicians, both primary care and specialists, are listed in the Affiliated Practitioner Directory. You may obtain a copy by calling Member Services at 1-888-681-7878 or by going to our Web site, my.kp.org/federalemmployees and clicking on "Affiliated Practitioner Directory".

- **Primary care**

Your primary care physician can be a family practitioner, internist or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist. We cover specialists' services only when your primary care physician refers you.

Note that your primary care copayment may apply to other providers, such as geriatricians, obstetricians and gynecologists (Denver/Boulder only), osteopaths and optometrists.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

In Colorado Springs, you may change your primary care physician at any time. Call Member Services at 1-888-681-7878. Notify us of your new primary care physician choice by the 15th day of the month. Your selection will be effective on the first day of the following month.

- **Specialty care**

You pay a different copayment for your specialty care.

To contact or make an appointment with a specialist:

- **Denver/Boulder area:** You may self-refer for consultation (routine office) visits to specialty care departments within the Plan with the exception of the anesthesia clinical pain department. You will find the Plan specialists eligible to receive self-referrals listed in the Member Resource Guide which is available on our Web site, my.kp.org/federalemmployees, by clicking on "Members", "Search our Medical Staff Directory", "Your Plan", then "Forms and publications". You may obtain a paper copy of the Member Resource Guide by calling **Member Services** at **303-338-3800**.

You are required to obtain a written authorization for laboratory or radiology services and for specialty procedures such as a CAT scan, MRI, colonoscopy or surgery. A written authorization is also required for specialty care visits to non-Plan physicians.

- **Colorado Springs area:** You may self-refer for consultation (routine office) visits to Plan specialists identified as eligible to receive self-referrals. You will find the specialists eligible to receive self-referrals listed in the Affiliated Practitioner Directory which is available on our Web site, my.kp.org/federalemmployees, by clicking on "Members", "Search our Medical Staff Directory", "Your Plan", then "Forms and publications". You may obtain a paper copy of the directory by calling **Member Services** at **1-888-681-7878**.

A self-referral provides coverage for routine visits only. A written authorization from the Plan is required for: (i) services in addition to those provided as part of the visit, such as surgery; and (ii) visits to Plan specialists not eligible to receive self-referrals; and (iii) non-Plan specialists. Colorado Springs members may not self-refer to Plan specialists in the Denver/Boulder area. Services other than routine office visits with a Plan specialist eligible to receive self-referrals will not be covered unless authorized by the Plan before you receive the services.

- If you have an ongoing care plan with a specialist, you may make appointments directly with the specialist's office.
- You may see a gynecologist, an optometrist, or our mental health and substance abuse Plan providers without a referral. You may make appointments directly with these providers.

Here are other things you should know about specialty care:

- A referral for specialty care services may be requested by either your primary care physician or by a specialist. You will receive a written authorization in the mail. This authorization will tell you the specialist's name, address and phone number. It will also tell you the time period that the authorization is valid and the services authorized.
- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician may develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan.
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - 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 days.

- **Hospital care**

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

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

If you are in the hospital when your enrollment in our Plan begins, for Denver/Boulder members, call Member Services immediately at 303-338-3800, or for Colorado Springs members, 1-888-681-7878. If you are new to the FEHB Program, we will arrange for you to receive care and reimburse you for your covered expenses 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; or
- 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.

Circumstances beyond our control

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

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. However, for certain services, such as bariatric surgery, oral and maxillofacial surgery, reconstructive surgery, DME, and pulmonary rehabilitation, your physician must obtain approval from us.

We call this review and approval process "preauthorization." Preauthorization is the process of collecting information so we can determine coverage, eligibility, medical appropriateness, and benefit limitations.

Preauthorization determinations are made based on the information available at the time the service or procedure is requested.

Registered nurses perform the first level of review using nationally recognized guidelines and resources, as well as our own internal guidelines and policies. The nurse coordinates with the requesting physician in evaluating the medical appropriateness of the service or procedure. The Utilization Management nurse will approve cases that meet our criteria. If the nurse is unable to approve the services based on the application of our criteria, the Medical Director will review the matter. If the Medical Director approves, you will receive the service. If the Medical Director denies the service we send a denial letter to your physician and you.

Section 4 Your cost for covered services

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

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: When you see your primary care physician, you pay a copayment of \$ 25 per office visit (Standard Option plan) or \$ 20 per office visit (High Option plan).

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them.

The calendar year deductible is \$500 per person under Standard Option. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach \$1,500 under Standard Option. There is a separate Standard Option plan calendar year pharmacy deductible of \$100 per person (see “Pharmacy deductible” below).

The High Option plan has no deductible except for the dental deductible (see “Dental deductible” below).

Pharmacy deductible

A pharmacy deductible is a fixed expense you must incur for certain prescribed drugs before we start paying benefits for prescription drugs.

The calendar year pharmacy deductible is \$100 per person under Standard Option. The High Option plan has no pharmacy deductible.

Once the calendar year pharmacy deductible of \$100 (Standard Option plan) is met, you pay your applicable prescription drug copayment.

Each of your covered family members must meet their individual calendar year pharmacy deductible before we pay any prescription drug benefit. This pharmacy deductible is calculated on a calendar year basis and does not carry-over from year to year. Once your pharmacy deductible has been met, you will pay your prescription drug copayment. If you are filling multiple prescriptions or refills, the deductible will be calculated in the order processed.

Dental deductible

A dental deductible is a fixed expense you must incur for Basic and Major dental services before we start paying benefits for those dental services.

The calendar year dental deductible is \$50 per person under High Option. Under a family enrollment, the dental deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year dental deductible for family members reach \$150 under High Option. The dental deductible does not apply to Diagnostic and Preventive dental services.

The Standard Option plan does not cover dental services, apart from accidental injury. The accidental injury benefit is subject to the Standard Option plan’s deductible.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for certain services you receive.

Example: In our Plan, you pay 50% of our allowance for infertility services.

Fees when you fail to make your copayment

If you do not pay your copayment at the time you receive services, we will bill you. You will be required to pay a \$10 charge for each bill sent for unpaid services. In Colorado Springs, affiliated physician offices may bill you an additional charge along with any unpaid copayments.

Note: Affiliated physician offices and other providers and facilities may bill you an additional charge along with any unpaid copayments, coinsurance or for missed appointments that you fail to cancel.

Your catastrophic protection out-of-pocket maximum

After your copayments and coinsurance total \$2,000 per person or \$4,000 per family enrollment (Standard Option plan) or \$2,000 per person or \$4,500 per family enrollment (High Option plan) in any calendar year, you do not have to pay any more for covered services. 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.

- Office visit copayments (Standard Option only)
- Prescription drugs
- Dental services
- Chiropractic services
- Extended care services
- Durable medical equipment
- External prostheses and braces
- The \$25 charges paid for follow-up or continuing care outside the service area

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

Copayments and coinsurance you pay for the following services are subject to your Standard Option deductible and to your out-of-pocket maximum for both Standard Option and High Option:

- Professional procedures received during an office visit and inpatient admission
- Diagnostic and therapeutic X-ray services
- Special diagnostic procedures such as CT, PET, MRI, and nuclear medicine
- Treatment therapies: chemotherapy, radiation therapy, respiratory and inhalation therapy
- Dialysis services
- Cardiac rehabilitation
- Home health services
- Outpatient surgery services
- Outpatient surgery facility services
- Hospice services
- Emergency services
- Urgent care procedures received after hours

For these services, you must pay full charges when you receive the service, until you meet the deductible. The only payments that count toward the deductible are those you make for services that are subject to the deductible, but only if the services would otherwise be covered. Any payments that you make toward the deductible for services you receive during the last three months of a calendar year will also apply toward the deductible for the next calendar year.

After you meet the deductible, you pay the applicable coinsurance for these covered services for the rest of the calendar year, subject to the limits described under “Your catastrophic protection out-of-pocket maximum.”

Please note: Payments made for prescription drugs will be applied only to the Standard Option pharmacy deductible and accumulate separately from the deductible for covered medical services described above. The High Option plan does not have a pharmacy deductible.

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.

High and Standard Option Benefits

See page 8 for how our benefits changed this year. Page 73 and page 74 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.

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Section 5 High and Standard Option Benefits Overview

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

The High and Standard Option Section 5 is divided into subsections. Please read the 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 303-338-3800 or at our Web site at my.kp.org/federalemployees.

Kaiser Foundation Health Plan of Colorado has been a leader in offering high quality integrated health care to FEHB for more than 37 years. This plan has an NCQA accreditation of excellent and has been ranked in the Top 10 health plans by the NCQA for quality of care and effectiveness. We are the only health plan in Colorado with a fully integrated network supported by an electronic medical record system.

• High Option

Our High Option provides the most comprehensive benefits. Our FEHB High Option includes:

- \$ 20 primary care and \$30 specialty care office visit copayments
- Inpatient hospital services covered at \$250 per admission
- Outpatient hospital services covered at \$100 per surgery
- Key preventive services at no charge, including annual well-checks for adults and children, routine mammograms, pre/post-natal office visits and childhood immunizations
- \$10 generic and \$25 brand-name prescription drug copayments
- Dental plan with the flexibility to see any provider
- An out-of-area student benefit, limited to \$1,200 each calendar year, which provides coverage for full-time college students attending an accredited institution outside any Kaiser Permanente service area. Routine, continuing and follow-up medical care is covered upon payment of 20% coinsurance of the usual and customary charges.

• Standard Option

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

- Calendar year deductible of \$500 per person and \$1,500 per family; separate calendar year pharmacy deductible of \$100 per person
- \$ 25 primary care and \$ 45 specialty care office visit copayments
- Inpatient hospital services covered at \$250 per day up to \$750 per admission
- Outpatient hospital services covered at 20% of our allowance after you have met your calendar year deductible
- Key preventive services at no charge, including annual well-checks for adults and children, routine mammograms, pre/post-natal office visits and childhood immunizations
- \$15 generic and \$35 brand-name prescription drug copayments after you have met your calendar year pharmacy deductible
- An out-of-area student benefit, limited to \$1,200 each calendar year, which provides coverage for full-time college students attending an accredited institution outside any Kaiser Permanente service area. Routine, continuing and follow-up medical care is covered upon payment of 20% coinsurance of the usual and customary charges.

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.
- Plan physicians must provide or arrange your care.
- The Standard Option plan's calendar year deductible is \$500 per person and \$1,500 per family. The calendar year deductible applies to almost all benefits in this Section. We added "(No Deductible)" to show when the calendar year deductible does not apply.
- There is no deductible for the High Option plan.
- 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.
- Different copayments apply for primary care visits and specialty care visits. Please refer to Section 10, Definitions, to learn more about when your primary and specialty care copayments will apply.

Benefit Description	You pay After the calendar year deductible...	
Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.		
Diagnostic and treatment services	High Option	Standard Option
Professional services of physicians and other health care professionals <ul style="list-style-type: none"> • In a physician’s office • Office medical consultations • Second surgical opinion • Initial examination of a newborn child covered under a family enrollment 	\$20 per visit to your primary care provider \$30 per visit to a specialist	\$ 25 per visit to your primary care provider \$ 45 per visit to a specialist (No Deductible)
Professional services of physicians and other health care professionals <ul style="list-style-type: none"> • In an urgent care center 	\$50 per visit	\$50 per visit (No Deductible)
Professional services of physicians and other health care professionals <ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility 	Nothing	20% of our allowance after you have met your calendar year deductible
At home	Nothing	20% of our allowance after you have met your calendar year deductible
Procedures received during an office visit	Nothing	20% of our allowance after you have met your calendar year deductible

Benefit Description	You pay After the calendar year deductible...	
Lab, X-ray and other diagnostic tests	High Option	Standard Option
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology 	Nothing	Nothing
X-rays and other imaging, such as: <ul style="list-style-type: none"> • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG 	Nothing	20% of our allowance after you have met your calendar year deductible
Special procedures: <ul style="list-style-type: none"> • MRI • CAT scans • PET scans • Nuclear medicine 	\$100 per outpatient procedure	20% of our allowance after you have met your calendar year deductible
Preventive care, adult	High Option	Standard Option
Routine screenings, such as: <ul style="list-style-type: none"> • Blood lead level • Total blood cholesterol • Colorectal cancer screening, including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 Notes: <ul style="list-style-type: none"> • You should consult with your physician to determine what is appropriate for you. • You will pay only one copayment if you receive your routine screening on the same day as your office visit. 	Nothing, except you pay \$100 per colonoscopy screening	Nothing, except you pay 20% of our allowance after you have met your calendar year deductible for colonoscopy screenings
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing	Nothing
Routine Pap test	Nothing	Nothing
Routine mammogram – covered for women age 35 and older, as follows:	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Preventive care, adult (cont.)		
<ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years <p>Note: In addition to routine screening, we cover mammograms when medically necessary to diagnose or treat your illness.</p>	Nothing	Nothing
<p>Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):</p> <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older 	Nothing	Nothing
<p><i>Not covered:</i></p> <p><i>Physical exams required for:</i></p> <ul style="list-style-type: none"> • <i>Obtaining or continuing employment</i> • <i>Insurance</i> • <i>Attending schools or camp</i> • <i>Travel immunizations</i> 	<i>All charges.</i>	<i>All charges.</i>
Preventive care, children		
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics • Well-child care including routine examinations and immunizations • Examinations, such as: <ul style="list-style-type: none"> - Eye exams through age 17 to determine the need for vision correction - Hearing tests through age 17 to determine the need for hearing correction 	Nothing	Nothing
<p><i>Not covered:</i></p> <p><i>Physical exams required for:</i></p> <ul style="list-style-type: none"> • <i>Obtaining or continuing employment</i> • <i>Insurance</i> • <i>Attending schools or camp</i> • <i>Travel immunizations</i> 	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Maternity care		
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Your physician will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Section 5(c) for hospital benefits and Section 5(b) for surgery benefits. 	<p>Nothing for prenatal and postnatal visits</p> <p>Nothing for inpatient professional delivery services</p>	<p>Nothing for prenatal and postnatal visits</p> <p>20% of our allowance for inpatient professional delivery services after you have met your calendar year deductible</p>
<i>Not covered: Routine sonograms to determine fetal age, size, or sex</i>	<i>All charges.</i>	<i>All charges.</i>
Family planning		
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Family planning services including counseling • Voluntary sterilization (See Surgical procedures Section 5 (b)) <p>Note: We cover surgically implanted time-release contraceptive drugs, contraceptive drugs, intrauterine devices (IUDs), and diaphragms under the prescription drug benefit.</p>	<p>\$20 per visit to your primary care provider</p> <p>\$30 per visit to a specialist</p>	<p>\$25 per visit to your primary care provider</p> <p>\$45 per visit to a specialist</p> <p>(No Deductible)</p>
<i>Not covered:</i>	<i>All charges.</i>	<i>All charges.</i>
<ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling</i> 		
Infertility services		
<p>Medical services for diagnosis of involuntary infertility.</p> <p>Treatment of involuntary infertility including artificial insemination limited to intrauterine insemination (IUI).</p>	<p>50% of our allowance</p>	<p>50% of our allowance</p> <p>(No Deductible)</p>
<i>Not covered:</i>	<i>All charges.</i>	<i>All charges.</i>

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Infertility services (cont.)	High Option	Standard Option
<p><i>These exclusions apply to fertile as well as infertile individuals or couples:</i></p> <ul style="list-style-type: none"> • <i>Intravaginal insemination (IVI)</i> • <i>Intra-cervical insemination (ICI)</i> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>in vitro fertilization</i> - <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost of donor sperm and donor eggs and services related to their procurement and storage</i> • <i>Drugs related to infertility treatment</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Allergy care	High Option	Standard Option
<p>Allergy evaluation and testing</p>	<p>\$30 per visit</p>	<p>\$45 per visit (No Deductible)</p>
<p>Allergy treatment and injections</p>	<p>\$20 per visit</p>	<p>\$25 per visit (No Deductible)</p>
<p>Allergy serum</p>	<p>Nothing</p>	<p>Nothing</p>
Treatment therapies	High Option	Standard Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: We limit high dose chemotherapy in association with autologous bone marrow transplants to those transplants listed under Organ/tissue transplants.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis <p>Notes:</p> <ul style="list-style-type: none"> • We waive office visit charges for dialysis if you enroll in Medicare Part B and assign your Medicare benefits to us. • Intravenous (IV)/Infusion Therapy – we cover home IV and antibiotic therapy and growth hormone therapy (GHT) under the Prescription Drug benefit. 	<p>\$30 per visit</p>	<p>20% of our allowance after you have met your calendar year deductible</p>
<p><i>Not covered: Chemotherapy supported by a bone marrow transplant or with stem cell support, for any diagnosis not listed as covered</i></p>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Benefit Description	You pay After the calendar year deductible...	
Physical and occupational therapies	High Option	Standard Option
<p>You receive two consecutive months of therapy per condition if, in the judgment of a Plan physician, significant improvement is achievable within a two-month period.</p> <ul style="list-style-type: none"> Physical therapy by qualified physical therapists to restore bodily function when you have a total or partial loss of bodily function due to illness or injury Occupational therapy by occupational therapists to assist you in achieving and maintaining self-care and improved functioning in other activities of daily life <p>Note: We may continue your therapy for up to 20 outpatient visits per therapy per condition if you have not received 20 or more outpatient visits during the two-month period that began with your first therapy visit.</p>	\$20 per outpatient visit	\$25 per outpatient visit (No Deductible)
<p>Cardiac rehabilitation in a secondary prevention program for coronary artery disease (CAD) that includes case management by registered nurses, promotes home self-monitored exercise, and offers educational sessions in the following areas: diet, exercise, risk factor modification, psycho-social support, medications, stress management, CPR training for friends and family, and drop-in recovery groups. The cardiac rehabilitation program also features lipid management, tobacco cessation counseling, and personalized exercise recommendations.</p>	\$30 per visit	20% of our allowance after you have met your calendar year deductible
<ul style="list-style-type: none"> Physical and occupational therapy while you are an inpatient in a Plan hospital if, in the judgment of a Plan physician, significant improvement is achievable within a two-month period. 	Nothing	20% of our allowance after you have met your calendar year deductible
<ul style="list-style-type: none"> Treatment in an organized, multidisciplinary rehabilitation services program in a designated facility or a skilled nursing facility if, in the judgment of a Plan physician, significant improvement is achievable within a two-month period. <p>Up to 60 days per medical episode</p>	Nothing	20% of our allowance after you have met your calendar year deductible
<p>Pulmonary rehabilitation. The program consists of:</p> <ul style="list-style-type: none"> Initial evaluation 6 education sessions 12 exercise sessions A final evaluation 	\$5 per visit	\$5 per visit (No Deductible)

Physical and occupational therapies - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Physical and occupational therapies (cont.)	High Option	Standard Option
<p>Note: You must complete the course within a two to three-month period.</p>	\$5 per visit	<p>\$5 per visit (No Deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<i>All charges.</i>	<i>All charges.</i>
Speech therapy	High Option	Standard Option
<p>Two consecutive months of therapy per condition:</p> <ul style="list-style-type: none"> • Speech therapy by speech therapists when medically necessary <p>Note: We may continue your therapy for up to 20 outpatient visits per therapy per condition if you have not received 20 or more outpatient visits during the two-month period that began with your first therapy visit.</p>	<p>\$20 per outpatient visit</p> <p>Nothing for inpatient therapy</p>	<p>\$ 25 per outpatient visit</p> <p>(No Deductible for outpatient visits)</p> <p>20% of our allowance for inpatient therapy after you have met your calendar year deductible</p>
<p><i>Not covered:</i></p> <p><i>Speech therapy that is not medically necessary such as:</i></p> <ul style="list-style-type: none"> • <i>Therapy for educational placement or other educational purposes</i> • <i>Therapy for tongue thrust in the absence of swallowing problems</i> 	<i>All charges.</i>	<i>All charges.</i>
Hearing services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> • Hearing testing to determine the need for hearing correction 	<p>\$20 per visit to your primary care provider</p> <p>\$30 per visit to a specialist</p>	<p>\$25 per visit to your primary care provider</p> <p>\$45 per visit to a specialist</p> <p>(No Deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>All other hearing testing</i> • <i>Hearing aids, including testing and examinations for them</i> 	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Vision services (testing, treatment, and supplies)		
<ul style="list-style-type: none"> • Diagnosis and treatment of diseases of the eye • Eye exam to determine the need for vision correction for children through age 17 (see Preventive care, children) • Eye refractions to provide a written lens prescription for eyeglasses only 	\$20 per visit to your primary care provider \$30 per visit to a specialist	\$25 per visit to your primary care provider \$45 per visit to a specialist (No Deductible)
<i>Not covered:</i> <ul style="list-style-type: none"> • Corrective eyeglass lenses or frames • Contact lenses, examinations for contact lenses or the fitting of contact lenses • Eye exercises • Radial keratotomy and other refractive surgery 	<i>All charges.</i>	<i>All charges.</i>
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.	\$20 per visit to your primary care provider	\$25 per visit to your primary care provider (No Deductible)
<i>Not covered:</i> <ul style="list-style-type: none"> • 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 of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery) 	<i>All charges.</i>	<i>All charges.</i>
Orthopedic and prosthetic devices	High Option	Standard Option
When prescribed by a Plan physician, we cover internal prosthetic devices, such as: <ul style="list-style-type: none"> • Artificial joints • Pacemakers • Cochlear implants • Surgically implanted breast implant following mastectomy Note: See Section 5(b) for coverage of the surgery to insert the device.	Nothing	Nothing
When prescribed by a Plan physician, we cover: <ul style="list-style-type: none"> • Artificial legs and arms 	20% of our allowance	20% of our allowance (No Deductible)
<ul style="list-style-type: none"> • Artificial eyes and stump hose 	20% of our allowance which is \$2,000 per calendar year. You pay all charges thereafter.	20% of our allowance which is \$2,000 per calendar year. You pay all charges thereafter.

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Orthopedic and prosthetic devices (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome 	20% of our allowance which is \$2,000 per calendar year. You pay all charges thereafter.	20% of our allowance which is \$2,000 per calendar year. You pay all charges thereafter.
<p>Notes:</p> <ul style="list-style-type: none"> We will pay no more than \$2000 per year. The \$2000 limit does not apply to artificial arms and legs. We cover only those standard items that are adequate to meet the medical needs of the member These items are covered only when preauthorized in writing by the Plan and when obtained through sources designated by the Plan. 		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Comfort, convenience, or luxury equipment or features</i> <i>Orthopedic and corrective shoes</i> <i>Podiatric use devices and arch supports</i> <i>Foot orthotics</i> <i>Dental prostheses, devices, and appliances</i> <p><i>Note: We will provide medically necessary orthodontic and prosthodontic treatment for cleft lip or cleft palate for the repair of congenital anomalies, unless these services are covered under a dental insurance policy.</i></p> <ul style="list-style-type: none"> <i>Spare or alternate use devices</i> <i>Replacement of lost prosthetic and orthotic devices</i> <i>Repairs, adjustments, or replacements because of misuse</i> <i>Devices, equipment, and prosthetics related to treatment of sexual dysfunction</i> 	<i>All charges</i>	<i>All charges.</i>
Durable medical equipment (DME)	High Option	Standard Option
<p>When prescribed by a Plan physician, we cover rental or purchase of durable medical equipment intended to be used repeatedly and in the home, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> Oxygen Insulin pumps for Type 1 diabetes 	20% of our allowance	20% of our allowance (No Deductible)

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Durable medical equipment (DME) (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Oxygen equipment • Dialysis equipment • Infant apnea monitors • Hospital beds • Wheelchairs, including motorized wheelchairs when medically necessary • Crutches • Walkers • Commodes • Respirators • Blood glucose monitors • Repair and adjustment 	<p>20% of our allowance which is \$2,000 per calendar year. You pay all charges thereafter.</p>	<p>20% of our allowance which is \$2,000 per calendar year. You pay all charges thereafter.</p>
<p>Notes:</p> <ul style="list-style-type: none"> • We will pay no more than \$2000 per year for all DME. Oxygen and insulin pumps are not subject to the \$2000 limit. When outside the service area, you must obtain your oxygen supplies and services from Apria. • We cover only those standard items that are adequate to meet the medical needs of the member. • We use a DME formulary to determine which items will be provided to members. • These items are covered only when preauthorized in writing by the Plan and when obtained through sources designated by the Plan. 		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Comfort, convenience, or luxury equipment or features</i> • <i>Devices, equipment, supplies, and prosthetics related to the treatment of sexual dysfunction</i> • <i>Electric monitors of bodily functions</i> • <i>Devices to perform medical testing of bodily fluids, excretions, or substances</i> • <i>Devices not medical in nature such as whirlpools, saunas, elevators, convenience, or comfort items</i> • <i>Disposable supplies</i> • <i>Replacement of lost equipment</i> • <i>Repair, adjustments, or replacements because of misuse</i> • <i>More than one piece of durable medical equipment serving essentially the same function, except for replacements</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Durable medical equipment (DME) (cont.)		
<ul style="list-style-type: none"> <i>Spare or alternate use equipment</i> 	<i>All charges.</i>	<i>All charges.</i>
Home health services		
<p>If you are homebound and reside in the service area:</p> <ul style="list-style-type: none"> You may receive home health services of nurses and health aides, physical or occupational therapists, and speech and language pathologists Services include oxygen therapy, intravenous therapy, and medications <p>Note: The services are covered only if a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home.</p>	Nothing	20% of our allowance after you have met your calendar year deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Custodial care</i> <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> <i>Homemaker services</i> <i>Home health care that a Plan physician determines may appropriately be provided in a Plan facility, skilled nursing facility or other facility we designate and we provide or offer to provide that care in one of these facilities</i> <i>Services outside our service area</i> 	<i>All charges.</i>	<i>All charges.</i>
Chiropractic		
<p>Chiropractic services, limited to 20 visits per calendar year, including:</p> <ul style="list-style-type: none"> Evaluation Associated laboratory X-ray services Treatment of musculoskeletal disorders <p>Note: You may self-refer to one of our participating chiropractors. For a list of participating chiropractors contact Columbine Health Plan at 303-825-7526 or toll free at 1-800-915-7526.</p>	\$20 per office visit	\$25 per office visit (No Deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Treatment for non-neuroskeletal disorders</i> <i>Vocational rehabilitation services</i> <i>Thermography</i> <i>Transportation costs, including ambulance</i> 	<i>All charges.</i>	<i>All charges.</i>

Chiropractic - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Chiropractic (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Prescription drugs, vitamins, minerals, nutritional supplements, or other similar type products • MRI or other types of diagnostic radiology • Durable medical equipment or supplies for use in the home 	<i>All charges.</i>	<i>All charges.</i>
Alternative treatments	High Option	Standard Option
No benefit	<i>All charges.</i>	<i>All charges.</i>
Educational classes and programs	High Option	Standard Option
Health education services and education in the appropriate use of Health Plan services	\$20 per visit to your primary care provider \$30 per visit to a specialist	\$25 per visit to your primary care provider \$45 per visit to a specialist (No Deductible)
Health education classes, such as smoking cessation, stress reduction, or weight control	The specific charge we set for the class you select	The specific charge we set for the class you select

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 we cover them only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care. Consult with your physician to determine what is appropriate for you. Services may be covered provided that established Plan physicians' criteria are met.
- The Standard Option plan's calendar year deductible is \$500 per person and \$1,500 per family. The calendar year deductible applies to almost all benefits in this Section. We added "(No Deductible)" to show when the calendar year deductible does not apply.
- There is no deductible for the High Option plan.
- 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 a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION OF SOME SURGICAL PROCEDURES.** Please refer to the pre-authorization information shown in Section 3 to be sure which services require authorization and identify which surgeries require pre-authorization.

Benefit Description	You pay After the calendar year deductible...	
Note: The Standard Option plan's calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply		
Surgical procedures	High Option	Standard Option
A comprehensive range of services, such as: <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Pre-surgical testing • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Epidural steroid injections • Surgical treatment of morbid obesity (bariatric surgery): You must be between the ages of 18 and 65 years and have either (1) a body mass index (BMI) of 50 or greater or (2) a BMI of 35 up to 49.9 when a combination of the following serious or life threatening conditions are also present: <ul style="list-style-type: none"> - Sleep apnea 	\$100 for outpatient surgery Nothing for inpatient surgery See Section 5(c) for facility charges.	20% of our allowance per outpatient and inpatient surgery procedure after you have met your calendar year deductible See Section 5(c) for facility charges.

Surgical procedures - continued on next page
High and Standard Option Section 5(b)

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Surgical procedures (cont.)		
<ul style="list-style-type: none"> - Diabetes - Degenerative joint disease leading to surgery - Hypertension - Swelling of legs and feet with ulceration <p>Note: You will need to meet the above qualifications before your Plan provider will refer you to our bariatric surgery program. This program may refer you to other Plan providers to determine if you meet the additional criteria necessary for bariatric surgery, including nutritional, psychological, medical and social readiness for surgery. Final approval for surgical treatment will be required from the Colorado Permanente Medical Group's designated physician.</p> <p>See Services requiring our prior approval in Section 3.</p> <ul style="list-style-type: none"> • Insertion of internal prosthetic devices. See Section 5(a) Orthopedic and prosthetic devices for coverage information. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) 	<p>\$100 for outpatient surgery</p> <p>Nothing for inpatient surgery</p> <p>See Section 5(c) for facility charges.</p>	<p>20% of our allowance per outpatient and inpatient surgery procedure after you have met your calendar year deductible</p> <p>See Section 5(c) for facility charges.</p>
<ul style="list-style-type: none"> • Surgically implanted time-release contraceptive drugs and intrauterine devices (IUDs). Note: Drugs and devices are covered under Section 5(f). • Other implanted time-release drugs. Note: Drugs are covered under Section 5(f). • Treatment of burns 	<p>\$100 for outpatient surgery</p> <p>Nothing for inpatient surgery</p> <p>See Section 5(c) for facility charges</p>	<p>20% of our allowance per outpatient and inpatient surgery after you have met your calendar year deductible</p> <p>See Section 5(c) for facility charges.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Implants or devices related to the treatment of sexual dysfunction</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Reconstructive surgery	High Option	Standard Option
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - The condition produced a major effect on the member's appearance; and - The condition can reasonably be expected to be corrected by such surgery. 	<p>\$100 per outpatient surgery</p> <p>Nothing for inpatient surgery</p> <p>See Section 5(c) for facility charges.</p>	<p>20% of our allowance per outpatient and inpatient surgery after you have met your calendar year deductible</p> <p>See Section 5(c) for facility charges.</p>

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Reconstructive surgery (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are protruding ear deformities, cleft lip, cleft palate, birthmarks, webbed fingers, and webbed toes. • Surgery for treatment of a form of congenital hemangioma known as port wine stains on the face or neck of members 18 years or younger. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - Surgery to produce a symmetrical appearance on the other breast; - Treatment of any physical complications, such as lymphedemas; and - Breast prostheses and surgical bras and replacements (see Prosthetic devices). • Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. 	<p>\$100 per outpatient surgery</p> <p>Nothing for inpatient surgery</p> <p>See Section 5(c) for facility charges.</p>	<p>20% of our allowance per outpatient and inpatient surgery after you have met your calendar year deductible</p> <p>See Section 5(c) for facility charges.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Oral and maxillofacial surgery	High Option	Standard Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate, or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Medical and surgical treatment of temporomandibular joint syndrome (TMJ) (non-dental) • Other surgical procedures that do not involve the teeth or their supporting structures 	<p>\$30 per visit with specialist</p> <p>\$100 for outpatient surgery</p> <p>Nothing for inpatient surgery</p> <p>See Section 5(c) for facility charges.</p>	<p>\$45 per visit with specialist</p> <p>20% of our allowance for outpatient and inpatient surgery after you have met your calendar year deductible</p> <p>See Section 5(c) for facility charges.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Shortening of the mandible or maxillae for cosmetic purposes</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Oral and maxillofacial surgery (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Correction of malocclusion</i> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> • <i>Dental care involved in treatment of the temporomandibular joint (TMJ) pain dysfunction syndrome</i> 	<i>All charges.</i>	<i>All charges.</i>
Organ/tissue transplants	High Option	Standard Option
<p>Solid organ tissue transplants are limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Kidney • Liver 	<p>Nothing</p> <p>See Section 5(c) for facility charges.</p>	<p>Nothing</p> <p>See Section 5(c) for facility charges.</p>
<ul style="list-style-type: none"> • Intestinal transplants <ul style="list-style-type: none"> - Small intestine 	Nothing	Nothing
<ul style="list-style-type: none"> • Intestinal transplants <ul style="list-style-type: none"> - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas 	Nothing	20% of our allowance per inpatient surgery after you have met your calendar year deductible
<ul style="list-style-type: none"> • Heart/Lung • Kidney/Pancreas • Lung: Single – Double • Pancreas 	<p>Nothing</p> <p>See Section 5(c) for facility charges.</p>	<p>20% of our allowance per inpatient surgery after you have met your calendar year deductible</p> <p>See Section 5(c) for facility charges.</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses: (The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the diagnosis and staging description.)</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for 	<p>Nothing</p> <p>See Section 5(c) for facility charges.</p>	<p>20% of our allowance per inpatient surgery after you have met your calendar year deductible</p> <p>See Section 5(c) for facility charges.</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Advanced neuroblastoma • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) 	<p>Nothing</p> <p>See Section 5(c) for facility charges.</p>	<p>20% of our allowance per inpatient surgery after you have met your calendar year deductible</p> <p>See Section 5(c) for facility charges.</p>
<p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogenic transplants for <ul style="list-style-type: none"> - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors <p>Limited benefits—Autologous blood or bone marrow stem cell transplants for breast cancer and epithelial ovarian cancer 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 and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p>	<p>Nothing</p> <p>See Section 5(c) for facility charges.</p>	<p>20% of our allowance per inpatient surgery after you have met your calendar year deductible</p> <p>See Section 5(c) for facility charges.</p>
<p>Notes:</p> <ul style="list-style-type: none"> • We cover related medical and hospital expenses of the donor when we cover your transplant. 		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of non-human or artificial organs</i> • <i>Bone marrow transplants associated with high dose chemotherapy for other solid tissue tumors</i> • <i>Transplants not listed as covered</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Anesthesia	High Option	Standard Option
<p>Professional services provided in</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	<p>Nothing</p>	<p>20% of our allowance after you have met your calendar year deductible</p>

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- The Standard Option plan’s calendar year deductible is \$500 per person and \$1,500 per family. The calendar year deductible applies to almost all benefits in this Section. We added “(No Deductible)” to show when the calendar year deductible does not apply.
- There is no deductible for the High Option plan.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Sections 5(a) or (b).

Benefit Description	You pay	
Note: The Standard Option plan’s calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply		
Inpatient hospital	High Option	Standard Option
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	\$250 per inpatient admission	\$250 per day up to \$750 per inpatient admission (No Deductible)
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood and blood products • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services Note: You may receive covered hospital services for certain dental procedures if a Plan physician determines you need to be hospitalized for reasons unrelated to the dental procedure. The need for anesthesia, by itself, is not such a condition. We cover general anesthesia for dental services for a member’s child with physical, mental, or behavior problems.	\$250 per inpatient admission	\$250 per day up to \$750 per inpatient admission (No Deductible)

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	High Option	Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • 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 • Inpatient dental procedures 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Outpatient hospital or ambulatory surgical center	High Option	Standard Option
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Dressings, casts and sterile trays • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Medical supplies, including oxygen • Anesthetics and anesthesia service 	<p>\$100 per visit</p>	<p>20% of our allowance after you have met your calendar year deductible</p>
Skilled nursing care benefits	High Option	Standard Option
<p>Up to 100 days per calendar year when you need full-time skilled nursing care.</p> <p>All necessary services are covered, including:</p> <ul style="list-style-type: none"> • 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 	<p>Nothing</p>	<p>\$250 per day up to \$750 per admission</p> <p>(No Deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care and care in an intermediate care facility • Personal comfort items, such as telephone, television, barber services, and guest meals and beds 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Benefit Description	You pay	
	High Option	Standard Option
<p>Hospice care</p> <p>Supportive and palliative care for a terminally ill member:</p> <ul style="list-style-type: none"> • You must reside in the service area • Services are provided in the home, or • In a Plan approved hospice facility. <p>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 twelve months or less.</p> <p>Note: Home-based hospice services are covered only if a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home.</p>	<p>Nothing for home-based hospice services</p> <p>\$250 per inpatient admission</p>	<p>20% of our allowance for home-based after you have met your calendar year deductible</p> <p>\$250 per day up to \$750 per inpatient admission</p>
<p>Special Services Program</p> <p>Hospice-eligible members who have not yet elected hospice care are eligible to receive 15 home visits by Plan special service hospice providers.</p> <p>Note: Hospice is a program for caring for the terminally ill that emphasizes supportive services, such as home care and pain control, rather than curative care of the terminal illness. A person who is terminally ill may elect to receive hospice benefits. These palliative and supportive services include nursing care, medical social services, physician services, and short-term inpatient care for pain control and acute and chronic symptom management. We also provide counseling and bereavement services for the individual and family members, and therapy for purposes of symptom control to enable the person to continue life with as little disruption as possible. 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.</p>	<p>Nothing</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Private duty nursing (independent nursing)</i> • <i>Homemaker services</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Benefit Description	You pay	
Ambulance	High Option	Standard Option
Local licensed ambulance service when medically necessary See Section 5(d) for emergency services.	20% of our allowance up to \$500 per trip	20% of our allowance up to \$500 per trip (No Deductible)
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider</i> 	<i>All charges.</i>	<i>All charges.</i>

Section 5(d) Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- The Standard Option plan's calendar year deductible is \$500 per person and \$1,500 per family. The calendar year deductible applies to almost all benefits in this Section. We added "(No Deductible)" to show when the calendar year deductible does not apply.
- There is no deductible for the High Option plan.
- If you receive special procedures (MRIs, CAT scans, PET scans and nuclear medicine) while in the hospital emergency room, you pay the amount specified in Section 5(a). Your copayment for the special procedures performed in a hospital emergency room will be waived if you are admitted to the hospital as an inpatient.
- 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 911. When the operator answers, stay on the phone and answer all questions.

Emergencies within our service area:

Denver/Boulder area: If you are in an emergency situation, call **911**, go to the closest emergency room or a Plan hospital. If you are not sure whether your situation is an emergency, call 303-338-4545 for advice, 24 hours a day, seven days a week. If an ambulance is necessary, we will authorize it.

Note: Please see "Plan facilities" in Section 3 for our contracted emergency services facilities in a non-life threatening emergency.

For urgently needed services, such as an earache or sore throat with fever that cannot wait for a routine visit, you may call your PCP's Medical Office to schedule a same-day appointment during regular office hours. You may obtain urgent care services after regular office hours at various facilities in the Denver/Boulder area. Please call 303-338-3800 for information on locations and hours of accessibility for after-hours/urgent care.

Colorado Springs area: If you are in an emergency situation, call 911, or go to the closest emergency room. If you are not sure your situation is an emergency, call your PCP.

For urgent care that cannot wait for a routine office visit, call your PCP to schedule a same-day or urgent care appointment during regular office hours. Urgent/after hours care is available by calling your PCP. You can also check our Web site, my.kp.org/federalemployees, for a listing of urgent care/after hours clinics.

Emergencies outside our service area:

We cover emergency situations, such as myocardial infarction, appendicitis or premature delivery, outside the service area. Note: Emergency services are limited to those services required before your medical condition permits your travel or transfer to care in our Plan. Continuing or follow-up care from out-of-plan providers is not covered.

You may obtain emergency and urgent care services from Kaiser Permanente medical facilities and providers when you are in the service area of another Kaiser Permanente plan. The facilities are listed 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 Member Services at 303-338-3800.

How to obtain authorization:

You or someone on your behalf must call us at **1-800-632-9700** or, in the **Colorado Springs** area at **1-888-681-7878** (these telephone numbers are also on the back of your ID card) to:

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

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

Benefit Description	You pay After the calendar year deductible...	
Note: The Standard Option plan's calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Emergency within our service area	High Option	Standard Option
Emergency care as an outpatient or inpatient at a hospital, including physicians' services <ul style="list-style-type: none"> • At a Plan medical office 	\$20 per visit	\$25 per visit
<ul style="list-style-type: none"> • After hours/urgent care services 	\$50 per visit	\$50 per visit
<ul style="list-style-type: none"> • In a hospital emergency room 	\$100 per visit	20% of our allowance after you have met your calendar year deductible
Notes: <ul style="list-style-type: none"> • Your emergency room copayment is waived if you are admitted to a Plan hospital as an inpatient. Your inpatient hospital copayment will still apply. • Transfers to an observation bed or observation status do not qualify as an admission to a hospital and your emergency room copayment will not be waived. 		
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</i>	<i>All charges.</i>
Emergency outside our service area	High Option	Standard Option
Emergency care as an outpatient or inpatient at a hospital, including physicians' services <ul style="list-style-type: none"> • Urgent care services 	\$50 per visit	\$50 per visit
<ul style="list-style-type: none"> • In a hospital emergency room 	\$100 per visit	20% of our allowance after you have met your calendar year deductible
Notes:		

Emergency outside our service area - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Emergency outside our service area (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Your emergency room copayment is waived if you are admitted to the hospital as an inpatient. Your inpatient hospital copayment will still apply. • Transfers to an observation bed or observation status do not qualify as an admission to a hospital and your emergency room copayment will not be waived. • See the Travel Benefit for coverage of continuing or follow-up care. 		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges.</i>	<i>All charges.</i>
Ambulance	High Option	Standard Option
<ul style="list-style-type: none"> • Professional ambulance services to the nearest hospital equipped to handle your medical condition where authorized by a Plan physician. • We will authorize air ambulance if ground transportation is not medically appropriate 	20% of our allowance up to \$500 per trip	20% of our allowance up to \$500 per trip (No Deductible)
<i>Not covered: Transports that we determine are not medically necessary</i>	<i>All charges.</i>	<i>All charges.</i>

Section 5(e) Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are clinically appropriate to treat your condition.
- Plan physicians must provide or arrange your care.
- The Standard Option plan’s calendar year deductible is \$500 per person and \$1,500 per family. The calendar year deductible applies to almost all benefits in this Section. We added “(No Deductible)” to show when the calendar year deductible does not apply.
- There is no deductible for the High Option plan.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible...	
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**Note: The calendar year deductible applies to almost all benefits in this Section.
We say “(No deductible)” when it does not apply.**

Mental health and substance abuse benefits	High Option	Standard Option
<p>We cover all diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Notes:</p> <ul style="list-style-type: none"> • We cover the services only when we determine that the care is clinically appropriate to treat your condition, and only when you receive the care as part of a treatment plan developed by a Plan provider. • OPM will base its review of disputes about treatment plans on the treatment plan’s clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment in favor of another. 	<p>Your cost sharing responsibilities are not greater than for other illnesses or conditions</p>	<p>Your cost sharing responsibilities are not greater than for other illnesses or conditions</p>
<p>Diagnosis and treatment of psychiatric conditions for children, adolescents, and adults. Services include:</p> <ul style="list-style-type: none"> • Diagnostic evaluation • Psychiatric treatment, including group and individual therapy • Medication evaluation and management <p>Diagnosis and treatment of alcoholism and drug abuse. Services include:</p>	<p>\$20 per individual therapy office visit</p> <p>\$10 per group therapy office visit</p>	<p>\$25 per individual therapy office visit</p> <p>\$13 per group therapy office visit</p> <p>(No Deductible)</p>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
<p>Mental health and substance abuse benefits (cont.)</p> <ul style="list-style-type: none"> • Detoxification (medical management of withdrawal from the substance) • Treatment and counseling (including individual and group therapy visits) • Rehabilitative care <p>Notes:</p> <ul style="list-style-type: none"> • Your 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. • You may see a mental health provider for these services without a referral from your primary care physician. 	<p>\$20 per individual therapy office visit</p> <p>\$10 per group therapy office visit</p>	<p>\$25 per individual therapy office visit</p> <p>\$13 per group therapy office visit</p> <p>(No Deductible)</p>
<ul style="list-style-type: none"> • Inpatient psychiatric care • Hospital alternative services, such as partial hospitalization, day and night care, and intensive outpatient psychiatric treatment programs • Inpatient care <p>Note: All inpatient admissions and hospital alternative services treatment programs require approval by a Plan physician.</p>	<p>Nothing for inpatient professional services</p> <p>See Section 5(c) for facility charges.</p>	<p>20% of our allowance for inpatient professional services after you have met your calendar year deductible</p> <p>See Section 5(c) for facility charges.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Care that is not clinically appropriate for the treatment of your condition</i> • <i>Services we have not approved</i> • <i>Intelligence, IQ, aptitude ability, learning disorders, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition</i> • <i>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</i> • <i>Services that are custodial in nature</i> • <i>Services rendered or billed by a school or a member of its staff</i> • <i>Services provided under a federal, state, or local government program</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Mental health and substance abuse benefits (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> <i>Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms</i> 	<i>All charges.</i>	<i>All charges.</i>

Limitation

We may limit your benefits if you do not obtain a treatment plan.

Section 5(f) Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- The Standard Option plan's calendar year pharmacy deductible is \$100 per person. The calendar year pharmacy deductible applies to almost all benefits in this Section. We added "(No Deductible)" to show when the calendar year pharmacy deductible does not apply.
- There is no pharmacy deductible for the High Option plan.
- 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 Plan or referral physician or licensed dentist (for acute conditions only) must write the prescription.
- **Where you can obtain them.**

Denver/Boulder area: You must fill the prescription at a Plan pharmacy. You may refill prescriptions through **Direct Rx**, our mail order service. We provide refills in the same quantities as the original prescription, up to a 60-day supply. You can obtain reorder envelopes at Plan pharmacies. **Direct Rx** mails refills by First Class U.S. Mail at no charge to you for postage and handling. You should receive your prescription within 7-10 days. To place an order by telephone, call **Direct Rx** at **303-340-5077**. This refill line can be used 24 hours a day. We do not deliver the following through the mail: certain drugs that have a significant potential for waste and diversion, drugs requiring special handling, drugs administered or requiring observation by medical professionals, drugs requiring refrigeration.

You may order prescription refills through **Direct Rx** online, using our Members Only Web site my.kp.org/federalempleyees. This site requires online registration. You can choose to have your prescriptions mailed to your home or to a Plan medical office pharmacy for you to pick up. Online prescription orders must be paid for in advance, by a credit card.

Colorado Springs area: You must fill the prescription at a pharmacy designated by the Plan. A list of designated pharmacies can be obtained by calling Member Services at 1-888-681-7878 or by accessing our Web site at my.kp.org/federalempleyees. You may refill prescriptions for maintenance drugs through **BioScrip**, our convenient mail order prescription service. Maintenance drugs are determined by the Plan. To place an order for maintenance drugs by telephone, call **BioScrip** at **1-800-677-4323**. Certain injectable medications (specialty drugs) may be filled through **BioScrip** for up to a 30-day supply, at the applicable prescription drug copayment. Please contact our Pharmacy Call Center at 303-338-4503 for the current list of these drugs. To place an order for specialty drugs by telephone, call **BioScrip** at **1-877-316-8921**. **BioScrip's** refill lines can be used 24 hours a day. Refills will be mailed by First Class U.S. Mail at no charge to you for postage and handling. You should receive your prescription within 7-10 days. We do not deliver the following through the mail: certain drugs that have a significant potential for waste and diversion, drugs requiring special handling, drugs administered or requiring observation by medical professionals, drugs requiring refrigeration.

You may order prescription refills through **BioScrip** online, using our Members Only Web site my.kp.org/federalempleyees. This site requires online registration. Your prescriptions will be mailed to your home. Online prescription orders must be paid for in advance, by a credit card.

- **We use a formulary.** A formulary includes the list of prescription drugs that have been approved for our members. A team of Kaiser Permanente physicians and pharmacists independently and objectively evaluates the scientific literature to identify the FDA-approved drugs best suited to treat specific medical conditions. When your physician believes a non-formulary drug is necessary, he may request a formulary exception. If the formulary exception request is approved, you pay your applicable generic or brand-name drug copayment. However, if the formulary exception request is not approved, the non-formulary drug will not be covered.

Note: In Colorado Springs, some prescription drugs, such as (but not limited to) Zyban or Interferon, require preauthorization. Your Plan physician should contact **MedImpact**, our pharmacy benefit manager, to obtain approval.

- **These are the dispensing limitations.** You may purchase covered drugs in prescribed quantities for up to a 60-day supply for maintenance drugs or part of a 60-day supply for non-maintenance drugs, except certain drugs that have a significant potential for waste will be provided for up to a 30-day supply (e.g., Avonex, Procrit). Please contact our Pharmacy Call Center at 303-338-4503 for the current list of these drugs. Refills of prescriptions will be provided subject to the same conditions as the original prescription.
- **A generic equivalent will be dispensed if it is available.** Plan pharmacies may substitute a generic equivalent for a name-brand drug unless prohibited by the Plan physician. If a generic equivalent is not available, you pay your brand-name drug copayment. If you request a brand-name drug on the formulary when your Plan physician has prescribed an approved generic drug, you pay your brand-name drug copayment plus the difference in price between the generic drug and your requested brand-name drug.
- **Why use generic drugs?** Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original name-brand product. Generic drugs cost you and your plan less money than a name-brand drug.
- **When you do have to file a claim.** When you receive drugs from a Plan pharmacy, you do not have to file a claim. For a covered out-of-area emergency, you will need to file a claim when you receive drugs from a non-Plan pharmacy.
- **If you have questions** about your prescription drug benefits, please contact our Pharmacy Call Center at 303-338-4503.

Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications should call 303-338-4503.

Benefit Description	You pay After the calendar year deductible...	
Note: The Standard Option plan's calendar year pharmacy deductible applies to all benefits in this Section.		
Covered medications and supplies	High Option	Standard Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below • Oral and contraceptive drugs, contraceptive devices, and intrauterine devices • Insulin • Growth hormone • Chemotherapy drugs <p>Notes:</p> <ul style="list-style-type: none"> • If we do not have a generic equivalent for a brand name drug, you will pay the brand name drug copayment (\$35 copayment (Standard Option) or the \$25 copayment (High Option)). • The brand name drug copayment applies to compounded products and to single source generic drugs. <ul style="list-style-type: none"> - A compounded drug is one in which two or more drugs or pharmaceutical agents are combined together to meet the requirements of a prescription. 	<p>\$10 per prescription for generic drugs</p> <p>\$25 per prescription for brand-name drugs</p>	<p>\$15 per prescription for generic drugs</p> <p>\$35 per prescription for brand-name drugs</p>

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Covered medications and supplies (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - A single source generic drug is a generic drug available in the United States only from a single manufacturer and that is not listed as generic in the then-current commercially available drug database(s) to which Plan subscribes. 	<p>\$10 per prescription for generic drugs</p> <p>\$25 per prescription for brand-name drugs</p>	<p>\$15 per prescription for generic drugs</p> <p>\$35 per prescription for brand-name drugs</p>
<ul style="list-style-type: none"> • Disposable needles and syringes for the administration of covered medications • Glucose test strips • Injectable hormone therapy prescribed for the treatment of prostate cancer 	20% of our allowance	20% of our allowance
<ul style="list-style-type: none"> • Implanted time-release contraceptive drugs • Other implanted time-release drugs <p>Note: We do not refund any portion of the copayment if you request removal of the implanted time-release medication before the end of its expected life.</p>	A one-time payment equal to \$10 times the expected number of months the medication will be effective, not to exceed \$200	A one-time payment equal to \$15 times the expected number of months the medication will be effective, not to exceed \$200
<p>Food supplements and supplies, for use in the home</p> <ul style="list-style-type: none"> • For individuals unable to absorb or digest food • Includes enteral and parenteral elemental dietary formulas and amino acid modified product for treatment of inborn errors of metabolism 	\$3 per product per day	\$3 per product per day
<ul style="list-style-type: none"> • Drugs to treat sexual dysfunction <p>Note: There are dispensing limitations for drugs to treat sexual dysfunction. Please contact us for details.</p>	50% of our allowance	50% of our allowance
<ul style="list-style-type: none"> • Immunosuppressant drugs after a covered transplant 	\$25 per prescription or refill	\$35 per prescription or refill
<ul style="list-style-type: none"> • Intravenous fluids and medications for home use 	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs available without a prescription or for which there is a nonprescription equivalent available</i> • <i>Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies</i> • <i>Vitamins and nutritional supplements that can be purchased without a prescription</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Drugs for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs related to infertility services</i> • <i>Drugs used in the treatment of weight control</i> • <i>Drugs to shorten the duration of the common cold</i> • <i>Condoms</i> 	<i>All charges.</i>	<i>All charges.</i>

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Covered medications and supplies (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Any packaging other than the dispensing pharmacy's standard packaging</i> • <i>Replacement of lost, stolen, or damaged drugs and accessories</i> 	<i>All charges.</i>	<i>All charges.</i>

Section 5(g) Special features

Feature	Description
<p>Flexible benefits option</p>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other treatments as a less costly alternative benefit • We review alternative treatments on an ongoing basis • By approving an alternative treatment, we cannot guarantee you will get it in the future • The decision to offer an alternative treatment is solely ours, and we may withdraw it at any time and resume regular contract benefits • Our decision to offer or withdraw alternative treatments is not subject to OPM review under the disputed claims process.
<p>Travel benefit</p>	<p>Kaiser Permanente’s travel benefits for Federal employees provide you with outpatient follow-up or continuing medical care when you are temporarily 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 and urgent care benefits and include:</p> <ul style="list-style-type: none"> • 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 conditions diagnosed and treated within the previous 90 days 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. We deduct this amount from the payment we make to you • We pay no more than \$1,200 each calendar year • For more information about this benefit call the Travel Benefit Information Line at 1-800-632-9700 • Claims should be submitted to the Claims Department, Kaiser Foundation Health Plan of Colorado, P.O. Box 373150, Denver, CO 80237-6970 (Denver/Boulder members) or Claims Department, Kaiser Foundation Health Plan of Colorado, P.O. Box 372910, Denver, CO 80237-6910 (Colorado Springs members) <p>The following are <i>a few examples of services</i> not included in your travel benefits coverage:</p> <ul style="list-style-type: none"> • <i>Non-emergency hospitalization</i> • <i>Infertility treatments</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> • <i>Transplants</i>

Feature - continued on next page

Feature	
Feature (cont.)	Description
	<ul style="list-style-type: none"> • <i>DME</i> • <i>Prescription drugs</i> • <i>Home health services</i>
<p>Services from other Kaiser Permanente or Allied Plans</p>	<p>When you visit a different Kaiser Foundation Health Plan or allied plan service area temporarily (not more than 90 days), 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. The availability of visiting member care in the visited service area ends after 90 days unless you receive prior written authorization from us to continue receiving care in the visited service area.</p> <p>Please call Member Services at 303-338-3800 in Denver/Boulder and toll-free at 888-681-7878 in Colorado Springs, 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.</p>
<p>Student coverage outside the service area</p>	<p>We provide a limited benefit to eligible dependents who are full-time registered college students (at least 12 credit hours per semester) attending a recognized accredited institution outside Kaiser Permanente’s service areas and within the United States. These benefits are in addition to your emergency benefits and will be applied before your travel benefit.</p> <ul style="list-style-type: none"> • Your dependent is covered for routine, continuing and follow-up medical care. • You pay 20% of the usual and customary charges. • Your benefit is limited to \$1,200 each calendar year. • There is no deductible. • You must certify your dependent’s student status annually. • For more information about this benefit, call 303-338-3800 (Denver/Boulder members) or 1-888-681-7878 (Colorado Springs members). • File claims as shown in Section 7. <p>The following are not included in your out-of-area student coverage benefit:</p> <ul style="list-style-type: none"> • Transplants and transplant follow-up care • Dental services • Services provided outside the United States

Section 5(h) Dental benefits

Here are some important things you should keep in mind about these benefits:

- There are exclusions and limitations to your dental coverage. For complete details regarding your dental benefits, exclusions and limitations, please contact Delta Dental of Colorado at 303-741-9305 or 1-800-610-0201 and identify your PPO – Preferred Provider Option Plan.
- Please remember that all benefits are subject to the definitions in this brochure and we cover only when we determine they are medically necessary.
- You can receive covered dental services from participating Delta Dental PPO dentists (PPO), Delta Dental Premier dentists (non-PPO) and non-participating dentists (non-PPO).
- If you choose to see a PPO dentist or a Delta Premier dentist, the fee schedules are set and you will pay the applicable coinsurance on contracted fees. If you see a non-participating dentist, the fee schedules are not contracted and your coinsurance amount could be higher.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5 (c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- The Standard Option plan does not cover dental services, apart from accidental injury. The accidental injury benefit is subject to the Standard Option plan’s deductible.
- For the High Option plan:
 - You have the accidental injury benefit and our Delta Dental Plan benefits described in the following pages.
 - Your calendar year benefit maximum for the Delta Dental Plan benefits is limited to \$1,000 per member.
 - There is a \$50 deductible per person or \$150 deductible per family enrollment for Basic Services and Major Services. There is no deductible for Diagnostic and Preventive 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.
- For a list of participating providers, please contact Delta Dental of Colorado at 303-741-9305 or 1-800-610-0201 and identify your PPO – Preferred Provider Option Plan or you may log on to www.deltadentalco.com.

Accidental injury benefit	You Pay	
<p>Note: The High Option plan's calendar year dental deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply. The Standard Option does not have dental benefits.</p>		
Accidental injury benefit	High Option	Standard Option
<p>We cover services to promptly repair (but not replace) a sound, natural tooth, if:</p> <ul style="list-style-type: none"> • Damage is due to an accidental injury from trauma to the mouth from violent contact with an external object, • The tooth has not been restored previously, except in a proper manner, and • The tooth has not been weakened by decay, periodontal disease, or other existing dental pathology. 	<p>\$20 per visit</p>	<p>20% of our allowance after you have met your calendar year deductible</p>

Accidental injury benefit - continued on next page

Accidental injury benefit	You Pay	
Accidental injury benefit (cont.)	High Option	Standard Option
<i>Not covered: Services for conditions caused by an accidental injury occurring before your eligibility date.</i>	<i>All charges.</i>	<i>All charges.</i>
Service	You pay - High Option After the calendar year dental deductible...	
Note: The High Option plan's calendar year dental deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply. The Standard Option does not have dental benefits.		
Dental Benefit	PPO dentists only	Non-PPO dentists
Diagnostic and Preventive Services, such as: <ul style="list-style-type: none"> • Periodic oral evaluation • Intraoral X-rays • Prophylaxis • Sealants (children to age 15) 	20% of our allowance (No Deductible)	50% of our allowance (No Deductible)
Basic Services, such as: <ul style="list-style-type: none"> • Amalgam and resin based fillings • Root canals • Periodontal scaling and root planning • Removal of impacted teeth 	20% of our allowance after you have met your calendar year dental deductible	50% of our allowance after you have met your calendar year dental deductible
Major Services, such as: <ul style="list-style-type: none"> • Crowns • Pontics • Dentures 	50% of our allowance after you have met your calendar year dental deductible	50% of our allowance after you have met your calendar year dental deductible
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Cosmetic dental services</i> • <i>Replacement of lost or stolen dentures or bridgework</i> • <i>Orthodontic services</i> • <i>Dental services not listed as covered</i> 	<i>All charges.</i>	<i>All charges.</i>

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.

As an FEHB enrollee in this Plan, you can receive acupuncture, chiropractic, and massage therapy services through American Specialty Health at a 25% discount off the practitioner's standard charges. Contact the Kaiser Permanente Centers for Complementary Medicine at 303-699-3670 (Denver/Colorado Springs), 303-239-7224 (Lakewood) or 303-440-2722 (Boulder) for participating practitioners and locations.

FEHB enrollees in this Plan can also receive selected health club memberships through American Specialty Health. For more information, call our Customer Service Department at 303-338-3800, or for Colorado Springs members, 1-888-681-7878.

Section 6 General exclusions – things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan physician determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- When a service is not covered, all services, drugs or supplies related to the noncovered service are excluded from coverage, except services we would otherwise cover to treat complications of the noncovered service;
- Care by non-Plan providers except for authorized referrals, emergencies, travel benefit, services from other Kaiser Permanente plans, or student coverage outside the service area (see Emergency services/accidents and Special Features);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs, or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies you receive without charge while in active military service; or
- Services provided or arranged by criminal justice institutions for members confined therein.

Section 7 Filing a claim for covered services

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

You will only need to file a claim when you receive emergency services from non-plan providers or when you use the travel benefit. Sometimes these providers bill us directly. Check with the provider. 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. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 303-338-3600 in Denver/Boulder and 1-888-681-7878 in Colorado Springs.

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

- Covered member’s name 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;
- Follow up services rendered out-of-area
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to:

Denver/Boulder area: Claims Department
 Kaiser Foundation Health Plan of Colorado
 P.O. Box 373150
 Denver, CO 80237-3150

Colorado Springs area: Claims Department
 Kaiser Foundation Health Plan of Colorado
 P.O. Box 372910
 Denver, CO 80237-6910

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond.

If you have a malpractice claim

If you have a malpractice claim because of services you did receive, or did not receive, from a Plan provider, you must submit the claim to binding arbitration. The Plan has the information that describes the arbitration process. Contact our Business and Clinical Risk Management Department at 303-344-7298 for copies of our requirements. These will explain how you can begin the binding arbitration process.

Section 8 The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3:

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none"> a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Business and Clinical Risk Management Department, Kaiser Foundation Health Plan of Colorado, P.O. Box 378066, Denver, CO 80237-8066; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians’ letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none"> a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or b) Write to you and maintain our denial - go to step 4; or c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request - go to step 3.
3	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within</p> <ul style="list-style-type: none"> • 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. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none"> • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p>

	<p>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.</p> <p>Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.</p>
<p>5</p>	<p>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.</p> <p>If you do not agree with OPM’s decision, your only recourse is to sue. If you decide to sue, 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.</p> <p>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.</p> <p>You may not sue 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.</p>

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

- a) We haven’t responded yet to your initial request for care or preauthorization/prior approval, then call us at 303-338-3800 in the Denver/Boulder area and 1-888-681-7878 in the Colorado Springs area and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM’s Health Insurance Group 3 at 202/606-0755 between 8 a.m. and 5 p.m. Eastern time.

Section 9 Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under any other health plan or have 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 payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ Guidelines.

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

When we are the secondary payer, 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 payer, and you received your services from Plan providers, we may bill the primary carrier.

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; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a 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 1, 1983, you will receive credit for your Federal employment before January 1, 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE 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 a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan, Kaiser Permanente Senior Advantage. Please review the information on Medicare Advantage plans on page 58.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at <http://www.socialsecurity.gov>, or call them at 1-800-772-1213 (TTY 1-800-325-0778). 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. The notice will give you guidance on enrolling in Medicare Part D.

• 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 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 are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various 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.

- **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.

- **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.

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 payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 303-338-3600 in Denver/Boulder and 1-888-681-7878 in Colorado Springs.

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

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private 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) 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 Senior Advantage plan: We offer a Medicare Advantage plan known as Kaiser Permanente Senior Advantage at no additional cost to our members eligible for Medicare benefits including Part D, as well as lower copayments and coinsurance at no cost to you. If you have already enrolled and would like to understand your additional benefits in more detail, please refer to your Medicare Annual Notice of Change (ANOC). If you are considering enrolling in our Senior Advantage plan, please call us at 303-338-3814. (Kaiser Permanente Senior Advantage is available in the Denver/Boulder area only. It is not available in the Colorado Springs area.)

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 if you use our Plan providers, but we will not lower or 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 payer, we process the claim first. If you enroll in a Medicare Part D PDP and we are the secondary payer, our Kaiser owned and operated pharmacies will not consider the PDP benefits. These Kaiser pharmacies will only provide your FEHB Kaiser benefits.

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

If you enroll in our Kaiser Permanente Senior Advantage plan, you will get all of the benefits of Medicare Part D plus additional benefits because Medicare Part D is included in our plan.

(Primary Payer Chart begins on the next page.)

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer 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.

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you?	The primary payer for the individual with Medicare is?	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) 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 #1 above	✓	
4) 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	✓	
5) 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 #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓ *	
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 payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
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.

**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 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 others are
responsible for 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.

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.
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.
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 expense you must incur for certain covered services and supplies before we start paying benefits for those services. See Section 4.
Durable medical equipment	Durable medical equipment (DME) is equipment that is intended for repeated use, medically necessary, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, designed for prolonged use, appropriate for use in the home, and serves a specific therapeutic purpose in the treatment of an illness or injury.
Experimental or investigational service	We carefully evaluate whether a particular therapy is safe and effective or offers a reasonable degree of promise with respect to improving health outcomes. The primary source of evidence about health outcomes of any intervention is peer-reviewed medical or dental literature. When the service or supply, including a drug: (1) has not been approved by the FDA; or (2) is the subject of a new drug or new device application on file with the FDA; or (3) is part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial; or is intended to evaluate the safety, toxicity, or efficacy of the service; or (4) is available as the result of a written protocol that evaluates the service's safety, toxicity, or efficacy; or (5) is subject to the approval or review of an Institutional Review Board; or (6) requires an informed consent that describes the service as experimental or investigational; then this Plan considers that service, supply, or drug to be experimental, and not covered by the Plan.
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."

Medically necessary	All benefits need to be medically necessary in order for them to be covered benefits. Generally, if your Plan physician provides the service in accord with the terms of this brochure, it will be considered medically necessary. However, some services are reviewed in advance of your receiving them to determine if they are medically necessary. When we review a service to determine if it is medically necessary, a Plan physician will evaluate what would happen to you if you do not receive the service. If not receiving the service would adversely affect your health, it will be considered medically necessary. The services must be a medically appropriate course of treatment for your condition. If they are not medically necessary, we will not cover the services. In case of emergency services, the services that you received will be evaluated to determine if they were medically necessary.
Our allowance	The amount we use to determine your coinsurance. When you receive services or supplies from Plan providers, it is the amount that we set for the services or supplies if we were to charge for them. When you receive services from non-Plan providers, it is either the amount that we have negotiated with the non-Plan provider, or if we do not have a negotiated amount, the amount that we believe is usual and customary for the service or supply, compared to the billed charges. Our allowance is based upon the reasonableness of the billed charges. If the billed charges exceed what we believe is reasonable, you may be responsible for the excess over our allowance in addition to your coinsurance.
Preventive care copayment	The copayment for your preventive care (adult and children) and maternity care is \$0.
Primary care copayment	The copayment for your primary care visit is \$ 25 (Standard Option plan) or \$ 20 (High Option plan) for the following services: internal medicine, obstetrics and gynecology (Denver/Boulder only), pediatric, family medicine and optometry.
Specialty care copayment	The copayment for your specialty care visit is \$ 45 (Standard Option plan) or \$30 (High Option plan). This copayment applies when you receive services from medical providers who are not primary care physicians (as defined above).
Us/We	Us and We refer to Kaiser Foundation Health Plan of Colorado.
You	You refers to the enrollee and each covered family member.

Section 11 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.

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

See www.opm.gov/insure/health 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 who 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 a *Guide to Federal Employees Health Benefits Plans*, 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;
- When your enrollment ends; and
- 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.

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

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a 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 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 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 benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorce, or when your child under age 22 marries.

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.

- **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 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 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 and Family coverage 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 and Family 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 and Family 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. 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 2007 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 2006 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.

• **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 to 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 RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM’s Web site, www.opm.gov/insure.

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

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **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 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.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/insure/health; refer to the “TCC and HIPAA” frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12 Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

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

Second, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Third, the new **Federal Employees Dental and Vision Insurance Program (FEDVIP)** offers a variety of dental plans and vision plans to anyone who is eligible to enroll in the Federal Employees Health Benefits Program. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents. Premiums are on an enrollee-pays-all basis.

The Federal Long Term Care Insurance Program - *FLTCIP*

It's important protection

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program (FLTCIP)**?

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” 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. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums. If you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions about your health. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.
- **To request an Information Kit and application.** Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses.

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum annual election of \$5,000.

- **Health Care FSA (HCFSA)** – Pays for eligible health care expenses for you and your dependents which are not covered or reimbursed by FEHBP coverage or other insurance.
- **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 dental and vision care expenses for you and your dependents, which are not covered or reimbursed, by FEHBP or FEDVIP coverage or other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

What expenses can I pay with an FSAFEDS account?

For the HCFSA – Health plan copayments, deductibles, over-the-counter medications and products, sunscreen, eyeglasses, contacts, other vision and dental expenses (but not insurance premiums).

For the LEX HCFSA – Dental and vision care expenses including eligible over-the-counter medicines and products related to dental and vision care (but not insurance premiums).

For the DCFSA – Daycare expenses (including summer camp) for your child(ren) under age 13, dependent care expenses for dependents unable to care for themselves

AND MUCH MORE! Visit www.FSAFEDS.com.

Who is eligible to enroll?

Most Federal employees in the Executive branch and many in non-Executive branch agencies are eligible. For specifics on eligibility, visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

When can I enroll?

If you wish to participate, you must make an election to enroll each year by visiting www.FSAFEDS.com or calling the number above during the FEHB Open Season or within 60 days of employment (for new employees).

Even if you enrolled for 2006, you must make a new election to continue participating in 2007. Enrollment DOES NOT carry over from year to year.

Who is SHPS?

SHPS is the Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is BENEFEDS?

BENEFEDS is the name of the voluntary benefits portal hired by OPM to work with the FSAFEDS Program to set up payroll deductions for FSAFEDS allotments.

The Federal Employees Dental and Vision Insurance Program -FEDVIP

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a new program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004.

OPM has contracted with several insurance carriers to make supplemental dental and vision benefits available to eligible Federal and USPS employees, annuitants, and their eligible family members.

Dental Insurance

Dental plans will provide a comprehensive range of services, including the following:

- 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 a 24-month waiting period

Please review the dental plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

Vision Insurance

Vision plans will provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Please review the vision plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

What plans are available?

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

Premiums

The premiums will vary by plan and by enrollment type (self, self plus one, or self and family). There is no government contribution to the premiums. If you are an active employee, your premiums will be taken from your salary on a pre-tax basis when your salary is sufficient to make the premium withholding. If you are an annuitant, premiums will be withheld from your monthly annuity check when your annuity is sufficient. Pre-tax premiums are not available to annuitants. For information on each plan's specific premiums, visit www.opm.gov/insure/dentalvision.

Who is eligible to enroll?

Federal and Postal Service employees eligible for FEHB coverage (whether or not enrolled) and annuitants (regardless of FEHB status) are eligible to enroll in a dental plan and/or a vision plan.

Enrollment types available

- Self-only, which covers only the enrolled employee or annuitant;
- Self plus one, which covers the enrolled employee or annuitant plus one eligible family member specified by the enrollee; and
- Self and family, which covers the enrolled employee or annuitant and all eligible family members.

Which family members are eligible to enroll?

Eligible family members include your spouse, unmarried dependent children under age 22, and unmarried dependent children age 22 or over incapable of self-support because of a mental or physical disability that existed before age 22.

When can I enroll?

Eligible employees and annuitants can enroll in a dental and/or vision plan during this open season -- November 13 to December 11, 2006. You can enroll, disenroll, or change your enrollment during subsequent annual open seasons, or because of a qualified life event. New employees will have 60 days from their first eligibility date to enroll.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. BENEFEDS is a secure enrollment website sponsored by OPM where you enter your name, personal information like address and Social Security Number, the agency you work for (or retirement plan that pays your annuity), and the dental and/or vision plan you select. For those without access to a computer, call 1-877-888- FEDS (TTY number, 1-877-TTY-5680). If you do not have access to a computer or a phone, contact your employing office or retirement system for guidance on how to enroll.

You cannot enroll in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

When will coverage be effective?

The new Program will be effective December 31, 2006. Coverage for those who enroll during this year's open season (November 13 – December 11, 2006) will be effective December 31, 2006. Coverage for any other enrollments will be effective on/or after December 31, 2006.

How does this coverage work with my FEHB plan's dental or vision coverage?

Some FEHB plans already cover some dental and vision services. When you are covered by more than one health/dental plan, federal law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered expenses.

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, 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.

Summary of benefits for the High Option of the Kaiser Foundation Health Plan of Colorado - 2007

- **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 Plan physicians, except in emergencies.
- The High Option plan has no deductible except for the dental deductible (see “Dental care” below).

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	\$20 per primary care visit; \$30 per specialty care visit	19
Services provided by a hospital:		
• Inpatient	\$250 per admission	36
• Outpatient	\$100 per visit	36
Emergency benefits:		
• In-area	\$100 per visit	40
• Out-of-area	\$100 per visit	40
Mental health and substance abuse treatment:		
	Regular cost sharing	43
Prescription drugs:		
	\$10 per prescription for generic drugs; \$25 per prescription for brand name drugs, compounded drugs and single source generic drugs	45
Dental care:		
	Various coinsurance levels based on provider and procedure rendered;	54
	\$50 deductible per person and \$150 deductible per family for covered Basic and Major dental services	13
Vision care:		
	One refraction annually; \$20 per office visit	25
Special features: Flexible benefits option; Travel benefit; Services from other Kaiser Permanente or Allied Plans, Student coverage outside the service area		
		48
Protection against catastrophic costs (out-of-pocket maximum):		
	Nothing after \$2,000 per person or \$4,500 per family enrollment per year	14
	Some costs do not count toward this protection	

Summary of benefits for the Standard Option of the Kaiser Foundation Health Plan of Colorado - 2007

- **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 Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the calendar year medical or pharmacy deductible.

Standard Option Benefits	You Pay	Page
Deductible:		
• Covered services	\$500 per person and \$1,500 per family	14
• Pharmacy	\$100 per person	14
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	\$25 per primary care visit, \$45 per specialty care visit	19
Services provided by a hospital:		
• Inpatient	\$250 per day, \$750 maximum per admission	36
• Outpatient	20% of our allowance *	36
Emergency benefits:		
• In-area	20% of our allowance *	40
• Out-of-area	20% of our allowance *	40
Mental health and substance abuse treatment:		
	Regular cost sharing	43
Prescription drugs:		
	\$15 per prescription for generic drugs*; \$35 per prescription for brand name drugs, compounded drugs and single source generic drugs *	45
Dental care:		
	No benefit.	
Vision care:		
	One refraction annually; \$25 per office visit	25
Special features: Flexible benefits option; Travel benefit; Services from other Kaiser Permanente or Allied Plans, Student coverage outside the service area		
		48
Protection against catastrophic costs (out-of-pocket maximum):		
	Nothing after \$2,000 per person or \$4,000 per family enrollment per year Some costs do not count toward this protection	14

2007 Rate Information for Kaiser Foundation Health Plan of Colorado

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable FEHB Guide.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	651	\$141.92	\$62.70	\$307.49	\$135.85	\$167.54	\$37.08
High Option Self and Family	652	\$321.89	\$146.68	\$697.43	\$317.81	\$380.01	\$88.56
Standard Option Self Only	654	\$117.69	\$39.23	\$254.99	\$85.00	\$139.27	\$17.65
Standard Option Self and Family	655	\$269.50	\$89.83	\$583.91	\$194.64	\$318.91	\$40.42